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Safe Start Initiative: Demonstration Project

Phase I

Case Studies I (2004)

Report #2005-1

September 2005

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Preface

This volume on the case studies was developed by the Association for the Study and Development of Community (ASDC) for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) for the National Evaluation of the Safe Start Demonstration Project for January through December 2004.

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

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I

BALTIMORE CITY SAFE START INITIATIVE

1. Introduction

To develop a full understanding of the Baltimore City Safe Start from January through December 2004, the National Evaluation Team (NET) visited the Baltimore City site on September 7 and 8, 2004, and conducted follow-up telephone interviews with key individuals in September 2004 and again in January 2005. The NET also reviewed existing documents about the Baltimore City SSI, including strategic, implementation, initiative overview, and progress reports.

The NET interviewed ten Safe Start participants, including staff members, point-of-service providers, collaborative members, representatives of mental health and other services, and the local evaluator. Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of the Baltimore City Safe Start (BCSS) in the past year?
- How did the composition and process of the collaborative in each site influence the types of strategies implemented, and as a result, the system change outcomes?
- How has the BCSS changed the service delivery system for children exposed to violence and their families?
- What organizational, point of service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of the BCSS?
- How did the BCSS handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?
- What are the lessons learned about the implementation and replication of a national initiative such as Safe Start?

This report covers the period from the start of the Baltimore City Safe Start in January 2004 through December 2004. Organized according to the Safe Start Demonstration Project logic model, it describes the economic, political, and social context of the Baltimore City; the technical assistance the initiative received; the collaboration among different community organizations and agencies participating in BCSS; the system change activities (i.e., development of policies, procedures, and protocols; service integration; new, expanded, or enhanced programming; community action and awareness; and resource development) by BCSS; the initiative's institutionalization of changes; and the challenges faced and lessons learned by the participants. A timeline of major milestones is included in Attachment A.

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2. Contextual Conditions

2.1 Local Contextual Conditions: Background

Baltimore City lies on the Patapsco River in the state of Maryland. The 2003[1] population was estimated at 629,000, with the population on the decrease since 1990. African Americans comprise the majority of the population (64.3%); European Americans, 31.6%; Latinos, 1.7%; and Asians and Asian Americans, 1.5%. Children five years and younger represent 6.4% of the total population. The median household income in the city in 2000 was $30,078.[2]

Baltimore has long been known as one of the most violent cities in the country, with crime rates exceeding national averages for all violent crimes except forcible rape. Although site visit participants repeatedly commented on the impact of the level of violence on community attitudes, crime has begun to decline in Baltimore; for the period 1999 to 2001, the city boasted the highest two-year reduction in violent crime of any city in the nation.[3]

Site visit participants characterized Baltimore City's municipal leadership as territorial and unwilling to genuinely collaborate; moreover, leadership changes at the state and local level have failed to facilitate new and productive partnerships. At the state level, Maryland installed a new governor in 2003. The Governor, in turn, appointed a new Secretary to the Department of Juvenile Services (DJS). Although DJS serves as the lead agency for the BCSS, the BCSS had to convince the new DJS leadership of the connection between the Department's mandate and the issue of children exposed to violence, following the appointment of the new Secretary. At the local level, the Baltimore City Schools and Police Department each have had three different leaders since the inception of the BCSS; in the fall of 2004, the Baltimore City Police Commissioner changed again, when the incumbent was fired as a result of controversy over allegations of domestic violence by his fiancé. In both organizations, each new leader brought on a new managerial staff, disrupting relationships with BCSS staff and organizational knowledge of the BCSS.

With respect to the mental health system in Maryland, a diagnosis is required for mental health providers to receive reimbursement for services; currently, diagnoses do not exist for children six years and younger. Although some states reimburse V Codes, which identify parent-child problems that do not reach the threshold of a DSM-IV diagnosis, Maryland does not. In addition, Maryland's mental health system does not reimburse providers for service linkage or family support services. This is a serious limitation in the system of care given that several site visit participants emphasized the vital role these services play in engaging families in mental health services initially.

2.2 Local Contextual Conditions: Specific to 2004

In 2004, the Governor requested that agencies such as the Department of Human Resources, DJS, and the Department of Health and Mental Hygiene devise ways to cut spending by an additional 12%. Baltimore City's Department of Social Services (BCDSS), therefore, suffered budget cuts that compounded the effects of prior (2003) cuts. Staff had to be released,

[1] US Census projections, 2003.
[2] US Census, 2000.
[3] Baltimore Police Department; http://141.157.54.34/bpdmaps/police.htm

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leaving fewer personnel to address social services and even fewer resources for the BCSS.

The BCDSS experienced additional staff turnover in 2004 due to a prolonged political dispute between the Mayor of Baltimore and the Governor of Maryland regarding the agency's oversight. After this extended period of disagreement, a new Director was appointed to the BCDSS in the fall of 2004. These changes and disruptions made it difficult for BCDSS decision-makers to sustain attention to the BCSS in 2004, in spite of the fact that the BCDSS is a key partner on the Safe Start Council.

A high profile BCDSS case involving the death of infant twins further beleaguered this central collaborative partner. The mother of the twins was involved with Child Protective Services (CPS) prior to their birth. Therefore, when they died under her care, the BCDSS found itself in a very public position of needing to explain itself—leaving even less time and attention for the agency to participate actively in the BCSS.

In another high profile act of violence in 2004, three young children were decapitated in their home. Two site visit participants raised the question of how such publicized acts of violence, as well as less newsworthy violence, may contribute to a collective numbness among inner city residents. According to six individuals associated with the BCSS, Baltimore City residents seem to have become indifferent to the violence in their communities and in their homes. As one participant put it, why would families think of mental health services as a meaningful way to address violence, when violence permeates every aspect of their lives?

Between January and June of 2004, the Child Development Community Policing program (CDCP)[4] responded to 47 trauma incidents. Eight children six years and younger were present at the incidents; four additional children were relatives of involved individuals but were not present at the time of the events.[5] Between July and December of 2004, CDCP responded to 42 trauma incidents. Of these, 33 involved community violence, eight involved domestic violence, and one involved another type of violence. A total of four children six years and younger were present at these incidents. Three of the children were victims and the fourth child was a witness.[6]

Baltimore City's 2004 homicides numbered higher than the number of homicides in 2003. According to the Baltimore City Police Department, 278 persons were killed in 2004, compared with 271 in 2003, 253 in 2002, 256 in 2001, and 261 in 2000. Of the 278 homicide victims in 2004, 213 died outside and 141 were shot multiple times. Thirty-three of the victims and 18% of the suspects were juveniles.[7]

3. Community Capacity

3.1 Service Delivery System Infrastructure and Capacity

The BCSS developed its strategic plan based on a capacity that would eventually be eliminated by funding cuts: the Success by 6

[4] The Child Development-Community Policing Program is one of the Child and Adolescent Psychiatry Community Programs that are run by The East Baltimore Mental Health Partnership.
[5] *Baltimore City Safe Start Initiative Semi-Annual Progress Report January-July 2004,* p. 13.
[6] *Baltimore City Safe Start Initiative Semi-Annual Progress Report July-December 2004,* p. 12.
[7] *Baltimore City Safe Start Initiative Semi-Annual Progress Report July-December 2004,* p. 19.

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(SB6) Initiative. In work seen as congruent and complementary to that of the BCSS, SB6 sought to develop a citywide, comprehensive system of community-based services for children six years and younger, first targeting communities with the highest risk of violence and violence exposure. The BCSS decided to focus its work within two of the seven SB6 communities, building on the community-based governance and service delivery structures that SB6 had begun to establish. One of these communities subsequently lost its SB6 program due to limitations in funding; however, the BCSS remained.[8]

During 2004, the BCSS strengthened its partnerships (described more fully in Section 6 of this report) with two important Baltimore City institutions that serve children exposed to violence and their families: The House of Ruth of Maryland and the Baltimore Child Abuse Center. These two organizations are the primary providers of services in Baltimore for domestic violence victims and child sexual abuse victims, respectively. The House of Ruth is one of the nation's leading domestic violence centers, helping thousands of battered women and their children find safety and security. The House of Ruth of Maryland has an 84 bed emergency shelter and offers transitional housing. Services available to victims and their children include: Esther's Place (designed to help battered women achieve economic security); a holistic health and wellness program; an on-site health clinic; domestic violence education classes and support group counseling; addictions and housing counseling; a children's program (including childcare and therapy); a legal clinic; and individual and group therapy for victims and their children.

Baltimore Child Abuse Center (BCAC) serves as the advocacy network for victims of sexual abuse. By providing a one-time session to interview suspected victims, the center lessens the trauma that an investigation inflicts upon abused children. During a BCAC investigative session, law enforcement personnel, social service workers, State's Attorney's Office personnel, and representatives of other appropriate agencies convene to witness the forensic interview of the child through a closed circuit system; a single trained forensic interviewer asks the child any questions these involved parties wish to have posed. The center also coordinates physical exams and referrals to other services, including referrals for treatment.

The BCSS, residents and mental health service providers in Baltimore City did not understand the potential effects of violence exposure on children six years and younger. Moreover, few mental health providers in Baltimore specialized in early childhood mental health. As a result, providers and other social service staff have required ongoing training to develop their capacity to serve families with exposed children, according to several participants. Several site visit participants also described community residents' understanding of the harm that exposure to violence can have on young children as limited. Limited awareness of the issue among Baltimore residents challenged BCSS efforts to connect families to services.

Further capacities required of mental health providers in Baltimore City, but not yet attained by all, include the ability to provide families with immediate incentives, such as books, transportation, or assistance with

[8] Background information on Success by 6 was obtained from the *Baltimore Year Four Strategic Plan (pp. 3, 5, 6).*

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bills. According to site visit participants, mental health organizations also must be willing to do the work of the BCSS by 1) hiring staff trained to work with the target population, 2) participating in planning processes, and 3) developing appropriate intervention services. In addition, mental health providers must be willing and able to develop relationships with the community and other service providers. Finally, providers who work with the target population must have access to ongoing training on violence, trauma, and effective therapeutic interventions. The presence of these capacities would help improve Baltimore City's overall capacity to address issues related to children exposed to violence, according to participants.

3.2 Collaboration Among Organizational Leadership Limited in Baltimore City

Despite Baltimore's relative capacity (e.g., House of Ruth, Child Abuse Center, the Kennedy Krieger Institute, etc.) to address children's exposure to violence, the BCSS staff and collaborative partners consistently characterized Baltimore City's organizational leadership as historically territorial. The lack of a collaborative spirit makes genuine partnership and systems change particularly difficult to achieve and decreases the capacity of the community to respond to issues of children's exposure to violence. As one participant described it, a small network of personal relationships drives local Baltimore politics, such that a few influential individuals can deem an initiative or organization unworthy of anyone's time.

Two key Baltimore City mental health providers for children six years and younger—the Kennedy Krieger Institute and the Taghi Modarressi Center for Infant Study at the University of Maryland—have not been engaged as BCSS point-of -service providers,[9] exemplifying Baltimore's territorial nature. BCSS referrals are not sent to these two organizations, nor are their waiting lists shared with BCSS providers. When asked to explain why the Kennedy Krieger Institute was not selected as a BCSS point-of-service provider, in spite of its traditional outpatient mental health clinic for addressing neglect, abuse, and violence, a BCSS staff person stated that the Institute was viewed as resource-rich and not in need of BCSS funding. The Institute representative did not provide a reason for the lack of formal relations with the BCSS.

Key agencies in Baltimore City lack a common leadership structure. According to the BCSS *Year Four Strategic Plan* (page 39), for example, the key agencies involved in responding to domestic violence incidents—the Baltimore City Police Department, the Department of Social Services, and the Office of the State's Attorney—do not fall under a single authority, despite the need for common leadership to ensure coordination of response and services.

3.3 Resident Utilization of Mental Health Services Limited in Baltimore City

Baltimore City residents bring two important capacity challenges to the table. First, according to two participants, residents identify strongly with their geographic location. Residents on one side of Baltimore (East or West) typically will not travel across town to access resources or

[9] The Kennedy Krieger Institute participated in the design of the Early Childhood Mental Health series, and the Taghi Modarressi Center for Infant Study participated in the validation study that was terminated.

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services on the other side of the city. The BCSS's first mental health service provider, Urban Behavioral Associates (UBA), is located in East Baltimore, just one block east of the East/West boundary; by contrast, the initial target communities were both located in West Baltimore. According to some site visit participants, however, residents perceived the service provider as within West Baltimore, despite its official location. During the summer of 2004, when the BCSS target communities were changed to encompass a larger base for referrals, the East Baltimore Mental Health Partnership (EBMHP) was added as a second provider.

Second, Baltimore residents stigmatize mental health services—to the extent that point-of-service providers and the BCSS staff discussed the intentional use of the word "counseling" to replace "therapy." Staff identified this broad community issue as impeding resident engagement in the intervention component of the BCSS.

4. Integrated Assistance

The BCSS found the Systems Improvement Training and Technical Assistance Program (SITTAP) useful around the issue of sustainability. SITTAP and the BCSS continued to work together throughout the last months of 2004, with SITTAP representatives 1) attending the last Safe Start Council meeting on December 2, 2004, as well as a prior staff meeting in preparation for the Council meeting, and 2) providing consultation to the BCSS to help identify an entity to oversee the Initiative after federal funding expires. In the absence of a single entity, the BCSS plans to identify multiple key agencies that will continue to address early exposure to violence as part of their mission. In 2004, BCSS worked on crafting agency-specific messages; in 2005, BCSS will approach identified agencies in an effort to secure their commitment to carry on the Safe Start mission.

Site visit participants suggested that the Office of Juvenile Justice and Delinquency Prevention (OJJDP) should have offered training and technical assistance (T&TA) on program development and evaluation one year prior to the implementation of the BCSS. This would have allowed for more responsive and timely assistance for the Initiative, because the national technical assistance providers would have had ample opportunity to assess the site's local expertise and capacity, and would have been prepared to provide necessary support at key intervals. The BCSS found it challenging to evolve as a local program, in parallel with the evolution of the Safe Start Demonstration Project at the national level. For example, despite BCSS need at the local level, Initiative staff perceived a lack of national-level expertise in the areas of 1) mental health services for children six years and younger and 2) forming an effective collaborative.

Participants also indicated that a clear and consistent focus for the BCSS, at both the national and local levels, would have been helpful. Some participants perceived a shift in OJJDP expectations of local sites midway through the Safe Start Demonstration Project. According to a few participants, OJJDP initially appeared to focus on prevention, with a later shift in emphasis to intervention. Finally, participants suggested that cross-site meetings could be enhanced to give sites the opportunity to learn from one another by sharing successes and challenges.

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5. Local Agency and Community Engagement and Collaboration

The BCSS is governed by the Safe Start Council, a Steering Committee, three subcommittees (Services/System Trauma Response, Community, and Policy), and three ad-hoc committees (Screening and Assessment Tools Development, Life Domain Assessment, and Consensual Screening Committee).[10]

Along with leadership changes within partner organizations, the BCSS itself experienced leadership turnover prior to 2004. Current BCSS staff and partners described the combination of external and internal leadership turnover as particularly challenging for promoting community engagement and collaboration; interim periods between BCSS Project Directors brought delays in BCSS activities, resulting in a loss of interest among partners.

In response to the above challenge, the BCSS Project Director spent most of 2004 reaching out to community agencies and organizations to solidify or establish relationships. Two events were held as part of this effort to revitalize the BCSS: the Baltimore City Safe Start Symposium and the Baltimore City Safe Start Council Retreat.

Organized around the theme "*A Strong Community Begins with Ensuring a Safe Start for Children,"* the Symposium created a forum for publicizing the BCSS to a large audience. More than 250 persons attended this event. After Dr. Bruce Perry, a trauma expert, delivered the keynote address, a panel responded to his comments; this panel included representatives from the BCDSS, the Police Department, the State's Attorney's Office, and the Department of Health and Mental Hygiene.

The Council Retreat focused on 1) funding and 2) sustaining core components of the BCSS beyond the funding year 2005.

All site visit participants agreed that the Symposium and Retreat were well attended and successful in their goal of reengaging partners in the BCSS, through strengthening the working relationships among key agencies and creating an opportunity for dialogue among core members. According to the *July-December Semi-Annual Progress Report* (page 18), the BCSS more successfully engaged Council members to do the work of the Initiative, following the Symposium and the Retreat. The full Council embraced the Initiative's components and agreed that core components of each of the five BCSS goals[11] need to be sustained. The four workgroups formed during the Retreat to develop strategies for implementation and sustainability convened several subsequent meetings in the latter part of 2004. Workgroup accomplishments are described in Section 7.

Core members of the collaborative in 2004 included agencies with direct access to the BCSS target population: the BCDSS, CPS,

[10] *Baltimore Year Four Strategic Plan (Baltimore City Safe Start Initiative Overview, p. 46).*

[11] The five goals include: (1) Community has knowledge of the impact of childhood exposure to violence. (2) Early and consistent detection of young children exposed to violence is achieved. (3) Young children identified as impacted by exposure to violence receive mental health services in their community from a provider who is Safe Start trained. (4) Young children identified as impacted by exposure to violence have access to improved, appropriate community-based services. (5) The coordination of services among key agencies that respond to incidents of family violence is enhanced.

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House of Ruth (a domestic violence agency), Baltimore Mental Health Systems, and Baltimore City Child Abuse Center. Given that 1) these collaborative partners serve the entire city, and 2) providers who have received BCSS training are located across the city, the BCSS decided to expand its efforts citywide in 2004.

According to site visit participants, several initiatives in Baltimore City compete for the attention of decision-makers. Many of the participants expressed a belief that, in retrospect, real leadership within the collaborative should have been established at the inception of the BCSS, with "real leadership" defined by several participants as the ability to motivate people and the authority to move people to action. Visible and respected leaders, such as key policymakers in the City, were identified as essential for implementing and sustaining an initiative such as the BCSS.

Weaknesses of the collaborative included a lack of active participation by the Police Department, the Baltimore City schools, and the State's Attorney's Office. Because the police and the State's Attorney's Office have not been actively involved, the BCSS has been hindered in its ability to improve coordination between these two key agencies involved in responding to domestic violence. Furthermore, decision-makers from partner organizations have failed to attend BCSS meetings, despite good working relationships among current collaborative partners. Several participants pointed out that the involvement of decision-makers from core collaborative agencies would empower the Safe Start Council to lead the Initiative and engage the community after federal funding ends. An engaged leadership also would help prioritize the work of the BCSS.

The BCSS continued to participate on the Community Advisory Board of the Kennedy Krieger Family Center Trauma Intervention Program.

6. System Change Activities

Site visit participants consistently identified the following events and activities as the BCSS's major accomplishments in 2004:

- The development and provision of the Early Childhood Mental Health Training Series;
- Over 400 persons participated in the Children's Exposure to Violence Trainings;
- A total of 36 individuals participated in the Children's Exposure to Violence Train-the-Trainer curriculum;
- Over 250 persons attended the BCSS Symposium, *"A Strong Community Begins with Ensuring a Safe Start for Children"*;
- The BCSS Council Retreat revitalized the Initiative;
- A second mental health provider, the East Baltimore Mental Health Partnership, was contracted by the BCSS; and
- The Baltimore City Department of Social Services initiated with the support of the BCSS its Domestic Violence Demonstration Project.

6.1 Development of Policies, Procedures, and Protocols

BCSS partner agencies were encouraged to incorporate core screening questions from the BCSS Screening Tool[12] into their own intake protocols.

[12] The validation study for the Screening Tool was terminated in 2004 as a result of low family participation.

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Retaining families in services after their initial engagement proved problematic in 2004. One barrier to retention was the lengthy assessment protocol administered to referred families; to remove this barrier, the assessment package was modified to include fewer assessment measures.
To assess referrals prior to 2004, the BCSS used an assessment package referred to as the Life Domain Assessment protocol. To identify child and family strengths, resilience, and areas of service needs, the assessment package included the following measures: Life Domain Questionnaire, Ages and Stages, Parenting Stress Index, Trauma Symptom Checklist for Young Children, and Post-Traumatic Stress Disorder Semi-Structured Interview, among others. Because UBA faced challenges in keeping parents engaged long enough to implement the entire assessment package, the package was reduced in 2004 to the following three measures: Ages and Stages (a developmental assessment of the child), the Parenting Stress Index (a measure of the parent's stress level), and the Trauma Symptom Checklist for Young Children (an assessment of the child's trauma level). No family completed the entire assessment package in 2004.

The Children Exposed to Violence curriculum developed by the BCSS will be maintained by the Family Tree (an organization that provides training to parents), the Baltimore City Resource Center (a technical assistance entity for child care providers in Baltimore City), and the Sidran Institute for Traumatic Stress beyond federal funding of the Initiative.

6.2 Service Integration

At a staff meeting, the BCSS invited the Baltimore City Department of Social Services Child Protective Services (CPS) Supervisor to hear some of the challenges encountered when working with CPS-referred families; as a potential solution to these challenges, the Supervisor suggested a collaboration between UBA and CPS, such that CPS workers would accompany mental health clinicians on their initial visit to referred families. Because CPS is mandated to visit families within a certain time frame, it made sense to coordinate this mandated visit with the clinician's introduction to the family. As a result of this collaboration coordinated through the BCSS, CPS will begin referring children six years and younger who need mental health services to UBA. Collaboration with both UBA and EBMHP also has provided child welfare staff at BCDSS with two additional resources to administer the required mental health assessments for reports of mental injury.

6.3 Resource Development, Identification, and Allocation

The Baltimore City Department of Social Services and the House of Ruth pursued and received a grant from the Safe and Bright Futures for Children (SBFC) Initiative, to continue their collaboration on domestic violence and child maltreatment issues. The purpose of the SBFC is to encourage communities to plan for, develop, implement, and sustain a coordinated system of prevention, intervention, treatment, and follow-through services for children and their families who have witnessed or experienced domestic violence. Because the House of Ruth is a BCSS partner, the awarding of these funds will contribute to sustaining and expanding the work of the BCSS, particularly within the domestic violence sector.

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6.4 New, Expanded, and Enhanced Programming

The BCSS in 2004 focused on building the capacity of service providers in various sectors to respond appropriately to young children exposed to violence and their families. All site visit participants identified at least one of the following three BCSS trainings as important in the effort to enhance and expand Baltimore City's system of care for children exposed to violence and their families:

- ***Early Childhood Mental Health Training Series.*** Several participants stated that the BCSS enhanced Baltimore City's existing mental health system by providing the Early Childhood Mental Health Training Series;

- ***Children's Exposure to Violence Trainings.*** Several BCSS staff members reported that the Children's Exposure to Violence Trainings raised awareness and educated participants about the BCSS. Safe Start staff presented these trainings to 201 persons over the course of the first six months of 2004, and to 200 persons over the course of the last six months of 2004. During the early 2004 trainings, participants represented both public and private sector organizations, such as the Baltimore City Community College, Baltimore City Housing Department, Baltimore City Child Care Resource Center, Department of Recreation and Parks, Baltimore City Department of Social Services, Baltimore City Police Department, Carrington House (a substance abuse transition facility), and Prime Time (a faith-based after school program). Child care providers represented the largest number of participants at these early trainings. At the later 2004 trainings, parents were significantly represented (132 out of 200 total attendees), participating in trainings for two Head Start programs, the Safe Start Third Annual Parent Retreat, and the Young Fathers, Responsible Fathers (YFRF) training; and

- ***Children's Exposure to Violence Train-the-Trainer Curriculum.*** This nine-hour curriculum, presented in three sequential three-hour sessions, was designed to prepare individuals to train others at the agency and community levels on the impact that exposure to violence has on children. By broadening the base of individuals capable of 1) talking about children exposed to violence and 2) providing training on the issues, train-the-trainer sessions are expected to help the Safe Start message permeate communities, resulting in action on behalf of children in the form of increased referrals to the BCSS. In 2004, a total of 36 individuals attended four separate presentations of the train-the-trainer curriculum.

Participants in the BCSS trainings reported increased knowledge of children's exposure to violence and the BCSS. Statistical analysis showed knowledge gains to be significant.

In addition to building the professional capacity of service providers in Baltimore City, the BCSS recognized in 2004 the need to work more directly with parents. This led to a contract with UBA to develop eight-week curricula for two types of parent groups: Resiliency Building and Parenting Skill Building. UBA presented the Parenting Skill Building curriculum to 12 parents during the last three months of 2004; eight parents completed the full eight-week curriculum. Those parents, along with other interested newcomers, began the Resiliency Building group in January 2005. Meanwhile,

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EBMHP began a Resiliency training group in mid-December 2004, with two of a target five parents enrolled. Specific goals for the parent groups are:

1. Educate parents on resilience;
2. Teach parents strategies to build their own resilience, with the idea that resilient parents have resilient children;
3. Provide parents with skills to help them identify resilient and traumatized behavior in their own children;
4. Increase parental knowledge of child development;
5. Provide parents with a menu of effective parenting skills, including appropriate play, effective discipline, and effective communication; and
6. Create a nurturing and positive environment for parents.

The BCSS believes that these parenting groups will offer families an avenue of assistance without the stigma of mental health treatment.

In 2004, the BCSS Project Director made a strategic decision to expand the pathway for identifying, referring, assessing, and providing services to children exposed to violence by working more closely with domestic violence service providers, CPS, and other agencies serving children and families in the target population. With the support of the BCSS, CPS implemented the Domestic Violence Demonstration Project, to respond to both child abuse and domestic violence using a specialized intake unit and protocol. BCSS support for this project has included funding for training, securing technical assistance, convening meetings with BCDSS administrators to ensure support, and garnering the support of the Safe Start Council to publicize the project—all in an attempt to promote policy change related to domestic violence response. Meanwhile, the specialized family violence unit within CPS has generated additional referrals to the BCCSI.

As of June 2004, the family violence unit had assessed over 200 families for domestic violence as a routine part of CPS investigations. Although the final analysis of the Domestic Violence Demonstration Project has yet to be completed, domestic violence appears to be part of the dynamic in a significant number of families referred to BCDSS for alleged child maltreatment. The family violence unit has been working very closely with several agencies in the Baltimore area to provide appropriate services and case management strategies for these families. Leaders at key agencies in Baltimore have begun to recognize that a specialized family violence unit within BCDSS would facilitate better communication across agency lines, thereby improving service delivery for families experiencing overlapping forms of violence; several local agencies have written letters of support for the family violence unit to the Director of BCDSS. The newly appointed (late 2004) BCDSS Director is supportive of the Domestic Violence Demonstration Project, according to the BCSS Project Director.

The House of Ruth Community Outreach Expansion Project, funded by BCSS, began implementation on December 1, 2004. Through this project, the House of Ruth will expand outreach into Baltimore communities to offer comprehensive domestic violence services to families residing in the community (versus those who come to live in the shelter). Services will include therapy for affected children, administered by a part-time child therapist. For children six years and younger, both in the community and in the shelter, the House of Ruth will adopt the protocol presented by

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the BCSS in its Children's Exposure to Violence Training. Data on children who receive the BCSS intervention will be reported monthly to the BCSS; these children will be counted in the BCSS tracking system as referred, assessed, and treated.

In 2004, the Baltimore Child Abuse Center (BCAC) identified the need to screen families in their caseload for siblings exposed to violence, and to connect families with needed services. A case manager funded by the BCSS will head up the BCAC's Violence Intervention Project (V.I.P.), working with over 400 families on the center's caseload, to identify and coordinate services for any children six years and younger who have been exposed to violence.

Also in 2004, the BCSS increased the potential to reach families by adding a second mental health service provider, the East Baltimore Mental Health Partnership (EBMHP), located on Baltimore's East side. Referrals to the BCSS can now be assigned to either of two mental health providers trained by the Initiative: UBA or EBMHP. The addition of EBMHP in 2004 increased the availability of appropriate mental health services. One of the two point-of-service providers also began to meet families in their homes, shifting the focus of intervention from the individual child to the family system as a whole.

Both BCSS mental health providers were encouraged to review their current caseloads for families who may be eligible for Safe Start services. As a result, both UBA and EBMHP began to screen existing clients to identify and internally refer children six years and younger who have been exposed to violence.

Three clinical site visit participants reported that families who have received BCSS treatment services have developed increased awareness of the impact that violence can have on young children. Unfortunately, few families have had the opportunity to benefit from the BCSS.

Accounts of the exact number of referrals to the BCSS varied among site visit participants; however, according to the *January-July 2004 Semi-Annual Progress Report*, the BCSS received seven new referrals in the first six months of 2004. At the end of June 2004, three of these referrals had enrolled in treatment and were considered "active cases." Four referrals made in 2003 remained enrolled in treatment during the first progress report period, for a total of seven active cases (nine children). According to the *July-December 2004 Semi-Annual Progress Report*, the BCSS received 31 new referrals in the last six months of 2004. Although the progress report for this period did not include case dispositions, the data reported in the evaluation section of the report indicated that 24 cases were active as of December 2004. The following figures were confirmed with the local evaluator after the May 2005 National Evaluation Meeting: 261 children were identified, 42 children were assessed, 38 children were referred.

6.5 Community Action and Awareness

The BCSS held a symposium in April 2004. Organized around the theme "*A Strong Community Begins with Ensuring a Safe Start for Children,"* the symposium created a forum for publicizing the BCSS to a large audience. More than 250 persons attended this event. After Dr. Bruce Perry, a trauma expert, delivered the keynote address, a panel responded to his comments; this panel

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included representatives from the BCDSS, the Police Department, the State's Attorney's Office, and the Department of Health and Mental Hygiene.

Efforts to raise awareness about the BCSS included 11 awareness presentations (by BCSS staff and the Child Development Community Police Program) in various venues, the distribution of the spring and summer *Safe Start Quarterly Newsletter*, and the distribution of over 500 brochures for agency waiting rooms.

According to the BCSS *July-December 2004 Semi-Annual Progress Report* (page 17), the Community Advisory Board of the Kennedy Krieger Family Center Trauma Intervention Program devised a strategic plan to launch a public awareness campaign in two Baltimore City areas to 1) educate residents on the consequences of trauma for children, 2) encourage families to seek help, and 3) reduce the stigma associated with mental health intervention. The Board has submitted a proposal for funding to a funding institution and hopes to start the campaign in July 2005. The BCSS will be one of the campaign sponsors.

7. Institutionalization of Change

The Baltimore City site demonstrated the following indicators of sustainability:

Professional and capacity development of point-of services. The BCSS has institutionalized change primarily through educating and training professionals within the systems most likely to reach families with young children exposed to violence.

Development of products. Currently, the BCSS is working to create a certificate program based on its Early Childhood Mental Health Series, to be adopted by a college or university and used for specialization within the early childhood mental health field. The BCSS also has entered into a memorandum of understanding with the Sidran Institute for Traumatic Stress, the Taghi Modarressi Center for Infant Study at the University of Maryland, and the Division of Services Research and the Department of Psychiatry at the University of Maryland School of Medicine (all located in Baltimore) to create curricula for varied audiences, based on the Children's Exposure to Violence Training. According to site visit participants, change will occur when more agencies that work with the target population integrate the Children's Exposure to Violence Training and the Early Childhood Mental Health Series into their own training programs and intake processes.

Establishment of sustainability committees. During the June 2004 Council Retreat, the BCSS Project Director developed four workgroups within the Safe Start Council, with the goal of creating ownership for the Initiative's work in the final year of federal funding and beyond. The four sustainability workgroups met periodically and worked diligently throughout the remainder of the year to develop strategies to sustain the core components of the Initiative. These strategies center around the idea of transferring ownership for issues related to children's exposure to violence to a core group of experts in the Baltimore area:

- ***The CEV[13] Training Workgroup*** identified three entities that have agreed to work as a consortium to continue children's exposure to violence awareness training. A major task for this workgroup

[13] Children's Exposure to Violence

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over the next few months is to identify funding for a part-time training coordinator and associated training costs, at minimum.

- ***The Screening Workgroup*** revised the BCSS screening questions intended for use by child-serving agencies to identify children exposed to violence at an early stage. This workgroup also made plans to train agency staff on 1) children's exposure to violence and 2) interviewing techniques.

- ***The Early Childhood Mental Health Training Workgroup*** formatted the Early Childhood Mental Health curriculum for presentation to the University of Maryland and Coppin State University.

- ***The Intervention Workgroup*** developed a strategy to increase the number of mental health providers capable of providing appropriate treatment and intervention to young children and their families. The group began by reviewing BCSS training material, and identified a training need: knowledge of sexual abuse and intervention skills. The group invited BCAC to their next meeting to find out about the skills and other resources required for working with children who have been sexually abused. This meeting led to the identification of a training resource: the Kennedy Krieger Institute. Staff from the Institute conducted the first training session on working with victims of sexual abuse on January 27, 2005.

Raising of new funds. The BCDSS and the House of Ruth pursued and received a grant from the Safe and Bright Futures for Children (SBFC) Initiative, to continue their collaboration on domestic violence and child maltreatment issues. The purpose of the SBFC is to encourage communities to plan for, develop, implement, and sustain a coordinated system of prevention, intervention, treatment, and follow-through services for children and their families who have witnessed or experienced domestic violence. Because the House of Ruth is a BCSS partner, the awarding of these funds will contribute to sustaining and expanding the work of the BCSS, particularly within the domestic violence sector.

Also, the Mayor's Office of Children, Youth, and Families asked the Safe Start Council to submit a request to collect statistics on police officer responses to incidents involving domestic violence, for inclusion in CitiStat. CitiStat is an accountability tool based on the ComStat program pioneered in the New York City Police Department. Every other week, agency and bureau heads meet with the Mayor, deputy mayors, and key cabinet members to review their CitiStat data for the preceding two-week period. Days before each meeting, each bureau or agency is required to submit those data to the CitiStat team. The Solid Waste Bureau, for example, submits data on everything from dirty alley complaints to the number of sick days taken in a particular division.[14]

8. Increased Community Support

The BCSS facilitated collaboration between the Baltimore City Department of Social Services and the House of Ruth on domestic violence and child maltreatment issues and in so doing, strengthened the Baltimore City system of care. The partnership created between the domestic violence and child protection sectors represents a significant

[14] Description taken from www.ci.baltimore.md.us/news/citistat/index.html.

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change in the Baltimore City service provider community that will increase community supports for families with children exposed to violence or at risk of exposure to violence.

The BCSS Early Childhood Mental Health Training Series created greater support for children exposed to violence and their families by expanding Baltimore City's community of qualified mental health providers. Families that do seek mental health services now have additional support available to them.

9. Lessons Learned In The Implementation and Evaluation of Safe Start Activities

The following lessons were identified by site visit participants, as well as through the NET's analysis of data collected from participants and existing site documents:

- **Develop a meaningful definition of the problem and a coherent approach to it.** The BCSS did not fully anticipate the attitudes and perspectives of Baltimore residents with regard to 1) the issue of young children exposed to violence, 2) whether or not children's exposure to violence constitutes a "problem," and 3) the use of mental health services. Residents' perspectives created unanticipated challenges to the implementation of the initiative. For example, vast resources were poured into a system of care (mental health) that residents avoid or fail to connect with easily due to its associated stigma.

- **Focus on integrating existing systems of care and filling gaps in service delivery.** In hindsight, too much effort was invested in developing new services and interventions, such as a screening tool, assessment protocol, and therapeutic intervention. Instead, time and energy might have been better spent on working with a group of existing agencies to help these organizations develop an integrated response to families with young children experiencing violence.

- **Establish real leadership within the collaborative at its inception.** Visible and respected leaders with the ability to motivate people as well as the authority to move people to action were identified as critical elements for implementing and sustaining an initiative such as the BCSS. Similarly, the collaborative must engage agency representatives with decision-making authority within their own organizations, as well as have a willingness to do the work of the Initiative.

- **Market the BCSS as other initiatives (such as Success By Six[15]) have been marketed in Baltimore City.** Regardless of their impact, other initiatives have enjoyed much higher visibility in target communities. As described in the first lesson learned, BCSS did not develop and communicate a mission statement or message that the target population could understand or embrace. BCSS also needed to be more creative in "selling" itself to collaborative partners as complementary to, rather than competitive with, existing professional services.

- **Provide program and evaluation T&TA teams one year prior to the**

[15] Success By Six (SB6) was mentioned independently by six of the 11 site visit participants as a marketing role model. One participant stated, "Many people know about Success by Six," but BCSS is "…not on the lips of everyone."

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implementation of local Initiative programming. With national providers 1) given ample opportunity to assess each site's local expertise and capacity, and 2) prepared to provide the necessary support at the right time, local sites could be assured of more responsive and timely assistance.

10. Barriers and Challenges

The barriers and challenges experienced by the Baltimore City Safe Start Initiative can be summarized as the following:

- Key Baltimore City organizations that address issues related to children exposed to violence have only recently joined the Safe Start Council or remain unofficially involved with the BCSS

- Individuals with authority and power within various agencies allow employees to participate in the BCSS, but remain personally disengaged from the collaborative;

- Personnel turnover both within the BCSS and at the state and city levels have impeded the Initiative's implementation;

- Frustration with low referrals resulted in high staff turnover within the mental health agency serving as the primary BCSS point-of-service provider. All of the clinicians trained by the Initiative in 2003 left, resulting in an entirely new staff of clinicians to be trained in 2004;

- Several site visit participants reported an essential need to allocate more money to improving technology, to help collaborative partners track and automatically share essential information about families and children exposed to violence. For example, the police need to be able to count their total responses to calls for domestic violence, as well as the number of calls that involve children six years and younger. Mental health providers need to track the number of families referred and their progress through treatment and services. A coordinated response to a family in crisis demands the ability to follow that family's pathway through various service agencies, which, in turn, demands adequate technology;

- Focusing almost exclusively on the mental health system has resulted in limited contact with the target population because of the stigma associated with mental health issues;

- The BCSS began with far-reaching plans that were unfeasible;

- The Police Commissioner was replaced again in 2004;

- The Baltimore City Mayor's primary goals are to reduce the city's homicide rate, with a specific focus on reducing juvenile violence. The Mayor has no long-range preventive plans;

- The large population of families and children likely to be exposed to violence have produced very few referrals to the BCSS;

- BCSS service providers have had difficulty engaging referred families; and

- As an overarching challenge, Baltimore City continues to lack an organized approach to the issue of children's exposure to violence, with a defined leader or champion. The city appears numbed and immobile. "When crime and violence is part of a long-standing pattern,

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communities have a tendency to get comfortable with it," says [Jeffery] Ross of the University of Baltimore. "People may not like that, but it's a habit that is tough to break." (*Baltimore Sun*. Sunday, Dec. 12, 2004. Page 6F).

11. Conclusion and Recommendations

The Baltimore City Safe Start Initiative accomplished important goals in 2004. Many individuals and agencies received training on issues related to children exposed to violence. The BCSS training curriculum will be maintained by three organizations beyond Safe Start funding. The BCSS enhanced Baltimore City's existing mental health system by providing the Early Childhood Mental Health Training Series. Service integration was deepened via the Domestic Violence Demonstration Project. Finally, the BCSS funded staff positions for two Baltimore City agencies that serve children exposed to violence, expanding the programming available to these children and their families.

As Baltimore City's Safe Start Council and Steering Committee enter the final year of the National Safe Start Demonstration Project, they may wish to consider the following recommendations:

- Continue to strengthen the core group of agencies that make up the Council and Steering Committee. Focus on empowering this core group to address the limitations of the law enforcement and mental health systems. This will require the Project Director to continue her efforts to engage decision-makers and secure the attention of key political leaders in the City.

- Encourage the core group to develop an integrated response to children exposed to violence. According to Shepard and Pence (1999),[16] a community intervention project such as the BCSS must have eight key components. The BCSS has begun to gather some of these components. Continued emphasis on these and additional components could enhance the BCSS in the upcoming year and after. The eight components are:

  - Create a coherent philosophical approach, centralizing victim safety;
  - Develop "best practice" policies and protocols for intervention agencies that are part of an integrated response;
  - Enhance networking among service providers;
  - Build monitoring and tracking into the system;
  - Ensure a supportive community infrastructure for battered women in the form of basic resources like shelter, long-term housing, a decent income, and a place to talk with other women in the same situation;
  - Provide sanctions and rehabilitation opportunities for abusers;
  - Undo the harm violence to women does to children; and
  - Evaluate the coordinated community response from the standpoint of victim safety.

- Continue with education and training, as they meet an important need within professional groups that serve the target population.

- Circumvent the stigma associated with mental health by focusing attention on

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

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reaching families via alternative pathways, such as parenting programs and other more natural settings. Consider reframing the issue as one of family and child safety, by offering support to families in their efforts to protect their children. Use a strengths-based approach that acknowledges what families are already doing to ensure their children's safety.

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ATTACHMENT A

Timeline of Baltimore City Safe Start 2004 Major Activities and Accomplishments

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Children's Exposures to Violence Training		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	
Early Childhood Mental Health Training Series				✔	✔	✔						
Children's Exposure to Violence Train-the-Trainer				✔		✔	✔	✔		✔		
Baltimore City Safe Start Symposium				✔								
Awareness presentations (by BCSS staff and the CDCP)							✔		✔	✔	✔	✔
Baltimore City Safe Start Council Retreat						✔						
Second mental health provider added to BCSS							✔					
Domestic Violence Demonstration Project (CPS)								✔				
BCSS Funded Staff Positions for Two Baltimore City Agencies that Serve Children Exposed to Violence												✔

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II

BRIDGEPORT SAFE START INITIATIVE

1.Introduction

To develop a full understanding of the Bridgeport Safe Start Initiative (BSSI) from January through December 2004, the National Evaluation Team (NET) visited the Bridgeport site on October 26 and 27, 2004, and conducted follow-up telephone interviews with key individuals in November 2004, January 2005, and February 2005. The NET also reviewed existing documents about the BSSI, including strategic, implementation, and progress reports. The NET interviewed nine people, including key BSSI staff, collaborating partners, point-of-service providers, a community leader, and the local evaluator.

The participants were asked between three and eight general questions, depending on their role with the BSSI. Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of the BSSI in the past year?
- How did the composition and process of the collaborative influence the types of strategies implemented, and as a result, the system change outcomes?
- How has the BSSI changed the service delivery system for children exposed to violence and their families?
- What organizational, point of service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of the BSSI?
- How did the site handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?
- What are the lessons learned about the implementation and replication of a national initiative such as the National Safe Start Demonstration Project?

This report covers the period of the BSSI from January 2004 through December 2004. Organized according to the Safe Start Demonstration Project logic model, it describes the economic, political, and social context of the BSSI; the technical assistance the BSSI received; the collaboration among different community organizations and agencies participating in the BSSI; the system change activities (i.e., development of policies, procedures and protocols; service integration; new, enhanced, and expanded programming; community action and awareness; and resource development) developed by the BSSI; the Initiative's institutionalization of changes; and the challenges faced and lessons learned by the participants. A timeline of major activities and milestones is included in Attachment A.

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2. Contextual Conditions

2.1 Local Contextual Conditions: Background

Bridgeport, the largest city in Connecticut, sits on the Long Island Sound in Fairfield County, one of the wealthiest counties in the country. The City of Bridgeport, however, is one of the poorest cities in Connecticut. While the median annual income in Fairfield County is $44,282, the median income in Bridgeport is $20,848[17]. Unemployment in 2002 was 7.6% in Bridgeport, compared to 4.3% in Connecticut as a whole. Sixty-seven percent of children in the Bridgeport school district are eligible for free or reduced-cost lunches. Site-visit participants also described affordable housing as scarce and difficult to access in the Bridgeport area.

According to the 2000 U.S. Census, Bridgeport is home to approximately 13,500 children under the age of six. Almost 10% of these children (1,200) were directly affected by violence in 2000: 603 were substantiated as abused/neglected, and approximately 800 were living with an adult victimized by domestic violence. According to one BSSI participant, Bridgeport children who are seen for services related to violence in the home experience an average of 5.3 traumatic events before the age of three.

Bridgeport and Connecticut have experienced several years of political turmoil. In 2001, the former mayor of Bridgeport, Joseph Ganim, was indicted in federal court on 24 charges of corruption-related crimes. He was convicted of 15 counts in 2003 and is currently serving an extended sentence in federal prison.

During the investigation, indictment, and trial of Ganim, the federal government withheld grants and funding from the city, according to several interviewees. Only in the last year has this ban been lifted, such that the city is once again eligible for federal assistance. According to several site visit participants, the current mayor, John Fabrizi, is more accessible and interested in human services than was Ganim.

At the state level, John Rowland resigned as governor in June 2004 under indictment for using state employees to do work at his personal residence, among other charges. At the time of his resignation, he was facing probable impeachment. Governor M. Jodi Rell, Rowland's former Lieutenant Governor, is scheduled to face election in 2005, although it is not known whether she intends to run.

2.2 Local Contextual Conditions: Specific to 2004

Over the course of 2004, more than 200 high school students were arrested as a result of violent incidents in the schools. This unusually high number of arrests generated a great deal of publicity, causing parents to interrupt Board of Education meetings, demanding an explanation. The cause of the increase in incidents was not reported.

Because of the violence in the Bridgeport schools, as well as other failings of the school district, the superintendent of the Bridgeport city schools was removed from her position in the fall of 2004. At the end of the year, the school district convened an advisory committee to oversee the selection of the new superintendent. Interviewees were not sure if and how this change would affect the BSSI.

[17] In 2002, according to the *Bridgeport Safe Start Initiative Community Asse*ssment, updated September 2003.

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For many years, Connecticut has had a mandatory arrest law in cases of domestic violence. This law states that, if a responding police officer has reason to believe that an act of domestic violence has occurred, an arrest must be made at the scene, regardless of whether the victim wants to pursue charges. As a result, police officers have often arrested both parties, when both claimed injuries, instead of taking the time to identify the aggressor. In 2004, the Connecticut General Assembly revisited the mandatory arrest law and fine-tuned its wording to outline the responsibilities of the responding officer in determining the aggressor. The new wording, which went into effect October 1, 2004, requires the officer to use discretion and investigative skills to identify and arrest the perpetrator.

3.Community Capacity

3.1 Social Service Infrastructure

Bridgeport and Connecticut have many capacities that contribute to healthier children and families. Since 1996, Bridgeport has had a specialized court docket that hears only domestic violence cases. The court takes a consistent cross-disciplinary approach to the organization of cases, using a team of victim advocates, law enforcement officers, and district attorneys to assist in prosecution. Three district attorneys in the city prosecute only domestic violence cases. Cases are triaged according to severity and level of risk to the victim, with level of risk based in part upon a court assessment of the perpetrator. Cases triaged as most serious are heard by the court the same day. According to BSSI staff, the domestic violence court works well in that each professional involved has a clear understanding of the dynamics of this form of abuse and the resources available to address the needs of families impacted by violence.

The Bridgeport Child Advocacy Coalition (BCAC) operates six task forces and committees open to anyone who wishes to participate. BCAC provides no direct services, does not accept public money, and has no public officials on its board. Each task force has an annual planning process, during which needs and gaps in child advocacy services are identified and working issues formulated. BSSI falls under the purview of three different BCAC task forces: the Early Childhood Task Force, the Violence as it Relates to Children Task Force, and the Substance Abusing Women and Their Children Task Force.

In the fall of 2004, BCAC facilitated a hearing held by Connecticut's Lieutenant Governor to evaluate the status of mental health services for adults and children. Seven people testified on the subject of children's mental health, including exposure to violence. Although the Lieutenant Governor expressed interested in improving mental health services for children, the plan that emerged from the hearing in December 2004 addressed neither prevention nor early intervention.

Originally the Mayor's Committee Against Domestic Violence, Communities Against Violence in the Home (CAVITH) is now run by the Center for Women and Families (CWF), BSSI's parent agency. CAVITH helped spearhead BSSI and worked with others to develop and write the original SSI proposal. CAVITH also was instrumental in establishing the Bridgeport court's domestic violence docket. Although recent participation in CAVITH has been sparse and identifying priority issues has been

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difficult, according to CWF, the collaborative is beginning to reorganize.

Connecticut is the only state in the nation with a statewide 211 system. This system, which connects callers to an electronic database of resources, was described by interviewees as more durable than hard-copy resource guides. Operators on the line are case managers, trained in all areas of information and referral systems and aware of social service delivery protocols throughout the state. BSSI site visit participants, however, reported that Bridgeport makes less use of the 211 system than do other parts of the state, indicating that both local service providers and residents lack knowledge and understanding of the system. BSSI plans to include information about the 211 system in their recently initiated community awareness campaign.

Site visit participants reported one capacity-related concern: the high rate of turnover in community and public agencies. Direct service staff turn over rapidly, often leaving the area or the human services industry altogether. This results in frequent loss of expertise and training, which replacement staff must acquire over time to rebuild the capacity of the agency.

3.2 Nature of Social Service Collaboration in Bridgeport

According to site visit participants, the Bridgeport social service community is large and territorial, making collaboration difficult; Bridgeport agencies have historically addressed issues in a "silo" (i.e., single-organization) fashion, rather than in a collaborative way. Several participants stated that agencies may join collaboratives and committees with the goal of remaining aware of funding opportunities; if such opportunities are not available, however, members quickly become disinterested and uncooperative. Providers have little enthusiasm for developing collaboratives to address unfunded or poorly funded issues.

Prior to the implementation of BSSI, social service organizations in Bridgeport were not held accountable for outcomes and had not been required to collect case-level data. With the implementation of BSSI, however, provider agencies were instructed to keep and monitor qualitative and quantitative records, to meet the Safe Start Demonstration Project requirement for outcome measurement. Initially, several agencies were resistant to collecting data; one agency lost its funding as a result. Other agencies, notably Child FIRST, are now keeping complete and accurate records and appreciate having data they can use to leverage additional funding.

The City of Bridgeport Central Grants Office is the direct recipient of OJJDP funds for the BSSI. Because of the city's recent political difficulties, however, representatives of city government have not been as involved in the Initiative as the BSSI would have liked. According to BSSI staff, this lack of involvement has detracted from the Initiative's potential sphere of influence, and, therefore, its ability to create systems change.

3.3 Child Welfare and the Judicial System in Connecticut

In 1989, the Connecticut State Department of Children and Families (DCF) was the subject of a class action suit that charged DCF with failure to protect the children under its care. Although the suit resulted in a consent decree in 1991, since that time, the state has failed to comply with court-ordered changes. In 2003, DCF went into

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receivership. A court monitor was assigned to take over complete management authority of the DCF. DCF has agreed to a transition/exit plan that will expire in 2006. The exit plan requires DCF to develop outcome measures for the following goals:

- Prompt services for children and families to protect children in the home and prevent the need for removing children;
- Prevention of further abuse while children remain in foster care custody;
- Reduction in the length of time children spend in foster care;
- Reduction in the number of moves for children while in foster care;
- Reduction in overcrowding of foster family homes;
- Prompt adoption for children when they cannot be returned home safely; and
- Delivery of necessary medical and mental health services to children.

As a result of the recent court action, DCF has redistricted several times since mid-2003, from five regions to three regions, which now encompass between eleven and thirteen areas. Decision-making and leadership have been decentralized, and control has been turned over to local area administrations, which are expected to solicit community input regarding child welfare services.

