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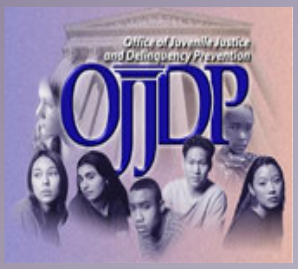
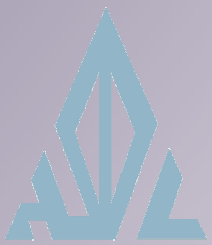
Safe Start Initiative: Demonstration Project

Process Evaluation Report II

Report 2006 - 3

November 2007





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Preface

The Safe Start Initiative Phase I Process Evaluation II (2000-2005), Report 2006-3 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. The report covers the first five years (2000-2005) of the Safe Start Demonstration Project.

We would like to recognize Katherine Darke Schmitt (deputy associate administrator, Child Protection Division, and Safe Start evaluation manager) for her leadership and support. We would also like to thank Kristen Kracke, Safe Start Initiative coordinator and manager, for her assistance. ASDC staff contributing to this report include: David Chavis (project director); Yvette Lamb (co-project director); Mary Hyde (deputy project director); Deanna Breslin (project coordinator); Joie Acosta (managing associate); Susana Haywood (associate); and Kien Lee (senior managing associate). Sylvia Mahon (office coordinator) assisted with production.

The process evaluation would not be possible without the collaboration of many people from the 11 Safe Start Demonstration Project sites, including each site's project director, local evaluator, and partners who were willing to meet with ASDC during site visits and provide key information.

Baltimore City Safe Start Initiative
Baltimore, Maryland

Bridgeport Safe Start Initiative
Bridgeport, Connecticut

Chatham County Safe Start Initiative
Chatham County, North Carolina

Chicago Safe Start Initiative
Chicago, Illinois

Pinellas Safe Start Initiative
Pinellas County, Florida

Pueblo of Zuni Safe Start Initiative
Pueblo of Zuni, New Mexico

Rochester Safe Start Initiative
Rochester, New York

San Francisco SafeStart
San Francisco, California

Sitka Safe Start Initiative
Sitka, Alaska

Spokane Safe Start Initiative
Spokane, Washington

Keeping Children Safe Downeast
Washington County, Maine

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Executive Summary

In 1999, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) created the Safe Start Demonstration Project as a demonstration initiative for preventing and reducing the impact of family and community violence on children six years and younger. The project seeks to create a comprehensive service delivery system that improves access to and delivery and quality of services for young children exposed to violence or at high risk of exposure, along with their families and their caregivers, at any point of entry into the system. 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.

OJJDP program staff and the National Evaluation Team generated eight questions to guide a process evaluation of the Safe Start Demonstration Project, involving a cross-site analysis of the main themes that emerged during demonstration site visits conducted in 2005. As available, data from before 2005 were used to provide additional insight into how the Safe Start Demonstration Project was fully implemented across sites. Overall, evidence from the process evaluation indicates that Safe Start Demonstration Project grantees were able to:

- Create mechanisms for systemic and more systematic identification of young children exposed to violence;
- Create comprehensive systems of care for children exposed to violence, by engaging multiple disciplines;
- Create responsive systems of care, by effecting policies and practices for responding to children exposed to violence;
- Create collaboration between organizations with fundamentally different philosophies, histories, cultures, and training of personnel for responding to children exposed to violence; and
- Advocate for the development of state-level changes.

Key findings from the process evaluation are outlined below. The findings fall into three main categories: 1) systems-level outcomes and improvements in local service delivery systems; 2) factors that affect systems change efforts, including approaches to collaboration, engagement of community residents and institutions, and readiness for implementing systems change; and 3) continuation and institutionalization of the Safe Start Demonstration Project.

Systems-Level Outcomes and Improvements in Local Service Delivery Systems

Safe Start Demonstration Project grantees were expected to increase the numbers of children exposed to violence identified, assessed, and referred, by improving the

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comprehensiveness and responsiveness of local service delivery systems. Findings from the process evaluation indicate the following key systems-level outcomes:

- A total of 15,622 children exposed to violence were identified over the course of the initiative. Based on available national and local prevalence estimates, Safe Start Demonstration Project grantees identified approximately one out of every five children (20%) estimated as potentially exposed to family violence in 2005. This compares with a 2004 figure of 4,546 children (16%) identified as exposed to violence (Association for the Study and Development of Community, 2005a).

- A total of 5,323 children exposed to violence were assessed over the course of the initiative.

- A total of 7,840 children exposed to violence were referred to appropriate services over the course of the initiative.

To achieve these outcomes required communities to prepare all public sector service providers that have regular contact with families and children, both in crisis situations and non-crisis situations, (e.g., early childhood education and child care settings)—to recognize and respond to children exposed to violence.

Examples of state-level changes likely to support further systems improvement include:

- Chicago Safe Start, in collaboration with the Illinois Violence Prevention Authority, worked to pass the Illinois Children's Mental Health Act of 2003.

- Pinellas Safe Start, in collaboration with statewide domestic violence agencies, developed a five-year prevention plan for Florida that includes priority resources for domestic violence prevention.

- The Washington County grantee spearheaded efforts to establish a 2-1-1 hotline in Washington County and statewide, to facilitate access to resources for children exposed to violence.

- The Pueblo of Zuni Safe Start worked with the Zuni Tribal Council to revise its Children's Code to recognize family violence as an issue for children.

Safe Start Demonstration Project grantees made local service delivery systems more comprehensive by:

- Creating multiple points of entry into local service delivery systems, in particular utilizing law enforcement and domestic violence agencies to engage families in needed services for their children and themselves; and
- Training professionals from multiple disciplines and educating community residents.

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Establishing collective responsibility for identifying young children exposed to violence or at high risk for exposure simultaneously opened multiple new gateways into grantee communities' service delivery systems. When different sectors of the service delivery system were made aware of this population, children and their families became more likely to gain access to needed services. Providing opportunities for professionals from multiple disciplines to learn about children exposed to violence was essential for engaging these professionals in the identification and referral processes.

Safe Start Demonstration Project grantees made local service delivery systems more responsive by:

- Developing screening processes to identify children exposed to violence,
- Centralizing access to appropriate services for children and families,
- Implementing the Child Development-Community Policing program with adaptations for local settings,
- Integrating services for children and families (e.g., co-locating and coordinating services across organizations, sharing case information, examining existing and/or past case records, developing new structures), and
- Enhancing or creating family-centered services responsive to multiple family needs (e.g., offering and coordinating holistic services in convenient locations, offering case management and counseling services in a sequence determined by families, institutionalizing the use of evidence-based therapeutic interventions).

Safe Start Demonstration Project grantees that engaged (i.e., identified, assessed, referred, treated) the highest numbers of children and families early in the initiative, and maintained these relatively high numbers over time, provided a range of family services, rather than mental health services exclusively. In addition, the more successful grantees referred families directly to service providers with relevant training and knowledge and, therefore, the capacity to provide services immediately. Finally, more families were engaged and retained in services when services were 1) sequenced according to the family's priorities and 2) provided in convenient locations.

Factors Affecting Systems Change Efforts

Approaches to collaboration and a number of preexisting conditions within demonstration sites (e.g., existing collaborative relationships, sufficient resources, favorable political environments) facilitated grantees' systems change efforts. The common collaboration features across sites that appeared to be most appropriate for effecting systems change were:

- Wide engagement from sectors that provide critical functions related to Safe Start Demonstration Project goals;
- Strategies for overcoming philosophical differences in how each sector traditionally responds to children exposed to violence and their families;

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- Structures (multi-tiered or loosely configured) for effectively coordinating Safe Start roles and input;
- Clear roles and tangible benefits for partners; and
- Credible, influential, and consistent leadership.

While the data support these patterns across grantees, it is important to remember that no single approach or condition alone drove systems change success; it was the combination of different approaches and conditions that maximized each grantee's potential to change the system.

Grantees also understood that their efforts to increase access and improve the quality of services would have less impact if families did not comprehend the harm caused by exposure to violence. Nine of the 11 grantees successfully engaged community residents and institutions to become aware of Safe Start services, use the services, and/or participate in decision making about the local Safe Start initiative. Common strategies for achieving community engagement included:

- Public education and awareness-raising activities,
- Collection of community input about strategies and messages for public awareness campaigns,
- Creation of a staff position dedicated to community outreach, and
- Inclusion of community members in governance.

Challenges associated with engaging community residents and institutions included:

- Grantees lacked sufficient connections to grassroots institutions and social support networks to educate the public about violence exposure.

- Domestic violence was a taboo subject, difficult to raise in the public arena.

- Residents in some of the large, urban areas did not trust public agencies to participate in the change process.

The following community readiness factors emerged as key to enabling systems change:

- History of collaboration for systems change;
- Sufficient resources, both financial (e.g., local funding) and human (e.g., trained and licensed mental health service providers);
- Community capacity for engaging in a dialogue about domestic violence; and
- Supportive legislation and public agendas.

Continuation and Institutionalization of the Safe Start Demonstration Project

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Throughout the five-year project and specifically during the final phase of implementation, Safe Start Demonstration Project grantees were expected to work toward sustainability of their projects. Continuation and institutionalization of local projects were accomplished in the following ways:

- Collectively, grantees raised over $3 million to support and continue the work of Safe Start in their local communities.

- All Safe Start Demonstration Project grantees increased community capacity to respond to the needs of children exposed to violence by increasing awareness of the issue, increasing knowledge and skills needed to help young children exposed to violence, developing and implementing tools to better serve these children, and facilitating working relationships among professionals.

- According to most site visit participants, 1) the collaborative relationships developed as a part of the Safe Start Demonstration Project would continue, either formally or informally, beyond the period of OJJDP funding, and 2) the communication resulting from these relationships would help families and children exposed to violence through improved coordination of services.

- All grantees found an organization or other entity to continue some aspect of the Safe Start Demonstration Project, whether a more tenuous aspect (e.g., the vision or mission) or a highly tangible aspect (e.g., positions and programs).

Challenges and Opportunities Associated with Implementing and Sustaining the Safe Start Demonstration Project

Safe Start Demonstration Project grantees experienced implementation challenges common to large-scale demonstration projects, for example:

- Sequencing systems change activities requires a delicate balance between increasing the demand for services and building capacity to meet the new demand. Most sites could not and did not dedicate equal grant funds to both community outreach strategies (e.g., public awareness campaigns) and programming improvements (e.g., new and enhanced interventions for children exposed to violence).

- To achieve unity among service provider sectors characterized by their own limitations and fundamentally different cultures and histories is an ambitious goal, even in the most supportive of contexts (e.g., resource-rich communities invested in collaboration).

- Relying on mental health professionals for record keeping and information sharing hindered documentation of Safe Start accomplishments.

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- The performance measures used to assess progress were defined differently across Safe Start grantees, and outcome measures were not collected consistently.

- Some grantees struggled to access training and technical assistance resources.

- Cultural and capacity differences diminished the National Evaluation Team's ability to assist tribal and rural sites.

- Turnover among Safe Start Demonstration Project staff (e.g., project directors, local evaluators) affected the ability of grantees to achieve their goals.

In terms of opportunities, the Safe Start Demonstration Project generated or provided:

- The opportunity for grantees to make the issue of children's exposure to violence part of the community's agenda and/or elevate the importance of the issue;
- Resources for pilot communities to enhance and integrate existing services for children and their families, or to develop those services in communities with fewer resources;
- The opportunity to further legitimize the role of human service professionals as agents of change within their systems, particularly with the support of federal funding; and
- The opportunity for grantees to form new working relationships, both locally and nationally.

Recommendations

The findings of this process evaluation suggest several recommendations for funders, practitioners, researchers, and public policy makers.

We recommend that *funders* of future, similar initiatives:

- Consider the importance of a community's existing capacity to accomplish project goals;
- Provide relevant and immediate technical assistance to prepare grantees for initiative implementation, as well as ongoing assistance to address barriers to project success;
- In partnership with national evaluators, prepare to address any non-compliance with data-collection requirements, through meaningful and immediate consequences for both grantees and evaluators.

We recommend that *service providers* who identify, refer, and treat children exposed to violence and their families:

- Engage professionals from multiple sectors to regularly screen children for exposure to violence and refer them to appropriate services;

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- Refer children exposed to violence and their families directly to a service provider with relevant training;
- Provide families with holistic services in convenient locations;
- Integrate and sequence services for families through sharing case information, joint service planning, and co-location of services; and
- Dedicate resources to data collection and management to ensure quality services.

We recommend that *researchers* in the field of children's exposure to violence:

- Establish strong working relationships with practitioners to facilitate quality and meaningful data collection;
- Establish networks among local researchers and researchers affiliated with national initiatives to increase the depth of knowledge generated at both the local and national levels; and
- Design and conduct studies that will generate more in-depth knowledge of the nature of children's exposure to violence.

We recommend that *public policy makers* support the efforts of practitioners and researchers by:

- Dedicating federal resources to the design and implementation of systems of care for children exposed to violence that are responsive to the various levels of risk to exposed children and their caregivers.

The Safe Start Demonstration Project provides the field with guidance on how to create systems of care responsive to local conditions. Over the course of the project, grantees changed relationships among formal and informal systems of support and infused local communities with resources for children exposed to violence and their families. As a result, more children exposed to violence were identified and linked to supportive services capable of increasing their safety and family stability. Safe Start illustrates that federal resources can be used effectively to create more comprehensive and responsive service delivery systems for children exposed to violence and their families.

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1. Introduction

In 1999, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) created the Safe Start Demonstration Project as a demonstration initiative for preventing and reducing the impact of family and community violence on children six years and younger. The project seeks to create a comprehensive system that improves access to and delivery and quality of services for young children who have been exposed to violence or are at high risk of exposure, along with their families and their caregivers, at any point of entry into the system. 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.[1]

To accomplish these goals, OJJDP expected participating communities to implement a balanced, comprehensive approach, spanning five domains of systems change activity: 1) development of policies, procedures, and protocols; 2) service integration activities; 3) resource development, identification, and reallocation; 4) development of 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, which illustrates its expected process of change, can be found in Appendix A.

A total of nine communities ("Safe Start demonstration sites") received grants from OJJDP in 2000 to plan and implement a local Safe Start project in three phases: Baltimore (Maryland), Bridgeport (Connecticut), Chatham (North Carolina), Chicago (Illinois), Pinellas (Florida), Rochester (New York), San Francisco (California), Spokane (Washington), and Washington (Maine). Two demonstration sites located in Native American communities, the Sitka tribe (Alaska) and the Pueblo of Zuni (New Mexico), were added in 2002, and therefore began their local Safe Start projects two years later than the other nine demonstration sites.

Though grantees were expected to complete Phase I of the project during their first seven months, all grantees spent between 18 and 24 months in assessment, planning, and initial development activities. In Phase II, slated for 18 months, grantees began implementation. In Phase III, which was expected to last 36 months, Safe Start Demonstration Project grantees worked toward full implementation and sustainability of their projects. While grantees were not expected to achieve sustainability for all elements

[1] This description of the Safe Start Demonstration Project's purpose was obtained from the Federal Register Notice (Vol. 64, No. 64/ Monday, April 5, 1999, p. 16556). In addition, according to the Office of Juvenile Justice and Delinquency Prevention, "exposure to violence" means being a victim of abuse, neglect, or maltreatment or a witness to domestic violence or other violent crime. This definition was also taken from the Federal Register Notice (p. 16556). These definitions guide the analyses described in this report.

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of the project, they were encouraged to develop, identify, and reallocate local resources to sustain the core goals of the local Safe Start project, as well as any systems change they had achieved. In 2005, all grantees were in the full implementation phase of the project, and were focused largely on sustainability of key project components.

This report highlights how the Safe Start Demonstration Project grantees helped their communities create comprehensive, coordinated, and knowledge-based service delivery systems for children exposed to violence and their families, including successes and challenges associated with implementation of the project. The evaluation was designed to increase knowledge of successful strategies for identifying and treating children exposed to violence and to answer questions to aid OJJDP in future grant making and program support; in particular, OJJDP staff requested that the National Evaluation Team from the Association for the Study and Development of Community (ASDC) identify factors that contributed to or impeded successful implementation of the Safe Start Demonstration Project in each grantee site. Information here represents one of two cross-site evaluation reports for which the National Evaluation Team is responsible.

1.1 Goals of the National Evaluation

A case study methodology (see Appendix B) was used to examine systematically the implementation and impact of the Safe Start Demonstration Project. Data were collected through document review, site visits, and follow-up telephone conversations; a site-visit protocol was developed to guide discussions with key stakeholders. Given the diversity of strategies employed across the 11 demonstration communities, local evaluators also conducted site-specific outcome studies to supplement the cross-site national evaluation. Six local evaluators provided information regarding 1) programs for reducing the impact of childhood exposure to violence and 2) methods and approaches to evaluate such programs.

Data collected according to this methodology were used to develop the following national evaluation reports:

- Interim and final cross-case studies,
- Interim and final case studies,
- Process evaluations, and
- Special reports.

Process evaluation. This report focuses on Safe Start grantee implementation processes and clients served (national evaluation goal 3). OJJDP program staff and the National Evaluation Team generated eight questions to guide the process evaluation:

1. How have Safe Start Demonstration Project grantees developed and/or improved the service pathways for children exposed to violence and their families?
2. When are formal (versus informal) methods of collaboration most appropriate for effecting systems change?
3. What factors contribute the most to systems change in policies and practices?

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4. How have Safe Start Demonstration Project grantees prepared themselves for sustainability?
5. How have Safe Start Demonstration Project grantees increased community capacity to respond to the needs of children exposed to violence and their families?
6. What are the best ways of engaging community residents and institutions for an initiative like the Safe Start Demonstration Project, and in what contexts?
7. What capacities and other resources are needed to change systems so that impact of exposure to violence on young children can be significantly reduced?
8. What challenges and opportunities do Safe Start Demonstration Project grantees see in the immediate future to expand and sustain this work?

1.2 Process Evaluation Methodology

The key findings reported here reflect a cross-site analysis of the main themes that emerged during Safe Start grantee site visits conducted in 2005. As available, data from before 2005 were used to provide additional insight into how the Safe Start Demonstration Project was fully implemented across sites. To identify and develop cross-site themes, three members of the National Evaluation Team analyzed the site visit report written for each local Safe Start project; themes summarized in individual site visit reports reflect a synthesis of the main themes that emerged during discussions with site visit participants. Site visit information was supplemented with information obtained from grantee documents (e.g., community assessment reports, strategic plans, implementation plans, progress reports, other relevant reports, and materials gathered on-site), local evaluation reports, and follow-up calls. Themes were considered valid if independently identified by two or more site visit participants. To further validate information, site visit reports were reviewed by each site's project director to ensure completeness and accuracy. (For more details about the methodology used for the national evaluation, please refer to Appendix B.)

Each site visit report organized themes according to the Safe Start Demonstration Project theory of change (see Appendix A); questions used to guide on-site discussions (see Appendix C) were linked to the theory of change such that responses could be used to test the theory. Questions for site visits also were linked to core questions about how the Safe Start Demonstration Project was implemented, as described in Section 1.1 of this report.

1.3 Organization of Report

This report is organized according to the questions posed by OJJDP. Section 2 of the report describes how Safe Start Demonstration Project grantees improved the service delivery systems in their communities. Section 3 of the report summarizes how grantees used collaborative relationships to effect systems change. In Section 4, the factors that affected systems change efforts within Safe Start sites are examined; capacities and resources needed to change systems are considered as part of this discussion. This report also describes the components of the Safe Start Demonstration Project that are expected

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to continue in grantee communities beyond the period of OJJDP funding. The report concludes with a summary of the accomplishments of grantees in creating a responsive system of care for children exposed to violence and their families, a discussion of the challenges and opportunities associated with implementing and sustaining the Safe Start Demonstration Project, and recommended next steps.

2. Improvement in Service Delivery Systems

A fundamental goal of the Safe Start Demonstration Project was to improve access to and delivery and quality of services for young children exposed to violence or at high risk of exposure, along with their families and caregivers. Each grantee was expected to improve upon existing service delivery systems by making them both more comprehensive (i.e., providing multiple points of entry among key service sectors) and more responsive (i.e., linking families to appropriate services in a timely fashion).

This section first summarizes current understanding of the scope and nature of children's exposure to violence nationally and examines the accomplishments of the 11 Safe Start Demonstration Project grantees in that context. The section then considers the ways in which grantees improved the comprehensiveness and responsiveness of their local service delivery systems.

In general, Safe Start Demonstration Project grantees made local service delivery systems more comprehensive by engaging multiple sectors that respond to families in crisis (e.g., law enforcement, domestic violence agencies/shelters), thereby ensuring that "no door is a wrong door" for accessing services for children exposed to violence. Training service providers from multiple disciplines on children's exposure to violence was central to engaging these sectors. In addition, grantees implemented community awareness activities with the goal of educating and engaging families, neighbors, and friends as partners in identifying children exposed to violence and linking these children to services.

