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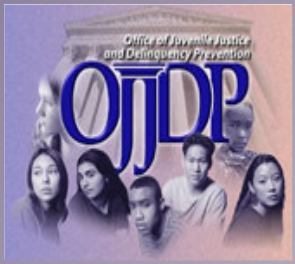
Safe Start Initiative: Demonstration Project

Process Evaluation Report I (2004)

Report # 2005 - 2

September 2005



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PREFACE

This report on the cross-site analysis for year four of the Safe Start Demonstration Project was developed by the Association for the Study and Development of Community (ASDC) for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) for the National Evaluation of the Safe Start Demonstration Project for January through December 2004. This is the first of two volumes on the process evaluation. The second volume contains case studies of all 11 sites.

We would like to recognize Katherine Darke Schmitt, Social Policy Analyst and Safe Start Evaluation Manager for her leadership and support. We would also like to thank Kristen Kracke, Safe Start Program Manager, and Bill Schechter, Consultant with OJJDP, for their assistance. ASDC staff contributing to this volume include: David Chavis (Project Director); Deanna Breslin (Associate); Mary Hyde (Senior Managing Associate); Inga James (Managing Associate); Kien Lee (Senior Managing Associate); Marjorie Nemes (Associate); and Varsha Venugopal (Associate). La'Shaune Barker (Production Manager) and Dale Cassidy (Administrative Assistant) assisted in the production of this volume.

ASDC would like to thank the Project Directors and Local Evaluators of the 11 Safe Start Demonstration sites for their assistance with their respective case studies, which informed the cross-site analysis and this report.

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EXECUTIVE SUMMARY

The Association for the Study and Development of Community (ASDC) conducted a process evaluation for the Safe Start National Evaluation consisting of two parts: 1) an analysis and report of the implementation process across all 11 Safe Start demonstration sites, and 2) a report of each Safe Start demonstration site's implementation process for 2004, except for the Native American demonstration site reports which describe the implementation process from 2002 until 2004 (included in Volume 2, a separate document). This report focuses on the cross-site implementation process findings. Process evaluation findings correspond to the following eight questions that guided the study:

1. What were the milestones reached, goals attained, and other indirect impacts of the Safe Start Demonstration Project in 2004?
2. How did the composition and process of the collaboration in each site influence the types of strategies implemented, and as a result, the system change outcomes?
3. How has the Safe Start Demonstration Project changed the service delivery system for children exposed to violence and their families?
4. What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes) that affected the successful implementation and goal attainment of the local Safe Start initiative in each of the 11 sites?
5. How did each Safe Start demonstration site handle anticipated or unanticipated critical changes at the program level when they occurred?
6. What organizational, point-of-service, and collaboration capacities are required for successful implementation and sustainability of the system changes at each site?
7. What strategies are being used to achieve sustainability in policies, procedures, and practices at each site?
8. What were the lessons learned about the implementation and replication of a national initiative such as the Safe Start Demonstration Project?

Activities, Milestones, Goals, and Service Delivery System Changes

Safe Start demonstration sites were expected to improve the system of care for young children exposed to violence and their families, by implementing a balanced, comprehensive approach, spanning five domains of system change at three levels in the system of care: 1) development of policies, procedures, and protocols; 2) service integration activities; 3) resource development, identification, and reallocation; 4) new, expanded, or enhanced programming; and 5) community action and awareness activities. The discussion of each domain of change explicitly describes the levels at which sites effected change: 1) at the point of service or contact between the individual service provider and the child and his/her family; 2) within the organization, including the organization's policies, operations, and programs; or 3) across organizations in the community, including how two or more organizations share information and work together on common goals.

Development of policies, procedures, and protocols. Safe Start demonstration sites were required to develop and adopt policies, procedures, and protocols to 1) increase the system's capacity to identify, refer, assess, and serve children exposed to violence and 2) reduce the

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impact of that exposure. Sites also were expected to create and support policy change at the local and state levels. The following strategies were most commonly used:

- Creation, development, and/or modifications in organizational policies for identifying children's exposure to violence;
- Creation, development and/or modifications in policies for responding to children exposed to violence;
- Local and state policy development and modification; and
- Adoption of Safe Start curricula by colleges and other agencies.

Service integration. Safe Start demonstration sites were expected to convene existing service providers and facilitate their collaboration to integrate service delivery systems and programs in each community. The most common service integration strategies were:

- Case sharing and management across services and sectors;
- Adaptation and implementation of the Child Development Community Policing (CDCP) model which involves law enforcement officials, mental health service providers, and sometimes domestic violence advocates; and
- Examination of existing case records for children exposed to violence by multiple sectors to develop a coordinated response.

Development, identification, and reallocation of resources. Safe Start demonstration sites were encouraged to develop, identify, and reallocate resources to promote Safe Start. In order to achieve this:

- Local funds were reallocated to support Safe Start goals or related activities; and
- Large grants were applied for and received that support Safe Start related work.

New, enhanced, and expanded programming. In addition to enhancing and expanding existing services, Safe Start demonstration sites also were expected to develop new programming or enhance existing programming to fill service gaps for children exposed to violence. The following strategies were most frequently used:

- Specialized and cross-agency training;
- Expansion of pathway for identifying and referring children exposed to violence and their families;
- Expansion of pathway for assessing and providing services to children exposed to violence and their families; and
- Funds for new staff positions located in other agencies.

Community action and awareness. Throughout the Safe Start Demonstration Project, demonstration sites were required to engage community agencies, systems, and leaders in promoting their local Safe Start vision. All 11 Safe Start initiatives implemented some type of community action or awareness strategy in 2004. The most commonly used strategies were:

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- Development and implementation of public education campaigns;
- Community-wide symposia, conferences, or presentations;
- Strengthened outreach capacity;
- Used public events to promote Safe Start initiatives;
- Used cultural presentations to raise awareness among families; and
- Conducted presentations for specific populations about the impact of exposure to violence on young children.

Local Agency and Community Engagement and Collaboration

One of the primary foci of the Safe Start Demonstration Project is to engage the community through active collaboration. With the exception of the Spokane Safe Start Initiative, which built on an existing and well-established coalition, all the local Safe Start initiatives created new processes and structures for collaboration, some formal, others informal. The most frequently reported partners across the 11 Safe Start demonstration sites were health departments and police departments, followed by mental health services. Emergency Medical Services, faith groups, and the State or City Office of Children Services were the least frequently reported as partners, yet they played a key role in either gaining access to the community or as referral sources.

Implementation of Safe Start Initiatives was facilitated by different factors among the demonstration sites. Furthermore, the relative influence of these factors varied by site. These facilitating factors included:

- Existence of a culture or spirit of collaboration (i.e., positive relationships and history of working together) prior to Safe Start;
- Diversity of sectors represented;
- Formal operating structure;
- Capacity of collaboration leaders or key members to influence and engage other necessary partners;
- Capacity of Safe Start project directors to lead collaboration and cultivate relationships with collaboration members; and
- Participation of agency and organizational representatives with relatively high levels of influence and power.

Implementation of Safe Start Initiatives was hindered by different factors among the demonstration sites. Furthermore, the relative influence of these factors varied by site. These challenges included:

- Limited to no support from local leadership (e.g., elected officials);
- Inadequate relationships with trusted and credible community entry points for children and families (e.g., faith, community leaders);
- Limited to no participation by service sector and professional entry points for families and children (e.g., schools, domestic violence);
- Philosophical differences among partners; and

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- Staff turnover in partner agencies.

External and Internal Changes Affecting the Successful Implementation and Goal Achievement of Safe Start Demonstration Sites

A system change initiative such as the Safe Start Demonstration Project occurs within a larger context. Because such an initiative interacts dynamically with its environment, changes in this larger context—such as gubernatorial elections, budget cuts, and new policies—can affect the initiative in multiple ways.

Each Safe Start demonstration site experienced external changes that affected initiative implementation and goal achievement. Sites most commonly experienced:

- Restructuring of agencies and services participating in Safe Start;
- Budget cuts;
- Turnover in leadership at the agency, city, county, and state levels; and
- Changes in federal and state policies that affected the provision of mental health services.

The primary internal changes that affected the ability of initiatives to achieve their goals were Safe Start staff turnover and the amount of time it took to fill certain key positions, resulting in inadequate staff capacity to 1) build relationships, 2) follow up with partners, and 3) conduct other initiative tasks and activities. Some sites were not fully prepared for these internal changes.

Point-of-Service, Within Organization, and Cross-Organization Capacities

Local Safe Start staff and partners, OJJDP staff, and national technical assistance providers found that it was critical for organizations and point-of-service providers in the system of care for young children exposed to violence and their families to have the following:

- Acknowledgement and commitment to changing the way they have historically thought about or responded to young children exposed to violence and their families;
- Willingness and ability to share confidential information and cases across organizations;
- Willingness and ability to engage in discussion and constructive conflict with other organizations and providers;
- Support for the knowledge and skill development of point-of-service staff;
- Ability to cultivate a learning community within the organization's staff and among its partners;
- Sensitivity and responsiveness to different cultural norms related to family violence;
- Relationships with credible and trusted community institutions and entry points;
- Relationships with other organizations in the system of care for children and families; and
- Specific knowledge and skills to work with young children exposed to violence, including state-of-the-art intervention techniques.

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Local Safe Start staff and partners, OJJDP staff, and national technical assistance providers found the following capacities essential across organizations:

- Understanding of what makes up the system of care;
- A single entity for facilitating cross-organization processes;
- Standard policies, procedures, and protocols for responding to young children exposed to violence and their families;
- Capacity to manage and transform inter-organizational and intergroup conflicts;
- Participation of decision-makers and influential individuals; and
- Structure for attending to process issues and taking action.

Sustainability of System Change Activities

Safe Start demonstration sites demonstrated the following eight indicators of sustainability:

- Improved professionalism and capacity at the point of service through specialized and cross-agency training, train-the-trainer activities, and distribution of educational materials;
- Identification and development of key champions who will help transmit the local Safe Start message;
- Spin-off activities, strategies, and programs related to Safe Start to other organizations;
- Adoption of the Safe Start vision by other agencies and organizations;
- Raising of new funds to support Safe Start or Safe Start-related activities;
- Development of products (e.g., training materials, protocol manuals);
- Mobilization of community residents to commit to sustaining Safe Start goals; and
- Establishment of sustainability committees to develop and monitor sustainability plans.

Significant Learnings

Safe Start demonstration sites reported many key learnings while implementing their initiatives that could benefit sites that are in the middle of their implementation as well as communities that are considering a Safe Start initiative or something similar. The learnings are:

- Initial community conditions that could facilitate implementation of a Safe Start Initiative include an existing culture or spirit of collaboration, agreement that violence and its impact on children is an important issue, sufficient resources and human capital for the adoption and adaptation of appropriate promising practices and interventions, and readiness to implement change strategies;
- It can be useful to set the stage for a local Safe Start Initiative through documented evidence of the nature and prevalence of children exposed to violence and dissemination of this information through a public education campaign;
- Characteristics of collaboration composition and processes that are important for successful implementation of a Safe Start Initiative include engagement of representatives from the professional sector and the community, involvement of

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influential people who could speak authoritatively on the subject and influence others, commitment of members to a reciprocal flow of information, and a sense of shared responsibility for the problem and the solution;
- The ability to manage conflicts that inevitably arise in groups representing multiple interests and cultures;
- Promotion of a learning community among collaboration members;
- Staff require four key capacities, including knowledge of policy development and advocacy, knowledge of service provision, skills for facilitating group processes and transforming conflict, and knowledge of community institutions;
- A family-centered approach to service delivery was more appropriate than individual-based approaches;
- Existing evidence-based interventions needed to be adapted and tailored to each community's context due to varying capacities and context;
- Engaging and retaining families and children in services was a challenge due to factors such as the stigmatization of mental health interventions, distrust of social service and law enforcement agencies, competing family needs (e.g., housing, employment), and language barriers between families and service providers ; and
- Institutionalizing systems change within a five year period is an ambitious goal given the difficulty of discussing community and family violence in the public arena, the invisibility of violence exposure in a young child, and the relatively limited knowledge of appropriate interventions.

Discussion and Conclusion

Common accomplishments and challenges experienced across the demonstration sites include the following.

Accomplishments:

- Brought attention to the impact of exposure to violence among young children in their communities;
- Helped agency directors and point-of-service providers begin to formally recognize and define the system of care for young children exposed to violence;
- Increased the capacity of organizations to respond to young children exposed to violence;
- Enhanced collaboration across sectors;
- Institutionalized changes that will reduce the impact of violence on young children exposed to violence; and
- Improved understanding of organizational, point-of-service providers, and cross-organizational capacities needed to assist young children exposed to violence.

Challenges experienced by most local Safe Start initiatives included:

- Procedures for assessing, treating, and following up with young children exposed to violence and their families were not as well-defined as procedures for identification and referral;

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- Existing interventions had to be adapted to fit the cultural context, especially in native and rural communities and communities with large and diverse immigrant populations;
- A supportive family and community environment was essential, but difficult to establish, for developing and sustaining a system of care for young children exposed to violence and their families; and
- The local Safe Start staff found it challenging at times to operate and manage the collaboration, which involved both policymakers and point-of-service providers.

In this report several challenges were raised for this relatively new area of intervention and treatment. These challenges raise important questions for future investigation and discussion:

1. What different intervention and treatment strategies, if any, are appropriate for children exposed to violence compared to children exposed to any other repeated, severe trauma?

2. What different ways, if any, should children exposed to different forms of violence (e.g., domestic and community) be treated?

3. What are the most effective ways to improve the practice of mental health service providers such that family recruitment, engagement, and retention barriers are reduced?

4. What are the appropriate short-term and intermediate outcomes that should be expected from intervention and treatment strategies for children exposed to violence?

5. How can cultural and philosophical differences and other conflicts among domestic violence, child welfare, law enforcement, mental health and other service systems be most effectively addressed?

6. What are the advantages and disadvantages of immediate and delayed engagement of children and parents in response to exposure to violence?

7. How can the simultaneous tasks of raising community awareness about the impact of exposure to violence on young children and preparing the system to respond to these children's needs be best balanced?

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1. INTRODUCTION

In 1999, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) created the Safe Start Demonstration Project, a demonstration initiative designed to prevent and reduce the impact of violence on children six years and younger, by creating a comprehensive service delivery system in selected communities. To create such a system, communities were expected to expand existing partnerships among service providers in the fields of early childhood education/development, health, mental health, family support and strengthening, domestic violence, substance abuse prevention and treatment, crisis intervention, child welfare, law enforcement, courts, and legal services. As a result, children at high risk of exposure to violence and children exposed to violence (victims of abuse and neglect as well as witnesses to domestic and community violence), along with their families and their caregivers, would benefit from improved service access, delivery, and quality, at any point of entry into the system.