According to site visit participants, the latest court action will have a positive effect on DCF and the child welfare system. Most described the requirement for outcome measurement as a positive change, but expressed skepticism about whether DCF will be able to meet its goals. Community agencies and providers serving children are currently meeting with local DCF administrators to discuss the future of the Bridgeport DCF and how they can collaborate for optimal outcomes.

The mandatory domestic violence arrest law and its updated wording require police officers to have a clear understanding of the dynamics of domestic violence and to develop the skills to put that knowledge into practice in a crisis situation. Although the updated wording clearly puts the onus of decision-making on the officer, commensurate training and capacity-building are not required of police departments. According to participants, the Bridgeport Police Department requires its officers to receive only two hours of domestic violence training every three years.

Connecticut has a rotating judicial system; each judge rotates to a different bench each year, making it difficult for any one judge to receive comprehensive education and training on the impact of violence on young children. Lack of specialized judicial knowledge in this area is exacerbated by the fact that the state does not mandate domestic violence training for any of its judges. BSSI met with the criminal judge assigned to the domestic violence docket throughout 2004, with the goal of providing information and technical assistance on court strategies that support children and families impacted by violence in the home. BSSI and the judge also discussed community resources available to victims of family violence.

4. Integrated Assistance

In general, BSSI staff did not report benefits from the training and technical assistance (T&TA) offered or provided by the national T&TA providers. Impediments to receiving beneficial T&TA included turnover of T&TA providers, difficulties in identifying appropriate sources for T&TA, and a sense that sources who did provide T&TA were not attuned to the circumstances of the

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Bridgeport community or the needs of the site.

When BSSI solicited specific T&TA for policy development and sustainability, additional challenges included the amount of time it took to be referred to an appropriate T&TA provider, a sense that BSSI had to advocate for its T&TA needs to receive approval, and the lack of established protocols or avenues for expressing concerns about T&TA providers. In short, many BSSI staff expressed a belief that the National Team had promised effective T&TA, but failed to deliver on that promise.

In 2004, the National Council of Juvenile and Family Court Judges released a report entitled *Navigating Custody and Visitation Evaluations in Cases with Domestic Violence: A Judge's Guide.* BSSI is using this report to aid in outreach to judges and to help develop its training for family judges.

Locally, BSSI hired a public relations firm to help with its public awareness campaign. Although BSSI had some problems with the early performance of the firm, including non-responsiveness and missed appointments, those problems had reportedly been resolved by the time of the site visit.

5. Local Agency and Community Engagement and Collaboration

To prepare its application for a Safe Start grant, Bridgeport convened a group of about 40 local service providers and other professionals to form a Design Team. In developing the original BSSI design, this group collaborated to identify the areas of greatest need for children exposed to violence. According to participants, however, attendance at Design Team meetings dwindled when members discovered they were not going to receive additional funding. According to BSSI staff, a failure to make meetings as purposeful as possible might also have contributed to dwindling attendance. Instead of a meaningful pursuit, the collaborative became one more meeting to attend and one more "ball" for busy professionals to juggle. As interest in serving on the BSSI collaborative dwindled, the Initiative lost the ability to develop long-range goals.

In response to the absence of a functional collaborative, BSSI developed a three member Management Team, made up of the BCAC, the City of Bridgeport, and the CWF. Since its inception, the Management Team has met once a month to discuss the goals and activities of the BSSI, despite experiencing a series of changes, including a change in BSSI directors. Team members expressed some concern that the Team should not be restricted to agency leaders, but should be enlarged to include a broader group of people, such as DCF, courts, healthcare providers, parent groups, and large child-serving organizations.

Recently, BSSI staff has focused on working with existing collaboratives to educate these groups on children's exposure to violence and BSSI. They have initiated this effort by developing a presence in existing groups, to better understand how the Initiative can integrate its work with the work of other collaboratives. The long-term goal of this networking is to receive input and feedback about the direction BSSI should take in 2005 and how BSSI can create sustainability.

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BSSI reported a working relationship with the following specific groups:

- **Connecticut Children and Domestic Violence Collaborative**, formerly known as the National Council of Juvenile and Family Court Judges' Greenbook Committee;
- **Domestic Violence Docket Team,** a cross-disciplinary collaborative that tracks and recommends policy for the domestic violence court docket;
- **Discovery Initiative**, funded by the Graustein Memorial Fund to address the socio-emotional wellbeing of young children;
- **BCAC Task Forces**, including the Early Childhood Task Force, the Violence as it Relates to Children Task Force, and the Substance Abusing Women and Their Children Task Force;
- **Children's Collaborative Advisory Board**, which advises programs serving high-risk children under the age of seven; and
- **Success by Six,** whose goal it is to ensure that all children are school-ready.

In the fall of 2004, the Safe Start Project Director convened a group of child-serving agency leaders to work toward developing leadership in Bridgeport in the support and advocacy of children exposed to violence. The five agency directors who participated in 2004 were focused on developing relationships and identifying other agencies for participation. According to the Safe Start Project Director, the group plans to develop goals and objectives in 2005.

6. System Change Activities

Site visit participants identified the following as major accomplishments for BSSI in 2004:

- Point-of-service providers began using the necessary assessment tools, including the Parent Stress Index (PSI) and the Traumatic Events Screening Inventory (TESI), as well as a new domestic violence assessment tool and protocols introduced and piloted by DCF;
- The Initiative started its public awareness campaign in September 2004;
- The site continued its well-received training; and
- The criminal and civil court advocacy programs updated their database to capture all necessary variables pertinent to children's exposure to violence.

6.1 Development of Policies, Procedures, and Protocols

In 2003, BSSI began an intensive training program with DCF to introduce a new domestic violence protocol developed by the collaborative (the regional office of the CT Department of Children and Families, the Center for Women and Families of Greater Fairfield County, Inc. and the Non-Violence Alliance) to be used with all DCF families. The protocol is used to collect information from DCF families about the extent and nature of violence in the home and the impact of that violence on children. According to findings reported by the local evaluator[18], the protocol was put into use in February 2004 by three of the teams from the Bridgeport DCF office. Family case file information and MIS data (pulled manually) were used to evaluate the impact of the protocol on identifying domestic violence within families served by DCF. The three agencies continue to work closely together on this protocol and are seeking support of the DCF commissioner to take it statewide.

[18] *Bridgeport Safe Start Initiative Local Evaluation Report Form (2004)*

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In 2004, Child FIRST, the agency that provides the Classroom Consultation Program for Early Childhood Educators (CCP) began using appropriate assessment tools, by administering the PSI and the TESI to families seeking services. As mentioned previously, Child FIRST initially resisted complying with the BSSI's data collection and family assessment requirements. Discussions with BSSI and its local evaluation team persuaded the organization to participate in this critical aspect of service delivery.

Prior to 2005, BCAC, a lead partner of BSSI, was given the task of policy analysis and development for children's exposure to violence. BSSI asked BCAC to dedicate its efforts to changing and creating organizational and systems policy (e.g., DCF policy); however, BCAC saw its focus as monitoring, analyzing, and developing government policy. In the fall of 2004, BCAC withdrew from the role of policy and systems change agent. While BCAC will remain on the Management Team, it will no longer participate as a subcontractor of BSSI. Instead, the leadership group being convened by BSSI and other providers of child and family services will take responsibility for the policy change and development aspect of the Initiative.

6.2 Service Integration

Integrating services in Bridgeport is difficult, according to site visit participants, due to competition among agencies. BSSI has been unsuccessful in several attempts to coordinate agencies and services that provide programming for children and families, including, as mentioned previously, the attempt to develop a functioning collaborative.

Although the NET asked only about programmatic changes in 2004, several site visit participants mentioned BSSI's attempt to initiate a Child Development-Community Policing (CDCP) program in Bridgeport, an effort that had been abandoned in 2003. Although the Bridgeport Police Department did refer a small number of children for services while CDCP was in operation, few children were six years or younger. According to site visit participants, members of the Police Department were never thoroughly convinced of the value of the program.

To serve families involved in civil and criminal court cases, including domestic violence and cases involving restraining orders, BSSI provides training and technical assistance to court advocates who assist individuals through the court process. Prior to BSSI, advocates did not regularly refer clients to community resources or screen for children's exposure to violence. Advocates now refer families to community agencies, including BSSI, and collect data about those families and referrals. This system allows BSSI to track families who are referred through the Court Advocacy Program.

6.3 Resource Development, Identification, and Reallocation

Site visit participants did not mention any resource development, identification, or reallocation activities for 2004. Several sustainability activities are listed in the *Bridgeport Safe Start Initiative Local Evaluation Report Form (2004)*, however, and they include:

- Plan for Child FIRST contract; review process for funded programs highlighted the ability for an agency to sustain program;

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- Partnership with the Center for Women and Families enables BSSI to sustain training activities;
- DV/CPS systems committed to sustaining Family Violence Training;
- Engaged consultant;
- Community is working on developing a leadership group; and
- Enhancing evaluation capacity of funded programs.

6.4 New, Expanded, and Enhanced Programming

The CCP, funded by BSSI and implemented by Child FIRST, 1) provides preschool teachers with the skills necessary to identify children exposed to violence and 2) increases the capacity of early educators to intervene with these children. Since March 2004, Child FIRST and BSSI have collaborated to provide early childhood classrooms in Bridgeport with a social worker who can 1) provide violence-specific assessments for high-risk children and 2) work with teachers to address the socio-emotional and behavioral needs of these children. The Child FIRST worker, along with classroom teachers, administers the Devereux Early Childhood Assessment (DECA), an instrument that measures the socio-emotional and behavioral functioning of young children. Individual interventions are based on the results of the child's DECA.

The Mental Health Consultation Program (MHCP) was developed by BSSI to increase the capacity of mental health clinicians to work with children exposed to violence. A mental health consultant contracted by BSSI works with four clinicians currently enrolled in the MHCP, providing group and individual clinical consultation. Although the clinicians report an increase in skills and knowledge, the low number of children served makes outcome measurement difficult.

BSSI has established itself among professionals as a provider of high-quality, free training, according to most of the site visit participants. BSSI training for professionals covers topics such as domestic violence, the impact of violence on children, and normal developmental changes in young children. Many site visit participants mentioned a beneficial byproduct of the training program: increased collaboration among providers, fostered by the training and the opportunity to get to know each other on an individual level.

BSSI originally contracted with a mental health provider, Child Guidance, to provide services to children exposed to violence. During the first six months of 2004, the number of BSSI children served by Child Guidance fell 60%, with services provided to only ten children six years and younger. This underperformance resulted in cancellation of the service contract for the 2004/2005 contract year. BSSI did not contract with another agency to provide these services.

Child-serving and family-serving agencies in the community can identify children at risk of exposure to violence or exposed to violence and refer them to BSSI funded programs. All funded programs are required to provide information on their referral sources. Once BSSI funded program receive a referral, the children and family are screened for exposure to family violence. After children and families are screened positively, a BSSI Service Plan is completed which identifies all of the services needed by a family. BSSI funded programs recommend and refer to services identified in the Service Plan and document the percentage of services recommended that

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were received. In 2004 231 children referred to a BSSI funded program screened positively on the TESI and were therefore identified as exposed to violence. All 231 children were referred to more intensive services. A total of 65 children were given a more comprehensive clinical assessment by Child First or one of the mental health clinicians. These figures were confirmed with the local evaluator after the May 2005 National Evaluation Meeting

6.5 Community Action and Awareness Activities

In September 2004, the BSSI held a press conference to launch a new public awareness campaign. Although BSSI had hoped to initiate the campaign in 2003, difficulty with their public relations firm necessitated a one-year delay. The campaign was designed to provide education on children's exposure to violence and domestic violence in the form of posters, fact sheets, and "flip books" (small wire-bound books) for both consumers and providers. The campaign also encourages the community to call InfoLine 211 for referrals to services for children impacted by violence in the home. The press conference elicited a strong response; agencies now regularly request materials for their offices, staff, and participants. As of the end of 2004, campaign materials had been distributed to more than 5,000 professionals working with young children.

7. Institutionalization Of Change

BSSI's capacity building efforts, including creation of the CCP and the MHCP as well as efforts within the court system, have increased skills among professionals and improved the community's ability to intervene with children exposed to violence. These changes will outlast the federal funding for BSSI. According to several site visit participants, BSSI has raised awareness of the impact that violence has on children, prompting dialogue about the issues among providers. The high-quality training offered by BSSI has contributed to a more informed and competent professional community in Bridgeport.

CAVITH, operated by the Center for Women and Families (CWF), has committed to including children's exposure to violence in its training curriculum past the end of the grant period. CWF will be hiring a full-time coordinator to oversee CAVITH work and training.

Several BSSI staff also noted an unintended outcome of their work. Because agencies in Bridgeport were not accustomed to keeping data or measuring outcomes, the introduction of BSSI and its accountability requirements set new standards for the Bridgeport social service community. Agencies that never considered outcome measurement are now interested in standards of accountability, according to site visit participants.

8. Increased Community Supports

The CCP social worker has increased the skill and awareness level of preschool teachers. These teachers will be in a position to continue their work with children exposed to violence even after BSSI's federal funding ends.

The BSSI presence within and among various community collaboratives and task forces dedicated to the wellbeing of children has increased the awareness of providers in

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the city, according to site visit participants. By continuing to draw attention to exposure to violence as a critical issue for children, BSSI has been instrumental in sparking and maintaining dialogue about services for children who have been exposed. This discussion is expected to continue.

9. Lessons Learned In The Implementation and Evaluation of Safe Start Activities

Site visit participants and the NET's analysis of data identified the following lessons learned:

- **Sustainability efforts should begin earlier.** Participants mentioned the importance of discussing sustainability and institutionalization from early on in the planning process. Leaving this discussion to the end of the Initiative caused undue frustration and stress, according to participants.

- **The SSI lead agency must have influence and clout in the community.** To make necessary systems changes in an effort as broad as a Safe Start Initiative, the lead agency(ies) should be well-positioned in the community to move the effort forward, influence other agencies and groups, and speak authoritatively on the subject of violence and violence exposure.

- **The collaborative should reflect the community.** Several participants mentioned that any group dedicated to family wellbeing should solicit the involvement of consumers, as well as providers and community leaders. Grassroots participation was identified as a critical ingredient in making services and changes relevant to the individuals served.

- **Goals should be developed with the community context in mind.** The DCF reorganization effort has had a major impact on the ability of BSSI to effect change in Bridgeport. BSSI staff reported that they did not accurately assess the extent to which DCF changes would impact their work, and did not develop contingencies for the upheaval the changes caused.

- **There should be a phase between planning and implementing to build capacity.** BSSI staff noted that they did not have adequate time to work with the community, providers, partners, and CWF staff to ensure that all participants were ready to implement a complicated systems change effort. This resulted in trying to develop capacity while simultaneously attempting to implement programs for system change.

10. Barriers and Challenges

BSSI has encountered the following barriers and challenges:

- Stigmatization and fear associated with receiving mental health treatment have contributed to low numbers of people willing to participate in BSSI services.

- The political and social contexts of Bridgeport have presented many challenges. Agencies do not collaborate well, in part due to long-standing competition over funding. Political upheaval within the city and state governments has disrupted service delivery and receipt of federal funds, as

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well as engendering considerable distrust and insecurity.

- Although BSSI has made great strides in increasing agency capacity to develop strong methods for data collection and accountability, resistance to outcome measurement persists.

- BCAC did not take the lead in advocacy and policy development that BSSI initially envisioned, according to BSSI staff. Engaging that agency and making it a full partner in the mission of the Initiative has been challenging.

- Because BSSI was unable to sustain the CDCP program and mold it into a viable program for children exposed to violence, the Initiative was forced to reassess its plan.

- Difficulties with funded agencies, including their inability to engage clients and their reluctance to produce meaningful data, have caused loss of time and deterioration of relationships.

- Turnover at the national level has made it difficult for BSSI to identify who can provide assistance and guidance. Turnover also has led to delayed approval of plans and inconsistent advice.

- Bridgeport suffers from a lack of consistent, strong leadership within the social service community, according to site visit participants, making it difficult to determine where efforts should begin and where ideas should be launched, and contributing to false starts and wasted time.

11. Recommendations and Conclusions

BSSI has had many hurdles to overcome, including political controversy within and around the city of Bridgeport, as well as a social service community ill-prepared to accept the standards of accountability required by the Safe Start Demonstration Project. BSSI has addressed these challenges and made considerable progress in bringing children's exposure to violence to the attention of providers and the community. Through their popular training curricula and interaction with numerous task forces and collaboratives, BSSI staff has begun to create an awareness of the serious impact of childhood exposure to violence.

As BSSI enters the final year of the Initiative, it may wish to consider the following recommendations, based on participants' comments:

- Continue to appeal and reach out to systems and organizations that have not been involved in the SSI in the past, including other collaboratives and task forces already operating;

- Work with the National Team to develop an appropriate T&TA plan that will work within the Bridgeport context;

- Take a proactive approach to developing relationships with the new mayor, chief of police (upon appointment), and superintendent (upon appointment), devising strategies to educate these community leaders on the impacts of childhood exposure to violence and the importance of services for children who have been exposed to violence;

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- Take a proactive approach to developing relationships with the local DCF administration, promoting the need to ensure services for children exposed to violence and participating in the community outreach to which DCF has committed; and

- Work with the new coordinator of CAVITH to ensure that training on children's exposure to violence will continue in its present form and that community attention to violence exposure will continue.

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ATTACHMENT A

Timeline of the Bridgeport Safe Start Initiative's 2004 Major Activities and Milestones

	Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Beginning of DCF DV pilot data collection		✔										
Beginning of CCP			✔									
ECMHP terminated						✔						
Beginning of data collection at the court advocacy programs							✔					
Beginning of the public awareness campaign									✔			
New judge orientation										✔		
BSSI participation in local collaboratives begins										✔		
Leadership group convened											✔	

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III

CHATHAM COUNTY SAFE START INITIATIVE

1. Introduction

To develop a full understanding of the Chatham County Safe Start Initiative (SSI) from January through December 2004, the National Evaluation Team (NET) visited the Chatham County site on December 6 and 7, 2004, and conducted follow-up telephone interviews with key individuals in March 2005. The NET also reviewed existing documents about the Chatham County SSI, including strategic, implementation, and progress reports. In addition, seven documents shared by the site during the site visit were reviewed for context and additional information:

- *Safe Start Update (October 21),* Chatham County SSI 2004;
- *Safe Start Collaborative Meeting Minutes (September 24),* Chatham County SSI 2004;
- *Services Handbook (Revised September 1),* Chatham County SSI 2004;
- *Results of the Safe Start Network Analysis Project,* George P. Cole 2004;
- *Chatham County Safe Start Fact Sheet (July)*, Chatham County SSI 2004;
- *Safe Start News (Volume 3 Number 1, June,)* Chatham County SSI 2004 Newsletter ; and
- *Chatham County Safe Start brochure*, Chatham County SSI.

The NET interviewed thirteen CCSS people, including key CCSS staff members, point-of-service providers, collaborative members, representatives from the Guardian ad Litem program, and the local evaluator. Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of the Chatham County Safe Start (CCSS) in the past year?
- How did the composition and process of the collaborative influence the types of strategies implemented, and, as a result, the system change outcomes?
- How has the CCSS changed the service delivery system for children exposed to violence and their families?
- What organizational, point-of-service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of the CCSS?
- How did the CCSS handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?
- What are the lessons learned about the implementation and replication of a national initiative such as Safe Start?

This report covers the period from the start of the Chatham County SSI in January 2004 through December 2004. Organized according to the Safe Start Demonstration

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Project logic model, it describes the economic, political, and social context of the Chatham County SSI; the technical assistance the SSI received; the collaboration among different community organizations and agencies participating in the SSI; the system change activities (i.e., development of policies, procedures and protocols; service integration; new, enhanced, and expanded programming; community action and awareness; and resource development) by the SSI; the Initiative's institutionalization of changes; and the challenges faced and lessons learned by the participants. A timeline of major milestones is included in Attachment A.

2. Contextual Conditions

2.1 The General Store and Café: A Snapshot of Life in Chatham County

As one of a handful of eating establishments in Pittsboro, the General Store and Café is a central gathering place for people who work, visit, and live in the small, rural town. During the December site visit, the NET saw five of 13 site visit participants eating at or walking by the General Store—an experience that captures the feel of Chatham County, and provides a snapshot of the community the CCSS serves.

Located at the geographic center of North Carolina, Chatham County encompasses an area of more than 707 square miles. Only one-fifth of Chatham's 54,645[19] citizens reside within the county's four municipalities: Siler City (7,002 citizens), Pittsboro (2,236 citizens), Goldston (321 citizens), and Cary (19 citizens). As evidenced by the distribution of its population, the county is predominantly rural in character.

Strong economic conditions in surrounding areas, such as Chapel Hill, Raleigh, and Research Triangle Park, contribute to the growth of the county's population and economy, in large part by providing employment for many Chatham County residents.[20] Nevertheless, agriculture and industry within the county continue to play a key role in its economy. Agricultural and industrial activities include poultry and dairy processing, as well as textile, wood-product, and general manufacturing. In the industry of poultry production, agricultural and manufacturing interests partner to complete the producer-grower-processor market.[21]

Chatham County government operates under the direction of an appointed County Manager and a five-member Board of Commissioners. The Town of Pittsboro serves as the county seat. Commissioners are elected at large, but must reside within a particular district. The Board appoints the County Manager, who administers the day-to-day business of the county, including personnel and budget oversight.

The population of Chatham County continues to grow at a healthy rate (26.6% increase from 1990 to 2000). The state estimates that the total population will grow to 60,066 by July 2009. Population growth

[19] There are currently 54,645 citizens living in Chatham County according to the July 2004 projected annual population totals (2004-2009) from the State Data Center. Go to http://demog.state.nc.us/, click on the County/State Projections link and then the Annual County Pop. 2004-2009 link.

[20] Much of the information about Chatham County and its demographic makeup was found at www.co.chatham.nc.us.

[21] http://communitylink.com/chathamcounty/Busi_Body.html

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has been a recent subject of hot debate, specifically in the context of two housing developments (900 homes and 500 apartments) that began construction in 2004.

Pittsboro currently has no apartments. Some county residents fear that the new apartments will increase crime (including domestic violence) and further increase the Latino population living in Pittsboro; Latinos already have increased in numbers from 1.45% of the county's population in 1990 to 9.62% in 2000. According to site visit participants who discussed the issue of population growth as a challenge for service agencies, the service system is currently unable to meet the needs of the Latino population due to a lack of Latino and Spanish-speaking providers and/or interpreters.

2.2 Changes in Chatham County's Service Delivery System

Generally speaking, statewide reductions in funding for agencies serving children continued in 2004. Smart Start, a school readiness initiative for all children run by the Chatham County Partnership for Children (CCPC), suffered a 25% funding cut for the second year in a row. As a result, the CCPC will conduct local fundraising in 2005 for the first time in its history, competing with agencies that have historically come to the CCPC for funding.

Chatham County experienced two additional significant changes in its human service delivery system during 2004:

Restructuring of the community-based mental health system. 2004 saw the statewide restructuring of community-based public mental health clinics and their parent agencies, referred to as Area Programs. As part of the statewide reform, 1) North Carolina will convert Area Programs into Local Management Entities that will manage state and county funding streams and provide care for the indigent, and 2) these Local Management Entities will largely divest of direct service delivery, to assume their more management-focused role. In Chatham County, Orange, Person and Chatham Counties (OPC) Mental Health Services, an Area Program, is moving toward privatization. A Request for Proposals is scheduled for release to private vendors by the end of calendar year 2005. The contracted private vendor will replace OPC and assume oversight of the Chatham Counseling Center, the local public mental health clinic in Chatham County.

Five site visit participants described this restructuring as an improvement in the system of care for children exposed to violence, in that the restructuring will open up an additional funding stream to local private sector providers who serve Medicaid-ineligible moderately severe mentally ill children, for example, undocumented Latino children with mental health needs.

The CCSS Project Director has approached the restructuring of the mental health system proactively, as an opportunity to leverage resources for local private mental health providers, including those who provide services for CCSS referrals, to allow these providers to serve families who might otherwise not have access to mental health care. The Project Director has taken an active role in determining how CCSS direct service providers can best navigate the Medicaid reimbursement system.

Child protection: Multiple Response System. When asked about external community changes that may have affected the CCSS in 2004, eight of the 13 site visit

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participants identified the philosophical shift within the state Department of Social Service (DSS). With this shift, the DSS adopted a family-support approach known as the Multiple Response System (MRS) for cases of child neglect in 45 of North Carolina's 105 counties; MRS will not be used in cases of abuse; abuse will continue to be investigated per existing protocols. Chatham County kicked off the MRS in September 2004, with implementation of the new approach in October 2004. Consistent with the CCSS framework and philosophy, the Multiple Response System gives Child Protective Services (CPS) workers the opportunity to help families keep their children. As an effort to make the child welfare system more responsive to and effective for families, the system is structured, in part, around the following strategies:[22]

- Strengths-based, structured intake process;
- Choice of two approaches to reports of child abuse, neglect, or dependency;
- Coordination between law enforcement agencies and CPS for the investigative assessment approach;
- Redesign of in-home family services;
- Child and family team meetings; and
- Shared parenting meetings.

In conjunction with this new approach to handling neglect cases, the North Carolina General Assembly awarded Chatham County funds to hire nine additional CPS social workers, to reduce the worker to family ratio from 1:20 to 1:10.

2.3 Perceived Social Context in Two Siler City Neighborhoods

Baseline data from a Neighborhood Listening Survey[23] conducted in 2004 provide vivid insight into the social context of two Siler City neighborhoods. The survey asked eight questions of 42 residents. Key questions included:

- *What is the first thing that comes to mind when you think about the issue of children and violence?* In response to this question, 44% of those surveyed thought of domestic violence; 22% thought of child abuse.
- *In the past six months, has anyone in your neighborhood asked you for help with a personal or family problem?* In response to this question, 85% responded in the negative.
- *In the past six months, have you asked anyone in your neighborhood for help with a personal or family problem?* Eighty-nine percent of those surveyed responded in the negative.
- *Do you feel like you and your neighbors, working together, could make your neighborhood a safer place for children?* Ninety-four percent of those surveyed responded in the positive.

3. Community Capacity

In close proximity to the University of North Carolina (UNC) and Duke University, as well as Research Triangle Park, the residents of Chatham County have access to many more services and resources than do the residents of most rural areas. For example, the hospital systems of both Duke

[22] http://sswnt7.sowo.unc.edu/fcrp/MRS.htm

[23] *Neighborhood Listening Survey Baseline (2004) Descriptive Analysis*. Power point slide show presented by the local evaluator, 11/04

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University and UNC are available to Chatham County residents. On the other hand, pockets of poverty and isolation in Chatham County can strain the local social services infrastructure.

CCPC, the CCSS parent agency, was created in 1994 to support Smart Start, a school readiness program. Because the Smart Start planning process included a requirement that the program represent key stakeholders, a base of stakeholders invested in children six years and younger developed in Chatham Country. This infrastructure of stakeholders is aware of the importance of early childhood intervention and has played a critical role in the successful planning and implementation of the National Safe Start Demonstration Project in Chatham County.

As mentioned above, Chatham County implemented MRS in October 2004; all site visit participants described the shift to MRS as positive, a change likely to increase identification of children exposed to violence and referrals to the CCSS.

Chatham County had a solid base of collaboration prior to the CCSS. Described by some site visit participants as a result of peer pressure arising from the rural character of the county, this collaboration facilitated buy-in for the National Safe Start Demonstration Project, helping to ensure that the CCSS would operate in an atmosphere of relationship-building and inclusive decision-making.

The Child Planning Conference provides just one example of collaboration in Chatham County. When a child is removed from his/her parent or guardian, the Child Planning Conference is convened; family support professionals, along with parents, lawyers, and CPS workers, meet to discuss the child's wellbeing and foster care placement. DSS organizes these meetings and the child's Guardian ad Litem facilitates.

With only two court days per month, the Chatham County Family Court is overburdened. Nevertheless, county judges are committed to and interested in improving the court system, according to some site visit participants.

The county Sheriff's Department has a Family Violence Unit that investigates calls involving minors and makes referrals to appropriate community agencies. The CCSS funds the Family Responder position in the Family Violence Unit to provide crisis services to children eight years and younger.

4. Integrated Assistance

In October 2004, consultants from the Systems Improvement Training and Technical Assistance Program (SITTAP) and the National Training and Technical Assistance Center (NTTAC) helped the CCSS begin to craft a plan for sustainability. The CCSS received funding through NTTAC to complete a resource development plan. The consultant who completed the plan continues to work with the CCSS to assist with the sustainability plan and efforts.

The CCSS experienced some challenges with obtaining national training and technical assistance (T&TA). The site did not always know where to seek T&TA. One site visit participant suggested that OJJDP provide sites with a T&TA manual or resource book early in the Initiative, to reduce the time required for sites to learn about T&TA opportunities (such as types and amount of T&TA available annually

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through approved providers, and how to access it) and prevent duplication of effort.

Some interviewees described communication at the national level as lacking; for example, CCSS submitted required documentation to the National Safe Start Demonstration Project and never received feedback. Without feedback, the staff always felt somewhat uncertain about the direction they were taking in implementing the Initiative.

At the request of the CCSS Project Director, the National Council for Juvenile and Family Court Judges (NCJFCJ) agreed to assess Chatham County's court system. Long-standing community interest in reducing the time children spend in foster care provided the necessary impetus for the NCJFCJ's agreement to perform an assessment. The CCSS expects the assessment to document challenges (see Section 6.1 of this report for more detail) facing the court system. These challenges have been informally acknowledged within the service provider community, including those working in the Family Court system; the CCSS has requested formal examination and documentation by an objective party, with the goal of lending credence to concerns about the court system at the state level.

The CCSS Research Specialist investigated *Strong Communities for Children in the Golden Strip.* A project of Clemson University's Institute on Family and Neighborhood Life and funded by Duke Endowment, *Strong Communities* is a comprehensive initiative to build support for families of young children in South Carolina. The project works to mobilize the entire community to keep children safe, prevent child abuse, and offer mutual support. The CCSS Research Specialist attended *Strong Communities* workshops, spoke with the *Strong Communities* Project Director, and reviewed annual reports and promotional materials. The Safe Start Project Director and Community Programs Coordinator have received the information gathered by the Research Specialist.

In November 2004, the CCSS Community Programs Coordinator attended a South Carolina *Caring Communities* training, sponsored by Duke Endowment and the Institute on Family and Neighborhood Life. *Caring Communities* trains religious leaders in counseling skills and child protection. The Community Programs Coordinator also serves on several committees sponsored by other organizations, such as the Community Outreach Task Force, the Delta Project, and the Immigrant Health Initiative at the Chatham Hospital.

5. Local Agency and Community Engagement and Collaboration

The CCSS is a formal collaborative, structured as a subcommittee of the CCPC Board of Directors, with a chairperson and standing committees. As the CCSS parent organization, the CCPC Board serves in an advisory capacity to the CCSS collaborative The collaborative meets monthly, inviting key decision-makers—such as judges, the University of North Carolina Evaluation Director (who supervises the local evaluator), and the Chatham County School Superintendent—to attend meetings on a quarterly basis.

With respect to key members of the collaborative, over half of the site visit participants identified the local domestic violence agencies (Family Violence and Rape Crisis Services/Coalition for Family

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Peace) as critical and engaged. Other important, but less active, partners mentioned included the Department of Social Services, the Health Department, and mental health agencies. Although the school system and law enforcement (the Sheriff's Office and the Siler City and Pittsboro Police Departments) were described as essential to the collaborative, their involvement to date has been minimal. According to the July-December 2004 Progress Report (p. 33), however, the participation of the Chatham County Public School in the CCSS increased during the last reporting period. Site visit participants less consistently mentioned the courts, the Assistant District Attorney's Office, Guardian ad Litem, the Community Childcare Network, Chatham Hospital, the local evaluator, and Safe Start staff as key members of the collaborative.

According to the July-December 2004 Progress Report, the OPC Mental Health Services Director has increased OPC's involvement with community partners, by 1) serving on the Safe Start Collaborative and the Child Well-Being Task Force, as well as 2) meeting with the CCSS Project Director and CCSS direct service providers about accessing Medicaid. OPC's increased engagement has brought the perspective of mental health providers to the table.

Seven of the site visit participants identified member commitment to 1) working for children and 2) achieving the goals of the CCSS as strengths of the collaborative. Collaborative members were described as interested in decision-making, willing to work outside of meetings, willing to reassess their course of action and modify as necessary, and willing to adjust their schedules and styles to accommodate one another—especially as agency representatives learned more about other representatives and their respective organizational cultures.

As an additional strength of the collaborative, site visit participants mentioned the diversity of agencies represented; however, participants also acknowledged the lack of community representatives (i.e., residents from neighborhoods) and the lack of formal involvement on the part of the school system.

Two site visit participants described the CCSS as bureaucratic, with long meetings, lots of paperwork, and a tendency to talk more than act. Several participants also mentioned the tendency for certain collaborative members to come to meetings with their own agenda, but not express their thoughts and feelings honestly with the group. Finally, some site visit participants referred to the number of other meetings similar to the CCSS meetings, with the same core group of attendees; with meetings of the CCSS, the Child Well Being Collaborative, the Community Child Protection Team, and other similar groups, it "[gets] a little murky about which is which." According to the July-December 2004 Progress Report, the CCSS has worked to improve its ability to involve Safe Start collaborative members in making informed decisions by sending all information, materials, and documents in advance of meetings.

6. Systems Change Activities

Site visit participants consistently identified the following events and activities as the CCSS's major accomplishments in 2004:

- NCJFCJ consultant visits;

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- Community Programs Coordinator position filled;
- Safe Havens Train-the-Trainer training and follow-up trainings;
- Early childhood educators, child care providers, law enforcement officials, justice system officials, mental health practitioners, social service representatives, domestic violence staff, and community groups trained on the CCSS identification and referral processes;
- Service pathway revised and documented in the updated *Service Handbook*;
- Sustainability planning initiated with Resource Development Consultant;
- Neighborhood Listening Project implemented;
- Partnered with other agencies to sponsor conferences that focused on CCSS and children exposed to violence; and
- Single database created for CCSS staff and all data entered.

6.1 Development of Policies, Procedures, and Protocols

In 2004, an effort to improve the court system in Chatham County was launched (see also Section 4 of this report). The CCSS expects the assessment to document challenges facing the court system. For example, at least one more judge is needed, as there are currently only two court days per month for Family Court, with an average of 20 cases each court day. In addition to the need for more judges, court space and equipment are challenges[24]. Finally, formal coordination among the courts (Criminal, Substance Abuse, and Family) is lacking, and knowledge of family services is either limited or inaccurate among members of the court system. These challenges have been informally acknowledged within the service provider community, including those working in the Family Court system; the CCSS has requested formal examination and documentation by an objective party, with the goal of lending credence to concerns about the court system at the state level.

In addition, several key CCSS procedures were modified in 2004. First, the CCSS service pathway was streamlined to make it more responsive to both referral sources and families, after a review of case files revealed time lags of up to three months between referrals and contact with families. Implemented in the fall of 2004, the changes to the service pathway are summarized and reflected in a revised version of the *Services Handbook for the Service Coordinator and Direct Service Providers*.

The revision of their service coordination procedures to improve responsiveness represented a significant accomplishment for the CCSS in 2004. The *Services Handbook* was revised in September 2004, with an improved service pathway described in detail on pages three to eight. Key steps of the revised pathway include the following:

1. Anyone in the community can refer children exposed to violence, including parents.
2. The child's caregiver must give informed consent for CCSS to process a referral. Once consent is received, all referrals are sent to the Siler City office.
3. The CCSS Service Coordinator matches the referred family with a direct service provider.

[24] In the winter of 2004, the CCSS purchased a laptop-compatible copier for the Family Court. Site visit participants described this purchase as important and necessary to aid the Court in making copies of court orders and resource contact information before families leave the courtroom. The equipment had not yet been integrated into the courtroom at the time of the site visit.

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4. The direct service provider receives the referral form and screens the family for eligibility. The provider has five days to contact the family and update the Service Coordinator on the status of the referral.
5. The provider forwards eligibility information to the Service Coordinator.
6. Appropriate services (i.e., referral to Safe Start or other services, depending on need) are identified for the family. Psychologists are available for clinical assessment and specialized therapy if needed. Direct service providers can provide play and family therapy.
7. The referring agent is informed of the referral status.
8. The Case Management Team (CMT) meets every two weeks to discuss case successes and challenges. Providers are required to present and discuss family progress based on single subject research design data. The local evaluator, who attends all CMT meetings, provides biweekly training to each direct service provider on how to use single subject research design.
9. At the time of this writing, the service pathway included no provision for follow-up with families after completion of CCSS services. As part of the overall streamlining of the service delivery process, a specific modification was made to the Case Management Team (CMT). During the initial CCSS implementation period, DSS staff and representatives from domestic violence and child advocacy agencies attended CMT meetings; the CMT, as a group, matched families in need with providers. Because information shared at CMT meetings prompted DSS investigation in a few cases, however, local law enforcement agencies and domestic violence agencies stopped making referrals to the CCSS. To remedy this problem, in the fall of 2004, the Service Coordinator took on the role of assigning families to direct service providers; assigned providers now make an initial contact with their families before presenting the family's case at a CMT meeting. Although direct service providers and CCSS staff are now the only participants in the CMT, they remain true to their responsibility to report child abuse and neglect to DSS according to state law. If CMT members agree on a potential child wellbeing concern, the direct service provider speaks with the family directly and asks the family to self-report. The provider explains that if the family refuses to self-report, he or she will be obligated to report the concern to DSS.

Also in 2004, the CMT encouraged a shift in the presentation of cases, promoting the use of single subject research design[25] data to guide discussions. At the time of the site visit, some direct service providers had started using the single subject design to gather and present data on their cases. Adopting a data-based approach to assessing family progress has created the potential for more systematic examination of the impact of therapeutic intervention on families and children. In theory, modifications to the treatment plan can now be made throughout the period of intervention, based on what the data reveal about family progress in achieving therapeutic goals.

The CCSS installed report boxes at the Siler City and Pittsboro Police Departments to help officers refer children exposed to violence. The purpose of the report boxes is simply to provide a visual reminder to police officers to make referrals to the CCSS and to

[25] Single subject designs are research designs that involve assessing change (such as reduced disruptive behavior or increased parental praise) on a single research subject (such as an individual child or family) over time (such as before, during, and after clinical intervention).

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facilitate the process for them. No referrals had been made by the end of 2004.

Toward the end of 2004, a local contractor created a database for CCSS staff. Data entry into the new database was completed by the end of December 2004.

The CCSS Safe Havens training will soon be incorporated into the early childhood/childcare curriculum at the community college in Chatham County. Included in the course will be eight hours dedicated to the topic of children exposed to violence and creating safe and trustworthy environments for these children.

6.2 Service Integration

In the fall of 2004, the CCSS worked closely with the Department of Social Services to kick off and implement the Multiple Response System in Chatham County, with the ultimate goal of establishing CCSS services as a key source of support for families who may be neglecting their children.

The CCSS Service Coordinator started attending Child Planning Conferences as appropriate, to speak with eligible families, introduce the CCSS, and provide families with brochures. Thus far, the CCSS has had no referrals from Child Planning Conferences.

Service integration was examined formally by the local evaluator in 2004. The evaluator surveyed local child-serving organizations "before," "during," and "after" the CCSS (2001, 2003, and 2005, respectively) to assess, at each time point, 1) extent of collaboration and 2) extent of system performance improvement due to collaboration. Criteria for collaboration included sharing information about services or cases; mutual planning, either at the program or case level; sharing resources; and coordinating activities. Criteria for system performance improvement included increased availability and accessibility of services; decreased time between referral and service provision; and decreased "falling through the cracks" between organizations. The evaluator found a small but statistically significant increase in overall performance and two specific aspects of performance (case information sharing and minimized duplication of services) from 2001 to 2005. Although these results cannot be attributed entirely to the CCSS, they do suggest a change in the level of collaboration among agencies, which may help institutionalize CCSS efforts beyond federal funding.

6.3 Resource Development, Identification, and Allocation

As mentioned in Section 4 of this report, consultants from the Systems Improvement Training and Technical Assistance Program (SITTAP) and the National Training and Technical Assistance Center (NTTAC) helped the CCSS begin to craft a plan for sustainability. The CCSS received funding through NTTAC to complete a resource development plan. The consultant who completed the plan continues to work with the CCSS to assist with the sustainability plan and efforts.

As mentioned in Section 2.2 of this report, the CCSS Project Director has approached the restructuring of the mental health system proactively, as an opportunity to leverage resources for local private mental health providers, including those who provide services for CCSS referrals, to allow these providers to serve families who might otherwise not have access to mental health care. The Project Director has taken an

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active role in determining how CCSS direct service providers can best navigate the Medicaid reimbursement system.

The CCSS-funded Family Responder position (also discussed in Section 6.4 of this report) will continue to be funded. The Sheriff has committed to continue funding the Family Responder position beyond Safe Start funding.

6.4 New, Expanded, and Enhanced Programming

In 2004, the CCSS strengthened enhanced the programming of community agencies by providing in-services to educate various staff about the CCSS referral procedures and eligibility. Numerous training activities took place in 2004. Trainings were conducted across several systems and programs and involved several topics. The groups who received training in 2004 included:

- Child care providers and early childhood educators;
- Law enforcement;
- Justice system officials;
- Mental health practitioners;
- Social service representatives;
- Domestic violence agencies; and
- Community groups and community members.

The types of trainings conducted included:

- *Dismantling Racism*[26];
- Safe Havens training and a Train-the-Trainer training;
- CCSS identification and referral process;
- Best practices and policies for working with children exposed to violence; and
- Child Development-Community Policing (CDCP). This training covered the effects of trauma on children, community policing, the importance of police officers in the lives of children exposed to violence, the CDCP program, and the importance of collaboration among police officers and mental health practitioners, among other pertinent topics.

Services to children and families have expanded in Chatham County, due to the ability of the CCSS to fund interventions for families that would otherwise be unable to access the help they need. The willingness of CCSS direct service providers to provide clinical services in the homes of families also has played a critical role in expanding the reach of services in rural Chatham County, where families can be deterred from utilizing needed services due to transportation and time barriers.

With CCSS funding, a Family Responder was assigned to the Sheriff's Office to work with officers on calls related to families in crisis. The Family Responder position has enhanced law enforcement's ability to respond to families with children who have been exposed to violence.

Between January 2004 and December 2004, 122 children exposed to violence were identified, 50 children/families were assessed, and 44 children/families were referred for services, according to the July-December 2004 Progress Report. These figures were confirmed with the local evaluator after the May 2005 National Evaluation Meeting.

[26] This was a two-day training offered to help representatives from various agencies develop a common understanding of institutional racism and how it can impede effective service delivery. The training also discussed ways to change daily operations within organizations and across organizations to overcome institutional racism.

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6.5 Community Action and Awareness Activities

Four key community awareness activities took place in 2004: 1) the hiring of a Community Programs Coordinator, 2) initiation of the Neighborhood Listening Survey, 3) planning for the 2005 community education and awareness campaign, and 4) partnering with other agencies on their community-based awareness activities.

The Community Programs Coordinator position was filled in July 2004. Since then, the Coordinator has worked with faith-based organizations, businesses, and schools to educate the community about children exposed to violence and the CCSS. Because of the scarcity of resources currently available to Latinos, the Coordinator has targeted primarily the Latino population.

Baseline data for the Neighborhood Listening Survey were collected in October 2004. These data will 1) enhance understanding of the Siler City neighborhoods chosen to test the impact of the Community Programs Coordinator's efforts and 2) provide a baseline from which to evaluate the eventual effectiveness of the Community Programs Coordinator's outreach activities. The survey was designed to gather information about residents' knowledge of children exposed to violence, the CCSS, social cohesion, and community efficacy.

Also in October 2004, the CCSS Communications Director presented materials and information collected for a 2005 joint education and awareness campaign to the collaborative, and began work with the Community Awareness Committee to develop the details of the campaign. As a campaign slogan, the Committee adopted the message, "You Don't Have to be Hit to be Hurt by Domestic Violence." Scheduled for kickoff in April 2005 (Child Abuse and Neglect Prevention Month), the campaign will teach people to call the Parent Resource Line, a toll-free number sponsored by the North Carolina Partnership for Children, if they have concerns about a child's exposure to violence.

Finally, in 2004, the CCSS participated in street fairs and partnered with other agencies to raise awareness during Child Abuse and Neglect Prevention Month (April) and Domestic Violence Month (October).

7. Institutionalization of Change

The Chatham County site demonstrated the following indicators of sustainability:

Professional and capacity development of point-of services. Service providers trained on the CCSS, issues association with children exposed to violence and the effects of institutional racism on service delivery have an increased capacity to identify, refer, and assist young children exposed to violence and their families that will be sustained beyond federal funding.

Infusion of Safe Start's vision by other agencies and organizations. Two standing CCSS committees merged with existing committees in Chatham County agencies. First, the CCSS Policy & Systems Change Committee merged with the Health Department's Community Child Protection Team, a mandated county group; the CCSS Court Development Workgroup is now a sub-group of this Team. Secondly, the CCSS's Focus on Training Committee and the Coalition for Family Peace's Provider

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Training Task Force merged to become the Community Peace Training Committee.

Development of a protocol manual. The CCSS developed and revised its *Services Handbook*, a product with long shelf life that could be replicated and redistributed among agencies or individuals that assume the CCSS service provider activities.

8. Increased Community Supports

In 2004, the CCSS supported and encouraged three change efforts within the community of service providers, thereby increasing community supports for families with children exposed to violence or at risk of exposure to violence. If these change efforts are fully realized over time, three essential sectors of the system of care for children and families—the courts, law enforcement, and social services—will be better able to support Chatham County families.

As discussed in section 6.2 of this report, the CCSS has been instrumental in leading court reform in Chatham County. By funding an assessment of the county's Juvenile Dependency Court, the CCSS hopes, in part, to encourage the county, and eventually the state, to reach consensus on the definition of child safety. NCJFCJ, the organization performing the assessment, is currently reviewing state statutes to determine how these statutes might impede local efforts to serve children. This information will be shared with the Administration of the Courts at the state level, and, in February 2005, may influence the content of juvenile code when the legislature meets to introduce new legislation. NCJFCJ also will review court rules to see how they affect families and children exposed to violence. Charlotte, North Carolina has a Model Drug Court; when the NCJFCJ study has been completed, Chatham County will have the opportunity to share juvenile court information with the Charlotte Model Court in exchange for expertise in drug court issues.

Prior to the implementation of the CCSS, law enforcement and social services sectors in Chatham County did not work together. With CCSS funding, a Family Responder was assigned to the Sheriff's Office to work with officers on calls related to families in crisis. As a result of the establishment of the Family Responder position, law enforcement and DSS have developed a closer working relationship.[27] The Sheriff has committed to continue funding the Family Responder position beyond Safe Start funding.

The 2004 introduction of the MRS philosophy prompted a change in the response of CPS to cases of child neglect. Historically, many neglected children have been removed from their families and placed in foster care. Guided by the philosophy of the MRS and with the support of the CCSS, however, CPS workers are now more focused on family preservation, and are more likely to refer an entire family to the CCSS.

[27] Site visit participants representing law enforcement and DSS described this working relationship as positive for themselves and for families. In contrast, site visit participants from domestic violence agencies described this working relationship as detrimental to family wellbeing, in part due to historical incidents in which children have been removed from their families.

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9. Lessons Learned in the Implementation and Evaluation of Safe Start Activities

The following lessons were identified by site participants, as well as through the NET's analysis of data collected from participants and existing site documents:

- **The scope of the Initiative was too broad.** In hindsight, more realistic planning and implementation would have been useful. Some site visit participants suggested that the Initiative should have begun at the resident level, focusing on shifting community norms and creating resident empowerment, in spite of the fact that this approach would have been more time-consuming than focusing on the system of care professionals.

- **Strong and flexible staffing is essential.** Site visit participants gave two examples. First, they stressed the importance of having a Service Coordinator with strong administrative capacity, capable of matching families with direct service providers and ensuring an efficient and effective service delivery process overall. These administrative skills were described as more important than a therapeutic or social work background. Participants also stressed the importance of having a flexible Project Director, capable of responding quickly to collaborative and community concerns, as well as considering the needs of the agency staff out in the community doing the work.

- **Know the culture and expertise of partner agencies.** Some interviewees commented on the need to be more strategic about meetings. Who needs to know what? Who can provide what information to whom? For example, law enforcement and court representatives quickly lost interest in attending the CCSS meetings, because they could neither use the information being shared nor offer information useful to others.

- **Establish and utilize a database immediately**. Data are essential to support Initiative efforts. Showing results to key stakeholders such as collaborative members can be useful for planning and decision-making. Site visit participants suggested that adapting an existing database for local purposes rather than creating a customized software package would allow for more immediate data-tracking.

- **Direct service providers require key capacities**. Service providers must have previous experience with children exposed to violence, knowledge of early intervention techniques and brain development, parental experience, and administrative skills.

10. Barriers and Challenges

The barriers and challenges experienced by the Chatham County Safe Start Initiative can be summarized as the following:

- Over half of those interviewed mentioned the growing Latino population as a challenge for service providers, particularly due to the fact that there has not been a commensurate increase in bilingual staff within service agencies.

- 2004 was a year for restoring CCSS credibility and rebuilding relationships. Prior to this, referrals had disappeared into a "black hole," reducing confidence in the capacity of the CCSS to provide services

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to children exposed to violence. Although CCSS staff and processes stabilized in 2004—a phenomenon described by a few as "getting its legs underneath itself"— the Initiative suffered setbacks in progress during prior periods of high staff turnover, especially in the Service Coordinator position.

- Families fear reports to DSS and losing custody of their children. Some CCSS partner agencies share this fear; site visit participants reported examples of cases in which children were removed from their homes after coming to the attention of the CCSS. Given DSS's historical role in removing children rather than working to preserve families, some site visit participants expressed the belief that the credibility of the Initiative as family-centric has been compromised by its close association with DSS.

- Differing philosophies among law enforcement and domestic violence agencies has created significant challenges for the CCSS. Varying opinions about whose protection should be prioritized also has challenged the ability of the CCSS to establish genuine collaboration among some agencies.

- Chatham County's geography is a challenge. For example, law enforcement officials described the Child Development-Community Policing model as infeasible for the county; with a population of over 50,000, six police officers covering 707 square miles, and no interstate highways, Chatham County is difficult, if not impossible, for one Family Responder to cover. As another example, mental health professionals discussed the challenge of treating rural families without phones. It is difficult to contact these families initially, and to complete treatment over time.

- The CCSS message has not yet reached the community level. Service providers know about the CCSS, but the general population does not. According to one interviewee, "a good old-fashioned community organizer" is needed to get the CCSS message out to residents.

- Some site visit participants reported that they had been excluded from certain key decisions made by the collaborative, despite their involvement with the CCSS from the beginning.

- Safe Start direct service providers have been reluctant to accept the importance of documenting family progress in a measurable way. This has interfered with the systematic evaluation of CCSS services and their impact on reducing the effects of children's exposure to violence.

- Community partners have struggled to determine who should sustain CCSS activities, and how. Although other agencies could assume the community development or service coordination components of the CCSS, this may require additional funding and staff. Identifying additional funding streams during the time remaining in the Safe Start grant will be a challenge.

