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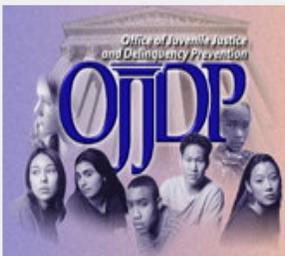
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# Safe Start Initiative: Demonstration Project

## Safe Start Initiative Phase I Case Studies II (2000 - 2005) Report #2006-2

*July 2006*



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

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## **Preface**

The Safe Start Demonstration Project Five Year Report (2000 – 2005) was developed by the Association for the Study and Development of Community (ASDC) for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) for the National Evaluation of the Safe Start Demonstration Project. The report covers the first five years (2000 – 2005) of the Safe Start Demonstration Project. Volume 2 includes each site's case study.

We would like to recognize Katherine Darke Schmitt (Missing and Exploited Children and Child Abuse and Neglect Programs Coordinator and Safe Start Evaluation Manager) for her leadership and support. We would also like to thank Kristen Kracke, Safe Start Program Manager, for her assistance. ASDC staff contributing to this volume include: David Chavis (Project Director); Yvette Lamb (Co-Project Director); Mary Hyde (Senior Managing Associate); Kien Lee (Senior Managing Associate); Joie Acosta (Managing Associate); Deanna Breslin (Associate); Susanna Haywood (Associate); Tina Trent (Senior Managing Associate); Dewitt Webster (Managing Associate). Sylvia Mahon (Office Coordinator) assisted in the production.

ASDC would like to thank the Local Evaluators and Project Directors of the 11 Safe Start Demonstration sites for their assistance with their respective case studies. These case studies would not be possible without the collaboration of many people from among the Safe Start Demonstration Project sites, including each site's partners who were willing to meet with ASDC during site visits.

## Table of Contents

Introduction .....	iii
Chapter I Baltimore Safe Start Initiative .....	1
Chapter II Bridgeport Safe Start Initiative .....	8
Chapter III Chatham County Safe Start Initiative .....	29
Chapter IV Chicago Safe Start Initiative .....	55
Chapter V Pinellas Safe Start Initiative .....	84
Chapter VI Pueblo of Zuni Safe Start Initiative.....	127
Chapter VII Rochester Safe Start Initiative.....	132
Chapter VIII San Francisco SafeStart .....	170
Chapter IX Sitka Safe Start Initiative.....	199
Chapter X Spokane Safe Start Initiative .....	218
Chapter XI Washington County Safe Start Initiative .....	251

## Introduction

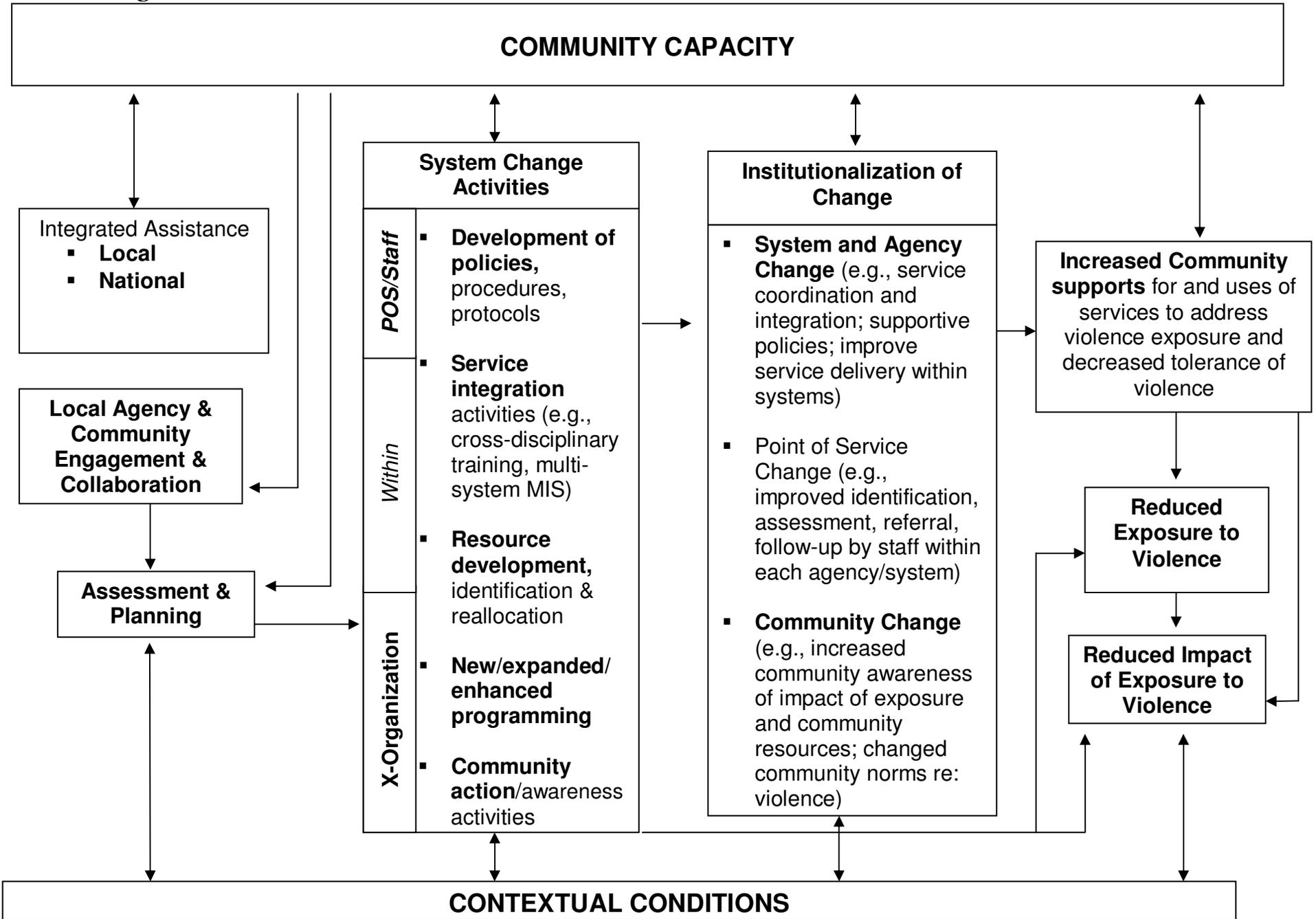
Eleven communities were competitively selected as Safe Start Demonstration Project sites: Baltimore, Bridgeport, Chatham, Chicago, Pinellas, Pueblo of Zuni, Rochester (New York), San Francisco, Sitka, Spokane, and Washington County (Maine). The Safe Start Demonstration Project is funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The goal of the project was to expand existing partnerships among service providers in key areas such as early childhood education/development, health, mental health, child welfare, family support, substance abuse prevention/intervention, domestic violence/crisis intervention, law enforcement, courts, and legal services. Each demonstration site was expected to create a comprehensive service delivery system to meet the needs of children and their families at any point of entry in the system of care. Furthermore, this comprehensive system was expected to improve the accessibility, delivery, and quality of services for young children who have been exposed to violence or are at high risk of exposure.

A theory of change was developed for the Safe Start Demonstration Project (See Figure 1). In essence, it was expected that collaborative planning and implementation of system change activities would strengthen communities in ways that would prevent young children from being exposed to violence and reduce the impact of exposure for those who were. More specifically, *contextual conditions* (political, economic, and social) were expected to influence project planning and implementation. For example, the

incidence and prevalence of child maltreatment or community violence might affect public awareness of related issues. Related to these contextual conditions are *community capacities* (the number and quality of initiatives focused on improving the well-being of young children, for example), also expected to impact project planning and implementation. According to the theory of change, community capacity would most directly affect *assessment and planning*, as well as *community engagement and collaboration*. Communities with relatively large numbers of qualified professionals, for instance, might be in a better position to reach out to the existing service provider networks and engage them in assessment and planning processes. In addition, the capacity to conduct an assessment of community needs and resources was expected to be greatly influenced by the availability of *local assistance*, the ability to access *national assistance*, and the availability of accurate community data. Partnerships were to be formed to plan and initially implement a number of *system change activities*. These activities were expected to change practice across organizations, within organizations, and at the point of direct services. The system changes achieved were expected to be continued, or *institutionalized*, in the form of service coordination and integration and improved service delivery. In turn, the result of continued system changes would be *increased community supports* for young children exposed to violence such that *fewer children would be exposed to violence and the impact of exposure would be reduced*.

**Figure 1**

**SAFE START OVERALL LOGIC MODEL**



July 2006 DRAFT

These site case studies describe how each Safe Start grantee changed its community to reduce the impact of exposure to violence on young children. Each site's case study represents a chapter in this volume of the Safe Start Demonstration Project Five Year Report (2000-2005). The analysis is based on the National Evaluation Team's site visit reports (2004 and 2005), the site's local evaluation report form (2005), and information obtained from site documents (e.g., progress reports, implementation plans, strategic plans, and other materials). Each report is organized according to the project's theory of change and covers the first five years of the Safe Start Demonstration Project. Core questions used to guide the analysis include:

- How did community conditions affect the implementation and impact of Safe Start?
- How did Safe Start change the community to meet the needs of children exposed to violence?
- How was Safe Start institutionalized in the community?
- How did Safe Start increase community support for children exposed to violence?
- How did Safe Start reduce the number of children exposed to violence?
- How did Safe Start reduce the impact of exposure to violence on children?

# I

## Baltimore Safe Start Initiative

### 1. Overview

The Baltimore City Safe Start Initiative (BCSSI) began in 2000 with high hopes of building on the momentum of existing efforts to address child and family issues in Baltimore City (e.g., Safe and Sound, Success by 6, Starting Points, Child Development-Community Policing program). The vision was to redirect and refocus some of this momentum to the issue of children exposed to violence; violence in Baltimore City had been identified as a critical public health and community issue by policymakers, service providers, and citizens. To realize its vision, BCSSI began a process to develop a unified screening and assessment procedure for young children exposed to violence, to integrate BCSSI with the Family League of Baltimore City's Family Support Strategy, and to expand access to mental health services in local communities for children six years and younger. The formal goals for the demonstration project were to achieve:

- Broad community awareness of the impact of exposure to violence on young children,
- Early and consistent identification of young children exposed to violence, and
- Access to specialized services (e.g., services from a Safe Start trained provider) and other appropriate community-based services for exposed children.

Over the course of the initiative, two major strategies emerged as the means by which the BCSSI would attempt to achieve these goals. The first strategy involved the training of community-based, child-serving professionals in (1) key concepts related to the impact of exposure to violence on young children and (2) clinically proven assessment and treatment modalities for exposed children. This strategy was developed in response to a needs assessment that indicated a lack of clinical expertise for identifying and treating young children exposed to violence in Baltimore City neighborhoods. BCSSI staff envisioned the creation of a unified system of identification and referral to treatment through training community providers and other professionals in a protocol that would position BCSSI as the gateway to mental health and other services for children exposed to violence and their families. To develop a unified system for identification and referral of children exposed to violence, the BCSSI sought to utilize the characteristics of existing provider agencies and to work with these agencies to create buy-in for the BCSSI referral protocol. Increasing the numbers of referrals, however, was a significant challenge throughout the implementation of BCSSI.

A second strategy for achieving the goals of BCSSI involved issuing requests-for-proposal for funded projects to create incentives for systems change within key provider agencies. For example, the Violence Intervention

Project was funded in response to a request-for-proposal from BCSSI to identify ways to create a domestic violence unit within Child Protective Services (Baltimore City Department of Social Services).

By 2005, more than 100 mental health professionals and other community-based service providers had been trained by the BCSSI. Two very successful responses to the request-for-proposal process had been implemented. Yet, despite the efforts of BCSSI staff, the number of children and families involved in Safe Start remained quite small. BCSSI staff, community members, and providers point to several factors that hindered the initiative, including the need for a local champion and an inability to create needed buy-in with community members and key agency providers. A decline in political will combined with changes in the economy at the federal, state, and local levels also served as barriers to the implementation of the Baltimore City Safe Start Initiative as it was initially envisioned.

These are among the multiple findings from an analysis of the Baltimore City Safe Start Initiative between 2000 and 2005. Using the National Safe Start Demonstration Project logic model as a framework, this report reviews data collected over five years as the basis of a case study of the BCSSI.

### **1.1 Mission**

The Baltimore City Safe Start Initiative focused on continuing the development of a comprehensive system of services to prevent and reduce the impact of family and community violence on children six

years and younger, their families, and communities. To what extent did the Baltimore City Safe Start Initiative accomplish these goals? What factors contributed to and impeded success? These questions are addressed in the following sections, and a timeline of major events is attached (see Exhibit I-A).

### **1.2 Baltimore City, Maryland**

The Baltimore City Safe Start Initiative was planned and implemented within the unique context of Baltimore City, Maryland. The following snapshot of Baltimore City is intended to help others interested in replicating Safe Start to compare their own communities to Baltimore City.

Baltimore City lies on the Patapsco River in the state of Maryland. The use of the name “Baltimore City” distinguishes this governmental entity from the County of Baltimore in which it resides. The city of Baltimore is the largest city in the state of Maryland, covering 80 square miles and including 55 neighborhoods (Baltimore City Safe Start Initiative, 2005, p 6). The 2003 population of Baltimore City was estimated at 629,000; the population has been declining since 1990. African Americans comprise the majority 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 of Baltimore City. The median household income in the city in 2000 was \$30,078.

From 2000 to 2005, the BCSSI sought to implement a demonstration project to address issues of children exposed to violence. Initially focused in seven

communities, BCSSI had expanded citywide by the end of the five-year demonstration project, in response to the increasing need throughout Baltimore City neighborhoods to address family and community violence brought on by severe social and economic distress.

The seven communities originally identified for implementation of BCSSI represented 15 neighborhoods in Baltimore City where risks of exposure to violence were highest for children and families, and where rankings were negative on indicators associated with child well-being (e.g., poverty, unemployment, infant deaths, access to prenatal care, teen birth rate, child mortality). The communities were predominately African American. Approximately 50% of the city's adult population, 60% of the city's children, and 33% of the city's children six years of age and younger resided in these neighborhoods. These communities were also the focus of several other capacity building, child, and family initiatives that will be described in later sections of this report.

## **2. Contextual Conditions**

Each of the 11 Safe Start initiatives was implemented within a political, economic, and social context that affected both the initiative and the broader community's response to children exposed to violence. The context in which Baltimore City implemented its demonstration project critically impacted the ability of the project to reach its identified goals.

Two contextual factors significantly impacted the development and

implementation of the BCSSI: political change and economic decline.

### **2.1 Political Context**

The political context for BCSSI changed significantly as program planning and implementation began. Prior to the funding of the Safe Start grant, key political stakeholders (e.g., the Mayor's Office, the State's Attorney) sought to expand the efforts already underway in Baltimore City neighborhoods to address issues of children and families. There was great political will to address issues of violence at the family and community level, as demonstrated by applications for federal funding dedicated to this purpose. Shortly after the BCSSI was funded, however, political leadership changed; by 2003-2004, as implementation of Safe Start began, these changes in local government had created a less favorable climate for implementing the project. Safe Start was no longer a key part of the agenda at the Mayor's Office, as much of the focus for violence prevention had shifted to programs addressing youth (i.e., adolescent) violence and crime prevention, leaving few, if any, political champions in Baltimore City for young children (i.e., six years and younger) exposed to family and community violence. In short, changes in leadership left the BCSSI without a political ally to ensure that resources, agencies, and other key stakeholders would remain committed to the project. In addition, during the first two years of the planning and implementation of the BCSSI, a state level restructuring of social services was undertaken when a new governor assumed office, resulting in a reduction of staff and operating budgets for state and local social service agencies. These local and state agencies

were primary partners in the BCSSI collaborative and principal service delivery resources.

At the local level, leadership changes in other key partnering agencies also occurred. For example, the police commissioner in Baltimore City was replaced several times over the course of BCSSI implementation. This turnover affected the capacity of BCSSI to engage front line law enforcement officers in following through on identification and referral of children exposed to violence during domestic violence incidents or other crisis interventions for which law enforcement served as first responder.

