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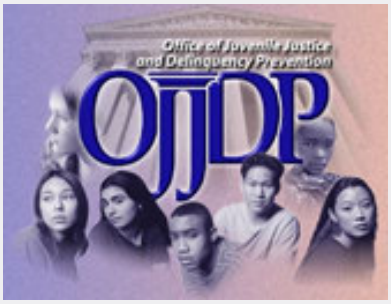
Safe Start Initiative: Demonstration Project

Phase I
Cross-Case Study II
(2006)

Report # 2007 - 1

November 2007



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Committed to building the capacity of organizations and institutions to develop the health, economic equity, and social justice of communities.

Preface

The final case studies of the seven continuing Safe Start sites were developed by the Association for the Study and Development of Community (ASDC) for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) for the national evaluation of the Safe Start Demonstration Project. Together with Volumes I and III of the cross-case report, this volume (II) covers the first six years (2000-2006) of the Safe Start Demonstration Project; please refer to Volume I for a mapping of the accomplishments of Safe Start grantees to the demonstration project's theory of change, and to Volume III for the case study of each site's system of care for children exposed to violence.

We would like to recognize Katherine Darke Schmitt, deputy associate administrator, Child Protection Division; and Kristen Kracke, Safe Start Initiative coordinator and manager, for their leadership and support. ASDC staff contributing to this report include: David Chavis (project director), Yvette Lamb (co-project director), Mary Hyde (deputy project director), Kien Lee (principal associate), Joie Acosta (managing associate), Sonia Arteaga (managing associate), Deanna Breslin (project coordinator), Susana Haywood (associate), Lutheria Peters (associate), Jocelyn Thomas (associate), and Sylvia Mahon (office coordinator).

ASDC also would like to thank the local evaluators and project directors of the seven continuing Safe Start Demonstration Project sites for assistance with their respective case studies. These case studies would not be possible without the collaboration of many people from among the Safe Start Demonstration Project sites, including site partners who were willing to meet with ASDC during site visits.

Bridgeport Safe Start Initiative
Bridgeport, Connecticut

Chicago Safe Start Initiative
Chicago, Illinois

Pinellas Safe Start Initiative
Pinellas County, Florida

Zuni Safe Start Initiative
Pueblo of Zuni, New Mexico

Rochester Safe Start Initiative
Rochester, New York

San Francisco SafeStart Initiative
San Francisco, California

Sitka Safe Start Initiative
Sitka, Alaska

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Executive Summary

Safe Start called for communities to expand, enhance, and adapt existing service delivery systems to fill the gaps for families needing more than one system of support. Structurally these systems of care included multiple community-based partners, which together had the capacity to provide a continuum of care, including early identification of children exposed to violence, referrals to services, intervention and treatment services, and follow-up. This report summarizes the findings obtained from seven individual case studies. Each case study focuses exclusively on the system of care for children exposed to violence established by one local Safe Start initiative. Core evaluation questions used to guide the analysis reported in each case study include:

- Who does what in the system of care for young children exposed to violence, and why?
- What barriers were encountered in developing the system of care for young children exposed to violence?
- What improvements are needed to create a more comprehensive and responsive system of care for young children exposed to violence?

Key findings are outlined below. The findings are organized according to five main categories: 1) identifying, screening, and referring children exposed to violence; 2) intervention and treatment services; 3) increasing service provider capacity to respond to children exposed to violence; 4) challenges associated with establishing a system of care for children exposed to violence; and 5) project accomplishments and contributions to the field of childhood exposure to violence.

Multiple Opportunities to Identify, Screen, and Refer Children Exposed to Violence

Safe Start grantees found that a system of care for children exposed to violence requires the participation of multiple service sectors to identify, screen, and refer children and families. Specifically:

- Multiple points of entry into the service delivery system are needed. All Safe Start grantees created new partnerships with law enforcement through adapting and implementing Child-Development-Community Policing (CD-CP),[1] making the law enforcement sector the most common point of entry established as part of the demonstration project. Partnerships with the health care sector, early childhood educators, and domestic violence centers created additional points of entry.

- Screening procedures and protocols designed specifically for children exposed to violence are needed. Children were identified or screened for violence exposure through: 1) observation/documentation; 2) existing protocols; 3) existing standardized measures; or 4) newly developed standardized measures.

- Children identified as exposed to violence and their families were linked to needed services in one of two ways: 1) referral to a help line or

[1] For a complete description of the Child Development-Community Policing model, visit the National Center for Children Exposed to Violence website (www.nccev.org).

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2) direct referral to a Safe Start service provider or care coordinator.

Integrated Services to Address the Diverse Needs of Children Exposed to Violence and Their Families

Successfully engaging and retaining families in services required the following:

- Services coordinated through multi-sector partnerships. Grantees developed formal service delivery collaboratives and a variety of partnerships among mental health professionals and other sectors were to ensure that families could access needed services more readily.

- Holistic and convenient services sequenced according to family priorities. Families had access to a range of family support services (e.g., child care, housing, employment, medical services), as well as therapeutic interventions.

- Services offered in appropriate locations. Therapeutic and family support services were most successfully delivered to families when offered in credible and convenient locations, such as community-based centers or in the family's home.

Increased Capacity of Service Providers to Respond Appropriately to Children Exposed to Violence and Their Families

To adequately identify, screen, and treat children exposed to violence, a system of care requires a significant training component:

- All grantees provided training to broad audiences, in an effort to increase awareness of children exposed to violence, possible signs of exposure, and resources available in the community to help children and their families;
- Discipline-specific training for non-mental health professionals (e.g., teachers, law enforcement officials) was provided to increase understanding of how violence impacts children and appropriate responses to a child who has been victimized;
- Specialized training (e.g., training on effective therapeutic techniques) was provided to mental health practitioners; and
- All grantees were able to sustain their training efforts beyond federal funding of the Safe Start Demonstration Project.

Challenges Associated with Establishing a System of Care for Children Exposed to Violence

Grantees experienced three common barriers to developing and implementing a system of care for children exposed to violence:

- Political and fiscal instability. Turnover or departure of key public officials stalled system development during the time needed to secure the support of new public officials.

- Limited involvement on the part of key stakeholders. The inability to more fully engage key systems

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responsible for the wellbeing of young children and their families (e.g., schools, community-based health centers, family courts) limited the capacity of the system of care in some sites. Limited involvement may have been an issue because key stakeholders (e.g., court advocates, pediatricians) struggled to establish the supports (e.g., case managers) needed to successfully link families to services once childhood exposure to violence was identified.

- An inability to recruit and retain competent staff. Lack of competent staff limited system scale and scope. Recruitment and retention of such staff were difficult because:
  - At present in the field of child exposure to violence, mental health professionals lack the level of linguistic and cultural competency needed to serve diverse communities;
  - Few clinicians specialize in child development, domestic violence, and therapeutic techniques appropriate for young children, leaving agencies particularly vulnerable to staff turnover; and
  - Law enforcement agencies experience relatively rapid turnover among trained officers.