11. Conclusion and Recommendations

The Chatham County Safe Start Initiative accomplished many goals in 2004. Many individuals and agencies received training on issues related to children exposed to violence. The CCSS *Services Handbook* was revised which increased the responsiveness

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of service providers to families and the responsiveness of the CCSS to referral sources. A database was developed that will improve the CCSS's ability to track families and provide high quality data to key stakeholders. The CCSS played an instrumental role in initiating dependency court reform in Chatham County. A Community Programs Coordinator was hired to improve outreach into the community. Another major accomplishment was the initiation of the Neighborhood Listening Project which will facilitate outreach to residents, enhance understanding of residents' perceptions of children's exposure to violence, and generate baseline data from which to evaluate the effectiveness of the Community Programs Coordinator's efforts.

In 2004, the Chatham County Safe Start Initiative rebuilt relationships and trust that had suffered due to an unresponsive service pathway. For 2005, several site visit participants recommended prioritizing activities with the potential to sustain core Safe Start elements in Chatham County. The NET endorses the following recommendations for the CCSS's final year of federal funding:

- Identify and implement best practices for serving the Latino population;

- Consider engaging the growing Latino population by developing resident leaders who could serve as liaisons between existing service providers and the Latino community;

- Develop a community education program with information more relevant to Latino cultures;

- Find a way to maintain the Service Coordinator position beyond the period of federal funding. The system of care for children and families in Chatham County lacks central coordination. Given the geography of the county, the Service Coordinator could close this gap. Maintaining a Service Coordinator position, along with the Case Management Team model, would facilitate multidisciplinary case management of families who have come into contact with various sectors of the service provider community. The courts, law enforcement, DSS, and the Chatham County Partnership for Children could jointly fund the Service Coordinator position to sustain this role after federal funding for the CCSS ends; and

- Facilitate a process of genuine collaboration, particularly among agencies with historically adversarial perspectives. This might help sustain the CCSS message, as well as ensure improvement in the overall system of care. The capacity to truly share power and reach mutual agreement on core issues associated with the wellbeing of families and children seems essential for a system dedicated to serving the same people. The CCSS staff may wish to consider the following resource: Shepard, M.F. & Pence, E. L. (Eds.) (1999). *Coordinating community responses to domestic violence: Lessons from Duluth and beyond.* Thousand Oaks: Sage Publications.

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ATTACHMENT A

Timeline of Chatham County Safe Start 2004 Activities and Milestones

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NCJFCJ consultant for court reform				✔							✔	✔
CDCP consultant from NCCEV visit				✔								
Dismantling Racism training						✔			✔			
Community Programs Coordinator position filled							✔					
Safe Havens Train-the-Trainer training							✔					
Head Start teachers trained on the CCSS identification and referral processes								✔				
Teachers at the Day Care Team in Siler City trained on the CCSS identification and referral processes									✔			
Service pathway and *Service Handbook* revised; direct service providers, community partners, and collaborative members trained on changes									✔			
Planning for community education and awareness campaign									✔	✔	✔	✔
CDCP training/CCSS identification and referral process										✔		
Resource Development Consultant (NTTAC)									✔			
Neighborhood Listening Project										✔		
Safe Havens training by train-the-trainers											✔	
Annual Chatham County Child Care Providers Conference: Safe Havens and CCSS theme											✔	
Domestic violence staff trained on CCSS identification and referral processes											✔	
Hispanic liaison staff trained on the CCSS											✔	
Working Together to Keep Families Safe Conference												✔
Singled database for CCSS staff created; all data reviewed and entered												✔

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IV

CHICAGO SAFE START INITIATIVE

1. Introduction

To develop a full understanding of the Chicago Safe Start (CSS) from January 2004 through December 2004, the National Evaluation Team (NET) visited the Chicago site on October 4 and 5, 2004, and conducted follow-up telephone interviews with key individuals in October 2004 and again in January 2005 to gather information about the site's progress between the time of the site visit and the end of 2004. The NET also reviewed existing documents about CSS, including strategic, implementation, and progress reports for 2004. The NET interviewed 17 CSS participants, including key CSS staff members, point-of-service providers, collaborative members, a representative of domestic violence services, and the local evaluator.

The participants were asked between three and eight general questions, depending on their role with CSS. Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of CSS in the past year?
- How did the composition and process of the collaborative in the site influence the types of strategies implemented, and as a result, the system change outcomes?
- How has CSS changed the service delivery system for children exposed to violence and their families?
- What organizational, point of service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of CSS?
- How did the site handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?
- What are the lessons learned about the implementation and replication of a national initiative such as the National Safe Start Demonstration Project?

This report covers the period from January 2004 through December 2004. Organized according to the Safe Start Demonstration Project logic model, it describes the economic, political, and social context of CSS; the technical assistance the CSS received; the collaboration among different community organizations and agencies participating in the CSS; the system change activities (i.e., development of policies, procedures and protocols; service integration; new, enhanced, and expanded programming; community action and awareness; and resource development) developed by the CSS; the Initiative's

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institutionalization of changes; and the challenges faced and lessons learned by the participants. A timeline of major activities and milestones is included in Attachment A.

2. Contextual Conditions

2.1 Local Contextual Conditions: Background

The City of Chicago is divided into 25 police districts. CSS provides services in two districts: District 5 ("Pullman") and District 7 ("Englewood"). District 5 is comprised of four communities: Pullman, West Pullman, Roseland, and Riverdale. District 7 is comprised of two communities: Englewood and West Englewood. Both police districts are on the south side of Chicago.

According to the 2002 census, the Pullman district has a population of 108,102 residents, of which 95% are African-American; children five years and younger comprise 8% to 10% of the district's population. Englewood has a population of 85,504 residents, of which 98% are African-American and approximately 9% to 12% are children five years and younger. Across both districts, 26% of the population falls below the poverty threshold. Among families living below poverty level, 9,414 have children and 4,506 have children under the age of five.

Teenage girls give birth to one-quarter of all children. Englewood and Pullman suffer from high infant mortality and a higher than average number of low-birth-weight babies. HIV rates and drug and alcohol use are higher in these two districts than in the city of Chicago as a whole. Residents of Englewood and Pullman face significant health and quality-of-life issues, in addition to the threat of violence.
According to 1999 Census data, the federal poverty threshold for an average family of three is $14,290. In West Englewood, the average family size is four; all other CSS communities have an average family size of three. In the Pullman district, the median income is $36,291, with 20% of families and 38% of children five years and younger living below the federal poverty level. In the Englewood district, poverty is more prevalent, with an average family income of $22,884 and 34% of families and 50% of children living in poverty.

According to the 2004 CSS *Strategic Plan*, violence is common in Englewood and Pullman. For instance, in 2002, the two police districts received a combined average of 95 domestic violence calls a day; the Pullman district received a total of 21,271 domestic violence calls, and Englewood received a total of 13,427 calls. According to data from the Department of Child and Family Services (DCFS) for fiscal year 2000, Englewood had 15.2 reports of child abuse per 1,000 children; Pullman had 10.8 reports per 1,000 children.

CSS communities comprise 7% of the city's total population. According to Chicago Police Department (CPD) data, 14% of all violent crimes committed in the City of Chicago occur in CSS communities. In the City of Chicago overall, violent crimes occur at a rate of 15.9 per 1,000 residents. In the Pullman district, 27.5 violent crimes occur per 1,000 residents; in the Englewood district, crimes occur at a rate of 40 per 1,000 residents.

CSS helped develop and pass the Children's Mental Health Act of 2003 in Illinois. The Act stresses intervention and treatment for

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all Illinois children 18 years and younger, including prenatal intervention and care.

Outside of the domestic violence sector, community organizers and political leaders in CSS communities have historically shown greater attention to community violence than to domestic violence, according to the local evaluation reporting form.

2.2 Local Contextual Conditions: Specific to 2004

The Englewood community and police have a strained relationship. There have been incidents of police shootings of Englewood residents, twice within the past year. Domestic violence incidents occur more frequently in Englewood than in Pullman. Interviewees described the relationship between the Pullman community and police as "good."

In 2004, the State of Illinois initiated a planning process to make changes to the mental health system for children, including expanded eligibility for mental health and family support services for children under the age of three. This planning process grew out of the efforts of CSS in collaboration with a multi-faceted statewide partnership, which convinced representatives that infants and young children can recall traumatic events, and that those events can have a lasting impact on children's wellbeing.

On July 1, 2004, the Illinois Department of Human Services (DHS) began a pilot initiative: the Maximizing Accountability and Excellence (MAX) Initiative. MAX is intended to 1) encourage DHS-funded programs to develop outcome measurement systems and 2) introduce a competitive bid process for DHS providers. As a result of MAX, DHS will no longer provide funding in the form of grant dollars, but as fee-for-service only. Under this new system, only clients with a medical (or psychiatric) diagnosis will be able to receive DHS-funded services; previously, clients without specific diagnoses could receive services through grant-funded programs. MAX is being piloted within several divisions of DHS, but has not yet been fully implemented. Once MAX is implemented throughout DHS, social service programs will have to 1) seek funds from non-state sources to serve undiagnosed clients, 2) charge undiagnosed clients fee-for-service, or 3) absorb the cost of treating these clients.

On the national level, Congress charged the U.S. Department of Housing and Urban Development (HUD) with the task of developing an accurate count of homeless individuals in the country and reexamining how homeless services are provided. In response, HUD created Homeless Management Information Strategies (HMIS), which requires human service agencies to record personal and demographic information about homeless clients served, including which services these clients use, and where. Agencies that do not comply with the new reporting rules risk loss of funding.

Domestic violence shelters are included in the new HMIS regulations; under HMIS, clients who seek shelter from abusive partners must be recorded and reported. Mandated reporting of a domestic violence client's information, however, raises serious security concerns, as such reporting could put the victim at risk of being located by the abuser.

Many CSS partner organizations saw changes in leadership over the course of 2004. The CPD hired a new Chief. Chicago Public Schools hired a new Superintendent and new Deputy Superintendents. The

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Assistant Mayor changed, as did the Mayor's liaisons for public safety and early education. According to interviewees, CSS has the "institutional currency" to make contact with the new leaders, minimizing disruption to services and relationships. In anticipation of future staff changes, one city department has built $50,000 into its 2005 budget for Safe Start training on children exposed to violence. CSS also provides training on children's exposure to violence when new individuals are introduced to the CSS collaborative.

3. Community Capacity

Both CSS districts have an operating community council: a group of residents and agencies that have come together to improve the quality of life for children exposed to violence. The Englewood Safe Start Council and the Roseland-Pullman Safe Start Council each consist of representatives of the CPD, DCFS, Chicago Public Schools, mental health services, community organizations, and other agencies. The Councils meet every one to two months to discuss community needs and to sponsor needed area activities. For example, when member agencies and residents in the Englewood community had concerns about adult offender reentry issues, the Safe Start Council invited representatives from the field of adult corrections to present information about their programs.

Several agencies in the Englewood and Pullman communities provide services to families. In the Englewood district, Family Focus serves families with children six years and younger, and the Community Mental Health Council (CMHC) provides mental health services. In the Pullman District, Metropolitan Family Services provides both family support and mental health services to individuals, regardless of medical or psychiatric diagnoses. All three agencies have strong reputations citywide and have been working in Englewood and Pullman for a number of years.

Several unique dynamics have impacted the ability of CSS to develop strong relationships in the community. According to participants, residents of the neighborhoods perceive an individual coming from a "downtown program" in Chicago as, "… not one of us… a bureaucrat, or …a student." Because of their demographic characteristics (high crime rates, low socio-economic status), Englewood and Pullman have frequently been tapped by federal initiatives and research projects for inclusion in time-limited programs. These programs often end without having developed a sustainable infrastructure, leaving residents frustrated and demoralized. Consequently, residents meet new efforts with distrust, and community advocates scrutinize plans closely.

Although DHS and other social service providers in Illinois have recently started to develop intervention standards and best practice models, these standards have not yet been implemented, and services for children exposed to violence have not yet been evaluated.

In the current fiscal year, the Illinois Coalition Against Domestic Violence has been awarded $207,000 to provide counseling and other services to children and an additional $1.1 million for children's therapy. The Illinois Violence Prevention Authority (IVPA) expanded the Coalition's funding for programs to include services for children exposed to violence.

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4. Integrated Assistance

A representative from the National Center for Children Exposed to Violence (NCCEV) oriented the Chicago Fire and Police Departments in December 2004 on how first responders fit into the Safe Start agenda. The CSS Project Director described the presentation as a success.

At the monthly CSS Implementation Advisory Board (IAB) team meeting in December 2004, the NET presented the preliminary results of their 2004 process evaluation for the National Safe Start Demonstration Project. IAB team members were eager to learn how CSS fit into the national picture.

5. Local Agency and Community Engagement and Collaboration

CSS activities are coordinated through the IAB, a collaborative comprised of CSS partners and chaired by a senior executive from Chicago Metropolis 2020. IAB members are selected based on expertise and are encouraged to work with specific implementation teams (see below) as appropriate. The IAB meets quarterly to review team updates and establish new plans.

Specific sets of CSS duties and activities are the responsibility of implementation teams. According to the CSS website (http://www.chicagosafestart.net) and the CSS *Implementation Plan*, the nine implementation teams are:

1. Direct Service: Responsible for 1) creating and implementing a core program and client services for children exposed to violence and their families and 2) reviewing client referrals, client service volume, and intervention instruments for the purpose of expanding services beyond pilot providers and locations;
2. First Responders: Responsible for developing protocols for first responders (police officers and emergency medical technicians) to identify children exposed to violence and provide their families with links to support services;
3. Training: Responsible for identifying and recruiting potential partners to develop and implement training about children's exposure to violence;
4. Evaluation and Data Collection: Responsible for 1) providing support and 2) consulting with the local evaluation team;
5. Public Awareness and Education: Responsible for implementing a public awareness campaign to inform community residents of the potentially harmful effects of exposure to violence and the community resources available to address children's exposure to violence;
6. Court Action: Responsible for identifying intervention points within the court system for children exposed to violence;
7. Englewood Safe Start Council: Responsible for advancing public awareness, client engagement, service development, and systems change for children exposed to violence in the Englewood district;
8. Roseland-Pullman Safe Start Council: Responsible for advancing public awareness, client engagement, service development, and systems change for children exposed to violence in the Pullman district; and
9. Sustainability: Responsible for 1) finding additional funding sources and 2) consulting on programmatic issues for CSS to ensure the longevity of the project.

A total of more than 100 agency representatives work on the nine

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implementation teams, with consistent participation rates of 80% or better. Site visit participants described CSS collaborative partners as "committed" to the CSS mission.

According to site visit participants, members of the collaborative have strong professional reputations, a critical contribution to spreading the Safe Start message. Members with preexisting ties to individuals in high-level policy positions have allowed CSS to access people with the power to act on behalf of children exposed to violence and the Initiative.

In 2004, the First Responders Team held an initial meeting with a Chicago Fire Department executive to solicit high-level support for designating emergency medical technicians as first responders to children exposed to violence. The Team also met with James Lewis of NCCEV to discuss first responder issues.

The Training Team has sponsored training on children's exposure to violence for childcare providers, violence prevention agencies, court workers, and others. In 2004, the training curriculum was expanded to target different levels of clinical knowledge and responsibility, with training for clinical personnel focused on treatment strategies, and training for non-clinical personnel focused on how to properly identify and refer clients. Also in 2004, the Training Team attended child maltreatment training offered by the Chicago Commission on Children and Violence, a group dedicated to safeguarding childhood by supporting teachers and other professionals concerned with children's exposure to violence. Team members who attended the training were certified as Shaken Baby curriculum trainers. The Shaken Baby Course will be added to the CSS workshop series in 2005.

The Court Action Team first met in May 2004. The Team hopes to convene all judges who hear child protection and domestic violence cases for an orientation about children's exposure to violence. Court Action Team trainers also hope to provide an orientation to area law offices, public defenders, and others working within the court system.

The Englewood and Roseland-Pullman Safe Start Councils have provided critical input to guide CSS in planning and implementing activities. The Councils also have provided essential venues for CSS to raise community awareness of children exposed to violence and the CSS agenda.

In November 2004, the Roseland-Pullman Safe Start Council held a forum on men's responsibilities for violence prevention. The 70 community members and consumers who participated represented a cross-section of ages. In addition to the panels and breakout groups for men, a room was set aside for women to discuss male involvement in violence prevention.

The Sustainability Team includes representatives from the Mayor's office, the DCFS, the Chicago Department of Public Health (CDPH) Office of Violence Prevention, IVPA, CSS service providers, Chicago Public Schools, and others. The Team has consulted with the Systems Improvement Training and Technical Assistance Program (SITTAP) to develop effective messages and explore potential funding sources. In 2005, the Sustainability Team will form more specific work teams, including smaller task groups such as a Systems Change Team.

Although domestic violence shelters and advocacy groups are not directly represented on the IAB or any of the implementation

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teams, the City Department of Human Services, which funds the shelters, joined the IAB in 2004. In addition, CSS has participated in domestic violence events and activities, such as public awareness walks, photo displays, and community committees. Nevertheless, CSS has not succeeded in repeated attempts to engage the domestic violence sector directly; philosophical differences continue to distance the domestic violence community from the violence exposure agenda. For example, domestic violence advocates fear "failure to protect" actions against their clients. According to site visit participants, a contractual relationship between CSS and a domestic violence program could help bridge this disconnect.

6. System Change Activities

6.1 Development of Policies, Procedures, and Protocols

In 2004, Illinois initiated a process through which children under the age of three years will become eligible for mental health and family support services, reflecting the state's recognition of the impact of violence on young children. This recognition can be attributed, at least in part, to the efforts of CSS. In the absence of training and education provided by CSS, the state may not have considered children exposed to violence in the planning of service delivery systems change.

Safer Foundation, a CSS partner organization dedicated to ex-offender community reentry, modified its intake questionnaire to identify adults parenting young children exposed to violence in their homes or the community. Safer Foundation will refer identified families to CSS.

6.2 Service Integration

The service system in Englewood has presented something of a challenge for service integration. Within the Pullman district, all referrals go to Metropolitan Family Services, regardless of the nature or severity of the family's need. In the Englewood district, by contrast, families requesting services are referred to Family Focus first, and then to CMHC for more serious treatment needs. Service providers from Family Focus and CMHC meet monthly to discuss cases and coordinate responsibilities.

Despite this practice of sharing information about cases, site visit participants reported that this separation of services has "not gone smoothly." Families often have difficulty transitioning to a CMHC provider after establishing rapport with their initial Family Focus provider. To help address this challenge, CSS has modified the referral system to allow CMHC to accept children exposed to violence from within their other programs.

6.3 Resource Development, Identification, and Reallocation

In 2005, which CSS has dubbed the "transition year," funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) will end. To address the need for continued funding, the Sustainability Team was formed in March 2004. With assistance from outside experts in sustainability such as SITTAP, the Team will identify the institutional functions that must be in place to enable CSS to continue to operate past 2005.

Currently, CSS receives most of its non-OJJDP funding from the Department of Public Health, which plans to maintain

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funding for CSS staff after the OJJDP grant funds end.

Additional funding sources are available to CSS. For example, the IVPA, which promotes violence prevention throughout the state, has worked with CSS to develop consistent branding of the Safe Start name and vision, with the goal of linking the phrase "Safe Start" to children exposed to violence, much as Head Start is linked to school readiness. According to site visit participants, branding will promote sustainability by raising the level of trust between CSS and the community. Over the first six months of 2005, the IVPA will provide CSS with approximately $150,000 for direct services and $50,000 for public awareness. After mid-2005, direct service funding may be continued, but no funds have been allocated for indirect or administrative costs.

CSS is exploring other funding possibilities. For example, the Initiative has contacted local foundations about funding for the video training project.

CSS is also exploring ways to fund community education in 2005, in an effort to engage additional community agencies as potential referral sources. CSS education funds for 2003 have been spent; the 2004 budget allocated no funds for education. According to site visit participants, additional funds for education will be essential in 2005.

6.4 New, Expanded, and Enhanced Programming

In the past, point-of-service providers engaged clients exclusively through referrals, primarily from CPD. CSS has since developed two distinct service pathways: incident-based and symptom-based. This eliminates the barrier of having only one pathway for identifying and engaging clients.

The incident-based pathway engages clients through first responders such as police and domestic violence workers. If a child is present at a domestic violence call, the responding officer completes a referral card summarizing the incident; referral cards are used primarily for tracking purposes. Although the CPD supports CSS training, police officers have many demands on their time, which may minimize the number of referrals. Filling out CSS referral cards is an added responsibility for officers. Added responsibilities, which may lead to burnout, are a sensitive issue for the police department. The officer also recommends that the family call the city's Domestic Violence Helpline, which refers the family to services, including CSS. The Helpline tracks the number of calls for children exposed to violence.

CSS recently engaged the Chicago Fire Department (CFD) as another first responder partner in the collaborative capable of providing an incident-based service pathway for children and families. In December 2004, CFD emergency medical technicians received training as first responders to children exposed to violence. These providers will join the CPD in making CSS referrals.

With the symptom-based service pathway, agencies can now provide CSS services to existing social service clients, either inside or outside the agency. Symptom-based clients, therefore, can enter the system through preexisting involvement with social services. If a CSS service provider notices that a child has symptoms suggesting the need for Safe Start services, the provider

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asks the family to consider services, and may facilitate a referral.

All CSS providers receive referrals from the Domestic Violence Helpline, from CPD, and from other community sources. CSS delegates make presentations to school and daycare groups, during which parents sometimes request help for a child who has been exposed to violence, potentially resulting in a symptom-based referral.

When a child is referred to a CSS provider, the provider first screens the child to determine the type, amount, and impact of exposure. Depending on need, clients then may be referred to family support services, mental health treatment, or both. Family support services provide for basic needs, such as food, physical safety, utilities, and housing. Families also receive information and training on parenting, child development, and referrals to other services as necessary. When a family support provider identifies a need for mental health treatment, the support provider refers the child or family to a mental health provider.

A client's service pathway depends upon the family's district of residence. Clients living in the Pullman District can receive both family support and mental health services from Metropolitan Family Services, which offers both services in-house. Clients from the Englewood District are first referred to Family Focus. For mental health treatment needs, Family Focus refers the family to the CMHC.

CMHC was designed to receive referrals from Family Focus. Although the ideal referral rate was calculated at 25 per year, CMHC initially received fewer than 10 referrals per year. To address this problem, CSS modified the CMHS policy to allow referrals from multiple sources, including in-house clinical therapy staff. Intake staff members were trained to screen children for exposure to violence, to determine eligibility for CSS services. Clients receive traditional family therapy or, less often, multiple-family group therapy.

CSS has a strong training component. In 2004, CSS held training sessions for police, DCFS, court personnel, child welfare workers, substance abuse workers, county and city government employees, members of the community, and others. Although all trainings focus on children exposed to violence, the specifics of the training differ based on the agency. For example, training for the CPD has focused on making referrals to CSS, whereas DCFS and court trainings have elaborated on options available to professionals working with children exposed to violence. CSS also has provided train-the-trainer sessions to enable agencies to conduct their own trainings. According to participants, the train-the-trainer component of the CSS curriculum will 1) increase the amount of training on children's exposure to violence offered citywide and 2) lead to sustained exposure to training as agencies eventually adopt the CSS model, in whole or in part.

In September 2004, CSS held its first train-the-trainer session, to teach participants how to teach others to 1) identify exposure to violence and 2) serve children who have been exposed. Both CSS and non-CSS agency representatives were trained as trainers. The training proved valuable not only in helping to build the skills of participants, but also in facilitating referrals. Post-training, participants were able to identify potential clients for CSS and refer these clients to available services. The resultant increase in referrals prompted non-CSS agencies to explore the possibility of

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providing services for children exposed to violence.

CDPH mental health and Maternal and Child Health (MCH) clinics continuously refine their data collection procedures regarding care of young children and screening of children exposed to violence by changing the population focus to include more children. CDPH and Domestic Violence and Mental Health Policy Initiative, a community collaborative, are collaborating to cross-train mental health and domestic violence providers to create a co-located response system, which will be a pilot for the entire CDPH mental health and MCH clinic system. The focus of the collaboration is on adult trauma with child trauma focused on development.

CSS is also developing a video of first responder training for police officers and emergency medical technicians. The video consists of live action vignettes illustrating the use of CSS referral cards. It is scheduled for completion in 2005.

As of June 30, 2004, CSS had identified and referred 246 children for services and had screened 115 children. During this same time period, 34 agencies and 307 individuals participated in BSSI training activities.

6.5 Community Action and Awareness Activities

In March 2004, CSS began to distribute a comprehensive five-page brochure at all public awareness events. The brochure includes a description of CSS, symptoms of exposure to violence, ways to address the needs of children who have been exposed, and community resources—enabling community members to find all the information they need in one document, as opposed to several different documents from various sources. According to site visit participants, this comprehensive brochure is a critical part of the CSS public awareness campaign.

Also in 2004, CSS developed three fact sheets for public awareness. One describes the impact of domestic violence on children, one describes the impact of community violence, and the third outlines the impact of media violence. These fact sheets are distributed at festivals, community meetings, and other public events and venues.

CSS is currently producing an animated video for use in child-related facilities to increase parental awareness of childhood exposure to violence, its behavioral symptoms, and ways in which parents can modify a child's response. An accompanying coloring book is designed to help children understand what is happening during an episode of violence. The video will be distributed to schools, childcare facilities, and other agencies that work with children. It is scheduled for completion in 2005.

CSS promotional T-shirts have contributed to public education and awareness efforts. In August 2004, staff wore CSS T-shirts and carried a CSS banner at the 75th Annual Bud Billiken parade and picnic, the largest parade in the Chicago area, held to promote child health and development.

In October, domestic violence awareness month, the Chicago Metropolitan Battered Women's Network sponsored a children's art exhibit. CSS partnered with the Network to place a large photography exhibit in the lobby of the state building in downtown Chicago. The exhibit featured children's photos, showing children[28] from Chicago

[28] The children in the photos were not victims of violence, but volunteers.

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communities, in an effort to raise awareness and personalize the problems of domestic and community violence during domestic violence awareness month.

At the CPD's Family Violence Conference held in October 2004, CSS presented information on Community Alternative Policing Strategies (CAPS), a community policing program developed for consumers and community organizers. Also in 2004, CAPS joined CSS as a partner. CAPS assigns police officers to community meetings focused on issues of community crime, quality of life, and other policing issues. CSS representatives attend CAPS meetings to 1) make direct contact with community members, a source of critical information for the collaborative; 2) publicize CSS; and 3) distribute CSS brochures and fact sheets.

CSS and its providers plan to cultivate "ambassadors," people with experience of community violence who are willing to provide outreach to the community. Ambassadors will attend media events, speak at conferences, and eventually may lead client groups. Developers of the ambassador program plan to work with Toastmasters[29] to create a public speaking curriculum.

7. Institutionalization Of Change

CSS would like to expand its services to include other areas of the city. Although specific sites for expansion have not been identified, many collaborative members hope to focus on the area of the city with the most documented violence. Other members are interested in neighborhoods with high birth rates or places with many or few daycare centers. CSS does not know how or when the expansion might occur. No funds have been secured to support a citywide expansion. Several participants expressed skepticism, describing expansion as a good idea in theory, but unlikely to succeed without funding.

To institutionalize CSS within the CPD, police leaders are contemplating an incentive system. Under such a system, responding officers who filled out CSS referral cards completely and correctly would receive a certificate of appreciation or other reward. This program is in the early stages of development.

In 2004, CSS initiated an "incubator" program, under which any agency with responsibility for serving children and families is considered a potential CSS "incubator." When such an agency expresses interest in developing competencies for serving children exposed to violence, CSS staff meets with agency leaders and representatives to determine the agency's capacity, including how much effort the agency is willing and able to expend to incorporate new policies and procedures. Based on this information, CSS develops a plan to conduct training in one or more competency domains. The following are the five general domains of competency:

- Training;
- Identification and screening for children exposed to violence;
- Modification of screening tools to be sensitive to children exposed to violence;
- Modification of practices to accommodate

[29] Toastmasters clubs were started in 1924 "to afford practice and training in the art of public speaking and in presiding over meetings, and to promote sociability and good fellowship among its members." At Toastmasters, members learn by speaking to groups and working with others in a supportive environment. (www.toastmasters.org)

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children exposed to violence; and
- Modification of policies.

CSS does not designate as "incubators" all agencies that receive training, but only those agencies that prioritize the issue of exposure to violence. The incubator strategy will help ensure continuation of Safe Start work, even if the current CSS collaborative dissolves.

In December 2004, CSS met with the Assistant Mayor and two liaisons from the Mayor's office. The Mayor called on the new early education liaison to focus on the issue of children exposed to violence. To engage the Mayor's public support, CSS will hold public events. The major players in the CSS collaborative are planning additional meetings to develop strategies for engaging the community at large.

8. Increased Community Supports

Safe Start Community Councils have provided a forum for CSS to meet community residents, gather information about community needs, and promote CSS services. The CPD, DCFS, Chicago Public Schools, churches, ministers, the Chicago Housing Authority, and mental health agencies all are represented on the Safe Start Councils.

The CPD has supported the CSS effort, making a critical contribution to the work of CSS by referring a large number of all CSS clients. The Police Superintendent supports CSS training efforts, including efforts to train first responders about childhood exposure to violence and the work of Safe Start.

In 2004, CSS agencies expanded service hours, number of program slots, and access to services by partnering CSS staff with other program staff, to implement CSS specific programming within other agency programs. In addition, CSS developed a model for placing CSS staff in many of the public clinics and programs in the community, to increase awareness and referrals. Finally, CSS providers can now accept in-house referrals through the symptom-based program model.

9. Lessons Learned in the Implementation and Evaluation of Safe Start Activities

The following lessons were identified by site participants, as well as through the NET's analysis of data collected from the participants and existing site documents:

- All Safe Start services (family support and mental health intervention) should be housed under a single roof. Families often face significant barriers in getting to a single provider, let alone two. Moreover, clients develop a level of comfort and emotional investment when seeing one provider. That trust may be lost upon moving to a new provider.

- The early efforts of an Initiative should include a strong public awareness campaign of six months or more.

- The Safe Start service delivery process must be clarified early on in an Initiative. All collaborative partners must be involved in the initial process and education regarding the Initiative's focus and goals.

- Training of first responders is critical for a smooth referral process. When services depend entirely on an incident-based referral system, programming is built on

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receiving referrals from first responders. Training for first responders and commitment from first responder agency heads are imperative.

- A Safe Start service curriculum, designed to train staff at the direct-service level, is essential. Such a curriculum would 1) provide guidance to shape consistent services for clients and 2) create a consistent Safe Start brand across service areas. Site visit participants expressed a desire for a fully formed curriculum, to be provided to all grantees when an Initiative begins.

- Tools to screen families must be developed. Developing these tools locally took a great deal of time, which may have delayed the delivery of services to those who needed them. Each site should be provided with a standard toolset.
- The Safe Start referral system should incorporate multiple referral sources, to reduce dependence on a single referral source and increase the number of referrals.

- Safe Start staff should meet with law enforcement leaders early on in an Initiative to 1) demonstrate the importance of Safe Start and 2) gain the support of law enforcement early in the design and implementation of the Initiative.

10. Barriers And Challenges

CSS has encountered a number of difficulties in working with the targeted Chicago community members:

- Families have many issues to deal with, making it difficult to engage and retain them in services for children exposed to violence, when more pressing and immediate responsibilities demand their time.

- Engaging clients is more difficult than retaining their involvement in services that are meeting a need. Community members referred to CSS through the symptom-based system are already involved in the service delivery system. Engaging clients through the incident-based system is more difficult, at least in part due to the stigma attached to police involvement.

- The attrition rate of CSS clients is relatively high. Preliminary site data indicate that children experiencing greater trauma symptoms at the time of intake are more likely to fall into the group of clients who have not yet completed services or who have terminated services prematurely. High family mobility in high stress communities contributes to the attrition rate.

- Residents in the targeted neighborhoods are wary of programs developed by outside entities. These neighborhoods have been a frequent target for agency, nonprofit, student, and research efforts, many of which leave the community after working with residents for only a short period. Community members do not trust the sincerity of these efforts, feeling as though they have been used for a purpose, with little gain.

- CSS struggled to produce public relations materials in a timely fashion. The attempt to procure pro bono assistance, a lengthy approval process, and one-on-one conversations contributed to the time lag. Public relations material needs to be completed quickly to provide support for public awareness campaigns.

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- Children in the target age group (children six years and younger) may be exposed to violence without parental knowledge, impeding the ability of families to mobilize and seek intervention. Additionally, if violence is pervasive and the family has no means to leave the community, seeking counseling may not be an attractive option.
- Services are not available in all neighborhoods served by Safer Foundation. In conjunction with Safer Foundations their efforts to expand the initiative to other parts of the city, CSS will also provide training to all Safer Foundations intake workers.

11. Recommendations and Conclusions

During 2004, CSS strengthened the service pathway for identifying and referring children exposed to violence. Enhancements included development of the symptom-based pathway and training of additional first responders. CSS sponsored several activities and events to further public awareness of childhood exposure to violence, such as the distribution of brochures and fact sheets, production of two videos, and a photography exhibit.

As CSS enters its final year of federal funding, the NET suggests that it consider the following recommendations:

- Decide on areas for the expansion of services. When expanding into these areas, 1) recognize and address the above lessons learned and 2) move at a conservative pace, emphasizing community relations and developing support from within the community;

- Work aggressively to cultivate incubator agencies. This will encourage the community to engage with and support services for children exposed to violence;

- Develop open lines of communication with the local government, police departments, and justice officials by training IAB members from target agencies to serve as ambassadors of the Safe Start message;

- Continue to appeal and reach out to systems and organizations that have not been involved with CSS in the past, including the child welfare and domestic violence sectors; and

- Continue to explore methods for increasing the commitment of police officers to their work as first responders, including training, incentives, and developing strong support from commanders.

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ATTACHMENT A

Timeline of Chicago Safe Start 2004 Major Activities and Milestones

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Implementation of symptom-based service pathway	✓											
Meetings with point-of-service providers	✓	✓										
CSS brochure completed			✓									
Start of sustainability discussions			✓									
First meeting of Court Team					✓							
Tier II funding awarded						✓						
Bud Billiken Parade								✓				
First meeting of Sustainability Team								✓				
Train-the-trainer training									✓			
Photography exhibit										✓		
Roseland Safe Start Council forum											✓	
CSS meeting with Mayor's Office liaisons												✓

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V

PINELLAS COUNTY SAFE START

1. Introduction

To develop a full understanding of the Pinellas County Safe Start Initiative (SSI) from January through December 2004, the National Evaluation Team (NET) visited the Pinellas County site on November 9 and 10, 2004, and conducted follow-up telephone interviews with key individuals in March 2005. The NET also reviewed existing documents about the Pinellas County SSI, including strategic, implementation, and progress reports.

The NET interviewed 15 people, including key SSI staff, point-of-service providers, collaborative members, representatives from the Guardian ad Litem program, and the local evaluator. Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of the Pinellas County Safe Start (PCSS) in the past year?
- How did the composition and process of the collaborative influence the types of strategies implemented, and, as a result, the system change outcomes?
- How has the Pinellas County Safe Start changed the service delivery system for children exposed to violence and their families?
- What organizational, point-of-service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of the PCSS?
- How did the PCSS handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?
- What are the lessons learned about the implementation and replication of a national initiative such as Safe Start?

This report covers the period from the start of the Pinellas County SSI in January 2004 through December 2004. Organized according to the Safe Start Demonstration Project logic model, it describes the economic, political, and social context of the Pinellas County SSI; the technical assistance the SSI received; the collaboration among different community organizations and agencies participating in the SSI; the system change activities (i.e., development of policies, procedures, and protocols; service integration; new, expanded, and enhanced programming; community action and awareness; and resource development) by the SSI; the Initiative's institutionalization of changes; and the challenges faced and lessons learned by the participants. A timeline of major milestones is included in Attachment A.

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2. Contextual Conditions

2.1 Local Contextual Conditions: Background

Pinellas County is located on Florida's West Coast, bordered by the Gulf of Mexico to the west and Tampa Bay to the east. Of the four hurricanes that struck Florida over the course of only a few months in 2004, two affected Pinellas County, disrupting PCSS activities temporarily and compromising collaborative member funding due to diversion of money to pay for hurricane cleanup. Site visit participants also reported that the number of incidents of domestic violence increased immediately following the hurricanes.

In 2000, Pinellas County had a total population of 921,495, with a projected total of 945,266 for 2005. The county's population is largely European American (86% in 2000), with significant African American (9% in 2000), Asian (2% in 2000), and Latino (5% in 2000) subpopulations. According to census estimates, 63,662 children six years and younger were living in Pinellas County in 2000, accounting for about 7% of the county's total population. Twenty-two percent of Pinellas County households in 2000 were family households with their own children under 18 years, 14.5% were married-couple families with their own children under 18 years, and 6% were female-headed households with no husband present and with their own children under 18 years. Pinellas County had a median family income of $49,925 in 2000 and a median household income of $37,111. Percentage of persons below poverty level was 9.9% in 2000.[30]

Pinellas County has 24 incorporated municipalities, governed by elected officials. City commissions typically include commissioners (also referred to as council members) and a mayor. Members serve two- to four- year terms, depending on the city. Terms are staggered, with most cities holding elections each year.

2.2 Changes in Pinellas County's Service Delivery System

Two significant legislative changes at the state level impacted the Florida child protection and mental health systems in 2004.

Child Protection. In 1996, the Florida Legislature enacted legislation requiring the Department of Children and Families (DCF) to develop a plan to privatize all child protective services and create community-based care. Privatization was to be phased in over a three-year period, beginning January 1, 2000, with the goal of building partnerships in the community by transitioning all foster, adoption, and child protective services to local providers.[31]

Six of 15 site visit participants identified the change in Pinellas County's lead agency for community-based care as an external change that required considerable stakeholder time and energy in 2004; Pinellas County Safe Start staff was actively involved in the planning and transition process, which included changes in leadership, organization, and strategy.[32]

[30] Demographic information in this paragraph obtained from www.pinellascounty.org.

[31] *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System,* p. 10.

[32] See pages 13 to 15 of *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System* for a full description of the new Pinellas community-based care model.

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Family Continuity Programs (FCP), a private service provider, was awarded the initial service contract as lead agency for community-based care in Pinellas and Pasco Counties. According to several sources, FCP seriously impeded the local system's ability to serve children and families in need, by operating in isolation from others in the service community. Furthermore, some site visit participants described Family Continuity's foster care, adoption programs, and child abuse prevention programs as deficient (e.g., children placed in foster care were "lost" in the system under FCP). In 2003, Florida's Department of Children and Families cited Family Continuity for a "fundamental lack of supervisory oversight," and identified a fundamental need to improve "the consistency of supervisory oversight, review of case work, and mentoring of staff if it is to ensure child safety, well-being, and permanency."[33]

In December 2003, FCP's parent corporation, Care Development of Maine, hired Providence Service Corporation to find a means of improving FCP management. Management problems continued, however, and a $3-million deficit was projected. Family Continuity therefore entered into a management agreement with the first agency to participate in the community-based care pilot project outside of Pinellas County: the Sarasota Family YMCA. FCP resigned as the Pinellas County community-based care lead agency effective March 31, 2004; the Sarasota Family YMCA agreed to provide administrative and management services through the end of the fiscal year (June 30, 2004). On July 1, 2004, lead agency responsibilities transitioned completely from FCP to the Sarasota Family YMCA.

Children's Mental Health and Medicaid. In 2003, the Florida Legislature passed Committee Substitute/Senate Bill (CS/SB) 2404, which the Governor signed into law. This law established Agency for Health Care Administration (AHCA) policy for implementing managed behavioral health care for Medicaid recipients (adults and children). The law called for a single managed behavioral health plan in each AHCA area, with a competitive bidding process in each area, and a three-year implementation schedule. In the 2004 session, the Legislature included language in the House Budget Conforming Bill (HB1843) that shifted services and money away from nonprofit community mental health centers to for-profit health maintenance organizations (HMOs). Previously, mental health services had not been included in managed care contracts, and families could access services from a variety of community Medicaid providers. Medicaid HMO enrollees and their children now must access mental health services through their HMO managed care plan.[34]

Referred to as the "Kid Care Cap," these changes in legislation on children's health insurance and mental health care may result in delays and decreased access to services for low-income children and families, in addition to a large reduction in the total dollars spent for actual services. The Kid Care Cap will decrease both enrollment in state-sponsored medical insurance, as well as dollars allocated per child for medical care reimbursements. Moreover, three site visit participants expressed concern that HMOs will divert a higher percentage of

[33] *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System,* p. 12.

[34] *Pinellas Safe Start Application for 2004-05 Funding, Section F: Resource Audit,* p. 5.

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funds to administration and profits, further reducing funds for direct services.[35]

3. Community Capacity

3.1 Spirit of Collaboration

The culture of the Pinellas County service delivery system emphasizes communication and collaboration. According to one site visit participant, Pinellas County has an "unspoken creed to work together," as evidenced by long-standing partnerships among agencies and organizations that provide services to children of the county. Examples of successful and effective collaborations include the School Readiness Coalition, Pinellas County Domestic Violence Task Force, Healthy Start Coalition, Healthy Families Pinellas, and many others.[36]

3.2 Support for Services Related to Child Well-Being

Pinellas County also "believes in a philosophy of helping kids," a philosophy borne out in practice through a property tax dedicated to children's services (discussed in more detail in Section 3.3 of this report). Virtually unanimously, site visit participants described Pinellas County as "ready" for system change. While several of the strong leaders that ultimately joined the PCSS collaborative were concerned about the impact of child *abuse*, Pinellas County at the start of the PCSS had little awareness and virtually no systematic response for children who *witness violence*. According to data from the 2004 key informant survey, however, service agencies have since developed a keen awareness of children's exposure to violence, with 82% (of 99 social service staff) aware of at least one way to contact the Pinellas County Safe Start Initiative.

3.3 Service Delivery System Infrastructure

In addition to its culture of collaboration, the Pinellas County service delivery community has material resources that facilitated the implementation of the PCSS and will likely contribute to its sustainability. Nearly every site visit participant described Pinellas County as "resource-rich" with regard to children exposed to violence. As documented in the PCSS community assessment,[37] the social service infrastructure in Pinellas County is extensive, with many programs and services available to families and better than average funding for these programs. This extensive service infrastructure derives from a solid foundation provided by five key agencies: the Juvenile Welfare Board, Help-A-Child, Inc., the Pinellas County Health Department, Coordinated Child Care, and Directions for Mental Health.

Juvenile Welfare Board. The Juvenile Welfare Board of Pinellas County (JWB) is the grantee and fiscal agent for the PCSS. A highly influential agency with a history of nearly 60 years in Pinellas County, the JWB is a special taxing district with the authority to plan, fund, and coordinate social services for children and families, using property taxes dedicated to children's programs. These taxes, created in the 1960s via public referendum, free the JWB from dependence upon state funding.

[35] *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System,* p. 24; Section F: Resource Audit, p. 5.
[36] *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System,* p.1.
[37] *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System,* p. 1.

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Three JWB Community Councils represent the needs of the community as a single voice. Members of the Community Councils include primarily concerned citizens. Social service and other professional personnel are allowed, but professional membership is limited and must be approved by each Council's executive director. Comprised of 15 members each, the Councils meet once per month to review key issues affecting each of three service areas: North, Central, and Southern Pinellas County. Members have the opportunity to voice concerns about any community matter, including child welfare issues. Such issues dominated the 2004 meetings, as a result of the legislative mandates and consequent service delivery changes described in Section 2 of this report.

With its vast funding capacity and positive reputation, JWB has been an influential ally for the PCSS, giving the Initiative the credibility and political capital to attract helpful partners and make changes within the service delivery system.

Help-A-Child, Inc. A member of the Pinellas County service delivery community for 25 years, Help-A-Child (HAC) acts as the umbrella agency for six programs, the largest of which is the Child Protection Team (CPT). The seeds for CPT were sown in 1979, when the Pinellas County legislative delegation worked with a local physician to secure a grant that was eventually awarded to All Children's Hospital in St. Petersburg, to provide the community with three important programs: the Child Protection Team, Medical Foster Care, and the Parent Aide Program.[38] Medically directed and multidisciplinary, the CPT program at Help-A-Child operates on the premise that child abuse and neglect involve complex issues, demanding the collaborative expertise of many professionals to protect children. The program provides medical and psychological assessments for abused children in Pinellas County, as well as for children in neighboring counties who are transported to All Children's Hospital. By providing diagnostic and assessment services, as well as case consultation, CPT assists child protective services and law enforcement agencies in their investigations of child abuse.

Other HAC programs include Medical Foster Care, the Parent Aide Program, and clinical services for child victims of non-familial abuse. In the past year, HAC assumed responsibility for the Sexual Assault Victim Examinations program (SAVE), which provides forensic examinations for adult victims of rape and sexual battery, in collaboration with the Pinellas County Health Department. As a mandated responsibility, HAC tracks co-occurring risk factors in child abuse reports. Factors frequently noted in initial reports include parental substance abuse, domestic violence, and other community violence exposure.[39]

Pinellas County Health Department (PCHD). The PCHD Violence Prevention Office meets several community needs related to domestic violence prevention and intervention.[40] In addition, the Department's Healthy Families home-visiting program works with new mothers, contacting every new mother who delivers a baby, conducting assessments, providing parents with any needed resources, and offering to follow each family for a period of five years. Finally, the PCHD contracts with the

[38] *Help-A-Child Newsletter,* Fall 2004.

[39] *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System,* p. 21.

[40] *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System,* p. 21.

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Healthy Start Coalition, which focuses on improving health services for pregnant women and children three years and younger, through mechanisms such as ensuring birthing facilities are located within a reasonable distance, recruiting physicians to areas in need, providing emergency transportation for pregnant women, etc.

Coordinated Child Care. Coordinated Child Care (CCC) is the central agency for child-care resource and referral in Pinellas County. It serves primarily as a service broker, by 1) coordinating services for children at risk of abuse and/or neglect and 2) providing child care scholarships for children with employed low-income parents or parents transitioning from welfare to work.[41]

Directions for Mental Health. Directions for Mental Health is an important "community partner"[42] for the PCSS due to its role in implementing the Child Development Community Policing program (CDCP). Directions for Mental Health also plays an important part in the service delivery infrastructure because of its role in the collaborative planning and funding of various trainings for early childhood mental health providers. In cooperation with organizations such as the PCSS and the National Child Traumatic Stress Network (NCTSN), Directions for Mental Health has planned and funded a year-long Child Parent Psychotherapy Project (led by the training director of the Child Trauma Research Project in San Francisco), replication training for Parent-Child Interaction Therapy (PCIT), and other short-term workshops. In addition, Directions for Mental Health has provided leadership in establishing an early childhood mental health committee in Pinellas County. In short, this agency plays an essential role in developing and supporting a network of early childhood mental health providers and building capacity in this area.

Although point-of-service providers in Pinellas County have a basic capacity to care for children exposed to violence, some service delivery providers interviewed by the NET acknowledged the need for additional capacities. Site visit participants identified essential point-of-service capacities as 1) the willingness to "retool" internally, for example, by making policy changes to accommodate additional clients, or by providing training and education for current and future professionals; 2) having staff capable of working with children exposed to violence; and 3) the ability to coordinate with other service providers. Representatives of Pinellas County agencies confirmed their capacity to retool and their willingness to train staff. Many, however, noted existing staff capacity and the need for additional personnel as concerns, in that treating children exposed to violence can, in some cases, create new clients who require additional staff.

4. Integrated Assistance

4.1 Technical Assistance Provided by the Local Evaluator

Pinellas County Safe Start's local evaluator facilitated the 2004 implementation of the PCSS evaluation plan, including the development of protocols for Coordinated Child Care staff to collect data for the comparison group. The evaluator also worked closely with the Safe Start

[41] *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System,* p. 7.
[42] The Project Director defined "community partners" as other organizations or individuals working in the community with missions similar to the PCSS and who work with the PCSS on various projects or issues but who do not have a contractual relationship with the PCSS .

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Partnership Center (SSPC, described further in section 5.1 of this report) to clarify the distinction between Level Three and Four Services (described further in Section 6.2 of this report), and to develop a standardized intake form for the five SSPC partner agencies (listed and described in section 5.1 of this report). Finally, the evaluator gathered and integrated data from multiple data sources for reporting and evaluation purposes.

In December 2004, the local evaluator achieved an important milestone, by facilitating unprecedented data-driven learning and decision-making during meetings with the PCSS Leadership Council and direct service staff. For example, the evaluator shared preliminary results from the analysis of follow-up surveys distributed to PCSS training participants. According to both the local evaluator and the PCSS Project Director, sharing this information at the Council meeting motivated those present to encourage their staff to return the surveys to the evaluator, to increase mutual understanding of the PCSS at the programmatic level. When the evaluator met with direct service staff regarding data, staff explained certain data patterns. For example, staff explained that they collected less data from families at the second data collection time point, as a result of fear that information from the Parent Stress Index might be used during custody battles. This discussion produced insights that allowed for modification of data collection procedures, such as creating two case files so that a parent's file could not be used in a custody case.

4.2 Technical Assistance Provided by the NET

Pinellas County Safe Start consulted with the National Evaluation Team several times in 2004 to request technical assistance. The NET worked with the PCSS to create new data fields in their database, complementing the work of the local evaluator for Pinellas County Safe Start and the administrative assistant for Help-A-Child, who made significant revisions to the database to improve tracking of children and families who receive services. The database revisions allowed for 1) a more detailed description of an individual's path through services and 2) generation of reports based on services rendered.

Pinellas County Safe Start also requested assistance in developing a plan to submit a proposal for Safe Start Tier II funding. The local evaluator designed a plan to enhance the site's capacity for evaluation and received assistance in building that plan. The NET provided guidance on how to best analyze the PCSS database and design the study. The proposal was accepted and the PCSS received an award in the amount of $45,665.

Pinellas County Safe Start sent representatives from the Health Department, Devereux Kids, and Gulf Coast Jewish Family Services to the Institute for Community Peace Conference in March 2004. The conference, held in San Diego, CA, focused on sustainability and creating community peace.

4.3 Technical Assistance Provided by the National Council of Juvenile and Family Court Judges (NCJFCJ)

Many items of Florida legislation address the issue of children living in families with domestic violence, including how to assess and report the risk of child maltreatment. Various service systems—domestic violence, child protection, law enforcement, and courts—however, do not agree upon

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guidelines for action when a child is experiencing violence in the home. Differing interpretations present barriers to the implementation of systematic screening, identification, and response to children exposed to violence, highlighting the need to clarify legislative intent, build consensus, and develop protocols for a coordinated community response. The PCSS has taken steps to address this priority issue with its community partners. With technical assistance provided by NCJFCJ, the PCSS researched and summarized pertinent Florida legislation and case law, presenting their preliminary research findings to the Pinellas Domestic Violence Task Force on July 20, 2004, for discussion and recommendations.[43]

The NCJFCJ and OJJDP have encouraged Safe Start Project Directors to reach out to judges as part of the Safe Start Demonstration Project. In 2004, two Pinellas County judges attended judicial institutes on child welfare and the Model Courts Conference, through support from the NCJFCJ, OJJDP, and the National Institute for Justice. The PCSS Project Director served on the faculty of the 2004 Model Courts Conference, through technical assistance provided by NCJFCJ.