Systems were made more responsive by employing the following strategies:

- Developing screening processes to identify children exposed to violence,
- Centralizing services for children and families,
- Implementing the Child Development-Community Policing (CD-CP) program with adaptations for local settings,
- Integrating services for children and families,
- Enhancing or creating family-centered services responsive to multiple family needs, and
- Adopting or adapting local- and state-level policies.

This section ends with a summary of the number of children identified, assessed, and referred to services as a result of grantee efforts.

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2.1 Increased Understanding of the Nature and Scope of Children's Exposure to Violence in Safe Start Demonstration Project Grantee Communities

Understanding how many children are exposed to violence at the community level and the types of violence to which children are exposed is essential to assessing the effectiveness of efforts to improve service delivery to this population. Reliable data on the incidence and prevalence of children exposed to violence in the United States, however, are not currently available because of a lack of systematic documentation; according to Edmond, Fitzgerald, and Kracke (2005, p. 6), "Every year millions of children are exposed to violence, but there are no reliable, current estimates of national incidence and prevalence of [children exposed to violence]." Even less data exist to document the extent to which young children witness community violence (i.e., as opposed to domestic violence) (Feerick & Silverman, 2006). Safe Start Demonstration Project grantee efforts, therefore, focused in part on identifying the scope and nature of violence exposure in their communities.

Evidence suggests that most children identified and documented by Safe Start Demonstration Project grantees as exposed to violence were exposed to domestic violence and possibly child maltreatment. For national evaluation purposes, grantees were asked to maintain databases with information related to the violent event that triggered each child's participation in Safe Start services. According to the data collected by some grantees,[2] children were most likely to have been exposed to domestic violence and/or child maltreatment. Preliminary analyses[3] of the Safe Start evaluation outcome database indicate that the two most common types of violent events that triggered participation in Safe Start were "verbal threats, stalking, etc." (24%) and "punching/hitting" (20.5%);[4] perpetrators of the violent events were "father" (25%), "mother" (8.6%), and "mother's partner" (4%);[5] and persons injured in the event were "mother" (19%), "child" (10.6%), and "father" (6%).[6]

Data obtained by two grantees as part of local research projects further suggest that the type of violence children experience is often exposure to domestic violence. Analysis of San Francisco's police data and a review of existing incidence research (Shields, 2006) lead to the estimate that at least 11,000 (35%) and as many as 16,500 (52%) of the city's children under five years old are exposed to at least one incident of domestic violence each year. In Spokane, the mental health system launched a screening pilot to determine the prevalence of exposure to family violence in children 12 years and younger who enter the mental health system for services. The clinical directors of Spokane's four major child-serving mental health agencies estimate that 60% to 70% of

[2] This information was not collected by all grantees.
[3] Final figures are expected in September 2007.
[4] The Safe Start evaluation outcome database has an "exposure to violence" section. Within this section, grantees were asked to document the type of violent event using the following categories: 1) punching/hitting; 2) strangling; 3) throwing an object; 4) verbal threats, stalking, etc.; 5) gun; 6) knife; 7) other weapon; and 8) other type of violent event.
[5] The perpetrator was "unknown" for 25% of the cases.
[6] The person injured was "unknown" for 25% if the cases.

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their child population is exposed to or victimized by violence prior to referral (Spokane Safe Start, 2005).

In addition to these data, the types of sectors that served as points of entry into local service delivery systems (see Table 3 below) also suggest that children identified by Safe Start grantees were most commonly exposed to domestic violence, child maltreatment, or both; law enforcement and domestic violence agencies and shelters were the most typical points of entry for children exposed to violence in the demonstration sites.

Safe Start Demonstration Project grantees identified a total of 15,622 children exposed to violence over three years and across 11 sites (see Table 1). During the full implementation phase, Safe Start grantees identified an annual average of approximately 5,000 children exposed to violence, with this figure remaining fairly consistent over three years. There was, however, a minor downward trend (36% average decline) in number of children identified in seven sites in the fifth year (2005). The National Evaluation Team asked the project directors in these seven sites for their interpretation of the downward trend. Of the five who responded, all identified the anticipated or actual reduction in resources during the final year of implementation as the reason for decreased numbers of children identified. Funding cuts impacted identification of children through both reduced staffing (e.g., individuals responsible for identifying children left for other jobs, fewer individuals were available to conduct outreach to service providers) and reduced availability of services (e.g., with fewer or no services available, it did not make sense to continue identifying children).

Based on national and local estimates of children's exposure to domestic violence each year, grantees identified approximately one out of every five children exposed to such violence. Carlson (2000) recently estimated that 10% to 20% of American children are exposed to domestic violence each year; approximately seven to 14 million American children might, therefore, be exposed to domestic violence annually, given 2000 population data (US Census Bureau, 2000). Note, however, that Carlson's (2000) estimates are considered rough because they rely on imprecise definitions of domestic violence, retrospective accounts, and indirect measurement to arrive at a final number (Edelson, et al., in press).

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Table 1. Number of Children Exposed to Violence Identified by Safe Start Demonstration Project Grantees[7]

Safe Start Site	# of Children Identified (2002)	# of Children Identified (2003)	# of Children Identified (2004)	# of Children Identified (2005)	Total # of Children Identified (2002-2005)
Baltimore	-	-	261	272	533
Bridgeport	-	316	231	187	734
Chatham	74	143	122	106	447
Chicago	-	463	528	395	1,386
Pinellas	306	2,243	1,942	3,897	8,388
Pueblo of Zuni	-	-	21	93	114
Rochester	-	493	536	234	1,263
San Francisco	351	572	452	170	1,545
Sitka	-	-	55	82	137
Spokane	-	476	378	144	998
Washington County	-	42	20	17	79
Total	**731**	**4,748**	**4,546**	**5,597**	**15,622**

In addition to Carlson's (2000) *national* estimate, Safe Start Demonstration Project grantees estimated the percentages of children in their *local* communities exposed to violence. As mentioned, the local evaluator in San Francisco estimated that 35% to 52% of San Francisco's children and youth are exposed to at least one incident of domestic violence each year. As another example, in Rochester, an analysis of findings from a questionnaire administered to parents of all kindergarteners entering city schools revealed that one in six children (17%) are exposed to violence at home or in the community before they reach kindergarten (Rochester Safe Start, 2005). In Pinellas County, a consultant hired as part of the community assessment process estimated that 15% of children six years and younger have been exposed to violence or are at high risk of exposure (Pinellas Safe Start, 2005)

Using these estimates, the figures generated by Safe Start grantees can be put in context. Table 2 includes each community's population of children under five years of age (US Census Bureau, 2000), uses a moderate estimate of 15% to calculate the number of these children likely exposed to domestic violence,[8] then estimates the fraction of these children identified by Safe Start Demonstration Project grantees during the reporting year 2005. As shown in Table 2, Safe Start Demonstration Project grantees identified approximately one out of every five children (20%) estimated as potentially exposed to violence in 2005. This compares with a 2004 figure of 4,378 children (16%) identified (Association for the Study and Development of Community, 2005a). As Table 2

[7] Percentages represent a comparison between the number of children exposed to violence identified by the grantee and the number of children estimated to be potentially exposed to violence (see Table 1).

[8] A 15% estimate seemed reasonable given the range of the national estimate (10% to 20%), which includes children 18 years and younger, and the range of various local estimates (San Francisco's 35% to 52% for children and youth, Rochester's 17% for kindergarten children, and Pinellas' 15% for children six years old and younger).

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indicates, a wide range (4% to 100%) of children exposed to violence was identified across sites.

Table 2. Estimates of Percentage of Children Exposed to Violence Identified Across Safe Start Demonstration Project Sites[9]

Safe Start Site	Population of Children Under Five Years (2000)[a]	Estimated 15% of Population of Children Under Five Years Exposed to Violence	# of Children Exposed to Violence Identified by Safe Start in 2005 (% of Estimated Total # of Children Exposed)
Baltimore	41,694	6,254	272 (4%)
Bridgeport	11,397	1,709	187 (11%)
Chatham	3,095	464	106 (23%)
Chicago	18,992[b]	2,849	395 (14%)
Pinellas	45,354	6,803	3,897 (57%)
Pueblo of Zuni	512	77	93 (100+%)
Rochester	17,227	2,584	234 (9%)
San Francisco	31,633	4,745	170[c] (4%)
Sitka	565	85	82 (96%)
Spokane	13,676	2,051	144 (7%)
Washington County	1,727	259	17 (7%)
Total	**185,872**	**27,880**	**5,597 (20%)**

[a] The most recent population data is based on 2000 U.S. Census Bureau data; estimates for 2005 were not available from the Census Bureau. In three sites (Baltimore, Pinellas, San Francisco), population estimates based on the 2004 American Community Survey were available. The change in total population of children under five years from 2000 to 2004 in Baltimore, Pinellas, and San Francisco was an increase of one percentage point or less. Population figures, unless otherwise noted, were obtained online at http://factfinder.census.gov using the Population Finder link.
[b] This figure was obtained from the Chicago Safe Start Strategic Plan Matrix (08/10/03).
[c] This figure presents the number of children exposed to violence identified between January and June 2005.

The estimated numbers of children exposed to violence presented in Table 2 are likely moderate estimates or potential underestimates for several reasons. First, the estimates do not include children and families who experience violence but are unknown

[9] It should be noted that the populations given are for children under five years; however, grantees were identifying children six years and younger (or, in some cases, even older children). In the percentages, therefore, the numerator and the denominator are based on two different sample sets. The category "under five years" is the one used by the U.S. Census Bureau (with the next category including children five to nine years of age).

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to relevant agencies. Second, relevant agencies do not always document the number of children identified as exposed to violence; even among those who do screen for violence exposure, screening and documentation may not be as systematic as possible. Finally, larger, more urban communities may face logistical challenges to identifying all children exposed to violence; these challenges may be greater than those in smaller, more rural communities, which may have fewer agencies among which to coordinate systematic screening and documentation.

The range of percentages of exposed children identified across grantees may be attributed, therefore, to diversity in population size and service delivery system capacity across communities. For example, relatively small populations of children are exposed to violence in small communities (e.g., Pueblo of Zuni, Sitka), which may make systematic identification of children more feasible than in larger communities with larger populations. Alternatively, sites with superior capacity to systematically collect data may have been better able to document the extent to which children were identified. In Pinellas, for example, the capacity to systematically collect data existed prior to implementation of the local Safe Start project; with partners already participating in the reporting of data related to child and family services, Pinellas Safe Start could relatively easily request and receive additional data specific to violence exposure. Conversely, some sites lacked sufficient agency infrastructure or buy-in to document the number of children exposed to violence by systematically collecting data. For example, in sites that did not have existing mechanisms for collecting and sharing child and family data among Safe Start partners prior to the initiative (e.g., Baltimore, Spokane), the grantees were unable to facilitate the full compliance necessary for effective implementation of a cross-system data-collection process.

2.2 Safe Start Demonstration Project Grantee Efforts to Create Comprehensive Service Delivery Systems

Safe Start Demonstration Project grantees improved access to services by creating multiple points of entry into local service delivery systems. A comprehensive system of care provides various opportunities for families in need to access help, with both professional and public participation in connecting families with services.[10] The range of key points of entry for prevention and intervention created by Safe Start Demonstration Project grantees and their frequency of use are reported in Table 3. Grantees most commonly used law enforcement and domestic violence agencies to engage parents/caregivers into needed services; that these two entities are important points of entry is not surprising, given that families experiencing violence most typically contact the police in crisis situations and domestic violence agencies for more sustained help. Many grantees also relied upon court personnel, child protection workers, and health and human services providers to refer families to needed services. Like the law enforcement and domestic violence sectors, these sectors have regular contact with families in need, which creates regular opportunities to intervene on behalf of children

[10] Nine of the 11 Safe Start Demonstration Project grantees identified the "community" or "self-referrals" as a point of entry into the service delivery system. The number of children exposed to violence identified by community members is largely unknown, however.

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who have been exposed to violence or who are at risk of exposure. It is important for communities to prepare all public sector service providers that have regular contact with families and children—both in crisis situations and non-crisis situations (e.g., early childhood education and child care settings)—to recognize and respond to children exposed to violence.

Table 3. Key Points of Entry into Service Delivery System Created by Safe Start Demonstration Project Grantees

Key Points of Entry	# of Safe Start Sites
Law enforcement	11
Domestic violence agencies/shelters	9
Community residents (e.g., family, friends, neighbors)/self-referrals	9
Early childhood development and child care, Head Start	8
Courts: judges, attorneys, guardians *ad litem*, court-appointed special advocates, administrative staff in dependency/juvenile courts, family courts, domestic-violence courts, and drug courts	8
Child protective services	7
Human/social/public health service agencies	7
Mental health/behavioral health services	6
Helpline/supportline/2-1-1	3

Creating collective responsibility for identifying young children who have been exposed to violence or are at high risk for exposure simultaneously opened multiple new gateways into grantee communities' service delivery systems. When different sectors of the service delivery system were made aware of the significance of child exposure to violence, children and their families became more likely to gain access to needed services. Providing opportunities for professionals from multiple disciplines to learn about children's exposure to violence was essential for engaging them in the identification and referral processes; this is discussed next.

Safe Start Demonstration Project grantees created multiple points of entry into local service delivery systems by training professionals from multiple disciplines and educating community residents. Two of the primary purposes for developing and implementing training were to teach service providers across disciplines to 1) identify children exposed to violence and 2) link these children to appropriate services. All 11 Safe Start Demonstration Project grantees developed training materials (e.g., curriculum manuals, training guides), now accessible to anyone interested in learning more about children exposed to violence.[11] In general, Safe Start Demonstration Project grantees conducted three types of training:

- Specialized training on early childhood development, brain development, specific therapeutic interventions (e.g., parent-child interaction therapy or PCIT),

[11] The Office of Juvenile Justice and Delinquency Prevention has collected all training materials (e.g., curricula, guides) developed by Safe Start Demonstration Project grantees to enable interested individuals to access these materials from one central location.

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gathering forensic evidence, or responding to children exposed to violence and their families;

- Cross-sector training, in which representatives from one sector trained providers in another sector (e.g., domestic violence workers trained child protection workers, social service providers learned about judicial processes and legal issues); and
- Training on how racism and cultural incompetence can negatively affect the delivery of services to children exposed to violence.

Specialized trainings achieved a third purpose; in addition to increasing the likelihood that professionals would 1) identify young children exposed to violence and 2) link these children to appropriate services, the topics addressed through specialized trainings increased the likelihood that professionals would 3) improve the quality of their own services to this population.

All grantees engaged in community education and awareness activities with the goal of increasing the general public's ability to identify children exposed to violence and knowledge of resources available to help these children and their families. Awareness activities ranged from presentations to community groups (e.g., schools and churches in Baltimore), to more formal community outreach efforts (e.g., Chatham's community outreach coordinator; Pinellas's community engagement coordinator, facilitators, and ambassadors), to social marketing campaigns (e.g., in Bridgeport, Chicago, Pinellas, Rochester, San Francisco, and Washington County). One grantee (Rochester) conducted a multifaceted social marketing campaign and evaluated its impact using a non-equivalent control group design. Findings indicated an increase in the proportion of adults in the campaign's target community who reported taking action (vs. doing nothing) after seeing a child being exposed to violence. There was no increase in such self-reported behavior in the comparison community.

Table 4 summarizes the number of individuals in grantee communities trained on issues related to children's exposure to violence. Over 11,000 persons of multiple disciplines were trained during the key implementation years (2003 and 2004) to help increase the identification of children exposed to violence and improve the quality of services provided to these children and their families. Training continued throughout the final phase of implementation, with over 9,000 more individuals trained. Training efforts most likely continued due to their role in sustaining the Safe Start mission; the more individuals in a community knowledgeable about children exposed to violence, the greater is the likelihood that these issues will continue to be addressed beyond the OJJDP funding period.

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Table 4. Total Number of People Trained Annually on Issues Related to Children Exposed to Violence[12]

Safe Start Site	# Trained (2002)	# Trained (2003)	# Trained (2004)	# Trained (2005)
Baltimore	-	20[a]	704	402
Bridgeport	-	1,298	1,113	645
Chatham[b]	499	554	990	959
Chicago	-	2,251	726	554/ 1,978[c]
Pinellas[d]	1,195	3,586	1,885	1,285
Pueblo of Zuni[e]	-	292	506	436
Rochester	37[f]	698/ 937[g]	131/ 671[h]	811/ 1,059[i]
San Francisco	303	725	1,167	1,031[j]
Sitka	-	-	-	139[k]
Spokane	529[l]	682	3,000	195
Washington County	-	975	1,045	1,762[m]
Total	2,563	11,081/ 11,320	11,272/ 11,812	8,222/ 9,894

[a] This figure is reported in the Baltimore Safe Start 2005 Local Evaluation Report Form.
[b] These figures are reported in the Chatham Safe Start 2005 Local Evaluation Report Form. The local evaluator communicated to the National Evaluation Team that these figures are more accurate than those reported in the semi-annual progress reports submitted to OJJDP.
[c] According to Chicago Safe Start's December 2005 Progress Report, the 1,978 figure includes partners and non-evaluated training.
[d] These figures are reported in the Pinellas Safe Start Implementation Phase Accomplishments (2002-2005) report submitted to the National Evaluation Team by the local evaluator in July 2006.
[e] These data were submitted by the Zuni project director to the National Evaluation Team via email on May 18, 2006.
[f] This figure is reported in the Rochester Safe Start 2005 Local Evaluation Report Form.
[g] According to Rochester Safe Start's December 2003 Progress Report, the 937 figure includes presentations as well as trainings of six hours or more. The 698 figure reflects the number of individuals that participated in trainings of six hours or more.
[h] According to Rochester Safe Start's December 2004 Progress Report, the 671 figure includes presentations as well as longer trainings. In addition, the 671 figure includes 200 physicians who attended pediatric grand rounds on children exposed to domestic violence in spring 2004.
[i] According to Rochester Safe Start's December 2005 Progress Report, the 1,059 figure includes presentations, as well as longer trainings and 115 police officers who participated in brief roll-call training on SAFE Kids. The 811 figure excludes both police officers and presentations (i.e., this figure includes only longer trainings).
[j] This figure reflects the number of persons trained from January to June 2005.
[k] Sitka's project director communicated this figure to the National Evaluation Team during the 2005 site visit.
[l] This figure is reported in the Spokane Safe Start 2005 Local Evaluation Report Form.
[m] This figure reflects the number of persons trained from January to June 2005.

[12] Unless otherwise indicated in the table notes, the sources for all figures in Table 4 are the semi-annual progress reports submitted by Safe Start Demonstration Project grantees to OJJDP.

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2.3 Safe Start Demonstration Project Grantee Strategies to Create Responsive Service Delivery Systems

In addition to creating more comprehensive service delivery systems, Safe Start Demonstration Project grantees made systems more responsive by employing the strategies described in detail below.

Identifying children exposed to violence required that Safe Start Demonstration Project grantees develop screening procedures and protocols. Prior to Safe Start, many child-serving agencies lacked screening procedures and protocols for identifying children exposed to violence. Grantees developed new screening procedures through instrument validation studies (i.e., testing whether or not an instrument measures what it is intended to measure), creation of screening forms designed specifically to detect violence exposure, or addition of a question or code to existing forms.

Screening forms developed by grantees included questions such as:

- *Has the child been exposed to violence?*
- *Has the child witnessed domestic violence (physical, verbal, emotional, and/or sexual abuse)?*
- *Has your child (name) been hurt or seen someone hurt through violence, at home, in the neighborhood, or somewhere else?*

These forms also typically included questions about symptomatic behaviors (e.g., sleep disturbances, more active or violent play) and emotions (e.g., frequent expression of fear, increased anxiety). Questions about frequency of exposure and nature of the violence exposure (e.g., community or domestic violence) also were included in some forms.

An example of a screening question added to an existing form is: "*Has your child experienced something potentially upsetting (such as an automobile accident or family violence)?*"

Additionally, documenting the presence of young children at the scene of a violent incident on a dispatch or police report was a common strategy used to increase identification of children exposed to violence. In the case of at least one site (Pinellas), if young children entered a domestic violence shelter with their parents, they were automatically assumed to have been exposed to violence or to be at high risk of exposure.

Using these screening procedures and protocols, Safe Start Demonstration Project grantees identified a total of 15,622 children exposed to violence over three years and across 11 sites (see Table 1). Based on the estimate of total number of children under five years of age exposed to violence in each site (see Section 2.1), the trend data indicate that, overall, grantees were able to identify one in five children (20%) potentially exposed to violence by the end of the first five years of the demonstration project. The high

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percentages of children exposed to violence identified during 2005 in tribal areas, as well as in Pinellas, drove the overall 20% identification rate, despite considerably lower rates in other sites. An additional trend worth noting is the decreased percentage of children identified in seven of the sites in the year 2005. The National Evaluation Team asked the project directors in these sites for their interpretation of the downward trend. Of the five who responded, all identified an anticipated or actual reduction in resources during the final year of implementation as the reason for decreased numbers of children identified; funding cuts impacted identification of children through both reduced staffing (e.g., individuals responsible for identifying children exposed to violence left for other jobs, fewer individuals were available to conduct outreach to service providers) and reduced availability of services (e.g., with fewer or no services available, it did not make sense to continue identifying children).