## ***2.2 Economic and Social Context***

High rates of poverty and crime exist in several Baltimore neighborhoods, particularly those that were initially selected for BCSSI services. Social indicators assessed at the beginning of BCSSI showed high levels of poverty, substance abuse, unemployment, and dependence on public assistance. Violent crime statistics in Baltimore City were significantly higher than national averages for cities of similar size, and family violence statistics indicated that child physical abuse cases in Baltimore City were more frequent than in all other counties in the state of Maryland. Actual implementation of BCSSI began in four of the seven communities initially selected; those were neighborhoods that felt the greatest economic impact of state and local budget cuts for social services. By year four and continuing through year five, however, BCSSI expanded the service delivery aspects of its program to include all neighborhoods citywide, to meet the increasing needs of neighborhoods affected by social and

economic decline. While economic decline necessitated that BCSSI expand citywide, little evidence exists that expanding the project either improved or impaired the capacity of BCSSI to achieve its project goals.

## **3. Community Capacity**

The Baltimore City Safe Start Initiative was part of a strategy developed by local government to increase community capacity for addressing child and family issues among at-risk populations, by building on existing community programs. Specifically, BCSSI was to complement the work of Success By 6 (SB6) (Baltimore City Safe Start Initiative, 2005, p 10).

### ***3.1 Existing Community Resources***

For several years prior to the funding of BCSSI, local government had secured funding and developed programs to foster better outcomes for children and families most at risk for negative outcomes frequently associated with living in poverty. These programs included (Baltimore City Safe Start Initiative, 2005, p 10):

- After School Strategy,
- Baltimore Success by 6,
- Hot Spots,
- Safe Schools/Healthy Students,
- Youth Violence Council,
- Starting Points, and
- Child Development–Community Policing.

A strong track record of success among these programs suggested that the Baltimore City Safe Start Initiative

would also do well in addressing another identified issue: family and community violence. Local leaders sought to replicate the success of current programs by linking a new program (BCSSI) with an existing program (Success By 6).

There were additional reasons to connect Baltimore City Safe Start and Success By 6. First, both projects had the same fiscal agent, Family League of Baltimore City (a further description of the work of the Family League of Baltimore City can be found in the “Community Collaboration” section of this report).

In addition, integration of SB6 and BCSSI was considered “congruent and complementary” for meeting the needs of children and families. Success By 6 would focus on community-based governance and service delivery; BCSSI would focus on training mental health and other service providers on issues of exposure to violence and related intervention services. An initial assessment had characterized community capacity for the delivery of mental health and social services in the neighborhoods to be targeted by Success By 6 and BCSSI as uncoordinated and duplicative. Linking the work of these two programs was seen as a means of leveraging resources for non-duplicative services in communities in need of capacity and infrastructure for mental health and other support services for children exposed to violence. In the end, the goal was to strengthen the infrastructure created by Success By 6 with specialization in concepts related to children exposed to violence.

The neighborhood assessment (Anderson & Ringgold, 2000) undertaken by BCSSI identified

additional significant gaps in service level capacities, limiting the ability of these neighborhoods to address the issue of children exposed to violence. These gaps included:

- Lack of a payment system for support of mental health and other services,
- Gaps in available mental health services and crisis intervention services,
- Critical shortages of mental health providers,
- No evidence of collaboration between agencies and across systems to address children exposed to violence,
- Lack of knowledge regarding children exposed to violence at the agency level, and
- Lack of knowledge of the availability of services on the part of community providers and community residents.<sup>1</sup>

### ***3.2 Training and Technical Assistance***

One strategy used to increase the ability of BCSSI partners to address existing gaps in community capacity was to secure technical assistance and training from Safe Start national resources. Training and technical assistance were provided under the Safe Start Demonstration Project to grantee sites to address identified programmatic needs. Over the course of the five-year implementation of BCSSI, technical assistance providers supplied training and technical assistance in key areas of need for BCSSI participants, particularly

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<sup>1</sup> The local evaluator’s scope of work did not include monitoring or measuring the extent to which BCSSI addressed issues identified in the neighborhood assessment. Activities described here were undertaken to address some of these issues. The impact of these activities cannot be ascertained because of the limited scope of the local evaluation.

agency and clinical service providers. Training and technical assistance, provided by local consultants, content experts, and national contractors, focused on: 1) clinical training, assessment, and treatment; 2) a management information system; 3) evaluation; 4) programmatic technical assistance on collaboration; and 5) sustainability (Baltimore City Safe Start Initiative, 2005).

## **4. Community Engagement and Collaboration**

### **4.1 Community Engagement**

Consultants for BCSSI conducted an initial community needs assessment. Seven themes emerged from the assessment and served as the foundation for program planning for the initiative; these themes provided significant insight into the perspectives and needs of community residents. The assessment identified a relationship between violence and substance abuse/drugs in Baltimore City neighborhoods that needed to be addressed as a part of the program to reduce exposure to violence (Anderson & Ringgold, 2000).

Accessible community and neighborhood mental health and counseling services with culturally competent service providers were identified as critically important for the success of the program. Structured activities for adults and children, along with improved educational resources, also were identified as necessary for reducing violence in neighborhoods.

While the above themes were considered important, two other major themes were perceived as critically important to

address. First, community residents and providers indicated that services for children were fragmented and uncoordinated, making it difficult for families to know where to turn to for help. Second, communities needed to be involved in and empowered to find their own solutions and strategies for reducing the impact of violence on young children and their families.

BCSSI program staff used the information gathered from the community assessment to focus its efforts to reduce the impact of exposure to violence on children. Staff intended to develop activities focused on the following:

- Educating the community about children exposed to violence (e.g., curriculum, marketing materials);
- Screening tools;
- Mental health professional training; and
- Identification of community-based, culturally competent service providers.

Following concepts of the Safe Start Demonstration Project program design, BCSSI sought to engage the community through these activities and increase the impact of its work by utilizing the strength of its collaborative.

### **4.2 Collaboration**

According to BCSSI staff, one of the keystones of the BCSSI was the effective collaboration that already existed in Baltimore for this type of project. The BCSSI intended to maintain close communication with all primary leaders and enable partners to use leadership and organizational authority to lead efforts of the project, such that

partners would remain engaged and invested in project outcomes. Collaboration was structured through key partnerships with the two most visible entities involved with families and children in Baltimore City: the Family League of Baltimore City and the Success by 6 Initiative.

### **4.3 Key Partnerships**

The Family League of Baltimore City (FLBC) served as the key agency for coordinating the BCSSI initiative. The FLBC was founded in 1991 as a quasi-public, non-profit organization, to serve as a local management board. Local management boards were established to focus attention and resources on improving the well-being of children and families by engaging communities and encouraging public and private partnerships. FLBC did not provide direct services, but instead initiated collaborative processes to enhance strategic planning efforts to improve child and family outcomes and indicators of well-being. In 1997, the FLBC further focused its efforts on (1) developing a set of results and indicators that would measure progress toward improved outcomes for children and families, (2) developing strategies that would have the strongest potential to actually improve those outcomes, and (3) establishing data mechanisms to collect baseline and ongoing data to track the impact of these strategies and to inform citywide and community-level planning and decision making. In addition to bringing this purpose to the collaborative, FLBC also was able to create formal agreements (Memoranda of Agreement) between 28 local agencies in support of the startup of the Baltimore City Safe Start Initiative.

Baltimore's Success By 6 Initiative was a movement adopted by Baltimore City to support children and families. Its mission was to ensure that young children were healthy, safe, nurtured, and ready to learn when they entered school. The goal of the initiative was to further Baltimore's effort, as organized by the Safe and Sound Campaign, to build a citywide network of programs and services to support the health, functioning, and self-reliance of the city's families and young children (six years and younger).

Success By 6 was already operating in the neighborhoods to which BCSSI would offer services. As BCSSI began to implement community-based strategies in its third year, Success By 6 was winding down in these targeted neighborhoods. The initial expectation that BCSSI would be able to build on the accomplishments of Success By 6 did not materialize. Instead, BCSSI failed to engage the targeted neighborhoods. Community members, both residents and providers, were unwilling to respond to yet another intervention that did not provide the types of services or resources they wanted. Over the five years of the BCSSI, community engagement efforts were limited to participation in community events and providing community training for providers and parents. Despite efforts by BCSSI staff to educate community members about children exposed to violence and mental health interventions to address this issue, these efforts did not produce significant buy-in at the neighborhood level. BCSSI staff were not able to significantly change the attitudes and behaviors of community members about using mental health

services to address issues of children exposed to violence.

#### **4.4 Collaborative Structure**

Under the leadership of the Family League of Baltimore City, the BCSSI collaborative was able to draw on the members of the existing Family Support Strategy, which included the Baltimore City Department of Social Services (BCDSS), Baltimore Mental Health Systems, Baltimore Substance Abuse System, Baltimore City Public Schools, and Baltimore City Head Start. The collaborative was loosely configured, with FLBC serving as the convener and facilitator. Over the course of the initiative, interest and leadership waned. After the initial planning years ended, key decision makers began to send lower ranking staff to collaborative meetings. Decisions that needed the input and buy-in of agency authorities were left to agency representatives who did not have the authority to agree to or implement change within their organization. As one collaborative member explained, “We had the right agencies at the table, but the wrong people from those agencies.”

Nevertheless, BCSSI was able to facilitate partnerships between individual agencies. For example, Child Protective Services and the domestic violence sector worked more closely together as a result of involvement in the BCSSI collaborative. The placement of a domestic violence provider in BCDSS and cross training between these two groups helped enhance the collaboration. Key components of this effort are described in the next section.

## **5. Systems Change**

### **5.1 BCSSI Theory of Change**

BCSSI staff envisioned a theory of change for their initiative that would address the issues faced by the target population. Using available *resources* (fiscal support, technical assistance, staff, data, management information systems, and coordination of planning) and through *collaboration* with key leaders, community-based agencies, the faith community, and the Family Support Strategy of Success by Six and Head Start, BCSSI proposed engagement in two types of activities. These activities were:

- Service coordination and capacity building, and
- Community awareness and education.

A critical result of these activities would be a standardized protocol for screening for and assessing violence exposure among children six years and younger, which would be shared with provider agencies. This protocol was viewed as essential for achieving short term outcomes related to changes in the service delivery system, identification of children, and mobilization of community action on behalf of children exposed to violence. Achieving short term outcomes would further lead to greater service integration and increased provider competence regarding issues related to children exposed to violence, as well as improvements in the condition of children six years and younger who were exposed to violence. In addition, community referrals to services for children exposed to violence would increase. These activities, outputs, and outcomes would ultimately achieve the

long term goals of the Safe Start Demonstration Project: reduced negative impact of exposure to violence on young children, and reduced (re)exposure to violence among children six years and younger.

### **5.2 Risk and Protective Factors**

Baltimore City Safe Start Initiative proposed to design a service component to address social risk factors contributing to children's exposure to violence. An early assessment of community needs for program development identified the presence of critical social risk factors among the target population for BCSSI services. Program planners for BCSSI endeavored to develop strategies to mitigate or ameliorate these risk factors by developing a project that would increase and reinforce protective factors. For example, the project sought to address a priority risk factor of teen parents by working with these teens in a manner that would substitute or provide positive values, identities, and role models; increase parenting knowledge, mentoring, motivation and achievement; and develop extended family/support networks. For ten priority risk factors identified as present in the seven communities to be served by the demonstration project, BCSSI, as part of its initial implementation plan, identified corresponding protective factors and activities that would lessen the impact of the risk factors and thereby reduce the risk of violence exposure. Subsequent implementation plans (after 2002) did not consistently focus on these concepts.

### **5.3 Service Delivery<sup>2</sup>**

To implement service coordination and to address ways to increase protective factors for children and families in Baltimore City, BCSSI identified and worked with local partners. Partners were originally drawn from political, community, and agency representatives. The major focus of change was the delivery of mental health services for children exposed to violence; the principal partnership was with Baltimore Mental Health Systems, the core mental health service provider that was to provide a direct link to mental health professionals for training in both children's exposure to violence and identification, assessment, and referral of children. During the five-year demonstration project, the House of Ruth—Maryland, East Baltimore Mental Health Partnerships, Baltimore Child Abuse Center, and Urban Behavioral Associates were the principal partners in service delivery for BCSSI. As federal funding for the project was coming to an end, BCSSI was able to expand this group to include six other providers. Local providers agreed to participate in Safe Start training and to self-identify as Safe Start providers after receiving Safe Start training.

The primary goal of BCSSI was to build strong alliances with existing programs to reduce service duplication, enhance positive outcomes for children and families, and sustain services and programs beyond the federal funding period. BCSSI envisioned a system continuum to include the following components:

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<sup>2</sup> Information summarized in this section of the report was found in the 18-month implementation plan (Baltimore City Safe Start Initiative, 2001).

1. Consistent screening for exposure to violence by system agencies and organizations;
2. Appropriate and comprehensive family assessment, case management, and follow-up via Family Assessment Centers (FACs);<sup>3</sup>
3. Developmentally, culturally, and family appropriate community-based services to reduce the impact of exposure for children six years and younger;
4. Electronic directory of services relevant to exposure;
5. Community response to violence provided by Child Development-Community Policing;
6. Training, education, and technical assistance;
7. Community awareness/education campaigns to raise knowledge about young children's exposure to violence; and
8. Management information system software capable of tracking families in the system and supporting evaluation.

Three groups were identified as key sectors responsible for creating a coordinated system of care at the

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<sup>3</sup> Family Assessment Centers (FAC) were designed to address gaps identified in the community assessment, specifically, the lack of comprehensive specialized assessments within an integrated and coordinated system of services. FACs were designed to provide family assessment, referral, and case management services at locations convenient to families within each of the targeted neighborhoods. These centers, however, were never implemented.

neighborhood level: 1) the Baltimore City Department of Social Services (BCDSS) for physical and sexual abuse; 2) the Baltimore City Police Department/Child Development-Community Policing/Department of Juvenile Services for domestic and community violence; and 3) community-based organizations for domestic and community violence. All agencies were to provide education and training to community-based service providers and education and screening to families. All agencies also would have relationships with Family Assessment Centers, the courts, and a medical care provider.

Child Development-Community Policing (CD-CP) was essential to the BCSSI strategy as a point-of-service provider. The CD-CP model had a demonstrated history of being effective and trusted in Baltimore City neighborhoods. According to the CD-CP design, law enforcement provided trauma response and community education and training in collaboration with East Baltimore Mental Health Systems. East Baltimore Mental Health Systems was also responsible for training neighborhood-based mental health providers. Most critically, however, CD-CP was to serve as the gateway for identification and referral for children exposed to violence, particularly when law enforcement responded to domestic violence incidents. Over the course of its five-year implementation, BCSSI provided resources to expand CD-CP to more and more neighborhoods, in an effort help focus on children six years and younger. By year five of the demonstration project, BCSSI had helped expand CD-CP citywide.

## **5.4 Service Integration**

The major strategy for service integration was to develop a common tool to be used by all child-serving agencies (public and private) to identify children exposed to violence. Central to BCSSI's efforts to ameliorate the harmful effects of exposure to violence on young children was an ability to identify when such exposure occurred. The BCSSI Best Practices Committee, convened during the planning stages of the demonstration project, researched processes used by human service and public safety agencies to accomplish this task. They concluded from their research that agencies use specific screening procedures to identify children exposed to violence. BCSSI decided to work with key agencies to expand, if necessary, current screening tools to include screening for children exposed to violence. Key agencies, (e.g., Baltimore City Department of Social Services, Baltimore City Police Department/CD-CP, University of Maryland Medical System, Baltimore Mental Health Systems, and Baltimore City Head Start) agreed to work with BCSSI to adapt their current screening procedures to include components that would be developed by BCSSI. In turn, BCSSI would provide training and technical assistance to the agencies to ensure that staff would be able to implement the protocols and tools, as well as have knowledge and understanding of available resources and interventions appropriate for children exposed to violence.

This process was never fully implemented because it required the development of uniform assessment, referral, and case management

procedures compatible with both BCDSS and other partnering agencies. Aspects of the process were piloted at the neighborhood level during the early stages of BCSSI implementation. The approach, however, proved difficult to implement and was considered a duplication of services; agencies viewed the process as costly and demanding. Several additional attempts were made over the course of the demonstration project to find a way to develop a coordinated system of care. By 2004, BCSSI had dropped screening as a referral requirement, in an effort to reduce the burden on partnering agencies and families. In 2005, a second attempt to integrate screening questions into protocols for child-serving agencies was attempted, but did not result in full integration across systems. As a secondary strategy, BCSSI developed an alternative process for referring and treating children exposed to violence. This approach (Safe Start Intervention Services) was an effort to use BCSSI as a gateway for referral and services and to track and monitor results (see Exhibit I-B for a model of Safe Start Intervention Services). Despite BCSSI's efforts to accommodate the diverse needs of its partnering agencies, however, these agencies continued to resist integrating screening and early identification of children exposed to violence into their practices. While Child Protective Services and Head Start showed evidence of using screening questions for referral, 53% of cases referred to Safe Start Intervention Services did not have completed screens. Furthermore, children and families who were referred were difficult to engage and retain in services.