To accomplish these goals, OJJDP expected participating communities to implement a balanced, comprehensive approach, spanning five domains of system change activity: 1) development of policies, procedures, and protocols; 2) service integration activities; 3) resource development, identification, and reallocation; 4) new, expanded, or enhanced programming; and 5) community action and awareness activities. These activities were expected to occur at three levels: 1) across organizations, 2) within organizations, and 3) at the point of service or among front-line service providers for families and children. The logic model for the Safe Start Demonstration Project is shown in Figure 1.

A total of nine communities ("Safe Start demonstration sites") received grants from OJJDP in 2000 to plan and implement a local Safe Start initiative in three phases. During Phase 1 (12 months), Safe Start demonstration sites assessed community conditions and planned local Safe Start activities. In Phase 2 (18 months), the Safe Start demonstration sites began implementation. Finally, in Phase III (36 months), Safe Start demonstration sites worked toward full implementation and sustainability of their initiatives. While sites were not expected to achieve sustainability for all elements of the initiative, they were encouraged to develop, identify, and reallocate local resources to sustain the core goals of the local Safe Start initiative, as well as any systems change they had achieved. Two demonstration sites located in Native American communities—the Sitka Tribe of Alaska and the Pueblo of Zuni—were added in 2002. These sites began their local Safe Start initiatives in 2002, two years later than the other nine demonstration sites.

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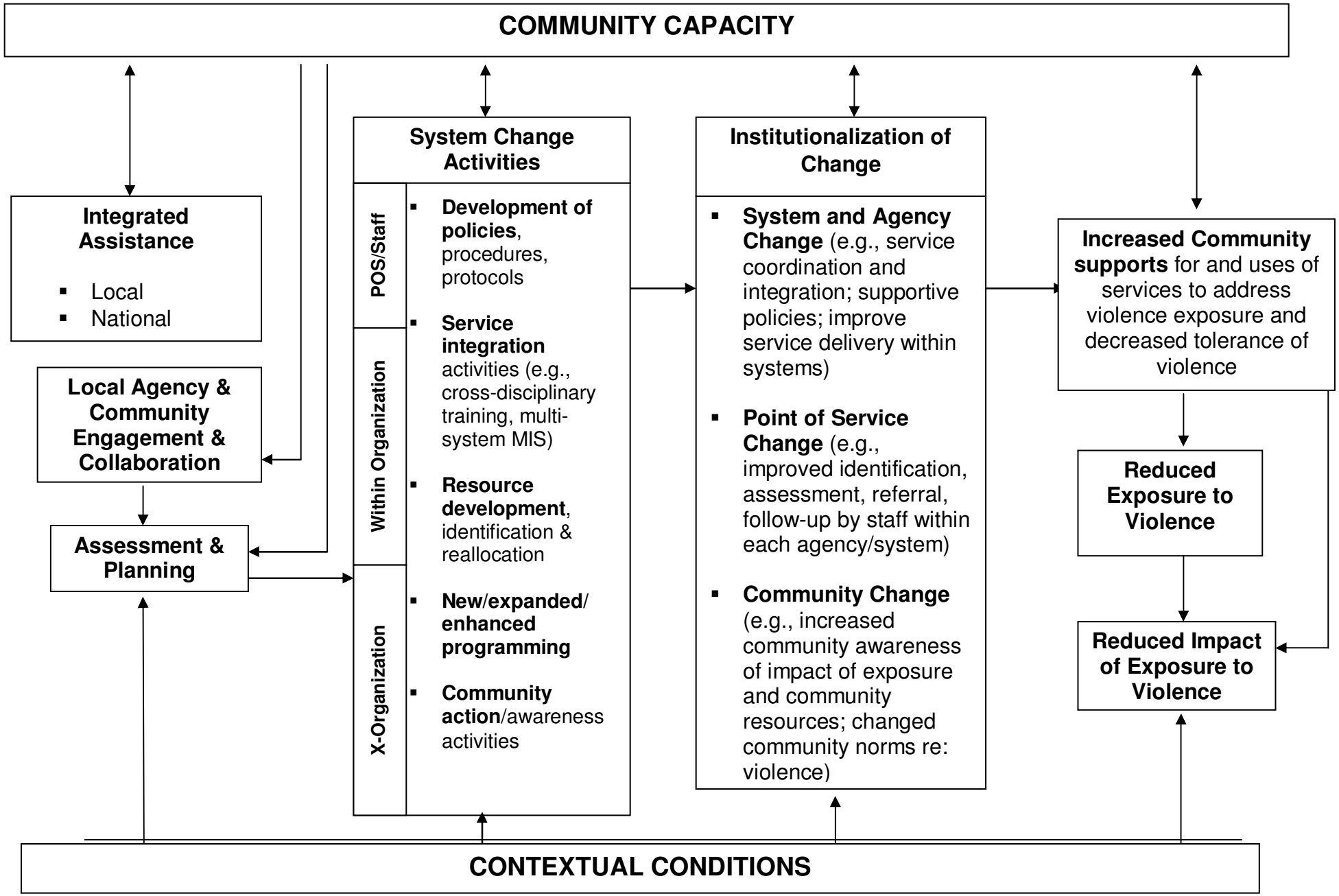
Figure 1: Logic Model for Safe Start Demonstration Project



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1.1 Goals of the National Evaluation

Overall goals. The goals of the Safe Start National Evaluation for the period beginning February 1, 2004, and ending January 31, 2006, are to:

1. Build the capacity of local Safe Start evaluators to design, implement, analyze, and effectively report the results of their evaluations;
2. Collaborate with local Safe Start evaluators to develop 11 case studies using a common framework and data elements for cross-case analysis and knowledge development;
3. Collect and report data on the 11 local Safe Start initiatives, with respect to implementation process and clients served (process evaluation);
4. Build the capacity of all local Safe Start initiative participants to use the information gained through evaluation activities, as well as increase their access to useable information, for the purposes of improving the quality of project implementation and outcomes; and
5. Disseminate knowledge obtained through evaluation activities to national scientific and practitioner audiences.

Process evaluation. This report focuses on the local Safe Start initiatives' implementation process and clients served (Goal 3). OJJDP program staff and project directors of the local Safe Start initiatives generated eight questions for use in the process evaluation:

9. What were the milestones reached, goals attained, and other indirect impacts of the Safe Start Demonstration Project in 2004?
10. How did the composition and process of the collaboration in each site influence the types of strategies implemented, and as a result, the system change outcomes?
11. How has the Safe Start Demonstration Project changed the service delivery system for children exposed to violence and their families?
12. What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes) that affected the successful implementation and goal attainment of the local Safe Start initiative in each of the 11 sites?
13. How did each Safe Start demonstration site handle anticipated or unanticipated critical changes at the program level when they occurred?
14. What organizational, point-of-service, and collaboration capacities are required for successful implementation and sustainability of the system changes at each site?
15. What strategies are being used to achieve sustainability in policies, procedures, and practices at each site?
16. What were the lessons learned about the implementation and replication of a national initiative such as the Safe Start Demonstration Project?

1.2 Approach to the Process Evaluation

The process evaluation for the Safe Start National Evaluation consists of two parts: 1) an analysis and report of the implementation process across all 11 Safe Start demonstration sites, and 2) a report of each Safe Start demonstration site's implementation process for 2004, except

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for the Tribal demonstration site reports which describe the implementation process from 2002 until 2004 (included in Volume 2).

Report of each demonstration site's implementation process for 2004. Each demonstration site report is based on the following information sources:

- Site visits and follow-up telephone calls by the National Evaluation Team (NET) in fall 2004;
- Follow-up telephone calls by the NET at the beginning of 2005, to gather information about additional accomplishments and activities between the time of the NET's site visit and the end of December 2004;
- Review of site materials submitted in 2004, including strategic and implementation plans, progress reports, and any other documents generated by the site; and
- Site evaluator reports on current findings.

During each site visit, the NET met with Safe Start staff; representatives from partner agencies and point-of-service providers; the site evaluator; and community leaders or advocates knowledgeable about the conditions in their community, but not extensively involved in the initiative. These individual were asked to share their experiences with Safe Start from January 2004 to the time of the site visit, focusing their discussion around the eight process evaluation questions listed above. In January and February 2005, the NET followed up by phone with key Safe Start participants, to obtain information about activities, outcomes, or changes that might have occurred between the time of the site visit and the end of 2004.

The two NET members who visited any given site analyzed and coded the data for that site, according to the questions listed in Section 1.1. The NET members then generated a data summary, extrapolating patterns and themes only when two or more independent information sources gave corroborating data. This summary provided the basis for a case study report organized according to the logic model for the National Safe Start Demonstration Project, telling the story of the site's collaboration process in 2004, the activities conducted by the local Safe Start initiative, the systems changes achieved, and the lessons learned by participants. Each site's project director reviewed the preliminary case study report for his/her site, to make comments and provide any additional information. These comments and information were integrated into the final document, as long as two or more information sources were found to corroborate the additional data. Individual Safe Start demonstration site reports are included in Volume 2 of this document.

Cross-site analysis and report. The data summary for each Safe Start demonstration site also provided information for this document. After the two NET members who participated in the site visit coded the data for each site, two other NET members reviewed the coded data, to ensure further consistency, accuracy, and inter-rater reliability in the coding and interpretation, both within-site and across sites. These two NET members then examined the data from all 11 sites, looking for patterns and themes that had emerged in two or more demonstration sites.

In addition, the NET interviewed representatives from OJJDP and from each national technical assistance provider (National Civic League, Systems Improvement Training and

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Technical Assistance Project, National Center for Children Exposed to Violence, and National Council on Juvenile and Family Court Judges). These representatives offered their perspectives on the capacities necessary for organizations, point-of-service providers, and collaborations to achieve Safe Start goals; sustainability of the strategies and changes brought about by each demonstration site; and overall lessons learned. Their insights and lessons were integrated into the relevant sections of this report.

1.3 Organization of Report

This report is organized according to the process evaluation questions listed in Section 1.1. For each question, relevant patterns or themes are described, followed by specific examples from Safe Start demonstration sites.

Section 2 describes the major activities, milestones, and goals attained by Safe Start demonstration sites (Question 1), thereby also explaining how the sites changed the service delivery system for young children exposed to violence and their families (Question 3). The findings are organized according to the five domains of system change: 1) development of policies, procedures, and protocols; 2) service integration activities; 3) resource development, identification, and reallocation; 4) new, expanded, or enhanced programming; and 5) community action and awareness activities. The discussion of each domain of change explicitly describes the levels at which sites effected change: 1) at the point of service or contact between the individual service provider and the child and his/her family; 2) within the organization, including the organization's policies, operations, and programs; or 3) across organizations in the community, including how two or more organizations share information and work together on common goals.

Safe Start demonstration sites were expected to achieve their goals through a collaboration process. Section 3 summarizes the composition and process of the 11 local Safe Start collaborations, through an analysis of their strengths and challenges, and how these strengths and challenges affected strategies and outcomes (Question 2). Section 4 describes both the external changes (e.g., leadership turnover, budget cuts, mental health policy changes) and internal changes (e.g., staff turnover) that affected the successful implementation and goal achievement of Safe Start demonstration sites, along with the ways in which sites handled anticipated and unanticipated changes (Questions 4 and 5).

Through analyzing site activities, collaboration strengths and challenges, and changes, the NET identified the point-of-service, within organization, and cross-organizational capacities reported by local demonstration sites for the successful implementation of a local Safe Start initiative (Question 6). These are described in Section 5.

Section 6 describes the strategies developed or under development to sustain the goals and changes thus far achieved across sites (Question 7). Section 7 reports lessons learned (Question 8). Finally, Section 8 discusses the NET's overall impression of the Safe Start Demonstration Project.

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2. ACTIVITIES, MILESTONES, GOALS, AND SERVICE DELIVERY SYSTEM CHANGES

Safe Start demonstration sites were expected to improve the system of care for young children exposed to violence and their families, by implementing a balanced, comprehensive approach, spanning five domains of system change at three levels in the system of care, as described above. Ultimately it was expected that the demonstration sites will reduce the impact of children's exposure to violence through the institutionalization of system changes achieved using these various strategies.

This section explores the extent to which the 11 demonstration sites implemented strategies across all five domains and at all three levels, as well as the extent to which change and improvement resulted. The first domain of system change activities considered is service integration. Demonstration sites used three primary strategies to integrate service delivery systems and programs in their communities: 1) case sharing and management, 2) adaptation of the Child Development Community Policing model, and 3) examination and follow-up of case records for children exposed to violence. Following the discussion of these strategies is a table that displays the levels at which sites effected change. So for example, the strategy of case sharing and management affected change at the point-of-service, within organization, and cross-organization levels. Examination of case records, however, affected change only within organizations (at the within-organization level).

The section continues with a discussion of strategies used to develop new programming or enhance existing programming to fill service gaps for children exposed to violence (a second domain of system change activities). Demonstration sites used four primary strategies to develop new, enhanced, and expanded programming: 1) specialized and cross-agency training, 2) expansion of identification and referral pathways, 3) expansion of assessment and intervention pathways, and 4) funding new staff positions. Three of these strategies affected change at the point-of-service and within organization system levels. The trainings, depending on the content and structure, affected only one level of change.

Development of policies, procedures, and protocols is the third domain of system change activities discussed in this section. Demonstration sites used five primary strategies (see Table 1) to increase the system's capacity to identify, refer, assess, and serve children exposed to violence and reduce the impact of that exposure. These strategies affected change within organizations and across organizations. Six strategies used by demonstration sites in the domain of community action and awareness (see Table 1) are discussed next in this section. Lastly, two common strategies used by demonstration sites in the domain of development, identification, and reallocation of resources (see Table 1) are described.

Table 1 summarizes the number of demonstration sites where information sources (e.g., partner representatives, staff, site progress reports, site evaluation reports) reported strategies in each of the five domains of system change. Although the local Safe Start initiatives implemented strategies in all five domains, the most frequently reported strategies were in the domains of 1) new, enhanced, and expanded programming and 2) development of policies, procedures, and protocols.

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Strategies for service integration improved the system of care both across and within participating organizations. With the exception of cross-agency training, strategies for new, enhanced, and expanded programming primarily improved capacity at the point of service and within individual organizations. Strategies for developing policies, procedures, and protocols improved the system of care at various levels, as did strategies for community action and awareness. The development, identification, and reallocation of resources improved capacity at the point of service, within organizations, and across organizations.

Table 1. Number of Demonstration Sites Implementing Strategies Within the Five Domains of System Change

Domain and Strategy	***Number of Demonstration Sites***
Service Integration	
Case sharing and management	6
Adaptation and implementation of the Child Development Community Policing model	4
Examination of existing case records for children exposed to violence by sectors other than behavioral and mental health services[1]	2
New, Enhanced, and Expanded Programming	
Training: specialized and cross-agency	11
Expansion of pathway for identifying and referring children exposed to violence and their families	11
Expansion of pathway for assessing and providing services to children exposed to violence and their families	9
Funds for new staff positions located in other agencies	6
Development of Policies, Procedures, and Protocols	
Changes in policies for identifying children exposed to violence	9
Facilitation of state and local policies	7
Changes in policies for responding to children exposed to violence and their families	5
Adoption of Safe Start training curricula by other institutions	5
Development of protocol manuals	2

[1] Examination of previous and existing caseloads by behavioral and mental health agencies was coded as a strategy for expanding identification and referral pathways for children exposed to violence (See section 2.2).