4.4 Technical Assistance Provided by the National Civic League

The National Civic League (NCL) also assisted in coordinating technical assistance for the PCSS. Two consultants from the NCL and two consultants from the Systems Improvement Training and Technical Assistance Program (SITTAP) visited the PCSS in the spring of 2004. Following this visit, one NCL consultant provided ongoing assistance with the development of a training and technical assistance (T&TA) plan and handled a request for speakers' fees for a three-day workshop to be held in 2005. The SITTAP consultants provided technical assistance in planning and implementing the 2004 Children's Summit (described in Section 6.6) and in the identification of potential federal funding for children's mental health.

5. Local Agency and Community Engagement and Collaboration

5.1 Critical Members of the PCSS Initiative

The PCSS Project Director distinguished the "overall collaborative" from the "formal" and "informal" relationships that exist within it. The overall collaborative is a coalition or network of relationships throughout Pinellas County. Formal relationships within this large collaborative exist in the form of the Leadership Council and the Safe Start Partnership Center (SSPC). The Leadership Council is an advisory board formed in response to the National Safe Start Demonstration Project solicitation and is the most formal committee, with limited member organizations. The PCSS created and funded the SSPC to deliver services to children exposed to violence and their families. Groups with informal relationships within the collaborative are collectively referred to as "community partners."

Leadership Council. Agency representatives on the Leadership Council are formally designated or appointed by agency senior management. Coalition representatives are designated by a constituent body of the coalition. The Council has both voting and non-voting

[43] *Pinellas Safe Start Application for 2004-05 Funding, Section C: Policy Analysis,* p. 2.

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members. Voting members approve funding requests to OJJDP, are responsible for strategic planning, determine Council membership, determine the Council's organizational structure, and decide on letters of support when pursuing funding. These members reach their decisions by consensus. Voting members include: the Safe Children's Coalition, Help-A-Child, Pinellas County School system, Pinellas County Sheriff's Office, the JWB Combined Community Councils (see description in Section 3.3 of this report), the 6th Judicial Circuit Court, the Pinellas County Administration (i.e., local government), the Pinellas County Health Department, the Police Chief's Council for Standards and Training,[44] the Domestic Violence Task Force, and the School Readiness Coalition. Non-voting (*ex officio*) members include: the State Attorney's Office, the Florida Department of Children and Families, the Healthy Start Coalition, the Florida Department of Juvenile Justice, the University of South Florida, the Public Defender's Office, and the JWB.

Safe Start Partnership Center. The Safe Start Partnership Center is a smaller collaborative within the PCSS: "a collaborative integrated within a collaborative." The PCSS selected members of the SSPC through a request-for-proposal process; SSPC point-of-service providers have contractual obligations to the PCSS. The SSPC became fully operational in 2002, and, in 2004, operated as a central point of access to services and information related to children exposed to violence.

The SSPC is physically housed at Help-A-Child; SSPC staff is supported either partially or fully by Safe Start funds, but are physically located at each of five SSPC partner agencies. These five agencies are: CASA (Community Action Stops Abuse, domestic violence sector), the Haven (operated by Religious Community Services, a collaborative of 82 Pinellas churches and synagogues), Help-A-Child, the Pinellas County Health Department, and 211 Tampa Bay Cares. 211 is the countywide hotline for citizens who need to be connected to community resources. Families with children exposed to violence may call 211 for solutions to immediate needs, such as a place to stay for a night, food and clothing, or financial assistance. 211 also has the ability to provide 1) information and referrals on local health and human services and 2) crisis intervention and problem solving counseling for individuals.

As one of many community service providers for children six years and younger and their families, SSPC provides the following: 24-hour assistance, information, crisis intervention, assessment, referrals to community resources, consultation, and training. There are at least nine points of entry into the SSPC system. A client may be referred through the Pinellas County Health Department, the Batterer's Intervention Program, a domestic violence shelter or outreach center, Healthy Start, Pinellas 211, Child Development Community Policing, Coordinated Child Care, other Help-A-Child programs, Guardian ad Litem, or another mental health organization (such as Directions for Mental Health).

Community Partners. Community partners are organizations or individuals with missions similar to that of the PCSS, for example, key agencies in child protection,

[44] The Police Chief's Council for Standards and Training makes recommendations to the police academy in Pinellas County. The Council was inactive in 2004, but is considered a voting member of the Leadership Council.

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family services, the court system, and other related sectors. Community partners collaborate with the PCSS on events such as the Children's Summit (see Section 6.6 of this report for a description), but have no contractual obligations to the PCSS. These organizations, such as Directions for Mental Health, also may have relationships with the Leadership Council and the Safe Start Partnership Center, but again, these relationships are not contractual.

When asked to identify the critical members of the PCSS, site visit participants most consistently identified Help-A-Child and the Juvenile Welfare Board. Also mentioned as important were Coordinated Child Care, the courts, domestic violence partners, and law enforcement officers in the Sheriff's Department and the Child Development Community Policing (CDCP) program.

5.2 Collaborative Strengths

Site visit participants described PCSS partners as committed to the cause of child trauma, as evidenced by their participation within multiple collaboratives and coalitions focusing on related issues. Considerable overlap in board and committee membership across various existing groups led to ease of cooperation within the PCSS from its inception. PCSS partners (both formal and informal) are apt to call on each other for help and follow up on outstanding issues. Partners were collaborating with one another to meet the needs of abused and neglected children prior to the PCSS, and they have not wavered since.

In Pinellas County, as in many Safe Start sites, child protection advocates and domestic violence advocates have historically differed in some areas of philosophy, policy, and practice. In 2001, however, Pinellas County developed the Domestic Violence-Child Protection Interagency Agreement, a working agreement for communication on shared cases. Officials of both systems signed the agreement in 2002. Parties to the agreement are: CASA, the Department of Children and Families, Family Continuity Programs[45], the Haven, Help-A-Child (Child Protection Team), and the Child Protection Investigations Division (CPID) of the Pinellas County Sheriff's Office (PCSO). The PCSS Project Director and a representative from the Pinellas County Health Department's Violence Prevention Office facilitated the development and signing of the Interagency Agreement. Key domestic violence advocates (CASA, the Haven) and child protection advocates (the Sarasota Family YMCA, Help-A-Child) continued to collaborate on the ongoing development of the agreement in 2004.

5.3 Collaborative Challenges

Because PCSS efforts to engage neighborhood and faith-based organizations have been less systematic than efforts to engage the service provider community,[46] PCSS partners (both formal and informal) do not include many representatives of the general public. Several site visit participants also mentioned the Department of Juvenile Justice as conspicuously absent from the collaborative.

[45] The Sarasota Family YMCA has since replaced Family Continuity Programs as the lead agency for community-based care in Pinellas County.
[46] The PCSS has conducted outreach activities to engage the faith-based community throughout its existence. In 2004, these activities became more focused and systematic when a Community Involvement and Training Coordinator was hired to oversee a group of Community Facilitators.

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5.4 Role of the PCSS in Other Collaborative Groups

The PCSS Project Director and members of her staff are involved in several collaborative groups in Pinellas County that assist in networking and raising awareness of 1) children's exposure to violence and 2) Safe Start's role in assessing and referring children exposed to violence. Some of these relationships include the Domestic Violence Task Force, Infant and Child Mental Health Policy Group, and the Early Childhood Mental Health Committee (School Readiness Coalition Committee).

6. Systems Change Activities

Site visit participants consistently identified the following events and activities as PCSS's major accomplishments in 2004:

- Many individuals and agencies received training on issues related to children exposed to violence;
- The Safe Start Ambassador Program was launched, with the training of over 40 Ambassadors;
- The PCSS played an instrumental role in supporting the transition of lead agencies for the Pinellas County community-based care system, by convening planning meetings and working closely with the JWB and Family Continuity Programs;
- A Community Involvement and Training Coordinator was hired to more systematically focus efforts on raising awareness of children exposed to violence at the neighborhood level;
- The Batterer's Intervention Program was initiated in the Pinellas County jail; and
- A successful second annual Children's Summit was held.

6.1 Development of Policies, Procedures, and Protocols

Child protection: community-based care. As mentioned in Section 2 of this report, in 2004, the PCSS was actively involved in the transformation of Pinellas County's community-based care model. The JWB and the PCSS supported the Sarasota Family YMCA and Family Continuity Programs in organizing two community planning meetings, and contracted with independent consultants to facilitate the meetings and prepare an objective report. The meetings were called to solicit input from the community on priorities and design for the new community-based care system. The feedback from these meetings informed the writing of the guidelines and criteria for an "invitation to negotiate," released by the Sarasota Family YMCA in April 2004. On July 1, 2004, the Sarasota Family YMCA began to use this document to select sub-contractors for the community-based care system in Pinellas County.

Domestic Violence-Child Protection Interagency Agreement. In late 2003, the PCSS continued to support the planning and dissemination of the Domestic Violence-Child Protection Interagency Agreement. In September and October 2003, the PCSS facilitated a series of planning meetings, with key agencies from both the domestic violence and child protection systems represented. At these meetings, representatives accepted assignments to prepare for dissemination of the Interagency Agreement to supervisors and other lead staff in all agencies. A series of seminars to discuss the implementation of the agreement is expected to take place in 2005.[47]

[47] *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System,* p. 8.

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PCSS screening, assessment, referral, and tracking protocols. In 2004, the Safe Start Partnership Center updated their referral form and general procedures for 1) identifying and recording gaps in services, 2) sending and recording information on Client Satisfaction Surveys, and 3) contacting clients for follow-up services and completion of the Parent Stress Index post-test. Coordinated Child Care established a protocol for assessment and referral, changing their intake assessment tool to include a children exposed to violence screening item. If a client responds to this item in the affirmative, CCC makes a referral to Help-A-Child. The Child Development Community Policing (CDCP) program revised its criteria and procedures for "wellness check" referrals. Finally, eight PCSS partners added a child exposed to violence screening question to their intake screening protocols.

PCSS service pathway. The Safe Start Partnership Center Program Coordinator is currently revising the Safe Start service pathway description. During the site visit, both the local evaluator and the Program Coordinator categorized Safe Start services by level as follows. Level 1 services include providing information to those who call 211 Tampa Bay Cares. Level 1 also refers more generally to the identification phase, in which SSPC partner agencies track and identify children exposed to violence within all of the families they serve. Level 2 services include referrals to services not offered by the SSPC, or referrals to in-house assessment, to provide a broad family consultation designed to address an array of needs and issues, such as therapeutic needs, behavioral problems or developmental delays in children, and general support for parents. Level 3 services involve opening a case for a 12-week assessment process. Assessment tools used include a family psychosocial assessment, the Parent Stress Index, the Temperament and Atypical Behavior Scale, the Traumatic Stress Inventory (as needed), and Ages and Stages (as needed). The child is observed at home or in daycare; a parent-child play interaction is observed at the Help-A-Child center. For all cases in which the identified child has siblings, a family service plan is developed. Families may receive short-term therapeutic intervention, crisis counseling, or case management services, most of which are provided in the family's home. Level 4 services involve multi-agency/multi-disciplinary staffing to develop a plan for a family. For example, a child may be identified as at risk for witnessing or experiencing violence in the home, but his or her parents are doing nothing reportable, with the exception of making poor choices. In this case, all service providers working with the family may attend a staffing, to problem-solve and develop possible strategies to prevent an incident of abuse or neglect.

Adoption of PCSS Training Curricula. The PCSS signed sustainability agreements with two partners to use children exposed to violence materials in institutional training programs (St. Pete College - Maternal Child Services, Pinellas Park, and St. Pete College/Gibbs Campus - Child Development & Education).

6.2 Service Integration

Six main occurrences of service integration occurred in 2004:

1. A new SSPC Program Coordinator was hired in August 2004. Since her hiring, SSPC has held more multiagency staff meetings for cases of children exposed to violence;

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2. The Guardian Ad Litem (GAL) program[48] began to 1) train volunteers on children exposed to violence, 2) make referrals to the PCSS, and 3) rely on the SSPC to provide consultation on cases;

3. The Leadership Council distributed to local judges in the Unified Family Court a laminated information sheet and related monograph published by NCJFCJ: "Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System." The sheet contains a series of questions about children's physical, developmental, and mental health; their educational or child care setting; and their home placement. During a site visit, an NCJFCJ consultant provided multiple copies of the sheet for initial distribution to the Leadership Council. Both the Council and the SSPC have promoted use of these guidelines;

4. The Safe Start Gap Funding Pool was utilized to purchase both clinical and interpretive services, as well as to provide parent-child groups at domestic violence centers. Gap Funding is designated for short-term clinical or assessment services that will make a difference in the life of the child, but cannot be funded through any other source. Because the need for Gap Funds for these clinical purposes was overestimated, the purchasing pool was redirected to provide interpretive services and parent-child groups;

5. A unidirectional electronic bridge was created between two management information systems used by Safe Start service providers and collaborative members. Proposals and specifications for making the bridge bidirectional were under review at the end of 2004; and

6. During both the site visit and follow-up telephone calls, several participants mentioned a critical service integration activity that occurred at the end of 2003: creation of an evaluation partnership between the PCSS and Coordinated Child Care. This partnership is critical in that it creates the opportunity to screen thousands of children five years and younger for exposure to violence; because CCC oversees all licensed child care in Pinellas County, each year, the CCC screens between 7,000 and 10,000 children five years and younger to determine their qualification for regular and specialized child care.

6.3 Resource Development, Identification, and Allocation

According to the *Pinellas Safe Start Semi-Annual Progress Report – July 2004* (p. 10), recommendations for a Resource Development Plan were presented to and accepted by the Leadership Council at its quarterly meeting in February 2004. The Resource Development Committee met in April, May, June, and November of 2004, and agreed to continue to meet as needed to address funding opportunities.

Resource Development Committee members also started discussing their roles as lead agencies, collaborators, and supporters with regard to specific services that will require funding to replace Safe Start grant dollars when the National Safe Start Demonstration Project comes to an end. These services include staff training, preparation and distribution of parent information packets, and direct client services (case management, assessment, counseling, consultation, and multi-disciplinary teams).

[48] The Guardian Ad Litem program advocates for children involved in the family court system. It is a state- and county- funded agency that assesses the unmet needs of children and recommends resources.

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Members of the committee developed and submitted an application for the Safe and Bright Futures grant; however, the grant was not funded. A smaller group of committee members (CASA, PCHD, Directions for Mental Health, and community youth programs) applied for and received JWB funds (up to $260,000 annually to the Pinellas County Health Department for the Delta Pinellas Program) for a violence-prevention program for boys. To be established at multiple sites within the county, the program will incorporate violence prevention with cognitive behavioral therapy for youth whose disruptive behaviors may be associated with exposure to violence.

According to the *July-December 2004 Progress Report*, the JWB awarded $75,000 to Directions for Mental Health in October 2004 to hire a full time CDCP coordinator, with the goal of 1) expanding the CDCP program to other districts in Clearwater, and then, potentially, to other jurisdictions in Pinellas, and 2) finding other sources of funding to sustain the program. After the program objectives and award were finalized in December 2004, planning for a site visit from NCCEV began.

Also according to the *July-December 2004 Progress Report*, the JWB renewed the Batterer's Intervention Program contract for a full year, at a cost of $5,200 and reserved $120,000 for child abuse early intervention funding for the Sheriff Department's Emergency Response Team.

To summarize, through efforts of PCSS partners, the JWB allocated new and expanded funds for: (1) the CDCP Program Coordinator position, (2) the contract renewal for the Batterer's Intervention Program, and (3) the gender-specific violence prevention program for boys. The JWB also reserved $120,000 for child abuse early intervention funding to be used by the Pinellas County Sheriff Office's Emergency Response Team. According to the *July-December 2004 Progress Report*, the JWB's partnership with the PCSS contributed to these programming and funding decisions.

6.4 New, Expanded, and Enhanced Programming

The PCSS offered training at several levels, to increase awareness of children's exposure to violence and to teach appropriate methods for responding to these children. As a result, the network of qualified service providers was enhanced and expanded. The SSPC children's exposure to violence curriculum includes four different modules, to be used based on desired length of training and training participant needs. Levels of training range from a brief introductory session on children exposed to violence (about one hour) to an intensive three-hour workshop. Those who participate in three-hour trainings list their sector and agency type on their attendance sheet. Based on this information, in 2004, individuals representing the following groups received the three-hour training:

- Business/private sector;
- Child welfare/protective services;
- Volunteer;
- Police/law enforcement;
- Early childhood education;
- Mental health services;
- Existing community collaboratives;
- Government;
- Community members/parents;
- Justice system officials;
- Domestic violence agencies;
- Child care providers;
- Female inmates (Pinellas County Jail's Project Success);
- Healthy Families/healthy start; and

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• Community health.

Additional types of trainings conducted in 2004 included:

• Train-the-Trainer (SSPC curriculum); and
• "Ambassador" Trainings.

Site visit participants specifically emphasized the significance of the training of 24 new trainers, the training of the first 23 Ambassadors, and the Parent-Child Interaction Training that continued in 2004. Ambassadors are trained to personally deliver the Safe Start message to 1) develop partnerships with philanthropists and sponsors to promote media buys for the public education campaign and 2) develop partnerships with media outlets. The Parent-Child Interaction Training (PCIT) is the product of collaboration between the National Child Traumatic Stress Network and Healing the Hurt (led by Directions for Mental Health). The PCSS funded PCIT for 15 clinicians from different mental health agencies, competitively selected for the training by the Early Childhood Mental Health Committee (part of the School Readiness Coalition). Individual trainees agreed to provide pro bono services for at least one PCSS-referred family for a period of one year. Agencies whose staff received support agreed to 1) accept PCSS-referred children for services, 2) support implementation of the Parent-Child Interaction model, and 3) otherwise coordinate services across agencies.[49]

To better serve PCSS families, SSPC enhanced its assessment capacities in 2004. Because 1) funders began to require SSPC partner agencies to show pre/post results in clients under age three, and 2) the PCSS found other instruments to have low sensitivity for measuring behavior in this age group, SSPC partner agencies piloted the Temperament and Atypical Behavior Scales (TABS) as one of the baseline measures for all children entering services as of October 2004. In 2004, PCSS also updated procedures for contacting clients for follow-up services and for completion of the Parent Stress Index post-test.

All of the activities described above appear to have improved the ability of SSPC to serve families and children. According to the PCSS database, SSPC opened and closed 90 cases between September 1, 2002 and November 1, 2004. (Note: Information about a family is not entered into the database until after a case is closed, which occurs when the family completes treatment or leaves the program for other reasons.) A total of 61 families completed assessments and received referrals, resulting in the assessment and referral of 93 children six years and younger and 22 children seven years and older. Twenty-three families partially or fully completed the assessment process, but withdrew or moved before finishing and/or receiving referrals for services. An additional 24 cases were open in November 2004, and therefore had not been entered into the database.[50]

The Child Development Community Policing (CDCP) program evolved in 2004 to provide additional services, when the PCSS provided stipends for five Directions for Mental Health clinicians to provide services at the scene of a violent incident, by accompanying community police officers to incidents involving children. A CDCP "ripple effect" also has been observed, as core CDCP personnel have moved from their initial Clearwater district to other

[49] *Pinellas Safe Start Application for 2004-05 Funding, Section D: Training Needs & Resources,* p. 3.

[50] *November 22, 2004 E-mail communication from Kristi Bisbee at Help-A-Child, Inc.*

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police divisions, where they continue to create and implement programming for children. Recently, at least one other local law enforcement district expressed interest in receiving training and potentially replicating the CDCP program.[51]

Coordinated Child Care hired a PCSS-funded Safe Start Coordinator in 2003; the Coordinator began to have an impact in 2004, following up when the children exposed to violence screening item added to the CCC needs-assessment indicated exposure. The Coordinator also provided consultation to families and child care providers for individual children impacted by exposure to violence.

In January 2004, a Batterer's Intervention Program began in the Pinellas County Jail, with 39 classes led weekly by a PCSS-funded, certified provider. Developed in collaboration with the Domestic Violence Task Force, the program was designed to educate participants on 1) the impact of violence on children and 2) available community resources. Families identified through this program may be referred to local domestic violence centers or to the SSPC.

6.5 Community Action/Awareness Activities

Four main community awareness activities took place in 2004: 1) the Children's Summit, 2) the hiring of the Community Involvement and Training Coordinator, 3) the kickoff of the public awareness campaign, and 4) a presentation to public officials running for office in 2004.

Children's Summit. The second annual Children's Summit was held in September 2004 at a local church. With the goal of engaging participants in a discussion of issues related to protecting children from violence, the one-day event followed a theme of "domestic violence and how it affects young children." Over 200 attendees, including several guest speakers, represented a cross-section of the community: pastors, substance abuse treatment providers, law enforcement officers, teachers, social workers, school counselors, judges, and several community residents. Following the success of this and the previous conference, a third is planned for 2005.

Community coordinator hired. In 2004, the PCSS made a systematic effort to be "invited into" versus "inviting themselves to" five neighborhoods. For example, a Community Facilitator[52] might identify a community leader within one of the target neighborhoods. The Facilitator would ask the leader to confer with other community members, to identify their priorities for families and children. The PCSS would then 1) request to present information to community members, based on their concerns and priorities, and 2) offer tailored assistance. In previous years, the PCSS focused on community outreach activities such as outreach through community councils, staff presentations to community organizations, and meetings held at Neighborhood Family Centers. In April

[51] *Pinellas Safe Start Application for 2004-05 Funding, Section B: Service Delivery System,* p. 7.

[52] The PCSS has contracted with three Community Facilitators from five different neighborhoods. Facilitators assist with outreach, planning, and coordination. They provide an average of four to eight hours per month of contractual service, including planning and coordinating community forums and events to 1) bring people and groups together, 2) identify issues and concerns, and 3) build consensus about neighborhood solutions. This encourages neighborhood groups to "invite in" the PCSS. Recruitment of Community Facilitators started with the leadership of the Neighborhood Family Centers.

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2004, the PCSS hired a Community Involvement and Training Coordinator to build upon the more informal relationships established in previous years, as well as to increase documentation of outreach efforts and to establish more consistent procedures of outreach, such as using Community Facilitators and Ambassadors in selected areas.

Public awareness campaign. The PCSS kicked off its 2004 public awareness campaign in April. The campaign involved several types of media messages, with the primary slogan "Children Reflect What They See." This message was disseminated through posters, billboards, television, and radio plugs. In addition, the PCSS had a day at the ballgame, during which their campaign slogan was displayed on the scoreboard. The public awareness campaign also produced a compact disk with public service announcements and other information for community members to share. As part of this strategy, Safe Start Ambassadors are being recruited from the private sector to further disseminate information on children's exposure to violence and appropriate responses. As of December 2004, 40 Ambassadors had been trained. In another approach to increasing Safe Start visibility, the PCSS Program Director threw out the first pitch at a Tampa Bay Devil Rays game. In June, the Campaign Manager strengthened PCSS's developing relationship with Florida's Major League baseball team by arranging for the Devil Rays to sponsor a Safe Start event during their regular season.

Candidate Connection Campaign. The Pinellas County Safe Start was invited to participate in a Candidate Connection Campaign,[53] as part of an initiative that gives local politicians the opportunity to sit down with a coalition of community agency representatives and receive education on various issues of importance to the community. Site visit participants considered it important for candidates to learn about one of the community's most important issues, such as children exposed to violence, before the election.

7. Institutionalization of Change

The Resource Development Committee (a sustainability committee) met regularly in 2004, applying for, but not receiving, the Safe and Bright Futures grant. A smaller group did obtain funding for a violence-prevention program for boys. The PCSS began to look for other sources of funding, as well, to support SSPC activities and encourage the continued participation of collaborative partners after federal funding ends. The Resource Development Committee will revisit funding priorities again in March 2005.

Several PCSS activities are expected to help institutionalize the work of the Initiative beyond the federal funding period. For example:

- **Infusion of Safe Start's vision by other agencies and organizations.** Through a training survey administered in December 2003, four of nine agencies affirmed that training had helped change their existing procedures. Of these agencies, some had added questions to their intake instrument to screen for children exposed to violence,

[53] The Candidate Connection Campaign is a statewide initiative with leadership from a Tallahassee-based advocacy group (Voice for Children). Local coordinators for the initiative in 2004 were executive directors and staff of Coordinated Child Care and R'Club (another child care organization).

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and others had added instruments to better measure behavioral symptoms in young children, such as the TABS;

- **Mobilization of community residents to commit to sustaining Safe Start goals.** Safe Start Ambassadors are working to establish connections with the business community, to obtain local funding for sustainability. The new Community Involvement and Training Coordinator, who manages the Ambassador Program, may call on Ambassadors to make presentations to interested businesses, philanthropists, or others. Alternatively, Ambassadors may arrange presentations through their connections in the community. The Community Coordinator also has been responsible for identifying and training Community Facilitators from PCSS target neighborhoods—ideally, individuals from the community who can communicate the PCSS message at a more grassroots level. Three facilitators had been hired by the end of 2004;

- The Pinellas County Children's Summits have made information available to the public, promoting awareness of issues related to children's exposure to violence among the general public and helping to ensure that the Safe Start message will be carried into the future. Based on the successes of the past two Children's Summits, a third is planned for fall 2005; and

- **Professional and capacity development at the point of service.** Those who have received Safe Start-funded therapist training—a highly sought skill training—will continue to have the special skills needed to deal with children's exposure to violence, even in the potential absence of the PCSS. Interviewees agreed that training for both clinicians and laypersons was among the chief strengths of the PCSS.

8. Increased Community Supports

In 2004, the PCSS increased community supports for families with children exposed to violence or at risk of exposure to violence in several ways. First, the PCSS played instrumental roles in the transformation of Pinellas County's community-based care model and in the planning and dissemination of the Domestic Violence-Child Protection Interagency Agreement. The selection of a new lead agency for community-based care in Pinellas County is expected to strengthen child protective services in the county. The implementation of the Interagency Agreement between the domestic violence and child protection sectors is expected to improve communication on shared cases and ultimately result in services that equally protect the wellbeing of both domestic violence victims and their children.

Second, through the efforts of PCSS partners, the Juvenile Welfare Board as allocated new and expanded funds for programs (i.e., Child Development-Community Policing, Batterer's Intervention Program, a boy's violence prevention program, and child abuse early intervention training) that address children exposed to violence or at risk of exposure to violence. These programs enhance the capacity of the Pinellas County community to support families and their children. Lastly, the PCSS Ambassadors and Community Facilitators play a critical role in educating members of the community about children exposed to violence issues and mobilizing them to support PCSS activities. It is expected that as more community members become aware

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of how violence exposure can harm young children, the likelihood that the problem will be recognized and addressed for more children increases. Community-based awareness and support of the Safe Start vision is expected ultimately to shift community norms about exposing young children to violence which in turn may protect future children from exposure to violence and increase support for those children who are exposed.

9. Lessons Learned in the Implementation and Evaluation of Safe Start Activities

Interviewees identified several lessons learned through implementing Safe Start in Pinellas County. Specifically:

- According to the Safe Start Demonstration Project logic model, an Initiative is expected to produce change at the community, point-of-service, collaborative, court, and legislative levels simultaneously. Site visit participants described this scope of activity as too broad and unwieldy, requiring a relatively small number of people to expend their energy in too many directions at once. According to site visit participants, a more modest plan needs to be established from the beginning of an Initiative, perhaps with activities unfolding in sequence: services first, then community outreach, then change at the level of system policies;

- Endorsement from a reputable and influential community institution such as the JWB is essential from the outset. According to site visit participants, "when JWB talks, people listen." This made it easier to attract and maintain relationships with key partners in the community; and

- Initiatives should begin by building on existing partnerships. Pinellas County was fortunate to have a large and active community of service professionals interested in serving child trauma victims. Although the PCSS enhanced relationships among these professionals, it did not have to build such relationships from the ground up. This enabled the Initiative to spend its resources in other, needier places.

10. Barriers And Challenges

Site visit participants identified several barriers and challenges to fully implementing the PCSS. Specifically:

- Two of the four highly destructive hurricanes that struck Florida in 2004 affected Pinellas County, disrupting PCSS activities temporarily as well as compromising collaborative member funding due to diversion of money to pay for hurricane cleanup. Moreover, because they had larger issues to contend with, such as housing and food needs, clients were unable to continue with their PCSS services during this time. Pinellas County has since recovered from the storms, and services for children exposed to violence have been restored;

- Partner agencies did not always know who else might be working with their clients—although they could reliably assume that clients referred to family support groups, parent groups, and child groups might contact all five SSPC partner agencies at some point in the chain of services. Site visit participants acknowledged the need for interagency communication to reduce service overlap. Currently, interagency tracking and communication are difficult, with no system for determining whether a

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client is being served by another agency, has been treated before, or has finished treatment at another agency;

- Related to the above is the need for a single data management system. Currently, partner agencies use at least three databases: NET, SAMIS, and Tampa Bay Information Network. To collect data from all five SSPC partners, an entity or individual such as the local evaluator must consult with each partner individually, hindering program improvement efforts; integrating multiple data sources and multiple reporting requirements has been challenging, and has taken longer to accomplish than originally anticipated. Service Point software currently under development will offer user licenses, as well as training and technical assistance to those who wish to use it;

- The change in the state contract for child protective services disrupted service for several months in 2004. Disruptions occurred due to major changes in the design of the system (to the community-based care model), reassignment of staff, delays in recruiting and training foster care providers, etc.;

- Turnover occurred in several key positions within the five SSPC partner agencies, slowing progress toward developing referral agreements and a shared information system. These positions now have been filled with staff who bring a great deal of experience and enthusiasm to the project;

- Representation from partner agencies in the Leadership Council changed in 2004. Several new representatives were identified and have begun to participate;

- Implementing a shared information system has been a challenge, due to issues related to linking, confidentiality, and data security, as well as turnover in key positions within user agencies; and
- 211 Tampa Bay Cares, a key PCSS partner, experienced funding loss and significant turnover during the last six months of 2004, in part due to the restructuring of two former funders (United Way of Tampa Bay and Family Continuity Programs). In addition, the full time Safe Start specialist at 211 appeared to be under-utilized.

11. Conclusion and Recommendations

The PCSS accomplished many goals in 2004. Many individuals and agencies received training on issues related to children exposed to violence. The Batterer's Intervention Program was initiated in the Pinellas County jail. The PCSS played an instrumental role in supporting the transition of lead agencies for the Pinellas County community-based care system, by convening planning meetings and working closely with the JWB and Family Continuity Programs. The Safe Start Ambassador Program was launched, with the training of over 40 Ambassadors. A Community Involvement and Training Coordinator was hired to more systematically focus efforts on raising awareness of children exposed to violence at the neighborhood level. Another major accomplishment was the second annual Children's Summit.

Throughout 2004, Pinellas County Safe Start took a number of steps to enhance the Initiative. As the PCSS enters the final year of the Safe Start Demonstration Project, leaders and partners may wish to consider

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the following recommendations, based on participants' comments:

- Consider a part-time data specialist to consolidate critical data from the various agency databases, to help 1) facilitate presentation of critical data to prospective funders, and 2) reduce overlap in services. Alternatively, the JWB may consider providing its staff (e.g., Planning and Research, Contract Managers) with additional data management support, such that the JWB can assume the role of data management after PCSS funding expires;

- Clarify the essence of the PCSS message, to ensure that Pinellas County's extensive service delivery system and the general public recognize children's exposure to violence as a distinct issue that must be addressed in a comprehensive, sustained manner;

- Prioritize the public awareness campaign and find funding for the Community Engagement Project (Community Facilitators, the Community Coordinator, etc.), to sustain the PCSS message in the broader community; and

- Leverage JWB resources to sustain PCSS training and screening. For example, the JWB Training Program could absorb the PCSS trainings. Alternatively, JWB could mandate that all of its grantees 1) screen for children exposed to violence, 2) refer children exposed to violence and their families to appropriate services, and/or 3) provide appropriate evidence-based therapeutic services for children exposed to violence.

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ATTACHMENT A

Timeline of Pinellas Safe Start 2004 Major Activities and Milestones

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Safe Start Training, Major Conference & Advanced Training Support & Collaboration, Advanced Clinical Training	✓	✓	✓	✓	✓	✓						
Batterer Intervention Program Began in Pinellas County Jail	✓											
Convened (with Healthy Start Coalition) Community-Based Care Planning Meeting		✓										
Co-Sponsored Two Community-Based Care Planning Meetings with Juvenile Welfare Board, Family Continuity Programs, & Sarasota YMCA			✓									
Ambassador Program Started with Training for First 23 Ambassadors			✓									
Community Involvement and Training Coordinator Hired				✓								
Sarasota Family YMCA Becomes Lead Agency for Pinellas Community-Based Care							✓					
NCJFCJ Presented Failure to Protect Brief to Pinellas Domestic Violence Task Force							✓					
Second Annual Children's Summit									✓			
Collaborated with Domestic Violence Task Force to support their Annual Conference										✓		
Media Training for Communications Group Using Ambassador materials											✓	
Public Awareness Campaign Manager Presented to JWB Board and Board will Make Contacts for Sponsorship												✓

[a] For a full explanation and list of trainings, conferences, and advanced training, refer to the *Pinellas Safe Start Semi-Annual Progress Report- July 2004* (p. 2, 6, 7, and 8).

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VI

PUEBLO OF ZUNI SAFE START INITIATIVE

1. Introduction

To develop a full understanding of the Pueblo of Zuni Safe Start Initiative (Zuni SSI) from the time of its inception through December 2004, the National Evaluation Team (NET) visited the Pueblo of Zuni on October 18 and 19, 2004, and conducted follow-up telephone interviews with the local evaluator after the site visit and with other key individuals in January and February 2005. The NET also reviewed various documents, including the Zuni SSI implementation plan, technical assistance and training plan, and other brief reports. The NET met with 12 members of the community, tailoring discussions to each individual's specific role in the Zuni SSI. Among the individuals with whom the team met were representatives from partner agencies and point-of-service providers, Zuni SSI key staff, and community leaders.

Site visit participants were asked to share their experiences with the Zuni SSI from its inception to the time of the site visit. Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of the Zuni SSI since its inception?
- How did the composition and process of the collaborative influence the types of strategies implemented, and as a result, the system change outcomes?
- How has the Zuni SSI changed the service delivery system for children exposed to violence and their families?
- What organizational, point-of-service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of the Zuni SSI?
- How did the site handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?
- What are the lessons learned about the implementation and replication of a national initiative such as the Safe Start Demonstration Project?

This report covers the period from the start of the Zuni SSI in January 2002 through December 2004. Organized according to the Safe Start Demonstration Project logic model, it describes the economic, political, and social context of the Zuni SSI; the technical assistance the SSI received; the collaboration among different community organizations and agencies participating in the SSI; the system change activities (i.e., development of policies, procedures and protocols; service integration; new, enhanced, and expanded programming; community action and awareness; and resource development) developed by the

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SSI; the Initiative's institutionalization of changes; and the challenges faced and lessons learned by the participants. A timeline of major activities and milestones achieved by the Zuni SSI is included in Attachment A.

2. Contextual Conditions

The Pueblo of Zuni is located on the western edge of New Mexico, 150 miles west of Albuquerque. The largest of the 19 pueblos in New Mexico, both in land (700 square miles) and population (about 11,000 people), it also is considered the most traditional of all the New Mexican pueblos, with a unique language and history. The main industry is the production of arts, including inlay silver jewelry, stone fetishes, and pottery.

The Zuni governing structure centers around a Tribal Council, consisting of a Governor, a Lieutenant Governor, and six Council Members, each of whom is elected for a four-year term. The Council Member who receives the largest number of votes in each election serves as Head Council Member.

Site visit participants frequently drew parallels between conditions in the Third World and those in their community. For instance, at one point, the water supply pipes for the community reached a level of erosion that significantly affected the water pressure in the system; "the water smelled like rotten eggs," according to several participants. The eroded pipes were finally replaced in the last several years.

A single medical facility on the Pueblo houses 45 inpatient beds, a dental clinic, an optometry clinic, a medical lab, a clinic for women, an obstetrics ward, and an x-ray department. This facility does not have surgical capacities; for surgical procedures, patients travel to a hospital 32 miles away—25 minutes by ambulance. For recreational activity (e.g., movies) or major supplies (food, clothing), Zuni members drive to Gallup, about 38 miles away.

The Zuni people have struggled to maintain their ways of life despite early European immigrant settlers, the Mexican-American war, and other external forces that have threatened their culture and oppressed their community (see www.mnsu.edu/Emuseum/cultural/northamerica/zuni.html for more information). Site visit participants frequently referred to this struggle to retain their ethnic and cultural identity, while also attempting to integrate into the Western world. They expressed concern that their children would continue to lose their cultural identity and fall victim to substance abuse and domestic violence.

Many participants mentioned competition for federal grants among providers and agencies as a source of conflict within their community. Although such competition contradicts Zuni values—which demand a seamless system of care for families and children—participants described it as inevitable 1) because of the way in which federal funds are distributed and administered, and 2) because the Zuni people depend upon these funds to support the wellbeing of various groups within the community. Prior to the Zuni SSI, competition and conflict were particularly evident in children's services, in which different agencies and departments (e.g., child protective services, family preservation, juvenile justice) each played a role in assisting Zuni children. Instead of *sharing* the responsibility collaboratively, however, agencies and providers *split* family and child needs into segments, creating a small-scale turf war and hindering collaboration across agencies and systems.

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The Zuni people all are related to one another through a clan system. Site visit participants mentioned the following challenges of clan relationships: 1) the boundary between professional and personal relationships is blurred; 2) a person's reputation within and outside an organization is affected by his/her family status and credibility in the community; 3) supervisors hesitate to give feedback to employees for fear of offending the employees and their families; and 4) establishing and enforcing a system of accountability for agencies and providers is challenging. On the other hand, everyone knows everyone else, expediting access and referrals for different type of assistance.

Domestic violence was described as a taboo issue in the community, eliciting feelings of shame at the individual, family, and clan levels. For the community as a whole, according to site visit participants, the occurrence of domestic violence within the Pueblo represents a loss of Native traditions and the community's diminishing capacity to endow future generations with Native cultural assets seen as absent from Western culture.

An understanding of the above context allows for full appreciation of the significance of the Zuni SSI. Based on the comments of participants, the Zuni SSI provides an opportunity not only to stop the cycle of abuse, but also to promote Native traditions by reestablishing a holistic and accountable support system for families and children, while reducing inter-agency competition. As one participant stated, "We need to look back at where we came from to see where we are going."

3. Community Capacity

By increasing support for raising children, the clan system provides an important capacity for the Zuni community. Children are raised not only by their parents, but by many other family members (e.g., grandparents, aunts, and uncles), as well. The Zuni culture places a high value on children. Traditionally, Zuni adults pray for the health of their existing children, as well as for children who have not yet been born. The child-centered focus of the Zuni SSI, therefore, has provided an opportunity for the community to bond around a common concern, despite the difficulty in addressing issues related to domestic violence.

There is a shortage of mental health clinicians for all age groups (local evaluation report form, 2005). Further, no agency or service provider in the Pueblo of Zuni specializes in providing assistance to children six years and younger who have been exposed to violence. Other specialized services for young children, however, do exist. Zuni Entrepreneurial Enterprises, Inc. (ZEE), a nonprofit 501(c)3 organization in the Zuni community, assists very young children (three years and younger) at risk for or suffering developmental delays or premature birth as a result of birth defects or maternal substance abuse.

ZEE does not have a specific process or assessment protocol for identifying and assisting children exposed to violence. The agency receives most of its referrals from the Indian Health Services, the University of New Mexico Developmental Care Center, and the Women Infants and Children (WIC) Program. The Zuni SSI did not approach ZEE until recently because of issues related to funding, authority, and tribal structure. ZEE receives funding directly from the State Department of Health and Medicaid, as well

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as private sources. This funding is not funneled through the Tribal Council, leaving the Council with no authority over ZEE mandates, and marking ZEE as an outside entity independent of Tribal social and health structures.

Site visit participants frequently reported inadequate communication and collaboration across agencies in the Zuni community, resulting in duplication of services and programs. With the hiring of a new Director for the Zuni Department of Human Services in early 2004, however, increased collaboration and decreased duplication became a goal. The new Director placed programs such as the Zuni SSI and others with a similar focus under his direct supervision, with the aim of identifying areas for inter-program cooperation, to reduce duplication and promote service integration. Prior to this, the Zuni SSI was housed in the Division of Social Services within the Department of Human Services. According to several participants, the new Director's credibility with the Tribal Council benefited the Initiative by 1) elevating its importance in the eyes of the Council and the community, and 2) ensuring that newly elected (2003) Tribal Council Members would be informed and educated about the Initiative's goals and expectations.

In October 2004, the Pueblo of Zuni received funding from the Tribal Youth Grant (TYG) program, a project administered by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The purpose of the program is to support and enhance tribal efforts toward 1) comprehensive delinquency prevention and control and 2) improvement of the juvenile justice system in Native American communities. The Pueblo of Zuni will use the grant to address violence among youth between the ages of seven and 18, further increasing the community's capacity to address violence.

4. Integrated Assistance

The Zuni SSI has received technical assistance and training from various national providers. The NET visited the Pueblo of Zuni in 2003 to collect information for the cross-site process evaluation. The National Council of Juvenile and Family Court Judges (NCJFCJ) visited the Zuni community in May 2003 to assist in the development of the Zuni Tribal Court, which had been selected as a tribal court demonstration site and model. In November 2003, staff from the National Civic League (NCL) and the OJJDP visited the Zuni community to assess the SSI's progress.

In March 2004, Zuni SSI staff attended training on sustainability sponsored by the Institute of Community Peace. In September 2004, representatives from the SSI and Pueblo law enforcement agencies visited the National Center for Children Exposed to Violence (NCCEV) in New Haven, Connecticut, to learn more about the Child Development-Community Policing (CDCP) model. The Zuni SSI received additional technical assistance from NCCEV in December 2004: In December 2004, police officers were trained on how children and adults react to and deal with exposure to violence differently, and how to better assess violent situations to include the children and not just the disputants. In early 2005, NCCEV is expected to provide further assistance to help the SSI further develop their CDCP program. In November 2004, Systems Improvement Training and Technical Assistance Project (SITTAP) staff conducted training on the Indian Child

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Welfare Act and provided assistance to SSI staff on their intake process.

Participants with significant involvement in the Zuni SSI expressed concerns about the technical assistance they received early on in the Initiative. They reported that the national providers had not tailored their assistance with consideration and sensitivity for the Pueblo's cultural traditions and contextual conditions (e.g., political, economic, and social structures). In addition, on two separate occasions, technical assistance site visits were scheduled, but did not occur because of last minute scheduling conflicts and logistical challenges. For instance, on one occasion, the technical assistance provider did not have a driver's license and could not get to the Pueblo of Zuni from the airport in Albuquerque. The SSI did not report these concerns to the national providers or to OJJDP at the time.

Technical assistance improved in the latter part of 2004 as national providers began to demonstrate more sensitivity to the unique context and culture of the Zuni community. For instance, the training conducted by SITTAP in November linked the history of Native Americans to the Child Welfare Act, helping police officers understand that it is not always necessary to separate a child from his/her family and place him/her in foster care, which typically removes the child from the reservation. Instead, officers should make an effort to contact the extended family to preserve the child's clan and cultural identity.

Zuni SSI staff has requested training and technical assistance with the following in the immediate future: methods for documenting the progress of the Initiative and capturing the infusion of Zuni culture into the Initiative; adoption and adaptation of screening protocols, consent forms, and case management procedures from the Chatham County SSI; and planning for sustainability. Staff members requested adaptation of Chatham County SSI materials based on a perception that the physical and social attributes of Chatham County most closely resemble those of their Zuni community. Specifically, the Chatham County SSI serves primarily two racial groups in a rural area. The Zuni SSI also operates in a rural community, serving Zunis and, to a lesser extent, members from neighboring reservations.

In addition to the assistance provided through the National Safe Start Demonstration Project, one of the Zuni SSI point-of-service-providers received assistance from the Director of the Early Childhood Multi-cultural Education Program at the University of New Mexico. The Director assisted the point-of-service-provider with a presentation on the impact of exposure to violence on the brain development of a child.

5. Local Agency and Community Engagement and Collaboration

5.1 Local Agency and Community Engagement

The Education and Career Development Center is a one-stop shop for family and child services in the Pueblo of Zuni, providing needs assessment and subsequent identification of appropriate providers and services. As a result, the Development Center has access to many service providers who work with children, as well as to families who may have children exposed to violence. As the agency's liaison to the Zuni SSI, the Development Center's Child Specialist has played an important role in

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information dissemination. According to the Child Specialist, people often ask her about the SSI and request presentations on issues related to children exposed to violence.

The Family Preservation Program provides services for children and families (including foster families) at risk or in crisis. It assists in returning children to families from which they have been removed, as well as placing children in planned, permanent living arrangements. A Preservation Program representative, who also served on the SSI training and technical assistance subcommittee, reported that she mandates all of her court-ordered clients, including families and adolescents, to attend SSI presentations on the values and traditions of the Zuni community—values and traditions inconsistent with domestic violence and child abuse and neglect. According to the representative, her clients valued these presentations so much that they asked for more frequent presentations. Younger clients, in particular, asked for traditional parenting classes because they lacked knowledge of traditional ways of parenting in their culture, and were concerned about their limited capacity to transfer their values and traditions to their children. The Program's participation in the SSI also enabled the SSI to engage foster parents with whom children exposed to violence might later be placed.

The Zuni SSI benefited significantly from the involvement of one particular community leader, described by several participants as having credibility and respect in the community because of her great wealth of cultural knowledge. Her knowledge allowed the SSI to make the connection between the Initiative and Zuni cultural traditions and engage the community at-large in a more culturally appropriate manner. Her presentations and facilitated discussions on such issues as the role of Zuni women and men in their families and the community were designed to raise awareness about the SSI, and also to help parents—particularly mothers—develop culturally-appropriate ways to deal with their children's exposure to violence.

One Tribal Council Member also was actively involved in the Zuni SSI. Because the Tribal Council sits at the pinnacle of the Zuni government, support from the Council was critical for the SSI to create systems change. The Tribal Council committed to developing a system of accountability among all social service agencies and programs, and stayed informed about SSI activities through the Member's participation, as well as through regular reports from the Project Coordinator and the Director of Human Services. Some of the Tribal Council Members viewed the Zuni SSI as an opportunity to infuse their cultural traditions into current services and to lay the foundation for systems change through collaboration.

5.2 Systems and Agency Collaboration

The Zuni SSI has provided a first-time opportunity for agencies and providers across sectors and disciplines to come together and address a common issue, an unusual occurrence in the Zuni community due to competition for federal funds. The transformation from inter-agency turf war to inter-agency collaboration has occurred gradually over the course of the Zuni SSI, as Zuni providers have worked to make a fundamental change in their paradigm for provision of services. Previously in the Zuni community, other collaboratives, such as the Model Court Collaborative and the Drug Court Collaborative, brought together

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agencies within a particular system, but not across systems.

Social services personnel have worked with law enforcement officers through the CDCP model. Law enforcement, which falls under the direction of the Department of Public Safety, has always been concerned with serving the community; for example, officers routinely check on the elderly. Prior to the SSI, however, officers lacked awareness of the impact of domestic violence on children. Once educated, the Department's leadership and officers began to participate in the SSI collaborative. The Department's Director served on the Initiative's core management team, and public safety staff members participated in all five committees of the Zuni SSI, chairing four of those five committees.

The Department of Public Safety and its officers also enthusiastically endorsed the development and implementation of the CDCP model in the Zuni community, as a tangible opportunity to help families in a way that extended beyond the realm of traditional police activities. During their trip to New Haven in September 2004, officers and SSI staff learned about one another as individuals who share a common concern for their community. At the time of the NET's site visit, the Safety Department's leaders had committed to implementing the CDCP model—a commitment reinforced by the inclusion of a CDCP line item in their performance budgeting process. The Zuni SSI received technical assistance from NCCEV in December 2004 to further develop the CDCP program.

According to several law enforcement officers, their collaboration with SSI staff has allowed for the sharing of information about family histories and situations, making it possible for law enforcement to provide the most appropriate services to victims of domestic violence, including both the mother and the child. One police officer described how information-sharing enabled him, in one instance, to contact an extended family member rather than removing children from their home and placing them in foster care with European-American parents. According to several site visit participants, such placement is potentially harmful, threatening the child's Zuni identity, a fear common within the Zuni community.

Law enforcement officers have further demonstrated their commitment to the SSI by taking the initiative to develop presentations to the community regarding domestic violence. Initially, the SSI Project Coordinator approached the Police Captain for assistance in encouraging officer involvement. At the time of the site visit, however, officers had started to take the initiative, seeking out the Project Coordinator for consultation and to share their ideas.

Other active members and key agencies engaged with the Zuni SSI include the Zuni Comprehensive Health Center (part of Indian Health Services), the Education and Career Development Center, and the Family Preservation Program. With a multidisciplinary domestic violence team consisting of providers and clinicians from different health sectors, the Comprehensive Health Center was a natural partner for the SSI. As a result of its participation in the SSI, the Health Center has developed awareness of 1) issues related to childhood exposure to violence and 2) the need to develop protocols specifically for exposed children six years and younger. The Zuni SSI Project Coordinator joined the Health Center's domestic violence team to ensure that issues related to children exposed to

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violence would always be included in the team's goals and responsibilities.

In fall 2004, the TYG project requested the assistance of Zuni SSI staff in developing a strategic plan. Collaboration between the two initiatives seemed natural because 1) they share similar goals (i.e., to reduce violence in their community) and provide a natural connection for strengthening the community's support system for children and youth, 2) Zuni SSI staff have experience with developing strategic and implementation plans for OJJDP, and 3) agencies and decision-makers involved in the Zuni SSI overlap with those of the TYG project (i.e., Directors of the Departments of Public Safety and Human Services, Director of the Division of Social Services, the Tribal Administrator, and the Police Captain).

5.3 Benefits and Challenges of SSI Collaborative

Zuni leaders have been cognizant of ZEE, but have not reached out to the organization to fully support its activities and services. Although a ZEE representative has been involved in the SSI since 2002, SSI staff did not formally contact the agency's director until September 2004, to initiate the process of entering into a memorandum of agreement. At that point, the SSI Project Coordinator recognized ZEE as the community agency with the greatest capacity to identify, assess, and treat children exposed to violence, due to ZEE's staff of service providers professionally trained and certified to assist children with developmental delays.

The Zuni SSI and ZEE developed and finalized their memorandum of agreement in late 2004. According to representatives from both the SSI and ZEE, a relationship with the Zuni SSI will allow ZEE to strengthen its relationship with the Tribal Council and its linkage to tribal programs, as well as expanding its services to include children exposed to violence. For the Zuni SSI, a relationship with ZEE provides an opportunity to create linkages to both resources at the state level and skilled therapists specializing in children or child-focused intervention (e.g., the New Mexico Family Toddler Program, in which one ZEE staff member participates). In October 2004, ZEE staff attended a training sponsored by the Zuni SSI, to learn how to identify abused and neglected children and children exposed to violence. According to the memorandum of agreement, ZEE will treat children three years and younger who have been exposed to violence; if the child is not eligible for Medicaid or is between the ages of three and six years, the Zuni SSI will pay for services.