Safe Start Demonstration Project grantees coordinated fragmented service delivery systems by centralizing access to appropriate services. Ten of the grantees (all of those that focused on implementing treatment interventions) established processes for referring identified children to a specialist in the field, typically a specialist funded by Safe Start and housed within the project's lead agency or another agency receiving Safe Start funding. (See Appendix D for figures depicting each site's service delivery model.)

Six of these ten grantees (Baltimore, Bridgeport, Chatham, Pueblo of Zuni, Sitka, and Washington County) implemented a two-step process, in which referrals were received by a Safe Start staff person and then forwarded to an appropriate service provider. Five of these six grantees referred families to mental health providers; in Bridgeport, however, referrals were sent to a children's advocacy center,[13] designed around a core model of multidisciplinary teams and co-located services.

Four of the ten grantees (Chicago, Pinellas, San Francisco, and Spokane) implemented a one-step process, in which referrals were sent directly to a service provider trained in issues related to children's exposure to violence. These individuals were located in community-based family-service centers (Chicago), a children's advocacy center (Pinellas), family resource centers[14] (San Francisco), or a crisis-intervention team (Spokane). More families received some type of help in sites that 1) did not rely on a "middleman" (i.e., a coordinator) to link families to services and 2) offered families more than mental health services.

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[13] Children's advocacy centers stress coordination of investigation and intervention services by bringing together professionals and agencies as a multidisciplinary team to create a child-focused approach to child abuse cases. Priority is given to cases of child sexual abuse and severe physical abuse. Child protection, law enforcement, prosecution, victim advocacy, medical, and mental health communities work together to provide children and their families with comprehensive services (e.g., medical, emotional, legal, investigative, victim advocacy), co-located in one child-focused and child-friendly center: a safe haven. See www.nca-online.org for more information about the National Children's Alliance, which is funded by OJJDP to improve services to children and families.

[14] Family resource centers are community-based organizations that serve families experiencing violence. Services provided include housing assistance, employment, counseling, and parenting skill development.

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The remaining site, Rochester, did not centralize access to therapeutic services, but did infuse Safe Start resources into existing community programs with the goal of addressing unmet community needs. Children's Institute, the lead agency for Rochester Safe Start, operates under fundamental principles that include 1) integrating community efforts to avoid duplication and 2) supporting existing alliances in the community. Consistent with this organizational approach to working in the community, the Rochester grantee dedicated Safe Start resources to enhancing ongoing efforts in the community. Specifically, Rochester Safe Start worked with early childhood providers, the courts, the police department, and mental health providers to offer children and families universal interventions (e.g., social marketing campaign, early childhood mentor program, community engagement/Safe At Home), as well as targeted interventions (e.g., SAFE Kids, mental health services for foster-care children, supervised visitation, court advocates), designed to reduce children's exposure to violence and its impact.

Safe Start Demonstration Project grantees implemented and adapted Child Development-Community Policing (CD-CP). [15] CD-CP programs partner police officers with mental health clinicians to provide families with short-term crisis intervention services. Grantees adapted this nationally known service-integration model to local conditions through 1) observing the original program in New Haven, CT; 2) receiving technical assistance from the experts who developed the program; and 3) accessing a peer network and other resources associated with the original program and its developers. Six grantees infused Safe Start resources (e.g., funded staff positions, funded training opportunities) into CD-CP programs, some of which existed prior to the Safe Start Demonstration Project. Though the CD-CP program was not necessarily a central component of the Safe Start service delivery system in these six sites, CD-CP served as an important source of referrals and provided some families and children with needed crisis intervention services.

In contrast to these six grantees, the Spokane Safe Start grantee utilized the Child Outreach Team, a program similar to CD-CP, as a core service delivery model. In this model, the 9-1-1 call center asked about the presence of children when receiving a domestic violence call. If children were reported as present, the 9-1-1 dispatcher entered a Safe Start code in the report that went out to the responding officer. Consenting families then met with an on-call Child Outreach Team clinician, who was called to the scene by the police officer to provide assessment and treatment for the family; clinicians were drawn from three partnering agencies, including a children's advocacy center.

Other Safe Start Demonstration Project grantees adapted the CD-CP model to local contexts in other ways. In Chatham, for example, the grantee used Safe Start funds to create a family responder position within the sheriff's department; the family responder worked with officers to link families to social services. Similarly, the Rapid Response Team in Washington County met with families following a police response and conducted preliminary and final assessments before referring children to other community service providers. In Chicago, the Safe Start grantee relied on first responders

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

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(e.g., police officers, emergency medical services) to document the presence of young children at the scene of violent incidents and provide families with information about the mayor's domestic violence helpline; in 2005, first responders started making direct referrals to Chicago Safe Start's family service providers. Similarly, in San Francisco, SafeStart funds helped support a coordinator position within the police department's Domestic Violence Response Unit; this individual works closely with family resource center family advocates to coordinate services for families and their children.

Safe Start Demonstration Project grantees implemented service integration practices. Efforts at human services integration began in the 1960s (Agranoff, 1991) and continue nearly 50 years later with initiatives such as the Safe Start Demonstration Project. According to Agranoff (1991), human services integration is "the quest for the development of systems that are responsive to the multiple needs of persons at-risk: victims of the most severe social problems." All Safe Start Demonstration Project grantees integrated services through various types of strategies (see Table 5 for a summary of strategies).

Table 5. Service Integration Practices Implemented by Safe Start Demonstration Project Grantees

Service Integration Practice	# of Safe Start Sites
Co-located and coordinated services across organizations	8
Shared case information	7
Examined existing and/or past case records for children exposed to violence	4
Developed new structures to integrate services system-wide	2

Co-located and coordinated services across organizations**.** Eight Safe Start Demonstration Project grantees either 1) co-located services for more integrated service provision or 2) coordinated services to allow families to receive services relatively seamlessly across sectors. In Baltimore, domestic violence outreach services were coordinated with counseling services; in some cases, families could receive both types of services in their homes. Child FIRST, in Bridgeport, co-located several types of services for abused children and coordinated community-located services for families. In Chicago, two of the organizations that provided Safe Start services not only made cross-referrals, but also cross-located selected staff one day a week to provide seamless counseling and family support services. Foster-care children received mental health services as a result of Safe Start in Rochester. In San Francisco, families receiving services through family resource centers were connected to behavioral health clinicians, as appropriate, via Safe Start. In Sitka, several services for families will be co-located at the Family Justice Center. Families seen by the Child Outreach Team in Spokane also had access to case management that linked them to services other than mental health treatment. Finally, in Washington County, forensic interviewing was implemented to reduce the need for various professionals (e.g., law enforcement, court personnel, social workers, physicians)

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to independently interview child abuse victims, thereby reducing the number of potentially re-traumatizing interviews.

Shared case information. Seven Safe Start Demonstration Project grantees (Baltimore, Chatham, Pinellas, San Francisco, Sitka, Spokane, and Washington County) improved the management of cases at the client level by sharing confidential case information across agencies. This was an important systems 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 sharing of confidential information, which can result in inadequate care and follow-up. Support for children exposed to violence requires a coordinated response among the organizations providing services, and information sharing is a critical component of coordinated care. The two strategies used for sharing case information were:

- Development and use of formal agreements. The organizations involved in initiatives that took this approach developed interagency agreements that 1) described each agency's roles and responsibilities in the information-sharing process and 2) established regulations for protecting client confidentiality.

- Coordination and collaboration during service delivery. Information sharing in this approach 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.

Examined existing and/or past case records for children exposed to violence. In 2004, law enforcement partners in one demonstration site (San Francisco) 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 officer. This improved the capacity of law enforcement agencies to support young children exposed to violence and their families, beyond arresting the batterer. In addition, mental health providers in three sites (Baltimore, Chicago, and Spokane) reviewed existing cases for the presence of family violence, with the goal of providing additional support services to families in need. Also in Baltimore, child protection workers were trained to screen existing and previous case records for domestic violence so that families could be linked to appropriate services.

Developed new structures to integrate services system-wide. Two grantees (San Francisco and Pinellas) most closely achieved system-wide service integration by developing and implementing new structures or working relations among agencies to facilitate the referral of children and families to appropriate services. Like other grantees, these two grantees relied on strategies such as case sharing and coordination of services across sectors, but also created overarching structures through which these strategies

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could be implemented. Overarching structures were responsible for convening service providers from multiple agencies on a regular basis to ensure that families received all appropriate services in a sequence useful to the family.

In San Francisco, the Service Delivery Team convened twice a month for case analysis; this team consisted of direct service providers (e.g., family advocates, clinicians), a representative from the police department's Domestic Violence Response Unit, and a child-trauma expert. Pinellas relied on a virtual center of service providers, contractually obligated to one another to refer families to Safe Start's Intensive Family Services program and to each others' services as appropriate; these service providers included domestic violence specialists, public health department home visitors, staff responsible for investigating reports of child abuse and neglect, and staff that fielded hotline (2-1-1) calls about community resources.

Safe Start Demonstration Project grantees engaged families in services by offering and coordinating holistic services in convenient locations. Families with young children exposed to violence typically have multiple needs, such as employment, housing, transportation, child care, and individual counseling for substance abuse and/or mental health issues. Safe Start Demonstration Project grantees that engaged (i.e., identified, assessed, referred, treated) the highest numbers of children and families early in the initiative, and were able to maintain these relatively high numbers over time, provided a range of family services, rather than mental health services exclusively. These grantees also provided services in credible community-based settings (e.g., Metropolitan Family Services and Family Focus in Chicago, family resource centers in San Francisco, Child FIRST in Bridgeport), in families' homes, within classroom settings, or in child care settings. The Baltimore grantee most successfully engaged families after funding a community outreach position, located in a domestic violence agency and responsible for providing a range of services (e.g., domestic violence, clinical) in families' homes. In Washington County, by contrast, the numbers of families engaged in services did not increase much over time; this grantee relied primarily on a strategy of funding slots within a mental health agency.

Providing holistic services in convenient locations are practices consistent with those identified by the National Wraparound Initiative[16] as having the most potential for making meaningful improvements in the lives of children with complex needs and their families. The wraparound process relies on a team working collaboratively to develop and implement a plan that meets the unique needs of each child and family; this team consists of the child/youth, parents/caregivers and other family and community members (e.g., neighbors, church members, co-workers), mental health professionals, educators, and others from the formal service system. Another key principle underlying the wraparound model is cultural competence: the intervention process must build on the unique values and preferences of children and their families. In addition, a quality wraparound process offers children and families individualized, community-based services that build on their strengths.

[16] For more information about the National Wraparound Initiative, go to: www.rtc.pdx.edu/nwi/NWIWork&Prod.htm.

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Principles similar to those of the wraparound model were identified by the National Evaluation Team (Association for the Study and Development of Community, 2005b) through a review of the literature on effective engagement and retention strategies. According to the literature, family and mental health service providers are more successful at engaging and retaining families in services when they focus on the following:

- Building relationships with families,
- Leveraging families' existing supportive relationships,
- Designing and providing responsive and respectful services,
- Using strategic and strengths-based marketing, and
- Addressing and removing participation barriers for families.

Three Safe Start Demonstration Project grantees improved existing mental health services in the community by institutionalizing the use of evidence-based therapeutic interventions for traumatized young children. Drs. Lieberman and Van Horn, two leading experts in the field of young children and trauma, specify four core principles of trauma treatment for infants, toddlers, and preschoolers (Lieberman & Van Horn, 2004):

1. Establish a safe environment for the child and caregiving adults.

2. Ground the therapeutic intervention in the parent/caregiver-child relationship. This principle reflects the fact that infants, toddlers, and preschoolers are completely dependent on their primary caregivers for their physical care and psychological wellbeing and rely on caregivers as a safe haven in dangerous situations.

3. Focus on key developmental tasks (e.g., development of secure attachments, balance between attachment and autonomy, regulation of emotion, achievement of age-appropriate socialization skills) that can be derailed by the traumatic experience.

4. Attend to the potential effect of trauma on future development (e.g., the ability to form satisfying relationships with teachers and peers, readiness to learn).

Appropriate therapeutic intervention with young children exposed to violence will apply these principles.

Furthermore, according to the most recent research on early trauma treatment (Lieberman & Van Horn, 2004; Feerick & Silverman, 2006), reducing violence exposure and its impact means in large part improving the ability of parents to protect their at-risk children. The parent-child relationship will either exacerbate or mitigate the effects of violence exposure, given the central role parents play in keeping young children safe. If parents cannot ensure the safety of their children, they jeopardize the child's ability to

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attain normal developmental functioning. Therefore, providing appropriate therapeutic services to families in need—and not only to victimized children—is an important way to improve the quality of services for families.

Three Safe Start Demonstration Project grantees institutionalized the use of appropriate, evidence-based therapeutic interventions for traumatized young children. In Pinellas, 29 private therapists received funding for specialized training in child-parent psychotherapy (CPP)[17] and parent-child interaction therapy (PCIT).[18] In San Francisco, a key partner was the Child Trauma Research Project at San Francisco General Hospital, where Dr. Van Horn provides case consultation as well as training to behavioral health practitioners who treat children exposed to violence. In Sitka, therapists responsible for treating children exposed to violence were trained to provide parent-child interaction therapy. In addition, the Sitka grantee received technical assistance from a Native American psychologist at the University of Oklahoma to adapt PCIT to a more culturally appropriate model for the Native community.

2.4 Safe Start Demonstration Project Grantee Identification, Assessment, and Referral of Children Exposed to Violence

As a result of the more comprehensive and responsive service delivery systems developed by grantees, increasing numbers of children exposed to violence were identified during the implementation of the Safe Start Demonstration Project. As summarized in Table 6, Safe Start Demonstration Project grantees identified a total of 15,622 children exposed to violence over the course of the initiative. A total of 5,323 of these children also received assessment, and 7,840 children were referred to appropriate services. These latter figures are challenging to interpret for several reasons, which are discussed next.

Table 6. Total Number of Children Exposed to Violence Identified, Assessed, and Referred Across All Safe Start Demonstration Project Sites

Total Number of Children Exposed to Violence	2002	2003	2004	2005	Total Across Years

[17] Van Horn and Lieberman (2006) define child-parent psychotherapy as a relationship-based model of intervention developed with the specific aim of helping young children (in the first six years of life) who have suffered traumatic life experiences, specifically, witnessing the battering of their mothers by father figures.

[18] The National Child Traumatic Stress Network defines parent-child interaction therapy as an evidenced-based treatment model with highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions, and, using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver-child patterns. PCIT was initially targeted to families with children aged two to seven years with oppositional, defiant, and other externalizing behavior problems, but has been adapted successfully to serve physically abusive parents with children aged four to 12 years. See www.NCTSNet.org.

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Identified	731	4,748	4,546	5, 597	15,622
Assessed	83	1,459	2,013	1,768	5,323
Referred	200	2,272	3,001	2,367	7,840

Safe Start demonstration sites were required to report the number of children identified, assessed, and referred for services because of exposure to violence. These figures were reported twice a year in the grantees' semi-annual progress reports. As described in the National Evaluation Team's 2004 Annual Process Evaluation (Association for the Study and Development of Community, 2005a), the figures are difficult to compare across sites for various reasons. Most fundamentally, "identified," "assessed," and "referred" were defined differently across grantees.[19] For example, in some sites, "assessed" was defined as a comprehensive mental health assessment conducted by a clinician; in other sites, "assessed" children were those who underwent 1) an initial screening for exposure to violence by family advocates or 2) an initial screening, via an instrument or question on an intake form, that formally "identified" the child as exposed to violence. Similarly, some sites defined "referred" as referred *to* Safe Start services; in other sites, "referred" meant referred *from* Safe Start services to other services.

The sequence of decision points in the service pathway also differed across sites. In some sites "assessed" and "referred" represented a simultaneous decision point, or step, in the service pathway. For example, in Rochester, Spokane, and Washington County, all children assessed were referred to service; therefore "assessed" and "referred" figures were identical when reported in the sites' progress reports (see Tables 7 and 8).

[19] OJJDP acknowledges known limitations in the performance measures and that demonstration sites were not provided consistent guidelines regarding definitions.

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Table 7. Number of Children Exposed to Violence who Were Assessed across All Safe Start Demonstration Project Sites[20]

Safe Start Site	# Children Assessed (2002)	# Children Assessed (2003)	# Children Assessed (2004)	# Children Assessed (2005)	Total # Children Assessed
Baltimore City	-	-	261	168	429
Bridgeport	-	116	65	130	311
Chatham County[a]	-	-	-	-	261
Chicago	-	-	226	248	474
Pinellas County	17	133	187	221	558
Pueblo of Zuni	-	-	21	93	114
Rochester	-	493	536	234	1,263
San Francisco	66	199	264	170	699
Sitka	-	-	55	82	137
Spokane	-	476	378	144	998
Washington County	-	42	20	17	79
Total	83	1,459	2,013	1,507	**5,323**

[a] The Chatham County Safe Start grantee provided updated figures in the feedback to the case study. The total number of children assessed was revised but not disaggregated by year.

Table 8. Number of Children Exposed to Violence who Were Referred for Services across All Safe Start Demonstration Project Sites[21]

Safe Start Site	# Children Referred (2002)	# Children Referred (2003)	# Children Referred (2004)	# Children Referred (2005)	Total # Children Referred
Baltimore City	-		261	173	434
Bridgeport	-	193	235	78	506
Chatham County[a]	-	-	-	-	204
Chicago	-	-	528	395	923
Pinellas County	66	817	746	777	2,406
Pueblo of Zuni	-	-	21	93	114
Rochester		493	536	234	1,263
San Francisco	134	251	221	170	776
Sitka			55	82	137
Spokane		476	378	144	998
Washington County		42	20	17	79
Total	200	2,272	3,001	2,163	**7,840**

[a] The Chatham County Safe Start grantee provided updated figures in the feedback to the case study. The total number of children referred was revised but not disaggregated by year.

[20] The sources for all figures in Table 7 are the semi-annual progress reports submitted by Safe Start Demonstration Project grantees to OJJDP. Some cells are missing data because the information was not reported to OJJDP.

[21] The sources for all figures in Table 8 are the semi-annual progress reports submitted by Safe Start Demonstration Project grantees to OJJDP. Some cells are missing data because the information was not reported to OJJDP.

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2.5 Safe Start Demonstration Project Grantee Adoption or Adaptation of Policies to Increase the Responsiveness of Local Service Delivery Systems

In addition to developing and implementing new pathways to services and specific practices, Safe Start grantees also sought to impact local and state policy.

Sites more easily changed local policies than state-level policies. Changes to local policies typically focused on adapting old or adopting new interagency practices regarding identification and referral of children exposed to violence and their families; these types of changes usually required the buy-in of key agency heads who championed the policy change within Safe Start partnering agencies.

State-level policy change, on the other hand, required grantees to participate in policy and advocacy groups beyond their immediate local collaboratives or advocacy groups, a much more challenging capacity to realize during the short implementation period of the Safe Start Demonstration Project. Nevertheless, in a few Safe Start sites, local leadership was able to promote state-level change. In Washington County, for example, under the leadership of the district attorney's office, a campaign is underway to implement forensic interviewing statewide in cases involving child exposure to violence; this law enforcement policy will likely be adopted across the state of Maine. Additional policies resulting from the work of Safe Start Demonstration Project grantees during the period covered in this report are as follows:

- Chicago Safe Start, in collaboration with the Illinois Violence Prevention Authority, worked to pass the Illinois Children's Mental Health Act of 2003;
- Pinellas Safe Start, in collaboration with statewide domestic violence agencies, developed a five-year prevention plan for Florida that includes priority resources for domestic violence;
- Pinellas Safe Start supported local domestic violence agencies and child protective services in developing an interagency agreement for actions to be taken when children are involved in a case of domestic violence;
- The Washington County grantee spearheaded efforts to establish a 2-1-1 hotline in Washington County and statewide;
- The Washington County grantee's mandated reporter training curriculum was adopted as the protocol for statewide training;
- Zuni Safe Start worked with the Zuni Tribal Council to revise the Zuni Children's Code to recognize family violence as an issue for children; and
- Zuni Safe Start worked with the tribal courts to establish a policy of mandated treatment for parents involved in domestic violence.

Achieving these changes in the service delivery system for children exposed to violence and their families required partnering agencies and others within the system to achieve a level of integration and collaboration. The ways in which Safe Start Demonstration Project grantees developed and utilized collaborative relationships to achieve systems change are discussed next.