Project Accomplishments and Contributions to the Field of Child Exposure to Violence

The Safe Start Demonstration Project changed local systems of services and supports to better respond to the needs of children exposed to violence and their families. Safe Start grantees achieved systems change by developing and implementing new policies, procedures, and practices within and across professional disciplines operating within existing service delivery systems. The following accomplishments characterize the work of this demonstration project:

- Sites developed new working relationships across disciplines and a shared community responsibility for children exposed to violence.

- Sites expanded and enhanced community service systems by:
  - Creating new and multiple opportunities to identify, screen, and refer children exposed to violence who, otherwise, would have fallen through the cracks;
  - Integrating services across sectors to address the diverse needs of children exposed to violence and their families and sequencing services according to the unique priorities of each family; and
  - Increasing the capacity of service providers to respond appropriately to children exposed to violence through a variety of training opportunities.

- Sites institutionalized knowledge, skills, and tools for responding to children exposed to violence among service providers and their organizations.

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1. Introduction

Service providers in 11 communities nationwide had the opportunity to build systems of care for children exposed to violence as part of the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Safe Start Demonstration Project. Building systems of care was a primary goal of the demonstration project. Structurally these systems of care included multiple community-based partners, which together had the capacity to provide a continuum of care, including early identification of children exposed to violence, referrals to services, intervention and treatment services, and follow-up. Over the course of the project, seven grantees successfully institutionalized local systems of care for children exposed to violence[2] by enhancing local service delivery systems. Together with Volume I of the cross-case report, this report (Volume II) summarizes the findings obtained from seven individual case studies of Safe Start grantees (available in Volume III).

Each case study focuses exclusively on the system of care for children exposed to violence established by one local Safe Start initiative. Core evaluation questions used to guide the analysis reported in each case study include:

- Who does what in the system of care for young children exposed to violence, and why?
- What barriers were encountered in developing the system of care for young children exposed to violence?
- What improvements are needed to create a more comprehensive and responsive system of care for young children exposed to violence?

This report summarizes the points of entry essential for a system of care for children exposed to violence, including a discussion of who can identify children exposed to violence, who can screen children for the type and severity of violence exposure, and who can effectively refer children to other needed services. Next, service provider partnerships and the integrated services these partnerships facilitate are described. Challenges to creating a comprehensive system of care for children exposed to violence are considered. The report concludes with an overview of the Safe Start Demonstration Project's accomplishments and how they further the field of children's exposure to violence. A brief description of each grantee's system of care for children exposed to violence and its accomplishments can be found in the Appendix.

2. System of Care for Children Exposed to Violence

Central to a system of care for children exposed to violence is the capacity to

[2] According to the Office of Juvenile Justice and Delinquency Prevention, "exposure to violence" means being a victim of abuse, neglect, or maltreatment or a witness to domestic violence or other violent crime (Federal Register Notice, Vol. 64, No. 64/Monday, April 5, 1999, p. 16556). Preliminary analyses of the Safe Start evaluation outcome data indicate that the two most common types of violence exposure identified were "punching/hitting" (20.5%) and "verbal/stalking" (24%) (Association for the Study and Development of Community, 2006, p.7).

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identify this population. All seven Safe Start Demonstration Project grantees created a variety of opportunities for families with young children exposed to violence or at high risk of exposure to access needed services. Grantees most commonly relied upon law enforcement, health care, early childhood, and domestic violence professionals to engage parents/caregivers into needed services for their children and themselves.

Systematically identifying and referring children exposed to violence required the development and implementation of the following policies, procedures, and practices: 1) documenting the presence of children during episodes of violence leading to agency interactions with caregivers in known settings (e.g., at a crime scene, in a domestic violence shelter, in dependency court), 2) incorporating screening questions into existing intake protocols, and 3) using a standardized screening tool (i.e., the Traumatic Events Screening Inventory [TESI]) as part of an intake or assessment protocol. Referral procedures used by grantees included: 1) referral to a help line and 2) direct referral to a Safe Start service provider or care coordinator.

Equally important in a system of care for children exposed to violence is the availability of services capable of meeting the multiple needs of children exposed to violence and their families. Safe Start grantees successfully engaged and retained families in services by creating cross-disciplinary partnerships that facilitated integrated family support and therapeutic services in credible and convenient locations. Mental health professionals partnered with: 1) law enforcement officials, 2) early childhood educators and care providers, 3) domestic violence support specialists, and 4) case managers. Offering a range of family support services (e.g., child care, housing, employment) together with mental health services most effectively addressed the short- and long- term needs of families.

In addition, successful interventions sequenced services to stabilize families and ensure the safety of children and caregivers before beginning mental health services. Bruner's (2006) review of the social service systems reform literature supports the importance of programs founded on family support principles (i.e., strengths-based, family-focused, community-connected programs) for families socially and economically isolated from support networks. Safe Start demonstration sites that achieved greatest overall success in engaging and retaining children and families in services provided an array of services to meet each family's range of presenting needs in a sequence determined by the family's situation and priorities.

Local Safe Start projects created the system capacities for identifying and serving children exposed to violence and their families through extensive training efforts. Grantees identified at least three types of training needed in a system of care for children exposed to violence: 1) training for broad, general audiences; 2) training for non-mental health professionals; and 3) specialized training in therapeutic techniques (e.g., parent-child interaction therapy) for mental health professionals. Grantees institutionalized training on children exposed to violence in their communities

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by incorporating their training materials into existing training schedules and developing train-the-trainer models.

Details from each Safe Start Demonstration Project site, illustrating these common system characteristics, are presented next.

2.1 Multiple opportunities to identify, screen, and refer children exposed to violence

Safe Start grantees found that a system of care for children exposed to violence requires the participation of multiple service sectors. In this section of the report, the most common points of entry into services established by grantees are first summarized. Next, the procedures used by service providers to identify and screen children exposed to violence are described. The section ends with a discussion of the two main types of referral pathways established by grantees to link families to needed services.

Multiple points of entry into the service delivery system. Each grantee developed at least four new points of entry from a variety of service sectors; across all seven grantees, ten new entry points were developed. The most common point of entry developed was law enforcement (police), followed by the health care sector, early childhood educators, and domestic violence centers. Table 1 displays the ten different points of entry and how many sites used each entry point.

Screening procedures and protocols designed specifically for children exposed to violence. Children were identified or screened for violence exposure in one of four ways: 1) interviewing the child/caregiver or observing that the child had been present during a violent event (seen or heard) or had been the direct victim of violence, 2) using non-standardized questions developed by the screening organization, 3) administering an existing standardized tool, or 4) administering a measurement tool developed by the site.