It is difficult to determine the exact reasons for the resistance to service coordination and integration on the part of BCSSI's partnering agencies. Several factors (e.g., cost, administrative burden, family resistance) were mentioned as possible factors for resistance. In addition, BCSSI staff changes, specifically in the position of project director, were frequent over the course of the development and implementation of the demonstration project. This might have contributed to a sense of shifting priorities and lack of continuity, hampering the development of a coordinated and integrated system of care.

### **5.5 Policy Changes**

During the Safe Start planning period (2000-2003), BCSSI's collaborative sub-committee conducted a policy analysis. Baltimore City's response to children exposed to violence was identified as a priority issue for policy change, because of the lack of a single authority responsible for responding to domestic violence and the need for leadership in this area. BCSSI identified 13 specific areas for policy change and developed recommendations. These recommendations focused on: 1) formal cross-agency governance; 2) defining exposure to violence; 3) including data on children exposed to violence in reports to the Mayor's Office; 4) mandating core in-service training on children exposed to violence for child-serving agencies; 5) developing specific actions for reporting and referring domestic violence incidents involving children; 6) utilizing a domestic violence unit to provide Safe Start information to victims; 7) expanding the Child Protective Services assessment tool to

include items on violence exposure; 8) establishing protocols for information exchange and referrals between the Circuit Court and Child Protective Services; 9) enhancing relationships between CD-CP, Child Protective Services, and the Domestic Violence Unit, so that CD-CP could function as a referral source for BCSSI; 10) promoting cross-referencing of information between the Domestic Violence Unit and Child Protective Services; 11) working with Child Protective Services, the State's Attorney, and Circuit Court judges to help ensure that identified children would receive treatment; 12) generating public awareness (e.g., through involvement of the Mayor's Office); and 13) identifying long term funding (Baltimore City Safe Start Initiative, 2005, p 30).

Of the 13 policy recommendations, BCSSI activities realized five:

- The Child Protective Services unit at the Baltimore City Department of Social Services (the Violence Intervention Project) established a domestic violence roundtable to foster cross-agency response to victims of family violence. The roundtable included the Office of the State's Attorney—Family Violence Unit, the Baltimore City Police Department, the Circuit Court, House of Ruth—Maryland, Maryland Network Against Domestic Violence, and BCSSI. The roundtable will continue to function beyond the federal funding of BCSSI;
- Acceptance of the OJJDP definition of exposure to violence;
- Extensive cross-agency training among the Baltimore City Police Department's CD-CP, the Baltimore

- City Department of Social Services, and various city and state agencies;
- Initiation of development of a credit card-sized referral form for the Baltimore City Police Department to use when responding to domestic violence calls; and
- Reporting and referral requirements for the Baltimore City Police Department for incidents involving children exposed to violence.

BCSSI attributed its difficulty in realizing all 13 policy recommendations to the relationship between local agencies and state governance. Many of the citywide agencies participating in BCSSI were obligated to conform to the guidelines of the state agency under which they operated. They were unable to advocate for or produce change at the state level to institute many of the recommendations above.

## **6. Institutionalization of Change**

BCSSI utilized two primary strategies in attempting to institutionalize change across the service delivery system for children exposed to violence. They used a comprehensive training process, including a train-the-trainer model, to help institutionalize theory and practice related to children exposed to violence among staff of partnering agencies. They used a process of funding local demonstration projects to gain a foothold in partnering agencies, in hopes that, once initiated, work in the interest of children exposed to violence would continue in individual agencies. These strategies and their results are described in this section.

### **6.1 BCSSI Training Strategies**

To address the gap in availability of mental health practitioners using appropriate mental health interventions for children exposed to violence, BCSSI trained mental health professionals in early childhood mental health and concepts of children exposed to violence. BCSSI training efforts included infusing principles related to children exposed to violence into agencies through a train-the-trainer model, as well as training on how to use play therapy as a tool to address exposure to violence. In addition, BCSSI training served to inform providers of contacts in collaborating agencies equipped to respond to children exposed to violence through Safe Start Intervention Services. Project evaluation data suggest that BCSSI training helped agency staff increase their professional skills and knowledge related to children exposed to violence; the long-term impact of training on practices related to children exposed to violence, however, is not yet clear.

To continue the training component of Safe Start beyond the demonstration project, BCSSI developed and implemented a train-the-trainer model and curriculum. Over 120 agency-based providers in 55 agencies citywide have participated in the train-the-trainer series. Between January and September 2004, four train-the-trainer graduates reported training 328 individuals using the BCSSI curriculum (Baltimore City Safe Start Initiative, 2005, p 39). Although train-the-trainer activities did not result in an immediate increase in referrals to Safe Start Intervention Services, two key mental health agencies now have trained staff to work with

children exposed to violence citywide. Moreover, evidence supports the contention that agency practices and provider knowledge of exposure to violence have changed as a result of BCSSI training models. The long term impact of these changes on improved conditions for children exposed to violence remains untested.

Throughout the implementation of BCSSI, it was necessary to train agency level staff continuously because of high staff turnover. This impacted the effectiveness of the training and compromised the institutionalization of both training and systems change activities.

## **6.2 Agency Funding Strategies**

During year four and continuing into year five of the demonstration project, BCSSI provided resources to the Baltimore City Department of Social Services to conduct a demonstration project focused on setting up a domestic violence unit within Child Protective Services (CPS). Integration of domestic violence issues and CPS came about as a result of the Department of Social Services Domestic Violence Continuous Performance Improvement Team, which worked for several years to help the Department of Social Services to understand the significant overlap between domestic violence and child maltreatment. Discussions between Child Protective Services and the BCSSI project director led to the funding of the CPS domestic violence unit as a demonstration project, which further led to the incorporation of domestic violence assessment and intervention into CPS investigations.

In a second demonstration project, BCSSI provided funds to the House of Ruth—Maryland for its Community Outreach Expansion Project, which focused on relationship building through community connections, creating an effective referral base, and providing clinical services for identified children and families. The project supported a community outreach worker who followed up on referrals by going into the community two times per week to meet with families in their homes.

These two projects provided BCSSI with its greatest numbers of identified and referred children. The House of Ruth demonstration project produced 53 identified and assessed children and families. Forty of these children and their families received services. The Child Protective Services project generated 89 referrals. Sixty-three of the referrals received services, with 41 of these cases receiving intensive case management and 22 cases receiving treatment only (Baltimore City Safe Start Initiative, 2005, p 34).

As a result of participating in the BCSSI demonstration project, collaborating agencies were able to leverage the experiences gained as BCSSI partners to obtain funding through other sources focused on children exposed to violence. For example, the House of Ruth—Maryland’s involvement with BCSSI contributed to expanding its program to include children six years and younger exposed to violence, thus opening the way for SAMHSA<sup>4</sup> funding of its Safe and Bright Futures program.

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<sup>4</sup> SAMHSA is the Substance Abuse and Mental Health Services Administration, a federal agency whose mission is to “build resilience and

BCSSI also provided funding for the Child Development Community Policing Project through East Baltimore Mental Health Partnership. As a result of these efforts, the Baltimore City Police Department is reportedly considering the development and staffing of a domestic violence unit. Despite providing funds to CD-CP, BCSSI was never able to systematically collect consistent data on family and domestic violence through CD-CP or its other law enforcement partners, possibly due to the very late implementation of a police order that mandates law enforcement officers to collect standard data when called to a family violence incident. It should be noted that data collection across all agencies regarding children's exposure to violence was never fully implemented.

## **7. Increased Community Supports**

There is little clear evidence that BCSSI resulted in a significant increase in supports available to Baltimore City neighborhoods. Nevertheless, BCSSI was able to expand the number of mental health providers trained to serve young children and, between 2003 and 2004, increased the number of Safe Start Intervention Service providers in participating neighborhoods. The Community Outreach Expansion Project of the House of Ruth, which funded a part-time clinician for in-home community outreach, shows promise of serving as a continued resource for families.

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facilitate recovery for people with or at risk for substance abuse and mental illness.”

## **8. Reduced Exposure to Violence**

It is difficult to ascertain whether the Baltimore City Safe Start Initiative reduced exposure to violence at the community level. Data were not collected for key benchmarks or changes in community level awareness, and community-wide incidence data were not part of the scope of the evaluation of the demonstration project.

During the five-year implementation of the project, involvement of BCSSI program staff with the community was limited to several trainings, community programs, and minimum participation in community-sponsored events. An assessment of the awareness and knowledge needs of the various neighborhoods in which BCSSI was active was not undertaken as part of the demonstration project's evaluation process.

## **9. Reduced Impact of Exposure to Violence**

Safe Start Intervention Services (SSIS) was developed by BCSSI to evaluate the impact of treatment on reducing (1) the symptoms of trauma in children exposed to violence and (2) the stressors in parents/caregivers associated with children's exposure to violence (the details of this research intervention are given in Exhibit I-C). Eighty-six client families were referred to SSIS from 2003 to 2005: 70% African American, 15% Caucasian, and 1% Native American, with the remaining percentage of unspecified racial identification. The average age of children in this group was four years.

In the research intervention, 40% of the children studied reported exposure to violence in the home in which they usually lived, 10% in a home in which they also lived, 4% in a relative's home, and 15% in their community. Of the children studied, 46% witnessed (heard or saw) the violence but were not the intended victim of the violent incident, 17% were the intended victim and were injured, and 3% were injured but were not the intended victim. Domestic violence was the most common type of violence reported (36%). Thirteen percent of the children were exposed to community violence, and 17% of the children experienced physical and/or sexual abuse.

Of the 86 referrals to Safe Start Intervention Services from 2003 to 2005, only six cases were active as of December 2005, and only two clients completed treatment. A comment from one of the participants in the study points to the challenges facing BCSSI in engaging and retaining children and families in research interventions: "the staff [are] caring and helpful...able to get concrete needs met, [but it] felt like being re-investigated, too many questions, felt like being judge[d] as a parent, felt like a guinea pig in a research project, did not believe the program would be helpful in the long run..." (Baltimore City Safe Start Initiative, 2005).

## 10. Conclusion

A great deal of planning and effort went into the development of the Baltimore City Safe Start Initiative. The strategy of continuing to build capacity within targeted neighborhoods in Baltimore City by coordinating programs to

address issues of children and families was considered sound practice; BCSSI was expected to follow the path of success that other programs had blazed in these neighborhoods. In the end, however, BCSSI was unable to fully realize the original vision of its staff and partners.

Several factors challenged the BCSSI staff, hindering the ability of the demonstration project to stay on track and move toward accomplishing its critical goals. In particular:

- Political and economic changes at the state and local levels shifted the focus away from children and families;
- Leadership (both within the collaborative and among BCSSI staff) failed to address the issues identified in the pre-planning assessment as critical to create both change and success. The most significant issue, community engagement and involvement, was not effectively carried out;
- Turnover in project leadership and agency leadership, as well as failure of collaborative leaders to continue to engage collaborative members, resulted in poor follow-through and compliance with project activities and goals;
- Dependence on two strategies (i.e., [1] training and [2] funding projects through a request-for-proposal process), to the exclusion of pursuing other means of creating agency and community ownership of the initiative, placed a tremendous burden on these two strategies to generate a meaningful reduction in children's exposure to violence; and
- Basic structural issues were never resolved. Who was BCSSI apart from

Success By 6 and other child-serving agencies? What authority did BCSSI have to command agency change? What was the role of the fiscal agent in ensuring the compliance of partnering agencies and service deliverers? How could BCSSI overcome the SB6 legacy of negative relationships at the neighborhood level? Key project leadership appeared to overlook the importance of developing strategies to address these basic structural issues.

Overall, the strategies developed and implemented by BCSSI appeared to lack consistency with the issues identified through the draft community assessment process. For example, the community assessment indicated that active community participation in finding solutions and strategies to reduce violence exposure and its impact would be critical to the project's success. In contrast, the development, validation, and implementation of a screening tool to be used by mental health professionals and agency staff consumed a majority of the project's resources during its first four years. As another example, exclusive reliance on training mental health professionals to address issues of violence exposure had no clear connection with the assessed need to create other changes in the existing fragmented service delivery system.

Although significant challenges impacted the work of the Baltimore City Safe Start Initiative, staff can point to several achievements resulting from the work of this demonstration project. These include:

- 86 families were assessed, and 10% of those families received treatment services for their children exposed to violence;
- 120 staff in 55 agencies were trained in the theory and practice of addressing the issue of children exposed to violence;
- 2 funded projects (the Violence Intervention Project and the Community Outreach Expansion Project) continued beyond the federal funding of BCSSI; and
- A train-the-trainer curriculum was developed and is being published for distribution to practitioners and students interested in learning about children exposed to violence.

While BCSSI as a demonstration project has ended, knowledge and skills related to children exposed to violence remain in the community at large. Two local agencies, the House of Ruth—Maryland and the Kennedy-Kreiger Institute, continue to build on this knowledge base as they implement other types of programming directed to serve children exposed to violence and their families.

## 11. References

- Anderson, P. & Ringgold, V. (2000, August). *Baltimore City Safe Start Initiative, Draft Assessment Report*. Baltimore, MD: Author
- Association for the Study and Development of Community (2005a). *Site visit report: Baltimore City January through December 2004*. Gaithersburg, MD: Author.
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- Baltimore City Safe Start Initiative (2001). *18-month implementation plan (July 2001 – December 2002)*. Baltimore, MD: Family League of Baltimore City
- Baltimore Safe Start Initiative (2005). *Local evaluation report form*. Baltimore, MD: Author (Available from the Association for the Study and Development of Community).