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3. Factors Affecting Safe Start Demonstration Project Systems Change Efforts

3.1 Approaches to Collaboration that Led to Systems Change

Safe Start Demonstration Project grantees were expected to expand existing partnerships among service providers in the fields of early childhood education/development, health, mental health, family support, domestic violence, substance abuse prevention and treatment, crisis intervention, child welfare, law enforcement, courts, and legal services. The collaboration promoted and supported by grantees was intended to improve service access, delivery, and quality at any point of entry into the system for young children exposed to violence and their families and caregivers.

Collaboration across diverse sectors can be both rewarding and challenging; many conditions, from leadership turnover to changing priorities, can facilitate or hinder collaboration. This section describes the collaborative features of Safe Start Demonstration Project grantees found to be most appropriate for effecting systems change, along with conditions that facilitated or hindered progress.

The following features of collaboration, common across the 11 Safe Start Demonstration Project grantees, appeared most appropriate for effecting systems change:

- Wide engagement from sectors that provide four critical functions related to Safe Start Demonstration Project goals:
    - Research and knowledge development;
    - Education for prevention purposes;
    - Identification and referral of children exposed to violence; and
    - Treatment, intervention, and other appropriate care;
- Strategies for overcoming philosophical differences about the way each sector responds to children exposed to violence and their families;
- Structures for effectively coordinating the roles and input of collaboration partners;
- Clear roles and tangible benefits for partners; and
- Credible, influential, and consistent leadership.

While the patterns derived from the data clearly pointed to the above features, there were occasional exceptions because of unique circumstances; these cases will be pointed out as appropriate. It is also important to remember that no single approach or condition alone led to systems change; it was the combination of different approaches and conditions that maximized each grantee's potential to change the system.

Wide engagement of sectors that provide four critical functions. Reports from grantees indicated that the wider the engagement in the collaboration, both vertically (across job roles, from point-of-service providers to agency directors) and horizontally (across sectors, from education to law enforcement), the more potential the collaboration

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had to influence systems change at the community, point-of-service, and organizational levels. Grantees commonly reported participation of the following sectors (listed here along with their specific collaboration functions and representative agencies):

- Research and knowledge development sectors, to help stakeholders learn more about the characteristics of children exposed to violence, the extent of the problem, and evidence-based solutions. These sectors include:
    - Universities and research institutes,
    - Internal research and evaluation units, and
    - Private research companies and consultants.

- Education sector, to help the public and families learn more about the harm of childhood exposure to violence. This sector includes:
    - Social support networks (e.g., faith institutions, neighborhood associations),
    - Agencies responsible for supervised visitation to increase child stability,
    - Classroom consultation for early childhood education and care providers,
    - Family support centers and family strengthening services, and
    - Media outlets.

- Identification and referral sectors, to help identify children exposed to violence and refer them to the appropriate resources. These sectors include:
    - Law enforcement agencies;
    - Child and family services;
    - Domestic violence victim advocates, shelters, and hotlines;
    - Courts and adult probation office;
    - Early childhood development agencies; and
    - Substance abuse prevention and treatment services.

- Treatment and care sectors, to help reduce the impact of violence exposure on children and their families. These sectors include:
    - Counselors and clinical psychologists, and
    - Hospitals and clinics.

Table 2 in Section 2 shows the number of Safe Start Demonstration Project grantees that engaged representatives from the above sectors.

Lack of or limited involvement from any one of the above sectors limited the potential of grantees to effect comprehensive systems change.[22] In almost all demonstration sites, the education/prevention sector was less engaged and, therefore, less impacted than the identification and referral sectors (see Section 3.2 for a discussion of how the grantees engaged community residents and institutions).

[22] Two Safe Start grantees intended to affect only one part of the system that responds to young children exposed to violence. As a result, they focused heavily on representatives from sectors within the targeted part of the system.

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Strategies for overcoming philosophical differences about the way each sector responds to children exposed to violence and their families. Safe Start Demonstration Project grantees learned that wide engagement is essential for systems change; they also learned that diversity of engagement surfaces differences about the way each sector responds to children exposed to violence and their families. These differences were particularly apparent among the sectors of law enforcement, child protective services, and domestic violence victim advocates, each of which responds to family violence based on sector-specific philosophy, history, culture, and training of personnel: law enforcement officers typically focus their attention on the perpetrator, child protective service workers prioritize protecting the child, and domestic violence victim advocates focus on protecting the adult victim.

These differences, when not addressed adequately, often gave rise to tension, hindering coordination, collaboration, and integration of services. This tension was a particular challenge for the majority of Safe Start Demonstration Project grantees that believed in a holistic family approach (i.e., keeping the family together to the extent possible). Grantees frequently reported two strategies for dealing with differences:

- Deliberately setting aside time to build cross-sector awareness and understanding. Several grantees dedicated time, early on and throughout the initiative, for participating agencies to describe their mission and work, to promote cross-sector and cross-profession understanding and reduce stereotypes. The San Francisco grantee, for example, asked its partners to conduct presentations about their agencies during the planning process.

- Engaging professionals from one sector (e.g., domestic violence) to train their counterparts in another sector (e.g., child protective services). Three grantees took this approach, resulting in improved mutual understanding between sectors about their philosophies, practices, and procedures.

In the rural and tribal sites, the "small-town" nature of the communities meant that agency directors and service providers already knew each other, which proved helpful in overcoming differences, enabling individuals to work together easily and/or find other willing partners. For example, in one tribal site where agency leaders did not get along, other agency representatives remained a part of Safe Start because of personal relationships, thereby maintaining a connection among services.

Structures for effectively coordinating roles and input. With wide engagement of community agencies, local Safe Start programs required structure to coordinate the role and input of each individual and agency in the strategies planned and implemented. Safe Start Demonstration Project grantees' structures for effectively coordinating roles and input fell into two broad categories: multi-tiered and loosely-formed structures.

Multi-tiered structures. Seven Safe Start grantees developed functional multi-tiered structures to manage their local initiative's wide variety of partners, range of participating individuals (i.e., high-level leaders to point-of-service providers), and

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spectrum of representative commitment and decision-making authority (i.e., number of meetings each representative could attend and types of decisions each affected). Safe Start collaboratives with multi-tiered structures operated more formally than those without. The multi-tiered structures included the following components:

- A high-level governing body (e.g., steering committee, management team, leadership council, or board), made up of influential people from agencies that interact frequently with children exposed to violence and their families; these influential people had either the authority to make decisions in their own agencies or the ear of those with authority. The role of this group was to make decisions about the direction of the Safe Start initiative and to change the way participating organizations work with each other to better respond to children exposed to violence and their families. The Rochester Safe Start grantee, for instance, established a leadership council made up of agency directors charged with the responsibility for making decisions about changes in the system and within their own agencies.

- A group made up of point-of-service providers who interact directly with children exposed to violence and their families. The role of this group was to identify children exposed to violence and provide appropriate services. For example, the Safe Start Partnership Center, a component of Pinellas Safe Start, was a service delivery collaborative with contractual obligations to the initiative's lead agency. The center's members met regularly to identify families in need, assess and prioritize their needs, and refer them to appropriate services.

- Standing functional or task-oriented committees. The role of standing committees was to focus in depth on a specific task (e.g., public awareness and education, training, evaluation) to help the Safe Start initiative meet its goals and grant requirements. A common committee across most grantees (e.g., Chicago Safe Start, San Francisco SafeStart, Rochester Safe Start Initiative) was one focused on public education.

- Ad hoc committees. The role of ad hoc committees was to focus on topics encountered during a particular moment in an initiative's development, within the specific context of the demonstration site. The San Francisco grantee, for instance, established a cultural competence committee to examine how Safe Start could be more responsive to the diverse cultural needs of families in the city.

Multi-tiered structures enabled partners to address multiple issues simultaneously and allowed participating individuals to engage with Safe Start at different levels of decision making with different degrees of time commitment. More complex structures included all of the above tiers, many committees, and large numbers of participants; simpler ones included only two tiers with fewer people and committees. Regardless, each tier's function was clear, keeping participants engaged.

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Complexity and size of multi-tiered structures depended on the local Safe Start project's design as well as the configuration of public agencies, nonprofits, and community grassroots groups in the demonstration site (e.g., organization of departments, number and type of existing coalitions or consortia, number and size of targeted areas). Grantees in large urban areas, such as San Francisco, Pinellas, and Chicago, were more likely to establish complex multi-tiered structures.

In contrast, grantees in more rural locations, such as Washington and Chatham Counties, were more likely to have simple structures because they had fewer agencies and other resources available. The Washington County grantee, for instance, utilized only two tiers of engagement (a board of 17 members and four committees); nevertheless, this structure successfully engaged a wide range of partners and promoted cross-agency collaboration by 1) providing a mechanism for collaboration otherwise unavailable to participants; 2) grouping agencies with similar functions into subcommittees; 3) addressing partners' question of how the initiative would spend its funds, thereby increasing trust among partners; and 4) providing tangible benefits to partners (i.e., cross-disciplinary training opportunities and support for forensic interviewing).

Chatham County's lack of a complex multi-tiered structure, on the other hand, affected the grantee's ability to engage and retain partners. Partners reported that their decision-making authority diminished after the planning phase of the project and in the second and third year of implementation. Moreover, because social service personnel dominated the single level of engagement available to initiative participants, non-social service agencies (e.g., law enforcement, courts) perceived their participation as meaningless.

Loosely-formed structures. Four Safe Start grantees did not create a highly structured collaboration for the following reasons:

- Presence of an existing informal collaboration. The Spokane Safe Start Demonstration Project grantee built on an existing, loosely configured collaborative that provided a point of contact for all child-service agencies in the city, including those involved in Safe Start. Because this collaborative had always functioned in an informal way, the grantee saw no need to create a separate or new, more organized structure.

- Preference or capacity for loosely-formed structures. The Baltimore grantee was not able to establish a formal structure because interest and leadership for Safe Start waned over time; consequently, the collaboration evolved into a set of relationships used as needed. In Spokane, the participants knew each other well and met only for case-conferencing purposes; consequently, layers of hierarchy for governance were unnecessary.

Among the four grantees with loosely-formed structures, it was unclear to whom partners were accountable, and collaboration depended largely on personal relationships.

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Consequently, the loss of any given individual frequently threatened the commitment and participation of the institution with which he/she was affiliated.

Clear roles and tangible benefits. To be effective in changing systems, collaboration needs to involve people who have the knowledge, skills, relationships, and resources to influence others. Such people are typically very busy, because they are likely to participate in several partnerships or collaboratives simultaneously. To retain their involvement, a collaboration must provide tangible benefits and a clear reason for their presence "at the table;" otherwise, they might perceive their involvement as a waste of time. Safe Start Demonstration Project grantees experienced and responded to this challenge in different ways.

Collaborating agencies often require signed agreements that prescribe their mutual involvement in an initiative or relationship. Safe Start grantees were no exception. Nine grantees used formal agreements (e.g., contracts, memoranda of understanding) to help ensure that all partners followed Safe Start-related policies and procedures (e.g., confidentiality, timely response to a child exposed to violence and his/her family, referral to Safe Start clinicians). As compared to tangible benefits of participation in Safe Start, however, these agreements were less useful in retaining partners' involvement.

Reports from Safe Start staff across all 11 demonstration sites indicated that continuing engagement of partners was most likely if involvement clearly benefited partners and each partner had a tangible function in the collaborative. Three Safe Start initiatives illustrate this point well. The first, Baltimore City Safe Start, developed 28 formal agreements in support of the initiative's startup; however, participation from partners waned over time. In the end, the most active partners were agencies with a clear role in implementing the Child Development-Community Policing model and in identifying children exposed to violence (e.g., police department, domestic violence victim advocates and shelter, and mental health service providers).

The Spokane Safe Start grantee, in contrast, did not have formal agreements among its partners; however, its partners stayed engaged because they benefited from 1) the initiative's data (e.g., data from the Family Violence Screening Study), which helped them make the case for systems change, and 2) training on issues related to children's exposure to violence. As another example, the Washington County grantee successfully engaged the Passamaquoddy Tribe by establishing a site for forensic interviewing on the reservation, for use by both tribal and non-tribal members.

Credible, influential, and consistent leadership. Over the course of five years, Safe Start Demonstration Project grantees inevitably encountered many changes, some external (e.g., local elections, reallocation of state resources) and some internal (e.g., turnover in partner agencies). The impact of these changes on the grantee's ability to effect systems change varied based on the presence or absence of:

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- Influential leaders within Safe Start, with the potential to affect decision making within their own agencies and across the system;
- Credibility and capacity of the lead agency in which the Safe Start initiative was located; and
- Consistent leadership from key stakeholders in the initiative, including the project director, local evaluator, lead agency director, and/or collaborative chairperson.

Influential leaders. To effect systems change, it was critical to engage people with the potential to influence decision making in their own agencies and, possibly, in other agencies. These people ranged from agency directors with the authority to change policies, to knowledgeable, credible, and skilled professionals with the ability to educate others and influence their thinking, whether or not from decision-making positions.

Nine Safe Start Demonstration Project grantees reported the involvement of influential people in their collaborative. As part of its multi-tiered collaborative structure, the Rochester grantee, for instance, deliberately established a leadership body made up of agency directors. According to participants in the Rochester project, this feature contributed to their success in institutionalizing parts of the initiative in different agencies. The San Francisco SafeStart initiative was chaired by a well-respected judge; many stakeholders reported that partners stayed engaged partly because of the judge's involvement, which elevated the importance of the issue of childhood exposure to violence and the initiative's value.

Participants from the remaining two grantees pointed to the absence of influential leaders in their collaboratives as a major barrier to effecting systems change. The Baltimore grantee, for instance, was able to engage representatives from all critical sectors; however, the representatives were typically low-ranking staff without influence on decision making in their agencies. Consequently, systems change, aside from institutionalization of training, was limited or absent.

Credibility and capacity of lead agency. The credibility and capacity (commitment, resources, knowledge, and stability) of the Safe Start lead agency played an important role in raising the visibility of the issue of children's exposure to violence, motivating other agencies to participate, and elevating the importance of the initiative. On the continuum of lead agency capacity and credibility, eight grantees fell on the high end, and three toward the middle or low end. The Juvenile Welfare Board in Pinellas County, Department of Public Health in Cook County, Children's Institute in Rochester, and Sitka Tribe of Alaska are examples of credible and capable homes for Safe Start. These agencies were able to leverage their track record as leaders in addressing child and family issues in their communities to position the local Safe Start initiative as a credible entity to recommend policies and practices for improving responses to children exposed to violence and their families. Partners in the respective demonstration sites frequently referred to the commitment, credibility, and capacity of these agencies as contributing factors to progress.

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In contrast, the potential of the Pueblo of Zuni grantee was limited because of multiple changes in the Zuni Safe Start lead agency, changes largely due to internal reorganization of the government system and turnover in leadership. Each relocation brought both uncertainty about the alignment of Safe Start's goals with those of the new lead agency, as well as loss of time and momentum as staff members adapted to new supervision and administrative procedures.

In a similar vein, two additional grantees had relatively limited credibility in their communities for various reasons. The Baltimore City grantee intended to build on the success of several child- and family- centered programs already underway, but the success of these programs did not provide sufficient credibility for the Safe Start project for several reasons. First, by the time the grantee started full implementation of Safe Start, the community's initial satisfaction with many of the previous programs had faded. In addition, some participants described the lead agency for the Baltimore Safe Start project as disconnected from the interests of community residents. As another example, the Chatham County Partnership for Children tried to build on its success with Smart Start, a school readiness program, to achieve organizational credibility for Safe Start. According to some site visit participants, however, the Partnership for Children was unwilling to share decision making with others when it came to the Safe Start initiative. Fewer system-wide polices and practices changed in these settings than in the other Safe Start Demonstration Project sites.

Consistent leadership. A third factor that contributed to a grantee's ability to effect systems change was consistent leadership from one or more key stakeholders (i.e., the project director, local evaluator, lead agency director, and/or collaborative chairperson for the initiative). Consistent leadership provided continuity in institutional memory; thus, one or two consistent leaders in key positions within the initiative could temporarily step in to buffer the impact of turnover elsewhere. At its best, consistency ensured that the initiative's vision was maintained throughout the five years of the demonstration project.

In seven Safe Start Demonstration Project sites, the position of project director was stable or experienced a single turnover early in the implementation phase, which had minimal impact because of the timing; however, such consistency was sometimes insufficient to maintain the course of the initiative in the absence of the two conditions previously described (i.e., influential leaders engaged in the collaborative and a credible, capable, and stable "home" institution). For example, the Pueblo of Zuni Safe Start retained a single project director for the initiative's lifespan, but the initiative changed homes twice for a total of three homes, counteracting the stabilizing effect of consistency in the project director position.

In the remaining four sites, the project director changed two to three times; however, a leadership team arose from the initiative as an independent entity focused on systems change, likely to continue beyond OJJDP funding. For example, in Washington County, a leadership team of key influential community members will continue to address issues of children exposed to violence beyond the period of federal funding.

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3.2 Engagement of Community Residents and Institutions

Throughout the Safe Start Demonstration Project, grantees were required to engage community agencies, systems, and leaders in promoting their local Safe Start vision. A key target audience was community residents and institutions. If engaged, residents and institutions could then educate their neighbors and constituencies about the harm of childhood exposure to violence and the resources available to help exposed children and their families, as well as prevent and/or reduce the impact of exposure.

Several grantees understood that their efforts to increase service access and improve the quality of services would be somewhat futile if families did not comprehend the harm of exposure to violence on their young children. In the worst case scenario, services would be accessible and available, but nobody would use them. Engaging community residents and institutions was a consistent challenge for the majority of grantees for several reasons:

- Grantees did not have sufficient connections to grassroots institutions and social support networks to get the word out.

- Domestic violence was a taboo subject within the community, making it difficult for some grantees to create a community-wide dialogue about the issue.

- Residents did not trust public agencies in some of the large, urban areas because previous initiatives had not lived up to their promise to improve services and systems.

Of the 11 Safe Start Demonstration Project grantees, nine were able to engage community residents and institutions to become aware of Safe Start services, use the services, and/or participate in decision making about the local Safe Start initiative. Except in two sites, insufficient data were obtained to determine the extent to which residents' knowledge of the impact of children's exposure to violence was improved. In Rochester, evaluation findings indicated an increase in the proportion of adults in the media campaign target community who reported taking action (vs. doing nothing) after seeing a child being exposed to violence; there was no increase in such self-reported behavior in the comparison community. In Pinellas, evaluation surveys were conducted after community presentations; participants reported a greater understanding of children's exposure to violence and a sense of being better equipped to help victims.

Public education and awareness-raising. All but two Safe Start Demonstration Project grantees conducted public education activities with the goal of spreading information about the harm of children's exposure to violence and the Safe Start initiative. Examples of such activities included photo and art exhibits (Chicago Safe Start), presentations at prayer breakfasts (Chatham County Safe Start initiative), and public service announcements (San Francisco SafeStart). The two Native American

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demonstration sites used Native traditions to entice their members into dialogue about domestic violence, a taboo subject impermissible for discussion in any other forum.

Collecting community input. Three Safe Start Demonstration Project grantees conducted focus groups and interviews to solicit input from community members about strategies and to shape messages for their public awareness campaigns. The Bridgeport Safe Start initiative, for instance, conducted five parent focus groups (including one in Spanish); moreover, with help from the local evaluator, the Bridgeport grantee trained six community members to develop questions for the focus groups, co-facilitate the groups, analyze the data, and present the findings.

Dedicated outreach staff. Two Safe Start Demonstration Project grantees created a staff position dedicated to community outreach. The Chatham County grantee was able to reach out to and educate the Latino community in Siler City as a result of its coordinator's dedicated effort.

Inclusion of community members in governance. Two Safe Start Demonstration Project grantees included community members in their governance. The Chicago Safe Start grantee, for instance, engaged residents from the two targeted neighborhoods in community councils that formed part of the local Safe Start collaborative structure. The San Francisco grantee established a team of domestic violence survivors who not only mentored eight additional survivors to raise awareness about the harm caused by child exposure to violence, but also participated in the initiative's advisory committee and helped make decisions. These two grantees believed that engaging community members in their initiatives provided more useful information about the issues facing families and allowed for the development of more responsive strategies. Insufficient evaluation data exist to support this link, however.

3.3 Readiness for Systems Change

Systems change in policy and practice is difficult to achieve, requiring time, readiness, and capable participants (Association for the Study and Development of Community, 2002). Over the course of the five-year implementation of the Safe Start Demonstration Project, grantees made variable progress toward implementation and institutionalization of system-wide changes in practice and policy related to children's exposure to violence. The following readiness factors emerged as key to enabling systems change:

- A history of collaboration,
- Sufficient human and financial resources,
- Community capacity for engaging in a dialogue about domestic violence, and
- Supportive legislation and public agendas.