Observation/documentation. Within the law enforcement, domestic violence, and court service systems, children were identified based upon interview or observation. For instance, in Pinellas, any child staying in a domestic violence shelter was assumed to have been exposed to violence. In five grantee communities (Chicago, Rochester, San

Table 1. Key Points of Entry into the System of Care for Children Exposed to Violence

Point of Entry (Service Sector)	Number of Safe Start Sites Using this Point of Entry
Law enforcement	6
Health care	5
Early childhood educators and care providers	5
Domestic violence centers	5
Child protective services/child welfare	5
Courts	4
Help lines	3
Schools	3
Social services	2
Substance abuse centers	2

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Francisco, Sitka, Zuni), when a police officer responded to domestic or community violence, he or she documented the presence of children at the scene, and families were given information about additional family support resources. Within the family and dependency court systems, children also were screened automatically. For example, in Bridgeport and Rochester, all families seen in domestic violence court or family court, respectively, were screened for children's exposure to violence. If violence exposure was identified, the family was referred to Safe Start Services.

Using existing protocols. Four grantees (Bridgeport, Chicago, Pinellas, Rochester) developed questions to identify children exposed to violence and incorporated these questions into existing protocols used by early childhood educators, help line telephone operators, child protective services workers, school-based health care providers, health care workers, and domestic violence advocates. For instance, in Bridgeport, The Center for Women and Families (a domestic violence center) now screens for the effects of violence on children, and mental health consultants in early care settings use a screening form that assesses for violence exposure in the home. In Chicago, the two Safe Start service provider agencies developed three questions about children's exposure to violence and incorporated these questions into their respective intake forms.

Using existing standardized measures. Three grantees (Bridgeport, Pinellas, Zuni) relied on mental health practitioners to screen children using an existing standardized tool, the Traumatic Events Screening Inventory. Standardized measurement tools are advantageous in having been normed on similar populations and having known psychometric properties. On the other hand, standardized instruments such as the TESI have disadvantages, as well, for example, lengthy time to complete or intrusiveness. These disadvantages may be unavoidable, however, when trying to determine the need for assessment for diagnostic purposes (versus screening for referral purposes).

Using newly developed standardized measures. A recognized need for a brief standardized instrument to identify children's exposure to violence led to the development of the Parent Report of Children's Experiences (PRCE). The Rochester and Bridgeport Safe Start grantees collaborated to develop the PRCE, which has 14 items including five questions designed to tap into five domains of potential violence exposure: family, neighborhood, other children, television and movies, and video games. Parents rate children's exposure to violence in each domain using a four-point Likert scale. The remaining nine items tap into symptoms associated with exposure (e.g., sleeping difficulties, headaches, nightmares). The PRCE, tested on 215 children six years and younger, was found to have good psychometric properties; this tool can aid researchers and practitioners to quickly and non-intrusively identify exposure to violence and the presence of several common symptoms.

In summary, Safe Start grantees did not use a single standard approach to identifying and screening children exposed to violence, instead developing

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a variety of identification/screening methods appropriate for their partner providers (e.g., domestic violence specialists, police officers, mental health providers). This led to an increase in the number of individuals recognizing the importance of children's exposure to violence and the number of referrals to appropriate services for these children.

Linking children identified as exposed to violence and their families to needed services. Safe Start grantees developed two main types of referral pathways. The first type of pathway consisted of referral to a help line, then to Safe Start services. For instance, in San Francisco, children identified as exposed to violence by police officers were referred to the Talk Line and then to family resource centers that housed Safe Start services. In Chicago, first responders (e.g., police, fire fighters/emergency medical services) also typically referred families whose children witnessed violence to a domestic violence hotline; the hotline was an established referral mechanism with staff trained to assess safety and risk, as well as refer families to appropriate services, including Safe Start services. The second pathway consisted of referral directly to Safe Start services and other needed services (e.g., development of a safety plan). Court advocates and direct service providers (e.g., domestic violence advocates, social service providers, health care providers) most commonly referred families to a service coordinator or a clinician. For example, in Bridgeport, court advocates referred children exposed to violence to The Center for Women and Families, where children and families received both mental health services and domestic violence support services. Law enforcement officials also referred families directly to a clinician in sites that implemented Child Development-Community Policing programs. Regardless of the type of referral pathway, Safe Start grantees each developed an infrastructure whereby children exposed to violence and their families were referred to appropriate services.

2.2 Integrated services to address the diverse needs of children exposed to violence and their families

As discussed in the previous section, a variety of professionals representing a range of disciplines successfully served as points of entry into local service delivery systems. After initial engagement, families with young children exposed to violence were most successfully linked with and retained in needed services when 1) care was coordinated among service providers and 2) services were sequenced to meet a family's most urgent needs first. Partnerships between mental health professionals and case managers facilitated the integration of family support and therapeutic services, as well as sequencing of services to support all family members and their multiple needs.

Services coordinated through multi-sector partnerships. Two sites (Pinellas, San Francisco) created teams of direct service providers responsible for coordinating case review. In Pinellas, five organizations (comprising the Safe Start Partnership Center) were funded to: 1) identify children exposed to violence, 2) assess and prioritize the needs of these children and their families, and 3) connect families and children to services best meeting their needs in a sequence

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acceptable to the family. In San Francisco, organizations representing seven service delivery sectors (the Service Delivery Team) provided early intervention and treatment for children exposed to violence and coordinated cross-agency activities to ensure child- and family- focused care and treatment for children and their families. As a core function, each of these service delivery structures facilitated case consultation. With confidentiality policies in place, service providers were able to share case information, coordinate services across organizations for families, and utilize their colleagues as resources and sources of support.

Mental health partnerships. In addition to these more formal models of care coordination, Safe Start grantees created a variety of partnerships among mental health professionals and other sectors to ensure ready access to needed services for families. For example, all seven sites created partnerships between law enforcement officials and mental health professionals,[3] allowing families to receive crisis intervention services from a mental health professional at the scene of a crisis or within 24 hours of the crisis event. In three sites (Bridgeport, Pinellas, Rochester), mental health professionals partnered with early childhood educators and care providers, "coaching" these teachers and other adults in early childhood classrooms and child care settings to increase their ability to identify and support children exposed to violence. In Bridgeport, domestic violence advocates and clinicians partnered successfully to provide families with both domestic violence support and therapeutic services. In Rochester, clinicians consulted with foster care workers and provided therapy to a clinical population of young foster children. In all of these examples, service providers worked together to provide families with different types of services more efficiently and in non-traditional settings.

Holistic and convenient services sequenced according to family priorities. In seven sites (Bridgeport, Chicago, Pinellas, Pueblo of Zuni, Rochester, San Francisco, Sitka), licensed clinical social workers or psychologists worked with case managers[4] to provide a range of family support services (e.g., child care, housing, employment, medical services), as well as therapeutic interventions. In Pinellas, a case manager partnered with family advocates to shorten waiting times and engage families in services more rapidly; after the case manager, responsible for addressing basic and immediate family needs, engaged a family, a family advocate could then start addressing therapeutic needs. Therapeutic and family support services were most successfully delivered to families when offered in credible and convenient locations, such as community-based centers (Bridgeport, Chicago, San Francisco) or in the family's home (Bridgeport, Pinellas). Three grantees (Bridgeport, Chicago, Pinellas) developed formal service plans as part of their holistic intervention

[3] Safe Start Demonstration Project grantees adapted and implemented the Child Development-Community Policing program. For a complete description of this model, visit the National Center for Children Exposed to Violence website (www.nccev.org).