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Domain and Strategy	*Number of Demonstration Sites*
Community Action and Awareness	
Development and distribution of public education materials	7
Symposia and conferences for the professional community	5
Strengthened outreach capacity	6
Use of public events to promote Safe Start	4
Cultural presentations to raise awareness among families	2
Education of special populations	2
Development, Identification, and Reallocation of Resources	
Reallocation of funds	5
Development of new funds	4

2.1 Service Integration

Safe Start demonstration sites were expected to convene existing service providers and facilitate their collaboration to integrate service delivery systems and programs in each community. Case sharing and management (e.g., multidisciplinary teams met to discuss shared cases) was the most common service integration strategy, followed by adaptation and implementation of the Child Development Community Policing (CDCP) model, and examination of existing caseloads for children exposed to violence by agencies in sectors other than behavioral and mental health services (e.g., law enforcement agencies reviewed existing case files for domestic violence incidents during which children were present) .

Case sharing and management. Safe Start initiatives in six demonstration sites improved the management of cases at the client level by sharing confidential client case information across agencies. This was an important system change strategy because multiple individuals representing different organizations are typically involved with children exposed to violence and their families yet there are significant organizational, logistical, cultural, and legal challenges to these individuals sharing confidential information. An inability to share information about these children and their families can result in inadequate care and follow-up. Support for children exposed to violence, therefore, requires a coordinated response among the organizations providing services and information sharing is a critical component of coordinated care.

The organizations involved in these initiatives developed interagency agreements that 1) described their respective roles and responsibilities in the sharing process and 2) established regulations for protecting client confidentiality. The sharing process took on different forms across sites, for example, joint home visits by two organizations that provide different, but complementary, services; regular meetings with clinical experts for case analysis and supervision; and use of technology to improve the management information systems of two or more organizations to enable information sharing.

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Adaptation and implementation of the Child Development Community Policing (CDCP) model. According to the National Center for Children Exposed to Violence (NCCEV), CDCP is a collaboration strategy designed to deliver acute mental health intervention to children and families at risk for psychological trauma, by linking law enforcement and mental health clinicians. Safe Start initiatives in four demonstration sites adopted and adapted this model to suit their community context. The implementation of CDCP in these four sites led to the development of police procedures for documenting the presence of children in violent situations, and referring these children and their families to mental health services. Also in these sites, CDCP enabled coordinated 24-hour crisis response from police officers, domestic violence advocates, and clinicians.

Moreover, by providing a tangible, action-oriented response, CID-COPS, the Sitka Safe Start adaptation of CDCP, motivated collaboration across sectors and between the Native and non-Native communities in Sitka. This collaboration, in turn, led the Sitka Police Department and the Sitka Tribe of Alaska to apply jointly for two grants: *To Encourage Arrest* and *Family Justice Center*. Both grants were awarded, in 2003 and 2004, respectively. Collaboration between non-Native and Native agencies was a *first time* event for the Sitkan community.

Examination of existing case records for children exposed to violence. In 2004, law enforcement partners in two demonstration sites began to examine existing case records for the presence of family violence and children exposed to violence, using dedicated staff members trained to identify cases and follow up appropriately, either with families directly or with the responding officers. This improved the capacity of law enforcement agencies in these communities to support young children exposed to violence and their families, beyond arresting the batterer.

Strategies for Service Integration

Point-of-Service	Within Organization	Cross-Organization
	Examination of existing case records by law enforcement agencies	
Case sharing and management through joint home visits, case analysis meetings attended by agencies in the system of care, and improved management information systems		
Adaptation and implementation of the Child Development Community Policing (CDCP) model		

2.2 New, Enhanced, and Expanded Programming

In addition to enhancing and expanding existing services, Safe Start demonstration sites also were expected to develop new programming or enhance existing programming to fill service gaps for children exposed to violence. In this domain of system change, Safe Start demonstration sites mostly commonly used the strategy of training, followed by the expansion of pathways for identifying, referring, assessing, and providing services to children exposed to

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violence and their families. Several Safe Start demonstration sites also created and supported Safe Start-related staff positions in partner agencies.

Note that adaptation and implementation of CDCP, as well as protocols for case sharing and management (described in Section 2.1 above), also were new programming strategies. In addition, two demonstration sites implemented mentoring programs designed to provide expert consultation and supervision for early childhood educators, to improve the capacity of these educators to assist preschoolers exposed to violence.

Training. Local Safe Start initiatives conducted three types of training: 1) specialized training on early childhood development, brain development, specific therapy methods (e.g., Parent Child Interaction Therapy or PCIT), gathering forensic evidence, and responding to children exposed to violence and their families; 2) cross-sector training, in which representatives from one sector trained providers in another sector; and 3) training on how racism and cultural incompetence can negatively affect the delivery of services to children exposed to violence.

All 11 local Safe Start initiatives provided specialized training to specific professionals, to enhance knowledge and skills for responding to children exposed to violence, thereby expanding the network of qualified service providers available to families. Specialized training improved the system of care at the point of service and within the organizations whose staff received training.

Specialized training was most frequently provided to law enforcement representatives (seven sites), early childhood educators (five sites), parents (five sites), court personnel and attorneys (four sites), child welfare/child protective service workers (four sites), clinicians (three sites), childcare providers (three sites), domestic violence advocates (three sites), and batterers intervention programs (two sites), according to site progress reports and other information sources. Six local Safe Start initiatives used a train-the-trainer approach, in addition to offering general training on issues related to children's exposures to violence. In some cases, initiatives engaged experts to conduct trainings; in other cases, initiatives paid the registration fee for professionals to participate in trainings not sponsored by Safe Start. For instance, Washington County Safe Start instituted a Training Scholarship Program for professionals who work with children six years and younger, awarding 21 scholarships in 2004.

In other unique approaches to training, Chicago Safe Start began production of a video intended to train first responders on how to respond and refer children exposed to violence and their families to Safe Start services, and Washington County Safe Start improved the quality of evidence gathered at scenes of domestic and community violence by purchasing digital cameras and training first responders in their use. Prior to this improved capacity, first responders had gathered largely unusable evidence at scenes of violence, and the community had lacked accessible expertise for improving the use of photography for evidence gathering.

Four local Safe Start initiatives provided cross-agency training. For instance, San Francisco SafeStart co-sponsored its annual 2004 conference with San Francisco Adult Probation, which mandated the attendance of Batterer Intervention Program (BIP) staff. At the

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conference, BIP staff trained family service providers, and a child trauma expert trained BIP staff.

Expansion of pathway for identifying and referring children exposed to violence and their families. In 2004, all 11 local Safe Start initiatives continued to use the sources they had engaged in the past to identify and refer children exposed to violence and their families. Eight initiatives engaged new referral sources as part of their strategy to increase family access to Safe Start services, by 1) expanding services to new geographic areas; 2) training new volunteers to identify and refer children exposed to violence; 3) engaging first responders who had not previously been involved, such as emergency medical services in the Chicago Fire Department and 911 command center; and 4) examining previous and existing caseloads. New referral sources improved the system of care within organizations that adopted these programming changes.

Expansion of pathway for assessing and serving to children exposed to violence and their families. Nine local Safe Start initiatives continued to provide mental health services to children exposed to violence and their families by paying for a certain number of service slots at a local provider; expanding to new geographic areas; contracting directly with a mental health provider; hiring clinicians as part of Safe Start staff; or implementing new assessment tools, such as Ages to Stages, the Parent Stress Index, and the Traumatic Stress Inventory. Local Safe Start staff frequently reported the use of Parent-Child Interaction Therapy or play therapy as their intervention approach on the progress report. Consultant/mentoring programs in the Bridgeport and Rochester Safe Start Initiatives succeeded in keeping children with behavioral problems in school; without this intervention, the children would have been asked to leave and not return.

Number of children identified, assessed, and referred for services. Safe Start demonstration sites were required to report the number of children identified, assessed, and referred for services because of their exposure to violence. These figures were reported twice a year in the site's semi-annual progress report. The Pueblo of Zuni did not report this information for 2004 because the demonstration site just developed the capacity to serve children exposed to violence and their families at the end of the year[2]. The local evaluator for this site, therefore, was excluded from the data verification process described next. In addition, the numbers for Washington County are lower than other sites because they reflect a six month period of service provision and a limited number of service slots.

Figures summarized in Table 2 were extracted from Safe Start demonstration sites' progress reports submitted to OJJDP by the Project Directors and further verified by nine local evaluators. One site did not respond to requests for additional verification. Local evaluators were each sent an email with the sites' figures and a summary of the service pathway and asked to confirm or correct the information. A total of 4,378 children interfaced with Safe Start Initiative services in 2004.

[2] Implementation was on hold pending the completion of this site's planning phase. This site also encountered internal challenges, and it was not until fall 2004 that a Family Service Coordinator and a clinician were hired.

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These data are difficult to compare across sites for various reasons. Most fundamentally, "identified", "assessed", and "referred" were defined differently across the sites[3]. The sequence of each decision point in the service pathway also differed across sites. For example, in some sites "assessed" was defined as a comprehensive mental health assessment conducted by clinicians, whereas in other sites "assessed" meant an initial screening for exposure to violence by family advocates. Alternatively, this initial screening (via an instrument or question on an intake form) was how some sites defined "identified." Finally, "referred" was defined as referred *to* Safe Start Initiative services by some sites, while in other sites, it meant referred *from* Safe Start Initiative services to other services.

As mentioned above, the sequence of each decision point in the service pathway varied across the demonstration sites. In some sites "identified" and "referred" represented a simultaneous decision point, or step, in the service pathway. For example, all children identified by the demonstration site's Safe Start Initiative as exposed to violence were referred to some type of service and therefore these figures were identical when reported in the site's progress reports. Or, in some sites, these figures were identical because if a child were "referred" by a source in the community to the Safe Start Initiative, the child was considered "identified." Alternatively, after the initial step of identification, children and families in some demonstration sites were then referred to the local Safe Start Initiative, assessed for needed services, and then referred to appropriate services. Sites that have this type of service pathway would report the largest numbers earlier in the pathway and lower numbers later in the pathway.

There was no systematic documentation (if any documentation) provided to the NET across demonstration sites with regard to the numbers of children and families who actually received and/or completed services. In some Safe Start demonstration sites such as San Francisco and Pinellas County, assessment and treatment were considered the same activity in the service pathway. One site treated this as a system-level measure and documented the total number of services children and families were referred to and the percentage of services recommended that were received (versus number of children who received services).

Safe Start Initiative services were generally organized according to one of two models. Some sites created a direct service model that typically involved Safe Start clinicians providing case management/family support services and mental health/therapeutic services to children exposed to violence and their families. Other sites created a 'broker' or 'clearinghouse' model that typically involved the coordination of the service system by Safe Start staff and Safe Start-funded staff working within other organizations (e.g., the court, early childhood education settings).

[3] OJJDP acknowledged that the performance measures have known limitations and that the demonstration sites were not provided consistent guidelines regarding the definitions.

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Table 2. Number of Children Identified, Assessed, and Referred for Services in 2004[4]

Safe Start Demonstration Site	# of Children Identified	# of Children Assessed	# of Children Referred
Baltimore City	261	42	38
Bridgeport	231	65	231
Chatham County	122	50	44
Chicago	528	226	528
Pinellas County	1,942	187	746
Rochester	536	536	536
San Francisco	452	264	221
Sitka	55	55	31
Spokane	465	302	465
Washington County	20	20	20
Total	4,378	1,747	2,860

Funds for new Safe Start-related staff positions located in different agencies. Six local Safe Start initiatives used Safe Start funds to support additional staff positions in partner agencies, with the goals of 1) supporting Safe Start activities and 2) ensuring that local Safe Start values will permeate the system of care for children exposed to violence and their families. In Chatham County, for example, the local Safe Start initiative funded a Family Responder position within the Sheriff's Department.

Strategies for New, Enhanced, and Expanded Programming

Point-of-Service	Within Organization	Cross-Organization
Funding for new Safe Start-related staff positions, including point-of-service providers and community outreach liaisons within different agencies in the system of care		
Specialized training on early childhood development, brain development, specific therapy methods (e.g., PCIT), and how to respond to children exposed to violence and their families for point-of-service providers (e.g., clinicians, law enforcement officers, child welfare workers)	Specialized training on early childhood development, brain development, specific therapy methods (e.g., PCIT), and how to respond to children exposed to violence and their families for early childhood educators and court personnel	Cross-agency training
Expansion of pathway for identifying and referring children exposed to violence and their families through engaging new types of first responders, extending to new geographic locations, or continuing to build on existing entry points for families and children		
Expansion of pathway for assessing and providing services through paying for a certain number of slots at a provider, contracting directly with a mental health provider, or hiring new clinicians		

[4] The Pueblo of Zuni is not included in this table for reasons discussed previously.

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2.3 Development of Policies, Procedures, and Protocols

Safe Start demonstration sites were required to develop and adopt policies, procedures, and protocols to 1) increase the system's capacity to identify, refer, assess, and serve children exposed to violence, 2) reduce the impact of that exposure and 3) integrate resources across organizations. For example, when people from different organizations are mandated to work together there is cross-organizational impact. Sites also were expected to create and facilitate policy change at the local and state levels. In this domain of system change, nine local Safe Start initiatives used the strategy of changing organizational policies for identifying children's exposure to violence. In seven demonstration sites, Safe Start staff also participated in or helped facilitate local and state policy changes. These activities, which primarily improved the system of care within and across organizations, have great potential to sustain components of Safe Start beyond the demonstration project. In addition, five revised their policies for responding to children exposed to violence, and Safe Start training curricula were adopted by other organizations in five demonstration sites. Two Safe Start initiatives compiled all of their protocols into a single manual, facilitating replication by other programs and interested parties.

Creation, development, and/or modifications in organizational policies for identifying children exposed to violence. Organizations participating in Safe Start initiatives in nine demonstration sites added at least one question to existing intake protocols to identify children exposed to violence, or made this identification an official part of a staff person's job description. The organizations that made these changes included police departments, domestic violence advocates, child protective services, court advocates, community behavioral health services, victim services, and 911 dispatchers. These policy changes, which will be sustained beyond the Safe Start Demonstration Project, improved the system of care at the point of service, as well as within the organizations that implemented the changes.

Creation, development, and/or modifications in policies for responding to children exposed to violence and their families. Fewer demonstration sites reported changes in policies for responding to (versus changes in policies for identifying) children exposed to violence. This difference may indicate that the majority of sites were in the earliest phase (i.e., identifying children exposed to violence) of implementing changes within the service delivery system in 2004. Alternatively, there are limited assessment and intervention options for this population and therefore some sites may have responded to children exposed to violence and their families in the same manner from the beginning of the demonstration project.