History of collaboration. In five sites (Chicago, Pinellas, Rochester, San Francisco, and Spokane), agencies had developed collaborative relationships through past work advocating for and implementing policy change. As a result, these grantees were

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ready to design and implement systems change strategies early on. In Pinellas, for example, leaders from several key service sectors had worked together for many years on advocacy projects, resulting in a readiness to focus on cross-agency practices and local policies early in the implementation of the Pinellas Safe Start project. Similarly, in Spokane, prior collaborative work on child-focused issues as part of the Breakthrough Collaborative laid the groundwork needed for implementing a Safe Start project.

Lack of previous positive experiences with collaboration led to fewer system-wide policy and practice changes. For example, in Washington County, partners spent a majority of their time establishing working relationships. While some of the agencies in Washington County had worked together in common affinity groups, they had no history of collective action resulting in policy or practice change. Similarly, in both tribal sites, the majority of resources (e.g., time, human effort, money) were dedicated to forming effective collaborative relationships to prepare the system for change; developing mental health interventions was a lesser priority. It is important to acknowledge, however, that these grantees are continuing their efforts toward establishing effective collaborative relationships, which should generate the capacity to develop and implement other systems change strategies.

Sufficient financial and human resources to support systems change. Adequate financial resources and baseline service capacity, like effective collaborative relationships, are prerequisites for making change to policy and practice.

Financial resources. Safe Start Demonstration Project grantees able to leverage project funding to engage local private and public resources found themselves better positioned to promote systems change. For example, Pinellas was described as a community rich in both human and financial resources, with issues of children and families at or near the top of the public agenda. The Pinellas grantee built upon this pre-existing community "platform" to improve services for young children exposed to violence. As a second example, for its public education campaign, San Francisco SafeStart was able to secure an additional $135,000 from the Department of Children, Youth, and Their Families; Advisory Council members; Saint Francis Memorial Hospital; and the California Attorney General's Office.

On the other hand, the Safe Start Demonstration Project unfolded at a time when some of the sites were beginning to experience significant resource constraints, resulting from economic decline and a change in political will. For grantees in those sites, undertaking systems change was much more difficult because of competing political and social agendas vying for resources, including resources provided through Safe Start funding. In Spokane, for example, budget cuts at the state and local levels significantly impacted the ability of the grantee and its partners to focus the political agenda on issues of children and families. Funds for partners were cut, and many services for children and families were eliminated, including those of the key Safe Start partner that provided outreach and treatment services for children exposed to violence. Similarly, just as the local Safe Start project was getting underway in Washington County, budget cuts in Maine resulted in restructuring of the health and human services sector, which was

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responsible for child and family services. As a final example, in Chatham County, the Safe Start lead agency experienced annual reductions in state funding that supported the treatment component of the local Safe Start model. In both Washington and Chatham counties, Safe Start funds were expected to sustain services rather than create additional capacity for systems change; instead of collaboration and cooperation, therefore, competition for Safe Start grant resources developed, yielding tensions and poor results with respect to systems change and policy development.

Human resources. In some sites, a lack of trained and licensed mental health providers compounded the lack of financial resources. Tribal sites and rural sites both experienced the challenge of insufficient human resources, in particular a lack of trained professionals with clinical expertise in the field of infant and early childhood mental health. Retaining professionals in these communities was also problematic. For example, only one psychologist in Sitka was trained in both early childhood mental health and working with Native populations. In Zuni, the psychologist hired by the grantee resigned after a few months because of competing demands. The single psychotherapy group in Washington County—an area the size of Connecticut—had few openings for families and a long waiting list. Finally, in Chatham County, funding cuts for state mental health providers reduced the availability of clinical treatment services. In addition, mental health providers were not prepared for the rapid increase in the Latino population; few providers were bilingual or culturally attuned to this population and its needs. Limited availability of highly trained service providers left these Safe Start sites poorly positioned to undertake systems change efforts.

Community capacity for engaging in a dialogue about domestic violence. The issue of domestic violence can be painful to raise, discuss, and address. Some of the larger Safe Start communities (e.g., Pinellas County, Chicago, San Francisco) found it relatively easy to put the issue in the public arena, perhaps because 1) the communities were large enough that anonymity was possible, and 2) domestic violence was perceived relatively simply as a social problem to resolve, similar to drug abuse or gun violence, rather than as a cultural indictment or source of shame.

In the rural and tribal sites (Washington County, Chatham County, Sitka, and the Pueblo of Zuni), however, it was more difficult to raise the issue, because people were more likely to know each other, and therefore, anonymity was less possible. For the tribal sites, in particular, the issue was linked to the historical trauma experienced by an oppressed group; domestic violence became a symptom of the oppression and elicited shame at the individual, family, and clan levels. Consequently, the rural and tribal sites allocated more time and resources for activities to "set the stage" for change, including raising community awareness, advocating for and creating culturally competent approaches to working with families, and engaging families.

These activities represent important progress toward implementing initial systems change and developing the experience necessary for larger systems change; in addition, their potential for continuation is promising, given that they require relatively few resources to maintain. On the other hand, these activities are more vulnerable to

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individual commitment to the issue of children's exposure to violence; without a sustainable infrastructure (e.g., an intervention that additional organizations can adopt or an entity that supersedes the individuals that comprise it), "readiness" activities rely on the passion of committed individuals. In the absence of concentrated technical assistance, therefore, rural, tribal, and similar grantees will not be able to accelerate their readiness for larger systems change.

Supportive legislation and public agendas. Existing legislation and public agendas focused on preventing violence and promoting early childhood development facilitated Safe Start Demonstration Project grantee efforts.

In two states, existing legislation supported local Safe Start initiatives. Domestic Violence-Child Protection Agreements in the state of Florida mandate that domestic violence service providers and child protection agencies agree on how they will communicate when an allegation of abuse involves a child or parent who may be staying at a domestic violence center (Association for the Study and Development of Community, 2006). As a result, agencies in the child protection and domestic violence sectors were mandated to work together as part of their mutual involvement in the Pinellas Safe Start Initiative. Similarly, in Alaska, domestic violence shelters are required to have a child advocate in addition to a victim's advocate; thus, the shelter in Sitka became a leading partner in the Sitka Safe Start project. By contrast, the majority of grantees, without existing supportive legislation, struggled to bring the domestic violence and child services sectors together.

In two other states (North Carolina and Illinois), legislative changes over the life of the Safe Start Demonstration Project helped local initiatives. In North Carolina, community mental health clinics were privatized, allowing Chatham County Safe Start service providers to access Medicaid reimbursement for the families they assisted. In Illinois, the Children's Mental Health Act was passed in 2003, requiring the state to develop a comprehensive Children's Mental Health Plan with short- and long- term recommendations for establishing coordinated mental health prevention, early intervention, and treatment services for children birth to age 18. The implementation of this act meant more awareness and funding for children's mental health issues.

In four sites (Chicago, Pinellas, Rochester, and San Francisco), an existing public agenda or momentum promoting the social and emotional wellbeing of young children provided a "platform" for the local Safe Start initiative, allowing the grantee to infuse resources across child-serving sectors (e.g., early childhood education settings, foster care, family court), specifically for the improvement of services for young children exposed to violence. For instance, the Chicago Safe Start grantee used the Chicago Department of Public Health's history of convening the community around violence prevention issues to gain a foothold for the creation and passage of legislation designed to improve the system of care for young children, including those exposed to violence.

On the other hand, state legislative changes had adverse consequences for two demonstration sites. The Florida legislature shifted services and money away from

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nonprofit community mental health centers to for-profit health maintenance organizations (HMOs). As a result, families and children who receive Medicaid benefits, including those served by the Pinellas Safe Start grantee, were restricted to certain providers and a limited number of treatment sessions (Association for the Study and Development of Community, 2005a).

In Alaska, the merging of substance abuse prevention and treatment services with behavioral health services meant a reduction in funds for both types of services. Consequently, Sitka Counseling and Prevention Services, a key partner in the Sitka Safe Start Initiative, could not afford to pay clinicians for on-call time as part of the initiative's Child Development-Community Policing team (Association for the Study and Development of Community, 2005a).

4. Continuation of the Safe Start Demonstration Project

Safe Start Demonstration Project grantees were expected to work toward sustainability of their projects during the final phase of implementation. This section considers the ways in which the grantees prepared themselves for sustainability. How grantees increased community capacity to respond to the needs of children exposed to violence and their families also is discussed.

4.1 Continued Funding

Seven sites secured new sources of funding to continue key components of the service system developed with Safe Start Demonstration Project funds; these seven grantees raised over $3 million to support and continue the work of Safe Start in their local communities.[23] The following are examples of how grantees will sustain Safe Start services after the end of the OJJDP grant:

- Baltimore. The Safe Start Demonstration Project grantee worked with the House of Ruth-Maryland to obtain a Safe and Bright Futures for Children grant ($75,000 awarded by the U.S. Department of Health and Human Services for fiscal year 2004) to enhance their ability to serve young children exposed to violence.

- Chatham. The Safe Start grantee obtained a Congressional Appropriation Earmark for $150,000 to continue funding Safe Start staff. In addition, the Child Well-Being Collaborative (an entity funded by the county in 2004 to monitor the mental health needs of children during the process of restructuring the local mental health service system) agreed to fund in-home services in Chatham County, based on intervention research conducted by the Safe Start local evaluator.

[23] The dollar figures for Rochester's Early Education Professional Development grant, United Way funds, and Ad Council support have not been provided to date. Based on the data provided by grantees to date, a total of $3,334,875 was raised. This information can be collected more systematically via the 2006 site visits and follow-up telephone calls with non-continuing sites.

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- Chicago. The three community-based service providers funded by the Chicago Safe Start grantee are now funded by the U.S. Department of Justice through Safe from the Start funds ($375,000 for 2005, 2006, and 2007). The Chicago Department of Public Health has assumed funding for two Safe Start positions (education and implementation coordinators; approximately $100,000 for salaries and fringe benefits). Lastly, to expand training and resource materials in 2005 and 2006, the Chicago grantee obtained a total of $275,000 from different sources (e.g., Chicago Department of Child and Youth Services, Illinois Department of Children and Family Services, Illinois Prevention Authority).

- Pinellas. The Juvenile Welfare Board, a local funder of social services, is now funding three core Safe Start services—the Safe Start Partnership Center, Coordinated Child Care's consultant, and the Clearwater Child Development-Community Policing coordinator—at a total of $376,875 for the first fiscal year. The Juvenile Welfare Board typically funds programs for three years, but the funding amount and program content are reviewed each fiscal year.

- Rochester. Children's Institute, the lead agency for Rochester Safe Start, was awarded an Early Education Professional Development grant from the U.S. Department of Education. This grant is being used to incorporate the knowledge, skills, and awareness needed to address the issue of children exposed to violence into the training of all mentors in the early childhood education system; educators in both center- and family- based care will have trained mentors. An additional $148,000 from the New York State Office of Children and Family Services was expected in 2005 for the mentor project. The Rochester Safe Start grantee obtained private sources of funding for two additional initiatives: the Society for the Protection and Care of Children now funds SAFE Kids, and the United Way of Rochester funds the Mt. Hope Family Center's partnership with the Foster Care Pediatric Clinic. The United Way also is working with the Rochester Safe Start grantee to continue the Safe Start infrastructure (e.g., staff positions). Finally, the Rochester Ad Council approved Safe Start as a community initiative for 2005 and 2006.

- San Francisco. The city and county of San Francisco supplemented Safe Start funds between 2000 and 2003 with awards from the San Francisco Children's Fund totaling $325,000, to support service delivery and evaluation (Fox & Mayer, 2005).

- Sitka. Sitka will continue the vision of Safe Start through the Family Justice Center. Family Justice Center grants are awarded by the U.S. Department of Justice;[24] in Sitka, tribal and state courts worked together to win this grant in the amount of $1.1 million for 1 ½ years with a no-cost extension until January 2007.

[24] For more information about Family Justice Centers, go to: http://www.ojp.usdoj.gov/pressreleases/OVW03164.htm.

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The Family Justice Center is expected to become a regional training center for reducing domestic violence and the impact of exposure to violence on young children. The Sitka grantee also obtained a To Encourage Arrest grant in the amount of $410,000 for fiscal years 2004 and 2005.

4.2 Increased Community Awareness and Capacity

Building community awareness and capacity to address the needs of children exposed to violence is another way to ensure the continuation of Safe Start goals in local communities. All grantees increased community capacity to respond to the needs of children exposed to violence by increasing awareness of the issue, increasing the knowledge and skills needed to help young children exposed to violence, developing and implementing tools to better serve these children, and facilitating working relationships among professionals.

Community education and awareness activities conducted by grantees included:

- Presentations to community groups (e.g., schools and churches in Baltimore),
- Formal community outreach efforts (e.g., Chatham's community outreach coordinator, Pinellas' facilitators and ambassadors),
- Social marketing campaigns (e.g., in Bridgeport, Chicago, Pinellas, Rochester, San Francisco, and Washington County),
- Engaging community residents (e.g., Rochester's Safe at Home project, Chicago's involvement of residents in developing marketing materials), and
- Developing training and other educational materials.

In Bridgeport, Chicago, and San Francisco, community residents were actively engaged in Safe Start through leadership and decision-making roles. In Bridgeport, a cadre of residents was trained to conduct focus groups on service improvements. In Chicago, residents sat on the community councils and provided input on the role of Safe Start in the community as well as on marketing materials. In San Francisco, parents who had experienced domestic violence were trained to mentor other parents and were recently invited to participate in the Service Delivery Team to facilitate improved outreach to parents. This level of involvement in Safe Start provided the opportunity for residents to become well versed in the issue of children exposed to violence and the resources available to help these children.

All 11 Safe Start Demonstration Project grantees developed training materials (e.g., curriculum manuals, training guides), now available to anyone in the community interested in learning more about children exposed to violence. Furthermore, all grantees obtained either formal or informal agreement from other service provider agencies to incorporate issues related to children exposed to violence into ongoing agency trainings, for example:

- Bridgeport. The Center for Women and Families will assume responsibility for trainings about children exposed to violence.

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- Pinellas. The Juvenile Welfare Board incorporated children exposed to violence trainings into its community training schedule.

- Chicago. Agencies receiving Chicago Safe Start funds embedded training across all offices (i.e.., for agencies with offices in multiple locations).

Two sites (Baltimore and Pinellas) developed or supported specialized trainings in the areas of early childhood mental health and specific therapeutic techniques. Clinicians who have participated in these advanced trainings are believed to be better prepared to intervene with young children exposed to violence.

Evidence suggests that all grantees improved community capacity to identify, assess, and treat children exposed to violence, through the approaches discussed in detail in Section 2 of this report. As a particularly tangible example, the new capacity of forensic interviewing in Washington County has improved outcomes for children by providing stronger evidence, to help the district attorney's office prosecute child abuse cases faster.

Sustained collaborative relations. Most site visit participants expected that 1) the collaborative relationships developed as a part of the Safe Start Demonstration Project would continue either formally or informally beyond OJJDP funding and 2) the communication resulting from these relationships would help families and children exposed to violence through improved coordination of services. Among those who worked together on local Safe Start projects, the knowledge of the appropriate person to call in another agency or organization was anticipated to facilitate more efficient referrals to needed services. Improved relationships across certain sectors or populations hold particular promise for helping children exposed to violence and their families.

For example, in Pinellas, communication between the child welfare and domestic violence sectors improved such that these two sectors reached agreement on principles for serving families experiencing both domestic violence and child abuse. This has great potential for helping families in a more coordinated and holistic fashion, such that the needs of all family members are considered in service and safety planning. As another example, in Spokane, working relationships were formed for the first time between the Native American population and Spokane Mental Health through the Native Project Teen Peace program, a substance abuse prevention program with an associated infrastructure for mental health services within the Native community; this infrastructure has the potential to help many families and youth. In Sitka, the police department and the Sitka Tribe of Alaska strengthened their relationship by working together to implement CID-COPS, an adaptation of the Child Development-Community Policing model. As a result, these two entities went on to co-apply for two grants: Family Justice Center and To Encourage Arrest. Several grantees (e.g., Bridgeport, Chatham, Pinellas, Rochester, Spokane) also worked with the court system to raise awareness of the issue of children exposed to violence and the community resources available to help these children and

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their families. Communication between the courts and service providers is expected to continue as a result of these efforts.

Adoption of program components by other community agencies. All grantees found an organization and/or an entity to continue some aspect of the Safe Start Demonstration Project. Aspects of the project absorbed range from the most tenuous (e.g., the vision or mission) to the highly tangible (e.g., positions and programs), as demonstrated by the following examples:

- Baltimore. The Family League of Baltimore City's Family Support Strategy Committee assumed responsibility for incorporating issues of children exposed to violence into their work. In addition, in Baltimore, a cross-sector "roundtable" was established to advocate for policy changes that affect domestic violence victims and their children.

- Bridgeport. The Bridgeport Leadership Team will continue to focus on children's needs, including the needs of children exposed to violence, and the Center for Women and Families will continue training efforts to teach the community about children exposed to violence.

- Chatham. The Community Peace Training Committee of Family Violence and Rape Crisis Services assumed responsibility for conducting trainings on children exposed to violence, to continue to teach the professional community about this population.

- Chicago. The Implementation Advisory Board, the decision-making and policy-setting entity created for the Chicago Safe Start project, will continue to meet for the purpose of addressing issues related to children exposed to violence after the end of OJJDP funding.

- Pinellas. Both the Leadership Council and the Safe Start Partnership Center, the entities that provide decision making and service coordination, respectively, for children exposed to violence and their families, will continue their work after OJJDP funding ceases.

- Pueblo of Zuni. The Tribal Council incorporated the issue of children's exposure to violence into its Children's Code and will continue to support the mission of Safe Start.

- Rochester. The Domestic Violence Consortium will continue to focus on children exposed to violence as part of its work (e.g., by auditing the implementation of service delivery protocols that include how to respond to children exposed to violence). The Children's Institute will continue its Early Childhood Mentor Project (i.e., providing mentors for early childhood educators), as part of its ongoing work in early childhood education.

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- San Francisco. The Department of Children, Youth, and Their Families will continue to support the mission of Safe Start by continuing as the fiscal agent for Safe Start (the city of San Francisco awarded money to Safe Start) and continuing to address issues of children exposed to violence.

- Sitka. The Safe Start initiative will become a subcommittee on children and youth within the Family Justice Center, which will include a focus on children exposed to violence.

- Spokane. The Eastern Washington School of Social Work expects to develop a certificate program in child development to include training on how to work with children exposed to violence. Early childhood education and substance abuse agencies may continue to use the data-driven decision making encouraged and modeled by the Spokane Safe Start grantee.

- Washington County. The Regional Medical Center-Lubec and the Washington Hancock Community Agency partnered to develop a community sustainability plan that includes increasing the community's knowledge of children exposed to violence.

5. Challenges and Opportunities Associated with Implementing and Sustaining the Safe Start Demonstration Project

5.1 Challenges

Safe Start Demonstration Project grantees experienced two primary implementation challenges common to large-scale demonstration projects and human services integration efforts. First, sequencing systems change activities requires a delicate balance between increasing demand for services and building capacity to meet the new demand. The Safe Start Demonstration Project grantees navigated this challenge fairly consistently: most grantees dedicated more resources to developing and enhancing programs than to increasing demand for these programs. Most sites could not and did not dedicate significant amounts of resources to both community outreach strategies (e.g., public awareness campaigns) and programming improvements (e.g., new and enhanced interventions for children exposed to violence).

A related tension underlies priority setting within the human services field. Early intervention service providers compete constantly for resources with "deep-end" service providers (e.g., providers who work with seriously emotionally disturbed children, violent youth offenders, and victims of violent crime). Inherent to this competition for resources are the ethical dilemmas faced by the field: Whose needs are most important? What are the ethical responsibilities of the field for raising awareness about a public health threat when equal attention and resources are needed for responding effectively to that threat? In the context of limited fiscal resources, how are decisions made and

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priorities set regarding children's wellbeing? These tensions and ethical struggles are not easily resolved.

Second, achieving unity among service sectors characterized by their own limitations[25] and fundamentally different cultures and histories is an ambitious goal even in the most supportive of contexts (e.g., resource-rich communities with an investment in collaboration). For example, the need for reform within the child welfare system is long-standing. Community need commonly outstrips the capacity of the child welfare system, such that in most states the ability to intervene early and effectively with families maltreating children is limited. Nevertheless, the system is mandated to protect the wellbeing of children when harm is inflicted by their caregivers. Asking providers in a system with this orientation to coordinate with a system like domestic violence victim advocacy, in which the mothers' safety and rights are typically paramount, can surface deep-seated conflicts about whose wellbeing is the priority. In communities with less capacity, bridging such diverse organizational cultures and perspectives requires commitment to a long-term process of building collaborative readiness, prior to working toward larger systems change.

Another implementation challenge associated with culture involved the reliance on mental health professionals to document the Safe Start Demonstration Project's accomplishments. Mental health agencies and professionals tend to operate independently. Being held accountable for service provision and outcomes by another entity (e.g., the lead agency for Safe Start or Safe Start staff) was in many ways counter-cultural and presented barriers to record keeping and information sharing. More specifically, many mental health providers resisted quantifying their "craft," making it difficult for Safe Start Demonstration Project grantees to describe in detail the treatments provided to children exposed to violence and their families.