**Exhibit I-A**  
**Timeline of Baltimore City Safe Start Initiative Activities and Milestones**

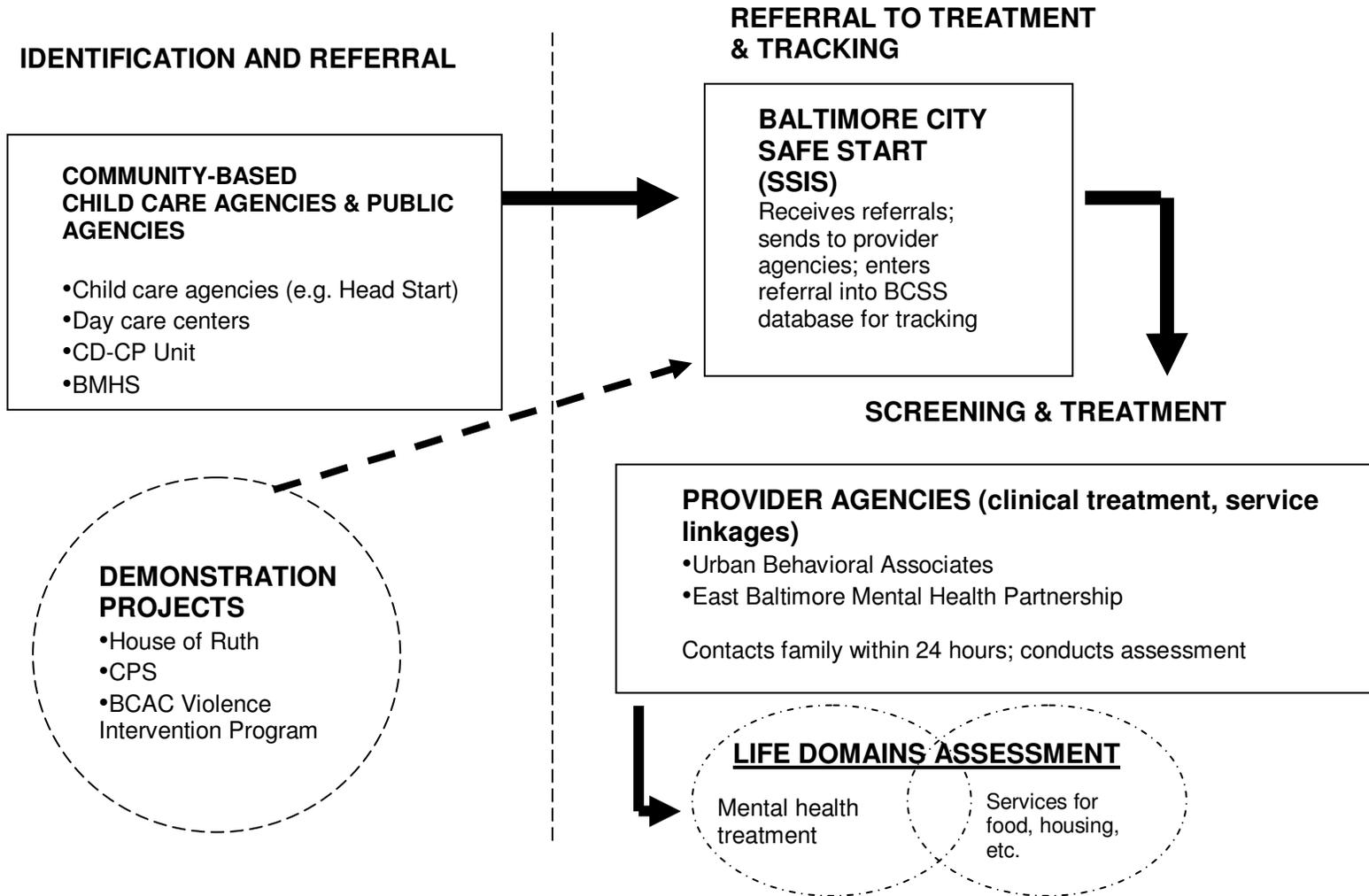
Major Milestone	1/01-6/01	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
Safe Start Council Collaborative (ongoing since 2000)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Safe Start Early Identification Trainings							✓	✓	✓	✓
Safe Start Early Childhood Mental Health Trainings				✓	✓	✓	✓	✓	✓	✓
BCSSI Quarterly Newsletter (established & ongoing)		✓	✓	✓	✓	✓	✓	✓	✓	✓
Safe Start Intervention Services (formed & ongoing)					✓	✓	✓	✓	✓	✓
Children Exposed to Violence (CEV) Trainings						✓	✓	✓	✓	✓
Children Exposed to Violence Train-the-Trainer Series							✓	✓	✓	✓
Domestic Violence Intervention Demonstration Project (CPS)							✓	✓	✓	✓
House of Ruth Community Outreach Expansion Project								✓	✓	✓
Provided financial assistance to the Baltimore Child Abuse Center for the implementation of the Violence Intervention Project									✓	✓
Safe Start Community Education Awareness Campaign							✓	✓	✓	
<ul style="list-style-type: none"> <li>• Baltimore City Safe Start Symposium</li> </ul>							✓			
<ul style="list-style-type: none"> <li>• BCSSI and Baltimore City Department of Social Services (BCDSS) Domestic Violence Forum</li> </ul>									✓	

Major Milestone	1/01-6/01	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
East Baltimore Mental Health Partnership (EBMHP) added as a BCSSI mental health services provider								✓		
BCSSI funded staff positions for two Baltimore City agencies that serve children exposed to violence								✓		
BCSS Project Director resigned		✓								
BCSS Project Director hired				✓						
BCSS Training Coordinator position filled		✓								
BCSS Training Coordinator resigned				✓						
BCSS Training Coordinator position filled					✓					

Sources: Local Evaluation Report Form 2005; Case Study 2005; Site Visit Summary 2005; Site Visit Report 2005; Progress Reports, July-December 2004 and January-June 2005.

# Exhibit B

## Baltimore City Service Delivery Model



## **Exhibit I-C**

### **Baltimore City Safe Start Initiative Research**

#### **Overview**

Initially, Baltimore City Safe Start Initiative (BCSSI) planned an intervention design that would study the impact of treatment on children exposed to violence with the goal of reducing (1) the impact of exposure to violence and (2) stressors related to a child's exposure to violence suffered by parents. BCSSI funded two providers (Urban Behavioral Associates and East Baltimore Mental Health Partnership, together known as "Safe Start Intervention Services") to identify, assess, treat, and refer children exposed to violence. Several challenges, however, prevented BCSSI from conducting its research as originally planned (see "Discussion" section below for more details). As an alternative, BCSSI opted to conduct a pre-post study of a non-uniform intervention program. This study sought to examine the effects of different treatment interventions on changes in (1) symptoms related to violence exposure and (2) stressors affecting parents/caregivers. Data were collected twice, at intake and nine or 16 months post-intervention, using the Trauma Symptoms Checklist for Young Children (TSCYC), the Parenting Stress Index-Short Form (PSI-SF), and the Conner-Davidson Resiliency Scale (CD-RISC).

#### **Method**

Clinical staff administered two tools, the TSCYC and the PSI. Baseline data were collected during enrollment, and post-treatment data were gathered after 16 treatment sessions. In addition, the Conner-Davidson Resiliency Scale (CD-RISC) was administered to those parents participating in the parent resiliency group. Data gathered with the CD-RISC were collected at intake and after 9 group sessions.

#### Sample:

The sample size included a total of 86 cases referred to Safe Start Intervention Services from 2003 to 2005. The average age of a child was 4 years. Seventy percent of the children were African American, 15% Caucasian, 5% bi-racial, and 1% Native American. The other 8% lacked information on racial identification.

#### Procedure:

Safe Start Intervention Services clinical staff was required to gather demographic information and data on client assessment, treatment, and referral services. All data were entered into a database at the time of enrollment and nine months or 16 months after the start of treatment, depending on the tool used. The local evaluator later retrieved the data for analysis. Analysis on the data was performed to investigate the effects of the more effective treatment in comparison to the less effective one, and to examine the changes in symptoms related to exposure to violence in children and caregivers at pre- and post-treatment assessment.

## Results

Outcome data are not available, primarily because providers had difficulty retaining clients. Of the 86 cases referred to SSIS, only 15 clients met criteria for follow-up assessment; of those 15, only seven were successfully contacted by one of the SSIS agencies. Of the seven clients, one refused to complete the PSI at follow-up; the other six completed it successfully and their scores fell within the clinical range.

SSIS providers reported event data on 86 cases, six of which involved multiple children. Data from these cases revealed the following event characteristics:

- Forty percent of children were exposed to violence in their primary home, 10% were exposed in a home in which they also live, 15% were exposed in their community, and 4% in a relative's home.
- Forty-six percent of the children were not the intended victim, but were witnesses to the violence; 17% were the intended victim and were injured; and 3% were not the intended victim, but were injured.
- Thirty-six percent of the children were exposed to domestic or family violence, 17% experienced physical/sexual abuse, and 13% were exposed to community violence.
- In 16% of the cases, the children witnessed violence with a weapon, while 37% of cases had no weapon involvement.

## Discussion

BCSSI's initial intervention design had to be modified for various reasons: (1) there were low referrals of clients to services; (2) by mid-2004, there were only 50 clients enrolled in SSIS services, which did not provide sufficient data for analysis; and (3) low client retention contributed to incomplete and inconsistent data collection. These challenges necessitated the development of a new research design (i.e., the pre-post design); however, the Safe Start Intervention Services agencies continued to face the same challenges, particularly that of engaging families into services and retaining clients in services. While BCSSI was not successful in conducting their intervention study, they were successful in gathering important demographic data about their community and their clients. They may wish to share these data with service providers in their community.

# II

## Bridgeport Safe Start Initiative

### 1. Overview

The Bridgeport Safe Start Initiative (BSSI) was designed to promote better integration of services to reduce the incidence and impact of exposure to violence on young children. The BSSI employed multiple strategies to achieve this goal. The strategies focused on improving interagency collaboration, increasing knowledge of the impact of exposure to violence on children, and increasing access and quick referral to services.

The BSSI funded several clinical agencies between 2000 and 2005 to provide services to children identified by court advocates, community members, school clinicians, and mandated reporters. In its effort to fill the knowledge gap, the BSSI provided a variety of trainings to professionals in different fields, such as clinicians, law enforcement, and Child Protective Services. As a result of its efforts, the BSSI accomplished the following (Bridgeport Safe Start Initiative, 2003; Bridgeport Safe Start Initiative 2004; Bridgeport Safe Start Initiative 2005a):<sup>1</sup>

- **734** children were identified. Of this number, **311** children were assessed using specialized tools, and **506** children were referred to other services; and

- **1,938** professionals participated in trainings on topics related to the impact of exposure to violence on children.

The BSSI embarked on a deliberate knowledge building effort to identify gaps in service provision, and to identify, adapt, and test “best practices” to improve service delivery and to achieve better outcomes for children and their families. Together with the PARK Project, which provides school-based mental health services, the BSSI trained parents to conduct focus groups with other parents to identify barriers to accessing available services. The BSSI helped Child Protective Services create a protocol to improve identification of children exposed to violence. The protocol was tested and determined to increase the number of substantiated cases of children exposed to domestic violence and reduce the number of “false positives” (i.e., children *not* exposed to ongoing family violence). The protocol’s demonstrated effectiveness led the Connecticut Department of Children and Families to adopt its use statewide.

In addition, the BSSI helped to build the community’s capacity to reduce the impact of exposure to violence on children by strengthening interagency collaboration and by engaging community leaders. When a small group of community leaders expressed interest in engaging in a broad dialogue about improving outcomes for children and families in Bridgeport, the BSSI

<sup>1</sup> These figures were compiled from Progress Reports (2003-2005) submitted by Bridgeport Safe Start Initiative to the Office of Juvenile Justice and Delinquency Prevention.

organized a leadership group that helped shape a vision for change in the community. Focus group findings and social network analysis confirmed BSSI's impact on increasing the number and quality of collaborations among organizations serving the mental health needs of children. By bringing organizations together for shared learning and networking opportunities, the BSSI worked to increase the interaction and trust level among child-serving agencies.

A number of BSSI-funded initiatives will endure beyond Safe Start funding. The Center for Women and Families has incorporated BSSI's domestic violence trainings into its standard community education unit, ensuring that workshops on the effects of domestic violence on children will continue to be offered to the community. The use of BSSI Service Plans also will continue to be utilized by key child-serving organizations. These service plans, which BSSI-funded programs were required to develop for each family, help integrate services as well as provide the foundation for systematic collection of service data and follow-up with families. Finally, the BSSI worked with the local United Way and other community organizations to create a community-wide strategic plan that will serve as a blueprint for creating a holistic approach to serving young children and their families. The BSSI was instrumental in incorporating the mental health needs of children, especially those exposed to violence, into the blueprint, which is expected to garner new funding from the governor's Early Childhood Investment Initiative.

### **1.1 Mission**

The mission of the Bridgeport Safe Start Initiative is to "...create a community that respects the right of Bridgeport's children and families to be safe and nurtured." The BSSI expected to realize this vision through its goal to reduce the impact and exposure of violence in the home among Bridgeport children six years and younger. The project hoped to address the needs of both victims and witnesses of violence in the home (i.e., abused children and children living in homes with domestic violence, respectively; Bridgeport Safe Start Initiative, n.d.). How did the BSSI grantee accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in the following sections, and a timeline of major events is attached (See Exhibit II-A).

### **1.2 City of Bridgeport, Connecticut**

Bridgeport, also known as Park City, sits on the Long Island Sound in Fairfield County, one of the wealthiest counties in the country. Bridgeport is the largest city in Connecticut, but also the poorest. It is densely populated, covering 16.0 square miles with close to 8,721 residents per square mile. According to the 2003 Census population estimate, there are 139,664 people living in the city of Bridgeport. The city's racial and ethnic makeup is largely African American (30.8%). Caucasians account for 45.0% of the population, while Asians account for only 3.3%. According to the 2000 Census, 28.4% of the population is under 18 years of age and 8.2% is under five years of age. The median household income for Bridgeport

is \$34,658, significantly lower than the state median household income of \$53,935. Approximately 18.4% of Bridgeport's population lives below the poverty line, compared to 7.9% for the state of Connecticut as a whole (U.S. Census Bureau, 2006).

## 2. Contextual Conditions

The city of Bridgeport faced several challenges between 2000 and 2005 that affected the Safe Start initiative. These challenges are explained in the political, economic, and social context sections below. On the other hand, BSSI experienced facilitating factors that resulted in gains for the initiative.

One of these facilitating factors was a reorganization of the Department of Children and Families (DCF). Before 2005, DCF managed statewide programs from three regional offices, making oversight by regional directors difficult and time-consuming. In 2005, DCF expanded the number of regional offices to 14, facilitating management of programs on the ground. In particular, the regional director responsible for Bridgeport now had to manage only six locales, instead of 22, providing the director with more time to focus attention on each location and more flexibility to participate in initiatives such as BSSI.

The other facilitating factor for BSSI was the 2005 hiring of a new project director, perceived as a good listener, community-minded, and resourceful at bringing key partners into the initiative. BSSI had employed two previous project directors, the last of

whom was perceived as being "mired" in the reviewing of documents, spending "a lot of time on process," and "working in a silo."<sup>2</sup>

### 2.1 Political Context

When Bridgeport received the grant for Safe Start, the city was in the midst of years of corruption. Corruption at both the city and state level had created barriers to interagency collaboration, as well as a high level of distrust among leaders. When Safe Start began in 2001, Bridgeport's mayor, Joseph Ganim, was under federal indictment; he was eventually convicted on 15 counts of corruption-related charges. In the meantime, his indictment led to a freeze on federal assistance to the city and limited funding available for the human services sector (Association for the Study and Development of Community, 2004, p. 2). At the state level, Governor John Rowland resigned in 2004 following an indictment also related to corruption. This difficult political environment improved in 2003 when John Fabrizi was elected as Bridgeport's mayor. Mayor Fabrizi's background as a long-time elementary school teacher made it easier for the BSSI to acquire his support and buy-in.

Meanwhile, turnover in a key law enforcement position created a temporary barrier to BSSI's implementation. In 2005, Bridgeport Chief of Police Wilbur Chapman

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<sup>2</sup> These perceptions were shared during the November 15 and 16, 2005 site visit with the Association for the Study and Development of Community (ASDC), which is the Safe Start Demonstration Project National Evaluation Team.

resigned from his position; Anthony Armeno stepped in as acting chief. Unlike Chapman, Armeno was not committed to issues of domestic violence and children's exposure to violence, and, in fact, had a known history of domestic violence (as a perpetrator). Therefore, BSSI lost critical support from law enforcement when Armeno took over. During the selection process began for a new chief of police, however, Mayor Fabrizi asked The Center for Women and Families (CWF) to form part of the selection committee, giving CWF a voice in the process. Although Armeno applied for the position, the committee selected Bryan T. Norwood as the new chief of police for the term beginning in April 2006.

## **2.2 Economic Context**

High unemployment and high levels of poverty characterized the economic conditions of Bridgeport. As previously noted, household income falls below the poverty line for nearly 20% of Bridgeport's population. According to the Connecticut Department of Labor (2006), Bridgeport has one of the highest unemployment rates in the state (7.7%, compared to 4.9% for Connecticut as a whole). Less than one-third of adults are high school graduates, and only 12% percent have a college degree. The homeownership rate is only 40%, compared to 63% for the state as a whole. This economic context makes Bridgeport's minority community particularly vulnerable to the risk of violence and exposure to violence; highly concentrated poverty and few economic opportunities make it difficult to address some of the underlying conditions that contribute to domestic violence, as well as other types of

violence that young children may experience.

## **2.3 Social Context**

There were 475 substantiated cases of abuse and/or neglect of children six years and younger in 2005. In 2000, there were 539 substantiated cases (Bridgeport Safe Start Initiative, 2005c). At the beginning of BSSI, providers who participated in the Design Team reported that at least 80% of the children they saw with behavioral problems had been exposed to violence (Bridgeport Safe Start Initiative, 2005b). The latest data on family violence arrests show 1,426 arrests in 2001, with 653 children either directly involved or present at the time (Bridgeport Safe Start Initiative, 2005c, p. 5).

## **3. Community Capacity**

In spite of a struggling economy and the public's generally negative view of local and state government officials, Bridgeport is a community of dedicated police officers, professional service providers, child-serving agencies, school teachers and administrators, court officials, and residents. The BSSI was able to take advantage of existing community capacity to help improve inter-agency collaboration and increase the focus given to reducing the impact and incidence of children exposed to violence.

BSSI's key partners in the community included:

**The Center for Women and Families of Eastern Fairfield County, Inc.** CWF is dedicated to strengthening

women and families and to eliminating violence and abuse through education, intervention, advocacy, and community collaboration. CWF provides services to victims of domestic violence and sexual assault, as well as to women returning to the community from correctional facilities. This agency also provides education in the public schools and to community groups, and works closely with the police, the courts, hospitals, and social service organizations to ensure an effective response to victims of domestic violence and sexual assault. Finally, CWF offers emergency shelter for those needing housing as a result of domestic violence (Bridgeport Safe Start Initiative, n.d.). BSSI was administered by CWF, which had fiscal responsibility for BSSI and served in a lead role as a member of its Advisory Board.