Five Safe Start initiatives developed new policies for assessing and treating young children exposed to violence. These policies affected sectors and agencies such as law enforcement, behavioral health services, social services, and mandated reporters of child neglect and abuse, with the goals of 1) improving procedures for obtaining parental consent for both follow-up and sharing case information with other service providers, 2) reducing time frames between crisis response and follow-up contact with families, and 3) improving the systematic documentation of client progress through the service pathway. In Chatham County, for example, the case management team responsible for coordinating client care adopted a method for ensuring systematic and accurate monitoring of a family's progress over time, in which providers

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select and focus on a single behavioral indicator for each client, and track change in that indicator over time.

San Francisco SafeStart developed eight policies embodying its core values, practices, and beliefs for responding appropriately to children exposed to violence. Throughout 2004, the initiative's advisory committee regularly reviewed and re-approved each policy, to ensure that all policies remained up-to-date; a total of 35 partner agencies reported that they adopted the policies, according to a site evaluation report. This activity improved the system of care at the cross-organizational level. Washington County Safe Start implemented a protocol for interviewing suspected victims of child abuse in a more respectful and less invasive manner. Under the protocol, a single individual trained in forensic interviewing techniques questions the child, collecting information on behalf of all involved parties and investigators. This eliminates the additional trauma that can result when a child interacts with more than one investigator.

Local and state policy development and modification. Seven Safe Start initiatives played a role in state and local policy changes, by taking part in a larger advocacy effort or introducing the issue of children's exposure to violence to policymakers. For instance, through its education and training activities, Chicago Safe Start helped the State of Illinois recognize the impact of violence on young children. As a result, the state modified its policies to enable children under the age of three to become eligible for mental health and family support services. The Pinellas County Safe Start Project Director worked closely with several key agencies to develop an interagency agreement between the domestic violence and child protection sectors, thereby establishing a coordinated community response to domestic violence in families with children. The Pueblo of Zuni Safe Start Initiative mobilized and coordinated revisions to tribal documents that explain agency responsibilities in the community system of care for children and families. The revisions clarified the definitions of child abuse and neglect and emphasized the need for services to be culturally competent and responsive to Zuni traditions.

Finally, Spokane Safe Start staff collaborated with other agencies to challenge the state's decision to centralize all child protective services procedures. Significant problems with centralized intake procedures had been documented by consultants hired by the Governor's office, including time lapses of as many as ten days between intake and response to children in crisis (e.g., acute physical evidence of abuse). In some cases, there was no response at all after intake. Given the mission of Safe Start, staff supported local first responders and service providers in their efforts to ensure the protection of children exposed to violence in Washington and the receipt of appropriate services. Additionally, Safe Start staff was concerned that the centralization would cause local law enforcement officials to inappropriately expect Safe Start to function as the local child protective services agency.

Adoption of Safe Start training curricula. As described in Section 2.2, local Safe Start initiatives offered a range of training opportunities to the professional community. Some training opportunities were brief and designed to raise awareness of and increase knowledge about the issue of children exposed to violence. Other trainings were longer in duration and designed to build specific skills for addressing the needs of children exposed to violence and their families. In five sites, Safe Start training content will be integrated into college curricula or assumed by other agencies as part of their staff training. The State of Maine adopted

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Washington County Safe Start's training curriculum for point-of-service providers and other mandated reporters about their duty to report abuse.

Strategies for Effecting Policies, Procedures, and Protocols

<table>
<tr><td>Point-of-Service</td><td>Within Organization</td><td>Cross-Organization</td></tr>
<tr><td colspan="2">Adoption of Safe Start curricula</td><td rowspan="2">Facilitation of state and local policy changes</td></tr>
<tr><td colspan="2">Changes in policies and procedures for identifying children exposed to violence</td></tr>
<tr><td colspan="3">Changes in policies and procedures for responding to children exposed to violence and their families</td></tr>
<tr><td colspan="3">Development of protocol manuals</td></tr>
</table>

2.4 Community Action and Awareness

Throughout the Safe Start Demonstration Project, demonstration sites were required to engage community agencies, systems, and leaders in promoting their local Safe Start vision. All 11 Safe Start initiatives implemented some type of community action or awareness strategy in 2004. The development and distribution of public education materials were the most commonly used strategy, followed by symposia and conferences for the professional community. Five demonstration sites focused on strengthening their outreach capacity. Four sites used public events to promote their local Safe Start Initiatives. Two demonstration sites used cultural presentations to raise awareness among families and two sites educated specific populations (i.e., batterers and fathers).

Development and distribution of public education materials. Seven local Safe Start initiatives developed and distributed public education materials, such as fact sheets, brochures, flyers, and posters. Chicago Safe Start began production of an animated video and accompanying children's coloring book, designed to raise parents' awareness of the impact of violence on children, the behavioral symptoms of violence exposure, and what parents can do in response.

The public education materials generated by three local Safe Start initiatives promoted specific slogans, in part to promote and "brand" their initiatives. For instance, Pinellas Safe Start used the slogan: "Children Reflect What They See." San Francisco Safe Start placed graphics inside 300 buses, on the rear of 50 buses, and on 30 bus shelters, and received coverage in local newspapers (including Chinese, Spanish, and Korean newspapers). Rochester Safe Start's media campaign received a national award in June 2004.

Symposia and conferences for the professional community. Five local Safe Start initiatives conducted conferences and symposia to raise awareness of children's exposure to violence among the professional community. Three of these five initiatives organized

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conferences for Safe Start staff; volunteers from partner agencies; and a wide variety of professionals, such as substance abuse treatment providers, teachers, judges, and law enforcement workers. These conferences focused on protecting children from violence, as well as on raising awareness of Safe Start and Safe Start services. Spokane Safe Start partnered with the Spokane County Domestic Violence Consortium to hold a conference about batterer intervention, resulting in the establishment of a workgroup to develop treatment for batterers. Spokane did not previously have a batterer intervention program, making this workgroup a *first time* event.

Strengthened outreach capacity. Six local Safe Start initiatives strengthened their outreach capacity in 2004, by 1) hiring a dedicated staff person with sole responsibility for community outreach; 2) developing and supporting a group of parents, to help engage other parents experiencing violence in the home; or 3) distributing mini-grants to community agencies for the education of their clients.

San Francisco Safe Start further developed its Parent Team in 2004. Established in 2003, the Team received a $5,000 grant from the San Francisco First 5 Commission to develop a parent-to-parent outreach and mentoring program that would provide support for individuals transitioning back into their family and community after a violent crisis. Seven parents attended a Team event to receive training on promoting SafeStart and issues related to children and violence. Washington County also used mini-grants to provide the opportunity for Mano En Mano to reach Spanish speaking parents with the Safe Start message about children exposed to violence.

Use of public events to promote Safe Start's goals and raise awareness. Four local Safe Start initiatives took advantage of public events and domestic violence month (October) to promote awareness of children's exposure to violence and Safe Start. Each initiative did this in a unique way. For example, Chicago Safe Start participated in the annual Bud Billiken parade, the largest parade in Chicago, attended by thousands of residents. Chicago Safe Start also partnered with a battered women's network to sponsor a photography exhibit. Displayed in the lobby of the State building during domestic violence month, the exhibit featured the children of Chicago as a way to promote community-wide responsibility for the well-being of all of the city's children.

The Pinellas County Safe Start Project Director threw out the first pitch at a Tampa Bay Devil Rays game. The Devil Rays, one of Florida's major league baseball teams, later sponsored a Safe Start event during their regular season. Washington County Safe Start sponsored a "Walk to End Family Violence" in various locations across the county. Agencies and local businesses sponsored remote radio broadcasts and solicited donations, Safe Start distributed flyers, and newspapers ran advertisements. A total of 300 individuals participated in the walk at multiple locations.

Cultural presentations to raise awareness among families. Safe Start initiatives in the two Native demonstration sites—Sitka and the Pueblo of Zuni—linked cultural traditions and values to Safe Start goals. Sitka Safe Start used the Native tradition of totem pole carving to raise the difficult issue of domestic violence in a more permissible and natural way, and to

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promote healing. Sitka youth told a story about their experience with violence, bringing the issue to the forefront and encouraging several tribal elders to initiate ongoing dialogue with youth about the topic. The Pueblo of Zuni Safe Start Initiative engaged two Zuni leaders, recognized for their cultural knowledge, to present the history and traditions of the Zuni people to families and children. These presentations pointed out that Zuni traditions and values run counter to the pattern of violence that had emerged in the Zuni community. These two activities allowed domestic violence to be publicly discussed or addressed in Sitka and the Pueblo for the *first time*.

Education of special populations. Two demonstration sites conducted activities to raise the awareness of specific populations: batterers in prison in Pinellas County and fathers in Washington County.

Strategies for Community Action and Awareness

Point-of-Service	*Within Organization*	*Cross-Organization (i.e., community wide)*
	Strengthened outreach capacity	Use of public events to promote Safe Start's goals and raise awareness
Symposia and conferences for the point-of-service providers (e.g., substance abuse treatment providers, law enforcement workers)	Symposia and conferences for professions such as teachers and judges	Cultural presentations to raise awareness among families
		Education of special populations (batterers in prison and fathers)
		Development and distribution of public education materials

2.5 Development, Identification, and Reallocation of Resources

Safe Start demonstration sites were encouraged to develop, identify, and reallocate resources to support Safe Start. Five demonstration sites reallocated funds to support Safe Start goals or related activities. Four sites applied for and received large grants to support their safe Start work. These initiatives used these funds to support Safe Start, Safe Start-related work conducted by a single organization, or Safe-Start related work conducted through cross-sector collaboration.

Reallocation of funds to support issues of children exposed to violence. In five demonstration sites, Safe Start and/or partner agencies reallocated funds to support Safe Start goals or related activities. For instance, in Pinellas County, increased awareness brought about by Pinellas Safe Start led the Juvenile Welfare Board to award several grants for activities designed to support young children exposed to violence.

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Development of new funds to support cross-sector collaboration. Four demonstration sites applied for and received large grants to support their Safe Start work. (In one site, the funds were committed in 2004 and will be awarded in 2005.). For the first time, the Sitka Police Department and the Sitka Tribe of Alaska jointly sought and received two grants (*To Encourage Arrest* in 2003 and a *Family Justice Center* grant in 2004), to enable the Sitka Police Department to strengthen its domestic violence unit and assist families experiencing violence. In Baltimore, the House of Ruth, a domestic violence agency and key Baltimore Safe Start partner, was awarded a *Safe and Bright Futures for Children* grant, to be used to continue much of the work that Safe Start initiated in the city. The House of Ruth plans to collaborate with the city's child protective services to develop strategies for improving coordination between the two agencies. San Francisco City and County made a $500,000 annual commitment to Safe Start for the next three fiscal years, after committing a total of $210,000 annually over the past two years.

Strategies for Developing, Identifying, and Reallocating Resources

Point-of-Service	Within Organization	Cross-Organization
	Raised or reallocated funds to support Safe Start goals or related activities	
		Raised new funds to support cross-sector collaboration

3. LOCAL AGENCY AND COMMUNITY ENGAGEMENT AND COLLABORATION

One of the primary foci of the Safe Start Demonstration Project is to engage the community through active collaboration. Safe Start collaborations should include key members of the community involved in children's services, domestic and interpersonal violence, mental health, law enforcement, the judicial system, and other entities that make up the support system for children exposed to violence. The purpose of the collaboration is to ensure the development of a comprehensive service delivery system, to reach all essential parts of the community dedicated to child and family services.

> The most frequently reported partners across the 11 Safe Start demonstration sites were health departments and police departments, followed by mental health services. Emergency Medical Services, faith groups, and the State or City Office of Children Services were the least frequently reported as partners, yet they played a key role in either gaining access to the community or as referral sources.

With the exception of the Spokane Safe Start Initiative, all the local Safe Start initiatives created new processes and structures for collaboration, some formal, others informal. Spokane Safe Start Initiative fell under the guidance of an existing coalition, with a ten-year history of addressing issues related to families and children in the city. Although members described this coalition as "loosely structured," with no chairperson or steering committee, the long-standing trust and relationships among members facilitated the achievement of Safe Start goals. In the other ten

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Safe Start demonstration sites, a small body of decision-makers (typically referred to as the steering committee, executive committee, or management committee) governed the Safe Start collaboration. Working committees, organized according to the main tasks of the Safe Start initiative, supported the small body of decision-makers.

All 11 local Safe Start initiatives engaged representatives from social services, health departments, and mental and behavioral health services in their collaborations. Additional groups engaged to varying degrees in different sites included law enforcement, child protective services, domestic violence, faith, education, and community groups. The participation of these groups depended primarily on their buying into Safe Start goals, their availability of time, and an existing spirit of collaboration (i.e., positive history of working together) within the community.

Collaboration composition across sites is described in more detail in the following paragraphs. For a full description of the organization of the collaboration in each Safe Start demonstration site, please refer to the individual site reports in Volume 2.

3.1 Strengths of Safe Start Collaborations

Safe Start staff and partners most commonly reported collaboration strengths in the following categories:

- Diversity of sectors represented;
- Formal operating structure;
- Capacity of collaboration leaders or key members to influence and engage;
- Capacity of Safe Start project directors to manage, educate, support, and communicate;
- Existence of a culture or spirit of collaboration (i.e., positive relationships and history of working together) prior to Safe Start; and
- Participation of agency and organizational representatives with various levels of influence and power.

These strengths had two common impacts thus far on the demonstration sites:

- For those sites with an existing culture, spirit, or process for collaboration prior to Safe Start, the staff was able to focus relatively more time on program implementation; and
- The Safe Start agenda influenced a wider spectrum of agencies and organizations.

> Safe Start collaborations that engaged a broad range of sectors exerted wider influence over the comprehensive support system for children exposed to violence.

Diversity of sectors represented in the collaboration. The more sectors represented in the collaboration, the more likely it was for a local Safe Start initiative to 1) establish a comprehensive support system for children exposed to violence and 2) have a system-wide effect. Staff and partners of six local Safe Start initiatives reported the diversity of sectors represented on their collaboration as a strength. Diverse collaborations included representatives from the following sectors: police; courts; legal services; domestic violence; social services, including child protective services; health and

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behavioral health services; education; child welfare; and community groups such as neighborhood councils and family resource centers.

Several Safe Start initiatives engaged additional unique members, noteworthy in that they strengthened the ability to reach out to the primary recipients of Safe Start services: families and young children exposed to violence. These unique collaboration members included the faith community in Pinellas County, batterers intervention programs in Washington County and San Francisco, parents in San Francisco, community leaders in the Pueblo of Zuni, and the Sitka Native Education Program and Native youth in Sitka.