In late 2004, a ZEE staff member conducted a workshop on the impact of exposure to violence on the brain development of a child. A member of a high school Parent Teacher Association who attended the workshop was affected by the information and recommended that ZEE and Zuni SSI staff present to a class with many teenage mothers. The presentation is scheduled for February 2005.

Site visit participants reported inadequate participation in the SSI collaborative from the following sectors: domestic violence, spiritual leaders, women's groups, teachers and other school representatives, and substance abuse prevention and treatment providers. From the inception of the Zuni SSI, the Project Coordinator has attempted to engage New Beginnings, the primary advocate for battered women in the Pueblo of Zuni, operating the sole shelter on the reservation. A New Beginnings staff member developed an informal relationship with SSI staff; however, development of a

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more formal institutional relationship at the leadership level has proven challenging, limiting the ability of the SSI to identify and engage children exposed to violence through the women who seek shelter with New Beginnings. Some participants suggested territorial issues as a barrier to collaboration between SSI and New Beginnings, further explaining that the energy supplied to overcome this challenge waned over time, given other programming priorities. A change in New Beginnings leadership at the end of 2004 has provided an opportunity to renew the effort to develop an institutional relationship, especially given that the agency also has recently been placed under the supervision of the Director of Public Safety (the director is also a member of the Zuni SSI management team). The SSI-New Beginnings relationship is expected to improve in 2005, starting with a formal presentation by SSI staff to New Beginnings staff in January, according to several participants.

6. System Change Activities

6.1 Community Assessment

The community assessment required by the Safe Start Demonstration Project provided a catalyst for agencies to examine the existing support system for children and families. Four subcommittees were established (data collection, training/technical assistance, policies/procedures, and education/awareness/media) to review the mission, policies, and procedures of all social service, law enforcement, and health-related agencies and identify gaps and overlaps in referral and services (Local Evaluator Reporting Form).

The assessment, conducted in 2002, included discussion groups with service providers, community leaders, and family members; review of hospital cases involving children; review of 911 calls for co-occurring presence of children and violence; and examination of national reports (e.g., KidsCount) to guide planning. Key findings from the assessment included:

- A total of 57 children witnessed domestic violence in 2001, according to Child Protective Services' records;
- The women's shelter on the Pueblo sheltered 26 children six years old and younger in 2001; and
- The police reported 184 domestic violence incidents from June through December 2002.

More detailed information about the assessment's findings can be found in the local evaluator's report for 2004.

6.2 Development of Policies, Procedures, and Protocols

The Pueblo of Zuni is one of five tribes in the State of New Mexico to revise their Children's Code, with technical assistance from the American Indian Development Associates. Written more than 30 years ago, the Code serves as the reservation's policy on child wellbeing, but did not originally contain any information on children exposed to violence. The revision process was planned as part of the development of a model tribal court for the Zuni community; however, the courts could not engage the agency and community leaders essential to make the revisions. When the proposed revisions came to the attention of the Zuni SSI Project Coordinator in 2002, she met with one of the judges to discuss how the SSI could assist with the process. They agreed to use the Zuni SSI as the vehicle to mobilize and coordinate the revision process.

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The Zuni SSI cooperated with a consultant on another grant initiative to gather and review policies related to children and domestic violence. After being revised, the Children's Code now has clearer definitions of child abuse and neglect, including exposure to violence. The Domestic Violence Code also was revised. Both Codes now explicitly state that services must be culturally competent and responsive to Zuni traditions. The Codes were scheduled for 1) review by the Governor and Tribal Council's legal counsel in January 2005, then 2) distribution to the community for input, as mandated by the Zuni tribal constitution.

The Zuni SSI Project Director reported that one of the criteria for referral is history of loss in the child's family as a result of a violent incident; according to SSI staff, this is an important criterion for referral, but one often overlooked. In 2004, the SSI hired a Family Services Coordinator with extensive experience in the grieving processes for children, adding this insight and experience to the Initiative.

6.3 Service Integration

The TYG Program Coordinator contacted the Zuni SSI Project Coordinator in fall 2004 to develop a link between the initiatives. Many of the agency and community leaders involved in the site visit reported that this type of collaboration and service integration should occur more frequently in their community.

Establishment of the CDCP team brought law enforcement and human service personnel together to respond to family crises. Directors of both sectors have worked to ensure integration of their staff and the services they provide.

In December 2004, the Pueblo of Zuni's Victims of Crime Advocacy (VCA) program was placed under the supervision of the Director of the Department of Public Safety. This program has not historically considered children who witness violence or criminal acts. Because of the Director's involvement with the SSI and his increased awareness of the impact of violence on children, however, he directed VCA staff to meet with SSI staff to consider ways for the two efforts to collaborate—another emerging example of service integration on the Pueblo.

6.4 New, Enhanced, and Expanded Programming

As a result of the SSI, a system to support children exposed to violence and their families has started to emerge on the Pueblo of Zuni. The system relies on the following sources for identifying and referring children exposed to violence: police officers (through CDCP), ZEE, community members who have attended SSI presentations, the Education and Career Development Center, and the Family Preservation Program. At the end of 2004, the Zuni SSI was relying primarily on the CDCP team to identify children exposed to violence. In October 2004, the Zuni SSI hired a Family Services Coordinator to work with the CDCP team and other agencies to follow up on referrals.

The Zuni SSI worked with the Department of Public Safety to develop procedures for CDCP response to calls and referrals to the SSI. At the time of writing this report, SSI staff were working with the Department of Public Safety to develop a train-the-trainer curriculum, for trainers who will teach police officers when and how to make referrals to CDCP. According to SSI staff, one particular police officer was doing an excellent job of paying attention to the presence of children in a violent situation;

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this officer was identified as a train-the-trainer candidate.

Also in late 2004, the Zuni SSI hired a clinician to assess and treat children exposed to violence. A retired police officer and a psychologist for the Pueblo school district for many years the clinician had the respect of the Tribal Council. His experience and background gave him credibility with both the Council and with police officers. He was scheduled to begin his work with the SSI in January 2005. He is expected to help the Zuni SSI develop and implement the Parent Child Interaction Therapy (PCIT) approach. He will attend a training, organized by the National Civic League (NCL), to learn from an expert at the University of Oklahoma who has adapted PCIT for Native American communities.

The Zuni SSI developed a memorandum of agreement with ZEE to assess and treat children exposed to violence three years and younger; children older than three years will be referred to the initiative's new clinician. To deepen the collaboration between the Zuni SSI and ZEE, staff from both organizations planned to attend a 2005 training on acting against violence. SSI and ZEE staff also planned to attend a January 2005 conference on the application of a tool, Ages to Stages Assessment, for assessing young children exposed to violence.

6.5 Community Action and Awareness

From the beginning, the Zuni SSI made a deliberate decision to emphasize community awareness activities. Several participants expressed the belief that the community (including service providers) had to be made aware of the Initiative; otherwise, community members would not be likely to participate in the SSI and its services.

The community awareness activities conducted by the Zuni SSI in 2003 and 2004 included:

- Training for childcare providers regarding child abuse and neglect, including issues related to children's exposure to violence. Participants received continuing education units for their participation;
- Workshops for specific professionals to increase their awareness of issues related to children exposed to violence and the resources available to assist in responding to these children; and
- Presentations for parents and children about Zuni traditions and values (e.g., the role of Zuni men and women in the community). During these presentations, facilitators raised issues of domestic violence and children exposed to violence for group discussion.

According to several participants, a wide variety of groups have attended these presentations, including Temporary Assistance for Needy Families (TANF) recipients and foster care parents. Presentations were publicized through the radio and flyers. All site visit participants agreed that community members were becoming increasingly aware of the Safe Start Initiative.

6.6 Development, Identification, and Reallocation of Resources

The Department of Public Safety has allocated some of its resources to support CDCP. This program was included as a line item in the Department's performance budgeting process in 2004.

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7. Institutionalization of Change

The Zuni SSI assisted in institutionalizing change through revisions to the Children's Code and the Domestic Violence Code. In addition, the November 2004 memorandum of agreement with ZEE and the hiring of a clinician will help to ensure permanent point-of-service providers for children six years and younger who have been exposed to violence. The SSI's plans for the clinician to develop a culturally appropriate PCIT also will strengthen the support system for exposed children.

As mentioned before, all department and division directors on the Pueblo were preparing their plans and performance-based budgets for 2005. As an early indicator of potential systems change, the Director of the Department of Public Safety asked the Police Captain to add CDCP as a line item in the Police Department's performance-based budget. In addition, police officers are now expected to work with the CDCP team as part of their official job description.

8. Lessons Learned in the Implementation and Evaluation of Safe Start Activities

Site visit participants identified the following lessons learned:

- The Zuni SSI's early emphasis on community awareness activities enabled the Initiative to become a familiar name and concept, positioning the SSI to obtain community support for and participation in services for children exposed to violence.

- Periods of spiritual and cultural activity affect the ability to engage the community. The month of December, for example, is a busy one for the Zuni people due to the preponderance of spiritual activities, leaving little time to attend community awareness activities. On the other hand, the gathering of large numbers of people for spiritual and cultural activities creates opportunities for raising community awareness through the dissemination of information to a wide audience.

- From the beginning, it was important to have an SSI leader with credibility among Tribal Council and spiritual leaders. The support of the community's spiritual leaders and the Tribal Council was critical to ensure the cooperation of leaders across systems and the participation of the community.

- To lay the foundation for CDCP, social service staff and police officers had to get to know one another as individuals, and not simply as representatives of a sector or agency. Their trip to NCCEV in New Haven gave them this opportunity.

- In a small community, personal relationships can be both an advantage and a disadvantage. Because of personal relationships throughout the Zuni community, any one person can easily identify appropriate contacts across systems. On the other hand, clan relationships blur the boundary between the professional and personal. A close-knit community such as the Pueblo of Zuni can expedite or delay collaboration.

- To establish and strengthen a collaborative among the Zuni took time, persistence, and perseverance. The leadership of the Zuni community had to learn to model collaborative behavior to convince others

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to collaborate; only then was change possible.

9. Barriers and Challenges

The Zuni SSI has encountered several challenges since its inception, which can be summarized by the following:

- The Zuni SSI was unable to hire a Family Services Coordinator until October 2004. Before that time, the Project Coordinator was responsible for outreach and facilitating the collaborative, as well as for coordinating the responses of agencies across systems. The new Family Services Coordinator will focus on coordinating the responses across systems, particularly the coordination of the CDCP team.

- Police officers have struggled to learn and understand their role in identifying children exposed to violence, including when they should contact the Family Services Coordinator. Police officers remain somewhat hesitant; continuous and frequent reinforcement from community leadership will be required to make CDCP a natural process among police officers.

- Some participants reported that SSI staff did not initially receive adequate support (e.g., feedback on ideas and reports) from the leadership of the Division of Social Services, in which the program is housed. When the new Director of the Department of Human Services was hired at the beginning of 2004 and placed the Zuni SSI under his immediate supervision, however, the staff and the Initiative began to receive the attention and support needed to progress quickly.

- People in the Zuni community have many roles and, therefore, stay very busy. With many competing demands on their time and attention, collaborative members did not readily develop a sense of ownership for the Zuni SSI, according to several participants. Members depended heavily on SSI staff for leadership, whereas staff members saw themselves as workers responsible for carrying out SSI goals, and considered collaborative members responsible for providing the leadership to develop those goals. Although this challenge remained at the time of the NET's site visit, it had decreased somewhat compared to earlier times.

- The SSI struggled to instill traditional values in the community's daily interactions, services, and programs due to 1) the influence of Western culture and the tensions between Western and Zuni cultures, and 2) federal programs that often lacked sensitivity to the experiences and context of the Zuni community. Some participants mentioned that the community as a whole struggled to strike a balance between the best values and traditions of two worlds (Native and Western) in efforts to overcome their social ailments, such as domestic violence and substance abuse prevention. The SSI addressed this challenge by inviting credible individuals with extensive knowledge of the Zuni culture to conduct presentations about Zuni family values. Such presentations helped to connect the community's traditional values with the Initiative's mission and goals. Another potential strategy for bridging the gap between Native and Western cultures is to develop a "best practices (values)"model, embracing best practices from both the Zuni and non-Native worlds. Zuni culture and traditions espouse many respectful childrearing, parenting, and clan roles and practices. Zuni forefathers advised the tribe to pick and choose wisely, but never

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to forget who they are and where they have come from. Zuni cultural traditions and practices should, therefore, always be the foundation upon which Zuni people build their ways of life, according to several participants.

- The Pueblo of Zuni is a small community in which every interaction is personal. The line between personal and professional is often blurred, making it difficult to overcome the personal differences that may interfere with business.

- Finally, domestic violence is a taboo subject and difficult to address. Individual and community pain surfaced with discussion of such violence, requiring the Zuni SSI to take the time to introduce the subject with care and sensitivity before designing and offering services. Several participants mentioned that domestic violence had affected them personally, and the Zuni SSI had made it more comfortable to discuss.

10. Recommendations and Conclusions

The Zuni SSI has made progress in bringing together representatives from different systems to discuss and implement a more integrated response to children exposed to violence. The staff spent the first two years of the Initiative engaging partners, building trust, and developing a strategic and implementation plan. In the third year, SSI staff began to focus on 1) efforts to publicize the Initiative's mission and goals to the community and 2) strategies to develop the service pathway for children exposed to violence, including the CDCP. By the end of 2004, with the hiring of a Safe Start clinician and a memorandum of agreement with ZEE, the time had come for the Zuni SSI to accelerate its progress toward creating a system for referring, assessing, and treating children exposed to violence, according to several site visit participants. Comments from all participants suggested a perception of the Initiative not simply as another federal grant program, but rather, as a significant opportunity for the community to pass on cultural assets and traditions to the next generation by confronting social ailments such as domestic violence. For the Zuni, children represent the future, hence the survival of their cultural identity and traditions.

The NET suggests that the Zuni SSI consider the following:

- Continue to strengthen relationships with law enforcement officers and reinforce their role in identifying and referring children exposed to violence through frequent training by the CDCP team;

- Develop a strategic communication plan to reach out to sectors and the larger community that have not yet been fully engaged. Consider a campaign that uses print materials, radio, and cultural events to promote awareness about the impact of violence on children; "branding" the Zuni SSI to gain name recognition; distributing information through the schools by sponsoring drawing competitions; etc.;

- Develop a parent engagement team to promote the SSI through a parent-to-parent peer approach. The NET recommends that the Zuni SSI contact the director of San Francisco's SafeStart to learn more about parent-to-parent mentoring; and

- Hold presentations in naturally occurring settings or where parents/guardians can be accessed in large numbers, such as at events within the school system to expand its outreach.

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ATTACHMENT A

MAJOR ACCOMPLISHMENTS AND MILESTONES IN THE PUEBLO OF ZUNI SSI, JANUARY 2002 – DECEMBER 2004

Major Milestone	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04
Project Coordinator hired	✓					
Strategic and implementation plans submitted to OJJDP			✓			
Retreat for Collaborative			✓			
Technical assistance site visit by NCCJ			✓			
Technical assistance site visit by NCCEV on CDCP				✓		✓
Training by SITTAP						✓
Trainings, workshops, and community presentations				✓	✓	
Visit to NCCEV in New Haven						✓
Participation in Sustainability Training by the Institute for Community Peace					✓	
Collaboration initiated with the TYG project and VCA						✓
Family Services Coordinator hired						✓
Clinician (Dr. James Sweeney) hired						✓
Memorandum of agreement with ZEE finalized and engagement of New Beginnings started						✓

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VII

ROCHESTER SAFE START INITIATIVE

1. Introduction

To develop a full understanding of the Rochester Safe Start Initiative (RSS) from January 2004 through December 2004, the National Evaluation Team (NET) visited the Rochester site on September 29 and 30, 2004, and conducted follow-up telephone interviews with key individuals in October and November 2004 and again in February 2005 to gather information about the site's progress between the time of the site visit and the end of 2004. The NET also reviewed existing documents about the RSS, including strategic, implementation, and progress reports, and monthly highlights for 2004. The NET interviewed 15 individuals that represented partner and point-of-service agencies, RSS key staff, and a local philanthropic organization.

The participants were asked between three and eight general questions, depending on their role with the Rochester Safe Start Initiative. Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of the RSS in the past year?
- How did the composition and process of the collaborative influence the types of strategies implemented, and as a result, the system change outcomes?
- How has the RSS changed the service delivery system for children exposed to violence and their families?
- What organizational, point of service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of the RSS?
- How did the site handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?
- What are the lessons learned about the implementation and replication of a national initiative such as the National Safe Start Demonstration Project?

This report covers the period from January 2004 through December 2004. Organized according to the Safe Start Demonstration Project logic model, it describes the economic, political, and social context of the Rochester Safe Start Initiative; the technical assistance the RSS received; the collaboration among different community organizations and agencies participating in the RSS; the system change activities (i.e., development of policies, procedures and protocols; service integration; new, enhanced, and expanded programming; community action and awareness; and resource development) developed by the RSS; the Initiative's institutionalization of changes; and the challenges faced and lessons learned by the participants. A

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timeline of major activities and milestones is included in Attachment A.

2. Contextual Conditions

2.1 Local Contextual Conditions: Background

The City of Rochester, with a population of 219,773,[54] is the seat of Monroe County and is located near the Genesee River and Lake Ontario in upstate New York. Before the rise of Silicon Valley, Rochester was considered a high-tech city, depending primarily on Kodak and Xerox to employ its residents. In recent years, however, both Kodak and Xerox have downsized, leaving many residents unemployed.[55]

The people of Rochester are ethnically diverse, with more than 50% identifying themselves as people of color: 40.1% African-American, 12.8% Latino, and a small percentage of Asian/Pacific Islander and Native American descent. The remaining 44.3% of residents are European American. Considered a point of entry for refugees, Monroe County was home to more than 1,100 refugees as of November 2003. According to a 2004 Monroe County report[56], refugees served by Monroe County's Catholic Family Center come from the Middle East, Bosnia/Kosovo, Latvia, Cuba, the former Soviet Union, and Africa.

The majority of violence in Monroe County occurs in Rochester. According to a 2004 Monroe County report,[57] Rochester, representing 30% of Monroe County's population, accounted for 71% of all incidents of domestic violence reported in Monroe County in 2003. Murders in Rochester occur at a rate of 50 to 60 per year. In recent years, the Rochester Police Department has responded to over 20,000 calls per year classified as "domestic/family problem," with 26,666 of these calls in 2003 alone. According to a 1999 study, children witnessed 20% of all incidents of domestic violence later tried in the Rochester City Court (Local Evaluation Report Form, 2005).

Among the 245 largest cities in the country, the Children's Defense Fund found Rochester to have the 11th highest poverty rate. Of all Monroe County cases of child abuse or neglect reported to Child Protective Services in 1999, 60% came from Rochester. Neglect was reported more commonly than violence (Local Evaluation Report Form, 2005).

New York has faced budget cuts at both the state and local level since the nation's economic downturn and the events of September 11, 2001. According to both site visit participants and RSS documents, the state budget will fall short by an estimated $5 to $10 billion in 2005, while the county budget will fall short by an estimated $20 to $50 million; official budget shortfall estimates and implications had yet to be released at the end of 2004. Counties in New York State are expected to fund 50% of residents' Medicaid bills.

Monroe County's previous and current local administrations have not supported tax increases to offset budget shortfalls.

[54] US Census, 2000

[55] http://www.epodunk.com/cgi-bin/genInfo.php?IocIndex=1538

[56] *Monroe County Profile for Human Services Planning for the 2004–2007 Integrated County Planning Process.*

[57] *Monroe County Profile for Human Services Planning for the 2004–2007 Integrated County Planning Process.*

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Although property values have increased, the amount of taxes collected has remained the same for a decade. In 2004 the tax rate (the amount of taxes collected divided by the property value) was held constant which meant more taxes were actually collected. The increased taxes were not enough to offset rising expenditures, however. Only the sales tax has increased, and only by one quarter of one percent. According to participants, county residents, in general, do not support tax increases.

2.2 Local Contextual Conditions: Specific to 2004

In 2004, Monroe County experienced changes in leadership and infrastructure. In January 2004, a new County Executive took office; in July 2004, a new Director was appointed to head the County Department of Human and Health Services (DHHS). Both new leaders publicly stated their intention to maintain services to the community without raising taxes. As noted above, however, in 2004 taxes (but not the tax rate) were increased, partly due to advocacy for children's services.

The Rochester Police Department was restructured in June 2004. The Police Department's seven precincts were reduced to two: the east and west side. The seven-precinct structure had linked to the city's six Neighborhood Empowerment Teams, established to help reduce neighborhood nuisances and solve neighborhood problems through the collaboration of residents and city staff. According to RSS staff, the restructuring of the Police Department prompted a departmental focus on successfully transitioning officers from the old system to the new one.

3. Community Capacity

According to RSS documents, state and local governments in New York have, historically, failed to prioritize mental health services for young children. As a result, Monroe County has few therapists with expertise in the area of children's exposure to violence, and mental health treatment for children six years and younger is not readily reimbursed. Rochester Safe Start funded an analysis of Monroe County's 2004 budget; this analysis prompted the inclusion of identifying child abuse as a priority issues on the Children's Agenda.

The Children's Institute, parent agency of RSS, has operated in Rochester since 1957. The Institute 1) provides over 20 programs and services to promote the social and emotional well being of children and their families, 2) conducts research, evaluation, and development on prevention and early intervention programs, 3) provides training, and 4) produces educational materials. Institute personnel include psychologists, a pediatrician, social workers, and experts in public policy, along with a number of other staff members with expertise in business and administration. In addition to sponsoring the Safe Start Initiative, the Children's Institute manages the Rochester Early Enhancement Project (REEP), an initiative made up of more than twelve organizations that focus their efforts on children five years and younger. According to RSS staff, the Institute's association with REEP, along with their leadership in the Rochester Early Childhood Assessment Partnership (RECAP), prompted the organization to apply for a Safe Start grant.

Over time, Monroe County has implemented a number of programs to counteract the impact of domestic and community violence. The Rochester Police Department houses a Family Crisis Intervention Team

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(FACIT) to assist police in their response to conflict, including family violence. The Team consists of civilian social workers who refer families in crisis to community services. Although neither FACIT nor police officers have historically focused on or recorded the presence of young children at the scene of a crime, RSS has provided FACIT members with training around issues of children exposed to violence, and now depends on FACIT, along with police officers, for referrals to its police mental health intervention.

In 2004, RSS began working more closely with the courts. One of 23 RSS Collaborative Council members, the Monroe County Family Court handles both child welfare cases and cases of domestic violence in which the parties involved are married, have a child in common, or are blood relatives. The Integrated Domestic Violence Court handles misdemeanors and felonies related to pending Family Court matters of domestic violence. The Domestic Violence Intensive Intervention (DVII) Court, a specialized family court, deals with orders of protection. In response to a general lack of sensitivity toward the victims of domestic and sexual violence, and in hopes of encouraging women to prosecute their abusers, the DVII Court created a separate waiting room in the court building to provide women with safe space, childcare, and support during court appearances. The Family Court also houses initiatives such as Babies Can't Wait, a project designed to educate judges, lawyers, and other court-related personnel about normal child development and responses to abused, neglected and violence-exposed children.

Other RSS partners within Monroe County include the Society for the Protection and Care of Children (SPCC) and Alternatives for Battered Women (ABW). SPCC was founded in 1875 to improve the quality of life for children and families through home visits, counseling, and training in parenting skills for adult and teenage parents. SPCC also provides supervised visitation between parents and their children when a court order is in place. SPCC focuses on creating nurturing and supportive families, preventing and reducing the impact of family violence, teaching about nutrition, and encouraging education. As a lead partner of the RSS, SPCC is responsible for implementing SAFE Kids, the RSS adaptation of the Child Development-Community Policing (CDCP) model. Prior to RSS, SPCC provided services for children at risk of entering foster care and children in families where intimate partner violence was occurring.

Alternatives for Battered Women (ABW) is a nonprofit organization that provides services to victims of domestic violence. ABW operates a 24-hour hotline and emergency domestic violence shelter; provides counseling, education, information, and access to support groups; and assists families with housing needs and legal information. ABW also offers trainings and presentations on domestic violence for community groups, professionals, and educational institutions in the greater Monroe County area. The agency provides RSS with domestic violence expertise and conducts domestic violence sessions at RSS trainings. ABW is a founding member of the Rochester/Monroe County Domestic Violence Consortium (DVC).

RSS staff also have participated in the DVC (Domestic Violence Consortium), a group dedicated to advocacy and public education about domestic violence. Originally an advisory council of nine agencies, the DVC acquired additional members over the years, leading to the decision to change the name

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to the DVC. Seventy agencies take part in the DVC; of these, 60 are considered active members and 10 are inactive members. RSS staff and collaborative partners are active members of the DVC; some of the DVC's original advisory council members, including ABW, are RSS partners.

4. Integrated Assistance

In 2004, RSS staff received technical assistance from a variety of sources. The Systems Improvement Training and Technical Assistance Project (SITTAP) provided technical assistance around community engagement, developing policy initiatives, and planning for sustainability. The National Center for Children Exposed to Violence (NCCEV) conducted three site visits to provide consultation around RSS sustainability and to assist with the continuous improvement of SAFE Kids. The NET assisted RSS staff with an analysis of their early childhood evaluation data and the development of a proposal to validate a screening instrument for young children exposed to violence. In June 2004, the NET conducted a site visit to collect data about RSS accomplishments and progress from 2001 to 2003. This visit gave RSS staff an opportunity to reflect on past, current, and future plans.

RSS staff would like to receive continued assistance with sustainability planning from an experienced external facilitator, as well as further assistance in areas such as policy change, strategic development of grassroots involvement, and cultural competency. RSS staff also reported that it would have been helpful to receive reports from the groups that made 2004 site visits.

5. Local Agency and Community Engagement and Collaboration

RSS collaborative members reported that the long history of collaboration in Monroe County has facilitated their Safe Start work. Many of the county's agencies and community leaders have collaborated in the past, and a number of RSS staff and collaborative members take part in other community efforts. Overlapping membership in numerous collaboratives and coalitions allows community agencies and organizations to maximize the use of community resources.

The RSS Collaborative Council consists of 23 members from the health, legal, law enforcement, philanthropic, and education sectors. Community residents and grassroots leaders were not invited to join the Collaborative Council and have not been involved. RSS staff and partners currently participate in other collaboratives and committees, including the DVC, Monroe County DHHS Children's Services Subcommittee, Rochester Early Enhancement Project Coordinating Council, Do Right by Kids Steering Committee, Ad Council Board, and Babies Can't Wait Advisory Committee. RSS staff advocate for attention to issues of children exposed to violence when participating in these committees and collaboratives.

Although basic principles have been developed to guide and focus the planning of efforts within a collaborative setting, formal policies have never been implemented to structure the RSS collaborative processes. Collaborative members do not vote; rather, they reach consensus on issues by allowing all members an opportunity to speak. The Collaborative Council met twice in 2004.

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According to participants who met with the NET, the most critical members of the RSS Collaborative Council are the members of the Strategy Team. The Strategy Team consists of representatives from the Rochester-Monroe County Youth Bureau, Monroe County Family Court, Monroe County DHHS, Monroe County Department of Public Health, United Way, and the University of Rochester Department of Psychiatry. The Mayor's Office and Rochester Area Foundation joined the Strategy Team in mid-2004. The RSS Project Director and Coordinator also are members of the Strategy Team. While the Collaborative Council provides input related to Safe Start activities and processes, the Strategy Team makes all final decisions. In 2004, when RSS entered its sustainability phase, the Strategy Team was identified as the most appropriate group to be charged with the development of a sustainability plan.

According to participants, a major strength of the RSS collaborative has been the influence and status of Strategy Team members. Because members of the Strategy Team have worked together on past collaborative efforts, they are familiar with each other's personalities and styles, facilitating communication and decision-making. Team members were described as highly committed, energetic, and effective in their respective fields.

Regarding weaknesses in the collaborative process, participants reported that staff roles and expectations could be more clearly articulated, and that the Collaborative Council could meet more often. Changes within the collaborative membership were said to have occurred, but were described as minimal.

6. System Change Activities

Participants mentioned the following as RSS accomplishments for 2004:

- Development of a protocol manual for early childhood consultant/mentors;
- Participation in the Domestic Violence Consortium's efforts to develop protocols and policies for a coordinated community response to domestic violence to be implemented within a number of sectors; RSS incorporated responses to children exposed to violence in the service provider protocols;
- Facilitated the Office of Probation in developing a policy on victims, drafting a set of questions for pre-sentence investigations, drafting an order and condition for parenting education for domestic violence perpetrators, and developing and delivering a pilot training on children's exposure to violence for probation officers;
- Creation of a memorandum of agreement between SPCC, Rochester Police Department/FACIT, and RSS for the SAFE Kids program;
- SPCC's work toward integrating crisis-response expertise into its Family Violence program;
- Evaluation of phase one of the *Shadow of Violence* Campaign and development of phase two;
- Publication of articles in a column of the *Daily Record* (the paper of record for attorneys); and
- Provision of financial support for the planning and development of a video about children's exposure to violence to educate parents appearing before the Monroe County Family Court.

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6.1 Development of Policies, Procedures, and Protocols

During the summer of 2004, RSS developed a protocol manual for early childhood consultant mentors. The manual outlined the role and responsibility of mentors, when coaching teachers of three- and four- year olds to respond appropriately to a child exposed to violence. The protocol development process provided mentors and consultant staff with an opportunity not only to formalize their procedures and responsibilities, but also to discuss which coaching methods are most effective and how other methods can be improved. Mentors now have formal policies and procedures to which they can refer in their work with teachers and children in Rochester daycare centers.

RSS staff members worked with the DVC to include responses to children exposed to violence in protocols for service providers. In October 2004, the DVC held a conference to complete the protocol development process. RSS staff was responsible for ensuring that the protocols developed for the service provider sector adequately addressed children's exposure to violence.

As a result of a study of the Monroe County Family Court, funded by RSS and conducted by the University of Buffalo's Family Violence Department, RSS decided to create a Probation Design Team. In this study, the Probation Department was identified as a system with high levels of contact with parents; of parents contacted, a high number had children who had been exposed to violence. The Probation Design Team was made up of probation officers responsible for developing both short- and long- term strategies for increasing services to children exposed to violence, planning and implementing interventions, and developing and distributing materials to parents of children exposed to violence. The Design Team created a pilot training curriculum for probation officers, which they submitted to the Probation Administration in July 2004. On September 22, 2004, 16 probation officers attended the pilot training.

The Supervised Visitation program is one component of the RSS Child in Court Intervention (see also Section 6.2 of this report) and was designed to "fast-track" supervised visitation cases for children six years and younger who had been exposed to violence. Prior to the inception of the program, the waiting period for a supervised visitation case was often 10 to 12 months. SPCC collaborated with ABW's Court Advocate to identify cases with a high-risk for violence; these cases were brought to the attention of the Court as cases that should be prioritized (or "fast-tracked"). After the establishment of the Supervised Visitation program, high-priority cases were heard in under a month's time. In addition, the program worked with the Court to develop a system to hold parents accountable for not following through with established visitation plans. When funding for "fast track" ended in October 2004, the waiting time for supervised visitation returned to the 10-to-12-month time frame typical prior to RSS involvement due to the reduction in service slots. SPCC continues to examine funding options and is considering charging fee-for-service. According to the Director of the Supervised Visitation program, the court is interested in continuing to fast-track high-risk cases.

6.2 Service Integration

SPCC's SAFE Kids program provides 24-hour crisis response for families with young children. The program was designed to receive calls from either the Rochester

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Police Department or FACIT, such that responders would arrive at the scene of a violent incident within 30 minutes. Initially, the SAFE Kids program responded only to referrals from the Maple section of Rochester, on the west side of the city. In 2004, the Rochester Police Department reorganized into two sections (east and west), at which point the SAFE Kids target area was expanded to provide services to the entire west side. The SAFE Kids office also changed location. At the end of 2004, SPCC arranged to house the SAFE Kids program in the same office as FACIT in the police department's west section. This would allow SAFE Kids to have greater interaction with both FACIT and the Police Department, the program's two primary sources of referrals. In addition, the collaboration between FACIT and SAFE Kids would help ensure that adult victims of domestic violence as well as their children would receive needed services.

From May 2003 through October 2004, RSS sponsored a Child in Court Intervention, which included a child advocate component and a supervised visit component (see also Section 6.1 of this report). ABW managed the child advocate component of the program, while SPCC managed the Supervised Visitation program. The child advocate component placed an advocate in the DVII Court, such that mothers entering the DVII Court could be educated and connected with resources and services for their children. Site visit participants, however, described the DVII Court as a poor placement choice for the Child Advocate; the Court has its own advocates to assist mothers, and very rarely are children present in court. Participants proposed training the Court's incumbent advocates on issues related to children's exposure to violence as a more efficient use of resources. Funding for the Child in Court Intervention ended in October 2004. ABW is looking into training court advocates on issues related to children's exposure to violence.

6.3 Resource Development, Identification, and Reallocation

The SAFE Kids program originally hired two full-time social workers as crisis responders. Site visit participants reported that it was difficult to keep these positions filled because of their short-term funding. Because the funding for SAFE Kids was scheduled to end in December 2004, in August 2004, the Assistant Vice President of Programs at SPCC appealed to the Board for funding to continue the program. The SPCC Board agreed to fund the program for 2005 on the condition that other sources of funding be sought. In addition, the Assistant Vice President decided that he would assume the crisis response position until the program could secure longer-term funding.

The Children's Institute applied for funding from the New York State Office of Children and Family Services to continue the early childhood Consultant/Mentor Intervention. In addition the Children's Institute secured an Early Education Professional Development grant from the U.S. Department of Education, which expanded mentors to infant-toddler programs. They used the protocols developed for the Consultant/Mentor Intervention for their new program.

Mt. Hope, the lead agency for the RSS Child in Context Intervention, applied for funding from The United Way to continue mental health services for children exposed to violence. In April 2004, Mt. Hope received United Way funding to continue the program.

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6.4 New, Expanded, and Enhanced Programming

RSS has provided the following services through designated local agencies:

- Consultant/Mentor Intervention;
- SAFE Kids;
- Child in Court Intervention; and
- Child in Context Intervention.

Rochester Safe Start's Consultant/Mentor Intervention, now in its second year, provides preschool teachers with an in-class consultant/mentor who visits at least four hours twice a month to help them improve their ability to identify and respond to children exposed to violence. Participating teachers of three- and four-year-old children in the City of Rochester are assigned a consultant/mentor. The consultant/mentor does not dictate the teacher's response, but helps guide the teacher's thinking to arrive at appropriate solutions for correcting a child's acting-out or withdrawn behavior. Consultant/mentors inform teachers of the resources available to parents of children exposed to violence. As a result of this program, teachers developed the skills needed to contribute to the healthy socio-emotional development of children exposed to violence.

As mentioned previously, SAFE Kids program provides 24-hour crisis response for families with young children. Unfortunately, SAFE Kids did not receive referrals at the rate they had anticipated for a number of reasons; according to site visit participants, the low number of referrals reflected the pressure placed on police officers to respond to a certain number of calls each day. In addition, throughout 2004, crisis responders turned over a number of times; as a result, SPCC staff took turns responding to crisis calls. RSS conducted a process evaluation of SAFE Kids, which found that the time between a violent incident and the family's first contact with a responder averaged five to six days. The program model, however, calls for contact within 24 hours. To improve the overall process of the program, the Assistant Vice President of SPCC Programs assumed the position of crisis responder at the end of 2004, and SAFE Kids was located to an office with FACIT in the Police Department's west side precinct. In 2005, SAFE Kids will continue to provide services to identified children six years and younger and their families, for a four- to eight- week period. The 24/7 response was eliminated, however, in the fall of 2004 because the number of calls after regular hours was so low as to make this capability prohibitively expensive. The Rochester Police Department and FACIT will continue to make referrals to SAFE Kids. RSS, the Police Department, and SPCC have provided funding for the program.

In 2004, the RSS Child in Court Intervention provided 1) support, linkage, and services to children exposed to violence whose parents were appearing before the DVII and IDV Courts and 2) fast-tracking of supervised visitation cases with high risk for violence. Through this program, ABW and SPCC worked together to educate members of the court and enhance the court's responsiveness to children exposed to violence.

The RSS Child in Context Intervention was designed to provide services to children in the settings in which they exhibited behavioral difficulties (i.e., school, daycare, foster care). However, few referrals were made from child care providers or schools and the program largely served foster children. Services include assessment; consultation with guardians and parents,

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foster care workers, and others serving the child; and therapy. Therapeutic services at three levels of intensity, depending upon the severity of the child's behavior, were provided by Mt. Hope, a mental health agency for young children who have been exposed to violence and, as a result, exhibit extreme behavioral or emotional problems. A total of 10 intervention slots were originally made available (eight for children in foster care and two for children not enrolled in a classroom served by a consultant/mentor). In April 2004, Mt. Hope received funding from The United Way to succeed expended RSS funds.

Police officers screen at the scene for children who may have been present during a domestic violence incident. The officer may refer the family to FACIT (who can then refer families to SAFE Kids) or directly to SAFE Kids. A crisis responder is expected to meet with the family within 24 hours of the crisis incident. Identifying, assessing, and referring represent essentially the same decision point in the service pathway. In 2004, 536 children were identified, assessed, and referred to SAFE Kids. After the initial crisis response, SAFE Kids provides services to the family for four to eight weeks.

RSS staff collaborated with a number of local organizations to conduct both clinical and non-clinical trainings in 2004. Six of the trainings were for diverse audiences of providers, while a seventh was held specifically for child associates from the Pre-Kindergarten Primary Mental Health Project. Two clinical trainings were held, using *Shelter from the Storm* curriculum. These two-day trainings were designed to raise the awareness of providers throughout Monroe County, and to develop provider skills and knowledge related to children exposed to violence. Clinical trainings were designed for social workers and therapists who work with young children. In 2004, 671 individuals participated in RSS training activities.

As a result of a training for law guardians held in November 2003, RSS staff decided to write a monthly column in the paper of record for attorneys, *The Daily Record*. The column has allowed RSS to educate attorneys who represent children on issues of children's exposure to violence.

6.5 Community Action and Awareness Activities

RSS staff continues to develop methods for raising awareness of children's exposure to violence throughout the City of Rochester. In collaboration with Rochester's Ad Council, RSS developed the *Shadow of Violence* campaign, which displayed shadowed images of violent acts being witnessed by children. The campaign received a national Telly award in June 2004. To evaluate the impact of the campaign, RSS surveyed residents of Rochester and a control community. Following the *Shadow of Violence* campaign in Rochester, the proportion of people who had actually encountered a child exposed to violence in the past six months and had done nothing was cut in half. Parents of children under 18 were fare more likely to "do something" than before the campaign. There was no change in the proportion of people who "did nothing" in the comparable community, although the evaluation design did not enable RSS to conclusively attribute these results to the *Shadow of Violence* campaign. RSS has begun development of phase two of the campaign. In 2004, RSS conducted five focus groups with community residents to inform the goals and design of the phase two campaign. In August 2004, RSS submitted an application

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requesting the support of the Ad Council for phase two, which was later approved.

In May 2004, the Children's Institute hosted a press conference organized by law enforcement officials, early childhood education activities, and local funders as part of their *Fight Crime, Invest in Kids* campaign. Law enforcement officials emphasized the need to make children a national priority, as well as the social benefits of investing in the development of young children.

In response to the study of the Monroe County Family Court conducted by the University of Buffalo's Family Violence Department, RSS and the Monroe County Family Court decided to collaborate to develop an educational video. The video will educate parents who enter the court system on both the court process and the impact of violence on their children.

7. Institutionalization of Change

In May 2003, the Strategy Team began planning to sustain and institutionalize the RSS Initiative. According to information obtained in follow-up correspondence with RSS, the Initiative has accomplished the following with its partners:

- Obtained funding for the Early Childhood Education mentors through NYS Office of Children and Family Services (received award notice in December 2004) and migrated learnings from RSS into the Early Education Professional Development grant that reaches infant-toddler classrooms;
- SPCC obtained grant funding for SAFE Kids;
- Mt. Hope obtained United Way funding for Child in Context;
- RSS infused children exposed to violence into the Domestic Violence Consortium protocols; and
- The RSS training initiative is designed to affect practice and incorporate sensitivity to children exposed to violence and responses across a variety of systems. Trainings occurred in 2004 and co-sponsorship was obtained from three coalitions in 2004 – the Domestic Violence Consortium, the Monroe Council for Teen Potential, and the Perinatal Network.

As of the end of 2004, the RSS Initiative was working to institutionalize its structure as part of the work for 2005.

8. Increased Community Supports

Throughout the two-year period during which RSS funded the Consultant/Mentor Intervention, teachers who participated in the program received assistance in developing skills for dealing with children exposed to violence. This program has increased the support available to children exposed to violence. The Mt. Hope Family Center stabilized and institutionalized its program to provide mental health services for foster children ages six and under.

SPCC members have gained expertise in children's exposure to violence from the RSS SAFE Kids program; SPCC plans to work toward integrating this expertise into its Family Violence program. The Family Violence program provides victims of domestic violence with home visits, counseling, parenting-skills training, advocacy, information, and referrals. The integration of knowledge gained from the

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SAFE Kids program will help improve the quality of SPCC services, which have not historically focused on children exposed to violence.

9. Lessons Learned in the Implementation and Evaluation of Safe Start Activities

The following lessons were identified by site visit participants, as well as through the NET's analysis of data collected during the site visit and from site documents:

- **Collaborative members should be influential**. According to RSS participants, a Safe Start collaborative should consist of individuals who are high ranking, have influence over their organizations' decision-making processes, and are knowledgeable and well connected. Programs should involve community leaders and agencies from various sectors; these leaders and agencies should be influential and have a reputation for success in their respective lines of work.

- **It is never too early to plan for sustainability and institutionalization**. To ensure institutionalization of an Initiative, a plan for sustainability should be considered, and even developed, during the design of the implementation plan.

- **Safe Start grantees should have opportunities to share knowledge on a more regular basis**. RSS staff acknowledged the extensive expertise among Safe Start Demonstration Project grantees. Staff members indicated that they would have benefited from regular opportunities to discuss programming with other grantees, without a pre-determined OJJDP agenda.

- **A diverse team is critical to develop a successful and responsive Initiative.** According to RSS staff, individuals from a variety of sectors and disciplines challenge one another in the development of ideas, to good effect. The RSS collaborative encouraged participants to speak up with differences of opinion.

- **The Safe Start Initiative needs to engage community residents, not just educate them or solicit their input**. In their initial efforts, RSS staff consulted with community residents about the community-awareness campaign through two waves of focus groups and attempted to educate residents about the issue of children exposed to violence through the campaign. Ideally, however, the Initiative would more fully engage the community by involving grassroots leaders who are closely connected to community members, for example.

10. Barriers and Challenges

The Rochester Safe Start Initiative faced the following barriers and challenges:

- Site visit participants reported less success in engaging community residents and grassroots leaders than they would have liked.

- Participants described the scope of the Safe Start Demonstration Project as too broad to manage. Given their limited resources, they have found the expectation that they impact every system unrealistic.

- Since its recent reorganization, the Rochester Police Department has focused

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much of its energy on ensuring a successful transition. Site visit participants reported that police officers frequently failed to follow through on their commitment to RSS, even before the reorganization. The reorganization seems to have made RSS an even lower priority for officers.

- Short-term funding has resulted in high staff turnover and work-hour reduction for RSS. The SAFE Kids social workers resigned shortly after being hired, and SPCC was not able to replace them successfully before funding came to an end. In the meantime, other SPCC staff members assumed responsibility for responding to crisis calls. ABW experienced similar difficulties with their Court Advocate. In addition, two RSS staff persons reduced their full-time status to 60% time. This required relationship building with newly hired staff.

- The consultant/mentor team does not adequately reflect the ethnic make-up of the City of Rochester. Although more than half the residents of Rochester are people of color, the team has only one ethnic minority mentor, an African American who bears full responsibility for translating cultural context and challenging the team to be more culturally responsive. This limits the ability of the Consultant/Mentor Intervention to provide appropriate assistance, responsive to the needs of children and their families.

11. Conclusion and Recommendations

In 2004, the Rochester Safe Start Initiative impacted several systems associated with child welfare, including law enforcement, early childhood education, the judicial system, and the domestic violence community. With its creation, and having assisted in the development of protocols and manuals, the RSS will continue to influence policy beyond the period of federal funding. In addition, the skills of early childhood educators and clinicians have improved in a lasting way due to RSS trainings and assistance.

As RSS enters the final year of the Safe Start Demonstration Project, it may wish to consider the following recommendations:

- Examine the ways in which the various ethnic groups in the City of Rochester conceptualize the notions of domestic violence and children's exposure to violence, to ensure culturally responsive and appropriate Safe Start services;

- Provide RSS staff, especially consultant/mentors, with cross-cultural competency training to provide them with the skills needed to work in an ethnically diverse community;

- Continue to seek funds for the SPCC to institutionalize its programs; and

- Train police officers in target areas on children's exposure to violence. All officers who have not yet participated in RSS training should be trained. It also may be helpful to offer a refresher course to individuals who have been trained in the past, to reinforce the importance of the work that the RSS and SPCC are doing in Rochester.

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ATTACHMENT A

Timeline of Rochester Safe Start 2004 Major Activities and Milestones

Activity	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Daily Record articles submitted	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Development of strategies to respond to children exposed to violence in the families of probationers	✓	✓	✓	✓	✓	✓	✓					
Development of Evaluation of *Shadow of Violence* Campaign report	✓									✓ (revised)		
ICP Immersion Training			✓									
SAFE Kids evaluation reports			✓						✓			
Creation of SAFE Kids memorandum of agreement				✓								
Training for law guardians				✓								
Mt. Hope funding from United Way for Child in Context Intervention				✓								
Children's Institute Fight Crime in Kids Press Conference					✓							
Planning for Phase Two of *Shadow of Violence Campaign*					✓	✓	✓	✓	✓	✓		
Tier II funding approved						✓						
Submission of Probation Design Team Protocol							✓					
SPCC Board commitment to fund SAFE Kids program in 2005								✓				
Development of consultant/mentor protocol manual									✓			
Probation officers' pilot training curriculum developed									✓			
Pilot Training for Probation Officers									✓			
DVC's Conference on children's exposure to violence protocols										✓		

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VIII

SAN FRANCISCO SAFESTART

1. Introduction

To develop a full understanding of the San Francisco SafeStart from January through December 2004, the National Evaluation Team (NET) visited San Francisco SafeStart from November 29 to December 1, 2004, and conducted a follow-up telephone interview with SafeStart's Project Director in January 2005. The NET also reviewed various documents generated by SafeStart and ETR Associates, including *SafeStart Strategic Plan, August 30, 2004*; *SafeStart Semi-annual Evaluation Report for October 2003 to March 2004 and for April to October 2004*; *SafeStart Progress Reports for January through June 2004 and for July through December 2004*; *SafeStart Cross Training: Evaluation Results*; and *Systems Change: Findings From Interviews with Key SafeStart Collaborators*.

The NET met with 19 individuals, tailoring discussions to each individual's specific role in the Initiative. Among the individuals with whom the team met were representatives from partner agencies and point-of-service providers, SafeStart staff, the local evaluation team (Education, Training, and Research Associates [ETR Associates]), and one community advocate not involved in the Initiative. The NET also attended a SafeStart Evaluation Committee meeting.

Site visit participants were asked to share their experiences with SafeStart from January 2004 to the time of the site visit.

Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of SafeStart in the past year?
- How did the composition and process of the collaborative influence the types of strategies implemented, and as a result, the system change outcomes?
- How has SafeStart changed the service delivery system for children exposed to violence and their families?
- What organizational, point-of-service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of SafeStart?
- How did the Initiative handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?
- What are the lessons learned about the implementation and replication of a national initiative such as Safe Start?

This report is organized according to the Safe Start Demonstration Project logic model. It describes the economic, political, and social context of San Francisco SafeStart; the technical assistance the initiative received; the system change

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activities and new and enhanced programming for children exposed to violence developed by the initiative; SafeStart's institutionalization of changes; and the challenges faced and lessons learned by the participants. A timeline of major accomplishments and milestones achieved by SafeStart in 2004 is included in Attachment A.

2. Contextual Conditions

2.1 Contextual Conditions: General

According to the U.S. Census, San Francisco in the year 2000 had a population of 776,733, of whom approximately 4% were children five years and younger. A large number of these children were of Asian/Pacific Islander, African American, or Latino descent. African American children, in particular, were disproportionately represented in the foster care system.

The above demographics on children five years and younger in San Francisco, as well as data on the prevalence of domestic violence, child abuse and neglect, behavioral health needs, community violence, and attitudes toward children's exposure to violence,[58] led San Francisco SafeStart to focus on particular geographic communities within the city. In 2004, six communities were served by SafeStart: Western Addition, Chinatown, the Mission, Bayview-Hunter's Point, Visitacion Valley, and Ocean View-Merced Heights-Ingleside (OMI).
The Western Addition, comprised of areas known as Westside, Fillmore, Japantown, Hayes Valley, and Lower Haight, has approximately 70,000 residents, or 9% of the city's population. Historically an African American community, the Western Addition experienced radical urban renewal in the late 1940s, resulting in the displacement of African Americans. Today, European Americans form the dominant group in Western Addition, and the community's historical African American identity has become less notable.

Bayview-Hunter's Point is home to approximately 31,000 residents (4% of the city's population), primarily African American. Another historically African American community, it is the most economically, politically, and socially isolated area in the city. Community violence is most prevalent in this area; police records indicate that the highest number of domestic violence calls originate from Bayview-Hunter's Point.

Visitacion Valley has about 39,000 residents (5% of the city's population), of whom half are of Asian/Pacific Islander descent, with a relatively visible African American community as well, south of the downtown area. Historically perceived as a transitional neighborhood for immigrants working their way up the economic ladder, Visitacion Valley once offered two major public housing developments, Sunnydale and Geneva Towers; the former was replaced with more modern and less dense housing in 2000, while the latter was torn down in 1998 and replaced with apartment complexes.

Approximately 15,600 residents, or 2% of San Francisco's population, reside in Chinatown. The second largest Chinese community in the United States after New York City's Chinatown, San Francisco's Chinatown has, historically, been an immigrant neighborhood; over time, however, its residents have moved to other

[58] The details of these conditions in San Francisco are documented in SafeStart's *Strategic Plan* submitted to the Office of Juvenile Justice and Delinquency Prevention on August 30, 2004.

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areas as a result of substandard housing, unemployment, and health problems. Today, it is a small community dominated by kinship networks and traditional values, some of which conflict with mainstream American practices (e.g., gender inequality).