The CWF also administers a number of other related initiatives, including Communities Against Violence in the Home (CAVITH) and the Family Violence Outreach Program (FVOP). CAVITH is a partnership that was created to promote a coordinated community response to domestic violence in the greater Bridgeport area. CAVITH members understand that domestic violence and sexual assault are community problems that affect everyone, and that each agency has a role to play in addressing these problems. FVOP is a joint program between CWF and the Department of Children and Families, which provides a defined program of crisis intervention, counseling, education, and support to families experiencing violence in the home that is affecting the children and/or the victim's ability to parent. CWF also provides court advocates who work to identify children exposed to violence.

When a court advocate determined that a child was present during a domestic violence incident, a form was filled out and forwarded to BSSI, which arranged follow-up with the family. In 2005 there was also a part time civil court advocate working with BSSI staff through the Court Programs at CWF.

**The Partnership for Kids or the PARK Project.** The PARK Project helps provide access to services for children and adolescents with behavioral and mental health challenges and their families, to make it possible for these children and adolescents to remain in school and in their own community. It uses a school-based system of care to meet this goal, placing staff in the five Bridgeport schools that the project serves. The PARK Project offers its programs in collaboration with local agencies and the Bridgeport Board of Education (PARK Project, n.d.).

**Bridgeport Child Advocacy Coalition (BCAC).** BCAC is a coalition of 82 member organizations committed to improving the well-being of Bridgeport's children through a program combining research, community planning, advocacy, community education, and mobilization. BCAC promotes policies and programs to ensure that all children have the opportunity to grow up healthy and safe and receive the education and skills to reach their full potential (Bridgeport Child Advocacy Coalition, n.d.).

**The Connecticut Department of Children and Families.** DCF's mission is to protect children, improve child and family well-being, and support and preserve families. As the state's child protection service agency, DCF pursues its mission by working with

individual cultures and communities in Connecticut and partnering with other agencies to address individual and group service needs. DCF has a regional office that serves Bridgeport. The agency collaborated with BSSI as a member of the Advisory Board and worked with Safe Start to develop and implement the Domestic Violence Protocol, a tool used to help DCF investigators identify the presence of domestic violence in a family setting.

**Child FIRST.** Child FIRST identifies and assesses the social, emotional, and developmental needs of children six years and younger, and connects these children and their families to services to address identified needs. Behavioral and developmental assessment is provided to families, and consultation is provided to childcare providers and other service providers. Child FIRST received funding from BSSI for assessment, consultation, care coordination, and service planning for children exposed to violence and their families.

**The Bridgeport Health Department and Central Grants offices** also both work with BSSI staff. The Central Grants offices was the grantee in 2005.

The BSSI added to the existing community capacity embodied in the agencies described above in three key ways: 1) providing resources to add staff capacity, 2) providing training and technical assistance, and 3) increasing collaboration among agencies.

### ***3.1 Adding Staff Capacity***

The BSSI funded the Child Guidance Center of Greater Bridgeport, allowing it to expand its early childhood mental health program by adding a full-time staff person; enabled Child FIRST to support a full-time program coordinator; and expanded CWF's Court Assessment Program through funding a full-time staff position to assist court advocates with identifying and assessing the needs of children exposed to family violence. Also through BSSI funding, the Mental Health Consultation program was able to provide supervision and consultation to five mental health clinicians to support their work with young children (six years and younger) exposed to family violence. Finally, the BSSI enabled the Classroom Consultation for Early Childhood Educators to offer 35 hours per week to provide mental health and early childhood consultation to early childhood educators and to assist with identifying children exposed to violence (Bridgeport Safe Start Initiative, 2005c, p. 38).

### **3.2 Providing Training and Technical Assistance**

One goal of BSSI was to increase service providers' knowledge of the impact of violence on young children. Between 2002 and 2005, BSSI provided 129 training sessions, free to Bridgeport service providers. Staff from 381 organizations attended, for a total of 1,938 participants. Among these sessions was a training program for 35 providers using the *Shelter from the Storm* curriculum, as well as a three-day training session for 94 Child Protective Services staff on the impact of exposure to domestic violence on young children.

### **3.3 Increasing Interagency Collaboration**

While a number of organizations addressed domestic violence and the mental health needs of children prior to BSSI, there was little collaboration among them, limiting the potential for positive outcomes for children and their families. The BSSI work facilitated improved relationships among agencies by convening organizations for shared learning experiences, increasing networking opportunities, and promoting knowledge development and exchange.

Over the life of the Safe Start initiative, collaboration among agencies serving families affected by violence improved as a result of BSSI activities (Bridgeport Safe Start Initiative, 2005c, p. 12). In 2005, service providers described collaborative relationships with other agencies that had strengthened as a result of treatment team meetings and ongoing phone and email communication. By contrast,

service providers in 2001 reported very limited communication and collaboration among agencies.

These findings were reinforced by social network analysis that revealed more collaborative relationships in 2005 than in 2001. Moreover, *direct* collaborative relationships (i.e. agency-to-agency, with no "middleman") increased from 2003 to 2005, suggesting the existence of a more close-knit collaborative network. Finally, reciprocal relationships (i.e. two-way collaborations) increased, suggesting more meaningful partnerships and more equitable sharing of resources within relationships (Bridgeport Safe Start Initiative, 2005c, p. 16).

## **4. Community Engagement & Collaboration**

BSSI engaged parents, service providers, and the broader community in a variety of ways. As part of its strategic planning, the BSSI invited professionals and providers to form a Design Team, and also created a Management Team (recently restructured into a more diverse Advisory Board) to oversee the implementation process. The community was engaged through a social marketing campaign that raised issues of domestic violence and children exposure to violence. Both professionals and the community were invited to training sessions that raised the same issues.

### **4.1 Community Engagement: Professionals**

The BSSI had mixed success with engaging professionals in the design and implementation of the

initiative. Initially, a group of about 40 local service providers and other community representatives came together to form a Design Team. This group worked to identify the areas of greatest need for children exposed to violence and to create an intervention design. After the initial effort, however, interest in Safe Start began to dissipate, and meeting attendance dwindled (Association for the Study and Development of Community, 2004, p. 6). In response, the BSSI put together a Management Team consisting of members from the City Central Grants Office, Bridgeport Child Advocacy Coalition, and Center for Women and Families, as well as the BSSI project director. The Management Team directed implementation and made policy decisions to guide the initiative.

In 2005, with the arrival of a new BSSI project director, the Management Team was restructured, and a new Advisory Board was formed. The Management Team had come to be perceived as making decisions without input from most of the partners or the community, and as keeping the partnership mired in bureaucratic process. The Advisory Board expanded participation in BSSI's strategic planning and oversight to 15 policy makers and direct service staff, including the regional director from the Department of Children and Families (Bridgeport Safe Start Initiative, 2005c, p. 1).

The BSSI played an additional important bridging role in connecting key community leaders in a dialogue for change, through a leadership group. The dialogue began among five agency leaders and later expanded to more than

30 social service agency executive directors and other community leaders. The BSSI provided logistical support to this effort, and has funded the use of a professional facilitator through the end of 2006. The new leadership group is helping to create a shared community vision around the needs of children and families and is encouraging learning and knowledge sharing across social service sectors. Although the BSSI convenes the meetings, the group does not serve in an advisory capacity to BSSI. Rather, it uses a systems change approach to discuss and address a myriad of health, education, and policy issues regarding children in Bridgeport.

The BSSI also successfully engaged local professionals in addressing existing knowledge gaps regarding service needs. The grantee conducted a series of focus groups with service providers in 2002, 2004, and 2005, to identify barriers to accessing services for young children exposed to violence in the home. Key findings from the 2005 round of focus groups included the following identified service needs: more timely follow-up to reports of child abuse and neglect, enhanced police and court response to domestic violence cases, more bilingual and culturally competent service providers, and help making services more affordable for families (Bridgeport Safe Start Initiative, 2005c, p. 31-32). As a way to encourage improvements in the system of care, BSSI shared the findings of each round of focus groups with local service providers.

## **4.2 Community Engagement: Parents and Caregivers**

The BSSI engaged in a bilingual social marketing campaign to inform residents about issues related to children exposed to violence. The campaign encouraged community members to call InfoLine 2-1-1 for service referrals for children exposed to violence; InfoLine 2-1-1 is a statewide system that connects callers to an electronic database of resources. As part of the InfoLine campaign, BSSI distributed more than 5,000 flip books (i.e., brochures) to mental health providers, medical staff, childcare centers, teachers, and other community members and caregivers who interact with young children. BSSI monitored the effectiveness of the social marketing campaign by analyzing call data for the six months before and after the campaign. While the analysis found no change in the overall InfoLine call volume, it did document a significant increase in calls to “Help me Grow,” the InfoLine referral service specifically relating to young children. In addition, there was a significant increase in the proportion of calls about family violence issues as well as child abuse and neglect (Bridgeport Safe Start Initiative, 2005c, p. 21).

The BSSI, together with the PARK Project staff, conducted a family engagement study to understand barriers to accessing available services. To conduct the study, six parents were trained in all aspects of focus group assessment, including recruitment, facilitation, and data analysis. These parents then conducted five focus groups (four with parents and one with providers). The findings echoed some of the same themes that emerged from the

service provider focus groups described above. Parents cited a lack of responsiveness when making inquiries about services, difficulty in connecting with the appropriate agency or person, and a lack of respect and trust in their engagements with agency staff.

Using the findings from the family engagement study, the BSSI and the PARK Project staff created a series of cultural competency trainings targeting front-line staff, particularly in the Department of Children and Families and the Connecticut Department of Social Services (Bridgeport Safe Start Initiative, 2005c, p. 34). To promote a broader dialogue on ways to improve responsiveness and respectful engagement in the system, the BSSI presented the parental focus group findings more than 15 times to a variety of audiences in Bridgeport and around the state.

The BSSI also provided formal training sessions to parents on issues related to children’s exposure to violence. Four parent training sessions were conducted; a total of 91 parents attended.

## **5. System Change Activities**

On the policy front, BSSI was hindered by the difficulties facing Bridgeport’s political leadership. For the first few years of the initiative, the Mayor’s Office was not engaged in the initiative, and other city government representatives were not involved in a meaningful way. Although the challenge of engaging city government leaders precluded a significant policy change effort, the BSSI was able to lay the

groundwork for future policy development, as well as contribute to significant changes in the system of care for young children exposed to violence in the home.

Through its focus group studies with service providers and parents, the BSSI identified gaps and barriers in the system. This knowledge was used to inform policy makers and service providers about how the system of care actually operated and what needs were not currently being met. The BSSI used the focus group findings to develop training programs and to make recommendations for improving the system of care. The BSSI-supported community leadership group (described above) is poised to advocate for public policy changes based on their peer sharing and the learning generated by the BSSI.

The BSSI also contributed to a number of system enhancements, leading to better identification of children exposed to violence in the home and more integrated service provision (see Exhibit II-B for BSSI's service delivery model). In working with the regional office of the Department of Children and Families, BSSI developed a protocol for use by Child Protective Services staff to assess the presence of and impact of domestic violence on children. After CPS staff attended a three-day training session, implementation of the protocol in the field was tracked for a period of six months. The results demonstrated that use of the protocol significantly increased CPS investigators' ability to determine when issues of domestic violence were present in the home, prompting the deputy commissioner of

the Connecticut Department of Children and Families to consider instituting the domestic violence training and use of the protocol statewide.<sup>3</sup>

The training and networking opportunities offered to Bridgeport's child-serving agencies served to strengthen collaboration over the five years of the Safe Start initiative. Collaborative relationships grew more frequent and reciprocal, leading to service integration across organizations. As an example, the Center for Women and Families and Child FIRST forged a partnership in 2005. Child FIRST provides comprehensive, family-centered services to young children and their families who face multiple, complex challenges. Its staff is highly trained in child development and the effects of violence and trauma on children. As the primary domestic violence service provider in Bridgeport, CWF provides crisis services, but not long-term counseling for children and families. In July 2005, the two organizations began collaborating to ensure that all young children at high risk for violence exposure identified through CWF programs would be referred to Child FIRST for an assessment and family services. In particular, Child FIRST arranged on-site services for families staying in the CWF domestic violence shelter. This partnership has increased the ability of

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<sup>3</sup> Statewide implementation is underway. According to the most recent communication with the BSSI project director, the Connecticut Department of Children and Families issues a request for proposals in April 2006 to provide training and support of workers statewide. The Center for Women and Families was awarded one of these contracts (training is administered regionally) but other regional efforts are going out to bid again.

both organizations to coordinate care and provide clinical services to this vulnerable population (Bridgeport Safe Start Initiative, 2005c, p. 36).

## **6. Institutionalization of Change**

For years, Bridgeport lacked a unified voice regarding the needs of young children and their families. Recently, a number of organizations have spearheaded an effort to develop a community-wide strategic plan or “blueprint” for serving young children and families in Bridgeport. The BSSI supported this effort, which was led by the United Way’s Success by 6 Initiative, the Bridgeport Board of Education School Readiness Council, the Collaborative Children’s Advisory Board, and the Bridgeport Discovery Group. The BSSI’s participation was instrumental to incorporating children’s mental health needs, especially as they relate to children’s exposure to violence, into the blueprint. In this way, the BSSI’s focus on reducing children’s exposure to violence and the impact of that exposure has gained legitimacy within a broader change agenda for the community. The blueprint is a vehicle by which the community expects to take advantage of funding opportunities provided by the governor’s new Early Childhood Investment Initiative.

Some changes in the system of care prompted by BSSI have been institutionalized. The adoption of the domestic violence training and protocol by the Connecticut Department of Children and Families will assist Child Protective Services staff throughout the state in substantiating domestic violence cases where children are present. Child FIRST will continue to use the

Traumatic Events Screening Inventory (TESI), which all BSSI-funded programs were required to use to collect specific information about the nature and type of children’s violence exposure. Child FIRST also plans to institutionalize the use of BSSI Service Plans, which were used in the initiative to map out children’s service needs and referrals and to collect system-wide data. By incorporating the Service Plan as part of its routine assessment process, Child FIRST will maintain the community’s capacity to gather system-level data to address the needs of young children exposed to family violence (Bridgeport Safe Start Initiative, 2005c, p. 42).

In Bridgeport, workshops developed by the BSSI on family violence, safety planning, and the effects of exposure to violence on young children will be continued as part of the Center for Women and Families’ standard community education curriculum. Given its expertise in domestic violence, CWF will incorporate training sessions on family violence and the court system, the effects of violence on children, childhood sexual abuse, and the dynamics of domestic violence and safety planning. Furthermore, CWF will continue to train staff in the Department of Children and Families, the court system, and the Police Department.

## **7. Increased Community Supports**

The BSSI helped to create a more supportive community environment for serving the needs of young children exposed to violence and their families. BSSI's proactive response to frustration expressed about the lack of engagement by community decision makers resulted in the formation of a leadership group, through which approximately 40 executive directors and other community leaders are discussing ways to improve the system of care through knowledge sharing and policy action.

BSSI's social marketing campaign to encourage parents, teachers, day care providers, and other caregivers to access resources through InfoLine 2-1-1 successfully engaged the broader community in the process of identifying, referring, and accessing services for children exposed to violence.

## **8. Reduced Exposure and Impact of Exposure to Violence**

By enhancing the system of care, the BSSI helped reduce the impact of exposure to violence on young children. In part, this was accomplished by providing mental health services, as well as other services as needed. Analysis of the BSSI Service Plan data demonstrates an increase in the ratio of recommended-to-received services as the initiative progressed. Each Service Plan documents the services to which clients were referred upon entry into the program, and then follows up with a 90-day assessment to determine if clients connected to the services to which they

were initially referred. For the three program years for which complete data are available, the ratio of recommended-to-received services increased from 0.52 in year one, to 0.56 in year two, to 0.65 in year three (Bridgeport Safe Start Initiative, 2005c, p. 53). These data suggest that, over time, families experienced fewer service system barriers that prevented them from obtaining needed services.