Additional data-related challenges included: 1) the lack of standardized data for incidence and prevalence of children exposed to violence nationally and locally, 2) cross-site variability in definitions of the performance measures used to assess progress of Safe Start Demonstration Project grantees, and 3) an implementation of the national evaluation design that did not result in consistently collected outcome measures across sites. Data and design limitations, therefore, significantly compromised the ability to examine systematically the accomplishments of all grantees.

During both the 2004 and 2005 site visits, Safe Start Demonstration Project grantees reported several additional challenges to implementation. For example, some grantees struggled to access training and technical assistance resources. According to

[25] See, for example, recent recommendations for reforming the child-welfare system [The future of children (Winter 2004), *Children, Families, and Foster Care: Analysis*. Available at www.futureofchildren.org/usr_doc/tfoc1401_execsum.pdf; Courtney, M., Needell, B. & Wulczyn, F. (December 2004). Unintended consequences of the push for accountability: The case of national children welfare performance standards.], children's mental health services (e.g., The National Wraparound Initiative, www.rtc.pdx.edu/nwi/NWIWorks&Prod.htm), and juvenile and family court (e.g., .the National Council of Juvenile and Family Court Judges Resource Guidelines for Improving Court Practice in Child Abuse & Neglect Cases, available at www.ncjfcj.org).

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these grantees, the Safe Start national team (OJJDP and its technical assistance and evaluation contractors) did not effectively deliver early assistance on service system models and changes (with the exception of Child Development-Community Policing), presenting an obstacle to implementing systems change efficiently and effectively. This was particularly true in communities with more limited professional and other resources. In tribal and rural sites, cultural and capacity differences further hindered the national team's ability to assist with training and technical assistance. For example, Native communities viewed evidence-based mental health treatment for children exposed to violence as culturally inappropriate; culturally sensitive adaptations and training opportunities were not readily available to the tribal sites. As another example, rural sites considered the CD-CP program inappropriate due to their large geographic size and low population density; this program was developed in a context that did not account for a situation in which a limited number of officers would be required to travel long distances to respond to crisis events.

Turnover in Safe Start Demonstration Project staff (e.g., project directors, local evaluators) also challenged implementation and sustainability, affecting the ability of grantees to achieve their goals. Staff turnover along with delays in filling certain key positions resulted in inadequate staff capacity to 1) build relationships, 2) follow-up with partners, and 3) conduct other initiative tasks and activities. Depending upon the adequacy of new leadership, departure of key leaders (e.g., project directors) to assume new positions or retire toward the end of the Safe Start Demonstration Project may impede sustainability efforts. This issue requires further and more systematic study.

5.2 Opportunities

Perhaps most significantly, the Safe Start Demonstration Project provided grantees the opportunity to put the issue of children's exposure to violence on the community's agenda and/or elevate the importance of this issue. The Safe Start Demonstration Project also provided pilot communities with resources to enhance and integrate existing services for children and their families, or to develop those services in communities with fewer resources. In Chicago, Pinellas, Rochester, and San Francisco, for example, the grantees were able to infuse Safe Start resources into a network of existing services that could then better meet the needs of children exposed to violence. In Chatham, Pueblo of Zuni, Sitka, and Spokane, Safe Start resources 1) brought professional services to communities without preexisting services specialized to address childhood mental health and 2) allowed providers to offer more accessible services (e.g., home-based services, extended office hours, more convenient treatment periods).

Through their efforts to create more comprehensive and responsive service delivery systems as part of local Safe Start projects, human service workers claimed a role in systems change activities and may have increased their capacity to effect change. Thus, the Safe Start Demonstration Project provided the opportunity to further legitimize the role of human service professionals as change agents within their systems, particularly with the support of federal funding.

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Safe Start Demonstration Project grantees also had the opportunity to form new working relationships, both locally and nationally. Locally, partners who worked together on Safe Start formed relationships with the ongoing potential to maintain a focus on children exposed to violence in other contexts (e.g., other collaborations and projects). Nationally, grantees had the opportunity to learn from and work with peers doing similar work, for example, at cross-site meetings, which created a forum for the exchange of ideas and development of relationships.

Maintaining public commitment (e.g., political leadership, financial resources) to meet the needs of children exposed to violence will be easier in some communities than in others; without the Safe Start Demonstration Project, however, the issue might never have been raised, and these children would have remained invisible to both professionals and the general public.

6. Conclusion and Recommended Next Steps

Safe Start Demonstration Project grantees were able to:

- Create mechanisms for systemic and more systematic identification of young children exposed to violence;
- Create comprehensive systems of care for children exposed to violence, by engaging multiple disciplines;
- Create responsive systems of care, by implementing policies and practices for responding to children exposed to violence;
- Create collaboration among organizations with fundamentally different philosophies, histories, cultures, and training of personnel related to addressing the issue of children exposed to violence; and
- Advocate for the development of state-level changes.

Through the Safe Start Demonstration Project, grantees were able to make visible a previously "invisible" population of children by engaging multiple service sectors as the eyes of the community; to enhance coordination of services, grantees reached out to people and institutions in the following sectors: law enforcement, domestic violence, mental health, early childhood education, and others. Together, professionals from these multiple sectors developed procedures, guidelines, and protocols for identification and referral of children exposed to violence and their families, resulting in identification of an estimated one out of every five young children exposed to family violence in Safe Start communities by the final phase of project implementation.

Successful Safe Start Demonstration Project service providers approached service delivery in a family-centered, child-focused manner. For example, all grantees recognized the importance of meeting the multiple needs of families, rather than focusing on a single need, such as a mental health intervention. Many grantees adapted services and processes to meet the multiple needs of diverse communities, for example, by integrating Native traditions and offering language-specific materials and practices.

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Nevertheless, grantees dedicated a significant portion of Safe Start resources to improving early childhood mental health services and increasing the capacity of community and clinical providers to understand how to address the mental health needs of children.

According to research in the field, a responsive system of care for children and families provides appropriate (e.g., culturally sensitive) services in a safe and convenient setting. More children were identified, referred, and treated when Safe Start Demonstration Project grantees provided holistic, linguistically competent, convenient services. These achievements are consistent with indicators of successful implementation of comprehensive and coordinated service-delivery systems (Northwest Territories Health and Social Services, 2004). In a successful system, parents and caregivers know the services available to them in their communities and are able to access these services when needed. In addition, service providers have strong working relationships across disciplines; coordinate services; and have procedures and guidelines for referral, case management, and data management.

The findings from this process evaluation suggest several recommendations for funders, practitioners, researchers, and public policy makers. These recommendations are considered next.

Recommendations for Funders

Funders need to consider the importance of a community's existing capacity to accomplish project goals. Existing (i.e., pre-award) capacity (e.g., experience working together, credible leadership, available resources) played a central role in grantees' abilities to accomplish systems change. Based on what we know now, the pre-award process undertaken by OJJDP and its partners accurately and thoroughly assessed sites' readiness for implementing an initiative like Safe Start, including early indicators of challenges that would ultimately impact level of success. Recommendations specific to improving the pre-award assessment process include:

- Assessing more formally the credibility of the lead agency in the community (both among service providers and the public). An organization's credibility may validate its capacity to lead a large-scale community initiative.

- Determining whether the community's prior collaborative experience or history is relevant to this type of systems change initiative. Systems change efforts require unique types of relationships, skills, and roles; such efforts also surface unique issues that must be resolved. Sites with a prior history of collaborating for systems change successfully implemented Safe Start; those without such experience, regardless of a history of collaboration for other purposes, struggled.

Funders need to provide relevant and immediate technical assistance to prepare grantees for initiative implementation, as well as ongoing assistance to address barriers to project success. Providing grantees with targeted technical assistance as soon as issues

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arise is essential to increasing the likelihood of success. Whether concerns or unanswered questions arise during the pre-award period, within the first few months of award, or later in the project, appropriate assistance must be readily available to grantees. In the case of the Safe Start Demonstration Project, many of the concerns and unanswered questions that surfaced during the pre-award assessment later emerged as barriers to success. For example, the pre-award reports of two sites noted a concern that certain planning or core management members viewed Safe Start as a potential source of money for particular interests. Both sites also noted a concern about local ownership of Safe Start. While there may have been no way of anticipating how these noted concerns would later become significant barriers to success, it seems feasible that early training and technical assistance focused on areas of concern could have helped these sites overcome their challenges and experience greater success.

Funders and evaluators must be prepared to address non-compliance with data-collection requirements, through meaningful and immediate consequences for both grantees and evaluators. Consistent monitoring and enforcement of careful and systematic data-collection processes help ensure quality data collection. Quality data, in turn, will contribute to a better understanding of the nature and impact of children's exposure to violence; conversely, lack of consistent, systematic data collection hinders our ability to ascertain the scope and nature of the problem. Lack of quality data also limits the evidence on outcomes needed to support specific policies and practices for improving the wellbeing of communities, families, and children.

Recommendations for Practitioners

Several findings from this process evaluation offer service providers specific guidance for practice.

Engage professionals from multiple sectors to screen children regularly for exposure to violence and refer them to appropriate services. Professionals in the fields of criminal justice, domestic violence, early childhood education and care, mental health, and social services all can effectively identify children exposed to violence and serve as points of entry into the service delivery system. Building the capacity to identify violence exposure requires significant training; in addition, for most professionals, identifying children exposed to violence requires that their agencies or institutions develop and implement screening and referral procedures and protocols.

Refer children exposed to violence and their families directly to a service provider with relevant training. Direct referrals reduce the steps that families must take to receive needed services and can increase their engagement in the helping and healing process. Many grantees successfully implemented one model for direct referral, the Child Development-Community Policing program, in which law enforcement officials make immediate referrals directly to clinicians or victim support service providers, allowing families to receive crisis intervention services either at the scene of a violent event or within 24 hours of the event's occurrence.

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Provide families with holistic services in convenient locations. Meeting the multiple needs of families with young children exposed to violence is essential for engaging and retaining families in services. These services must be accessible to families, i.e., located in credible community-based settings or in families' homes.

Integrate and sequence services for families. Sharing case information among service agencies facilitates care coordination, to prevent duplication, gaps, or fragmented services. Establishing mechanisms (e.g., cross-agency case conferencing) for convening service providers from multiple agencies on a regular basis helps families receive all appropriate services in a useful sequence.

Dedicate resources to data collection and management. Collecting standardized data associated with a project's quality assurance monitoring and research and evaluation goals requires significant resources. Research and evaluation requirements typically justify at least one qualified staff person with primary responsibility for managing a project's data demands (e.g., data collection, quality, storage, and reporting).

Recommendations for Researchers

Researchers in the field of children's exposure to violence can contribute to the knowledge base in the following ways.

Establish strong working relationships with practitioners to facilitate quality and meaningful data collection. The most useful evaluation data emerged from sites where the project director, the local evaluator, and key service providers established mutually beneficial relationships. The local evaluator understood the information needs of the project, was able to work with service providers to interpret data, and worked with the project director to equip service providers with information relevant to their work with children and families.

Establish networks among local and national researchers to increase the depth of knowledge generated at both the local and national levels. Local evaluators participating in the Safe Start Demonstration Project contributed to the national evaluation in critical ways. Most importantly, perhaps, local evaluators generated in-depth knowledge of issues such as 1) prevalence of children exposed to violence based on local police reports, 2) characteristics and outcomes of families who received crisis intervention services, and 3) outcomes for families and children who received Safe Start services. The national evaluation also benefited from the implementation data collected and reported by local evaluators as part of their annual reports to the National Evaluation Team. Local evaluators, in turn, benefited from regular technical assistance provided by the national evaluators, as well as networking opportunities facilitated by the National Evaluation Team.

Design studies that will generate more in-depth knowledge of the nature of children's exposure to violence. Data on the types of violence children see and hear are not systematically collected. Fully understanding the impact of exposure and how to

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reduce any negative developmental consequences for children will require a deeper understanding of the nature of violence exposure. Local studies of these issues would enhance national survey data designed to examine the national incidence and prevalence of children's exposure to violence.

Recommendations for Public Policy Makers

Policy makers can inform their funding decisions with evidence from this process evaluation.

Provide the resources necessary for locally customized responses to children exposed to violence that create a continuum of care. Evidence from this process evaluation provides a compelling argument for public policy that translates into resources that allow for locally customized responses to children exposed to violence. As proposed by Edleson (2006), a response system for children exposed to domestic violence must have the flexibility and resources to ensure the safety not only of physically abused children, but also of children who are indirectly exposed to violence or may be victims of neglect. Both formal supports (e.g., child protective services) and informal supports (e.g., family resource centers, victim services) are needed to create a continuum of care responsive to the various levels of risk that violence presents to children and their caregivers.

The Safe Start Demonstration Project provides the field with guidance on how to create a system of care responsive to local conditions. Grantees changed relationships among formal and informal systems of support and infused local communities with resources for children exposed to violence and their families. As a result, more children exposed to violence were identified and linked to supportive services capable of increasing their safety and family stability. Safe Start illustrates that federal resources can be used effectively to create more comprehensive and responsive service delivery systems for children exposed to violence.

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Appendix A
Safe Start Overall Logic Model

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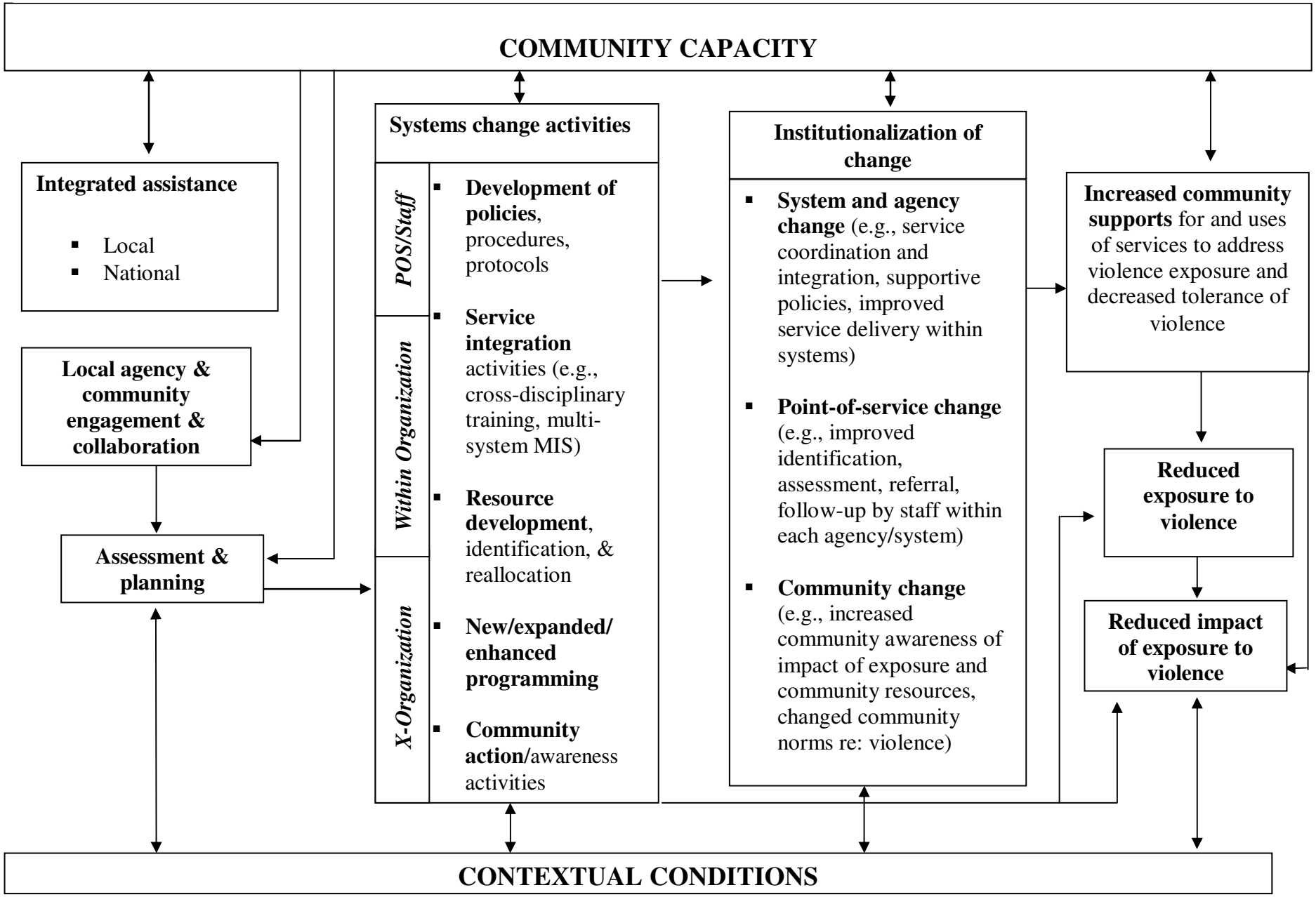
Safe Start Overall Logic Model



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Appendix B
The National Evaluation Case Study Methodology

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The National Evaluation Case Study Methodology

The case study is an empirical inquiry that:

- Investigates a phenomenon within a real-life setting, when
- The researcher has little control over the events, in which
- Multiple sources of evidence are used to verify the story.[26]

A case study is most useful when the research is examining "how" and "why" questions. A case study can use both quantitative and qualitative data. It can be the product of a mixed-method study.

There are different types of case study. A single-case study examines in depth a single entity such as a school, a person, a city, a program, or a Safe Start Demonstration Project pilot site. A multiple-case study asks the same questions in more than one setting (e.g., multiple Safe Start Demonstration Project pilot sites). A cross-case analysis can be conducted using a multiple-case study. Both types of case study can be explanatory (e.g., to explain causal links), descriptive (e.g., to describe a context), or exploratory (e.g., to explore a situation with no clear expected outcomes).

Data were collected for the Safe Start Demonstration Project case studies through document review and site visits. A site visit protocol was developed to guide discussions with key stakeholders. The protocol explains six primary procedures:

- Scheduling the site visits,
- Preparing for the site visits,
- Conducting the site visits (e.g., the primary purpose of the discussion with each stakeholder group, frequently asked questions),
- Creating an outline of key themes while on site and within 24 hours of completing the site visit,
- Creating the site database that includes key themes and their sources, and
- Creating a site visit report that summarizes the key themes.

The site visit protocol also offers guidelines for reviewing site documents and the standards of evidence. These standards are:

- All data collected, regardless of source, will be subjected to a strict standard to be judged valid.
- Data are collected during site visit discussion, through document review, and during follow-up conversations.

[26] Yin, R.K. (1989). *Case study research: Design and methods.* Thousand Oaks, CA: Sage Publications.

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- To be considered valid data, the following standards of evidence must be met:

    1. A minimum of two independent sources (i.e., participants or documents), preferably three, must provide the same information; no information will be reported based on a single source.
    2. The more frequently a piece of data is encountered, the more important or relevant it is.
    3. All assumptions will be confirmed during discussions with participants.

The complete protocol manual is available from the National Evaluation Team upon request.

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Appendix C
2005 Site Visit Core Discussion Questions

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2005 Site Visit Core Discussion Questions

1. What are the major accomplishments of Safe Start since the beginning of the year?
2. Can you please describe the process by which children exposed to violence are identified, referred, assessed, and treated?
3. Has the Safe Start collaborative changed in any way since the beginning of this year? If yes, in what ways?
4. How will Safe Start, whether as an initiative, a vision, or a set of principles, be sustained in the future?
5. In general, how has Safe Start increased the capacity of organizations and agencies to respond to the needs of children exposed to violence and their families?
6. In general, how has Safe Start increased the capacity of residents to respond to the needs of children exposed to violence and their families?
7. In your opinion, what capacities (such as knowledge, skills, relationships, resources) need to be in place for an initiative like Safe Start to be successful? Are these capacities different at different stages throughout the course of the initiative?