OMI is a racially and ethnically diverse area with a total of 73,104 residents (almost 10% of the city's population). Approximately 45%, 28%, 6%, and18% of its residents are Asian, Latino, African American, and European American (respectively), according to the 2000 Census. Its racial and ethnic diversity is matched by its economic diversity; it has one of the highest rates of owner-occupied housing in the city, as well as a large number of families who receive government assistance. Throughout the 1990s, it was known for drug dealing, gang activity, and street crime.

The Mission is home to 77,673 residents (10% of the city's population), including one-third of San Francisco's Latino community; since the turn of the 20th century, immigrants from Mexico and South and Central America have chosen to settle in the Mission area. Of the six communities served by SafeStart, the Mission is the most populous and the most prosperous.

2.2 Contextual Conditions: 2004

Participants who met with the NET reported a number of city-level changes with potential to affect SafeStart. In 2004:

- Substance abuse prevention services and community mental health services merged at the city level to form community behavioral health services. This merger could benefit SafeStart by bringing more attention to the ways in which substance abuse and other co-occurring conditions affect domestic violence;
- Mayor Gavin Newsom appointed a new director to lead the Department of Children, Youth, and Their Families. The new director is a community organizer and well-known proponent of children's issues. Participants were unsure about what the future holds for children's issues under her leadership; and
- The Honorable Judge Donna Hitchens completed her two-year term as Presiding Judge for San Francisco's Superior Court. Consequently, she will no longer chair SafeStart's Advisory Council. Her leadership has been critical to SafeStart's credibility and visibility, and participants were concerned that the Initiative's potential may be diminished without her. She has been replaced on the Council by the Honorable Katherine Feinstein, Presiding Judge of San Francisco's Family Court.

3. Community Capacity

Prior to SafeStart, the City and County of San Francisco had limited capacity to address and respond to children exposed to violence. The Child Trauma Research Project ("the Project"), a joint endeavor of the University of California San Francisco's Department of Psychiatry and the San Francisco General Hospital, was the most frequently cited local resource for issues related to children's exposure to violence. The Project provides services to children six years and younger and their families who have been involved with domestic violence. Within San Francisco, the Project also engages in community outreach, training, consultation, and advocacy on child trauma issues. The Project is funded by federal grants, state funds appropriated by

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California's Proposition 10[59], and private foundations.

When SafeStart began, several groups in the city had already begun to examine issues related to children exposed to violence, creating a "buzz" around these issues, according to participants. Factors contributing to this momentum included the First 5 California, created by California's Proposition 10; a media campaign sponsored by the Family Violence Prevention Fund; and efforts by the Department of Human Services and the Department of Children, Youth, and Their Families to develop a system of early intervention services. SafeStart differed from these efforts in its dedication to bring together multiple sectors (e.g., courts, child welfare, police, domestic violence) and serve families at different income levels; nevertheless, the Initiative benefited from the existing momentum, using it as a catalyst to maintain a focus of attention on the issue of violence exposure.

Participants who met with the NET reported several significant conditions in San Francisco that challenged the development of a support system for families and children who were experiencing violence. First, there were no major resources for children exposed to violence, aside from that mentioned above (i.e., the Child Trauma Research Project). Few professionals specialized in children's exposure to violence, and even fewer had the linguistic and cultural competency to assist children and families from racially and culturally diverse backgrounds. This was a critical gap in a city where many children five years and younger are non-White.

Second, many battered women were unaware of available services and resources, or reluctant to get help for fear of being ostracized by their families and community. In Asian families, for example, the woman is traditionally subservient to her husband and in-laws, according to site visit participants familiar with San Francisco's Chinatown. In some situations, an abused Chinese immigrant's inability to speak English, undocumented status, and compliance with cultural norms would be likely to prevent her from seeking help. In San Francisco's Chinatown—a small community in which most people know one another—the victim might be even more reluctant to seek help because of the likelihood that a family acquaintance or relative might see her approaching a service provider's facility.

Third, many immigrant women feared involvement with the police, due to prior experience with oppressive or unjust law enforcement in their home country. Some were unaware of their rights, particularly if they did not have legal immigrant status; some doubted their ability to support themselves and their children if they left an abusive spouse. A tremendous amount of education must be provided to encourage these women to seek help, according to the community advocates and parents who met with the NET.

Fourth, San Francisco had few batterer intervention programs, especially for Asian men. Participants knew of only one such program for Chinese men, and none for Filipino and other Asian men. To stop the cycle of abuse, such programs are as

[59] Also known as the California Children and Families First Act of 1998, this Proposition imposed an additional surtax of 50 cents per pack on cigarettes and increased the tax on other tobacco products (cigars, chewing tobacco, pipe tobacco, etc.) by the equivalent of a dollar a pack. The new tax monies are allocated to the California Children and Families First Trust Fund to promote, support, and improve early childhood development from the prenatal stage to age five.

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essential as support programs for battered women and their children.

Lastly, community-based family resource centers, with high potential for reaching out to families because of their accessibility, had difficulty hiring and retaining staff trained in working with families and children experiencing violence. Staff burnout and low salary led to frequent staff turnover. These centers also struggled to maintain sufficient funding to provide the range of support services—such as parenting classes and child development activities—required to engage and retain families in need.

4. Integrated Assistance

SafeStart received extensive technical assistance from Dr. Patricia Van Horn, Training Director for the Child Trauma Research Project and Assistant Clinical Professor at University of California San Francisco. Dr. Van Horn served on the SafeStart Advisory Council and the Evaluation Committee, and provided case consultation to the Initiative's Service Delivery Team (see Section 6.3). SafeStart also benefited from assistance provided by the Systems Improvement Training and Technical Assistance Project (SITTAP), in the areas of strategic planning, systems change, and sustainability.

5. Local Agency and Community Engagement and Collaboration

5.1 Agencies and Organizations Engaged in SafeStart

SafeStart engaged the following sectors and agencies in its collaborative (known as the "Advisory Council"):

- Police and probation (San Francisco Police Department and Adult Probation Department);
- Courts (San Francisco Unified Family Court, Superior Court);
- Legal representation (City Attorney);
- Domestic violence (La Casa de las Madres, Domestic Violence Consortium, Asian Women's Resource Center, and San Francisco Department on the Status of Women);
- Batterer intervention programs (POCOVI, manalive);
- Health and behavioral health (San Francisco Department of Public Health's Community Behavioral Health Services and Maternal and Child Health units, University of California San Francisco/Mt. Zion Center of Excellence in Women's Health);
- Schools and childcare (San Francisco Head Start, City College, Unified School District, and Wu Yee Children's Services);
- Family resource centers (Asian Pacific Islander Family Resources Network, Bayview-Hunter's Point Family Resource Center, Instituto Familiar de la Raza, OMI Family Resource Center, Homeless Prenatal Program, and TALK Line Family Resource Center); and
- Child welfare (University of California San Francisco's Child Trauma Research Project, Child Abuse Council, First 5 San

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Francisco, Kids' Turn, Rally Family Visitation, and Boys & Girls Club).

In addition to the above agencies and organizations, SafeStart actively involved a group of parents with experience of violence in their lives. These parents formed the Parent Team, which functioned as a committee of the Advisory Council. Their involvement ensured that Advisory Council and SafeStart strategies were informed by the perspectives of families affected by violence, in addition to those of service providers and other professionals. A more detailed description of the Parent Team and its accomplishments is included in Section 6.

Education, Training, and Research (ETR) Associates also has played a critical role in SafeStart as its evaluator. ETR Associates staff collected and analyzed data, reporting frequently to the Advisory Council's Evaluation Committee, which met every month in 2004. SafeStart used the information provided by ETR Associates to strategize and improve its capacity (e.g., to prompt improved police reporting of children's exposure to domestic violence, as described later in Section 5.3).

The Honorable Donna Hitchens, Presiding Judge for the San Francisco Superior Court, chaired the Advisory Council. Site visit participants described her presence as "commanding, but not forceful." Her distinguished position in the city government leant tremendous credibility to the Initiative. In late 2004, when her two-year term as Presiding Judge for the Superior Court ended, she was replaced on the Advisory Council by the Honorable Katherine Feinstein.

5.2 Structure and Process for Engagement

Initially, the Advisory Council served as the primary forum for SafeStart discussion and decision-making. Approximately 25 to 30 agency representatives attended meetings every two months. Over time, however, members found it increasingly difficult to engage extensively in particular issues and tasks, because of the large number of people at each meeting. Members debated over semantics, which took time away from the actual work, according to some participants. As a result of the above challenge, the Advisory Council's role evolved to one of issuing final approval and endorsement. Extensive engagement with specific research, discussion, and decision-making fell to committees, several of which had been organized at the inception of the Advisory Council. These original committees included: Steering, Evaluation, Public Education, Parent Team, and Batterers Intervention. The Steering Committee acted as the Advisory Council's executive committee, leading the development of the Initiative's sustainability plan. The Public Education Committee disbanded at the end of 2004, after the public education campaign concluded. An ad hoc committee on cultural competence was established in 2004, to strengthen SafeStart's response to the city and county's growing diversity. Several participants cited its efficient committee structure as a strength of the SafeStart collaborative.

5.3 Improved Relationships in 2004

Many participants who met with the NET cited improved relations between SafeStart and the San Francisco Police Department (SFPD) in 2004. Two significant events

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contributed to the improved relationship. First, in January 2004, ETR Associates published a report examining officer compliance with the SFPD's revised (2001) policy to improve the documentation of children exposed to violence. This document—ordered by the San Francisco Superior Court and supported by SafeStart and Polaris Research on behalf of the San Francisco Greenbook Project—was the first ever to evaluate SFPD response to domestic violence, and provided insight into the extent to which police officers 1) knew of the revised documentation policy and 2) were trained to report on the presence of children in a violent situation. ETR Associates and SafeStart staff discussed the report's findings with both the Police Captain and the Lieutenant responsible for the Domestic Violence Response Unit (DVRU), giving them the opportunity to make suggestions and revisions before the findings would be presented to the Advisory Council. According to site-visit participants, SFPD representatives responded positively to the report; at an Advisory Council meeting, the Deputy Chief of Police and the Police Captain committed to improving their department's documentation of children exposed to violence.

Second, SFPD hired a SafeStart police liaison in June 2004. When Mayor Newsom was elected, he appointed a new Police Chief who, in turn, appointed a new captain for the Division of Juvenile and Family Services. SafeStart recognized the positive impact these leadership changes would be likely to have on the Initiative and the issue of children exposed to violence; therefore, the Project Director waited until the new captain was hired to fill the liaison position. The liaison, a retired police officer hosted by SFPD's DVRU, was responsible for reviewing police reports of domestic violence cases, to ensure that officers completed all information correctly. If reports were inadequate, the liaison followed up with the officer(s) and the unit's commander. He also communicated each case to a domestic violence advocate and referred the victim to shelters and SafeStart services. He conducted police roll-call training on issues related to children exposed to violence.

5.4 Benefits and Challenges of SafeStart's Collaborative

Participants repeatedly emphasized the way in which SafeStart provided a mechanism for representatives from different sectors to engage with each other and exchange information; many participants commended SafeStart for creating this opportunity for interaction. ETR Associates heard similar comments during interviews with representatives from 12 agencies participating in SafeStart (ETR Associates, August 2004). Although many of the representatives interviewed knew one another before SafeStart, the Initiative allowed them to strengthen their existing relationships through collaborative work. For example, a staff person from Manalive became a member of the Rally Family Visitation's Steering Committee—thereby creating crossover between intervention with batterers and intervention with children—as a result of relationships developed through SafeStart (ETR Associates, August 2004). The Child Trauma Research Project, through its participation in SafeStart, enhanced its relationship with shelters by providing training to shelter staff and assessments for children five years and younger housed at shelters (ETR Associates, August 2004). According to participants, the opportunity for information exchange and collaboration across sectors distinguished SafeStart from other efforts in the city intended to reduce family violence and its impact on children.

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SafeStart also enabled point-of-service providers to work collaboratively to engage and retain families in services, while encouraging representatives from different sectors to overcome their organizational differences and work together on common issues (e.g., client confidentiality and a standard for adequate treatment of children exposed to violence). The involvement of different sectors led to cross-disciplinary training and development of a common set of policies and procedures for responding appropriately to children exposed to violence.

Participants reported several challenges that limited the potential of the SafeStart collaborative. Inevitably, philosophical and organizational differences arose in the large and diverse Advisory Council. For instance, domestic violence advocates and Child Protective Services differed according to service population and approach to family violence. Members also differed in their views of cultural competence; some defined such competence as the capacity to work across ethnicity and culture, while others understood it as the capacity to work within an ethnic group and culture outside the mainstream European-American culture. Philosophical and organizational differences such as these were often as challenging as ethnic differences, but were never extensively discussed, according to site visit participants; on the whole, participants reported insufficient Advisory Council discussion of philosophical and organizational inconsistencies.

Several participants also described estrangement between members of the domestic violence prevention sector and those associated with other family and child services, including providers that participated in SafeStart. Such estrangement had been present prior to SafeStart and, therefore, was not unusual; in fact, many other demonstration sites in the National Safe Start Demonstration Project reported similar tensions within their community and collaborative. Site visit participants reported three factors contributing to the estrangement: 1) the domestic violence sector's deliberate isolation from the rest of the service community due to the sensitive nature of information about domestic violence clients, including their whereabouts; 2) the perceived lack of recognition by the general community for the efforts of domestic violence advocates to address issues of children exposed to violence long before the inception of SafeStart; and 3) the stereotypes and distrust that members of the domestic violence prevention sector and family and child services already had of each other, which affected their relationships in SafeStart. A domestic violence advocate explained that it was not as if SafeStart had acted in a way that caused distrust; rather, it was the stereotypes and distrust that already existed among domestic violence advocates and family and child services that made them skeptical of SafeStart's intentions. Participants reported that SafeStart has responded adequately by continuing to engage the domestic violence community and acknowledging the views of its representatives in the context of Advisory Council discussions and decisions.

Participants identified two sectors as entirely absent from the collaborative at the time of the NET's site visit: faith and foster caregivers. Early education was underrepresented. (Note: SafeStart engaged representatives from the early education sector early on; however, these representatives did not attend meetings regularly, as the Advisory Council expected of Initiative partners. As such, early educators remained engaged only

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peripherally, through reports of Initiative activity from SafeStart staff. Nevertheless, they also remained cooperative and responsive to requests for assistance, according to SafeStart's Project Director.) Site-visit participants described the un- and under-represented sectors as critical entry points for families in need. For example, according to participants serving the Asian community, the involvement of early childhood educators is always helpful for this community, because Asian parents hold teachers in high regard. Therefore, teachers are in a strong position to convince Asian parents of the importance of seeking help for children exposed to violence.

Several participants commented on the limited racial and ethnic diversity of the Advisory Council, although they acknowledged SafeStart's extensive efforts toward achieving cultural competence. Such efforts included establishment of the Parent Team, whose members were required to be residents of targeted neighborhoods. Furthermore, in 2004, the Council established an ad hoc committee to address issues of cultural competence, and conducted a cultural competence assessment. The assessment results led to discussions of how to engage the gay, lesbian, and transsexual community in issues related to children exposed to violence. Despite these efforts toward cultural competence, site visit participants reported too few people of color in decision-making positions (i.e., on the Steering Committee or Advisory Council); some also reported that the Council had not dealt directly with issues of race and ethnicity (i.e., power, class, gender, and race), but skirted around them.

Finally, some participants expressed concern that, with the exception of Judge Hitchens, members of the SafeStart Advisory Council did not hold senior leadership positions in their own agencies and organizations, potentially detracting from the sustainability of achieved system changes. They recognized that the current members were influential in their agencies and organizations and had made major strides in effecting initial changes in the service pathway for young children exposed to violence and their families; however, in order to fully institutionalize and sustain SafeStart's goals, the involvement of higher-ranking leadership was essential.

6. System Change Activities

Participants who met with the NET reported the following system change activities in 2004:

<u>Development of Policies, Procedures, and Protocols</u>
- Operation of the SafeStart Support Line
- Review and approval of policies

<u>Service Integration</u>
- Continued coordination of the Service Delivery Team (SDT)

<u>New/Expanded/Enhanced Programming</u>
- SafeStart Academy
- Other trainings
- Expansion of SafeStart from neighborhood-based to citywide
- Hiring of the police liaison
- Enhanced service pathway for young children exposed to violence and their families

<u>Community Awareness/Action</u>
- Public education campaign
- Further development of the Parent Team

<u>Resource Development, Identification, and Reallocation</u>
- New local funds raised to support SafeStart

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- New funds raised to support the public education campaign

6.1 Development of Policies, Procedures, and Protocols

Policies. SafeStart created eight policies embodying its core values, practices, and beliefs. As one approach to institutionalization, the Initiative encouraged partners and other agencies working with families and children to adopt these policies:

- Policy 1: Victim Services
- Policy 2: Developmental Disabilities
- Policy 3: Consent & Confidentiality
- Policy 4: Standards of Care
- Policy 5: Family Support Practices
- Policy 6: Child Abuse and Neglect
- Policy 7: Domestic Violence (under development)
- Policy 8: Batterer's Intervention

Policies 3 and 4 address the service pathway and model practices; others specifically state how systems should respond to children exposed to violence. Throughout 2004, the Advisory Council and SDT regularly reviewed and re-approved each policy, to ensure that all policies remained up-to-date. According to the local evaluator, a total of 35 agencies adopted the policies.

SafeStart also increased family access to services through a policy that required family advocates at each point-of-service provider to respond promptly to requests for help (within two days). If a child had been harmed in any way, the family was asked to go directly to the Child Trauma Research Project at the San Francisco General Hospital or the Department of Behavioral Health Services' Child Crisis Center for immediate assistance. The clinician to whom the family was then referred was required to respond within 24 hours. The clinician was expected to provide parenting support (i.e., information how the parent or parents could assist their children) and to schedule an appointment to take place within 48 hours.

Over the last four years, San Francisco SafeStart has been able to standardize its procedures and processes, such as the SDT and its trainings. The project's infrastructure and leadership have grown stronger, according to all site visit participants. As a result, other agencies have started to look to SafeStart for guidance and structure in providing services to family violence victims. In the beginning, SafeStart learned from its partners; over time, the partners have begun to learn from SafeStart.

Operation of the SafeStart Support Line. The SafeStart Support Line began operating in November 2002; by 2003, agencies were receiving referrals through the Line. An internet-based referral system located in agencies serving families and children, the Support Line was designed to provide a single point-of-entry for families experiencing violence. Each of the ten SDT member agencies was given one user account to access information and referrals. The line was publicized through brochures, referral cards, child protective services (CPS), and other public education campaign materials.

The number of referrals received through the line started out low; between April and September 2004, however, the number increased to 81 total referrals. Mothers of children exposed to violence were the most common referral source, followed by the police and FRC workers. (ETR Associates, December 2004).

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6.2 Service Integration

Continued coordination of the Service Delivery Team (SDT). The SDT served as a coordinating body for information exchange, case analysis, and training. Its members—forming the core support system for victims of family violence—included 24 individuals from batterer intervention programs, Child Protective Services (CPS), mental health services, family resource centers, and sometimes, adult probation and domestic violence agencies. Dr. Patricia Van Horn from the Child Trauma Research Project provided clinical assistance to the SDT. The SDT met three times every month, twice for case analysis and once for policy development and training. Each meeting lasted about two hours. The SDT discussed cases without disclosing client names.

The SDT developed a structure and process for information sharing that was both compliant with state laws related to client confidentiality and non-threatening for SDT members. For example, when a point-of-service provider needed to review a case and no family advocate or supervisor was available, she felt comfortable calling the CPS director for consultation without having to reveal the client's name. This sense of comfort was possible as a result of the relationship the provider had built with the CPS director through the SDT.

In 2004, SDT members were offered between 24 and 32 training opportunities, for example, a 40-hour training designed to give participants legal protection from future subpoenas requiring that they divulge confidential client information, under California penal code (ETR Associates, April 2004; December 2004). SafeStart offered more than half of these trainings, funding many of them, to increase SDT member knowledge and skills in child crisis intervention, supervised visitation, safe exchange, mandated child abuse and neglect reporting procedures, family-centered care, risk assessment, immigration issues for battered women, and SafeStart client grievance procedures (ETR Associates, April 2004). Trainings were offered repeatedly, on a regular basis, because of staff turnover at SDT member agencies. Although not all SDT members took advantage of training opportunities, some participants described the trainings as useful, despite their repetition; in many cases, these participants used their new skills and knowledge to conduct trainings in their home agencies.

SDT members used regular meetings to discuss issues in their jobs. Participants expressed mixed views about the extent to which the SDT was involved in SafeStart policy development and decision-making. Some participants described their discussions and insights as informing SafeStart policies; SDT then helped translate these policies into real practice. Others perceived little opportunity for input, reporting that, by the time the SDT reviewed a policy or idea, the decision had already been made.

The SDT differentiated SafeStart from other family services, according to several participants who met with the NET. It gave service providers a safe way to seek advice from each other about a family's situation, and to understand how each agency in the system might respond. For instance, family resource center staff found it very helpful to hear directly from the police liaison how the police would respond to a specific situation, making it possible for the center to now explain these procedures to clients.

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6.3 New, Expanding, and Enhanced Programming

SafeStart Academy. SafeStart's annual training academy occurred in January 2004. A total of 45 people representing 26 agencies attended the academy, including members of SafeStart's Service Delivery Team (SDT) and other professionals who work with families with young children. (The composition and function of SafeStart's SDT is described in more detail in section 6.3.) The academy was co-sponsored by the University of California San Francisco's National Center of Excellence in Women's Health. Participants received general training on how to perform a series of tasks related to working with families in which children had been exposed to violence. Family court mediators received continuing education credits for their attendance.

SafeStart also conducted its annual conference in September 2004. The conference was co-sponsored by the San Francisco Adult Probation Department, which mandated the attendance of Batterer Intervention Program (BIP) staff; SafeStart's Committee on Batterer's Intervention developed the conference's cross-training curriculum. A total of 120 people attended. BIP staff trained point-of-service staff, and a facilitator from the Child Trauma Research Project trained BIP staff. Pre- and post-test scores indicated that knowledge of batterers as parents increased as a result of the conference (ETR Associates, October 2004). According to many of the participants with whom the NET met, the conference was particularly significant because it gave providers who worked separately with batterers, victims, and children an opportunity to exchange information and learn from each other.

Other trainings. SafeStart offered many training opportunities to SDT members, as well as to staff members of partner agencies. For example, between April and September 2004, SafeStart funded 14 training opportunities; SDT members, in turn, provided training to staff at their individual agencies. The trainings covered a wide range of issues related to children exposed to violence, such as transitional housing for victims of domestic violence and the neuro-developmental impact of child maltreatment.

Initiative partners, as well as a community provider not involved in SafeStart, described the SafeStart Academy and other trainings as the Initiative's strength, reporting that SafeStart did an "excellent" job of researching and sharing the latest understanding of the impact of children's exposure to violence. SafeStart offered education to both professionals and paraprofessionals. Trainers included facilitators from the Child Trauma Research Project and the Infant Parent Program, as well as others with extensive experience in the field of violence exposure. Because the SafeStart trainings serendipitously coincided with a new mandate for mental health professionals to be trained in spousal and partner abuse, participation levels were particularly high.

Expansion of SafeStart from neighborhood-based to citywide. SafeStart expanded its services to two additional neighborhoods in 2004: Visitacion Valley and OMI. Two agencies, Homeless Prenatal Program and YMCA Urban Services, were selected through a competitive process and engaged as point-of-service providers. Homeless Prenatal Program, engaged to provide services in Visitacion Valley, provides homeless parents and pregnant women with access to the support and care necessary to have a healthy baby—

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everything from perinatal care, counseling, and advocacy to referrals for housing, substance abuse problems, and legal aid. YMCA Urban Services, engaged as OMI Family Resource Center, provides support services for families and youth, such as mentoring, counseling, and other activities to ensure the healthy development of young people. These agencies were able to build on existing staff capacities, programs, and clients to promote SafeStart services.

Later in 2004, SafeStart decided to expand its efforts further, from specific neighborhoods to the entire city. All participants interviewed by the NET agreed that this was a positive move, because it gave families the option to receive services within or outside their neighborhood. It also diminished the perception that 1) some neighborhoods, particularly low-income and ethnic neighborhoods, were targeted because of their high rates of violence, as well as 2) the assumption that neighborhoods in San Francisco were segregated by race and ethnicity. Asian families, for example, no longer lived in certain ZIP codes, but throughout the city.

Hiring of the police liaison. The new police liaison was hired in June 2004. Referrals to one of the family resource centers increased after the liaison was hired, according to some participants. Prior to the liaison's hire, SFPD demonstrated 50% compliance in completing all information on a domestic violence reporting form. The compliance rate increased to approximately 90% after the liaison was hired, according to a SFPD staff person.

Enhanced service pathway for families and children exposed to violence. Families and children accessed SafeStart services through three major types of entry points: walk-ins or calls to community-based family resource centers, the SafeStart Support Line, and SFPD Domestic Violence Response Unit. To a lesser extent, other agencies serving families and children (e.g., CPS, District Attorney's Office) and the Parent Team also functioned as referral sources.

SafeStart used a family support approach to assist referred families and children exposed to violence. In this approach, the adult and/or child victim participated in an intake process with a family advocate at the point-of-service. The family advocate then typically assisted the victim in making a police report and obtaining a restraining order, accompanied the victim to a shelter, and developed a safety plan for the family. The family, including the child, received family support services from the advocate and the family resource center. All the family resource centers had the capacity to provide such support services, including parenting classes and counseling services. The Bayview-Hunter's Point Family Resource Center is the only family support provider that also had an approved batterer intervention program and, therefore, had the capacity to assist adult offenders. The family advocate used the Child Behavior Checklist (CBCL), a standardized individual outcome assessment tool, to monitor behavioral health services and outcomes for SafeStart families; however, the instrument was too clinical. SafeStart implemented a new tool developed locally (Early Childhood Behavioral Health Screening Tool), which was much easier and simpler to use than the CBCL and more appropriate for administration by the family advocates (SafeStart Progress Report, July to December 2004).

If the family advocate determined that the child and the family needed further intervention, he/she referred the family to a SafeStart clinician. The family advocate also

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had the option of contacting the clinician for immediate assistance with crisis intervention, if necessary. Once the referral was made, the clinician was required to call the family within 24 hours to schedule an appointment to take place within 48 hours for clinical assessment, case planning, and therapeutic services. The child may also be referred to the Child Trauma Research Project for clinical services if he/she needed more intensive treatment.
At the scheduled appointment (within 48 hours of the referral), the victim and children were assessed by the SafeStart clinician. If the clinician had a full case-load and could not take any more cases, he/she referred the victim and children to a second SafeStart clinician or to another clinician within the referring agency or the Department of Public Health Community Behavioral Health Services unit.

SafeStart engaged one Spanish-speaking clinician and one Cantonese-speaking clinician. The Spanish-speaking clinician reported a caseload of 18 to 22 families attending therapy sessions at any given time. She received more referrals; however, not every family required therapy after a thorough assessment or completed the entire course of therapy. Consequently, the number of "open" cases, in which families were actively participating in therapy, tended to be lower than the number of referrals might have suggested.

Referrals through the Support Line were forwarded directly to a family advocate located in the same geographic area as the family or to one of the two SafeStart clinicians. According to SafeStart's semi-annual evaluation reports for October 2003 to April 2004, family advocates contacted the family within two business days; if the family could not be reached, the advocate made at least another four attempts to contact the family within the first 30 days.

A total of 452 children exposed to violence were identified by SafeStart in 2004 (SafeStart Progress Reports). Of these 452 children, 264 were assessed and 221 were referred to for services. As mentioned before, not all families and their children have needed therapy and even fewer have completed the full course of therapy. Retention of families has been a major challenge, according to point-of-service staff who met with the NET. They reported that many victims either changed their mind about getting help after they passed the crisis moment, or decided not to continue with SafeStart after the first session. Participants cited three factors contributing to the challenge of retention: 1) distrust of any type of agency or organization perceived to be associated with mental health services, because of the stigma; 2) distrust of any organization associated with the local government, because of historical racial marginalization and negative experiences with government; and 3) other referral networks that operated independently from SafeStart (e.g., the domestic violence community had its own referral system). Childcare and transportation also were reported as challenges for many families. SafeStart had respite childcare, but this service was available only on the west side of the city.

Participants expressed mixed opinions about the usefulness of family resource centers in engaging families in services. According to one perspective, the involvement of family resource centers helped increase a provider's access to families because these centers 1) were neighborhood-based, 2) were not clinics, and 3) encouraged families to seek help in a "friendly, and not professionalized" way. On the other hand,

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the participants feared that some families misperceived family resource centers as extensions of the local government and, therefore, were distrusting of the staff and their services. This was particularly true in Bayview-Hunter's Point, an African American neighborhood historically marginalized from the rest of San Francisco, both socially and economically.

Finally, several participants who were not part of the SDT commented on their lack of knowledge regarding outcomes of referrals they had made. Their comments suggested an incomplete understanding of the service pathway developed by SafeStart and its effectiveness thus far.

6.4 Community Awareness and Action

Public education campaign. San Francisco SafeStart launched a public education campaign in January 2004. The goal was to raise public awareness about issues related to children exposed to violence. The theme was "You're Not Just Hitting Her—Domestic Violence Hurts Children Too." About $135,000 ($120,000 from San Francisco Department of Children, Youth, and Their Families; and the remaining $15,000 from Advisory Council members, Saint Francis Memorial Hospital, and the California Attorney General's office) was leveraged for the campaign. The campaign distributed 30,000 flyers to every elementary school, child development program, and Head Start program; placed graphics inside 300 buses, on the rear of 50 buses, and on 30 bus shelters; made public service announcements on SFGTV, AccessSF, and six AM and FM radio stations; and conducted a television interview. SafeStart also conducted a press conference to launch the campaign; unfortunately, it was scheduled on the same day as the first gay marriage in San Francisco, making it less newsworthy than anticipated.

Nevertheless, the campaign received coverage on four television stations, five radio stations, and three newspapers, including the *San Francisco Observer*, *San Francisco Bay View*, *El Mensajero*, and *Sing Tao Daily* (ETR Associates, December 2004). All these materials contained the telephone number for the SafeStart Support Line. The campaign increased the visibility of San Francisco SafeStart and enabled several organizations, including two organizations that were not members of the Advisory Council—the Saint Francis Memorial Hospital and the California Attorney General's Office—to demonstrate their commitment to children exposed to violence by contributing funds to the campaign.

Participants believed that the campaign increased 1) public awareness of family violence and children exposed to violence, 2) public knowledge of available resources and professional services, and 3) viability of children's exposure to violence as an acceptable subject of discussion. For example, a member of the city's Board of Supervisors granted the SafeStart Project Director's request for a hearing on how trauma impacts a child's brain. Independent of SafeStart, the San Francisco Chronicle published an article about infant mental health. Whether or not these events were directly attributable to SafeStart, many participants described SafeStart's contribution to public awareness as increasing the visibility of children exposed to violence. One point-of-service provider interviewed by the NET mentioned that her clients started to realize that even corporal punishment could potentially harm their children, an awareness she attributed to SafeStart. Children's exposure to violence

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was receiving more attention in San Francisco, and SafeStart was viewed as contributing to the awareness. According to some participants, this would be the legacy of SafeStart.

Further development of the Parent Team. In 2002, Safe Start established the Parent Team as part of a strategic goal to 1) put parents in a leadership role and 2) apply the principles of the family support approach, which requires parents to be involved in planning, implementing, and evaluating services. The Team consisted of survivors of family or community violence and residents of the targeted neighborhoods. The Parent Team developed a mentoring program, based on the premise that one adult survivor could support another survivor through peer exchange and mentoring. SafeStart also expected the Parent Team to reach out to their communities to recruit additional members. Each parent received a $100 monthly stipend.

During its first twelve months, the Parent Team focused on developing leadership. The Team started out with four members; in March 2004, two additional parents joined the Team. One of the parents had more experience in outreach, and provided technical assistance to the other five parents.

6.5 Development, Identification, and Reallocation of Resources

The City and County of San Francisco made a $500,000 annual commitment to SafeStart for the next three fiscal years. A total of $210,000 annually was committed during the past two years. As mentioned before, about $135,000 ($120,000 from San Francisco Department of Children, Youth, and Their Families; and the remaining $15,000 from Advisory Council members, Saint Francis Memorial Hospital, and the California Attorney General's office) was leveraged for the campaign. SafeStart's Parent Team also received a $5,000 grant from the First 5 San Francisco to develop a parent-to-parent mentoring program.

7. Institutionalization of Change

SafeStart directly effected the following changes as a result of the above activities:

Enhanced capacity of family resource centers. SafeStart enhanced the capacity of family resource centers to better serve families by adding to their menu of services. As SafeStart partners, these centers expanded their historical support for families experiencing violence by developing a special focus on violence-exposed children six years and younger and their families. For example, SafeStart funds enabled the Asian Perinatal Advocates (the family resource center in Chinatown) to hire a part-time coordinator and two family advocates to focus specifically on children six years old and younger. This agency also revised its intake form to include assessment of domestic violence and children exposed to violence. SafeStart further enhanced the capacity of family resource centers in that families without insurance could now get services.

Changes in identification and assessment procedures for children exposed to violence. As a result of involvement in SafeStart, Child Protective Services changed its assessment and hotline procedures to include screening for domestic violence. Similarly, SFPD changed its reporting form to include a blank space for responding officers to note the names and pertinent details about children found to be present at domestic violence incidents. The San

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Francisco Department of Public Health's Community Behavioral Health Services unit reorganized their clinical assessment procedures to include assessment of exposure to domestic violence as determinants for the level of mental health services required. The Victim Services Unit of the San Francisco District Attorney's Office redesigned its assessment tool to collect more detailed information about the presence of children at the scene of an incident, particularly the age of the children.

Guidelines for responding to children exposed to violence. SafeStart developed eight policies, as described in Section 6.1, and shared them with their partners and other agencies as a step toward institutionalizing SafeStart goals, objectives, and values, such that they will be practiced beyond the Initiative's life. Thirty-five agencies reported to the local evaluator that they adopted these policies.

8. Community Supports

A community support system for families and children exposed to violence appeared to be emerging as a result of SafeStart. This system consisted of professionals and community advocates, including the Parent Team, SDT, family resource centers, and all the agencies participating in SafeStart's Advisory Council. Family resource centers, which support families experiencing violence through parenting classes, support groups, and early childhood intervention classes, have been enhanced by SafeStart.

The Parent Team received and used a $5,000 grant from the First 5 San Francisco to develop a parent-to-parent mentoring program, as mentioned previously. The mentoring program was established in response to the lack of support for people who were transitioning back into their family and community after a crisis. The first program activity occurred in October 2004; seven new parent mentors attended and were trained on mentoring and on issues related to children and violence in their communities.

9. Lessons Learned in the Implementation and Evaluation Of Safe Start Activities

The participants who met with the NET identified the following lessons learned:

- Continuous reiteration of SafeStart goals and policies was essential because of staff turnover among its partner agencies;
- A highly credible official in a position of leadership in the Initiative helped engage and retain partners, and bring attention to the issue;
- It was important to understand and leverage each partner's self-interest to engage and retain their participation. Personal outreach and contact by SafeStart staff, particularly the Project Director, helped a great deal in retaining partner involvement;
- For effective intervention with children exposed to violence, training must be provided on the following: individual reactions to trauma; family norms; group dynamics in a family (how each family member reacts to trauma); psyche of the batterer; and working with multiple systems, such as the court system.

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10. Barriers and Challenges

In addition to the above lessons learned, participants also pointed out several barriers and challenges that limited the full potential of SafeStart. These included:

- ***Capacity of SafeStart.*** As San Francisco SafeStart gained recognition, it came to be perceived as a leader in the field of children's exposure to violence, resulting in an increased demand on its staff. At the time of the site visit, SafeStart only had two staff members; a third position, while available, was not filled.

- ***Staff turnover.*** High staff turnover in partner agencies required SafeStart to conduct frequent training to orient new staff members to its goals and policies. For staff members with greater longevity, the continuous training became redundant. Because the intervention model is based on the relationship between family and staff, staff turnover in point-of-service agencies also caused some families to stop participating. Families typically become comfortable and attached to a family advocate or case manager; when that person leaves, the family may be resistant to accepting someone new.

- ***Institutionalization.*** Related to staff turnover was the issue of institutionalization. Participants were concerned that the institutionalization of SafeStart within specific agencies was dependent on particular individuals; when those individuals leave, the goals of SafeStart might be lost. Some participants also expressed concern that SafeStart has achieved engagement only with mid-level managers, and not with agency leaders (with the notable exception of Judge Hitchens). Consequently, systems change has been limited.

- ***Need for continued funding.*** Almost all SDT member agencies have been funded through a series of service agreements; to sustain SafeStart, funds must be leveraged to support SDT member agencies; to pay staff to coordinate the SDT; and, perhaps, to keep everyone at the table. Innovative ways to raise funds to support SafeStart (e.g., licensing fees) will have to be considered, according to participants.

- ***Approach to assisting families and children exposed to violence.*** Partner agencies did not unanimously accept SafeStart's family-centered approach to assisting victims of family violence. Different agencies held varying philosophies regarding the most appropriate services for family members, including the batterer. Partners in the SafeStart collaborative faced some difficulty in overcoming these differences. Further, a distrust of service providers and the stigma of mental health issues posed major challenges in some of the racially and economically marginalized communities.

- ***Legal assistance.*** What is missing and is needed is more legal advocacy for SafeStart clients to help with their appearances before the bench, particularly for victims who are not proficient in English. There are many organizations that provide legal services; however, not all of them were perceived to be responsive. A few participants mentioned one particular provider that took too long to respond; consequently, the victim changes her mind about seeking help by the time the provider contacted her. SafeStart funds a court liaison to identify families with children exposed to violence, to assist SafeStart families with their court issues, and to provide seamless case coordination with other members of the Service

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Delivery Team. As a court employee, the SafeStart Liaison could not advocate on behalf of any party to a court proceeding. SafeStart submitted a proposal to the Blue Shield Foundation to fund legal advocacy; however, the grant was not awarded. Several SafeStart participants reported that clinicians also needed to strengthen their capacity to interact with legal services.

- ***Stigma of mental health.*** SafeStart appeared to evolve in a more clinical direction over time, creating limitations for itself as a result of parental fear of the clinical. "People tended to become very protective about allowing someone they did not know into their child's head." Negative stereotypes about people who sought therapy also limited the full potential of SafeStart.

- ***Racial, ethnic, and cultural diversity of San Francisco***. While everyone who met with the NET agreed that the Initiative had been culturally responsive (e.g., information published by SafeStart was translated into three languages), staff believed SafeStart did not fully overcome the challenge of diversity in San Francisco. The view of cultural competence as competence in one particular culture (e.g., Latino) vs. competence across cultures remained an unresolved issue for SafeStart Advisory Council members. Involvement of African Americans in the SDT and as clinicians for SafeStart was limited. The city had few Tagalog-speaking case managers or clinicians; at the time of the NET's site visit, the Tagalog-speaking family advocate at one of the family resource centers had left, leaving a gap in services for Filipino families. As a consequence of the limited linguistic capacity of many providers, children present during a domestic violence incident were likely to be asked by responding police officers to translate for parents who did not speak English, causing further harm to the child, according to several participants.

- ***Lack of awareness, distrust, and fear among battered women.*** Many battered women were still either unaware of the help available to them or reluctant to get help for a variety of reasons. A tremendous amount of education must be provided to encourage these women to seek help for themselves as well as for their children.

11. Recommendations and Conclusions

Based upon the above accomplishments, systems changes, barriers, and challenges, the NET recommends that San Francisco SafeStart do the following as it moves forward:

- Build upon the established foundation for ensuring competence across race, ethnicity, and culture (e.g., committee dedicated to issues of cultural competence, availability of services and information in other languages) to further the capacity of the Advisory Council and individual service providers to address family and community violence in a racially and culturally diverse setting. Consider engaging a facilitator who specializes in relationship- and alliance- building across different cultural groups, as well as one who can facilitate analysis of the impact of racism on family and community wellbeing. The NET suggests that the SafeStart Project Director contact the director of Sitka's Safe Start Initiative to benefit from the latter's lessons learned in engaging partners in building cultural competence. SafeStart might also find it

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useful to review *Structural Racism and Community Building* by the Aspen Institute Round Table. As part of building this competence, SafeStart should also continue to build trust between communities and service providers, including family resource centers, by engaging the natural support networks in different cultures (e.g., teachers in Asian cultures, faith leaders in African American and Latino cultures) and learning more about the help-seeking behavior of people from different cultures. Service providers and the Parent Team could conduct an informal survey among the families they know, finding out where these families go for help and types of support they seek. This information could further enhance SafeStart's capacity to reach families and children exposed to violence.

- Expand the definition of "culture" and "cultural competence" to include competence to work across professional sectors and to help promote dialogue among the wide spectrum of agencies addressing domestic violence. Differences between professional sectors tend to be overshadowed by racial and ethnic differences; yet, they are equally important in an initiative like SafeStart, which requires the cooperation and involvement of agencies that constitute the system of care for young children exposed to violence and their families. A facilitator who specializes in coalition building and organization cultures could be engaged to develop and facilitate a process for transforming these differences into enhanced and collective capacity.

- Consider a potential institutional home for the SDT in case SafeStart cannot be continued due to lack of funding. The SDT was repeatedly reported as a new and important capacity developed by SafeStart and, therefore, should be sustained. A new institutional home will ensure continued coordination of SDT meetings in the absence of SafeStart staff who have played this role since its inception.

- Consider strategies for engaging more extensively the top leadership of agencies that are part of the system of care for young children exposed to violence and their families. San Francisco SafeStart had succeeded in engaging influential mid-level leaders who have laid the foundation for systems change. Many participants suggested that the initiative is now ready for furthering its efforts to institutionalize and sustain SafeStart's vision, goals, and policies by involving elected, appointed, and other leaders with larger constituencies.

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ATTACHMENT A: TIMELINE OF SAFESTART'S KEY ACCOMPLISHMENTS AND MILESTONES, JANUARY TO DECEMBER 2004

	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec
Presentation of police reports of children's exposure to violence	✓											
Full operation of Support Line	✓											
SDT training and policy meetings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SDT case consultation meetings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Evaluation Committee meetings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Batterers Intervention Program Committee meetings	✓	✓	✓	✓	✓	✓	✓	✓			✓	
Advisory Committee meetings	✓		✓		✓		✓		✓		✓	
Steering Committee meetings		✓		✓		✓		✓		✓		✓
Launching of Public Education Campaign	✓											
Selection of two new members for the Parent Team			✓									
Hiring of police liaison						✓						
Safe Start Academy	✓								✓			
Parent Team Mentoring Training										✓		

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IX

SITKA SAFE START INITIATIVE

1. Introduction

To develop a full understanding of the Sitka Safe Start Initiative (SSI) from the time of its inception through December 2004, the National Evaluation Team (NET) visited the Sitka site on October 14 and 15, 2004, and conducted follow-up telephone interviews with key individuals in November 2004 and again, in January 2005. The NET also reviewed existing documents about the Sitka SSI, including strategic, implementation, and progress reports. The NET interviewed 14 people, including key SSI staff, collaborating partners, point-of-service providers, a community leader, and the local evaluator.

The participants were asked between three and eight general questions, depending on their role with the Sitka SSI. Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of the Sitka SSI in the past year?
- How did the composition and process of the collaborative in each site influence the types of strategies implemented, and as a result, the system change outcomes?
- How has the Sitka SSI changed the service delivery system for children exposed to violence and their families?
- What organizational, point of service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes at each site?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of the Sitka SSI in each site?
- How did each site handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?
- What are the lessons learned about the implementation and replication of a national initiative such as Safe Start?

This report covers the period from the start of the Sitka SSI in January 2002 through December 2004. Organized according to the Safe Start Demonstration Project logic model, it describes the economic, political, and social context of the Sitka SSI; the technical assistance the SSI received; the collaboration among different community organizations and agencies participating in the SSI; the system change activities and new and enhanced programming for children exposed to violence developed by the SSI; the Initiative's institutionalization of changes; and the challenges faced and lessons learned by the participants. A timeline of major milestones is included in Attachment A.

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2. Contextual Conditions

Sitka is located on Baranof Island in Southeastern Alaska. Physically isolated from the rest of Alaska and accessible only by boat or airplane, Sitka covers 2,882 square miles; the rest of Baranof Island is uninhabited. The cost of living is very high (*Sitka SSI Implementation Plan, November 1, 2004 to October 31, 2004*). The average annual rainfall in Sitka is 80 to 100 inches, and the average daily temperature in the summer is 51.1°F (*All About Sitka 2004*).

With a population of approximately 8,835, Sitka is the fifth largest city in Alaska. Of Sitka's residents, 70.7% are European American, 23% are Alaskan Native (the Sitka Tribe), 7.4% are Latino, 5.6% are Asian/Pacific Islander, and less than 1% are African American (*Sitka SSI Implementation Plan, November 1, 2004 to October 31, 2004*; *All About Sitka 2004*).

The 2000 U.S. Census reported a median household income of $51,901 for Sitka, with approximately 7.8% of Sitkans living below the poverty level and an unemployment rate of about 5%; Alaskan Natives represent a disproportionate number of those impoverished (*Local Evaluation Reporting Form, 2005*). Of 3,650 total housing units in Sitka, slightly more than 10% are vacant and slightly less than 5% are used only seasonally (see www.beringsea.com/communities/index.php?community=338).

The seafood industry is the major employer in Sitka. According to several site visit participants, the area's physical attributes make the non-Native workforce in Sitka difficult to retain; employers competing for a limited pool of potential employees must provide competitive wages and benefits to get the employees they want. Social service agencies find it particularly difficult to acquire and retain staff, due to their limited resources and consequent inability to offer competitive wages. The seasonal nature of the seafood industry further contributes to the transience of the workforce. Because Sitka is their permanent home, however, Native workers tend to turn over less rapidly.

Sitka has two local governments: the tribal government (Sitka Tribe of Alaska or STA) and the municipal government. The tribal government is administered by an elected Tribal Council, while the municipal government is administered by the General Assembly for the City and Borough of Sitka, also elected. Each government agency in Sitka has two separate organizational structures: tribal and municipal (*Sitka SSI Implementation Plan, November 1, 2004 to October 31, 2004*). These structures interface, but do not necessarily collaborate with one another, according to many site visit participants.

The State of Alaska has the highest rate of domestic violence in the nation (*Sitka SSI Strategic Plan*); within Alaska, the City of Sitka has the highest domestic violence rate, according to law enforcement representatives interviewed by the NET. Alaska also ranks highest in the number of female homicides per year, with almost twice the rate of Louisiana, which ranks second. A 2001 study by the Alaska Network on Domestic Violence and Sexual Assault reported that Native families were twice as likely as other families to experience domestic violence, and Alaskan Native women were murdered at a rate 4.5 times that of other women. In 2001, the Sitka Police Department responded to 84 domestic violence calls, 141 domestic violence calls that did not meet the state statute standard for filing assault charges, 26

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sexual assault crimes, 164 harassment calls (frequently classified as domestic violence), and 35 violations of restraining orders (*SSI Framework Worksheets, 2005*).
Because of the small town character of Sitka, everyone knows everyone else, both within and across the Native and non-Native communities. Personal and professional relationships are intertwined, and the same people are involved in every major initiative, according to all the community and agency leaders who met with the NET. As a result, conflicts can be difficult to resolve because they are often perceived as personal. On the other hand, information sharing is often facilitated because of preexisting personal relationships.

Since the invasion of the Russians in 1804, the Alaskan Native community in Sitka has experienced decades of trauma. According to Native interviewees, citizens of the Sitka Tribe—of Tlingit, Haida, Aleut, and Tsimpsian heritage—have had experiences similar to those of many Native American groups. Early Russian and European American settlers took tribal lands and forced the Native people to assimilate by prohibiting their practice of spiritual and cultural traditions. The oppression of the Native people has led to a deep sense of loss of culture and powerlessness. Further, the ongoing tensions inherent in bicultural life often cause conflicts within the self and within the community, which in turn affect a person's mental health (see for example, Nofz, 1988; U.S. Dept. of Health and Human Services, 2001). For example, the tribal elders, in particular, are afraid that their children will become too "Westernized," according to several Native persons. These factors lead to disproportionate rates of substance abuse and violence within Native families.

Some site visit participants implied pervasive institutionalized racism in Sitka, while others did not appear to share this perception. According to certain participants, racial differences and racism often make a convenient excuse for tensions when, in fact, conflicts are personal.

The services available to the Native community in Sitka are typically not culturally competent. All participants agreed that there are major cultural differences between the Native and non-Native communities. Non-Native service providers have a poor understanding of these differences, particularly those pertaining to the role of extended family and clan relationships. As a result of their sense of oppression and culturally incompetent services, Native individuals distrust the providers in Sitka, including the police and mental health providers.

According to Native participants, the Tribal Council initially felt reluctance to focus on the issue of domestic violence, because tribe members find it such a painful subject to discuss. At the same time, Council members instinctively knew they must start the discussion, because domestic violence threatens their identity and cultural traditions, which emphasize kinship, respect between generations, and community. As a result, they voted to support the Safe Start grant application, and, subsequently, the grant *To Encourage Arrest* and the *Family Justice Center* grant.

By contrast, the current elected leaders in the General Assembly have not bought into the concept of social services or prevention. General Assembly leaders do not participate in the SSI collaborative. Domestic violence issues are a low priority for the Assembly. According to some site visit participants, Assembly leaders are in denial of domestic

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violence in the general community, as well as in the Native community. Because of this limitation in support from the city's leadership, the Sitka SSI has not been able to achieve its full potential.
Historically, the relationship between the STA and other agencies in the municipal government has not been strong because of long-standing conflict between the Native and non-Native cultures. The two governments, communities, and their leaders have typically operated on parallel paths. The Sitka SSI provided an opportunity for these paths to converge in support of an important issue.

Leadership changes in both governments could affect the Sitka SSI. The tribal government held elections in November 2004; four members were replaced. Site visit participants were unsure of the impact these leadership changes would have on the SSI and domestic violence; the new leaders have seemed supportive of the Initiative thus far.

3. Community Capacity

Several capacities in the Sitkan community facilitated the implementation of the Sitka SSI. First, the Native community has a firm commitment to its members, with a strong tradition of cherishing and supporting its children through clan networks. Because the Sitka SSI also supports children, through reducing their exposure to violence and the impact of that exposure, the SSI aligns with Native traditions. Leaders and service providers in the Native community, therefore, have offered extensive support for the SSI.

Second, everyone in Sitka knows everyone else. Providers and other agency representatives know whom to call for assistance, and personal relationships facilitate information exchange.

Third, Sitkans Against Family Violence (SAFV), a critical member of the Sitka SSI collaborative, is a well-established and credible organization within the general community as well as the Native community. All agency representatives who met with the NET reported good relations with SAFV. Some SAFV advocates have had relationships with certain Sitkan families for many years; according to one advocate, SAFV advocates do not see these families as victims, but rather as friends who need help and support. Unlike many other domestic violence shelters and advocacy groups across the country, SAFV has a division dedicated to children. As a standard element of all domestic violence shelters and advocacy groups in the State of Alaska, this division ensures that children receive the attention they need. Its counselors help teach abused women how to talk to their children about the violence in their home. According to SAFV philosophy, if the mother is not safe, the children are not safe.