Three instruments were used to assess children's exposure to violence, trauma-related symptoms, and parent stress. The Traumatic Events Screening Inventory was used to screen for exposure to traumatic experiences. The Trauma Symptom Checklist for Young Children (TSCYC) was used to assess children's trauma-related symptoms. The Parenting Stress Index was used to examine parental stress. All instruments were administered at baseline and again at discharge from services. On average, families participated in services for 6.6 months (Association for the Study and Development of Community, 2006b).<sup>4</sup> The number of families for which baseline and discharge data are available varies by instrument. Overall, however, there were observed decreases in children's exposure to violence, the number of trauma-related symptoms presented by children, and parenting stress over time (e.g., between baseline and discharge). For a more detailed summary of the intervention research findings, see Exhibit II-C.

## **9. Conclusion**

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<sup>4</sup> This information was presented during the Safe Start Demonstration Project National Evaluation Meeting held May 8-9, 2006.

The Bridgeport Safe Start Initiative promoted better collaboration among service providers by funding existing services and by forming partnerships with community and government agencies to better serve children six years and younger exposed to violence and their families. The BSSI achieved the following while working towards its goals:

- Trained 1,938 service providers and professionals in recognizing the signs of exposure to violence and identifying children exposed to violence or at risk of exposure;
- Launched a social marketing campaign to train the community in the same issues and to educate them about the services available in the community, such as InfoLine 2-1-1;
- Formed partnerships with community and government organizations (e.g., PARK Project and Department of Children and Families, respectively), to better serve children and families;

- Helped the Department of Children and Families reduce the number of “false-positive” children identified as exposed to violence with the creation of the DCF Domestic Violence Protocol; and
- Facilitated the creation of a “blueprint” for a holistic approach to serve young children and their families in Bridgeport.

Between 2000 and 2005, the Bridgeport Safe Start Initiative and its partners helped to identify 734 children as exposed to violence, of whom 311 were assessed by a BSSI-funded program, and 506 were referred to other services. While impact data are limited, the BSSI found that, overall, children in services were less prone to experience traumatic events, and that the number of family violence events decreased. There is also evidence that barriers to services were reduced, with families receiving a greater proportion of recommended services, as the initiative progressed.

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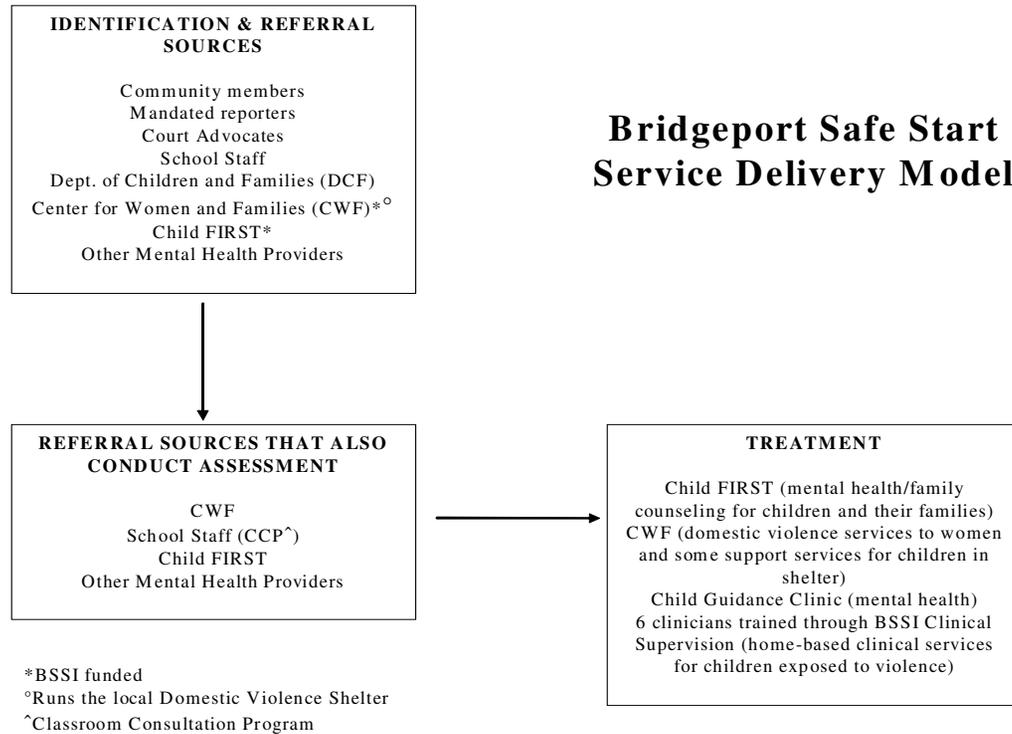
**Exhibit II-A**  
**Timeline of Bridgeport Safe Start Initiative Activities and Milestones**

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	1/05-6/05	7/05-12/05
BSSI Bulletin		✓	✓	✓	✓	✓		
The Center for Women and Families of Eastern Fairfield County, Inc. <i>Court Assessment Project</i>		✓	✓	✓	✓	✓	✓	✓
• Domestic Violence Legal Intervention Trainings				✓	✓	✓	✓	On Hold
Early Childhood Mental Health Program		✓	✓	✓	✓			
Child and Family Interagency Resource, Support, and Training Program (Child FIRST)		✓	✓	✓	✓	✓	✓	✓
Mental Health Consultation Program		✓	✓	✓	✓			
BSSI Service Providers Trainings		✓	✓	✓	✓	✓	✓	
BSSI Public Awareness Social Marketing Campaign						✓	✓	
BSSI and Bridgeport Discovery Group <i>Classroom Consultation for Early Childhood Providers Initiative</i>				✓	✓	✓	✓	✓
Family Violence and Its Effects on Children Trainings				✓	✓			
Community Focus Groups Assessments	✓			✓			✓	
Resource Awareness Project (2-1-1 InfoLine Resource Trainings)				✓	✓	✓	✓	✓

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	1/05-6/05	7/05-12/05
BSSI Project Director resigned	✓ The first project director resigned prior to 2002 during the planning year.						✓	
Domestic Violence Assessment Project					✓	✓		
Child Guidance Center of Greater Bridgeport Collaborative Initiative		✓	✓	✓				
BSSI Symposium			✓					
Interagency Collaboration Survey	✓		✓				✓	

Sources: Bridgeport Safe Start Semi-Annual Progress Report, July-December 2003, January-June 2004, July-December 2004, January-June 2005; Bridgeport local evaluation form 2004; and Bridgeport local evaluation form 2005.

## Exhibit II-B



## **Exhibit II-C**

### **Bridgeport Safe Start Initiative Intervention Research**

#### **Overview**

The Bridgeport Safe Start Initiative (BSSI) grantee funded six community-based organizations in an effort to increase service capacity and reduce the impact of exposure to violence on children six years and younger. These organizations included the local domestic violence prevention agency (Center for Women and Families [CWF]) and five mental health serving agencies: Child Guidance (including two programs: Early Childhood Mental Health Program and Child Development-Community Policing), Child FIRST, the Classroom Consultation for Early Childhood Educators, and the Mental Health Consultation Program (Association for the Study and Development of Community, 2004). Funding for the two Child Guidance programs was discontinued, however, due to the difficulty these programs experienced in identifying and providing services to children exposed to violence.

All mental health-serving agencies were required to administer three standardized instruments (the Traumatic Events Screening Inventory [TESI], the Parenting Stress Index/Short Form [PSI/SF], and the Trauma Symptom Checklist for Young Children [TSCYC]) and a patient satisfaction questionnaire at intake and then three months later or at discharge, whichever came first. Results indicated that children experienced a significant decrease in exposure to violence and trauma related symptoms while receiving services, and parents experienced a decrease in stress around parenting related issues.

#### **Method**

The BSSI funded programs according to community needs, but focused on the enhancement of services to children exposed to violence. Regardless of the services provided, all agencies were required to collect data on the child victim and to document the service plan developed for individuals at the point of referral. All mental health programs administered the TESI, the PSI, the TSCYC, and the Patient Satisfaction Questionnaire III (PSQ-III). In addition, Child FIRST used the Rochester Safe Start Early Childhood Education Program Survey of Parents to help validate the instrument, and Classroom Consultation for Early Childhood Educators used the Devereux Early Childhood Assessment (DECA) to identify children with socio-emotional concerns. The results of the latter, however, are not included because only five cases were matched at baseline and discharge. Baseline data were collected at the point of intake and then three months later or at discharge, whichever came first.

#### **Sample:**

BSSI-funded program staff screened and identified a total of 665 unduplicated children six years and younger in the Bridgeport area. Characteristics of the 248 unduplicated cases served by BSSI-supported mental health programs were reported. The majority of the children served were from a racial/ethnic minority (42.3% Hispanic and

32.3% African American), compared to 12.5% described as White. At least 85% of the children were Medicaid eligible (Bridgeport Safe Start Initiative, 2005, p. 64).

### Procedures:

Mental health clinicians collected data at baseline and at discharge, and entered it into an ACCESS database provided by the evaluation team. De-identified data were sent quarterly and annually to the evaluators, who routinely updated their database as data were submitted. Data gathered by clinicians were analyzed to collect the following:

- Information around children's exposure to violence
  - Number of traumatic events experienced by children in their lifetime
  - Number of family violence traumatic events experienced by children in their lifetime
- Information on children's trauma related symptoms
- Information on levels of parenting stress
- Information on recommended services vs. services obtained by families

## **Results**

### Decreased exposure to violence

BSSI-funded program staff screened and identified a total of 665 children (Bridgeport Safe Start Initiative, 2005, p. 65). Overall, the mental health programs screened at least 222 unduplicated clients. Child FIRST, a primary BSSI-funded mental health provider, screened all children using the Traumatic Events Screening Inventory. According to the most recent data analysis (Association for the Study and Development of Community, 2006), 49 cases were matched at baseline and at discharge using the TESI instrument. The baseline number of events ranged from 1 to 15. The mean number of traumatic events reported at baseline was 3.77 events. The mean number of baseline family violence events was 2.2 events. The mean number of non-family violence events at baseline was 1.5 events. There was a statistically significant decrease in the number of traumatic events experienced by children over time ( $t = 3.42, p < 0.001$ ).

### Decreased trauma-related symptoms

A total of 20 matched baseline and discharge Trauma Symptom Checklist for Young Children instruments was administered. For these 20 cases, there was a statistically significant decrease on the posttraumatic stress-intrusion subscale ( $t = 3.37, p < 0.01$ ), the posttraumatic stress-avoidance subscale ( $t = 2.25, p < 0.05$ ), the posttraumatic total subscale ( $t = 2.33, p < 0.05$ ), and the dissociation subscale ( $t = 2.46, p < 0.05$ ), indicating that children's trauma-related symptoms decreased over time (Association for the Study and Development of Community, 2006).

### Decrease in parenting stress

A total of 45 matched baseline and discharge Parenting Stress Index instruments was administered. For these 45 cases, there was a statistically significant decrease on the parental distress subscale ( $t = 3.00, p < 0.01$ ), indicating a decrease in stress resulting from personal factors directly related to parenting (e.g., impaired sense of parenting competence, lack of social support, presence of depression). There was also a statistically significant decrease on the overall stress scale ( $t = 2.80, p < 0.01$ ; Association for the Study and Development of Community, 2006).

### Patient Satisfaction Questionnaire III

Clients completed the PSQ-III at discharge. A total of 43 questionnaires was completed during the first three years of the BSSI. Results showed overall satisfaction with services (93% agreed or strongly agreed that the services were “just about perfect”). Only three families (7%) were disappointed with the services they received. On the other hand, most families (93%) agreed that the system needs improvement (Bridgeport Safe Start Initiative, 2005, p. 72).

### Number of Referrals

BSSI-funded program staff documented all services to which families were referred, barriers to receiving services, and whether or not each referred service was received. Over four years, 3,009 services were recommended, and 57% of these services were received (Bridgeport Safe Start Initiative, 2005, p. 68).

## **Discussion**

BSSI-funded services, especially Child FIRST, were successful in working with parents and children to decrease the number of traumatic events in the life of a child and the number of family violence traumatic events. Furthermore, services were successful in reducing a child’s overall exposure to violence. Child FIRST offered families holistic care coordination focused on assessment and referral services; foremost, they ensured that families’ primary needs were met before beginning treatment. Although parents were satisfied with the treatment they received, a lot of work remains to optimize the system of care, as the majority of parents agreed with the statement that the system needs improvement.

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# III

## Chatham County Safe Start Initiative

### 1. Overview

The Chatham County Safe Start (CCSS) improved the ability of the county to respond to the needs of children exposed to violence and their families by formalizing a process to refer them to services. Prior to the CCSS initiative, Chatham County did not have a systematic process to identify and refer exposed children to the services they needed. The CCSS created a centralized point of referral for children and utilized a multi-faceted outreach strategy to encourage a wide range of agencies, as well as community members, to make referrals. Through a collaborative partnership, the CCSS helped build the capacity of key child-serving organizations to address the needs of children exposed to violence. As a result of these systems change activities, the CCSS accomplished the following between May 2002 and December 2005:

- **447** children exposed to violence were identified by 20 different community sources;
- **261** children were assessed by the services coordinator or direct service providers funded by the CCSS; and
- **204** children received clinical or home-based therapy, and/or family advocacy services from direct services providers

specially trained to meet their needs<sup>1</sup>.

In the CCSS process, a services coordinator functioned as the centralized point of referral for families and children, distributing referrals to direct service providers who offered services tailored to child and family needs. For example, bilingual services, home-based therapy, comprehensive therapeutic services, psychological clinical assessments, and family advocacy services were offered by direct service providers funded by the CCSS.

The CCSS system of identification and referral operated on the philosophy that there is “no wrong door” for children or families to enter the system of care. To operationalize this philosophy, CCSS staff created a *Services Handbook* for service providers and community members, which clearly defined the processes to identify, refer, and respond to children exposed to violence. CCSS staff and partners educated community residents and professionals about the identification and

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<sup>1</sup> The numbers of children identified, assessed, and referred are larger than the numbers officially submitted by Chatham County Safe Start to the Office of Juvenile Justice and Delinquency Prevention between January 2003 and October 2005. These revised numbers are based on a recent review of the Chatham County Safe Start Client Database for May 2002 to December 2005 by the Association for the Study and Development of Community (ASDC), which is the Safe Start Demonstration Project National Evaluation Team.

referral process through targeted community outreach and formal training workshops. CCSS staff and partners also facilitated the development of a shared definition of violence, which helped to create a common language for discussing the impact of exposure to violence on children.

Overall, the CCSS greatly increased the numbers of children identified and increased the number of children served, to a lesser extent. Between May 2002 and December 2005, CCSS served approximately 25-30% of the children under nine years of age who witness violence so severe it results in a call to the police<sup>2</sup>. While the CCSS demonstration project experienced a number of successes, as suggested by these numbers, challenges to implementation limited its potential impact. For example, institutional restructuring in key state and local agencies led to turnover in personnel and inconsistent participation in the initiative. Low existing community capacity in Chatham County, particularly with regard to serving children and families in at-risk areas, limited the availability of mental health service providers. Turnover in CCSS staff, especially in the critical project director and services coordinator positions, created implementation challenges as well. Finally, differences in philosophical approaches among the participating partners created conflicts in priorities and implementation hurdles, some of which were mitigated, others of which continue to challenge the demonstration project.

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<sup>2</sup> This figure is based on a revised estimate from Chatham County 2002 police call data and 2002 data from the local domestic violence agency.

## **1.1 Mission**

The vision of the CCSS was to reduce the risk and impact of witnessing or experiencing violence for young children (8 years and younger) by creating safe communities, an integrated system of care, and safe families. How did the CCSS accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in the following sections and a timeline of major events is attached (III-A).

## **1.2 Chatham County, North Carolina**

The CCSS initiative was planned and implemented within the unique context of Chatham County, North Carolina. The following snapshot of Chatham County is intended to help others interested in replicating Safe Start to compare their own communities to Chatham County.

Chatham County is located in the geographic center of North Carolina and encompasses an area of 683 square miles (U.S. Census Bureau, 2000). Sixteen percent of the county's approximately 58,002 residents (U.S. Census Bureau, 2006) live within the county's two towns: Siler City (6,966 citizens) and Pittsboro (2,226 citizens; North Carolina Data Center, n.d.). The county's population is White (82%), Black (15%), and Asian (2%). According to the U.S. Census Bureau (2006), people of Hispanic or Latino origin account for 11% of the population (double the percentage for North Carolina as a whole). Safe Start staff indicated that the Hispanic population may be larger than

11%, however, issues of language, culture, and immigration status make it difficult to survey this population. Six percent of the population consists of children under five years old. The median value of a home in Chatham in 2000 was \$127,200 and the median household income in 1999 was \$42,851 (U.S. Census Bureau, 2004).