A formal structure for operating the collaboration. Collaboration structure and operation varied across sites. Five collaborations had a formal structure, including a chairperson, an executive committee with final decision-making power, and working committees with specific tasks. Staff and partners in these sites viewed their formal collaboration structure as a strength due to:

- Clear roles and responsibilities;
- Clear procedures for making decisions; and
- Breakdown of goals into smaller, manageable tasks conducted by committees and task forces.

> Clarity of goals, roles, and procedures was necessary for smooth operation of the collaboration and, consequently, Safe Start programming. This clarity could be conveyed through a formal or informal collaboration structure.

Only Spokane Safe Start participants considered their lack of formal structure a strength, primarily because the Breakthrough Coalition, which served as the Safe Start collaboration, had always functioned successfully in an informal way.

Capacity of collaboration leaders or key members to influence and engage. Successful implementation of local Safe Start initiatives required that collaboration leaders or key members have the capacity to use their relationships to 1) influence decision makers, 2) make decisions about their organization's policies, 3) communicate effectively with partners, and 4) guide the initiative. Effective key members and leaders, including chairpersons of the collaboration, workgroups, or subcommittees, were often described by participants as "charismatic," "committed," and "influential." By increasing the credibility and visibility of the local Safe Start initiative, these leaders facilitated the engagement of partners and "get[ting] things done." They also knew how to support the knowledge and skill development of point-of-service providers and other staff, within and across organizations, with regard to young children's exposure to violence (e.g., training, symposia). Participants in six Safe Start demonstration sites reported such characteristics as strengths of their leadership, contributing to their collaboration's ability to engage a wide diversity of sectors in the progress report.

> Essential capacities for leaders and key members of an effective Safe Start collaboration were identified as:
> - Ability to build relationships and influence others;
> - Make decisions about their organization's policies;
> - Communicate effectively with partners; and
> - Guide the initiative.

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Essential capacities for Safe Start project directors were reported as:

- Skills in supervising staff and managing and supporting collaboration leaders;
- Skills in navigating the political landscape and systems;
- Ability to educate and engage influential individuals;
- Ability to identify needs and leverage resources
- Knowledgeable about issues related to childhood trauma.

Capacity of Safe Start project directors to manage, educate, support , and communicate. Representatives from partner organizations in six Safe Start demonstration sites reported the project directors' capacity to manage, educate, support, and communicate as a strength. These project directors were described as individuals who have relationships with influential leaders, skilled in navigating the political landscape and systems in their community, able to facilitate relationship and trust building among organizations and leaders in the collaboration, skilled in managing the implementation of the local Safe Start initiative, and knowledgeable about issues related to childhood trauma. More importantly, they had the skills to identify information and other resource gaps, and knew to whom and where to go for assistance in filling the gaps. They also knew how to educate, manage, and support their collaboration leaders to continuously promote shared leadership and responsibility for Safe Start's goals.

Existence of a culture or spirit of collaboration prior to Safe Start. To develop and support collaboration can be challenging, requiring time, trust, and attention to process. The pre-existence of a culture or spirit of collaboration (i.e., past positive experience and history of working together) among organizations in four Safe Start demonstration sites expedited the formation and functioning of Safe Start collaborations, as compared to the remaining seven sites with less experience working collaborationly. In the four sites with a history of collaboration, representatives came to the Safe Start collaboration with knowledge and experience of how to compromise with each other when necessary, allowing them to move forward on other activities during the time it otherwise would have taken to develop a trusting, engaging environment to begin to take action.

An existing collaboration culture or spirit allowed sites to shorten or eliminate the process of building relationships and trust, thereby allowing more time for other Safe Start activities.

Participation of organizational representatives with various levels of influence and power. Five local Safe Start initiatives engaged agency and organization directors and managers on the Safe Start collaboration. These individuals have different levels of influence and power within their home organizations, increasing the potential for sustainability of Safe Start goals. Some of the individuals had decision-making authority; others had relationships with people who had decision-making power. In Chicago, for example, the involvement of the Director of the Department of Public Health resulted in the department's commitment to support three Safe Start staff positions after OJJDP funding ends. San Francisco Safe Start developed a structure to engage persons with decision-making authority and an "alternate" or someone who could influence the decision-makers in their organization. This structure ensured the organization's participation in the collaboration, regardless of turnover in the organization's leadership or among its staff.

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3.2 Challenges for Safe Start Collaborations

Staff and partners in Safe Start demonstration sites reported the following challenges in their collaborations:

- Inadequate relationships with trusted and credible community entry points for children and families (e.g., faith, community leaders);
- Lack of participation by service sector and professional entry points for families and children (e.g., schools, domestic violence);
- Philosophical differences among partners; and
- Staff turnover in partner agencies.

These challenges had the following impacts thus far on the demonstration sites:

- Safe Start services were under-utilized;
- Referrals were lower than expected;
- Cooperation and collaboration among certain agencies were hampered;
- Time was lost in training new staff and orienting new collaboration members; and
- Infusion of Safe Start goals and values into the system of care for young children exposed to violence was limited.

> Lack of Safe Start participation by credible and trusted entry points for families and children resulted in development and implementation of partial support systems only, compromising the potential for a comprehensive service delivery system for children exposed to violence and their families.

Inadequate relationships with trusted and credible community entry points for children and families affected by violence. Staff and partners of six local Safe Start initiatives reported that they did not reach out to and engage community leaders and families as extensively as they ought to have done because they did not have 1) staff persons with strong relations with community-based institutions, such as faith-based, neighborhood, and cultural groups, or 2) staff persons dedicated to the responsibility of community outreach and engagement. These factors resulted in a disconnect between Safe Start activities and the specific challenges and needs of families and children exposed to violence, according to participants who met with the NET. For example, families either lacked knowledge of the local Safe Start initiative, or were skeptical, due to the stigma and fear associated with police involvement, mental health assistance, and/or child protective services. In some communities, for instance, residents in target neighborhoods have learned to be wary of programs developed by outside entities. Past experience with agencies, research groups, and nonprofits have led these neighborhoods to distrust the sincerity of efforts such as Safe Start.

Lack of participation by service sector and professional entry points for families and children exposed to violence. Staff and partners in five Safe Start demonstration sites reported this challenge during this reporting period, which further contributed to the development of an incomplete system for identifying young children exposed to violence and referring these children to Safe Start services. Participants in three sites most frequently reported law enforcement and the courts as missing sectors. Key service sectors and professional

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organizations failed to participate for a number of reasons, including changes in partner organization leadership and staff. Section 4 provides more detail about such external conditions that affected collaboration capacity to achieve the goals of Safe Start.

> Philosophical differences among collaboration partners made it difficult for some organizations to fully engage in Safe Start. At best, these organizations placed representatives on the Safe Start collaboration and supported Safe Start goals, but did not refer their clients to Safe Start services.

Philosophical differences among partners. Staff and partner organization representatives of three local Safe Start initiatives reported philosophical differences among their partners, especially between the domestic violence sector and other service providers. While this challenge did not pose a major barrier to the three initiatives, it did hinder use of the domestic violence sector as a source of referrals. The philosophical differences between domestic violence advocates and other family and child services were historical in nature, arising from past negative experiences and stereotypes they had about each other; Safe Start had limited capacity to transform such deeply entrenched stereotypes and, frequently, misperceptions during the first four years.

Leadership and staff turnover in partner organizations. Local Safe Start initiative staff and partners in four demonstration sites described turnover in the leadership and staff of partner organizations as a challenge because it required Safe Start staff to 1) repeat trainings on an ongoing basis to orient new staff, particularly point-of-service providers, and 2) spend time to continuously build relationships. Leadership turnover occurred because of elections, new appointments, or resignations, which also often led to staff changes.

> Local Safe Start staff had to devote time to ongoing building and rebuilding of relationships, as well as reiteration of goals to orient new leaders and point-of-service providers due to turnover in partner organizations.

4. EXTERNAL AND INTERNAL CHANGES AFFECTING THE SUCCESSFUL IMPLEMENTATION AND GOAL ACHIEVEMENT OF SAFE START DEMONSTRATION SITES

4.1 External Changes

A system change initiative such as the Safe Start Demonstration Project occurs within a larger context. Because such an initiative interacts dynamically with its environment, changes in this larger context—such as gubernatorial elections, budget cuts, and new policies—can affect the initiative in multiple ways.

Each Safe Start demonstration site experienced external changes that affected initiative implementation and goal achievement. Sites most commonly experienced:

- Restructuring of agencies and services participating in Safe Start;

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- Budget cuts;
- Turnover in leadership at the agency, city, county, and state levels; and
- Changes in mental health policies.

These changes had an impact on agencies and sectors essential to each initiative's agenda and collaboration process, including social services, child welfare, law enforcement, and early childhood education.

Restructuring of agencies and services. Participants in seven Safe Start demonstration sites reported the restructuring of agencies and services within the system of care for children exposed to violence. Because the Safe Start initiatives had little control over these changes, the staff had little choice but to spend additional time building relationships and training new staff hired as a result of the restructuring. In some cases, positions were left vacant, requiring the Safe Start initiative to be flexible and continue its work without the participation of certain agencies.

> In some cases, restructuring hindered the ability of the local Safe Start initiative to engage the restructured agencies; in other cases, restructuring created the potential for further improvements to the service pathway for children exposed to violence.

Although it did not have an impact on any of the Safe Start initiatives, an external change worth noting was a federal policy requiring human service agencies to record personal and demographic information about homeless clients, including battered women seeking shelter. In the case of such women, this policy jeopardizes safety from the abuser. Chicago Safe Start staff reported that the domestic violence community in their city had been very busy contesting this policy.

In five sites, the local Safe Start initiatives had difficulty engaging key agencies because of restructuring. The specific changes that presented a challenge were:

- The State of Washington's Department of Social and Health Services decided to centralize most of Child Protective Services, which diminished the decision-making authority of local CPS agencies. Consequently, representatives of CPS did not actively partner with the Spokane Safe Start or engage in the initiative's agenda;
- A 1989 class action suit brought about the 2004 restructuring of the Connecticut State Department of Children and Families, with several rounds of redistricting. The incumbent regional administrator over Bridgeport was transferred to another district, and the new regional administrator was too busy with the departmental changes to participate in the Bridgeport Safe Start;
- The Rochester Police Department restructured from seven to two precincts, and the transition has taken up a lot of time, causing the department to pay less attention to Rochester Safe Start; and
- The merging of behavioral and human services in Washington County decreased the involvement of these agencies' representatives in Washington County Safe Start due to budget cuts.

Staff and partners in four demonstration sites reported that the restructuring of key agencies as potentially positive for improving the referral process for children exposed to violence, for the following reasons: 1) the changes placed more emphasis on a family-support

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approach to assisting children exposed to violence and their families; 2) contracts were awarded to more responsive and competent community-based behavioral health providers and domestic violence agencies; and 3) programs in the system of care were consolidated under a single department, facilitating cross-program collaboration.

Budget cuts. Budget cuts occurred at the state level in nine Safe Start demonstration site states. As a result:

- Safe Start partners such as the Department of Health and Human Services, school districts, and early childhood services became less involved in the initiative;
- Local Safe Start initiatives began to question their ability to sustain Safe Start services in 2005; and
- Funding for behavioral and mental health services for children was reduced because of cuts in federal Medicaid funding.

> Because of budget cuts in nine states, the responsibilities of staff in partner agencies were reprioritized, which frequently led to reduced involvement in the local Safe Start initiative. Funds for services for children exposed to violence were significantly reduced, increasing the importance of Safe Start funds to fill the funding gap, while diminishing the availability of new resources to sustain Safe Start.

Leadership changes in local government and partner organizations. Three Safe Start demonstration sites experienced such changes. In San Francisco, for instance, the election of a new mayor resulted in a new police chief, who hired a new captain for juvenile services. This captain has been supportive of San Francisco Safe Start, resulting in a stronger relationship between the initiative and the police department. In contrast, the incarceration of Bridgeport's mayor and Connecticut's governor during 2004 limited monies available for human services and created a high level of distrust of municipal and state leadership. Spokane Safe Start Initiative had hoped to develop a referral system that included Head Start as a major referral source for young children exposed to violence. However, there was no Head Start director for 18 months until mid 2004 which hampered the inclusion of this agency as a referral source.

Changes in mental health policies. Mental health policy changes in the States of North Carolina and Illinois had the following positive effects on the Safe Start initiatives in Chatham County and Chicago:

- Community mental health clinics are being privatized in North Carolina, creating the potential for Chatham County Safe Start direct service providers to access Medicaid reimbursement as local providers for mental health services; and
- The Illinois Children's Mental Health Act of 2003 was passed, stressing intervention and treatment for all Illinois children from the womb through adolescence. The Chicago Safe Start Initiative played a major role in the passage of this act, which supports the initiative's agenda.

A mental health policy change in the State of Florida had a negative impact on Pinellas Safe Start. Through the House Budget Conforming Bill (HB 1843), the Florida Legislature shifted services and money away from nonprofit community mental health centers to for-profit Health Maintenance Organizations (HMOs). Because of this policy change, families and

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children who receive Medicaid benefits, including those served by Pinellas Safe Start, are now restricted to certain providers and a certain number of treatment sessions.

4.2 Internal Changes

The primary internal changes that affected the ability of initiatives to achieve their goals were Safe Start staff turnover and the amount of time it took to fill certain key positions, resulting in inadequate staff capacity to 1) build relationships, 2) follow up with partners, and 3) conduct other initiative tasks and activities. The sites could not and did not anticipate these internal changes.

Five Safe Start initiatives experienced leadership changes (project directors) in 2002 and 2003, delaying implementation and presenting major challenges that staff and partners continued to feel in 2004. Three initiatives left key positions unfilled for a longer period of time than desired, due to the challenge of finding a qualified person or the need to wait for external leadership changes to occur before making a decision. However, when the new project directors were hired and the key positions were filled, the initiatives progressed quickly. For instance, the new project director of Baltimore City's Safe Start Initiative was able to reengage some of the partners who had become inactive. The hiring of the Family Services Coordinator for the Pueblo of Zuni Safe Start Initiative enabled the Initiative to follow up with its partners to identify young children exposed to violence.

5. POINT-OF-SERVICE, WITHIN ORGANIZATION, AND CROSS-ORGANIZATION CAPACITIES

Analysis of 1) the activities and system changes that occurred as a result of Safe Start initiatives, 2) the role of Safe Start collaborations in the implementation process, and 3) the external and internal changes that affected the initiatives led to the following findings about the capacities required within organizations, across organizations, and at each point of service to achieve Safe Start goals. In addition, the NET asked national partners, including staff from OJJDP and organizations that provided technical assistance to the sites, about essential organizational, point-of-services, and collaboration capacities. Their insights were integrated into the findings.

5.1 Point-of-Service Capacities

Information sources, including staff, representatives from partner organizations, and site progress reports, for the Safe Start demonstration sites repeatedly cited the following essential capacities in their point-of-service providers.