These discussion questions are linked to the Safe Start Demonstration Project's theory of change as follows:

- **Community capacity**
  - *In your opinion, what capacities (such as knowledge, skills, relationships, resources) need to be in place for an initiative like Safe Start to be successful? Are these capacities different at different stages throughout the course of the initiative?*

- **Local agency and community engagement and collaboration**
  - *Has the Safe Start collaborative changed in any way since the beginning of this year? If yes, in what ways?*

- **Systems change activities**
  - *What are the major accomplishments of Safe Start since the beginning of the year?*
  - *Can you please describe the process by which children exposed to violence are identified, referred, assessed, and treated?*

- **Institutionalization of change**
  - *How will Safe Start, whether as an initiative, a vision, or a set of principles, be sustained in the future?*

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- **Increased community support**
  - *In general, how has Safe Start increased the capacity of organizations and agencies to respond to the needs of children exposed to violence and their families?*
  - *In general, how has Safe Start increased the capacity of residents to respond to the needs of children exposed to violence and their families?*

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Appendix D
Service Delivery Models

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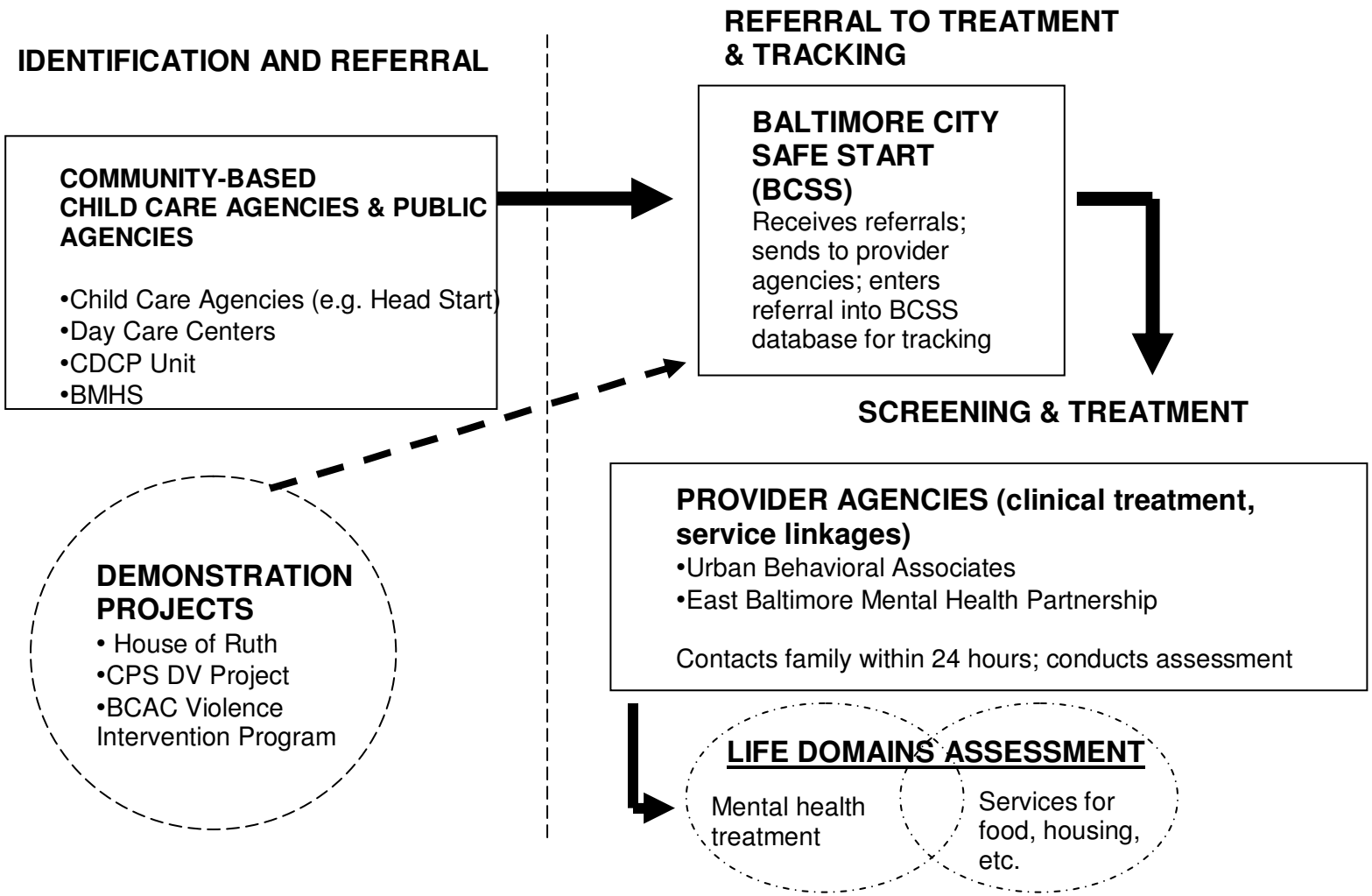
Baltimore City Service Delivery Model



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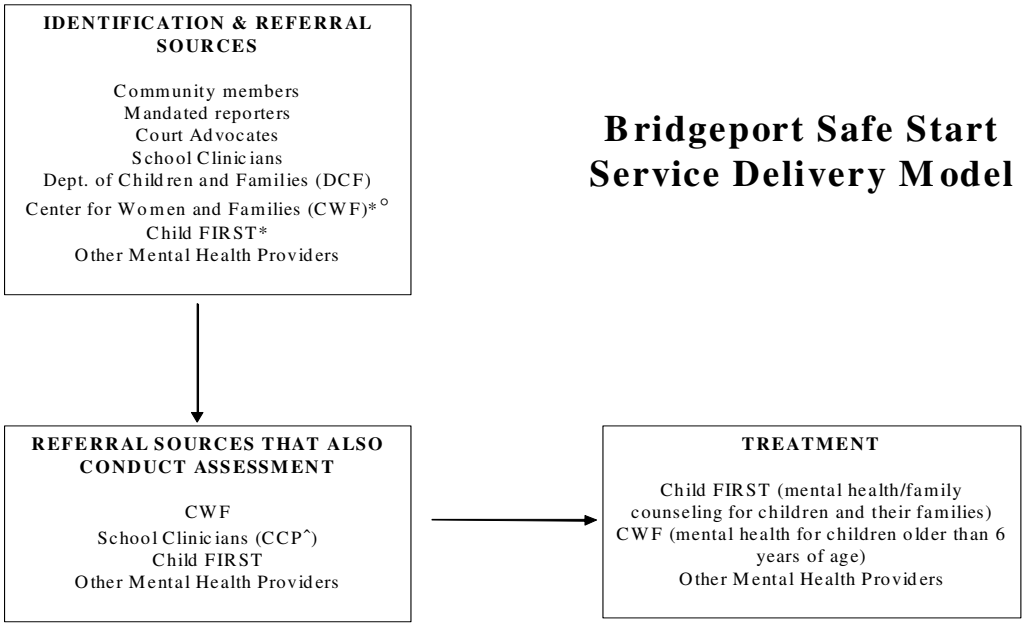
Bridgeport Safe Start Service Delivery Model



*BSSI funded
°Runs the local Domestic Violence Shelter
^Classroom Consultation Program

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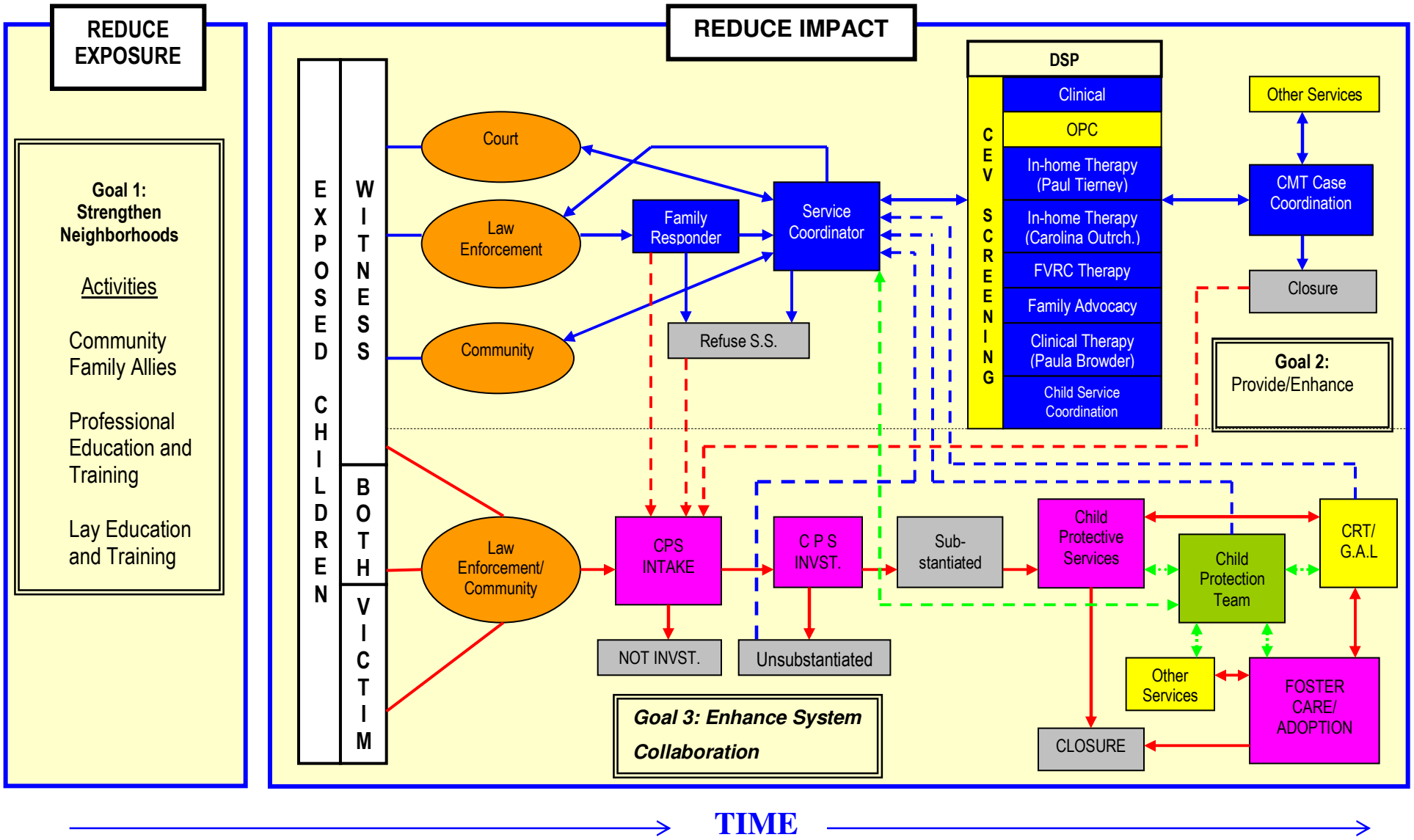
Chatham County Safe Start Service Delivery Model



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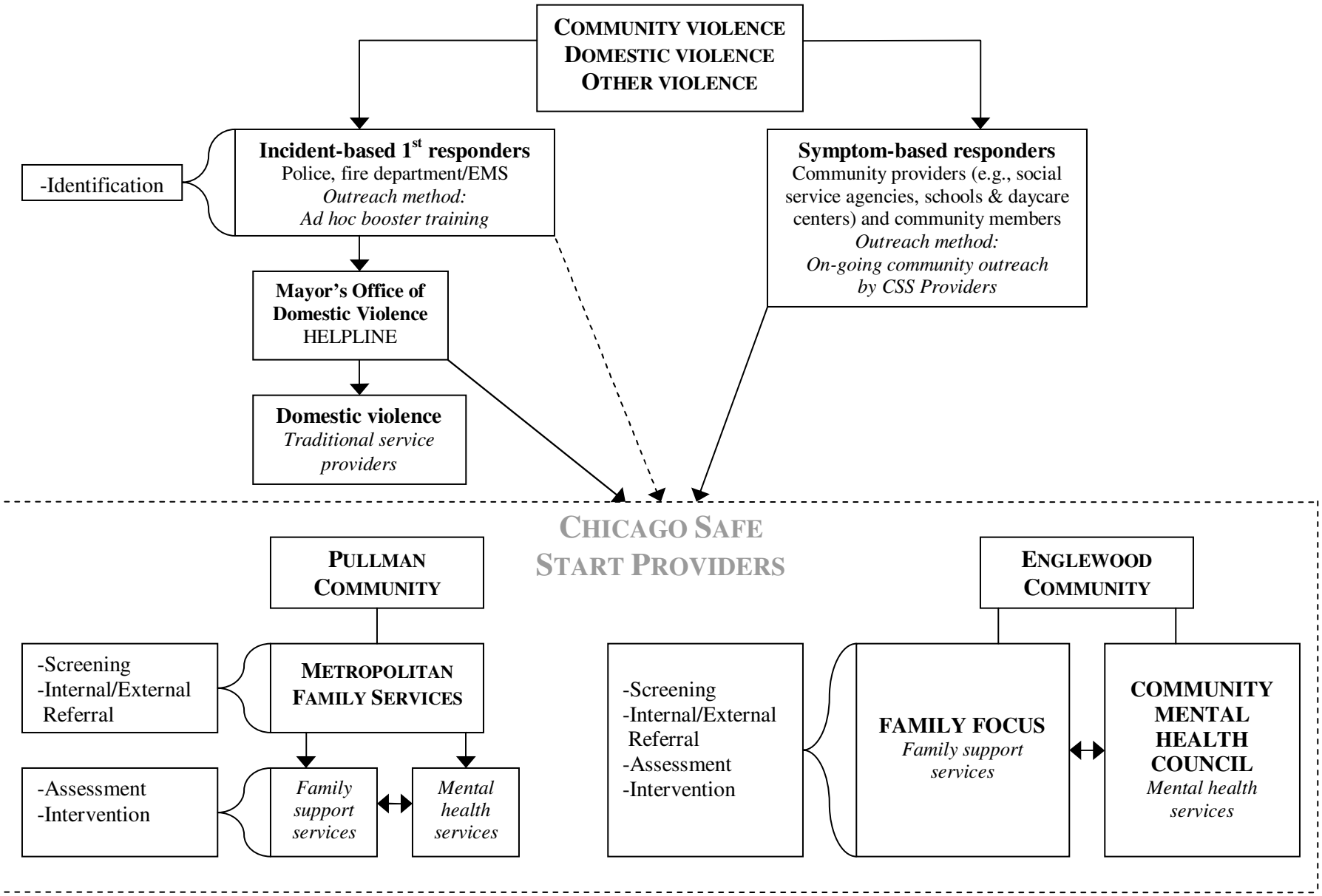
Chicago Safe Start Service Delivery Model



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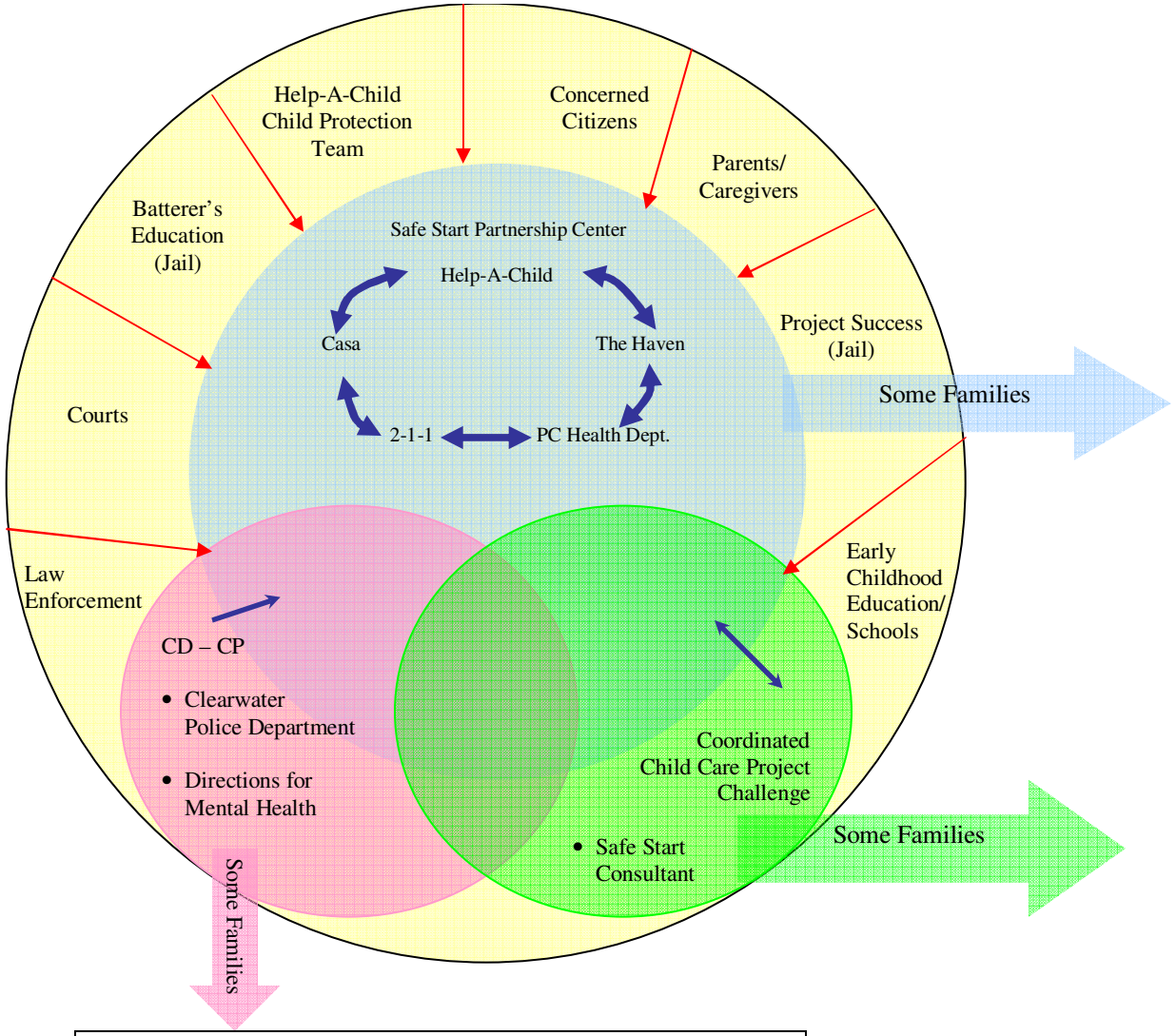
Pinellas Safe Start Service Delivery Model



Red Arrows: All Families with Children Exposed to Violence
Blue Arrows: Referrals

Intensive Family Services (Help-A-Child)

- Crisis Counseling
- Comprehensive Family Assessment
- Parent-Child Observations
- Weekly Home Visits
- Support Services for Parents
- Family Plan Assistance
- Resource Referral and Service Coordination
- Multi-Disciplinary Team, if Needed

Average 12–16 Weeks of Intensive Services
90-Day Follow-Up

Coordinated Child Care Project Challenge

- Behavioral and Developmental Screening
- Observe Child in Child Care Setting
- Monthly Home Visits
- Support Services for Parents
- Consultation with Child Care Providers to Maintain the Child in Care
- Therapeutic Child Care, if needed
- Behavior Management and Developmental Activities for Parent and Child Care Provider
- Resource Referral and Service Coordination

Average 12–16 Months of Service

Child Development–Community Policing

- Crisis Counseling/Support
- Consultation
- Provide Information to Parents About Impact of Violence Exposure
- Referrals to Mental Health Services

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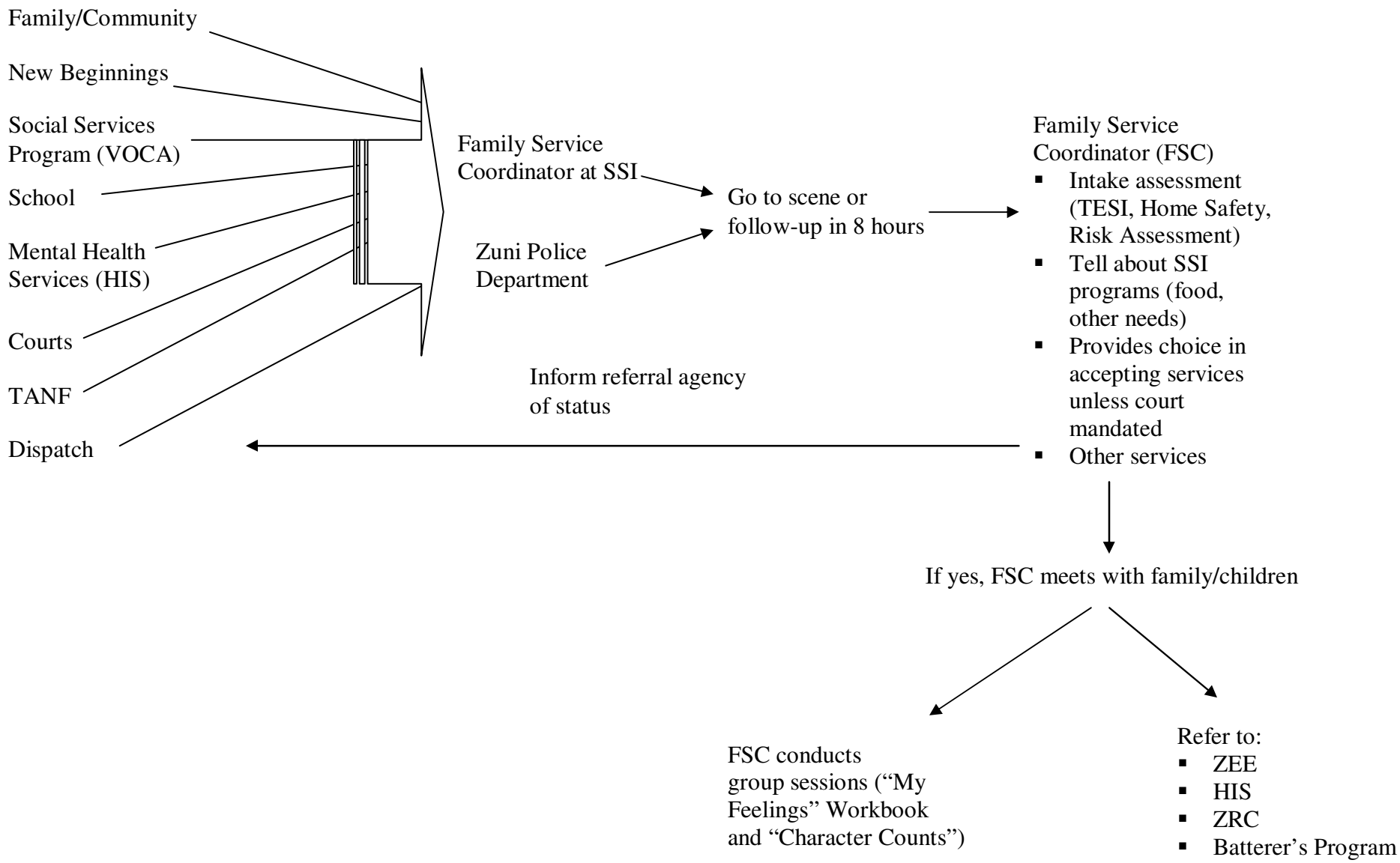
Pueblo of Zuni Safe Start Service Delivery Model