[4] Depending on the specific site, this position was called a case manager, a care coordinator, or a family service coordinator.

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services, allowing families' connections to non-therapeutic services to be monitored more systematically.

According to 2006 site visit participants in two sites (Bridgeport, Pinellas), sequencing is a key consideration when providing family support and clinical services in the context of domestic violence. Families experiencing violence require stabilization and safety planning before they can be engaged in a therapeutic process. Case managers typically address stabilization and safety by linking families to services that meet basic needs. After basic needs are addressed, clinicians can then address parents' psychological needs and resources (e.g., empathic ability, depression, substance abuse, general emotional availability to the child). After a parent's clinical needs are addressed, she or he can be engaged in addressing the parent-child relationship, a critical focus of clinical treatment. In addition, according to site visit participants, children must be allowed to express the feelings evoked by exposure to violence and tell their stories of exposure to remove the element of secrecy; to ensure safety and promote healing, children, as well as parents, must be taught strategies to cope with the feelings they identify and experience. Throughout the intervention process, active parental involvement in determining the family's most immediate needs is essential for building the relationships critical to a successful intervention.

2.3 Increased capacity of service providers to respond appropriately to children exposed to violence and their families

To adequately identify, screen, and treat children exposed to violence, a system of care requires a significant training component. Most communities lack public and professional awareness of the negative impact that all violence exposure (i.e., direct and indirect) can have on even the youngest children. Furthermore, knowledge of how to reduce the impact of violence exposure is still emerging. Thus, even with increased awareness of the problem, professionals need guidance on how to intervene effectively with families experiencing violence. To address this need, Safe Start grantees 1) developed educational content to be targeted to broad audiences or specialized professionals and 2) established an infrastructure to sustain training efforts.

Training for broad, general audiences; non-mental health disciplines; and mental health professionals. All grantees provided training to broad audiences, including a variety of service providers, early childhood educators, family advocates, and other individuals who interact with young children. This training sought to increase awareness of children exposed to violence, possible signs of exposure, and resources available in the community to help children and their families. Trainings ranged from brief 15-minute presentations to longer, more in-depth sessions that lasted several hours.

A second type of training offered by grantees was discipline-specific and targeted non-mental health professionals

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such as dependency court judges and law enforcement. For instance, grantees adapted the Child Development-Community Policing model for their local police departments and provided officers with several trainings throughout the course of the Safe Start Demonstration Project. In Rochester, a memorandum of understanding between the police and the Society for the Protection and Care of Children (SPCC) required police to be trained to focus on child safety and to refer children to SPCC social workers. As part of their judicial leadership training, the Spokane grantee trained dependency court judges on children's exposure to violence, with the expectation that judges who started asking more questions about violence exposure would issue more court orders for appropriate services, thereby moving the child welfare system in a positive direction for victimized children.

The third type of training offered by Safe Start grantees targeted mental health practitioners. Two grantees (Bridgeport, Pinellas) provided specialized trainings to this service sector. In Bridgeport, the training initiative was designed to educate mental health professionals in the latest therapeutic techniques (including family and group therapy) to address children's exposure to violence; in Pinellas, clinicians were trained to deliver child-parent therapy and parent-child interaction therapy.

Broad training for general audiences, training for non-mental health disciplines, and specialized training for mental health practitioners all were needed to ensure that a broad representation of the community received education appropriate to their level of interaction with children. General information allowed for service providers and individuals who work with young children to identify and refer children exposed to violence and their families, while training in specific therapeutic techniques empowered mental health professionals to work effectively with this population.

Development of infrastructure to sustain training efforts. All grantees were able to sustain their training efforts beyond Safe Start federal funding, with varying levels of success, in one of three different ways: 1) continued general presentations on children's exposure to violence, 2) trainings and materials on violence exposure incorporated into other training schedules, or 3) a train-the-trainer ("incubator") model to maintain information within the system of care.

In the first type of sustained training, training is expected to continue without formal agreements. For instance, in Zuni and Sitka, Safe Start grantees have made verbal commitments, though no formal agreements, to provide general trainings and presentations on children's exposure to violence to community members and service providers. During the last site visit (2006), participants assured the National Evaluation Team that these presentations would continue to be offered as needed.

For the second type of ongoing training, grantees institutionalized their educational work by creating training materials and/or embedding training within community organizations. For instance, in Bridgeport, service providers will be able to receive training on the impact of domestic violence on children

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through The Center for Women and Families. According to Bridgeport site visit participants, Safe Start provided the opportunity to enhance existing training on domestic violence, allowing Safe Start partners to become recognized in the community as a resource with expertise on this issue. In Rochester, Children's Institute will continue to offer training to the community through the Training in Prevention System. As part of the Early Childhood Mentoring Project, the Rochester grantee developed a mentoring training manual, consisting of materials and procedures for training mentors to educate teachers on how to 1) observe behavioral indicators of exposure to violence, 2) implement action plans to help children exposed to violence, and 3) best use available knowledge and resources. In Chicago, the Department of Public Health will continue to fund two Safe Start positions, including the education coordinator. In Pinellas, the Juvenile Welfare Board will continue to offer resources on children exposed to violence through its own training divisions, as well as through the Safe Start Partnership Center. In San Francisco, the Safe Start training academy will continue to offer educational opportunities to the community.

The Chicago grantee best illustrates use of a unique train-the-trainer model to institutionalize knowledge about children exposed to violence and how best to serve this population. Chicago's "incubator program" infused training on children's exposure to violence into five service systems (Mayor's Office of Domestic Violence, Department of Mental Health, Mayor's Office of Interfaith Leadership Advisory Committee, Illinois Action for Children, and Treatment Alternatives for Safe Communities). Each incubator site was expected to have a network of at least 15 partners, and each site received $30,000 to $50,000 over a period of nine months, with the goal of sustaining Chicago Safe Start services and practices by integrating policies and procedures that address children's exposure to violence into each site and its associated service system.

Regardless of level of formality (e.g., verbal commitment versus funded position) and type of training (i.e., general versus more specialized), all grantees were successful in sustaining their training efforts. The materials developed by Safe Start grantees furthered the professional development of various service providers and the knowledge of others in the community who interact frequently with young children. Additionally, innovative programs such as Chicago's "incubator program" ensured that various service organizations would develop capacity by training staff not only on the issue of violence exposure, but also on the policies and procedures needed to serve exposed children effectively. Collectively, the Safe Start grantee training materials and models prepared individuals and institutions to more effectively identify, screen, refer, and treat children exposed to violence.

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3. Challenges Associated with Establishing a System of Care for Children Exposed to Violence

Volatile political and economic conditions compromised the development and implementation of a system of care in three sites (Bridgeport, Rochester, Zuni). In addition to these broader contextual conditions, the inability to more fully engage key systems responsible for the wellbeing of young children and their families (e.g., schools, community-based health centers, family courts) limited the impact of the system of care in some sites. Finally, recruiting and retaining qualified mental health professionals to serve children exposed to violence was a common challenge for grantees.