Fourth, the Sitka Police Department (SPD) had preexisting capacity for addressing issues related to domestic violence. Since 1996, the SPD has had a Domestic Violence Coordinator on staff, responsible for ensuring appropriate service referrals for families experiencing violence. In 2003, the SPD established a domestic violence unit with funds provided by *To Encourage Arrest*, a grant submitted jointly with the STA. The Domestic Violence Coordinator became part of this unit. Along with a 2004 *Family Justice Center* grant, the establishment of a domestic violence unit significantly increased the capacity of the SPD to assist families experiencing domestic violence, as well as to support the goals of the Sitka SSI.

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On the other hand, a lack of certain capacities in Sitka challenged the Sitka SSI. The Native community had limited capacity to provide mental health services or other assistance because most Native staff members did not have higher education degrees. This lack of capacity left Native Sitkans dependent on non-Native providers, typically of European descent, who did not understand the history and traditions of the Tlingit people.

Sitka also lacked specific mental health intervention for children six years and younger exposed to violence; these children received general psychological treatment that was not specific to their age or the impact of exposure to violence. For example, the SouthEast Alaska Regional Health Consortium (SEARHC), a major health provider for the Native community, had certified professionals trained in mental health services, but none with specific training in treating trauma in children six years and younger. Even though SEARHC is led and operated by a board of Native members and charged with providing services to the Native community, its clinicians and physicians were not all Alaskan Natives. Many of the individuals who met with the NET perceived SEARHC as a culturally incompetent bureaucracy.

In January 2004, the Island Counseling, a local mental health service, and the Sitka Prevention and Treatment Services merged to create the Sitka Counseling and Prevention Services (SCAPS). This merger occurred due to the merging of prevention and treatment services at the state level. Following the merger, SCAPS could serve severely emotionally disturbed children three to 12 years old, and could provide emergency assistance for a maximum of 72 hours. SCAPS substance abuse services, which served children 12 to 18 years, were less restrictive. Children who were not severely emotionally disturbed could be treated through these services.

The creation of SCAPS had advantages and disadvantages for the Sitka SSI. SCAPS now served a larger age range—children and adolescents from three to 18 years old—and could treat co-occurring illnesses. On the other hand, a funding cut accompanied the merger. This funding cut prevented SCAPS from keeping clinicians on-call at night to assist CID-COPS, resulting in lost opportunities to intervene at a crisis moment and convince a family to get services. (See section 5 for a more thorough description of CID-COPS.) At the end of 2004, however, the Sitka SSI hired a psychologist with the appropriate higher education degree, who was able to organize a team of clinicians from several agencies to fill this gap.

4. Integrated Assistance

To strengthen its capacity, the Sitka SSI received technical assistance from several sources. In 2002 and 2003, it engaged the TODOS Institute in Oakland, California, to conduct training on building relationships and alliances across race, ethnicity, gender, class, sexual orientation, and age. The events were open to everyone in the community. Approximately 50 people attended each training event. According to several people who met with the NET, these events helped increase awareness of 1) the differences between Native Alaskans and non-Natives and 2) the importance of building relationships among individuals from the two communities. This increase in awareness, however, was not universal; some who attended the trainings did not find them helpful, perhaps because they required a level of self-reflection that was uncomfortable. The individuals who met

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with the NET expressed a desire for the Sitka SSI to continue to sponsor such trainings, to reinforce the interest and commitment sparked by the TODOS Institute. At the end of 2004, the Sitka SSI conducted a similar training for the SPD (described later in Section 6).

The Sitka SSI received extensive assistance from the National Center for Children Exposed to Violence (NCCEV) on the Child Development-Community Policing (CDCP) model. Seven participants from the Sitka SSI, including police officers, SSI staff, teachers, and domestic violence advocates traveled to New Haven, Connecticut, to learn more about CDCP. This trip, which gave participants the opportunity learn about each other as individuals, thereby debunking many stereotypes and assumptions, was reported as the turning point for the Sitka SSI. Their newfound trust in each other, combined with their newly developed CDCP knowledge and skills, motivated the participants to put the CDCP model into action immediately upon their return to Sitka (in the form of CID-COPS).

In 2004, Sitka SSI staff attended The Institute for Community Peace's sustainability training, a training described by several participants as valuable. These participants identified the training as their first opportunity to openly discuss issues of race and power as related to violence.

The Sitka SSI also received assistance from the National Council on Juvenile and Family Court Judges (NCJFCJ) for the development of its Tribal Court. Convening State and Tribal Court personnel for the first time, NCJFCJ provided a one-day training for the State Superior Court Judge, the State Magistrate, three Tribal Court judges, the Prosecuting Attorney and her assistant, the Juvenile Justice Officer, and the Public Defender.

The Sitka SSI received training from staff at the University of California at Davis on the Parent Child Interaction Therapy (PCIT) model. The SSI then sought technical assistance from a Native psychologist at the University of Oklahoma to mold PCIT into a more culturally appropriate model for the Native community. Because of schedule conflicts, however, the Sitka SSI staff was not able to meet with the psychologist until late 2004, delaying implementation of PCIT in Sitka. In late 2004, the National Civic League (NCL) coordinated a training session, led by the psychologist, for the clinical staff of the Sitka SSI and the Pueblo of Zuni SSI, the other Native American site participating in the Safe Start Demonstration Project.

The Sitka SSI staff described the technical assistance received as generally helpful and sensitive to the history and challenges of Native communities. The Systems Improvement, Training, and Technical Assistance Program (SITTAP), in particular, helped the staff develop language and skills for policy analysis. The NET's understanding of systems change and community development also proved helpful, in part due to its more direct alignment with the philosophical orientation of the Sitka SSI Project Director.

5. Local Agency and Community Engagement and Collaboration

Sitka has seven collaboratives, five focused on children. The Sitka SSI collaborative has been the most unique and successful, according to many site visit participants, due to tangible results such as CID-COPS.

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Participants who met with the NET described the Sitka SSI as "a collaborative where people don't just sit around, plan, and talk." SSI action has led to tangible benefit, which has continued to feed forward in the form of additional progress for the collaborative.

When asked which agencies were critical to the Sitka SSI, all participants mentioned the SPD, STA Social Services, and SAFV. These three agencies comprise the core CID-COPS team. Other essential partners mentioned included SCAPS and the state Office of Children Services (OCS). SEARHC was described as a critical agency that should have been engaged earlier and more extensively, but, in fact, did not participate significantly in the SSI until the end of 2004. The School District also was reported as an important partner, but was not well represented in the Sitka SSI.

Until the end of 2003, members of the Sitka SSI collaborative met every month. At that point, however, busy schedules forced a switch to more manageable quarterly meetings that would focus on administrative issues; the CID-COPS team continued to meet monthly. This change in meeting process was not communicated effectively to collaborative members; some site visit participants did not know why meetings had not occurred in the last six months. Other participants did not have accurate information on the status of the protocols for identifying, referring, assessing, and treating children exposed to violence, or the status of the PCIT component of the SSI. Communication and information deficits such as these might have occurred due to the resignation of the Safe Start Program Coordinator, which temporarily diminished the SSI's capacity to maintain its previous level of activity and communication.

Until recently, partners in the collaborative have been bound by memoranda of understanding; however, these memoranda were written in general terms. The Sitka SSI was working with SITTAP to revise the memoranda to specify the roles that each partner would play in the collaborative and to make explicit the requirement for cultural competence at the end of 2004.

The two most frequently reported barriers to collaboration were the intertwining of personal and professional relationships in Sitka, and confidentiality issues related to case management. Although the small town relationships in Sitka can be a community asset, they can also hamper collaboration. Professional conflicts can easily become personal, according to all participants. The lack of protocol for handling confidential information about families and children also hinders collaboration; certain agencies are less comfortable sharing information, which creates difficulties for everyone.

Five agencies (SPD, SAFV, SCAPS, SEARHC, and OCS) were most often described as essential to the Sitka SSI, which has provided these agencies with an opportunity to work together. The SSI also has allowed these agencies to improve their relationship with STA Social Services, thereby enhancing their credibility in the Native community.

STA Social Services is the lead agency for the SSI grant, a significant accomplishment for the STA, according to Native leaders. The involvement of STA social services and support from the STA Tribal Council have been critical for bringing issues of domestic violence to the forefront of tribal discussion and reflection.

The Sitka SSI strengthened the relationship between the STA and the SPD through CID-

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COPS. Prior to the Initiative, the STA and the SPD had a relationship; CID-COPS moved this relationship to a new level. The two agencies have gone on to collaborate on two grants: one to address domestic violence (*To Encourage Arrest*) and one from the Family Justice Center Initiative. After approaching the STA about collaborating on these grants, the SPD took the lead in writing both grant proposals, while the STA served as lead agency. Both grants were awarded, enabling the SPD to go beyond its basic law enforcement duties and support the community, particularly the Native community, in more specific ways. The *Family Justice Center* grant, in particular, has energized police officers to continue to address domestic violence issues, according to officers who met with the NET.

The STA also has allocated $10,000 each year for the next three years to support the position of School Resource Officer, who will act as liaison between the SPD and the school district on domestic violence cases involving both Native and non-Native children. This allocation was viewed by some site visit participants as a demonstration of the STA's commitment to the entire community—and not just to Native citizens—which should further encourage non-Native agencies to collaborate with the STA.

When asked what facilitated the SPD's involvement in the Sitka SSI, police officers and other participants in the collaborative reported four factors: the commitment of two officers, one of whom has extensive experience working with Native communities in other parts of Alaska; the Police Chief's support; the officers' participation in the trip to New Haven to learn more about CDCP, which both strengthened their relationship with other collaborative members and convinced them to adapt and implement CDCP right away; and the officers' recognition that collaboration facilitates their work every time they are able to pick up the phone and contact another resource for support. The police officers interviewed by the NET reported initial difficulties in convincing the Police Chief and other officers of the need for a comprehensive solution to issues of domestic violence. Over time, however, the Chief and other officers became convinced of the value of collaboration. For example, the relationship between the SPD and the STA helped facilitate the development of the STA Tribal Court, with the strong support of the Police Chief. The first court order of protection was issued in November 2003.

The Sitka SSI "kicked the relationship between the STA and SAFV into a different gear," according to several participants. SAFV was involved in the collaborative from the beginning; now, it is primarily involved in CID-COPS. CID-COPS also helped strengthen SAFV's relationship with the SPD, leading to daily inter-agency conversations. Several site visit participants mentioned that police officers and domestic violence advocates no longer view each other as "enemies."

Mid-2004 saw some tension between STA Social Services and SAFV, due to a personnel change at SAFV. One STA staff person interviewed by the NET described the tension as the result of racial conflict within SAFV; others described it as a simple personality conflict. In this instance, the intertwining of personal and professional relationships among staff at STA Social Services and SAFV complicated the problem. According to almost all of the site visit participants, however, the tension gradually dissipated without any lasting effect on the collaborative. SAFV and STA Social Services representatives continued to

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work together. SAFV agents continued to play a critical role in CID-COPS by advocating for victims of domestic violence and their children.

The Sitka SSI also helped strengthen the relationship between the STA and SCAPS, according to several participants. STA Social Services representatives and SCAPS staff members worked together on the community needs assessment to identify gaps in the continuum of care for children exposed to violence. As a result of this activity, SCAPS identified its own need to move toward family-centered therapy and provide services in the home. While SCAPS has been supportive of the Sitka SSI, however, its participation has been limited because of 1) state policies that affected its criteria for service eligibility (see Section 2, Community Capacity) and 2) funding cuts that prevented it from paying clinicians to be on-call after working hours to assist the CID-COPS team. Although clinicians from SCAPS have continued to participate in CID-COPS, they have been less available than clinicians from other agencies, including the STA and SEARHC.

According to the Sitka School Superintendent, "Safe Start has been one of the better initiatives I have been associated with in 29 years as an educator." Under the SSI protocol for serving children exposed to violence, when a student is exposed to domestic violence, the School Resource Officer communicates to the student's school principal and counselor the next day. This prepares the school counselor, principal, and teachers to help the child if he/she behaves inappropriately in school. Some of the participants wished that school district personnel were more involved in the SSI, beyond the participation of an elementary school principal who regularly attended the CID-COPS meetings.

The Sitka SSI brought the state OCS and STA Social Services together for the first time. In an unprecedented step toward collaboration, the OCS supervisor in Sitka arranged to commit 20% of her time to assisting the STA; the Sitka SSI provided the opportunity for this collaboration. Many of the participants, however, initially doubted the extent of OCS commitment to the SSI. Some perceived the supervisor as a barrier to collaboration based on bureaucratic differences. Nevertheless, participants reported that the relationship between OCS and the SSI improved at the end of 2004; unfortunately, budget cuts required the OCS supervisor to divide her time between Sitka and Juneau, thereby diminishing her capacity to work closely with the STA.

Some of the participants suggested that SEARHC could be more active in the collaborative. Their comments implied tensions between SEARHC and STA Social Services because of 1) differences in their respective approaches to treating children exposed to violence and 2) SEARHC's level of cultural incompetence. Specifically, SEARHC takes a "Westernized" clinical approach to mental health treatment, which can make Native families uncomfortable. According to some participants, SEARHC failed to provide adequate clinical oversight for the PCIT element of the Sitka SSI after being contracted by the STA; the failure of this contractual relationship hampered any further collaboration between SEARHC and STA Social Services.

When the STA hired a psychologist in late 2004, SEARHC's participation in the SSI appeared to improve, perhaps because of the mutual benefit of his involvement. He began to evaluate SEARHC clients five years and younger, as the agency's staff psychologist was not experienced with this age group. In

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return, SEARHC provided 1) clinicians to join the CID-COPS team, and 2) assistance for SSI referrals who required psychiatric treatment (e.g., autistic and bipolar children).

6. System Change Activities

6.1 Community Assessment

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) required Safe Start Demonstration Project grantees to identify gaps in the system for helping children exposed to violence. This proved useful for the Sitka SSI, increasing the Initiative's visibility in the Native community when the SSI Project Director used a Native education program as an access point to solicit the opinions of Native residents, including youth. Upon its completion, the community assessment also provided an opportunity to convene the Tribal Council to develop a strategic plan. The Tribal Council had never experienced a strategic planning process before. With a consultant from Anchorage facilitating, however, the planning process led to tangible outcomes (a needs assessment summary and a strategic plan), demonstrating the collaborative's action-oriented approach. According to all of the participants with whom the NET met, other collaboratives in Sitka have been less successful than the SSI because they have not demonstrated the same action-oriented character.

A total of 235 Native citizens participated in the community assessment. The assessment summary included the following major findings:

- Cultural and language barriers, racism (actual or perceived), and distrust of the system were the most frequently reported barriers for not accessing existing services;
- Strong interagency cooperation, community awareness and education on the effects of domestic violence on children, and early intervention programs and support groups were the most frequently reported gaps in the service system;
- Safety and fear were reported by almost half of the participants as the reason for not getting help; and
- Pediatric counseling was identified as the top resource needed in Sitka.

6.2 Community Action and Awareness

The Sitka SSI engaged the TODOS Institute to conduct training on relationship building across race, ethnicity, class, gender, and other attributes that tend to divide people. The training occurred twice during the first two years of the Sitka SSI, with both training events open to the public; the second training was co-sponsored by the school district. Approximately 50 people attended each training event. Participants included the School Superintendent, teachers, and school counselors; SCAPS' clinical director; SEARHC's psychiatrist; SAFV advocates; and several other agency leaders and representatives, as well as youth.

The training allowed the STA to identify allies for the continuous improvement of the relationship between Native and non-Native communities. According to participants interviewed by the NET, however, those who attended the training had mixed reactions. Some found it very useful in helping them to become more comfortable with discussions of race. Others did not find it helpful, perhaps because it required an uncomfortable level of self-reflection. The School Superintendent was among those

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who found it useful, and expressed the desire to provide such training in all Sitka schools in the future. Some of the participants interviewed by the NET would like to see ongoing training, to engage more people in reflection and discussion, and to sustain the dialogue.

The SSI Project Director and a European American on staff with the STA conducted a cultural competence training for the SPD at the end of 2004. This training marked the beginning of a series of planned activities to raise the awareness of non-Natives about the Tlingit people and culture, as well as to build relationships between the two communities. The Tribal Council and the General Assembly agreed to the importance of such a process, and the City Administrator requested that the SPD receive the first training. The training strengthened the inter-community relationships among certain individuals in both communities; it also made explicit the officers' lack of understanding of the historical trauma experienced by Native Americans. The SSI Project Director remained positive about continuing the trainings in 2005.

Because of the difficulty and pain associated with discussing domestic violence in the Native community, the Sitka SSI Project Director decided to use the Native tradition of totem pole carving to raise the issue in a more natural and permissible way. She asked a group of youth to tell a story as part of their participation in a totem pole carving. The youth chose to tell a story about domestic violence, bringing the issue to the forefront and prompting the elders who participated in the process to acknowledge the youth's pain. Since then, several tribal elders have continued to meet with the youth to carry on the dialogue.

6.3 Development of Policies, Procedures, and Protocols

The Sitka SSI drafted an interagency protocol to describe the role of each agency in the continuum of care for children exposed to violence, from identification to treatment to follow-up. Under the protocol, SPD officers were required to record the presence of children during all domestic violence responses. Each morning, the SPD's Domestic Violence Coordinator reviewed the officers' reports, and immediately informed the child's school principal or counselors, to ensure that the child was handled appropriately in school; the SAFV Children's Services Coordinator, to ensure the SAFV advocate visited the family's home accompanied by a police officer; and STA Social Services, to ensure that the STA clinician followed up with treatment.

This protocol was both helpful and challenging, according to some participants. Although it provided all participating agencies with a standard process for responding to an incident, a standard protocol for the assessment of children exposed to violence proved difficult to implement, in that each agency must ask its own set of questions to fulfill its unique responsibility. Agencies also differed with regard to point of entry into the protocol, as well as in staff capacity for implementing the protocol.

CID-COPS also developed a response protocol. Members of CID-COPS included the SSI's psychologist and other on the STA Social Services staff, clinicians from SEARHC and sometimes SCAPS, SAFV staff, SPD officers, the OCS supervisor, the principal of the Baranof Elementary School, and representatives from the Alaska State

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Department of Juvenile Justice and Probation.

Of these members, two were required to respond to each domestic violence call: one for the victim (typically a woman) and children, and one for the perpetrator (typically a man). After receiving all necessary background information on the perpetrator (e.g., repeated offense, violation of restraining order), the victim, and the children, the SAFV advocate on-call would be picked up to ride to the scene with the responding police officers. The advocate was responsible for bringing the CID-COPS bag, containing the release of information form, toys, and information about CID-COPS and the SSI. At the scene, the advocate would schedule a follow-up call or visit with the family, with the goal of arranging to accompany the victim to the arraignment (if any) and ensuring that the victim schedules an appointment with the Sitka SSI's psychologist.

The CID-COPS team met every two weeks during the last quarter of 2004 to discuss cases. All members signed an agreement to protect the confidentiality of families. The CID-COPS team members who responded to situations were expected to obtain a release of information from the victim to allow for sharing of information at the bimonthly meetings.

6.4 Service Integration

CID-COPS. CID-COPS is the Sitka SSI's adaptation of CDCP. Site visit participants described this program as the most tangible component of the Sitka SSI and, therefore, the motivating factor for collaboration by all partners and point-of-service providers, who could clearly see and understand the program's direct results and benefits. Prior to CID-COPS, partners and point-of-service providers were acutely aware of the potential impact of violence on children; only after the introduction of CID-COPS, however, were they made aware of a solution. As described in the previous section, the CID-COPS team included staff from the SPD, SAFV, STA Social Services, SEARHC, a local elementary school, OCS, SCAPS, and the Department of Juvenile Justice and Probation. Initially, CID-COPS faced a significant challenge in recruiting clinicians to the team because of 1) the additional cost incurred by partner agencies to place their clinicians on-call after working hours, and 2) the lack of a supervising clinician to coordinate and follow-up with on-call staff. When the STA hired a psychologist, this challenge was alleviated.

All SPD police officers have completed a four-hour CID-COPS mini-training conducted by a police officer and a domestic violence advocate from SAFV; eight officers have completed the full eight-hour training course. Representatives from the District Attorney's Office and the Alaska State Troopers also participated in the eight-hour training in August 2004. As representatives of CID-COPS, SPD officers accompanied STA Social Services and SAFV staff from house to house to offer support to the grieving community when a 13-year old Native American girl was found dead after disappearing days earlier. The Native families opened their doors and welcomed the team members into their homes. According to many of the participants with whom the NET met, this was the first time that police officers were invited into Native homes, marking a significant change in the relationship between the SPD and the Native community. The SPD also was invited to speak at an event attended by tribal community members. The police officers who met with the NET described this, too,

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as unprecedented, and a significant accomplishment in itself.

CID-COPS not only helped young children exposed to violence, but also worked with older children through referrals received from schools. Finally, CID-COPS members provided additional assistance to battered women, such as help with accessing emergency funds, finding housing, applying for jobs, and dealing with legal issues.

Family Justice Center Grant. The *Family Justice Center* grant, received in fall 2004, provides another example of service integration and collaboration between the STA and the SPD. The grant is being used to remodel a building; this building will house the SPD's Domestic Violence Coordinator and other services for families as of its scheduled completion in May 2005. The *Family Justice Center* grant also will provide for additional technical assistance that could benefit the SSI.

6.5 New, Expanded, and Enhanced Programming

The SSI developed two major programs to assist and support children exposed to violence: CID-COPS and PCIT. At the time of this writing, CID-COPS had been firmly established and was well on its way to self-sustainability, according to several participants. Implementation of the PCIT program, on the other hand, was delayed until the end of 2004 and the hiring of a psychologist (as explained in greater detail below).

CID-COPS. In 2004, CID-COPS served 55 children from 23 families (*SSI Framework Worksheets, 2005*). OCS referred approximately 45 to 50 families through CID-COPS; however, not all of the children in these families were assessed for exposure to violence. In some cases, families were having other problems, and an agency representative participating in the SSI collaborative was able assess the situation and help the family. Sitka SSI's psychologist reported working with seven children and their families from the time he was hired to the end of 2004.

Several participants reported that such referral and support for children exposed to violence was only possible because of the collaboration and progress brought about by the Sitka SSI, specifically, CID-COPS, the ongoing meetings among partners, and the hiring of the psychologist.

PCIT. The Sitka SSI contracted with the University of California at Davis to provide training on PCIT. Clinicians from SEARHC were trained to incorporate PCIT into their treatment plans for families. Two Native persons were also trained as paraprofessionals, to make PCIT more comfortable for Native children and families. The paraprofessionals trained in PCIT included the Director of the Sitka Native Education Program (SNEP), a program that works with over 100 children and youth each year through its traditional Tlingit education activities. SNEP staff members have relationships with many Native families, making them a valuable resource for identifying and referring children exposed to violence.

Following the PCIT training, families referred to the Sitka SSI for treatment were scheduled to receive Relationship Enhancement Training (RET) during the first phase of their treatment plan (the first 12 to 18 weeks); RET was provided by the trained paraprofessionals. After completing RET, families were referred to SEARHC to complete the second phase of their treatment, which required the involvement

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of certified clinicians. The STA paid SEARHC to provide oversight in this second treatment phase.

Many Native families did not seek assistance after completing the RET component of their treatment plan. The Sitka SSI staff conducted focus groups to find out why families were not continuing with their sessions, and learned that transportation and daycare were not accessible, and that times for therapy sessions were not convenient for families. The families also told STA Social Services staff that they felt more comfortable seeking assistance at STA, where they knew the staff. The Sitka SSI decided not to continue SEARHC's services.

As a result of the above experience, the Sitka SSI contacted an expert at the University of Oklahoma, a psychologist who has done work to adapt the PCIT model for Native American communities. This adaptation would allow for the training and certification of paraprofessionals to implement PCIT, a more realistic solution for using Native providers in Sitka, where the tribal community lacks professionals with higher education degrees. The adaptation and application of culturally appropriate PCIT, however, was delayed because of timeline and scheduling conflicts.

In the meantime, STA Social Services hired a psychologist who also serves as the department's deputy director. This immediately increased the Sitka SSI's capacity for direct supervision of paraprofessionals. This person will receive training in early 2005 from the expert at the University of Oklahoma to enable him to provide the necessary PCIT supervision in the future. He also will explore ways to make PCIT less clinic-based and more community- and home-based as well as culturally appropriate (i.e., services will be provided at the family's home, and Native traditions will be incorporated into the approach). Paraprofessionals familiar with the Native culture will be trained to provide services. The use of paraprofessionals will also allow families to receive assistance for other needs, including food, shelter, and employment.

6.6 Development, Identification, and Reallocation of Resources

To Encourage Arrest and *Family Justice Center* grants have provided additional resources for Sitka to address issues of violence, including domestic violence. The STA and SPD jointly applied and received an *Encourage to Arrest* grant and a *Family Justice Center* grant, as mentioned before. A total of $210,000 was received in FY 2004 as part of the Encourage to Arrest grant. The *Family Justice Center* grant amounted to $1.1 million. This grant is being used to remodel a building; this building will house the SPD's Domestic Violence Coordinator and other services for families as of its scheduled completion in May 2005. The *Family Justice Center* grant also provided funds for three new positions to work with domestic violence victims and their families.

Further, as a result of the collaboration between the SPD and STA, the STA decided to give $10,000 per year for the next three years to fund a School Resource Officer who will help identify children exposed to violence and act as a liaison between the school and police officers.

7. Institutionalization of Change

Institutionalization of changes, such as CID-COPS and the community's increased awareness of domestic violence and its

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impact on children, became possible through improvement in the relationships, knowledge, and skills among service providers and the STA. Site visit participants mentioned several specific factors as facilitating institutionalization:

Commitment and volunteer support from SAFV and the SPD. According to many participants, CID-COPS will continue even after the SSI grant because of the firmly established relations and protocols and the absence of new staff costs. All SPD officers have received training in CID-COPS. Several participants reported that the CID-COPS team has received positive responses from police officers not intimately involved in CID-COPS, as well as from community members

Inclusion of issues related to children exposed to violence in SAFV trainings. As a result of the Sitka SSI, SAFV added issues related to children exposed to violence to all of its trainings. SAFV has trained three more advocates to participate in CID-COPS.

Hiring of a psychologist as Deputy Director for the STA Social Services. The recent hiring of a psychologist with the appropriate education and background as Deputy Director for the STA Social Services further ensured that children exposed to violence will continue to receive proper treatment through implementation of a modified PCIT model. This hire increased the STA Social Services capacity to address issues related to children exposed to violence.

Use of Medicaid funds. The Sitka SSI began to explore the possibility of Medicaid billing to continue to provide treatment services to children exposed to violence. The Project Director was to work closely with SCAPS on this issue, because SCAPS already had a Medicaid billing structure in place. In late 2004, however, participants reported that SCAPS was struggling with Medicaid issues due to policy changes and budget cuts, making the SSI's Medicaid billing option less feasible.

8. Increased Community Supports

The Sitka SSI has helped to increase two forms of support for the community: additional funds and collaborative relationships. First, the SPD's ability to leverage grants in collaboration with the STA increased resources to strengthen the continuum of care for children exposed to violence and their families. Second, the General Assembly, the governing body for the municipality, and the Tribal Council, the governing body for the Native community, began to meet, initiating a process of collaboration and exchange after 200 years of conflict and parallel operations. The STA's improved relationship with many of the agencies in the mainstream community also will help to initiate and ensure integrated services in the future.

9. Lessons Learned in the Implementation and Evaluation of Safe Start Activities

The Sitka SSI showed participants how to "just do it and don't sit around and talk." The participants learned that starting small to produce tangible benefit helped feed the Initiative's success, particularly with regard to CID-COPS.

According to several participants, a therapy-and-medical model is unfamiliar to Native persons because it does not include their

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cultural traditions. This may explain their poor response to SEARHC's PCIT services. Tribal traditions (e.g., drumming, rites of passage rituals, basket weaving) must be integrated into the therapy model to create an intervention that is culturally responsive and familiar. Interventions also must be responsive to social context. For example, it is unrealistic to expect a mother with seven children who is constantly at risk of being evicted to keep weekly appointments. To offer adequate help, assistance and support to families must be able to address issues such as housing and employment.

A local person with expertise in policy development must be part of an SSI from the very beginning, to ensure a consistent link between the program and other governing bodies. This, in turn, would enhance institutionalization and sustainability.

10. Barriers and Challenges

The participants who met with the NET identified the following challenges and barriers:

Racism and cultural incompetence. According to many participants, the interface between mainstream and tribal culture has presented many challenges, because of issues related to racism and cultural incompetence. Tribal issues have rarely been emphasized in general programs and services. Because the STA is the lead agency for the Sitka SSI, however, the Project Director has, for the first time, had the opportunity to engage other providers and agency leaders in discussion of the issues faced by the tribal community. At the same time, the Project Director continuously struggled with being the only Native voice, professional, and agency leader at the table. The Project Director also struggled with getting the tribal leadership and community members to discuss issues related to race and oppression, in part due to the fact that they are unaccustomed to having a safe place, either within or outside their community, to discuss the pain that has transferred from one generation to the next.

Some participants reported that issues of race and power were unnecessarily emphasized, in that institutionalized racism is not prevalent. This perception made it even harder for the Sitka SSI to address issues related to culturally incompetent services for Native families and children.

Adaptation of the PCIT model. As described in Section 6, the implementation and sustainability of PCIT in Sitka has been a challenge, due in large part to 1) the failure of SEARHC supervisory services and 2) the delay in obtaining assistance from the expert at the University of Oklahoma to adapt the PCIT model. Further, the lack of Native professionals in Sitka licensed to provide mental health treatment has meant that Native providers must be paraprofessionals, trained and certified to provide certain elements of PCIT. The hiring of the psychologist to oversee these paraprofessionals was an important first step towards overcoming the challenge of using PCIT in a culturally competent way.

To engage Native families in services, the Sitka SSI must adapt its services to suit the cultural traditions of the Native community. Some families preferred to seek services from the advocates at SAFV, rather than from SSI's psychologist. These families were afraid to overwhelm their children with a physician, as they perceived the psychologist to be. The challenge for the SSI in the future will be to shift such perceptions to make it possible for Native families to fully utilize SSI services.

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Systems change. The need to review the changes initiated by the Sitka SSI from a policy perspective was critical for sustainability. The changes, such as CID-COPS, needed to be institutionalized so that staff or leadership turnover would not affect the program, or cause domestic violence to become a low priority. CID-COPS was initially dependent on key representatives from the SPD, STA Social Services, and SAFV; however, the protocols developed late in 2004 reduced that dependence. Systems change also takes a long time, as many participants acknowledged. According to these participants, systems change within the context of the Sitkan community requires an understanding of the historical trauma experienced by the Tlingit people; the capacity to empower and build community; the knowledge and skills to address issues related to race and power; and recognition of the intersection between exposure to violence, school dropout rates, and substance abuse.

Organizational differences. Organizational differences among SSI partners proved as challenging as cultural, ethnic, and personality differences. In combination, these differences made early collaboration difficult. Over time, however, the partners in the Sitka SSI collaborative learned to appreciate each other's unique roles in the continuum of care, and differences in philosophy and approach have become less challenging.

The Western idea of professionalism and the Native idea of cultural competence, however, have engendered ongoing tension. From a Western standpoint, Native organizations do not run their programs in the same professional way as do non-Native agencies; from a Native standpoint, non-Native agencies do not run their programs in a way that is culturally responsive or sensitive to the experiences of Native persons. This difference in perception, if not addressed, could lead to difficult working relationships between Native- and non-Native-directed programs and organizations in the future.

Overlapping personal and professional relationships. In a small town like Sitka, where everyone knows everyone else, personal friendships intertwine with professional relationships, often blurring the line between client and friend. In the tribal community, in particular, a client of the STA Social Services was likely to be a relative of a staff person through clan networks, making the "client" not a client, but a family member in need. Every relationship was personal.

11. Conclusion and Recommendations

The Sitka SSI has made significant progress in 2004, particularly with CID-COPS; discussion of CID-COPS has shifted from implementation to sustainability. With the psychologist on board, the PCIT program also is expected to make rapid progress at the beginning of 2005.

The collaboration among agencies and leaders appeared to strengthen throughout 2004, as a result of the tangible benefits of the Sitka SSI. The police officers developed greater awareness of the resources available to assist children exposed to violence and their families. The Sitka SSI brought about unprecedented collaboration between the tribal and municipal governments, as well as between service providers in the Native and mainstream communities.

The SSI, and particularly CID-COPS, also has become an increasingly visible resource

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for other regions in Alaska. Representatives from the SPD, SAFV, and the SSI have been asked to present at statewide conferences and provide assistance to Native families with children exposed to violence in other Alaskan locations.

Based on comments provided by participants at the site visit, the NET recommends that the Sitka SSI continue to explore and strengthen itself in the following areas:

- **Communication**. The STA Social Services needs to strengthen its communication with the Tribal Council and other service providers, as well as its partners in the SSI. In the last six months, communication appears to have decreased, leaving partners with different understandings of the status and progress of the Sitka SSI. Partners must stay informed, to maintain momentum and excitement. Better communication also will encourage the Tribal Council to further commit to and support the SSI.

- **Cultural competence**. Building cultural competence is essential and needs to be ongoing. Activities such as the TODOS Institute trainings need to continue, to help promote awareness and understanding on an ongoing basis. Technical assistance with cultural competence also will be critical, to help the Sitka SSI adapt PCIT to a Native context. The NET recommends that the Sitka SSI work with NET members to apply for a Tier II research grant to develop a culturally competent protocol for identifying, assessing, and treating Native children exposed to violence.

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ATTACHMENT A
TIMELINE OF SITKA SAFE START INITIATIVE'S MAJOR ACTIVITIES AND MILESTONES, JANUARY 2002 TO DECEMBER 2004

Major Milestone	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04
Collaborative meetings	Monthly meetings until September 03; first quarterly meeting occurred in December 03				X	
Staff and other internal changes					Hired new local evaluator Safe Start Coordinator left STA	Hired Social Services Deputy Director
Community assessment	X					
Training by the TODOS Institute	X		X			
Cultural competence training for SPD						X
Technical assistance from NCCEV on CDCP			X (training in New Haven)	X		
Implementation of CID-COPS, including trainings for law enforcement officers			X	X	X	X
Technical assistance from NCFJCF on judicial system				X First Tribal Court order issued	X	
Training for PCIT		X (two trainings by Univ. of California at Davis staff)		X (staff attended PCIT conference in Sacramento)	X (by Univ. of Oklahoma staff)	Training at Univ. of Oklahoma scheduled
Implementation of PCIT		X				
New funds				*To Encourage Arrest* grant received		*Family Justice Center* grant received

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SPOKANE SAFE START INITIATIVE

1. Introduction

To develop a full understanding of the Spokane Safe Start Initiative (SSI) from the time of its inception through December 2004, the National Evaluation Team (NET) visited the Spokane site on September 14 and 15, 2004, and conducted follow-up telephone interviews with key individuals in September and October 2004 and again in January and February 2005. The NET also reviewed existing documents about the Spokane SSI, including strategic, implementation, and progress reports. In addition, two documents shared by the site during the site visit were reviewed for context and additional information:

- *Safe Start Lessons and Program Direction Draft Recommendations*, written by the SSI staff, January 2004; and
- *Principle Findings and Policy Recommendations from the Spokane County Superior and District Court and Municipal Court Domestic Violence Case Study: 1998-1999*, sponsored and presented by the Spokane County Domestic Violence Consortium, March 2004.

The NET interviewed ten people, including key SSI staff, collaborating partners, point-of-service providers, a community leader, and the local evaluators. Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of the Safe Start Initiative in the past year?
- How did the composition and process of the collaborative in each site influence the types of strategies implemented, and as a result, the system change outcomes?
- How has the Safe Start Initiative changed the service delivery system for children exposed to violence and their families?
- What organizational, point of service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes at each site?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of the SSI in each site?
- How did each site handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?
- What are the lessons learned about the implementation and replication of a national initiative such as Safe Start?

This report covers the period from the start of the Spokane SSI in January 2004 through December 2004. Organized according to the Safe Start Demonstration Project logic model, it describes the economic, political, and social context of the Spokane SSI; the

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technical assistance the SSI received; the collaboration among different community organizations and agencies participating in the SSI; the system change activities and new and enhanced programming for children exposed to violence developed by the SSI; the Initiative's institutionalization of changes; and the challenges faced and lessons learned by the participants. A timeline of major activities and milestones is included in Attachment A.

2. Contextual Conditions

2.1 Local Contextual Conditions: Background

The city of Spokane, located in the County of Spokane on the eastern edge of the State of Washington, is separated from the wealthier and more populous western side of the state, including the state capital, by the Cascade Mountains. According to several participants, the geographic distance between Spokane and the state capital (Olympia) means that Spokane often struggles to 1) command attention on the state's legislative agenda and 2) bring services to its residents.

Spokane is a city of 195,629, of whom the majority is European American. The small minority population, less than 10% of the total number of residents, includes African Americans, Asian Americans, and Native Americans. Additionally, Spokane has experienced an influx of Russian immigrants in the last decade.

The rate of violence among the small Native American population in Spokane is disproportionately high. For example, two interviewees stated that nearly half (40%) of the 2003 homicides in the city involved Native American residents, despite the fact that Native Americans make up far less than 10% of the total population of the city. According to several interviewees, the rates of domestic violence and violence in general seem disproportionately high in Spokane, for a city of its size.

According to the 2000 U.S. Census, the County of Spokane also suffers from a relatively high poverty rate, as compared to the nation as a whole (13.7% vs. 11.3%). Thirty-six percent of all schoolchildren qualify for free school lunches.

A 2004 study commissioned by the Spokane County Domestic Violence Consortium (SCDVC) found that the average domestic violence victim in Spokane was between 25 and 35 years of age, prime child-rearing years. In Spokane County, approximately 22% of all domestic violence cases heard in Superior Court were perpetrated in the presence of children.

Several site visit participants indicated that Spokane prides itself on highly collaborative and inclusive planning and implementation of social services. Service providers in the community recognize the need for diverse groups to provide comprehensive services to residents, and the collaborative process is respected and honored. At the same time, participants expressed some concern that the focus on collaboration makes decisions difficult and slow, thereby delaying service design and implementation.

2.2 Local Contextual Conditions: Specific to 2004

All participants agreed that the overarching difficulty in Spokane in 2004 was the declining economic health of the area. All major systems (education, mental health, law enforcement, welfare, etc.) suffered budget cutbacks and struggled to maintain

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acceptable levels of services. In general, agencies absorbed budget cuts by downsizing administration, but some community services also were lost. For example, the school district was forced to scale down its early intervention and public health services, which had an impact on the SSI's ability to collaborate with the schools for outreach and services.

During the site visit, several participants mentioned the critical nature of the November 2004 elections, due to the many local, statewide, and national races on the ballot: three county commissioner seats; governor and attorney general; and president, vice president, and members of congress, respectively. In the end, however, participants did not anticipate that the election results would impact services to children and families in Spokane. Note: As of the end of 2004, the governor's election remained uncertified, due to the closeness of the vote. Vote recounts and challenges to the completed counts were ongoing, engendering rancor in the Washington legislature as the two political parties vied for the governorship. According to the SSI Project Director, children's services are unlikely to be affected by the final electoral decision; however, the frustration and enmity that have developed in the state capital *are* likely to ripple through the next four years.

Several developments in other agencies closely associated with the SSI have had, or soon will have, a broad impact on the ability of the SSI to deliver services and mobilize systems change. For example, in the State of Washington Mental Health Division's (MHD) strategic plan for 2004 to 2009, the mental health needs of children between the ages of 9 and 17 years are mentioned only briefly, and children younger than age nine are not mentioned at all. Instead, the plan describes a public *education* effort geared toward the mental health needs of children. There is no plan stated for improving or even delivering treatment *services* to children of any age.

In addition, the Temporary Assistance to Needy Families (TANF) program is operating at a deficit of $1 million per month. To address this issue, the state is considering extreme measures, such as ending financial assistance to children whose parents are not actively engaged in a work- or school-related activity, or eliminating work supports such as childcare and drug treatment currently available to WorkFirst clients.

The child welfare system also saw vast changes in 2004. According to several interviewees and pertinent SSI reports, the results of these changes are still being felt. In February 2004, the State of Washington received the results of its federal child welfare audit. In August of that year, a state court heard a suit brought against the Department of Social and Health Services (DSHS) Children's Administration. According to the court ruling, the Administration was not providing minimum protections to children in the state foster care system; foster care children were being subjected to multiple placements and moves, placement in unsafe homes, and denial of needed mental health care.

As a result of these events, the state developed its Kids Come First, Phase II Plan (Phase I was launched in 2000).[60] The building blocks of Phase II are:

- Keeping children safe in their own communities;

[60] http://www1.dshs.wa.gov/mediareleases/2004/pr04131.shtml

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- Finding permanent, safe, and stable homes for children in state care;
- Preserving family connections for children removed from their homes;
- Improving children's mental and physical health and enhancing educational opportunities;
- Involving families in case planning;
- Providing an expanded array of services for adolescents;
- Enhancing kinship care and support for caregivers;
- Recruiting and retaining foster and kinship families;
- Using consultation and collaboration to expand capacity to serve children and families in their own communities;
- Refining services and accessibility to better meet the needs of children and families in their own homes and when children come into state care; and
- Refining the DSHS Children's Administration commitment to quality assurance methods and best practice standards.

One of the outcomes of the federal audit and the court's ruling was a decision by DSHS to centralize most of Child Protective Services (CPS) in its main office in the Olympia region. This move necessitated changes in intake and investigation, case management, and contract monitoring and awarding. The new plan called for all child abuse and neglect reports to be funneled through the central CPS office, where CPS workers would determine whether or not to investigate. Once a decision was made to investigate an allegation, the case would be assigned to local CPS workers for investigation; however, subsequent decisions on each case would continue to be made at the central office. In short, centralization of CPS eliminated all local decision-making authority. Furthermore, DSHS chose to centralize CPS without seeking the input of local law enforcement, courts, education systems, local child-serving agencies, or other involved parties.

In response, the child-serving community across the state mobilized to meet individually and in groups with state legislators. The message they brought was clear: centralizing such a sensitive and complicated operation would be disastrous for local organizations, the community, and families. As a result, most services reverted back to the local level. Contracting, contract monitoring and off-hours intake, however, will remain centralized.

In addition to the upheaval in the child welfare system, the local Spokane Head Start system remained without a director for nearly 18 months, including much of 2004. The SSI had hoped to develop a system for Head Start staff to identify and refer children exposed to violence. Until the new director was chosen in mid-2004, however, development of this system was put on hold.

3. Community Capacity

Several issues of capacity were mentioned by those involved in the Spokane SSI.

Services were described as scarce, as compared to a level of family services considered necessary and sufficient. For example, Spokane has no intervention services for batterers. While services for victims are available, courts and family service providers have no resources for referring perpetrators, leaving the legal

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system with few options for sentencing and treatment stipulations. Lack of services for batterers also means a lack of public awareness efforts pertinent to such services, thereby decreasing overall community awareness of issues related to domestic violence.

Representatives of CPS have not actively partnered with the SSI or engaged in the SSI agenda, perhaps due to the movement of CPS toward centralization. According to some interviewees, the child welfare system has recently seemed more open to the prospect of direct engagement with the SSI. Because CPS priorities are established in the state capital, however, it may remain difficult for the child welfare system to form a strong partnership with a local initiative such as Safe Start.

Prior to the SSI, Spokane knew very little about the prevalence of children's exposure to violence or the impact of such exposure. Neither the community nor organizations serving children had a clear understanding of the impact of domestic violence on child witnesses. As a result, the city lacked the capacity to respond to the problem, either on a case-by-case basis or through a coordinated systems response. Filling this gap was identified early in the SSI process as an important first step in developing the Initiative.

In 1993, an eleven-year-old girl living on the streets was murdered in a Spokane hotel room. To prevent such tragedies in the future, a group of agencies and community leaders came together to create the Breakthrough Coalition. The Coalition soon became the community group for advocacy, strategy development, and planning around concerns of family wellbeing. Since its inception, the Breakthrough Coalition has brought in $8 to $9 million in new services and grants to the community.

Although still meeting regularly when the Spokane SSI began its planning process, the Coalition was in need of revitalization, according to two participants. The Coalition quickly incorporated the SSI into its mission and discussions, helping to conceptualize the original Safe Start model. An active group of Breakthrough Coalition members formed the Breakthrough Steering Community, to function as the SSI collaborative while continuing to work toward preexisting Coalition goals.

The Spokane County Domestic Violence Consortium (SCDVC) provides training to various sectors, including industry, schoolchildren, and agencies serving children and families. In 2004, the SCDVC trained approximately 1,000 employees of local industry on the cycle of violence and the impact of domestic violence on exposed children. This training elicited several calls from participants who were concerned about the children of coworkers.

In addition to providing training, SCDVC has spearheaded a grassroots effort to form a neighborhood-based women's drop-in center. A local nonprofit organization has been engaged to provide oversight, and funding is being sought for implementation.

4. Integrated Assistance

To address the limited awareness of the Spokane Juvenile Court around issues of children exposed to violence, the National Center for Juvenile and Family Court Judges (NCJFCJ) recently began working with the Spokane SSI and court system to create a web-based resource that will enhance the capacity of judges to make informed

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decisions about children who may have been exposed. The technical assistance of NCJFCJ will provide the Spokane courts with a foundation for developing a model juvenile court and for incorporating issues of children's exposure to violence into their decision-making processes.

5. Local Agency and Community Engagement and Collaboration

The SSI did not convene a unique collaborative to address issues specific to Safe Start. Instead, the Breakthrough Steering Committee has taken a lead role in guiding the efforts of the SSI. Consisting of seven to twelve agency representatives who plan and develop strategies for family and child wellbeing in Spokane, the Committee acts as a sounding and advisory board for the SSI, reviews all reports and presentations to the community, and provides feedback.

As described by several participants, the Breakthrough Coalition and Steering Committee are informal and relatively unstructured. Members of the Coalition include organizations and individuals dedicated to family and child wellbeing; regular meeting attendees include representatives from community health centers, juvenile courts, family- and child-serving agencies, and the education sector. Members do not have written memoranda of understanding or agreement, but meet each month on a volunteer basis, forming working groups to address specific issues as needed.

Early on, the SSI recognized that the planning and implementation stages of the Initiative would be process-heavy and slow moving. As many participants stated, "the Initiative can only move as fast as its slowest member." By respecting this dynamic, the SSI has been able to maintain involvement of Coalition agencies that are more invested in planning than in implementation.

In addition, because the members of the Breakthrough Coalition have been working together for more than a decade, they have developed comfortable working relationships and an ability to compromise when necessary. Members have a high level of trust due to a shared history of tackling challenging issues. In keeping with the informal nature of the Coalition, meetings have no official rules of communication or decision-making. Members share their opinions with one another, and conflict is minimal, according to Coalition members with whom the NET spoke.

One challenge facing the Coalition is the absence of the child welfare community at the table. Participants expressed hope that child welfare representatives would engage with the SSI at some point; however, CPS efforts to centralize decision-making may make it unlikely that the SSI's relationship with CPS will improve dramatically. On the other hand, in 2004, Partners with Families and Children entered into a memorandum of understanding with the local child welfare administration. Because Partners with Families and Children is an SSI partner agency, this memorandum has resulted in increased case sharing and referrals to Safe Start by the child welfare agency.

Representatives of the law enforcement sector also are absent from the Breakthrough Steering Committee. This gap, however, may not be a significant challenge, as both local law enforcement agencies in Spokane (the Spokane Police Department and the Spokane County Sheriff's Department) have

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publicly expressed their support for the work of the SSI.

The Breakthrough Coalition existed prior to the inception of the SSI and has other issues on its agenda, making the Coalition likely to outlive the Safe Start Demonstration Project funding. Because the Coalition has taken Safe Start on as an important initiative, continuation of the Coalition is likely to mean continuation of the mission and vision of the SSI, as well. On the other hand, in the late fall of 2004, the Breakthrough Coalition hired a consultant to assist with strategic planning and goal setting. At year's end, the Coalition was discussing its function in the community and whether it should continue or disband.

Outside the Coalition, several participants identified the SCDVC as an important SSI partner, because of SCDVC's work in educating the community about the dynamics of domestic violence, including the impact of violence on children. SCDVC has been providing community education since 1992; its work is neither driven by nor contingent upon the work of the SSI. Moreover, because SCDVC does not generally attend Breakthrough Coalition meetings, it is not involved in all aspects of the SSI.

In 2004, the Spokane SSI began a series of discussions with health and behavioral health providers in Spokane. These discussions focused on sustainability of Safe Start work and the possibility of merging the interests of medical and behavioral health agencies, in light of the concern that children exposed to violence suffer from physical health problems as well as behavioral health troubles.

Site visit participants repeatedly referred to the importance of developing and maintaining relationships to accomplish Safe Start goals. Several participants described the Safe Start Project Director, Principal Investigator, and Co-Principal Investigator as having excellent group facilitation and mobilization skills. Furthermore, because they have different professional niches (child welfare, research, and law enforcement, respectively), these SSI leaders have been able to reach and engage different individuals and organizations.

In 2004, the YWCA of Spokane began collaborating with the SSI through its Alternatives to Domestic Violence (ADV) program. The ADV program operates the only certified domestic violence shelter in Spokane County. Prior to 2004, according to several interviewees, the relationship between the Spokane SSI and ADV was strained due to perceived differences in philosophy and activities. In particular, according to the Safe Start view, substance abuse is an important component of domestic violence. Because of a concern that this view minimized the responsibility of the batterer, ADV rejected the contribution of substance abuse. The SSI has since been able to produce scientific evidence demonstrating a relationship between substance abuse and domestic violence. This, along with persistence on the part of the SSI, has brought ADV closer to accepting a partnership relationship with Spokane Safe Start, beginning with a collaborative effort to co-sponsor the 2004 annual law enforcement officer's appreciation breakfast.

6. System Change Activities

Site visit participants mentioned the following as the Spokane SSI's major accomplishments for 2004:

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- Completion of the report, *Safe Start Lessons and Program Direction Draft Recommendations,* and subsequent presentation to the community;
- The initiation of a screening study within mental health centers to determine prevalence and case identification rates for children exposed to violence;
- Commitment from the 9-1-1 command center to send the SSI copies of all domestic violence reports in which the presence of children was mentioned;
- The Fathering Conference held in early 2004;
- Planning for the development of a system of care for children;
- Enhanced collaboration with the domestic violence advocacy network in Spokane; and
- Recent increase in referrals from domestic violence advocates and CPS workers.

6.1 Development of Policies, Procedures, and Protocols

In 2004, the Spokane SSI began to develop a system of care for young children's mental health treatment, including policies, procedures, and protocols. Prior to this effort, the Spokane service community lacked written protocols or procedures for working with mentally disturbed children, and the SSI faced an ongoing challenge in developing a consistent system of care for referred families. Because each of the three SSI provider agencies had its own internal protocols and methods of service delivery, many discussions and compromises centered around the issue of ensuring that all families would receive the same care, regardless of the agency providing services. As a result, one agency began to develop child mental health treatment protocols. These protocols will provide a framework for use by mental health professionals when providing needed services to children who may have been exposed to violence, and will be used by all agencies that treat SSI families.