Specific knowledge and skills to work with children six years and younger exposed to violence and their families. Safe Start staff and partners reported that many clinicians did not have the specific knowledge and skills required to work with young children exposed to violence. Consequently, all 11 local Safe Start initiatives had to provide specialized training to

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specific professions. The professionals were made aware of the impact of exposure to violence and trained to identify the symptoms.

Knowledge of state-of-the-art techniques for assisting young children exposed to violence appropriate to their responsibilities in the continuum of care. Many point-of-service providers also did not have knowledge of state-of-the art techniques for assisting young children exposed to violence, according to Safe Start staff and partners. It was important for these providers to develop the appropriate knowledge based on their responsibilities in the continuum of care. For instance, law enforcement officers were trained at some Safe Start demonstration sites to properly question the victim about the presence and location of young children at the scene of the violence. Family advocates at another demonstration site were trained to administer an assessment tool.

Willingness and commitment to gather quality data about families and children. Some of the local Safe Start initiatives found that the quality of data about families and children was not consistent, making it difficult to determine their progress during the treatment period. They emphasized the importance of having point-of-service providers who are willing and committed to gathering quality data in order to ensure a comprehensive service delivery system.

Knowledge of different cultural norms related to family dynamics. Point-of-service providers need to be knowledgeable about different cultural expectations related to family dynamics, gender roles, response to domestic violence, and ways for seeking help, according to Safe Start staff and partners in several demonstration sites that had a diverse population. Without this knowledge, it would be difficult for the point-of-service provider to engage and retain the family in the treatment services.

Critical capacities for organizations and point-of-service providers in the system of care for young children exposed to violence and their families include:

- Acknowledgement and commitment to changing old ways of thinking and practices;
- Willingness and ability to share information and cases across organizations;
- Willingness and ability to engage in discussion and even conflict with other organizations and providers;
- Support for the knowledge and skill development of point-of-service staff;
- Ability to cultivate a learning community within the organization's staff and among its partners;
- Sensitivity and responsiveness to different cultural norms related to family violence;
- Relationships with credible and trusted community institutions and entry points and organizations in the system of care; and
- Specific knowledge and skills to work with young children exposed to violence, including state-of-the-art intervention techniques.

5.2 Organizational Capacities

Based on the information gathered from each Safe Start demonstration site, the following capacities were found to be critical in an organization in the continuum of care for young children exposed to violence and their families.

Understanding the unique needs of young children exposed to violence. The majority of clinicians were not prepared to provide the specialized intervention that young children exposed

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to violence require due to the unique impact of exposure on their psychological and physical development, as discovered by many Safe Start staff and partners. Current support systems, from law enforcement to clinicians, treat young children exposed to violence and their families just as they treat any child with physical and psychological challenges. To improve the quality of care for children exposed to violence and their families, therefore, an organization had to first acknowledge the specificity of the issue and the specialized type of support that these clients require. Only then could the organization's leadership engage in activities to develop and institutionalize procedures, policies, and protocols to improve its services. Organizations that participated in local Safe Start initiatives also had to reflect on how their mission and goals affect assistance to children exposed to violence (e.g., family-centered approach to mental health services vs. placement of child in foster care), and be willing to reconceptualize their role in the overall support system.

Willingness and ability to share information. In order to develop a comprehensive service delivery and support system for young children exposed to violence and their families, the local Safe Start initiatives found that they needed 1) a comprehensive management information system to reduce duplication, increase accessibility to certain providers, and standardize data collection; 2) a process for sharing, discussing, and managing cases across systems, both of which must be regulated by interagency agreements to maintain client confidentiality; and 3) a mechanism for informing families of interagency case sharing and obtaining their consent. The inadequacy of current information systems used to track families and children exposed to violence posed a challenge in all Safe Start demonstration sites.

Willingness and ability to engage in discussion and even conflict with other organizations and providers. The development of a comprehensive system of care for young children exposed to violence and their families could only occur through a collaboration process involving a wide diversity of sectors, including law enforcement, courts, domestic violence, child protective services, substance abuse treatment services, behavioral health services, social services, and grassroots organizations, as demonstrated by all the local Safe Start initiatives. Also demonstrated by several initiatives was a capacity was an organization's ability to engage in discussion and potential conflict with another organization or provider. Without this ability, the development of a comprehensive service delivery system could be hindered. Each organization's decision-makers and point-of-service providers had to be willing to engage conflicting perspectives; seize the opportunity to learn from differences; and combine resources and knowledge to strengthen the collective capacity to assist young children exposed to violence and their families.

Support for point-of-service providers. Because issues related to the impact of exposure to violence on young children are unique, point-of-service providers need the support (time, funds) to attend 1) specialized training about childhood trauma and 2) case management meetings with staff from other provider agencies. Demonstration site visit participants repeatedly emphasized the importance of service providers with knowledge and skills related to responding to children exposed to violence. They also mentioned the usefulness of interagency case management meetings to ensure 1) full understanding of the situation of a particular family and 2) proper follow-up. Some of the local Safe Start initiatives that engaged a clinical supervisor or expert consultant to provide clinical supervision to point-of-service providers

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described the supervision as a critical resource for enhancing the point-of-service providers' capacity to identify, refer, assess, and treat a young child exposed to violence.

A learning community. Given limited baseline knowledge, the local Safe Start initiatives had to develop strategies for transferring knowledge about the impact of exposure to violence on young children to staff in the organizations that are part of the continuum of care. These organizations needed to be able to increase the knowledge of both decision-makers as well as point-of-service providers by adopting train-the-trainer approaches.

Cultural competence. An organization in the continuum of care for young children exposed to violence needed the capacity (resources, access to expertise) to develop staff knowledge of family dynamics and gender roles across cultures, according to staff and partners in culturally diverse Safe Start demonstration sites. Staff must understand the cultural norms that reinforce certain behaviors and responses related to violence. Organizations must be able to provide adequate translation and interpretation services, to avoid retraumatizing children in a family experiencing violence by depending on them to translate for the victim of that violence.

Relationships with credible and trusted community institutions and entry points. Any single service organization could not possibly have in-depth knowledge of every culture represented among its clientele. The local Safe Start initiatives found that they needed to have the capacity to reach out to and engage other individuals and/or organizations that have 1) the necessary intimate knowledge of unfamiliar cultures and their conditions, and 2) credibility with families and children within those cultures. For example, Safe Start demonstration sites hired community organizers or outreach workers; appointed community "ambassadors;" partnered with faith groups; or developed special teams, such as the Parent Team in San Francisco. This same capacity is needed within any organization in the continuum of care.

Relationships with other organizations in the system of care for children and families. The local Safe Start initiatives found that in order to engage partners and develop a cross-agency system for information sharing and case management, participating organizations must have good relationships with each other in the system of care for children and families. The more influential, respected, and credible the organization, the greater its capacity to lead and participate in collaboration across sectors and organizations. The initiatives also worked with organizations in the community to develop memoranda of agreement to spell out their expectations and protocols for working with each other.

5.3 Cross-Organization Capacities

The following capacities were reported by local Safe Start initiatives to be essential across organizations.

A defined system of continuous care. All the organizations that participated in the local Safe Start initiatives did not always have a uniform understanding of 1) the organizations, processes, and structures that define this system; and 2) the service pathway for identifying, referring, assessing, treating, and following up with young children exposed to violence and their families. Local Safe Start staff spent a large amount of time developing and streamlining the

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service pathway, as well as in engaging organizations that were part of the system of care, but were operating independently and providing fragmented services. The batterer, victim, and child receive individualized care; consequently, the context within which they interact was not adequately addressed. Additionally, they may not have received the follow-up support they needed to engage and retain them in services. Local Safe Start staff helped organizations understand their respective role in the system in terms of their specialized knowledge and skills; the critical points at which decisions that affect the child and his/her family are made; the policies, procedures, and protocols that guide this decision-making; their power to facilitate or hinder the provision of services and support; and the resources available to assist them. Such understanding is a capacity required across organizations.

Capacities essential across organizations include:

- Understanding of what makes up the system of care;
- A single entity for facilitating cross-organization processes;
- Standard policies, procedures, and protocols for responding to young children exposed to violence and their families;
- Capacity to manage and transform inter-organizational and intergroup conflicts;
- Participation of decision-makers and influential individuals; and
- Structure for attending to process issues and taking action.

A facilitating entity. Local Safe Start initiatives served as facilitators for developing a comprehensive system of care for young children exposed to violence and their families. As such, they had to 1) identify gaps in the system; 2) facilitate the development and sharing of policies, procedures, and protocols to improve the system's capacity to identify, refer, assess, and treat young children exposed to violence and their families; 3) understand and know how to navigate systems; 4) understand and know how to engage point-of-service providers; 5) be sensitive and responsive to the professional culture across sectors; and 6) have relationships with community institutions and entry points, such as faith groups, neighborhood councils, and community centers. The initiatives also had to establish and work with committees, workgroups, and task forces to focus on and conduct specific activities. A single facilitating entity such as the local Safe Start initiative is a capacity required to initiate or sustain an existing effort to develop a comprehensive system of care for young children exposed to violence and their families.

Standard policies, procedures, and protocols specific to responding to children exposed to violence and their families. Because young children exposed to violence and their families require specialized attention and intervention, local Safe Start initiatives had to develop specific policies, procedures, and protocols for responding uniformly to this special population. These included:

- Intake forms that ask questions and screen for exposure to violence in a way that is mutually useful to the agencies and organizations within the system of care, rather than duplicative;
- Standard forms and procedures for obtaining the family's informed consent for assistance and for information sharing across agencies and organizations;

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- Humane interview procedures that do not retraumatize suspected victims of child abuse by requiring them to interact with multiple investigators; and
- Protocols that specifically assess for violence exposure in young children.

Such policies, procedures, and protocols had to be continuously reviewed and renewed to ensure compliance with the latest requirements for serving young children exposed to violence and their families. The capacities to research, review, and develop these policies, procedures, and protocols are critical for establishing cross-organization collaboration and effecting systems change.

Ability to transform conflicts into strengthened capacity. Engagement of diverse sectors and cultures (across professions and across race and ethnicity) inevitably increased the potential for inter-organizational and intergroup conflict. This challenge, reported by three local Safe Start initiatives, illustrates how important it is for the facilitating entity to have the capacity to manage and transform conflict. None of the local Safe Start initiatives reported specific and effective strategies for addressing the inter-organizational and intergroup conflict that arose in their collaborations. They continued to reiterate to their partners the importance of overall common goal: to reduce young children's exposure to violence and the impact of that exposure.

Participation of decision-makers and influential individuals. Individuals with the power and influence to effect system change within their own organizations were described by five local Safe Start initiatives as their collaborations' asset, making it easier for the infusion of local Safe Start values and goals into various organizations. Participants from the remaining six demonstration sites, along with national partners, also repeatedly cited this capacity as essential to the cross-organization collaboration required to support systems change.

Structure for attending to process issues and taking action. Staff and partners of several local Safe Start initiatives reported that they did not spend enough time in their collaborations on getting to know one another, building relationships, and discussing their differences. On the other hand, some individuals described their collaboration as having a tendency to "talk more than act." In short, action and process must be balanced to develop an effective collaboration across organizations.

6. SUSTAINABILITY OF SYSTEM CHANGE ACTIVITIES

The NET examined the indicators of sustainability developed by the Department of Health and Human Services[5] and Backer (2003).[6] Safe Start demonstration sites demonstrated the following indicators of sustainability:

- Professional and capacity development at the point of service;
- Identification and development of key champions for Safe Start goals;

[5] U.S. Department of Health and Human Services. (2003). *Sustainability self-assessment tool*. Washington, DC: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
[6] Backer, T. (Ed.). (2003). *Evaluating community collaboration*. New York: Springer Publishing Company.

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- Spin-off activities, strategies, and programs related to Safe Start;
- Adoption of the Safe Start vision by other agencies and organizations;
- Raising of new funds;
- Development of products (e.g., training materials, protocol manuals);
- Mobilization of community residents to commit to sustaining Safe Start goals; and
- Establishment of sustainability committees.

Professional and capacity development at the point of service. Through specialized and cross-agency training, train-the-trainer activities, and development and distribution of training materials, all 11 local Safe Start initiatives increased the capacity of point-of-service providers to identify, refer, assess, and assist young children exposed to violence and their families.

Identification and development of key champions for Safe Start goals. In all 11 demonstration sites key champions for the Safe Start vision and goals were identified and engaged. These champions included agency directors, elected officials, appointed leaders, point-of-service providers, and community leaders. These champions will help keep the local Safe Start message alive in a variety of arenas and systems.

Spin-off activities, strategies, and programs related to Safe Start. Seven local Safe Start initiatives spun off their strategies, activities, and programs to other organizations. For example, other groups adopted Safe Start training curricula, new entities were established to address Safe Start-related issues (e.g., a committee to address batterers intervention in Spokane), and law enforcement agencies in Sitka and the Pueblo of Zuni took on responsibility for CDCP.

Adoption of the Safe Start vision by other agencies and organizations. The Safe Start vision permeated other organizations in five demonstration sites through the development of policies for identifying, referring, assessing, and treating children exposed to violence.

Raising of new funds. Grants and new funds were committed or obtained in 2004 to support Safe Start and/or Safe Start-related activities in four Safe Start demonstration sites. Federal, state, and local private sources contributed a total of approximately $2 million to these four sites.

Development of products (e.g., training materials, protocol manuals). Seven local Safe Start initiatives created products with a long "shelf life" that could be replicated and redistributed, such as protocol manuals, training videos and curricula, and posters.

Mobilization of community residents to commit to sustaining Safe Start goals. Local Safe Start initiatives in three demonstration sites educated a group of community residents regarding children's exposure to violence, and mobilized these residents to share their new knowledge with other people in their neighborhoods. The resultant increase in community capacity is a significant Safe Start contribution to each of the target neighborhoods.

Establishment of sustainability committees. Two local Safe Start initiatives established dedicated sustainability committees to develop sustainability strategies.

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7. SIGNIFICANT LEARNINGS

Safe Start demonstration sites reported significant learnings while implementing their initiatives. Some of these learnings could still be helpful to demonstration sites that are in the middle of their implementation (e.g., obtaining assistance for effectively transforming conflicts and promoting a learning community among collaboration members). Other learnings could be helpful to communities that are considering a Safe Start initiative or something similar (e.g., initial contextual and community conditions that help facilitate implementation and the readiness of families and residents to talk about the violence affecting their lives).

7.1 Initial Community Conditions that Facilitate Implementation of a Safe Start Initiative

> Initial community conditions that facilitate implementation of Safe Start activities include:
>
> - Existing culture or spirit of collaboration;
> - Willingness to deal with the issue of violence and its impact on children;
> - Sufficient resources and human capital for the adoption and adaptation of appropriate promising practices and interventions; and
> - Readiness to implement change strategies.