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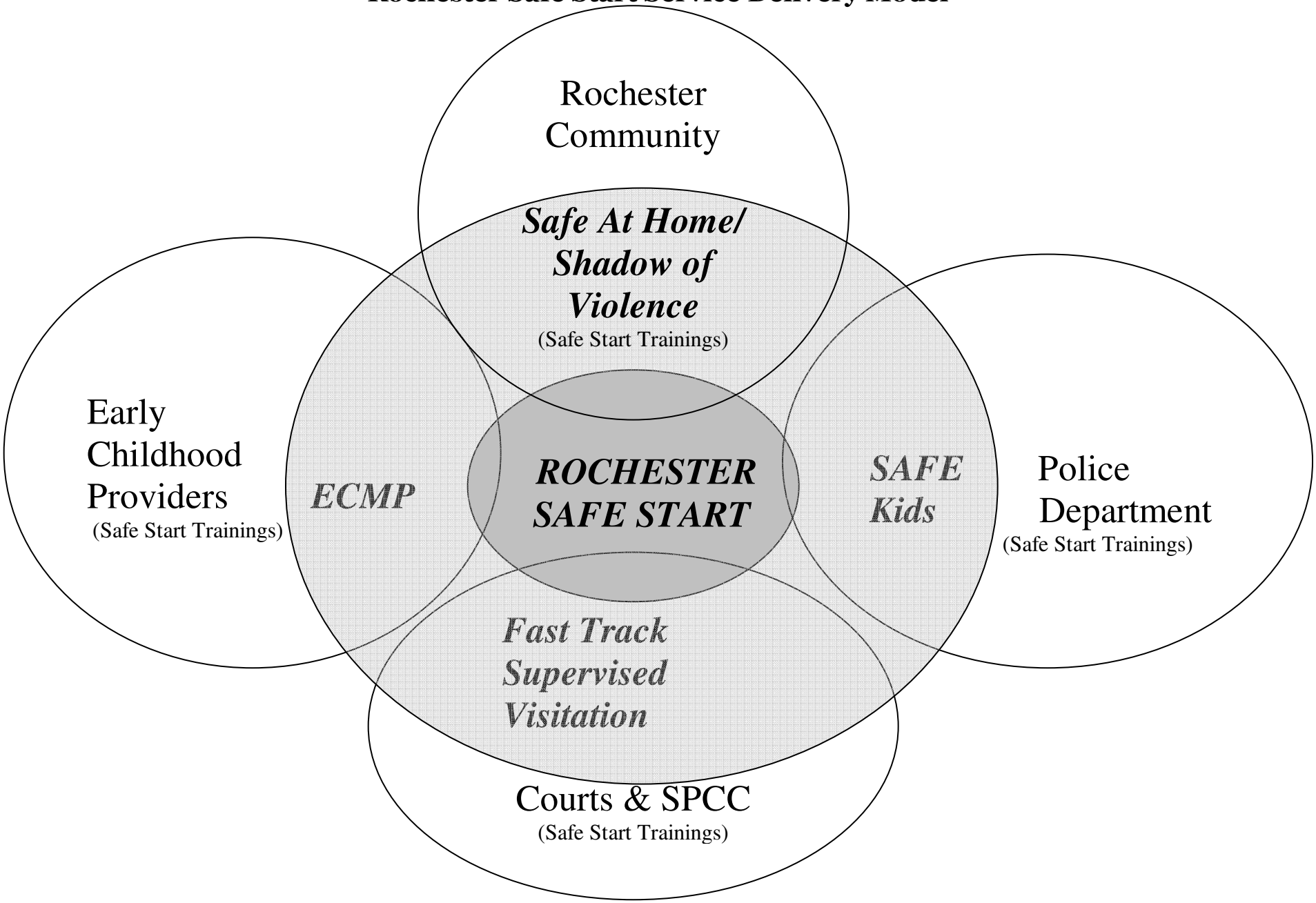
Rochester Safe Start Service Delivery Model



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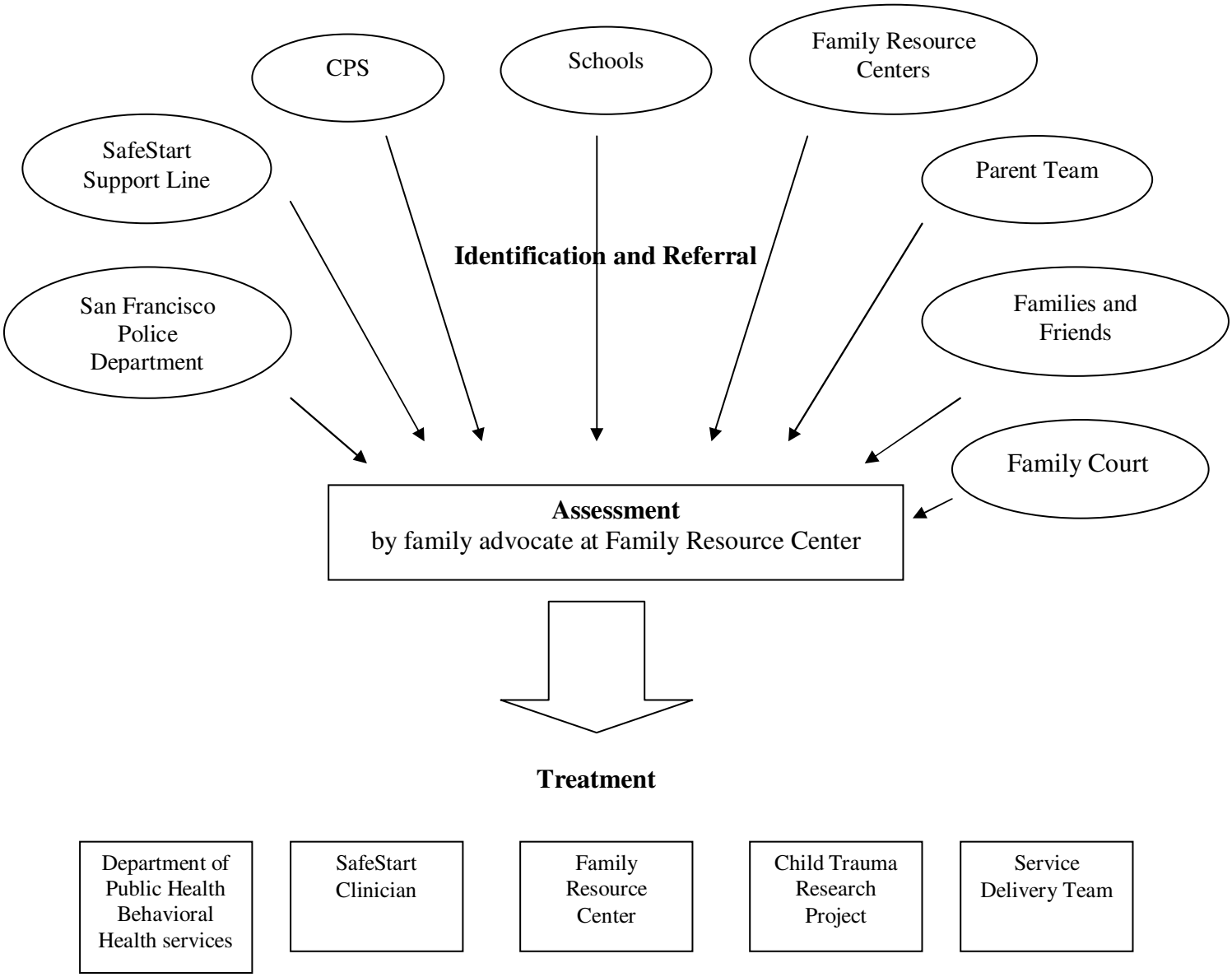
San Francisco SafeStart Service Delivery Model



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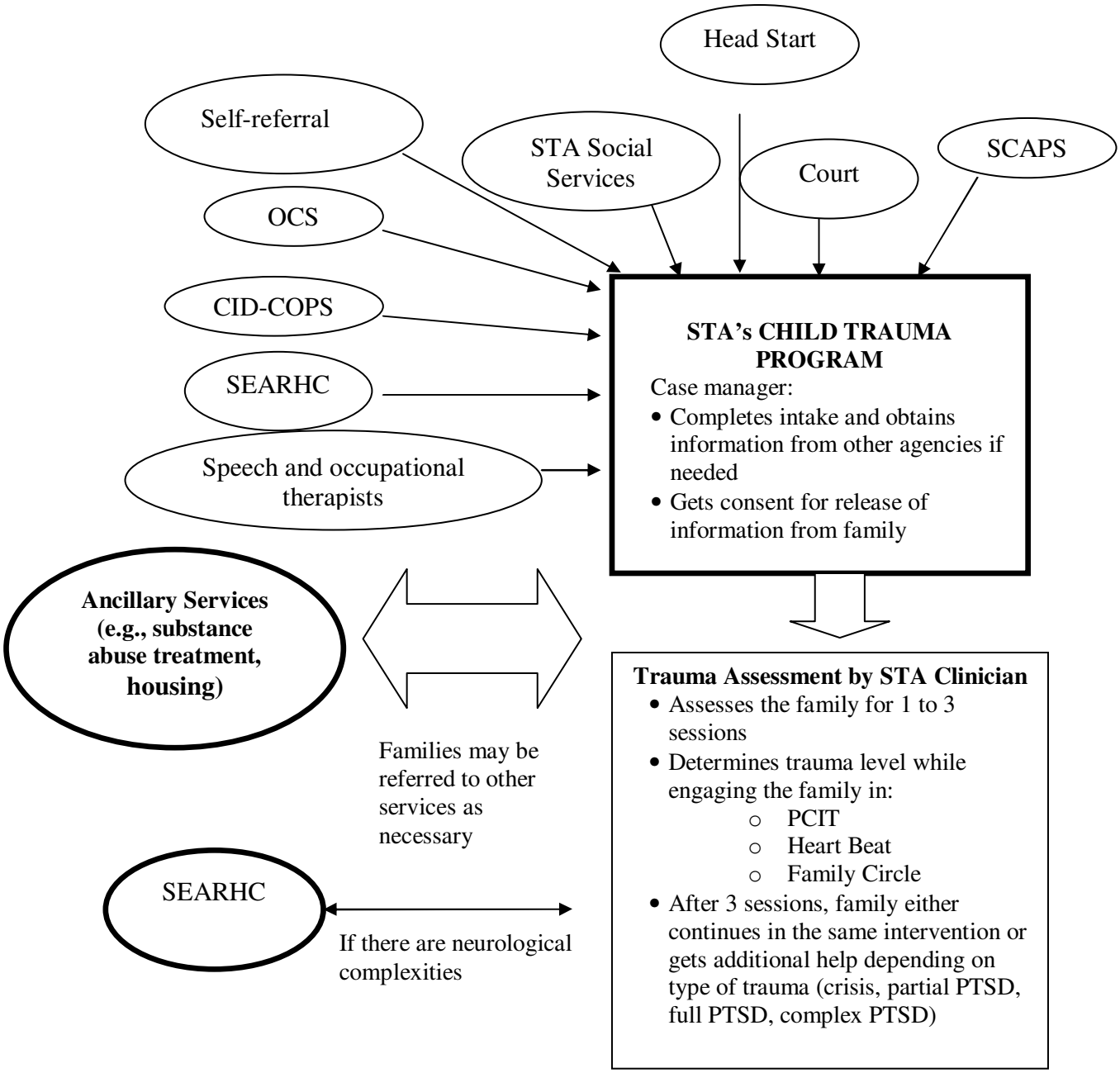
Sitka Safe Start Service Delivery Model



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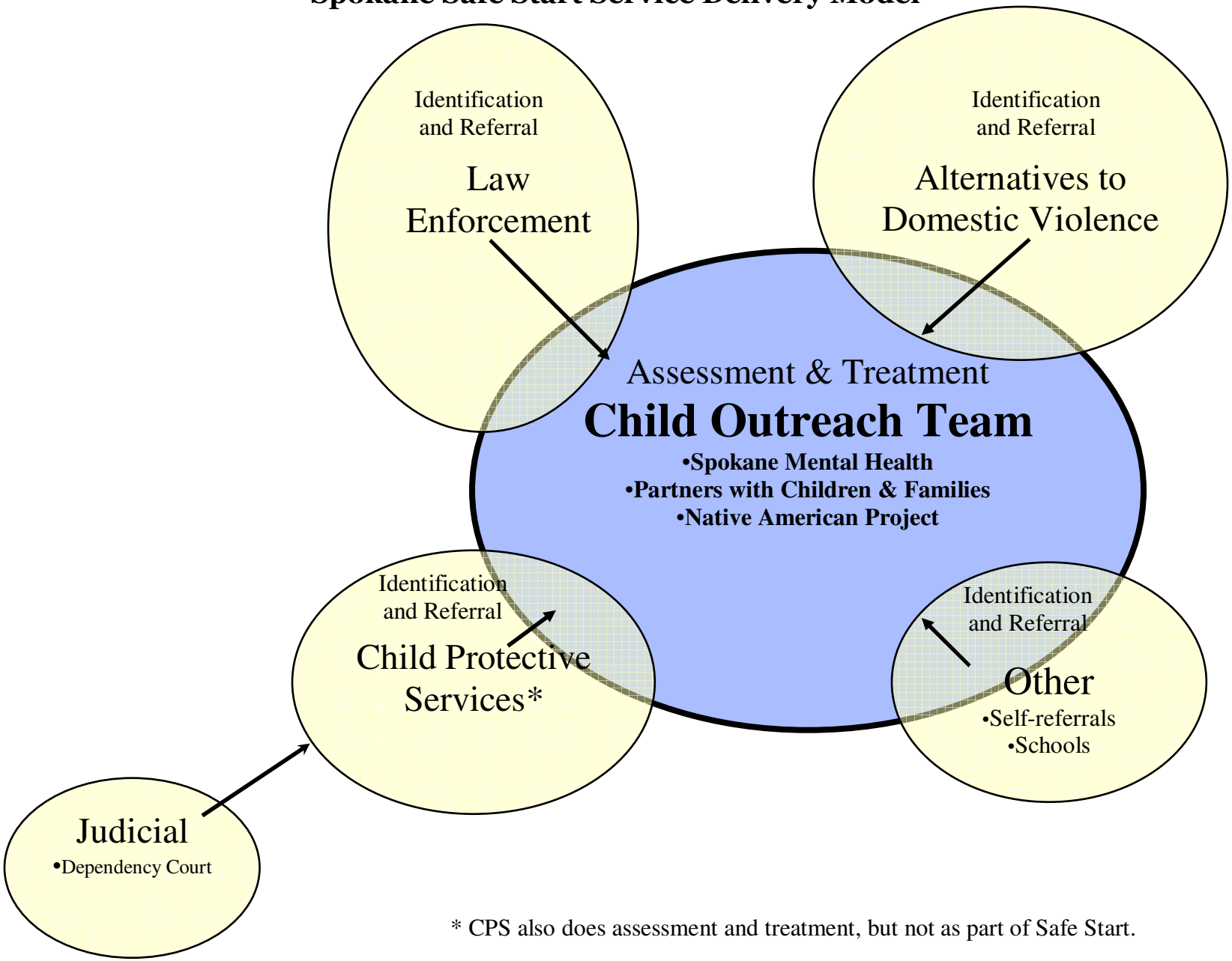
Spokane Safe Start Service Delivery Model



* CPS also does assessment and treatment, but not as part of Safe Start.

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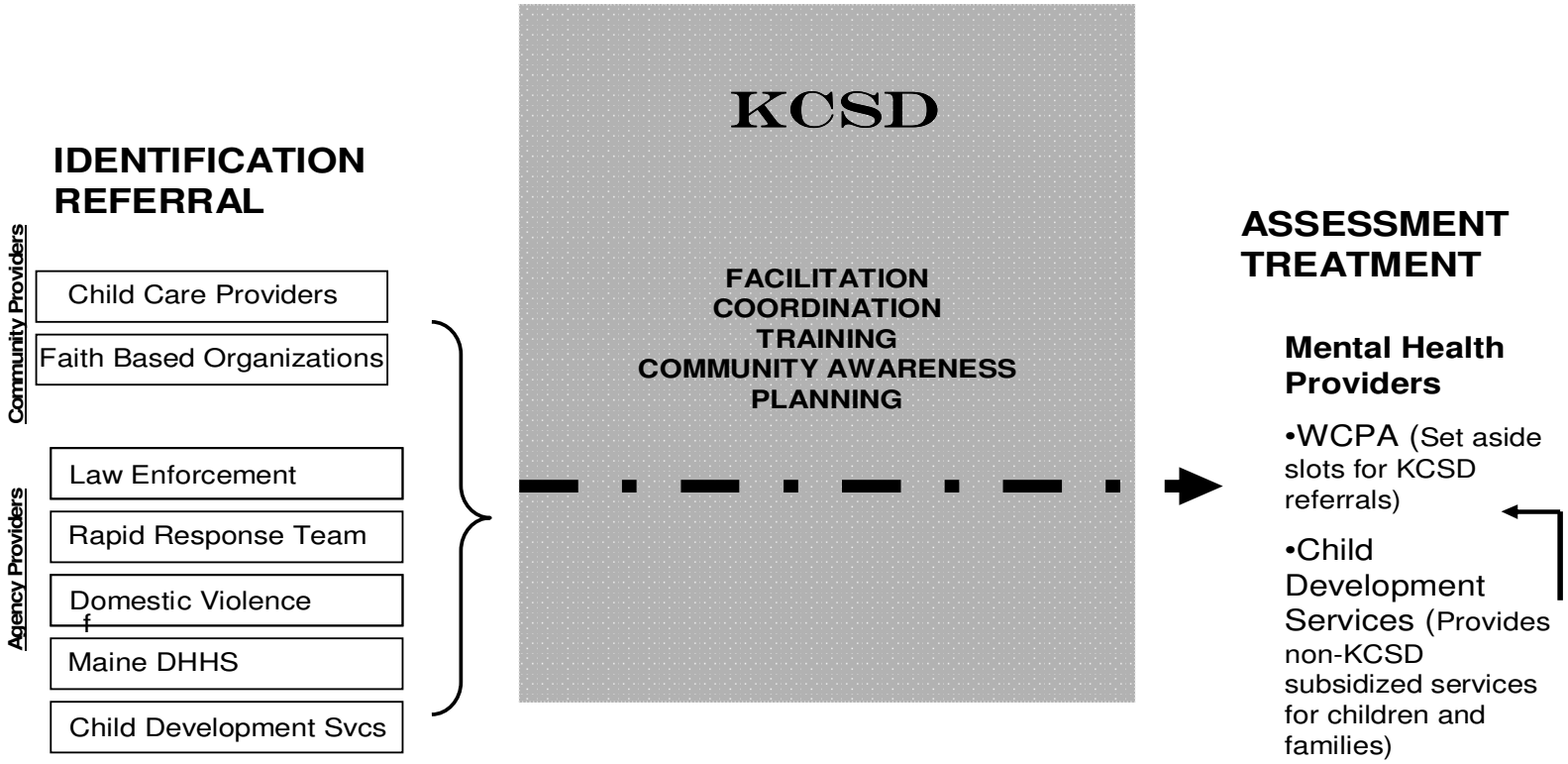
Washington County Safe Start Service Delivery Model

Washington County, Maine

Developing CEV Service Pathway