## **2. Contextual Conditions**

CCSS was implemented in a rural context during a time of change for many of the major state and local systems that serve children and families. These contextual conditions affected the CCSS and the broader community's response to children exposed to violence.

### **2.1 Rural Conditions**

As a small rural community, Chatham County had limited capacity to address challenges to the community such as changes in population diversity, a lack of accessible and affordable public transportation, and inconvenient service hours that created barriers to services for children and families. CCSS was designed to address these conditions through fully-funded direct services tailored to children exposed to violence and their families.

The Latino population in Chatham County, one of the largest in North Carolina, increased 741% between 1990 and 2000. For the most part, social services have inadequately responded to this changing demographic (e.g., no substance abuse treatment available in Spanish, one part-time bilingual case worker, one police officer that speaks Spanish; North Carolina Data Center, n.d). To meet the needs of Spanish-

speaking children and families, the CCSS funded bilingual service providers to respond to the growing Latino population.

Resources for non-profit prevention and protection services (e.g., intensive home visitation for children and their families) and child welfare and family support services were reduced or eliminated in North Carolina when funding priorities were shifted to meet federal mandates against terrorism. The state social services budget decreased by over 6% in 2002, and continued budget deficits in North Carolina have further reduced social welfare services (e.g., education, mental health, child care, juvenile justice). Smart Start, a local school readiness initiative for children run by Chatham County Partnership for Children, suffered a 25% funding cut over the past five years. Finally, as part of a state-wide restructuring of the mental health system, the state narrowed the scope of Medicaid-funded early intervention services to exclude children exposed to violence. Direct service providers funded by the CCSS provided clinical assessment and in-home and therapeutic services for children and families to fill the gap in services created by these budget cuts and changes in the public mental health system.

Home-based therapy also addressed the lack of accessible and affordable transportation and inconvenient hours of service, which made it difficult for families to access services in Chatham County. Many people in the county work multiple jobs and would prefer to access services during evening or weekend hours.

## **2.2 Changes in State and Local Systems**

In 2003, the Chatham County Department of Social Services became a pilot site for the family-focused Multiple Response System, greatly facilitating implementation of CCSS. The Multiple Response System allowed Child Protective Services the opportunity to help families keep their children by providing an alternative to removal from the home when there were reports of child abuse or neglect. By using a collaborative approach, including in-home services and child and family team meetings, the Multiple Response System represented a change in philosophy and approach that helped to strengthen relationships between child welfare and other family-focused community organizations and agencies, including the CCSS. The adoption of the Multiple Response System statewide provided the CCSS with an opportunity to encourage and assist the Chatham County Department of Social Services in applying to be a pilot site, solidifying the collaborative relationship between the CCSS and child welfare and helping to more closely align the Department of Social Services and the mission of the CCSS. The consistent and strong participation of the Department of Social Services in CCSS implementation was reflected in their 132 referrals (the most from any agency) and was critical to helping families and children access the coordinated services of the CCSS.

Other changes in systems and leadership at the state and local levels, however, disrupted existing relationships with CCSS, slowed the implementation process, and limited the ability of the CCSS to achieve its goals.

The Orange, Person and Chatham Counties Mental Health Clinic, the public mental health agency for Chatham County, was an inconsistent collaboration partner because a statewide restructuring of the mental health services system created uncertainty in leadership and resulted in high turnover. Orange, Person and Chatham Counties Mental Health Clinic also had difficulty keeping their funded bilingual service provider position filled and it remained vacant for a year. The CCSS was left to rely on a small number of private providers to meet the needs of children and their families.

Turnover in local political leadership and within local partner agencies also affected the project. On the negative side, on the Board of County Commissioners, turnover among supporters of early childhood initiatives resulted in a shift of agenda away from children exposed to violence, in favor of issues of growth and land use, development of water and sewer services, and rural taxation issues. The turnover of four commissioners (out of a total of five) reduced political support for Safe Start and hindered the ability of the CCSS to impact local policy in Chatham County. Instead of focusing efforts on a community level policy agenda, therefore, CCSS staff emphasized the creation of a *Services Handbook* to impact agency level procedures related to the identification and referral of children exposed to violence. Though practical, this approach limited the range of the CCSS impact. Past research has shown that environmental strategies (e.g., state and local legislation) are critical when trying to impact health-compromising

behaviors at the community level (Birckmayer et al., 2004).

On the other hand, turnover in the Department of Social Services had a positive impact on the CCSS because the incoming director believed in the mission of CCSS and was invested in the family-focused approach. As a result, the Department of Social Services increased its involvement in community-based planning and collaborative efforts, and ultimately provided the CCSS with 30% of its referrals for identification or services, the most referrals from any single agency.

### **3. Community Capacity**

Despite challenges presented by a rural context and reorganization of public mental health agencies at the state and local levels, the CCSS built a greater capacity to serve children and families exposed to violence by facilitating the development of a shared definition of violence and creating a mechanism to track the identification and referral of children exposed to violence in Chatham County. The CCSS was able to augment the relatively low existing capacity of the community, and more importantly, begin to integrate and link services through its centralized identification and referral system.

Prior to CCSS, the community did not have a common language to discuss the impact of violence exposure on children. The CCSS engaged in an extensive process (from November 2001 to May 2002) of soliciting feedback from professionals and community members regarding which types of negative acts were considered tolerable

and which needed professional and active intervention. To develop a working definition of violence for Chatham County, this feedback was compiled and integrated with research-based definitions of violence from the Centers for Disease Control, the Child Witness to Violence Project, and the National Evaluation Team. The full Chatham County definition of violence is available in III-B.

According to CCSS staff and community partners, this process helped to assess community norms around violent behavior (identifying areas to be targeted for change) and created a common awareness and understanding of “children’s exposure to violence.” This common understanding was necessary as a first step to engage community partners for both collaboration and referrals. Additionally, the early investment in developing this common definition facilitated communication among CCSS staff throughout the life of the initiative, allowing time and energy to be spent on planning and implementation activities rather than on resolving confusion or miscommunication around the focus of the initiative.

With support from the National Civic League, the CCSS developed the community capacity to track identification and referral of children exposed to violence by creating and using a computerized tracking and monitoring system. The Chatham County Partnership for Children’s executive director attended the Unified Fiscal Planning Peer-to-Peer Meeting to learn how a database for managed care could serve as a tool for utilizing blended funding. Consequently, the

CCSS contracted with a computer specialist to create a database for tracking and monitoring children exposed to violence. This database was used to extract complete and accurate data, which CCSS staff used to apply for additional funding from a variety of sources to sustain critical elements of the CCSS project. Although the CCSS was not awarded all of the funding that it sought, this system offered the initiative the capacity to track information in a way that was relevant to both the CCSS and funders, and may help the CCSS initiative procure future funding for services for children exposed to violence.

To develop these capacities, the CCSS engaged the assistance of support at both the national level (e.g., National Civic League) and the local level (e.g., professionals, community residents, and agencies and organizations). Strategies to engage local agencies and community members are discussed next.

#### **4. Local Agency and Community Engagement and Collaboration**

For the CCSS to achieve its goals, it was critical for the initiative to engage local professionals, parents and community residents, and agencies and organizations. Initial engagement of the professional community was achieved during the early assessment and planning phases of CCSS and continued through CCSS-sponsored trainings. Community stakeholders also participated in the initial community assessment, and in community forums to inform planning and implementation. The CCSS continued to reach out to community

members through a local outreach coordinator and social marketing campaigns. Local agencies also were engaged in initial planning efforts through strategic planning work groups; agencies invested in the process continued on with Safe Start by participating in the CCSS collaboration.

##### **4.1 Engaging Professionals**

Between 2000 and 2005, the CCSS conducted extensive training with professionals to raise awareness of violence exposure issues and to engage the professional community in the identification and referral of exposed children. Professionals attended multiple trainings and the attendance at these trainings totaled 3,455. Additionally, the CCSS conducted 53 small group trainings for CCSS staff and community partners. These trainings resulted in 447 referrals to CCSS from 20 different community sources, including social services, domestic violence agencies, law enforcement, parents, direct service providers, schools, and child care providers. To increase service providers' capacity to serve the diverse population of Chatham County, the CCSS also funded specialized training on the treatment of children (e.g., trauma and loss in children certification training), on the effects of exposure to violence on brain development and child development, on marriage counseling, and on culturally competent practice (e.g., Best Practices for Serving the Latino Population). The CCSS also offered Safe Havens training to child care providers and teachers and hosted an annual Focus on Child Care Conference, which included issues related to children's exposure to violence on its agenda.

## **4.2 Engaging Parents and Community Residents**

The CCSS conducted outreach to communities through partnering agencies and an outreach coordinator. Having identified the faith community as an important avenue for reaching community members in a rural setting, The CCSS supported Family Violence and Rape Crisis Center/Coalition for Family Peace prayer breakfasts, conferences, and other activities as a way to engage faith communities and help them train youth and young adults to develop healthy relationships and prevent domestic violence. Members of the faith community attended multiple activities and attendance at these activities totaled 600.

Beginning in 2004, the CCSS also conducted outreach through a community outreach coordinator, to engage the Hispanic community in two high risk neighborhoods in Siler City. Originally, CCSS staff and partners had envisioned extensive community outreach across the county. Due to competing priorities and staff turnover, however, the initiative was unable to initiate their community development and outreach program and hire the outreach coordinator until October 2004, which limited their focused outreach efforts to two targeted neighborhoods. The outreach activities included:

- Going door-to-door on a biweekly basis to talk with parents and distribute literature on issues related to exposure to violence,

- Conducting presentations to ministers from the faith community,
- Publishing a Spanish newsletter on children and violence,
- Participating in community events,
- Contacting 19 local businesses to solicit their support in reaching employees and customers and distributing literature about Safe Start, and
- Participating as a monthly guest on a Spanish radio show (“La Charla”) beginning in June 2004.

The outreach coordinator was successful in engaging families from the targeted neighborhoods, especially Spanish-speaking families. The community outreach efforts increased the number of residents informed of Safe Start, with one out of every two residents having heard of Safe Start (Cole, G., 2005).<sup>3</sup> Almost half (46%) of all Safe Start clients lived in Siler City (one of the locations targeted by the outreach coordinator), and 35% were Spanish-speaking.

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<sup>3</sup> Preliminary results from the Neighborhood Listening Survey conducted by Chatham County Safe Start.

Although the CCSS focused outreach efforts on two target areas, the initiative also worked to increase countywide community awareness by:

- Sponsoring public awareness events for the prevention of child abuse and neglect (e.g., family festivals, blue ribbon campaigns) in coordination with Allies for Chatham Children, a multi-agency group focused on preventing child abuse in Chatham;
- Organizing public awareness events for Domestic Violence Awareness Month in collaboration with the Coalition for Family Peace (Chatham County Safe Start Initiative, 2004); and
- Sponsoring booths at 19 street fairs in Pittsboro and Siler City between May 2001 and October 2005.

It is difficult to determine what impact these activities had on countywide community awareness or tolerance of violence because countywide data were not collected.

### ***4.3 Engaging Collaboration Partners***

The CCSS engaged partners in group-based collaboration through a Memorandum of Agreement; the Board of Directors of the Chatham County Partnership for Children maintained oversight of the initiative. During the first year of the collaboration, partners were an integral part of the decision making process. After the planning phase, however, collaboration partners found it difficult to maintain the

authority to make decisions on the strategic direction of the initiative (Association for the Study and Development of Community, 2005b). Members reported that their decision making authority began to diminish when program implementation began, during the second and third years of the project. While members were kept informed, they did not have an active role in decision making. Frustrated by this artificial division between planning and implementation, members raised the issue with the lead agency, the Chatham County Partnership for Children. The partners then participated in collaboration training, which greatly enhanced the participatory process. During the end of year four and throughout year five of the initiative, collaboration members once again took a more active role in the decision making process. Unfortunately, the tension between collaboration members and the lead agency may have slowed the progress of the CCSS during a crucial point in implementation.

The CCSS collaboration partners included key agencies from the law enforcement, social services, public health, and domestic violence sectors, specifically the following community members and agencies: the Chatham County Partnership for Children; the Department of Social Services; the Family Violence and Rape Crisis Center; the Public Health Department; Chatham Counseling; Orange, Person and Chatham Counties Mental Health Clinic; and individual direct service providers. The courts, Chatham County Public Schools, and law enforcement agencies (i.e., Chatham County Sheriff's Office and Pittsboro Police Department) participated to a lesser degree.

The model that the CCSS selected to improve service delivery and coordination used partnerships in the collaboration for planning, decision making, and referral of children and families for services; this model proved ineffective in helping the CCSS integrate the system of care for children and families. The system of care in Chatham County before CCSS was described as a “collection of services” rather than a “coordinated and integrated system of services.” Although the CCSS developed a mechanism to guide case design, planning, and coordination, this mechanism did not encourage interagency communication and information sharing or change the existing “one-way” relationships between agencies (i.e., child-serving community partners did not experience any change in level of collaboration or formal processes of interaction).

Evidence from the network analysis of collaboration between child-serving agencies in Chatham<sup>4</sup> supports this observation, indicating that no meaningful change occurred in the amount of collaboration between child-serving agencies, their perceived productivity, or their importance to each other over the life of the initiative.

The collaboration that seemed to occur depended on positive relationships between individuals in different organizations, making it vulnerable to staff turnover. Thus, CCSS collaboration may not have had the expected impact

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<sup>4</sup> Results of the Chatham County Safe Start Network Analysis indicated that the level of collaboration between key child-serving agencies in Chatham County did not change as a result of Chatham County Safe Start efforts.

on service delivery and coordination because turnover in both staff and leadership in the child-serving systems in Chatham County made it difficult for agencies to collaborate.

Although the CCSS did not improve collaboration between agencies in Chatham County, the initiative did engage in efforts to improve the system of care for children. These activities are discussed next.

## 5. System Change Activities

The CCSS developed and refined a system of identification and referral that encouraged a range of agencies and community members to make referrals, used a centralized point of referral to connect those referred to service providers, and expanded and enhanced existing services to meet the unique needs of the community. A diagram of the CCSS identification, referral, and treatment model is attached (Exhibit III-C). As a result of these systems change activities, the CCSS accomplished the following between May 2002 and December 2005:

- **447** children exposed to violence were identified by 20 different community sources;
- **261** children were assessed by the services coordinator or direct service providers funded by the CCSS; and
- **204** children received clinical or home-based therapy and/or family advocacy services from direct services providers specially trained to meet their needs.

In addition, the CCSS created the foundation to improve the court's responsiveness to children and families involved in violent events through a comprehensive court assessment and support of a supervised visitation program.

### ***5.1 Identification from Multiple Points of Entry***

In the vision of the CCSS, "whenever and wherever a Chatham County child is a victim or witness of a violent event, a coordinated community system responds to the needs of that child, so that every child has the opportunity to grow healthy and strong" (Chatham County Safe Start Initiative, 2004). This vision guided the planning and implementation of system change activities.

The CCSS paved the way for identification of children exposed to violence in Chatham County by identifying economically disadvantaged neighborhoods with a high incidence of children exposed to violence through an analysis of police data (Chatham County Safe Start Initiative, 2001).<sup>5</sup>

As previously mentioned, both community residents and professionals in Chatham County were informed about how to identify and refer children exposed to violence. The CCSS received referrals from 20 different sources in the community, including social services, law enforcement, and domestic violence agencies, as well as community

residents. This represented a significant accomplishment in that, prior to CCSS, no agency or system routinely identified children exposed to violence or at risk for exposure.

To help identify and refer families to the CCSS service coordination system, the initiative also funded a Family Responder position to answer all domestic violence calls with Sheriff's Office deputies. This position increased police awareness of children at the scene of domestic violence and improved the ability of law enforcement to refer to the CCSS service coordination system, as evidenced by 102 referrals (third most frequent referral source, constituting 23% of referrals to CCSS). On the other hand, this position exacerbated existing tensions between domestic violence and social service sectors created by philosophical differences between the mother's rights and the child's need for safety. Because of the serious nature of the situations that the Family Responder encountered, he/she directed many referrals to traditional child welfare services rather than to the CCSS services coordinator. This proved frustrating to the domestic violence advocates who believe that removing a child from a home that exposed him/her to domestic violence will further punish the domestic violence victim making it difficult for him/her to seek help. The large number of referrals to child welfare services not only exacerbated existing tensions and negatively impacted the ability of some key partners to work together on CCSS activities, but also made it difficult for the CCSS to maintain a steady stream of referrals from the Family Responder.