Political and fiscal instability can impede system development. The political and fiscal realities of Safe Start communities impacted the development of systems of care for children exposed to violence and their families. Three grantees (Bridgeport, Rochester, Zuni) stated that turnover or departure of key public officials stalled system development during the period of time needed to secure the support of new public officials; in addition, after personnel turnover, funding that may have been intended for services to children exposed to violence and their families might no longer be allocated because of new priorities among the new officials. According to site visit participants in Bridgeport, political corruption in the mayor's office, corruption at the state level, and turnover in the position of police chief slowed Safe Start project momentum. In Rochester, economic decline at the state and local levels required the grantee to turn to a more limited pool of support (e.g., exclusively private sources) for Safe Start interventions. In Zuni, police chief turnover hindered implementation of a key Safe Start service, Child Development-Community Policing.

Limited involvement on the part of key stakeholders curtailed system capacity. Five grantees (Bridgeport, Chicago, Pinellas, San Francisco, Zuni) reported marginal participation of certain key organizations and entities in the system of care developed for children exposed to violence; in these sites, efforts to identify, screen, and treat children and their families would have benefited from greater involvement of schools, other early childhood initiatives, health care centers, family courts, and other jurisdictions. For instance, two grantees (Chicago and San Francisco) reported that the schools should have been a part of the system of care. Chicago stated that they tried to engage the school system, but were not able to penetrate its many layers of policies and regulations.

Limited involvement may have been an issue because it was difficult to find meaningful roles for all stakeholders; a productive role for each stakeholder group is critical if all groups are to be engaged in a system of care for children exposed to violence. For example, in Bridgeport and Rochester, working with families in the context of the court system was a challenge because families in crisis are often focused on the incident that brought them to court, rather than the impact of the incident on the child. Furthermore, families may not disclose violence exposure, for fear that this information may be used to take their

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child away. In addition, court advocates have a high volume of clients, making comprehensive screening and follow-up challenging. As another example, the Bridgeport grantee worked with pediatricians and found that the level of trust and rapport between pediatrician and family is often insufficient for the family to disclose domestic violence and children's exposure. Furthermore, many pediatricians do not have the necessary support staff (e.g., social workers) to make referrals for appropriate services.

An inability to recruit and retain competent staff limited system scale and scope. With limited professional expertise in a community, fewer children and families can be served; grantees experienced several challenges associated with developing the professional expertise needed to identify, screen, and treat children exposed to violence and their families:

- Recruiting culturally competent mental health professionals. Diverse communities such as San Francisco and tribal communities (Sitka, Zuni) required a level of linguistic and cultural competency among mental health professionals that simply does not exist in the field at present. Communities such as Zuni and Sitka, with small professional populations generally, encountered particular challenges in finding culturally competent clinicians willing to relocate or remain in the community.

- Retaining mental health professionals who specialize in issues of children's exposure to violence. Few clinicians specialize in child development, domestic violence, and therapeutic techniques appropriate for young children exposed to violence and their families. Grantees invested substantial resources, therefore, in developing this expertise in their communities, but then struggled to retain the expertise. For instance, in Pinellas, clinicians trained to deliver parent-child interaction therapy eventually left their agencies and often the community. Pinellas now trains clinicians in supervisory roles across multiple agencies, to increase the training of other clinicians (i.e., supervisors' staff) and ensure a continuous presence of trained clinicians in the community.

- Retaining police officers trained in Child Development-Community Policing. Both tribal and urban communities struggled in this regard. For instance, in Zuni, police officers were trained in CD-CP; over time, many trained officers left the Zuni police department. Because new officers have not been trained, only a few officers with training in CD-CP remain. Hence, ongoing training of police is necessary. For example, to ensure consistency in officers' knowledge of children exposed to violence, Chicago developed a video for police officers on how to recognize exposure to violence and refer children to appropriate services. The video is shown repeatedly to officers in Chicago.

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4. Project Accomplishments and Contributions to the Field of Children Exposed to Violence

Through the Safe Start Demonstration Project, seven communities institutionalized local systems of care for children exposed to violence. Practitioners from multiple sectors enhanced local service delivery systems and in the process raised community awareness of children's exposure to violence. Several organizations in demonstration communities now regularly screen children for exposure to violence. Children and their families also are routinely linked with appropriate and accessible services in these communities. Thousands of service providers have been trained and as a result better understand the impact of violence on young children, as well as the resources available to help this population.

Practitioners from multiple sectors can regularly screen children for violence exposure. As seen in the Safe Start sites, multiple sectors that serve families with young children experiencing violence or at high risk of violence exposure can successfully identify and help families access needed services; to do so, local agencies and organizations must develop and implement identification and referral protocols for children's exposure to violence. The demonstrated success of Safe Start sites in identifying children exposed to violence is consistent with Edleson's (2006) argument that a range of community-based service providers is needed to create a system of care for children exposed to domestic violence and illustrates the importance of engaging multiple sectors to identify all forms of childhood exposure to violence.[5]

Integrating and sequencing services retains families experiencing violence. Consistent with social service systems reform literature (Bruner, 2006) and children's mental health system of care principles (Stroul & Friedman, 1996), integrated service delivery designed to be convenient for families facilitates participation in recommended interventions and treatment. Safe Start grantees found that 1) families experiencing violence typically require a range of support services and 2) these services need to be sequenced in a way that prioritizes the safety and protection of children and their caregivers. After safety is established, the family can be stabilized with short- and long- term services, including but not limited to therapeutic services. Support services need to be provided in a way that allows families to fully participate in decisions about what services and supports are most appropriate to meet their needs (Groves & Gewirtz, 2006).

Investing resources in evidence-based programs and staff competency increases service quality. Three grantees invested resources in therapeutic interventions proven to be effective with young children exposed to violence (c.f., Van Horn & Lieberman, 2006) and their families, increasing the quality of services available to this population. Seven grantees invested resources in Child Development-Community Policing and as a result successfully identified children exposed

[5] Edleson uses the term "domestic violence" solely in reference to adult-to-adult domestic violence.

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to violence and referred their families to crisis intervention services. Finally, the resources invested in training materials and models increased the competency of a wide range of practitioners in the community and increased community capacity to identify and respond to children exposed to violence.

Local contextual conditions influenced the form and function of each system, as well as the types of demands placed on each system. Despite characteristics common across grantee systems of care, as summarized in this report, conditions unique to each community affected system development. For example, the urban communities (e.g., Chicago, Pinellas, Rochester, San Francisco) typically had more service providers with greater capacity than did the two tribal communities (Pueblo of Zuni, Sitka). As a result, the tribal communities were more vulnerable to the departure of professionals from the community and to inter-agency competition for relatively scarce resources. As another example, a history of collaboration among service providers in a community (e.g., Pinellas, Rochester) greatly facilitated the development and institutionalization of systems of care. Similarly, communities in which the lead agency for the Safe Start initiative had a long-standing commitment to children's wellbeing, as well as evidence-based programs, experienced the most success with institutionalization efforts (e.g., Pinellas, Rochester). Finally, cultural factors such as historical trauma (Whitback, Adams, Hoyt, & Chen, 2004) and racism presented unique challenges. Overcoming mistrust of mainstream service providers was a challenge in both urban (e.g., Chicago, San Francisco) and tribal communities. Creating interventions appropriate for diverse groups of people was not always feasible due to language and other cultural barriers.