Early in 2004, the 9-1-1 command center agreed to send the SSI copies of all domestic violence reports in which the presence of children was mentioned. The SSI planned to use these reports to 1) compare the number of incidents to the number of referrals and 2) inform law enforcement policy-makers about the prevalence of children exposed to violence and the referral rates of responding officers, with the goal of increasing referral rates. By year's end, however, the number of referrals from law enforcement had dropped, rather than increasing. According to Safe Start staff, budget cuts created morale problems among police officers, thus decreasing interest in and referrals to Safe Start.

6.2 Service Integration

In 2004, the Spokane Police Department and County Sheriff's Department continued to support the Safe Start Initiative. The Police Chief, in particular, informed his command of the importance of Safe Start as a critical aspect of their work; the Chief instructed officers to make referrals whenever a child was present at the scene of a domestic violence incident.

The Spokane SSI developed the Child Outreach Team (COT), a Child Development-Community Policing (CDCP) team of five clinicians from the three SSI provider agencies. Under the COT system, when a law enforcement officer arrives at the scene of a domestic violence call and finds children present, he/she should contact the COT for assistance. The Spokane police command has emphasized to officers the importance of contacting the COT while still at the scene of the call; the likelihood of engaging a family in services increases

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dramatically when providers intervene at the time of crisis.

6.3 Resource development, Identification, and Reallocation

Site visit participants did not mention any resource development, identification, or reallocation activities for 2004.

6.4 New, Expanded, and Enhanced Programming

In 2004, the Spokane SSI made a strategic decision to seek referrals from sources other than law enforcement. Other sources would include CPS, domestic violence advocacy, mental health providers, and Head Start. Because of the low number of referrals from law enforcement, involving other child-serving agencies seemed an appropriate step. Moreover, by including more systems in the referral process, the sustainability of the SSI would be enhanced.

As part of their agreement with the SSI, the 9-1-1 command center also has participated in identifying children exposed to violence. In response to a domestic violence call, the 9-1-1 dispatcher asks the caller about the presence of children. If the caller indicates children present, the dispatcher alerts the responding officer by making a "Safe Start?" note on the electronic referral. The officer receiving that referral then knows that he/she should confirm with the victim that Safe Start should be contacted. If so, the police officer contacts the COT; a COT member is sent to the location of the call immediately.

If the family accepts Safe Start services, the COT member becomes their service provider. Services are individually tailored to the needs and resources of the family, and may include assistance with housing, mental health treatment, help with navigating the justice process, etc. A family is maintained in service as long as requested. As of now, there is no plan for follow-up after the completion of services.

Meanwhile, the dispatch center submits reports to the SSI on the number of 9-1-1 domestic violence calls in which children are reported as present. The SSI follows up with the police department about the status and progress of referred families, providing closure for responding officers and strengthening the relationship between beat officers and the SSI, according to SSI staff. As mentioned previously, however, referrals from law enforcement dropped toward the end of 2004.

In 2004, the mental health/children exposed to violence universal screening study began within Spokane's four publicly funded non-profit mental health centers (of which three are clinical partners of the SSI). To prepare for the study, each center provided in-depth training to its clinicians and intake workers. This training covered the dynamics of domestic violence, its impact on child witnesses, and clinical issues related to serving children exposed to violence. The centers intend to continue this training, along with upgrading the skills of their clinicians around issues of exposure to violence.

In 2004, discussions with chemical dependency organizations also began, with regard to their involvement in the universal screening work. Although the SSI did not initially approach chemical dependency providers as potential partners, the realization that domestic violence and substance abuse are often intertwined prompted the inclusion of this sector. The chemical dependency community expressed interest in participating in the universal screening project; however, their staff must

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be trained to identify and assess domestic violence and children's exposure to violence, making it unclear when their active participation will begin.

In 2004 465 children were identified and referred to the Spokane SSI. A total of 302 children were assessed and engaged by the clinician. All children are identified and referred through a source. About 74% of children are identified and referred by law enforcement officials but other sources include CPS/CWS, domestic violence advocates, schools, public health nurses, and self-referrals. The Child Outreach Team (COT) is comprised of Safe Start clinicians who provide both case management and therapeutic services. The clinicians engage in a global assessment with the families and children. Separate researchers administer a more comprehensive assessment battery to consenting families. In general, the COT provides crisis intervention and some level of brief treatment. Longer term mental health and skill building services are usually provided through a mental health provider but this is determined on a case-by-case basis. These figures were confirmed with the local evaluator after the May 2005 National Evaluation Meeting.

6.5 Community Action and Awareness Activities

Recently, the SSI contracted with SCDVC to raise community awareness about domestic violence and children's exposure to violence. SCDVC will provide a part-time outreach worker to spend time in high need (e.g., high crime) areas, to locate and recruit neighborhood groups that can help identify 1) children exposed to violence and 2) community needs around children's exposure to violence. One community representative who has expressed an interest in participating in this program is a Laundromat owner who knows of children in the community who have been exposed to violence.

Spokane lacks intervention programs for batterers. To address this gap, in January 2004, the Spokane SSI sponsored a Fathering Conference geared toward exploring intervention techniques and programs. The conference, featuring Drs. Oliver Williams[61] and Ed Gondolf,[62] was much more successful than anticipated, attracting 280 professionals involved in family violence programming and response, including judges, attorneys, advocates, and mental health professionals.

As a result of the Fathering Conference, the SSI and SCDVC partnered to form a workgroup, chaired jointly by the Executive Director of the SCDVC and the Safe Start Project Director, and charged with the task of developing an integrated response to the absence of treatment for batterers in Spokane. For the first time in Spokane, professionals began to work together to address the co-occurrence of battering and mental health and chemical dependency problems. The Fathering Conference helped expand recognition of 1) the problem of battering and 2) the importance of addressing co-existing challenges such as drug abuse, post-traumatic stress disorder, and mental illness.

In general, SCDVC has handled the Spokane SSI public awareness strategy. As a membership organization dedicated to educating the public on domestic violence,

[61] Dr. Williams is the Executive Director of the Institute on Domestic Violence in the African American Community and an Associate Professor in the Graduate School of Social Work at the University of Minnesota in Minneapolis.
[62] Dr. Gondolf is the Director of Research at the Mid-Atlantic Addiction Training Institute, located at Indiana University at Pennsylvania.

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SCDVC also includes the impact of domestic violence on child witnesses in its community awareness campaigns.

Site visit participants raised concerns that lack of a dedicated public awareness campaign headed by the SSI may be a weakness in SSI operations. Participants described the SSI as adept at mobilizing community organizations and leaders, but also expressed concerns that the Initiative did not reach out to the grassroots community in a more concerted manner.

7. Institutionalization of Change

The Spokane SSI has focused on generating information and data about domestic violence and children's exposure to violence, with ongoing information dissemination geared toward community leaders and social service agencies through discussion and presentations at Breakthrough Coalition meetings. Although SSI representatives acknowledged that information generation and dissemination are only one part of the overall Initiative, they expressed general agreement that their focus on data and information has contributed to the Initiative's success in Spokane, enabling the SSI to build a broad base of support throughout the community of service providers. The physical location of the SSI within a university played a critical role in both 1) establishing the academic focus of the SSI and 2) legitimizing the SSI message among providers; according to several participants with whom the NET spoke, an SSI housed in a different venue probably would not have had such a strong information-gathering and knowledge-dissemination component.

The Breakthrough Coalition has integrated the SSI into its overall mission and work. Members of the Coalition interviewed by the NET described the SSI as a movement, rather than a program, suggesting that issues of children's exposure to violence will continue to be addressed after federal funding for the Safe Start Demonstration Project ends. Likewise, because of the collaborative nature of the Spokane human services community, site visit participants expressed general agreement that if the Breakthrough Coalition were to disband, another similar group would form to address issues of families and children.

Point-of-service providers have begun to institutionalize the Safe Start vision through their universal screening for domestic violence and exposure of children to violence. As noted previously, the decision to conduct universal screening prompted the training of clinicians, which is meant to be ongoing.

Participants expressed an expectation that the COT would continue to provide services to children exposed to violence, although future funding possibilities are still being explored. Like other Safe Start Demonstration Sites, Spokane partner agencies hope to fund COT through Medicaid.

Because law enforcement agencies have demonstrated commitment to the goals of Safe Start, participants also expressed an expectation that these agencies would continue their Safe Start work. It is hoped that first responders will continue to make referrals to the COT, and the 9-1-1 dispatch center will continue to note when children are present at domestic violence calls. Given the bleak funding situation in Spokane, however, it is unclear how each of these components will come together.

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Site visit participants often mentioned the importance of building and nurturing relationships in the community to address issues of children's exposure to violence. Several informants described the ability of the SSI Project Director, Principal Investigator and, Co-Principal Investigator to recruit and develop support among leaders in the city. It is unclear how Spokane intends to continue developing such relationships when federal funding ends and the current SSI leaders have moved on to other projects.

8. Increased Community Supports

Because of the efforts of the SSI to educate and network with Spokane law enforcement agencies, these agencies have committed their support to serve children exposed to violence. The Police Chief has made responding officers accountable for linking families to the SSI. Likewise, the County Sheriff has indicated commitment to the SSI vision and efforts.

The four publicly funded mental health providers in Spokane have integrated screening for domestic violence and children's exposure to violence into their intake protocols and intend to continue this practice. These agencies also have begun to train their clinicians on family violence and its impact on children exposed.

Primarily due to misunderstanding and lack of communication, the SSI and domestic violence community have not collaborated in the past. In 2004, however, they began to discuss similar goals and shared cases. Members of the domestic violence community interviewed by the NET indicated that this new relationship would continue.

9. Lessons Learned in the Implementation and Evaluation of Safe Start Activities

The following lessons were identified by site participants, as well as through the NET's analysis of data collected from participants and existing site documents:

Make contact with families at the time of crisis. SSI staff repeatedly mentioned that families accepted Safe Start services at a much higher rate when providers made contact and offered services at the time of crisis; according to SSI data for 2004, families contacted at the time of crisis were engaged in services at a rate six to eight times that of families contacted at a later date.

Work with the chemical dependency community from the outset. Because of the strong link between chemical dependency and domestic and interpersonal violence, strong SSI relationships with the chemical dependency community mean access to additional families in need of Safe Start services. In Spokane, discussions with the chemical dependency community did not begin until midway through the implementation of the Initiative, which delayed buy-in, support, and collaboration from this community.

Do not limit referral sources. The Spokane SSI found that law enforcement did not refer enough families to services. Several site visit participants recommended expanding the view of potential referral sources, to include not only social service agencies, but also residents of the community, such as apartment managers, grassroots organizers, and other individuals with strong neighborhood ties.

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- **Be mindful of cultural interpretations of violence and child abuse.** Although Spokane is largely homogeneous (more than 90% European American), the SSI has always been committed to serving the city's racial and ethnic minority groups. To meet this goal, however, several participants mentioned the importance of actively engaging the minority community in discussion early on, to ensure the incorporation of their perspectives on interpersonal violence. Instead, the Spokane SSI hoped to engage minority communities after designing and implementing services, an approach that may alienate these groups and result in non-usage of services.

- **Develop a strong community awareness strategy early.** Several site visit participants identified the lack of a dedicated SSI community awareness strategy as a weakness in the Spokane program. These participants recommended the use of multiple forms of media, such as billboards, television, radio, and community outreach (e.g., locating Safe Start staff at neighborhood gathering spots) to disseminate information about the impact of children's exposure to violence, the types of SSI services available, and other pertinent messages. Community awareness efforts should begin early, to build interest and knowledge about children's exposure to violence and the SSI.

- **Develop relationships with community leaders.** Most site visit participants expressed admiration for the relationship-building skills of the Spokane SSI leadership. Participants agreed that the ability to engage a wide range of community leaders is critical for systems change. Participants described the Spokane SSI as fortunate in having individuals with connections to all pertinent systems.

- **Be willing to modify existing models.** Several of those involved in planning the Spokane SSI visited Yale University's National Center for Children Exposed to Violence to learn about the Child Development Community Policing (CDCP) model. The planners decided that the CDCP model, in its pure form, was not a good fit for the law enforcement culture in Spokane. Thus, the site modified the original model to better fit the community's needs and current resources and developed the COT.

10. Barriers and Challenges

The barriers and challenges experienced by the Spokane Safe Start Initiative can be summarized as the following:

- Although the site has discussed and worked toward sustainability and institutionalization, these efforts remain to be finalized.

- Because of concerns about the SSI philosophy, the domestic violence community has been reluctant to commit to collaboration. More open communication between the SSI and the primary domestic violence provider in Spokane has begun to resolve this problem.

- Although the SSI has the support of law enforcement agency leaders, responding officers are not all attuned to the Safe Start message and priorities. Personal safety, the safety of those on the scene, neutralizing dangerous situations, arresting perpetrators, and other concerns compete for the attention of a responding officer. A

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first responder may not remember to call COT until after leaving the scene of a domestic violence call, which decreases the likelihood of engaging the family.

- An inability to engage the Head Start system has hindered use of that system as a source of referrals and community outreach. Although the recent appointment of a new director has increased the likelihood of engaging Head Start, the SSI probably does not have the resources to capitalize on this opportunity immediately. Nevertheless, SSI partner agencies have committed to working with Head Start providers in the future, even after the end of the contract term. Funding for this effort has not yet been worked out.

- Working with the state CPS has presented many challenges, especially after a federal audit and a lawsuit against DSHS prompted a knee-jerk reaction to centralize most CPS activities and decisions. Although many services have since returned to a decentralized structure, some will still be operated out of Olympia.

11. Conclusions and Recommendations

In 2004, the Spokane Safe Start Initiative continued its course of providing its community with high quality data and research findings to continue the momentum begun by the SSI. There is strong movement toward including sectors that previously had not been involved in the Initiative, including the chemical dependency community and Head Start. In addition, the SSI has begun working with the mental health community to develop systems of care for young children and has begun identifying these children as their families seek mental health services.

As Spokane Safe Start's leadership and the Breakthrough Coalition enter the final year of the Safe Start Demonstration Project, they may wish to consider the following recommendations, based on participants' comments:

- Continue to appeal and reach out to systems and organizations that have not been involved in the SSI in the past, including the chemical dependency sector, Head Start, and the domestic violence sector. The site might want to consider discussing issues of Native American engagement with the other sites that have Native American stakeholders: the Pueblo of Zuni, Sitka, and Washington County;

- Continue to work toward involving racial and ethnic minority groups in SSI discussions. In particular, focus on engaging the Native American community, which has a disproportionately high rate of domestic violence;

- Develop creative ways to reach communities by engaging grassroots leaders, faith leaders, and community center representatives. Develop a strategy for engaging community residents in discussions of sustainability and other issues; and

- Use the momentum created by the Fathering Conference to develop or recruit intervention programs for batterers. Consider as a model the programs developed by the Pinellas County SSI, which have shown initial promise in reducing children's exposure to violence.

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ATTACHMENT A

Timeline of Spokane Safe Start 2004 Major Activities and Milestones

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Safe Start Lessons and Program Direction Draft Recommendations written	✓											
Fathering Conference	✓											
9-1-1 routing calls tagged for SSI services		✓	✓	✓	✓	✓	✓	✓	✓			
Treatment protocols for young children created		✓	✓	✓	✓	✓	✓	✓	✓			
Screening for DV at Spokane mental health centers	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Discussions initiated with the chemical dependency community about DV screening			✓									
Outreach program with Spokane County Domestic Violence Coalition initiated									✓			
Consultant began working with Breakthrough Coalition												✓

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XI

WASHINGTON COUNTY SAFE START INITIATIVE

1. Introduction

To develop a full understanding of Keeping Children Safe Downeast (KCSD, the Washington County Safe Start Initiative) from January 2004 through December 2004, the National Evaluation Team (NET) visited Washington County on October 19 and 20, 2004, and conducted follow-up telephone interviews with key individuals in October 2004 and again in February 2005 to gather information about the site's progress between the time of the site visit and the end of 2004. The NET also reviewed existing documents about KCSD, including strategic, implementation, and progress reports for 2004. Additional documents reviewed included:

- *Keeping Children Safe Downeast Sustainability Plan 2005-2009*, written by the Keeping Children Safe Downeast (KCSD) staff;
- *Washington Hancock Community Agency (WHCA)* Newsletters and *Keeping Children Safe Downeast* Newsletters;
- *KCSD Semi-Annual Evaluation Report, January 1, 2004 through July 31, 2004*, written by Bill Goddard, Evaluation Services Team; and
- *Community Needs Assessment Report,* written by the Regional Medical Center-Lubec (RMCL).

Seven KCSD participants were interviewed during the two-day site visit and four more were interviewed by telephone later in October. In February 2005, the NET followed up by telephone with three previous participants and one new participant. The participants interviewed included key staff members, point-of-service providers, collaborative members, and local evaluators.

The participants were asked between three and eight general questions, depending on their role with KCSD. Key questions included the following:

- What were the milestones reached, goals attained, and other indirect impacts of KCSD in the past year?
- How did the composition and process of the collaborative influence the types of strategies implemented, and as a result, the system change outcomes?
- How has KCSD changed the service delivery system for children exposed to violence and their families?
- What organizational, point of service, and collaborative capacities (knowledge, skills, resources, relationships) are required for successful implementation and sustainability of the system changes?
- What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) that affected the successful implementation and goal achievement of KCSD?
- How did the site handle anticipated or unanticipated critical changes at the program level when they occurred?
- What strategies are being used to achieve sustainability in policies, procedures, and practices?

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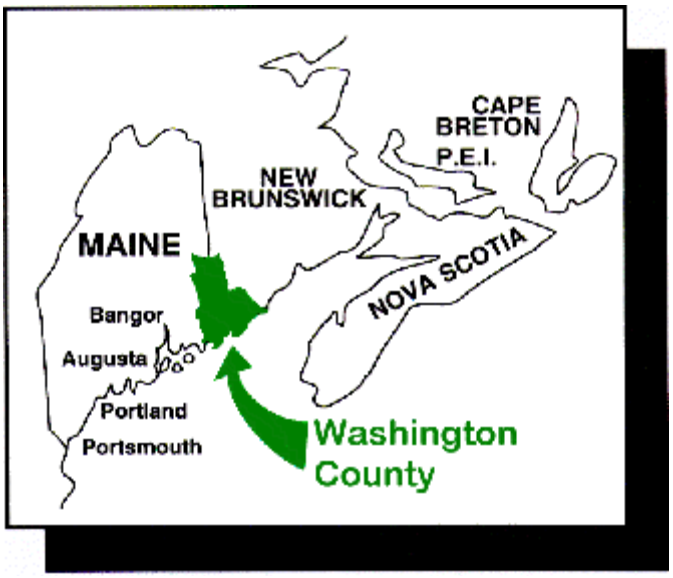
- What are the lessons learned about the implementation and replication of a national initiative such as the National Safe Start Demonstration Project?

This report covers the period from January 2004 through December 2004. Organized according to the National Safe Start Demonstration Project logic model, it describes the economic, political, and social context of the KCSD; the technical assistance the KCSD received; the collaboration among different community organizations and agencies participating in the KCSD; the system change activities (i.e., development of policies, procedures and protocols; service integration; new, enhanced, and expanded programming; community action and awareness; and resource development) developed by the KCSD; the Initiative's institutionalization of changes; and the challenges faced and lesson learned by the participants. A timeline of major activities and milestones is included in Attachment A.



Source: http://www.mainerec.com

2. Contextual Conditions

Referred to as "Sunrise County" because the rising sun first touches U.S. soil here, Washington County is considered typical of Maine's traditional downeast coastal area. Though tourism is important in the county, it is not as pervasive as elsewhere in the state. Washington County is bordered by York County and New Brunswick (Canada) to the Northeast; Charlotte County and New Brunswick to the East; Aroostook County to the North; and Penobscot County and Hancock County to the West. The Bay of Fundy coastline forms its southern boundary. Machias is the county seat.

The county has two cities (Machias and Calais), 44 towns, and a population of 32,000. Of 2,628 total square miles of land, more than 85% are forested.

The county is larger in area than the states of Delaware and Rhode Island combined. This large area, combined with the rural and isolated nature of the county and the lack of public transportation, make travel within the county long and relatively difficult.

In a 2003 report prepared for the Maine Community Action Association (MCAA), the author states:

> *"Washington County's people are poorer, older, and have lower levels of educational attainment than the state average. By almost any measure, it is Maine's poorest county."*

The average unemployment rate in Washington County (according to the Maine Department of Labor, 2002) is extremely

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high (8.8%) compared to the state average (4.4%). The state economy is based on natural resources, with 11% of the population engaged in agriculture, forestry, fishing and hunting, or mining. Within these industries, many employment opportunities are seasonal. Site-visit participants mentioned seasonal jobs in Washington County within the primary sector (such as blueberry farming and processing, fishing, etc.) as common occupations affected by seasonal variations and natural diseases. The paper processing industry, another important aspect of the economy in the region, has been affected recently by external economic factors, resulting in layoffs. A site visit participant mentioned that 50 to 100 people were laid off in December 2004. Employee turnover in the region is high, resulting in stalled projects and long durations of time required to build trustful relationships within and among organizations.

All participants identified drug abuse as a significant problem in the county, particularly the use of prescription drugs such as OxyContin. Participants also reported a perception of high rates of violence in the county, especially domestic violence. A number of participants joked that Bingo and alcohol are the only forms of recreation in the county.

Although a large percentage of the county population is European American (93.4%), the county has two Native American communities: Passamaquoddy Pleasant Point Reservation (population 640 with 88% Native American, according to the 2000 Census) and Passamaquoddy Indian Township (population unknown), together accounting for 5% of the county's population. The median income for a household in Pleasant Point is $15,956; 38% percent of the population falls below the poverty line.

Most of the site visit participants perceived a strong sense of community in the county, reporting their belief that, in the case of an emergency, the entire community would mobilize to support the affected individual(s). At the same time, all participants noted that trust takes a long time to build, both on individual and institutional levels. The reasons cited for mistrust included "turf issues" and inter-agency competition for scant resources. Certain participants further noted that the community is wary of initiatives brought in from outside the county.

3. Community Capacity

Site-visit participants identified Washington County's rural isolation and lack of public transportation as impediments to all initiatives and projects, including KCSD. In addition, all interviewees confirmed the findings of the 2003 MCAA report: the county has been losing population (especially youth) steadily.

The two Passamaquoddy reservation sites share a tribal council and are located in two different parts of the county (Princeton and Perry). They function independently of each other, with two separate systems of government. Peaceful Relations provides domestic violence services for Pleasant Point Reservation. In addition, Pleasant Point has Head Start classrooms on site, and is very involved in addressing drug abuse, particularly among youth. By contrast, site visit participants noted that Indian Township Reservation has a childcare center, but has not been providing other services for children and families, such as preventing domestic violence and drug abuse. In short, participants described Pleasant Point as more human-service oriented and more involved in KCSD; however, they noted

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difficulties in integrating Native and non-Native services in general.

According to participants, social services in Washington County depend upon interpersonal relationships, as well as individuals who have knowledge of the history of the region, its challenges, and its services. A number of participants identified the Washington County origin of the KCSD Project Director as an asset. Local agency involvement in Washington County included the Domestic Violence Project and partnerships with the Passamaquoddy Tribe.

A recent statewide economic downturn resulted in a major reorganization of public child welfare and behavioral and developmental health structures. In July 2004, the Bureau of Behavioral and Developmental Services and the Department of Human Services (DHS) merged to form a new Department of Health and Human Services (DHHS). The mission and overall operating philosophy of the new DHHS remain to be fully articulated. According to a 2004 KCSD progress report, accounting errors made by the previous DHS during the period 1999 to 2003 resulted in the loss of an estimated $150 million in federal Medicaid funding to the state, impacting availability of funding for behavioral and mental health services to eligible children. Currently, Washington County has only five caseworkers dedicated to child welfare at the DHHS.

The State of Maine passed laws a decade ago that define child abuse and neglect as including exposure to domestic violence. Thus, it is the statutory responsibility of Child Protective Services (CPS) to intervene in cases of violence at home, even if the child is not a physical victim. According to DHHS, this statute is taken seriously, particularly in the case of pre-verbal children.

The CPS intake telephone line is centralized in the state capital, Augusta, and is often answered by a machine. Although calls to the intake line are theoretically confidential, with the possibility of anonymity, callers are often greeted by an answering machine that asks for contact information. According to site-visit participants, this discourages reports of suspected abuse.

In 2004, the Director of the DHHS Bureau of Child and Family Services retired, and a new Director was appointed. The KCSD Collaborative Board is attempting to make contact with the new Director.

In July 2004, the Washington County domestic violence program, Peaceful Choices, run by the Washington Hancock Community Agency (WHCA), lost its funding. Next Step, from neighboring Hancock County, was named the interim domestic violence agency. Some site visit participants described Next Step as more competent than Peaceful Choices; however, WHCA continues to hold the lease on the only domestic violence shelter in the county, and reportedly has denied Next Step access. As a result, Next Step is currently sheltering victims of domestic violence and their children in motels and people's homes. KCSD has established an excellent interim relationship with Next Step. When the permanent domestic violence agency is named, KCSD plans to collaborate with DHHS and domestic violence providers in Passamaquoddy and the county to review and/or develop standardized policies and protocols for use by CPS caseworkers and domestic violence advocates.

Introduced in Washington County in 2004, the Downeast Batterers Intervention

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Program (DEBIP) was designed to provide treatment services to batterers. For a number of reasons, however, the program met with limited success. First, DEBIP did not develop legitimacy with the courts, which typically make the majority of referrals to intervention services for batterers. In addition, the Department of Corrections required DEBIP to be monitored by the local domestic violence program, to ensure compliance with legal standards; the transition of domestic violence providers in Washington County complicated DEBIP's ability to meet this requirement. Finally, DEBIP lacked funding to support additional facilitators. For all of these reasons, the DEBIP Advisory Board voted to dissolve the program until a domestic violence provider in Washington County is awarded a permanent contract and collaboration can begin again.

Mental health services in Washington County are provided by Washington County Psychotherapy Associates (WCPA), a for-profit agency with trained, licensed, and skilled clinicians on staff. WCPA contracts with KCSD to provide services to children exposed to violence.

The Rapid Response Team (RRT), a program of Catholic Charities, responds to emergencies such as accidents or acts of violence, and provides services for children and families. Staffed by volunteers, RRT is funded through OJJDP and serves children older than the KCSD target range of six years and younger. KCSD has a RRT member on its Board and intends to partner with the agency more extensively in the future.

4. Integrated Assistance

Within the past year, KCSD has given increasing attention to the administrative and organizational changes needed to sustain the Initiative. In October 2003, KCSD invited Dr. Tom Wolff[63] to work with the Interdisciplinary Team (IDT), the original KCSD collaborative, at its fall conference. Dr. Wolff facilitated the Team's exploration of structure, organizational capacity, and leadership, along with other pertinent areas. As a follow-up, Dr. Wolff facilitated two meetings on sustainability in 2004. He helped participants develop a more objective view of the community's sense of self, definition of strengths and weaknesses, and commitment to KCSD.

The Mental Health Collaborative (MHC), a subcommittee of the KCSD collaborative, consulted with James Lewis of the National Center for Children Exposed to Violence (NCCEV), Mark Raines, representatives of the Muskie Institute, and others to identify a sustainable model for providing mental health assessment for children exposed to violence.

The Multidisciplinary Team (MDT), another subcommittee of the collaborative, is working towards sustainability. Sandra Hodge, a child welfare expert, attended the MDT's annual meeting in December. At this meeting, the MDT reflected on the past year. The Team also considered membership protocols, case review procedures, confidentiality assurances, memoranda of understanding for best practices, and protocols for future Team meetings.

KCSD assisted Rapid Response in training first responders by inviting Dr. James Lewis

[63] Dr. Wolff is the President of the Board and Senior Consultant of AHEC/Community Partners at the University of Kansas Community Toolbox.

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of the National Center for Children Exposed to Violence (NCCEV). Along with the Systems Improvement Training and Technical Assistance Program (SITTAP), NCCEV also provided KCSD with training and technical assistance (T&TA) on sustainability. Two members of the KCSD Board and the KCSD Project Director attended the Institute for Community Peace's conference on sustainability in San Diego, California, and brought back information to share with members of the collaborative.

KCSD is planning a trip to the Pueblo of Zuni, New Mexico in May or June 2005. Passamaquoddy Tribal Council members, members of the police department, and other members of the collaborative plan to examine how Safe Start is implemented in Zuni, a Safe Start site with a large Native American population.

5. Local Agency And Community Engagement And Collaboration

Established in May 2000 to broaden the participation of KCSD stakeholders, the KCSD Board operates as KCSD Collaborative and oversees the strategic plan, all projects and committees, and the work of the Project Director.

In 2003, the Board evolved from a Management Team comprised of the three lead agencies (WHCA, Regional Medical Center-Lubec [RMCL], and DHHS) to a Board of 17. The KCSD Board membership consists of representations from several sectors, including:

- The Passamaquoddy tribe;
- Child welfare;
- Law enforcement;
- Physical and behavioral health;
- Domestic violence;
- Education;
- Substance abuse;
- Home visiting;
- Community members; and
- Community collaboratives.

Prior to the inception of the Board, KCSD's Interdisciplinary Team (IDT) acted as the KCSD Collaborative. In 2004, however, interest in the IDT waned as members directed increasing attention to specific topics. In June 2004, the IDT disbanded, resulting in a number of offshoot subcommittees: the Multidisciplinary Team (MDT) (see section 6.2 for more about the MDT), the Child Abuse Response Team (CART), the Training Collaborative, and the Mental Health Collaborative (MHC). Many members of the IDT participate on more than one committee, as well as on the KCSD Board.

The Child Abuse Response Team (CART) was formed to focus on the forensic interviewing and investigation process for children exposed to violence. The KCSD Project Director originally assumed the role of CART convener, but, at the time of the site visit, was working with the District Attorney to transition this leadership responsibility. The District Attorney has agreed to take the lead in institutionalizing CART, in part by collating the protocols developed by KCSD, the Muskie Institute, and CART in a policy letter to be sent to local law enforcement departments and personnel. This letter will describe the forensic interviewing protocol developed by KCSD, which is currently under review by CART.

The Mental Health Collaborative (MHC) was formed to address the issue of waiting lists for children's mental health services.

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To circumvent the problem of waiting lists, KCSD reserves a certain number of client "slots" at WCPA, to ensure prompt services for children exposed to violence. At the end of the Safe Start Demonstration Project, however, these slots will no longer be held; therefore, the MHC is working with WCPA on a model to establish protocols for sustainable provision of prompt services. The MHC also monitors the WCPA in its assessment of children exposed to violence, recommending changes as needed.

Low attendance at meetings is a challenge for KCSD and its sub-committees. Multiple demands on time and geographical distance were mentioned most often as barriers to strong meeting participation. KCSD has experimented with telecommunication and teleconferencing at meetings, but many participants described face-to-face interactions as important. Staff turnover at all KCSD agencies also was mentioned as a concern. For example, the Policy Associate at KCSD resigned in April 2004, resulting in project delays.

Several site visit participants referred to the need to better involve Native American sites in the collaborative processes. Members of the tribe were involved in forensic training and served on sub-committees and the Board, but were not involved in other aspects of the initiative. A majority of participants cited cultural differences as the main reason for the lack of optimal involvement. This could not be verified by the representative of the Native American site interviewed who described the relationship of the Passamaquoddy communities with KCSD as 'great' and the process of engaging sites as 'fantastic.'

The KCSD Board held a special meeting in December 2004, inviting the DHHS Deputy Commissioner to meet with members of the collaborative. Following the meeting, members of the Board had dinner with the Deputy to discuss areas of mutual concern, including the lack of confidentiality and other deficits in the DHHS system for intake and reporting of suspected child abuse. The Deputy was open to feedback and promised to follow up on some of the issues.

6. System Change Activities

6.1 Development of Policies, Procedures, and Protocols

The Muskie Institute of the University of South Maine, KCSD's local evaluator, has committed to developing a protocol book for MDT and for CART. This will include the KCSD train-the-trainer and forensic interviewing protocols.

Train-the-trainer protocol. KCSD developed a train-the-trainer protocol and curriculum for training individuals tasked with the responsibility of teaching point-of-service providers and other mandated reporters about their duty to report abuse. The train-the-trainer curriculum has been delivered several times; the protocol and curriculum are now being adopted statewide. KCSD receives many requests for copies of the protocol. In 2004, a total of 516 individuals were trained. KCSD staff and a revision team of six trainers have since met and revised the curriculum and guide. The new curriculum and revised guides will be printed in 2005.

Children exposed to violence awareness training curriculum was developed and 13 agencies were provided with this training tool. CHCS staff Rose St. Louis began training her supervisory staff, and other agencies began to follow (Child Development Services, etc.) Agencies have

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begun to integrate children exposed to violence training in their agencies and some agencies have offered to provide a training for other agencies.

Forensic interviewing protocol. KCSD assisted the District Attorney and law enforcement officials in their development of forensic interviewing protocols. These protocols provide guidance for law enforcement and child welfare social workers who interview young children about suspected abuse or neglect. The protocols have been put in place and are updated and reviewed regularly.

6.2 Service Integration

The Multidisciplinary Team (MDT) was developed to fill an identified vacuum; prior to the inception of this Team, Washington County lacked a systematic structure for learning from past child welfare cases. The goal of the MDT is to improve the systems response to child abuse, and to support and enhance existing systems through communication, shared knowledge, and experience. Members of the MDT include DHHS Bureau of Child Protection staff, Department of Corrections staff, domestic violence advocates, state police officers, the Director of Rapid Response, the District Attorney, and the Assistant District Attorney. The MDT has reviewed closed cases with a variety of disciplines sharing a case study. Domestic violence advocates, Mental Health professionals and DHHS representatives have presented case studies with the participation of probation/parole officers, health providers, law enforcement representatives, prosecutors, and the Attorney General's office.

Site-visit participants noted a recent decrease in MDT attendance; the District Attorney, in particular, has missed meetings. The Team is contemplating an annual reunion to rekindle interest and attendance. Participants also expressed an interest in expanding the scope of the MDT, by including additional members of different disciplines.

The forensic interviewing protocol resulted in a collaboration with the Hancock County Forensic Interviewing Team and the Passamaquoddy Tribe. Collaboration among and between the Passamaquoddy Tribe, DHHS, Maine State Police, and Prosecutorial District 7 has been strengthened as a result of this collaboration. Training is ongoing for team members.

6.3 Resource Development, Identification, and Reallocation

According to information obtained in follow-up correspondence with KCSD, the Initiative has accomplished the following with its partners:

- A member from the community continues to provide monthly financial support to community awareness;
- Agencies share space and resources for training; and
- KCSD partnered with several agencies to seek funding for a Washington County 2-1-1 Call Center. A $7500 grant was received from the Maine Community Foundation. The Washington County Drug Action Team provided funding. Several service providers also contributed to develop the first year of funding.

6.4 New, Expanded, and Enhanced Programming

Although KCSD is viewed as a systems change initiative, it has achieved several programmatic advances. For example, its train-the-trainer curriculum for mandated

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reporters of abuse has been delivered to more than 500 individuals, including local high school and elementary school teachers. KCSD also has instituted a Training Scholarship Program for professionals who work directly with children six years and younger. Twenty-one scholarships were awarded in 2004, to send professionals to workshops that included *Trauma Recovery and Empowerment Model for Women, Promoting Self-Regulation through Sensory Integration and Adaptive Coping*, and others. The scholarship program was designed to enable agencies without funding for staff training to send staff to KCSD-sponsored workshops. KCSD also staff worked with the Washington County 0-3 Infant Mental Health Coalition, a group of infant mental health providers, to 1) share the Baby's Blossoming Brain curriculum and 2) offer a three-day course with a representative of the 0-3 Infant Mental Health Coalition. Twenty people participated in the three-day course, and 30 people participated in the sessions with Dr. Raines.

KCSD also was instrumental in developing the forensic interviewing protocol mentioned earlier, and in sending forensic investigators for training. Prior to Safe Start, children who were beaten or sexually abused were interviewed more than once in a process that was potentially re-traumatizing. Participants mentioned that the forensic interviewing protocol has made the interviewing process for children more humane. Under the protocol, designated rooms are used to interview suspected victims of abuse or neglect. While a trained investigator questions the child in the interviewing room, other investigators and case managers observe from an adjacent room. This set-up creates a friendly environment and has proven highly successful in allowing children to disclose abuse and neglect.

Four investigators have been trained in forensic interviewing using the "Finding Words" methodology, creating two teams of Washington County forensic interviewers who work collaboratively with Hancock County to question suspected victims. After interviewing a suspected victim, trained investigators report back to CART and make recommendations on adjustments to the protocol. The Passamaquoddy Pleasant Point Reservation inaugurated a forensic interviewing room in early 2004; DHHS and law enforcement officials currently conduct interviews using that room. Another forensic interview room was renovated for use at the DHHS office in Machias. Several members of CART have shared the Washington County Forensic Interviewing model outside the county and state with other agencies. Ten children involved in child abuse case investigations experienced the forensic interview process in 2004.

KCSD contracted with WCPA to perform mental health assessments for young children exposed to violence. As described above, KCSD decided to purchase a certain number of slots at WCPA, to circumvent the waiting lists for mental health treatment common in Washington County. The goal of this arrangement was to ensure that children exposed to violence were referred to WCPA and fully assessed within 72 hours of an incident, such that these children could then receive appropriate services as soon as possible—for example, prompt referral to a different provider or up to three sessions provided by WCPA and paid for by KCSD funds. After the initial three WCPA sessions, the child and his or her caregiver could be connected to continuing services through other funding sources, depending on need.

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Difficulties were identified at several levels of this process. Clinical and evaluation staff had trouble agreeing on an assignment of responsibilities that would not overburden clinicians. Referral agencies were initially uncomfortable with the process, perceiving it as a cumbersome task with too much paperwork. A key WCPA employee was deeply involved with the project early on, but left the agency not long after the process began. Finally, KCSD's purchase of reserved assessment slots did not eliminate waiting times for all children exposed to violence and referred to WCPA. The KCSD contract with WCPA ended in January 2005; KCSD hopes to have all difficulties resolved before renewing the contract, and also plans to revise the assessment protocol with an alternative evaluation method for capturing WCPA recommendations for families.

KCSD also has made programmatic impacts by providing digital cameras for forensic evidence collection, to help police officers, DHHS officials, emergency responders, and health officials gather quality evidence in the case of interpersonal violence. The cameras are used to photograph injuries; images are sent to an expert on identifying child abuse through digital photos, and may later be used to assist in the prosecution of perpetrators. In November 2004, the Spurwink Institute, the Maine State Police Crime Lab, and the Maine State Police Crime Investigation Division III collaborated to lead forensic digital photography training. Over 50 participants attended, including domestic violence personnel; district attorney office staff; warden service staff; marine patrol staff; local, state, and county law enforcement personnel; and others from outside the county.

In 2004 Keeping Children Safe Downeast (KCSD) identified and referred 20 children to Washington County Psychotherapy Associates (WCPA). Identifying and referring represent a simultaneous decision point in the service pathway. Identifying has not involved a formal screening to date but has been the result of a first responder recognizing a child's involvement in a violent event. During this year Rapid Response (a first responder in Washington County) started using a screening tool recommended by the Yale Child Study Center but there has not been a universal adoption of this tool to date. Once a child is identified and referred to WCPA, it is incumbent upon the parents to schedule an assessment session with the clinician. Typically this process results in fewer children assessed than identified/referred. In 2004, however, 20 children were also assessed by WCPA. These figures were confirmed with the local evaluator after the May 2005 National Evaluation Meeting.

6.5 Community Action and Awareness

To educate community agencies about children's exposure to violence, while simultaneously encouraging those agencies to buy into the Safe Start mission, KCSD awarded six small grants to agencies thought to have a positive impact on young children exposed to violence in Washington County. For example:

- Catholic Charities Rapid Response was awarded $1,500 to enhance its community education efforts and to provide materials for staff members who work directly with children exposed to violence. These materials included "healing boxes" of educational materials for parents and children.

- Community Health and Counseling Services was awarded $1,500 to provide

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Children and Trauma training for staff and the public, with the goal of raising awareness of the developmental impact of childhood trauma and available treatment interventions.

- The Indian Township Child Care was awarded $1,000 for a violence prevention training program entitled BABES (Beginning Alcohol and Addiction Basic Education Studies). This training uses puppets to assist young children in developing positive living skills and making positive early decisions about alcohol and other drugs.

KCSD also recently contracted with the Regional Medical Center-Lubec (RMCL), a healthcare provider in Washington County, to spearhead KCSD's community awareness campaign. RMCL will be continuing KCSD's Blue Ribbon campaign, encouraging families, parents, and children to work together and live peacefully. The campaign provides different messages at different times of the year. For example, because April is *Child Abuse and Neglect Month* and October is *Domestic Violence Month,* the April and October messages have corresponding focuses. Some of the ways in which KCSD markets Safe Start services is by putting placemats and table tents with the themed message in local restaurants and diners.

The "Walk to End Family Violence" was designed to raise awareness of domestic violence in various locations across the county. As part of the Walk campaign, agencies and local businesses sponsor remote radio broadcasts and solicit donations. Public service announcements are broadcast on the radio, advertisements are placed in newspapers, and flyers are distributed throughout the county. In April 2004, the Walk was used to kick off the *Child Abuse and Neglect Month* Blue Ribbon Campaign.

The popularity of the Walk has grown in recent years. Initially, participants included only eight to ten walkers; now, many more walk. The large number of walkers makes investment in the event more profitable for businesses and the community. In 2004, a total of 300 individuals walked in multiple locations; of the 300 participants, 90 came from outside Washington County. Articles were published in five local newspapers and a live radio broadcast of the event included interviews with many community members who could provide information on domestic violence.

KCSD offers a library of books and videos related to the issue of children's exposure to violence; this library is open to all people who live or work in Washington County. KCSD has also designed bags for all new Washington County parents. With brochures on home visiting and KCSD, booklets, an infant toy, and a video, these bags promote home visiting programs in the county.

KCSD collaborated with Head Start to conduct Fatherhood Workshops. These Workshops help teachers encourage fathers to become more involved in their children's lives. Together, KCSD and Head Start purchased a workshop curriculum and kit ("Fatherhood USA: A Workshop on Effective Fathering," published by The Fatherhood Project at Families and Work Institute[64]). The kit contains instructional videos, books on father involvement, and several books for fathers to read to their children. Trainings occurred at three of the

[64] "Fatherhood USA: A Workshop on Effective Fathering," is published by The Fatherhood Project® at Families and Work Institute, the longest-running national initiative on fatherhood.

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five Head Start centers in Washington County. Fifty participants were trained, with a resultant impact on 350 families and children in 2004. A fatherhood kit has been provided to the Pueblo of Zuni Safe Start Project for review.

A coalition of domestic service providers, advocates and other agencies collaborated to plan for the domestic violence awareness campaign in October 2004. The Regional Medical Center-Lubec has developed an operating procedures manual for the coalition to use for future campaigns.

For the first time, The Sexual Assault Agency, the Domestic Violence Project at Pleasant Point and The Next Step (the new Washington County domestic violence provider) and the Child Abuse & Neglect Council collaborated to develop a shared awareness Tri-Pin to be distributed by these agencies as part of their annual awareness campaigns conducted in April and October of each year.

7. Institutionalization of Change

KCSD is working with members of CART, MDT, and MHC to institutionalize the processes and protocols of each committee. As part of its sustainability efforts, KCSD also is working toward reassigning leadership roles to committee members most likely to continue the work of their group; although many committee members are interested in sustainability, busy schedules and conflicting demands leave them with little time to contribute. Finally, the KCSD Board is developing criteria to identify the agency whose role will be to *"keep the brand going."* Once this partner agency is selected in April 2005, a transition plan will be put into place.

In addition to promoting sustainability of committees and their work, KCSD has contributed resources to the community that will survive beyond the National Safe Start Demonstration Project. These resources, including the aforementioned digital cameras and the forensic interviewing protocol/training, are expected to benefit children exposed to violence.

In its recent strategic plan, KCSD identified the need for a single point of entry to services. In response to this need, the collaborative has selected a consultant to help develop a community resource locator in the form of a web-based database, in addition to signing a memorandum of understanding with Ingraham (a nonprofit organization in a neighboring county that assists persons in crisis) and 211 Maine to collect data for the database. Work is now underway to create a round-the-clock 211 call center for Washington County; thus far, this work has included the formation of a coalition of county providers and requests for funding submitted to a number of sources, including the Maine Community Foundation, Washington County Commissioners, RMCL, Rapid Response and others. In addition, a bill has been introduced into the Maine Legislature to make it possible to obtain a 211 number for Washington County. The county Senator and House member co-sponsored legislation to create a 2-1-1 number in Maine. The legislation passed and was signed by the Governor KCSD plans to provide funding for a liaison to work with Ingraham to 1) coordinate the collection of data from the county, 2) coordinate entry of these data into the database, and 3) facilitate flow of these data into the 211 system. The Maine Public Utilities Commission is currently considering a statewide provider to take the calls. KCSD and WHCA have partnered to create a web data base for access for

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agencies and for the basis of support for the call center. KCSD has currently collected 90% of the information from Washington county and 45% of the services in Hancock County (some services cross over county lines). In 2005, KCSD hopes to integrate its database with a 211 information line currently being developed in Maine. If all goes as planned, Washington County will become the second county in Maine to set up its 211 line.

8. Increased Community Supports

Agencies whose capacities were increased through the work of KCSD include law enforcement (through the use of digital cameras and forensic interviewing training) and Head Start (in its ability to serve fathers better). Other community supports developed as a result of KCSD include CART, MDT, and MHC, all of which are dedicated to improving service delivery for children exposed to violence.

9. Lessons Learned in the Implementation and Evaluation of Safe Start Activities

The following lessons were identified by site visit participants, as well as through the NET's analysis of data collected from participants and site documents:

- **A comprehensive needs assessment should be conducted at the outset.** A number of participants recommended a thorough needs assessment with a clear focus on outcomes, activities, and agencies to be involved. The KCSD needs assessment did identify 1) organizations with the capacity to serve children and 2) existing problem areas in the community (such as lack of psychiatrists and psychologists). Issues such as uneven or negligible agency capacities, geographic access, cultural issues, and level of trust in the community might have been captured by a more intensive needs assessment.

- **Partnerships should be institutionalized.** Participants mentioned the importance of memoranda of understanding to ensure the commitment of agencies to partnerships and plans.

- **Do not plan too far ahead**. Participants reported that planning for five years at the outset of the Initiative resulted in loss of valuable time. They recommended the development of implementation plans and sustainability plans prior to working on five-year plans.

- **Cross-site meetings should provide time for networking.** KCSD staff mentioned the need for cross-site meetings to allocate additional time for networking and interaction with other Safe Start Demonstration Site members.

- **OJJDP should take a stronger role.** Some participants indicated that OJJDP could have been more prescriptive. Although they acknowledged the need for balance between serving community needs from a local level and dictating how funds are spent from a federal level, some would have liked a more accurate idea of the expectations of OJJDP.

- **Strong project leadership is necessary.** The Safe Start Project Director must be a strong leader with prior knowledge of 1) the region, 2) local service providers, and 3) the culture of the area. The Project Director also should have pre-existing

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knowledge of and access to policy makers at all levels of government.

- **Face-to-face interaction is important.** Participants noted the necessity for face-to-face interaction between and among local teams and the National Safe Start Demonstration Project. Several participants stated that, while convenient, teleconferencing does not always work well.

- **Building trust takes time.** When agency members and staff change, time must be set aside to build new relationships.

- **More resources need to be assigned to collaboration, networking, training, and trust building.** These resources are important especially at the outset of the process, to build a solid foundation for the future and ensure sustainability.

10. Barriers and Challenges

The barriers and challenges encountered by KCSD can be summarized as follows:

- KCSD struggled with dividing its resources and focus between systems change and the provision of services. Site visit participants indicated that the broad expectations communicated by OJJDP made it difficult to prioritize operations.

- In a small community, the stigma of receiving mental health treatment can be inhibiting. KCSD has had to confront negative community attitudes and perceptions regarding help-seeking and the need for treatment.

- KCSD has been unable to engage the Native American communities to the extent it would like. Reasons cited included need for a better understanding of the Passamaquoddy culture, needs, and interests.

- Safe Start staff turnover has been high in all agencies, both locally and nationally. According to participants, KCSD lost valuable momentum and time when staff members resigned or took extended leave. Likewise, turnover at the national level has caused confusion.

- According to participants, the national T&TA has not been adequate to meet the needs of a rural community with a dearth of resources. KCSD staff also stated that they were not always aware of the types of technical assistance to which they were entitled.

- The geographic spread of Washington County presents serious challenges to developing and maintaining working relationships, collaboratives, and countywide services. All participants discussed the difficulty of ensuring strong participation at meetings, due to the distance most members had to travel.

11. Conclusion and Recommendations

KCSD has focused primarily on improving and changing the systems that respond to and intervene with children exposed to violence. This focus gave KCSD the opportunity to examine the operations of several state and county systems and to develop operational improvements to promote positive outcomes for children. These improvements have included the digital camera program, the forensic interviewing protocol, and awareness trainings related to children's exposure to violence. KCSD continues to work with

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professionals to institutionalize its efforts and maintain the high level of attention to children exposed to violence.

As KCSD enters the final year of the National Safe Start Demonstration Project, the NET suggests that it consider the following:

- Continue to work with members of standing committees to develop interest in and commitment to sustainability. Pursue lines of discussion with committee members that emphasize and promote their self-interest in maintaining existing committees.

- Continue to reach out to other regions of the state that are making current efforts to address the issue of children's exposure to violence. For example, site visit participants mentioned that central Maine has instituted a child trauma initiative. Participants in this initiative have access to the state capital, as well as to essential knowledge, information, and infrastructure. Linking with such initiatives should be a priority.

- Continue to identify gaps in services and resources in the county and advocate for filling those gaps.

- Advocate for the reinstatement of services that have been lost, such as intervention treatment for batterers and a permanent domestic violence provider.

- Create an explicit, well thought-out strategy to involve the Native American sites in every facet of the process.

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ATTACHMENT A

Timeline of Washington County Safe Start 2004 Major Activities and Milestones

Activities	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec
Passamaquoddy Pleasant Point Forensic Room Opened	✓	✓										
IDT meeting with Dr. Wolff as facilitator	✓											
IDT disbanded						✓						
KCSD Policy Associate resigned				✓								
Blue Ribbon Campaign to raise awareness on Child Abuse				✓								
Blue Ribbon Campaign to raise awareness on Domestic Violence										✓		
Peaceful Choices as Contractor of Domestic Violence*	✓	✓	✓	✓	✓							
DHHS formed by merging DHS and BDS*							✓					
Digital Camera Equipment Program enhanced by Digital Forensic Photography Training											✓	
WCPA Contract ends												✓

**** Not a KCSD activity but has impact on KCSD***

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