An existing culture or spirit of collaboration. Based on the experiences of the demonstration sites, an existing culture of collaboration within the professional community can facilitate Safe Start efforts. Developing and sustaining a comprehensive system of care is a more feasible goal when various professional sectors, such as mental health services, law enforcement, domestic violence, and child welfare, 1) have pre-existing relationships; 2) understand each other's professional cultures; and 3) are willing and committed to improve their functions, both individually and collectively. The existence of a collaborative spirit also can expedite program development by eliminating the time and effort required to build relationships and trust from the ground up. Those sites without an existing culture and successful experiences were delayed in initiating major strategies until these conditions could begin to be established.

Willingness to deal with the issue of violence and its impact on children. A community must be willing and ready to deal with the issue of violence. Domestic violence can be especially difficult to discuss in the public arena, because of the shame and stigma associated with both the problem and seeking help for the problem. Children's exposure to violence also can be difficult to address, because it is an invisible problem; victims do not display easily identifiable symptoms, nor are they able to speak and advocate for themselves. If the community is not ready to engage in public discussion of children and violence, even the best of services will be underutilized and ineffective.

Sufficient resources and human capital for the adoption and adaptation of appropriate promising practices and interventions. As compared to rural and Native communities, urban communities tend to have more service providers and other readily available resources. In particular, resource-rich communities are likely to have professionals with the education, certification, and licensing necessary to implement mental health interventions that require clinical supervision and specialized training. These communities also tend to have more

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individuals capable of sharing the responsibility and workload of a community initiative. In rural communities, by contrast, geographic spread can hinder access to services, due to long travel distances coupled with lack of public transportation. A dearth of trained, culturally competent professionals was especially problematic in the two Native Safe Start demonstration sites, where the few professionals with higher education degrees tended to be of European ancestry, rather than Native American. Small and rural communities also have fewer individuals to share the responsibility and workload of an ambitious community initiative.

Differential resources demand differential strategies. In resource-rich communities, with large pools of highly trained professionals, tertiary prevention methods may be employed along with primary and secondary methods. Smaller and rural communities, by contrast, should focus on using paraprofessionals to implement primary and secondary strategies, thereby bypassing the need for highly trained and educated professionals. In addition, rural and Native communities should consider adapting key elements of effective therapy models for implementation by paraprofessionals or other available providers or community systems. Strategies and models chosen for use in these communities should examine the protective and risk factors associated with violence, especially family violence, and emphasize ways to increase the protective factors and reduce the risk factors.

Readiness to implement change strategies. While the above conditions—culture of collaboration, willingness to address violence, and resources for adoption and adaptation of promising practices—are not indispensable prerequisites for a Safe Start initiative, they do expedite planning and implementation; if these conditions are not present prior to an initiative, the initiative must devote its initial time and resources to developing them. Whether or not these conditions exist prior to an initiative, they must receive continuous strengthening attention throughout the life of the initiative. Readiness to embark on an initiative like this is an important consideration: without which, extra time and technical assistance needs to be provided.

7.2 A Public Education Campaign Can Be Useful for Setting the Stage for the Local Safe Start Initiative

The right balance between preparing the community to address young children's exposure to violence and organizing the system to respond to the issue has yet to be determined. Several site visit participants reported the importance of devoting resources to the development and implementation of a strong community awareness and public education campaign from the outset. They regretted the relatively late timing of their community outreach and education efforts. A campaign that emphasizes the idea that children are *everyone*'s responsibility in a caring and supportive community could 1) help create a community norm of collective responsibility and 2) educate residents about the Safe Start Initiative, including types of services available, how to access these services, and how to intervene appropriately in a case of suspected or known violence exposure. The campaign could also highlight how violence exposure affects the whole family and the importance of prioritizing the family's well-being.

> Policy makers, community leaders, service providers, first responders, and parents must understand that they are *all* responsible for the well-being of *all* children in their community.

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7.3 Characteristics of Collaboration Composition and Processes that Facilitate Implementation of a Safe Start Initiative

Representatives from both the professional sector and the community must be engaged. The development and sustainability of working relationships among local Safe Start stakeholders required careful attention to group composition, leadership, and dynamics. Ideally, a Safe Start collaboration should reflect the demographics of its community, representing all members of the community who 1) come into regular contact with children six years and younger and 2) have a professional and/or personal responsibility to protect and serve these children.

In practice, local Safe Start collaborations consisted primarily of representatives from various sectors of the professional service provider community, with little or no representation for community-based stakeholders, such as neighborhood association leaders, faith-based organizational leaders, or non-professional caregivers. In addition, each collaboration lacked the participation of at least one key service provider sector (e.g., domestic violence, law enforcement, court personnel, child protection). Limitations in collaboration composition limited the scope of some of the demonstration sites.

A collaboration comprised of influential people was far more likely to accomplish a local Safe Start Initiative's goals. Members of Safe Start collaborations needed decision-making authority and/or the ability to influence others in both their professional and personal environments. They also needed the ability to speak authoritatively on the subject of children exposed to violence, as a result of personal experience and/or professional training. Organizational leaders are in a position to change their organization's policies, while community leaders are in a position to influence their community's norms about violence.

Correspondingly, to reduce the potential impact of political leadership turnover on Safe Start systems change efforts, two layers of leadership must be involved in a Safe Start initiative: 1) high-ranking leaders, including elected officials; and 2) second-tier leaders in the public and private sectors who have influence on decisions made by their superiors. The involvement of leaders in the first group increases the likelihood of policy and system change; the involvement of leaders in the second group helps to ensure continued agency support for Safe Start in the event of first-tier leadership turnover.

Due to the fact that political elections and other factors can affect city, county, or state leadership at any time, Safe Start leaders and staff must allocate resources and time to the ongoing need to educate and build relationships with new leaders. In anticipation of elections, credible and respected individuals in the collaboration should be assigned the responsibility of engaging new leaders.

Collaboration members had to view their participation as creating a reciprocal flow of information. To build investment in a local Safe Start mission and goals, collaboration members needed to make important contributions to the collaboration, as well as derive benefits from their participation. Reciprocal exchange of information among collaboration members required knowledge of others' self-interests, expertise, and culture, both as individuals and as organizational representatives.

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Promote shared responsibility for changing systems of care. The local Safe Start collaborations represented networks of relationships that required mutual trust and a sense of shared responsibility for the well-being of young children exposed to violence. Local Safe Start staff and partners learned that 1) collaboration members needed to be willing to publicly acknowledge the need for systems change and 2) members differed strongly in prioritizing the well-being of perpetrator, victim, and child(ren) in a family experiencing violence. It took a lot of time to address these differences and develop mutually agreeable expectations. Demonstration sites with a foundation of positive relationships among key stakeholders prior to the local Safe Start initiative were in a better position to devote attention to the specific domains of system change.

7.4 Collaborations Require Assistance with Effectively Transforming Conflicts

Safe Start staff had difficulty transforming conflicts that arose from inter-organizational and intergroup differences because 1) they had limited knowledge of conflict transformation techniques and 2) their "insider" status as a member of the collaboration challenged their ability to step back and reflect. Outside technical assistance could have helped staff members anticipate potential conflicts and establish processes for handling conflicts, as it did for some sites.

An initiative designed to serve young children exposed to violence and their families must have the participation of all relevant agencies and sectors. These agencies and sectors typically include: child welfare, law enforcement, domestic violence advocates, behavioral health services, public health services, early childhood educators, childcare providers, court personnel, legal services, batterers intervention programs, and family or parent support groups. Any one of these agencies is likely to conflict with at least one other agency with regard to philosophical approach, professional culture, or values. In particular, the goals of a local Safe Start initiative inevitably surface the differences among domestic violence advocates, batterers intervention programs, and child protective services, which, respectively, focus on the victim (typically the woman), the batterer (typically the man), and the child(ren) in a family experiencing violence. Existing or historical negative relationships among these groups can lead to stereotyping, fear, and hostility, hindering collaboration and the development of a comprehensive system of care.

In addition, large established agencies in the public sector tend to differ from small grassroots community organizations with regard to professional culture. Large public agencies may have greater resources, but a less personal connection to their clients and, therefore, less knowledge their clients' needs. Small grassroots groups may have fewer resources; a volunteer workforce; and feelings of frustration toward their larger counterparts, who receive more funding despite their lack of connection to service recipients. Nevertheless, both types of organizations play an integral role in the system of care for young children exposed to violence.

> Conflict typically arose as a result of three types of differences: differences among agencies and professions in the system of care for young children; differences between large established agencies and small community organizations; and differences among agency and organization representatives of different racial, ethnic, and cultural backgrounds.

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Differences in race, ethnicity, and culture among representatives in the collaboration also require attention. In some communities, decision-makers and service providers are primarily of European descent, while community leaders and service recipients tend to be people of color. Because differences among these groups can affect communication, interaction, and strategy development, techniques must be implemented to build understanding across race, ethnicity, and culture. Building awareness and knowledge of institutionalized and structural racism are particularly important, because of the system change nature of a Safe Start initiative.

Participating agencies and organizations, therefore, must establish and agree upon a process for addressing tensions and conflicts that may arise due to their differences. The engagement process should include strategies to help participating agencies learn about and appreciate each other's history, approach, unique functions, and self-interest. Equal attention should be paid to process and action. Collaborations should consider adapting techniques for strengthening competence to work across racial, ethnic, and other group lines, to build the competence of collaboration members to work across profession, discipline, and organizational type.

7.5 Promoting a Learning Community Among Collaboration Members is Important

At the identification and referral stage, first responders must be trained on 1) the criteria for exposure, 2) how to gather evidence and other information related to the child's exposure, and 3) the appropriate recipient for the referral.

At the assessment and treatment stage, clinicians and paraprofessionals should be trained to use the appropriate protocols and tools to determine and reduce the impact of the child's exposure to violence.

Knowledge of violence exposure and its impact on young children is relatively limited, even among experts. Agencies in the system of care for young children exposed to violence should develop knowledge and skills specific to this content area, as well as knowledge of what it takes to transform systems. Agencies must define the system of care; specify the decision points that affect the child, from identification to treatment; and determine knowledge, skills, and capacities required to make the most appropriate decision at each point. A standard protocol should be developed to enhance the quality of information collected and mandate the amount of time allowed between identification, referral, and assessment.

Collaboration members need to develop knowledge about protocols and tools to determine and reduce the impact of exposure to violence on young children. Staff at Safe Start demonstration sites learned about and used assessment tools such as Ages and Stages, the Parent Stress Index, the Temperament and Atypical Behavior Scale, and the Traumatic Stress Inventory; treatment approaches included Parent-Child Interactive Therapy and play therapy. The paucity of knowledge about specific psychological interventions for assisting a young child exposed to violence presented a challenge for most of the demonstration sites, as it does for the field in general.

Therefore, Safe Start funders, technical assistance providers, trainers, program directors and staff, policymakers, and other stakeholders must create a learning community to promote knowledge exchange. A learning community can be supported through a variety of mechanisms,

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including listservs, regular meetings with equal emphasis on expert presentation and information exchange among staff, and distribution of pertinent new materials.

7.6 A Safe Start Initiative Requires a Staff with Key Capacities

Safe Start project directors needed to be effective facilitators within their communities. Because they were responsible for identifying and mobilizing professional and community stakeholders with the greatest ability to address the issue of young children exposed to violence, project directors needed 1) in-depth knowledge of the community (e.g., cultural traditions of various groups living in the community; the local service delivery system; national, state, and local policies that affect service delivery; and policy makers at all levels of government), 2) access to entry points for families and children, and 3) an understanding of the impact of exposure to violence. Given that any single individual is unlikely to possess all of the above knowledge and skills, project directors had to have the resources to hire complementary staff.

Safe Start staff must have four basic capacities: 1) knowledge of policy development and advocacy, including skills for navigating systems; 2) knowledge of service provision, including skills for engaging and supporting point-of-service providers; 3) skills for facilitating group processes and transforming conflicts; and 4) knowledge of community institutions, including skills to reach out and engage these institutions. Staff with these capacities would enable local initiatives to broaden and deepen their impact, through expanding Safe Start beyond the realm of simple service provision. By contrast, an initiative is likely to be pigeonholed as a service provider if its lead agency lacks policy advocates and system navigators among its decision-makers and staff.

> Staff members with complementary skills in group dynamics, community outreach, knowledge about children's exposure to violence and systems change, social marketing, and community building were necessary for the success of a Safe Start initiative.

Just as Safe Start staff needed extensive knowledge and skill sets, each local initiative required a variety of knowledge and skills related to children's exposure to violence, collaboration and group processes, cultural competence, systems change, prevention, social marketing, and community building. Again, a single individual or organization was unlikely to have all of these capacities, necessitating a team of experts with a comprehensive set of collective capacities from the outset. To provide the local Safe Start initiative and its staff with seamless and comprehensive support, team members must develop a strong strategy for exchanging information, keeping each other updated, and coordinating assistance to the initiative.

Finally, while local Safe Start staff acted as critical catalysts for change in their communities, it was essential to recognize their temporary role as part of a five-year initiative. From the outset, it might have been helpful for all participants to recognize staff as temporary shepherds of the Safe Start vision, with primary responsibility for developing community capacity to decrease the impact of children's exposure to violence and infusing the Safe Start vision into the system of care. It also might have been helpful for collaboration members to identify a potential institutional "home" for the local Safe Start initiative early on in the initiative.

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7.7 A Family Approach to Service Delivery was More Appropriate

Some sites found that a family-centered approach to therapy was more appropriate than individual-based therapy. This lesson could be extrapolated to the entire system of care: the system must be family-centered and not individual-centered. A more holistic approach to family members and needs could reduce the challenge of engaging and retaining families in services. With respect to professional service providers, a family-centered approach may take the form of centralizing services for the family under one roof to reduce the fragmentation of care.

> Some demonstration sites found that a family-centered approach to services was more appropriate than individual-based approaches to reduce the impact of exposure to violence on young children.
>
> A family-centered approach does not negate the necessity of centralizing victim safety but rather includes components that address each family member's needs.

System change means not only increasing coordination and communication among service providers, but also shifting from a predominant organizational culture of prioritizing individual well-being over family well-being. First responders and point-of-service providers such as police officers, mental health providers, domestic violence advocates, and child protective services workers are typically trained to focus attention on one member of a family (e.g., the victim of abuse, the perpetrator of abuse), rather than the whole family. Future demonstration sites should consider deliberately addressing this organizational culture of focusing more on individual family members than on family systems.

Adoption of a family approach does not negate the necessity of centralizing victim safety (e.g., Shepard & Pence, 1999[7]) in situations where interpersonal violence is present. Rather, a family-centered approach may include components that respect each family member as well as the desire among some families to remain together. Initially, such an approach would prioritize victim safety and the provision of sanctions for perpetrators of violence. Over time, rehabilitation opportunities for abusers and healing opportunities for the victims could be offered to those families seeking to stay together.