Overall, the Safe Start Demonstration Project successfully established the foundation for a system of care for children exposed to violence by identifying components essential for meeting the multiple needs of this population. Findings from the Safe Start Demonstration Project corroborate current thinking in the field of child exposure to violence and thus contribute to other knowledge-building efforts underway.

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Appendix[6]

[6] Complete reference lists for each site's overview may be found in Report #2007 - 2.

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1. Overview of Bridgeport System of Care

To respond systematically to the needs of children exposed to violence and their families in Bridgeport, The Center for Women and Families contracted with Child FIRST and the Bridgeport Area office of the Department of Children and Families. The Center for Women and Families and Child FIRST also created partnerships with other community-based organizations to create a system of care for this population. Court advocates working for The Center for Women and Families screen children exposed or "at risk" for exposure to family violence and refer them for domestic violence support services as well as clinical mental health services. Women and children living in The Center for Women and Family's Safe House received clinical mental health services from Child FIRST clinicians for one year. Although Child FIRST clinicians are no longer providing clinical mental health service, an in-house staff clinician has continued to provide these services.

Child protection workers at the Department of Children and Families also use a domestic violence screening protocol, provided by The Center for Women and Families, to identify families in which domestic violence is an issue. In addition to the screening protocol, The Center for Women and Families provides consultation and training on domestic violence issues to child protection workers. The training addresses the impact of domestic violence on children and appropriate case planning for families impacted by domestic violence.

In 2006, The Center for Women and Families also partnered with Bridgeport school-based health centers as part of a pilot program funded by the Safe Start grantee. Through this program, children are screened for exposure to violence; if exposure is an issue, intervention and treatment services are provided to the family and child in their home as well as in the school-based center.

Child FIRST provides wrap-around services to children five years and younger at risk for developmental delays for various reasons, including exposure to violence in the home. These services are provided both in Child FIRST's hospital-based center as well as families' homes. To identify children exposed to violence, Child FIRST developed a tool now used in all pediatric settings within Bridgeport Hospital to screen for a variety of developmental issues, including domestic violence exposure. A positive response to the self-administered domestic violence question results in an immediate referral to Child FIRST for further assessment.

Child FIRST clinicians also provide classroom consultation to early childhood educators; care providers; and, in some cases, parents. Classroom consultants utilize a screening form to assess for exposure to violence in the home, and provide services to individual children and groups of children as needed.

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Together these organizations accomplished the following between 2003 and 2006 (Association for the Study and Development of Community, 2006; Bridgeport Safe Start Initiative (BSSI), 2006):

- **818** young children exposed to violence were identified[7] by mental health workers using a standardized tool, court personnel, domestic violence personnel, police, and early childhood educators;
- **454** children and families were assessed for violence exposure using a standard protocol developed by BSSI;[8] and
- **649** children identified as exposed to violence were referred to support services documented in a BSSI family plan.[9]

A Safe Start evaluation outcome database was created as part of the national evaluation. This database includes "exposure to violence" variables (e.g., type of exposure), but this information was not collected consistently across grantees or for all children assessed by BSSI service providers. Specific information about the type of violence exposure was documented for 640 children. Fifty-nine percent of children witnessed (heard and/or saw) a violent event, but were not the intended victim. Seven percent of the children were physically injured as the intended victim of violence. One percent of the children were physically injured, but not the intended victim. For 5% of the children, service providers categorized the violent event to which the child was exposed as "other." For 10% of the children, the type of violence exposure was unknown.

Finally, information about the effectiveness of Child FIRST program services for children exposed to family violence was obtained for a subset of families and children. Three instruments were used to assess children's exposure to violence, trauma-related symptoms, and parent stress. The Traumatic Events Screening Inventory, which was used to screen for exposure to trauma, revealed a statistically significant decrease in the total number of traumatic events experienced by children (N = 82) from baseline to discharge from program services. The Trauma Symptom Checklist for Young Children was used to assess children's trauma-related symptoms, and showed a statistically significant decrease in children's (N = 38) trauma-related symptoms from baseline to discharge (i.e., on the posttraumatic stress intrusion subscale). The Parenting Stress Index, which was used to examine parental (N = 76) stress, indicated a statistically significant decrease in parental stress from baseline to discharge (i.e., on the parental distress subscale and the overall stress scale; Crusto, et al., submitted).

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[7] Each child is "identified" through a report or observation that the child was present during a violent event (heard or seen) and/or has been the victim of a violent event, including child abuse or neglect (Bridgeport Safe Start Initiative, 2006).

[8] Only children with written releases of information are included in this count (Bridgeport Safe Start Initiative, 2006).

[9] Referred services may include services that address the needs of the child and/or the family. This count includes only children with written releases of information who received Safe Start sponsored services (Bridgeport Safe Start Initiative, 2006).

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2. Overview of Chicago System of Care

In the Chicago Safe Start (CSS) system of care for young children exposed to violence, the infrastructure consists of the police department (in the Englewood and Calumet districts[10]), the fire department/emergency medical services (EMS, in the Englewood and Calumet districts), Metropolitan Family Services, and Family Focus.[11] This core structure derives support from the Mayor's Office of Domestic Violence and several community service providers (discussed in more detail in section 1.1). First-responder organizations (e.g., police, fire, EMS) and community providers serve as the points of entry into the Pullman and Calumet service delivery systems; several of these agencies modified their protocols and practices during the Safe Start grant period to better identify children exposed to violence and refer them to appropriate services. The primary service providers for children identified by these agencies are Metropolitan Family Services and Family Focus, both of which provide mental health and family support services.

Chicago Safe Start staff work closely with the local police department to train police officers on how to respond to incidents in which children may have been exposed to violence. Family Focus and Metropolitan Family Services staff receive mandatory 40-hour domestic violence training to better serve children exposed to domestic violence. Furthermore, Chicago Safe Start staff conducts community outreach and training targeting other community service providers to increase overall community capacity to identify children exposed to violence.

Through these efforts, CSS and its partner organizations designed and implemented a system of care for young children exposed to violence that accomplished the following during the Safe Start grant period:

- **1,614** children exposed to violence were identified between 2003 and 2006 (Association for the Study and Development of Community, 2006a; Chicago Safe Start Initiative, 2006a);
- **1,366** children exposed to violence were referred to Chicago Safe Start services between 2004 and 2006 (Chicago Safe Start Initiative, 2006a); and
- **680** children were screened by CSS providers between 2004 and 2006 (Chicago Safe Start Initiative, 2006a).

Information about the effectiveness of Chicago Safe Start services was obtained for a subset of children and their families. Following Chicago Safe Start services, caregivers reported a reduction in trauma symptoms among their children. Therapists reported that caregivers had greater knowledge of the impact of violence on children and were better able to care for themselves and their children following exposure to violence. Therapists also noted that a majority of children had no significant additional exposure to violence after treatment began (Chicago Safe Start Initiative, 2006a).

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[10] The Calumet police district serves four community areas including Pullman.
[11] In 2006, family support and mental health services were combined under one agency and co-located within a health clinic in the Englewood community.

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3. Overview of Pinellas County System of Care

Pinellas Safe Start's centerpiece is the Safe Start Partnership Center, a funded service delivery collaborative comprised of a lead agency (Help-A-Child) and four other subcontracted point-of-service providers (2-1-1 Tampa Bay Cares, The Haven, CASA, and Pinellas County Health Department; each is described in more detail in sections 1.3 and 1.4). During the Safe Start grant period, these five local agencies implemented policies and protocols for the identification and referral of children exposed to violence and their families. Children and families are referred to appropriate services, including the Safe Start intensive family services provided by family advocates at Help-A-Child.

As another component of Pinellas Safe Start, Clearwater Police Department and Directions for Mental Health partnered to implement a modified Child Development-Community Policing (CD-CP) program.[12] Police officers responding to violent incidents document the presence of young children at the scene, and have the option of making a referral (i.e., a Directions for Mental Health clinician follows up with the family within 48 hours) or an immediate call (i.e., the clinician responds to the scene of the call immediately). Clinicians provide consenting families with crisis intervention services as well as referrals for any immediate or longer-term family needs, including longer-term therapy.

As an additional means of identifying children exposed to violence, Coordinated Child Care, the central agency for child care resources and referral in Pinellas County, added a violence exposure screening question to its existing family needs questionnaire. Families that confirm violence exposure are referred to a Safe Start specialist who provides supportive services to parents.

Safe Start resources also were used to bring an evidence-based therapeutic intervention appropriate for young children exposed to violence to clinicians in the community. These new partnerships, policies, practices, and resources were supported by training efforts provided initially by Pinellas Safe Start and sustained by the Juvenile Welfare Board.

Together, the Safe Start Partnership Center, the Child Development-Community Policing program, and Coordinated Child Care accomplished the following between May 2002 and November 2006 (Pinellas Safe Start, 2006a; 2006b):

- **13,921** young children exposed to violence were identified through Safe Start programs;
- **2,990** young children exposed to violence were referred for services; and
- **833** young children exposed to violence were assessed by a Safe Start family advocate, a CD-CP clinician, or the Project Challenge Safe Start consultant, to develop appropriate support and service plans.

[12] For a complete description of the Child Development-Community Policing program, visit the National Center for Children Exposed to Violence website (www.nccev.org).

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Specific information about the type of violence exposure was documented for 441 children.[13] Forty-two percent of children witnessed (heard and/or saw) the violent event, but were not the intended victim. Six percent of the children were physically injured as the intended victim of violence. Three percent of the children were physically injured, but were not the intended victim. For 4% of the children, service providers categorized the violent event to which the child was exposed as "other." The most common type of event within the "other" category was sexual abuse (National Children Exposed to Violence Database).

Finally, information about the effectiveness of Pinellas Safe Start services was obtained for a subset of families and children. Information was collected from families receiving Safe Start services over time (i.e., at the beginning, during, and at the completion of treatment). Families that received Safe Start services reported a statistically significant decrease in overall parenting stress. A comparison group of similar families that did not receive Safe Start services did not report a decrease in parenting stress over time. The size of the comparison group, however, is small; the results should be reviewed with this in mind (Pinellas Safe Start, 2006a, pp.16-20).

4. Overview of Pueblo of Zuni System of Care

To create a system of care for children exposed to violence, Zuni Safe Start created referral procedures now used by nine key organizations and community members to link children exposed to violence to a Safe Start service provider (Association for the Study and Development of Community, 2006a). According to a formal agreement with Zuni Entrepreneurial Enterprise (ZEE),[14] ZEE refers children to Zuni Safe Start and vice versa. Zuni Safe Start also established a formal agreement with the Zuni Public Schools, under which the school system 1) provides space to Zuni Safe Start and 2) allows the Safe Start family service coordinator to meet with her clients at the school. Although Zuni Safe Start partnered with other Zuni organizations (e.g., police department, social services), as well, these partnerships do not rely on formal agreements because all Zuni organizations are considered part of the same governance structure. The following lists the organizations that partnered with Zuni Safe Start and the number of referrals they made to Zuni Safe Start in 2006:

- Pueblo of Zuni Education Career Development Center/Temporary Assistance for Needy Families/General Assistance (5 referrals);
- Pueblo of Zuni Tribal Court (4);
- Pueblo of Zuni Tribal Social Services (4);
- Pueblo of Zuni Police Department (3);
- New Beginning (domestic violence shelter; 3);

[13] A Safe Start evaluation outcome database was created as part of the national evaluation. This database includes "exposure to violence" variables (e.g., type of exposure), but this information was not collected consistently across grantees or for all children assessed by Pinellas Safe Start service providers.
[14] ZEE is a nonprofit 501(c)3 organization that provides services in the Pueblo and elsewhere in southern McKinley County. ZEE assists children three years and younger at risk for or suffering development delays as a result of birth defects, premature birth, or maternal substance abuse.

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- Pueblo of Zuni Public Schools, including Head Start (1);
- Zuni Entrepreneurial Enterprise (0);
- Zuni Recovery Center (0); and
- Indian Health Services Mental Health Services (0).

These agencies make referrals to Safe Start. The Safe Start family services coordinator provides child and caregiver assessment, counseling, and referral services in a holistic and culturally sensitive manner. The family services coordinator also provides regular updates to referring agencies on the status of their referred cases (Association for the Study and Development of Community, 2006b).

During the grant period, Zuni Safe Start accessed national technical assistance sources and used the knowledge acquired to provide local trainings and presentations about the impact of exposure to violence on young children. The family service coordinator continues to provide presentations on the impact of exposure to violence on young children, but no one is currently accessing national technical assistance sources on children's exposure to violence.

5. Overview of Rochester System of Care

Rochester Safe Start embedded resources in existing evidence-based community programs across a comprehensive spectrum of community settings. Universal and targeted interventions provided in these various community settings established a continuum of care for children exposed to violence that includes prevention, early intervention, intervention, and treatment. To increase the focus on child safety among service providers in Rochester, Safe Start resources were used to develop and implement six core interventions designed to bridge gaps and address barriers in the existing service delivery system, as follows:

1. A media campaign aimed at changing community norms and attitudes related to the impact of violence on children was implemented as a universal intervention. To increase the effectiveness of the campaign to reach the entire population (e.g., those that are illiterate, have limited English language proficiency, or do not receive publications used in the campaign), Rochester Safe Start paired the campaign with an outreach coordinator. This intervention is discussed in more detail in last year's case study (Association for the Study and Development of Community, 2006a) and will not be discussed further in this case study[15]

2. The Early Childhood Mentoring Project is a second universal intervention, designed to provide early intervention to all children, including those who may be exposed to violence. Through the project, teachers and other adults in early childhood classrooms and child care settings receive coaching to recognize that

[15] The primary focus of this final case study is the formal system of care established for children exposed to violence.