7.8 Existing Interventions Needed to Be Adapted to Each Community's Context

The community assessments conducted prior to implementation should be used to construct an approach tailored to the community's needs, resources, context, and culture, and aligned with the community's capacities over time. Demonstration sites varied in their capacity to analyze the data generated by the community assessments and apply the findings during the implementation phase. Understanding local context and its implications for implementing interventions in the community might be better achieved through more information exchange between experts in 1) the Safe Start conceptual framework and 2) the local community. Technical assistance providers, trainers, and Safe Start participants should

> Due to varying capacities and context, interventions need to be adapted and tailored to each community.

[7] Shepard, M. F. & Pence, E. L. (Eds.). (1999). *Coordinating community responses to domestic violence: Lessons from Duluth and Beyond.* Thousand Oaks: Sage Publications.

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continuously examine what is likely to work within a community, what is unlikely to work, and why, given the context of past history, current capacity, and anticipated challenges.

Intervention models are developed and refined within a particular context, which may or may not be similar to any other community context. Although Safe Start initiatives should strive to identify and adopt promising models and practices to ensure evidence-based approaches, each initiative must pay an equal amount of attention to *adapting* such models and practices. For example, a rural setting may not be conducive to the implementation of CDCP, and a highly clinical treatment approach may not be appropriate for peoples of non-Western ancestry. To determine adaptation needs, the conditions (human capital, funds, and setting) that facilitate each promising model or practice should be identified, examined, and compared to those of the community in which the model will be implemented. Identification and analysis of the facilitating conditions may require contact with the innovator of the model or other individuals who have adopted it. Once facilitating conditions are identified and analyzed, local Safe Start staff and other key leaders in the community should be consulted to assess local community conditions that require change or development to successfully implement the model or practice.

In the adaptation of models, the racial, cultural, and ethnic differences among community groups and subpopulations require close attention, especially with regard to gender roles within families, cultural norms that reinforce violence, culturally appropriate responses to trauma, and the cultural competence of solutions. With regard to cultural competence of solutions, careful consideration must be given to 1) the entity or "messenger" that encourages the community to talk about violence, particularly domestic violence among its members; and 2) the entity that provides services to families and young children. A community that has suffered historical marginalization due to its demographic characteristics (e.g., an underrepresented, primarily low-income, African American community with limited access to resources and opportunities) may, for historical reasons, mistrust particular entities, messengers, or service providers.

7.9 Engaging and Retaining Families and Children in Services Was a Challenge

All of the local Safe Start initiatives reported difficulty in engaging and retaining families and children in services. According to participants, several factors could have contributed to this challenge, including: the stigmatization of mental health interventions, distrust of social service and law enforcement agencies, perceptions among families that staff did not respect them, inability to reach families (e.g., no telephones) for follow-up sessions, other competing family needs (e.g., housing, employment), cultural insensitivity of point-of-service providers, and language barriers between families and service providers.

Additionally, Safe Start staff and partners across demonstration sites disagreed regarding the timing of intervention services and how timing affects engagement and retention of families after initial contact has been made. Some Safe Start participants believed that intervening at the crisis moment increases the likelihood of engaging the family in services; in fact, many demonstration sites found that intervention at the point of crisis increased the likelihood of a first visit to the point-of-service provider, but did not necessarily predict completion of the full course of therapy or service plan. In addition, participants at one demonstration site believed that a parent in crisis could not provide valid informed consent for treatment of his or her child.

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The Association for the Study and Development of Community, as the National Evaluation Team (NET) for the Safe Start Demonstration Project, prepared a paper summarizing evidence-based practices and principles for engaging and retaining families in services. While the knowledge of how to improve the engagement and retention of families in services is only emerging, useful principles include thoughtful planning that responds to the perspectives of the target population; cultural competency; relationship-building; and relationship-leveraging in the form of using familiar, informal social networks. Providing practical support in familiar places enables many families to benefit from services and programs designed to strengthen and build upon their inherent ability to protect their children from harm. Point-of-service providers also must recognize that low-income and racial minority families may be particularly likely to stigmatize mental health services, distrust mainstream service providers, and experience cultural incompetence in service design and delivery. The design and planning of local initiatives such as Safe Start should reflect this recognition.

> Thoughtful planning that responds to the perspectives of the target population, cultural competency, relationship-building, relationship-leveraging in the form of using familiar and informal social networks, and providing support in familiar and "safe" places are important principles to remember in engaging and retaining families in services.

7.10 Institutionalization of Change

For a local Safe Start initiative to institutionalize systems change in less than five years is an ambitious goal. Given the difficulty of discussing community and family violence in the public arena, the invisibility of violence exposure in a young child, and the relatively limited knowledge of appropriate interventions, a local Safe Start initiative must expend a tremendous amount of time and resources simply to lay the foundation for full initiative implementation; systems change will take time.

Nevertheless, the involvement and leadership of key sectors and agencies may allow for the institutionalization and sustainability of certain initial changes, such as greater awareness of children's exposure to violence, changes to protocols and procedures for identifying and referring exposed children, reallocation of existing resources to assist these children, and development of knowledge and skills among professionals.

8. DISCUSSION AND CONCLUSION

The NET found converging information that the efforts across all 11 Safe Start demonstration sites have continued according to the logic model conceptualized by OJJDP, the NET, technical assistance providers, and Safe Start Project Directors (see Figure 1). This section summarizes and discusses the NET's overall impression of the Safe Start Demonstration Project and the efforts of the 11 local Safe Start initiatives, with a focus on considerations for future initiatives with similar goals as Safe Start.

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8.1 Major Accomplishments of Local Safe Start Initiatives

Brought attention to the impact of exposure to violence among young children in their communities. All 11 initiatives accomplished this goal through the development and distribution of public education materials, community-wide symposia and conferences, and training for point-of-service providers and other professionals. Several demonstration sites described elected officials, agency directors, point-of-service providers, and families as more attentive to children's exposure to violence after the introduction of the local Safe Start initiative. In a few of the Safe Start demonstration sites, for example, legislation was changed to increase support for children six years and younger exposed to violence. Given the limited knowledge of violence exposure and the inability of young victims to advocate for themselves, the local Safe Start initiatives have played a critical role in bringing the issue into the public arena and placing it on the public agenda.

Major accomplishments of Safe Start initiatives:

- Brought attention to the impact of exposure to violence among young children in their communities;
- Helped agency directors and point-of-service providers begin to formally recognize and define the system of care for young children exposed to violence;
- Increased the capacity of organizations to respond to young children exposed to violence;
- Enhanced collaboration across sectors;
- Institutionalized changes that will benefit young children exposed to violence;
- Improved understanding of organizational, point-of-service provider, and cross-organizational capacities needed to assist young children exposed to violence.

Some agency directors and point-of-service providers were aware of the impact of exposure to violence on young children prior to Safe Start; however, they reported that they had no avenue or foundation for engaging each other to deal with the problem collectively. Local Safe Start initiatives provided the opportunity for personally and professionally committed individuals to come together and work jointly on their common concerns.

Helped agency directors and point-of-service providers begin to formally recognize and define the system of care for young children exposed to violence. The federal grant requirements of the Safe Start Demonstration Project encouraged local initiatives to define and streamline the processes for identifying, referring, assessing, and treating young children exposed to violence. This resulted in the acknowledgment and engagement of agencies considered part of the system of care for children and families experiencing violence, including non-traditional entry points and referral sources (e.g., fire departments, childcare providers, spiritual leaders).

Representatives of agencies identified as part of the system of care were inspired to reflect on their organization's role in the system, and what they were doing or not doing to identify and refer young children exposed to violence. As a result, many partner organizations, including 911 dispatchers, police departments, child protective services, community behavioral health services, victim services, and court advocates changed their intake protocols to include questions about exposure to violence. They began to function more as a system and less as independent entities.

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Increased the capacity of organizations to respond to young children exposed to violence. As a result of some of the local Safe Start initiatives, organizations changed their policies for responding to young children exposed to violence by 1) implementing new assessment tools appropriate for this special population (e.g., Ages to Stages), 2) hiring clinicians with specialized knowledge of childhood trauma, 3) designating a staff position to handle cases involving young children, 4) improving procedures for obtaining parental consent for follow-up and sharing case information, or 5) developing interagency agreements for protecting client confidentiality.

Additionally, all the Safe Start initiatives developed and offered a range of training opportunities to enhance the capacity of professionals responsible for serving children exposed to violence and their families, including cross-agency training and specialized training for particular audiences. Some Safe Start initiatives developed training curricula, manuals, and products that were adopted by other institutions, including academic institutions for future use.

Overall, the result was an expansion of the network of qualified service providers available to families in these communities.

Enhanced collaboration across sectors. The Safe Start demonstration sites developed and sustained working relationships among representatives from various sectors of the professional service provide community by creating new processes and structures for collaboration. Implementation of system change activities was facilitated in some Safe Start demonstration sites by building on an existing culture of collaboration within the professional community and leveraging existing resources and human capital.

Institutionalized changes that will benefit young children exposed to violence. In addition to improving the capacity of organizations to respond to young children exposed to violence, all 11 demonstration sites identified and engaged key champions (e.g., agency directors, elected officials) for the Safe Start vision and goals. These key champions' own capacity to keep the Safe Start vision alive was enhanced through their participation in the initiative. They deepened their knowledge about the issue and developed new relationships and alliances. Additionally, four demonstration sites raised new funds to support Safe Start and/or related activities.

Improved understanding of organizational, point-of-service provider, and cross-organizational capacities needed to assist young children exposed to violence. Local Safe Start staff and partners, OJJDP staff, and national technical assistance providers identified several essential capacities for organizations and point-of-service providers in the system of care for young children exposed to violence, including:

- Acknowledgement and commitment to changing traditional thinking about or response to young children exposed to violence and their families;
- Willingness and ability to share information and cases across organizations which requires engaging in discussion, and even conflict, with other organizations and providers;

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- Support from organizational leaders for the professional development of point-of-service staff; Ability to cultivate a learning community within the organization's staff and among its partners; Relationships with credible and trusted community institutions and entry points as well as with other organizations in the system of care for children and families; and
- Specific knowledge and skills, including state-of-the-art interventions to work with young children exposed to violence.

Several essential cross-organizational capacities were also identified, including:

- Organizations comprising the system of care for children exposed to violence and their families need to understand the system of care and not just their own organization's role in the system;
- A single facilitating entity for cross-organization processes such as the local Safe Start initiative;
- The capacity to research, review, and develop policies, procedures, and protocols for responding uniformly to young children exposed to violence;
- Ability to manage and transform inter-organizational and intergroup conflicts;
- Participation of decision-makers and influential individuals; and
- A structure for balancing process issues (e.g., building relationships across organizations) and taking action (e.g. developing and implementing system change strategies).

8.2 Challenges

All 11 Safe Start demonstration sites encountered certain common challenges. These challenges raised questions about establishing and sustaining a system of care for young children exposed to violence and their families. The Safe Start National Evaluation can seek answers to these questions through future evaluation activities, for the benefit of future initiatives similar to Safe Start.

Procedures for assessing, treating, and following up with young children exposed to violence and their families were not as well-understood as procedures for identification and referral. The points of identification and referral in the service pathway for young children exposed to violence were clearly strengthened as a result of the local Safe Start initiatives. The points in the pathway beyond referral, however, remained less well-defined. Specialized assessment techniques were not adopted in all Safe Start demonstration sites, and a systematic process for tracking and following up with families throughout a course of treatment was lacking in most sites. Several Safe Start staff and partners, including clinicians, acknowledged the limited knowledge available for assessing and treating this special population, raising the question: how can the knowledge base continue to expand to build the capacity of point-of-service providers to intervene appropriately with young children exposed to violence and their families?

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In rural and Native communities, existing interventions had to be adapted to fit the cultural context. Rural and Native communities tend not to have the same resources (financial and human) as urban communities. Additionally, the knowledge base of promising practices and interventions for these communities are limited, raising the questions: what are the special considerations for these communities with regard to interventions, how can promising interventions be adapted, and what types of technical assistance and other resources do these communities need to support the adaptation of promising practices?

Challenges faced by Safe Start initiatives were:

- Procedures for assessing, treating, and following up with young children exposed to violence and their families were not as well-understood as procedures for identification and referral
- In rural and Native communities, existing interventions had to be adapted to fit the cultural context.
- A supportive family and community environment was essential, but difficult to establish, for developing and sustaining a system of care for young children exposed to violence and their families.
- The local Safe Start staff found it challenging at times to operate and manage the collaboration, which involved both policymakers and point-of-service providers.

A supportive family and community environment was essential, but difficult to establish, for developing and sustaining a system of care for young children exposed to violence and their families. Many local Safe Start initiatives discovered that it was critical to create a supportive environment for their efforts. This required the examination and transformation of community and cultural norms that had rendered family and community violence acceptable or, at least, tolerable. In the Native communities, domestic violence elicited shame at the individual, family, and clan levels, representing a loss of Native traditions and the community's diminishing capacity to endow future generations with Native cultural assets. Therefore, to address domestic violence in these communities, the local Safe Start initiatives also had to engage in community healing and building. Local Safe Start staff experiences suggest that prevention and environmental strategies (e.g., social marketing) play a role in creating a supportive environment for systems change, raising the question: what types of prevention and environmental strategies are most appropriate, and what would it take to integrate these strategies into a local Safe Start initiative from the outset?

The local Safe Start staff found it challenging at times to operate and manage the collaboration, which involved both policymakers and point-of-service providers. The Safe Start Demonstration Project required local Safe Start initiatives to pay equal attention to systems change and change at the point-of-service. This meant that collaborations had to include agency directors and appointed leaders, as well as point-of-service providers. Such individuals differed in their roles, perspectives, priorities, and approaches to the problem. Racial, ethnic, and cultural differences and inter-organizational philosophical differences added to collaboration dynamics, raising the questions: what strategies and processes need to be put in place for staff and partners to manage collaboration dynamics and, at the same time, take action to improve the system of care? Are there specific techniques for dealing with inter-organizational and intergroup differences in this context?

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8.3 Conclusion

Almost all Safe Start sites have had important impacts on how children exposed to violence are identified, referred, assessed, and treated. Their efforts and accomplishments have helped to expand the knowledge base about what it takes to reduce the impact of exposure to violence on young children. At the same time, they have encountered several challenges which raise important questions for future investigation and discussion, including:

1. What different intervention and treatment strategies, if any, are appropriate for children exposed to violence compared to children exposed to any other repeated, severe trauma?

2. What different ways, if any, should children exposed to different forms of violence (e.g., domestic and community) be treated?

3. What are the most effective ways to improve the practice of mental health service providers such that family recruitment, engagement, and retention barriers are reduced?

4. What are the appropriate short term and intermediate outcomes that should be expected from intervention and treatment strategies for children exposed to violence?

5. How can cultural and philosophical differences and other conflicts among domestic violence, child welfare, law enforcement, mental health and other service systems be most effectively addressed?

6. What are the advantages and disadvantages of immediate and delayed engagement of children and parents in response to exposure to violence?

7. How can the tasks of raising community awareness about the impact of exposure to violence on young children and preparing the system to respond to these children's needs be best balanced?

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