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difficult child behaviors may be caused by exposure to violence. A mentor manual describes procedures, roles, policies, and continuous training for mentors to help teachers adopt strategies and develop and implement action plans that support children exposed to violence.

3. The Safe Kids program[16] is a partnership between police and social workers designed to provide early intervention to children exposed to violence in the community or home. A memorandum of agreement between the Rochester Police Department and Society for the Protection and Care of Children (SPCC) required that police 1) receive training to focus on child safety and 2) refer children to SPCC social workers, who assess families and help them with safety planning, concrete needs (e.g., shelter, clothing), and the emotional impact of witnessing violence.

4. The Children in Courts program provides families with advocates who understand the impact of exposure to violence on children. These advocates provide legal assistance. Advocates can also arrange for quality child care during court proceedings, as well as supervised visitation between non-custodial parents and children when appropriate.

5. Specialized mental health services are provided by the Mt. Hope Family Center to abused and neglected children placed in foster care. Clinicians at Mt. Hope assess the child and offer consultation to the foster family, child care provider, or other caretakers. When necessary, intensive therapy is provided for this population of children exposed to violence.

6. The Rochester Safe Start training initiative was designed for a range of people who serve children and families, to educate them about the effects of violence exposure and how they can help exposed children. Mental health professionals are educated in the latest therapeutic approaches, including assessment techniques and group and individual therapy. This essential capacity building mechanism will continue through courses and training offered by the Children's Institute.

6. Overview of San Francisco SafeStart System of Care

The San Francisco SafeStart system of care has two distinct components: a management/oversight component and a service delivery component. The Advisory Council and its Steering Committee, which serve as the management component, consist of influential leaders who are well respected in the community and in positions to affect decision-making and policies for agencies participating in San Francisco SafeStart. The Service Delivery Team (SDT) interacts directly with children exposed to violence and their families. Together these components work to address the strategic goals of San Francisco SafeStart: 1) to increase the effectiveness of services by training point-of-

[16] Safe Kids is an adaptation of the Child Development-Community Policing program. For a complete description of this program, visit the National Center for Children Exposed to Violence website (www.nccev.org).

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service providers on how best to respond to children exposed to violence; 2) to prevent childhood exposure to violence by sensitizing the public to the issue; 3) to reduce the impact of exposure by providing early intervention and treatment; and 4) to improve systems by promoting a core set of values, beliefs, and practices for responding to young children exposed to violence. The two-tiered structure of SafeStart not only enables the work of the Service Delivery Team to be coordinated across child- and family- serving agencies, but also has allowed for SafeStart's core principles, policies, and protocols to be institutionalized within the community (Association for the Study and Development of Community, 2006b).

The San Francisco SafeStart Service Delivery Team, made up of point-of-service providers, coordinates early intervention and treatment services for children exposed to violence and their families; in accordance with the core principles of SafeStart, these services are child-centered, family-focused, and community-based. The Service Delivery Team consists of family resource center (FRC) family advocates, SafeStart staff liaisons, the Talk Line coordinator, a domestic violence victim advocate, representatives from Unified Family Court, behavioral health service providers, and child trauma and child development specialists. Batterer's intervention program staff serve as consultants to the team. The team plans and coordinates responses to a child and his/her family to ensure that the child and family receive all support needed (e.g., batterer intervention, treatment, parenting support, and/or shelter) (Association for the Study and Development of Community, 2006b).

Children exposed to violence receive treatment from behavioral health specialists in family resource centers; if the condition is beyond the expertise of these specialists, children may be referred to other clinicians available through the Department of Public Health Behavioral Health Services (DPHBHS) or the Child Trauma Research Project (a joint endeavor of the University of California San Francisco's Department of Psychiatry and San Francisco General Hospital). The Service Delivery Team also provides case conference review and other support to professionals in SafeStart-participating agencies (Association for the Study and Development of Community, 2006b).

During the SafeStart grant period, the Service Delivery Team accomplished the following:

- **1,545** children exposed to violence were identified through SafeStart programs between May 2002 and October 2005;
- **776** children exposed to violence were referred for service between May 2002 and October 2005; and
- **699** children exposed to violence were assessed by SafeStart family resource centers and the Department of Public Health Behavioral Health Services (Association for the Study and Development of Community, 2006c).

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Further, the Service Delivery Team coordinated the following between 2002 and 2005:

- The Talk Line responded to **408 calls** and referred **262 callers** to SafeStart Services; and
- SafeStart family resource centers provided services (e.g., case management, assessment, and treatment) to **185 families** and **367 children** (Association for the Study and Development of Community, 2006c).

7. The Sitka SSI's Local System of Care and Accomplishments

1.1 Points of Entry

The system of care for children exposed to violence established by the Sitka SSI includes eight organizations that now function as points of entry in the service delivery system. The Sitka SSI identified existing service providers in the community and brought them together to develop and implement a system of care for young children exposed to violence. Over time, eight organizations emerged as the primary points of entry into the system of care:

- Sitka Police Department (SPD), representing the law enforcement sector;
- Sitkans Against Family Violence (SAFV), domestic violence sector;
- Sitka Tribe of Alaska (STA) Department of Social Services, social services sector;
- The school district, education sector;
- Sitka Counseling and Prevention Services (SCAPS), substance abuse prevention and treatment sector;
- Early Learning Program, early childhood education sector;
- Office of Child Services (OCS), child welfare sector; and
- South East Alaska Regional Health Consortium (SEARCH Clinic II), tribal health and mental health sectors.

Functioning as points of entry in the service delivery system is natural for many of these organizations because their staff frequently interact with children exposed to violence and their families.

The continuum of care available to children exposed to violence and their families is strongest at the points of identification and referral, as a result of CID-COPS and informal case conferencing. Child Intervention and Development-Community Oriented Policing Services (CID-COPS), an adaptation of the Child Development-Community Policing (CD-CP) program,[17] provides a structure within

[17] For a complete description of the Child Development-Community Policing program, visit the National Center for Children Exposed to Violence website (www.nccev.org).

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which several organizations have enhanced their function as points of entry to the system of care for children exposed to violence. The Sitka Police Department formally documents the number of children exposed to violence identified by police officers. After children exposed to violence are identified, they and their families are referred to various services. Cross-organizational referrals also occur at biweekly case conferences, during which a group of service providers, law enforcement officers, school staff, advocates, and judicial staff voluntarily meet to discuss cases of children's exposure to violence and work together to determine child and family needs. Assessment, intervention, and treatment services are provided by a family advocate and a psychologist; however, these components of the system of care are frequently unavailable to families due to staff turnover and absences from the community.

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