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<sup>5</sup> More information can be found about this effort in the Police Call Data Study in the Chatham County Safe Start Strategic Plan, 2001 submitted by Chatham County Safe Start to the Office of Juvenile Justice and Delinquency Prevention.

On the other hand, by acting as a bridge between law enforcement and child welfare, the Family Responder strengthened the relationship between these two sectors, which helped them to build trust and work together more efficiently. This improved relationship led to improved response time of child welfare to calls from law enforcement and increased support offered by law enforcement to child welfare workers (e.g., escort services to dangerous situations, testifying for child welfare case; Chatham County Safe Start Initiative, 2005).

### **5.2 Centralized Referral Point**

To complement its identification and referral system, the CCSS established a services coordinator position to receive referrals and connect children and families to a group of CCSS-funded service providers specially trained to meet their needs.

To facilitate the referral process and support service coordination, the CCSS developed a *Services Handbook*, available in Spanish and English, which included key documents such as the CCSS Clients Rights Brochure, Confidentiality Policy and Agreement, Grievance Policy and Procedures, and Client Record Policy and Procedures. The *Handbook* was used as a training and information dissemination tool for community residents and professionals. The CCSS also produced a condensed five-page version of the handbook entitled *Identification and Referral Guide* to streamline the information for service providers.

The services coordinator was a critical element of the service

coordination system; turnover in the services coordinator position created insufficient follow-up with referral sources and delayed initial contact with parents which decreased the likelihood they would accept Safe Start services. However, the services coordinator hired in year three was able to implement a more efficient service coordination system.

Turnover also occurred in the CCSS project director position. The second project director was hired in 2003; her leadership was considered an asset to the project because she helped to repair relationships damaged by inconsistency and confusion during the initial implementation of the identification, referral, and service coordination process. Even so, philosophical differences and pre-existing tensions between the social services and domestic violence sectors—two of the three sectors that provided the majority of referrals to CCSS—may have hindered the ability of the CCSS to maintain a steady stream of referrals from law enforcement (i.e., Family Responder) and domestic violence agencies.

### **5.3 Expanded and Enhanced Services**

The sparse population density and rural geography of Chatham County made it difficult to coordinate and provide services to families. The local public mental health agency did not serve children ages 0 to 3. In addition, the number of service providers was insufficient to meet the needs across the county; any one service provider in Chatham County had insufficient the capacity to adequately serve the entire

county. In response to these challenges, the CCSS worked with a diverse group of local public and private direct service providers to tailor services to meet community needs and increase access to services for children and families. Specifically:

- Child, couples, and family therapy for the Spanish-speaking population were provided by bilingual service providers from the Family Violence and Rape Crisis Center;
- In-home counseling and parent education were offered by the Healthy Families Program of the Chatham County Health Department and the Family Violence and Rape Crisis Center. Intensive, home-based, multi-systemic therapy was offered by a local private provider. Home-based services helped to decrease the stigma of mental health treatment that families in a small community face, as well as making services available at a time and place that accommodated parents' work schedules, daily routines, and family needs; and
- Child and adult psychotherapy using multiple therapy techniques (e.g., play therapy, cognitive behavioral, and psychodynamic) were offered by a local private service provider, Carolina Outreach, and Chatham Counseling Center to fill a gap in therapeutic services in Chatham County.

The CCSS was able to expand the availability of services to families and children because its services were

fully funded. Thus, families and children who did not meet the new, more narrow Medicaid eligibility for mental health services and/or could not afford to pay were still able to take advantage of CCSS services.

The quality of service coordination was improved by engaging CCSS-funded service providers in ongoing discussions to refine the centralized referral process; as a result of feedback from service providers, service coordination was streamlined, and children and families received services more quickly. Also to improve quality of services, the CCSS brought direct service providers and the services coordinator together on a regular basis to share information and treatment strategies at Case Management Team meetings. Prior to CCSS, direct service providers in Chatham County had a strong desire to work together, but joint case planning was difficult because each organization had its own focus, treatment goals, and funding sources.<sup>6</sup>

In addition to expanding the scope and improving the quality of services in Chatham County, the CCSS improved the system's ability to engage families by carefully addressing their concerns about privacy and confidentiality. To safeguard privacy and confidentiality, the CCSS closed Case Management Team meetings to collaboration partners and removed all community partner information from consent forms. Families were educated on their right to confidentiality and privacy through a Clients Rights Brochure, Confidentiality Policy and

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<sup>6</sup> This information is based on a review of records to explore case level collaboration that existed prior to Chatham County Safe Start.

Agreement, Grievance Policy and Procedures, and Client Record Policy and Procedures. The development of Client Record Policy and Procedures also improved the consistency of client data collected by the CCSS .

## **5.4 Responsiveness of the Court System**

With support from the National Civic League, the CCSS completed an assessment of strengths, weaknesses, and areas for possible future reform in Chatham's child welfare court system. The assessment created a mechanism for the court and the Department of Social Services to work together on systems reform to improve their responses to children exposed to violence. The assessment was completed in 2005, and the CCSS has set aside some of its remaining funds to dedicate to future reforms.

Additionally, supervised visitation for families in Chatham County will be funded as a result of a grant, which CCSS staff helped to write, from Safe Havens Grant Program established by the Violence Against Women Act of 2000. The CCSS will continue to support the supervised visitation program by offering training to supervised visitation staff through the Community Peace Training Committee and the Court Development Workgroup, and the Executive Director of the Chatham County Partnership for Children will continue to serve on the Advisory Committee of Family Visitation Services.

In addition to court reform and supervised visitation, several other changes created by the CCSS will be sustained. These changes are discussed next.

## **6. Institutionalization of Change**

The CCSS was successful in institutionalizing several changes to the system of care in Chatham County,<sup>7</sup> and in November 2005 was approved to receive a Congressional Appropriation Earmark for \$150,000 to continue funding CCSS staff. Although institutionalization of change occurred at both the system and agency level as well as at the point of service, the CCSS model of service delivery and coordination is ultimately sustainable only if the services coordinator position continues to be funded.

### **6.1 System and Agency Change**

The CCSS developed a mechanism to collect data needed to apply for additional funding to sustain critical elements of the initiative. For example, the Child Well-Being Collaborative agreed to fund in-home services in Chatham County based on single-subject research conducted by the CCSS. The Child Well-Being Collaborative was formed by the county in 2004 to monitor the mental health needs of children during the process of restructuring the local mental health services system. It is also charged with disbursing community alternative funds made available through the mental health reform.

### **6.2 Point of Service**

The CCSS impacted the point of service in Chatham County by

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<sup>7</sup> Chatham County Safe Start made efforts to plan for sustainability through funds provided by the Child Well-Being Collaborative, as well as national support from McCoy Associates and Systems Improvement Training and Technical Assistance Program, which assisted Chatham County Safe Start with their Resource Development Plan.

increasing professional awareness of issues related to children and violence; infusing the vision, mission, and focus of the CCSS into other agencies; and providing a mechanism for collaborative case management that will continue to be used by service providers.

Professionals in Chatham gained an increased awareness and knowledge of the system of care and issues related to children exposed to violence, which will remain in the community after CCSS funding ends, as evidenced by the following comments:<sup>8</sup>

- “We are aware of the problems that we face in Chatham County.”
- “Community professionals perceive [children exposed to violence] as a problem and have responded through the creation of new positions and services.”
- “[Coalition for Family Peace staff] used to just focus on the adult and not think about the child. There is greater awareness of how domestic violence impacts children. When mothers complain about their children’s behavior problems, the workers model appropriate parenting techniques. Women are starting to change. Children are also changing. At our last blue ribbon campaign in April, children understood the significance of the ribbon. One child said, ‘They don’t have to spank me.’”

The extensive training of professionals on issues related to

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<sup>8</sup> These comments were made during a focus group of professionals in Chatham, conducted in 2003.

children and violence contributed to this increased awareness.

The vision and mission of the CCSS was infused into other agencies. For example, the CCSS collaborated with El Futuro, a non-profit established in 2005 to provide culturally competent bilingual mental health services to Latinos in Chatham and Orange Counties. The CCSS helped El Futuro plan and develop services appropriate to the mental health needs of children exposed to violence; these services will continue to be offered after Safe Start funding ends. In addition, the Community Peace Training Committee of the Family Violence and Rape Crisis Center volunteered to maintain a focus on children exposed to violence in its trainings, because the committee had participated in implementing CCSS training during the initiative.

Direct service providers funded by the CCSS are transitioning into community agencies and will continue to participate in Case Management Team meetings, unfunded, to maintain the improved quality of services for families and children exposed to violence.

As a result of systems change activities, the CCSS has increased community supports for children and families exposed to violence.

## **7. Increased Community Supports**

The CCSS increased supports and services for children and families exposed to violence through its efforts to coordinate and expand services, as well as through its focus on educating

professionals and community members on how to identify and refer children exposed to violence. Increased community supports resulted in:

- Professionals who received training from the CCSS and increased their knowledge of issues related to the identification and treatment of children exposed to violence; and
- Expanded, enhanced, and better coordinated services to identify and treat children and families exposed to violence, whereby the CCSS identified 447 children through 20 different referral sources, assessed 261 children, and referred 204 children exposed to violence to treatment.

The CCSS was able to identify and serve these children because several key child-serving institutions (i.e., social service, law enforcement, and domestic violence agencies) were committed to helping children, and the CCSS offered these agencies resources to fulfill their commitment.

Law enforcement, social service, and domestic violence agencies in Chatham County demonstrated their commitment to helping children through their participation in the CCSS collaboration and through the referrals that they made.

The CCSS offered these agencies resources that helped to improve their capacity to meet the needs of children exposed to violence. As previously mentioned, pilot-testing of the Multiple Response System expanded the Department of Social Services' capacity to meet the needs of families

with cases that would otherwise not have been serious enough to qualify for social services. Additionally, the CCSS worked collaboratively with the Sheriff's Office to fund a Family Responder position (social worker) to accompany police officers to the scene of calls involving violence and children. This position helped to expand the capacity of the domestic violence unit within the Sheriff's Office, which consisted of a single officer. The CCSS funded the Family Violence and Rape Crisis Center to provide home-based family advocacy services to meet the needs of children and families exposed to violence. These three partners provided the majority of referrals to the CCSS for assessment and/or services:

- The Department of Social Services referred 132 children (30%);
- The Chatham County Sheriff's Office referred 102 children (23%); and
- Domestic violence agencies referred 100 children (22%).

However, the quality and efficiency of service coordination was inconsistent because of limited community capacity, and CCSS staff turnover. As previously mentioned, restructuring and/or leadership turnover in the public mental health system, public school system, Sheriff's Office, local police department disrupted existing relationships and made it difficult for the CCSS to consistently engage these partners in the service coordination system. Pre-existing tensions between social services and domestic violence agencies were exacerbated as a result of the Family Responder, a position funded by the

CCSS , contributing to inconsistent referrals from law enforcement and domestic violence agencies to the CCSS services coordinator.

The limited community capacity of a small rural community like Chatham, which was further limited by cuts to funding for social services, made it difficult for overburdened systems to find the time, resources, or staff to participate in CCSS activities. The Safe Start project director and services coordinator positions each turned over three times during the life of the initiative. This turnover created inconsistency and confusion during the initial implementation of the child identification, referral, and service coordination aspect of the project and damaged relationships between the CCSS and referring community sources. Although the CCSS worked to repair these relationships, the initiative's ability to impact the system of care in Chatham County was reduced.

Nevertheless, the CCSS demonstrated a viable way to reduce the impact of exposure to violence for children and their families, discussed next.

## **8. Reduced Exposure to Violence and Impact of Exposure to Violence**

The CCSS demonstrated that direct services tailored to family needs are an effective way to reduce the impact of exposure to violence on children and their families (see Exhibit III-D). By tailoring intervention strategies, the CCSS offered service providers the opportunity to sustain a therapeutic

relationship with clients. Single-subject data indicated that interventions tailored to the unique needs of children and families are related to positive changes in the conditions associated with violence exposure. To measure progress toward case goals, service providers tracked indicators that clients were meeting objectives related to their goals. By August 2005, clients had completed 75 (78%) of established objectives successfully, a statistically significant finding.<sup>9</sup> However, threats to validity and limitations of the study make it difficult to establish a causal link between the services funded by CCSS and a positive change in target conditions. More information on the intervention research conducted by the CCSS is available in III D.

Although changes in the rates of abuse, neglect, and violent crime from 2000 to 2004 cannot be attributed to CCSS, there were positive trends in the total number of child abuse and neglect reports in Chatham (27% decrease), total number of substantiated cases of child abuse and neglect (25.5% decrease), and violent crime rate (5% decrease), following the implementation of CCSS.

## **9. Conclusions**

The planning and implementation of CCSS was guided by the vision that a coordinated community system can best serve the needs of children who are victims or witnesses of violence. To realize this vision, the CCSS worked to create safe communities, an integrated system of

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<sup>9</sup> Statistical significance suggests that it is highly unlikely the improvement occurred by chance.

care, and safe families. The CCSS was successful in (1) developing an identification system that allowed referral from any point of entry, (2) establishing a centralized referral point, and (3) enhancing and expanding existing services to meet community needs.

The greatest challenge that the CCSS faced was the change and reorganization in major child-serving systems at the statewide and local levels. The rural conditions of the community also challenged project design and implementation, but the CCSS successfully tailored direct services to meet the unique needs of a rural community, offering home-based therapy, bilingual services, and comprehensive therapeutic services for

families. The greatest challenge that the CCSS will face in the future is finding funding to continue the services coordinator position, which is key to sustaining the CCSS model of service coordination and delivery. After CCSS funding ends, services in Chatham County will continue to be expanded and enhanced through home-based therapy funded by the Child Well-Being Collaborative and continued opportunities for service providers to share information and treatment strategies through Case Management Team meetings. The greatest footprint that the CCSS will leave, however, is increased awareness of issues related to children exposed to violence in the professional and targeted communities.

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**Exhibit III-A**  
**Timeline of Chatham County Safe Start Initiative Activities and Milestones**

Major Milestones	1/01-6/01	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
<i>Definition of Violence</i> constructed		✓	✓							
Direct service providers funded to provide services to families and children			✓	✓	✓	✓	✓	✓	✓	✓
• Hired three direct service providers and contracted with four agencies in targeted communities			✓							
• Contracted with seven direct service providers						✓				
Case Management Team (formed and ongoing)			✓	✓	✓	✓	✓	✓	✓	✓
<i>Services Handbook</i> (revised annually)			✓	✓	✓	✓	✓	✓	✓	✓
Family Responder position					✓	✓	✓	✓	✓	✓
Neighborhood listening project					✓	✓	✓	✓		
Community outreach activities	✓		✓	✓	✓	✓	✓	✓	✓	✓
• Participation on a Spanish radio show			✓	✓	✓	✓		✓	✓	✓
• Presentations to faith community and Hispanic community				✓	✓	✓	✓	✓	✓	✓
• Published Spanish newsletter on children and violence									✓	✓
• Sponsored booths at local street fairs	✓		✓	✓	✓	✓	✓	✓	✓	✓
• Public awareness events with Allies for Chatham (e.g., family festivals)			✓	✓	✓	✓	✓	✓	✓	✓
• Domestic Violence Awareness				✓		✓		✓		✓

Major Milestones	1/01-6/01	7/01-12/01	1/02-6/02	7/02/-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
Month events with Coalition for Family Peace										
Judicial forums						✓	✓	✓		
Court assessment							✓	✓	✓	✓
Database to monitor children exposed to violence created and revised					✓			✓		
Child Witness to Violence Project			✓	✓						
OJJDP no-cost extension approved										✓
Received funding for in-home services from Child Well-Being Collaborative										✓
Congressional Appropriation Earmark for \$150,000 approved										✓
CCSS Project Director position filled	✓					✓				✓
Project Director resigned					✓					✓
CCSS Services Coordinator position filled			✓		✓					
Services Coordinator resigned				✓						
CCSS Community Outreach Coordinator position filled			✓				✓			
Community Outreach Coordinator resigned					✓					

Sources: Local Evaluation Report Form, 2004 & 2005; Evaluation Plan 2004; Progress Reports, January-June 2002, January-June 2003, July-December 2003, January-June 2004, July-December 2004, January-June 2005, July-December 2005.

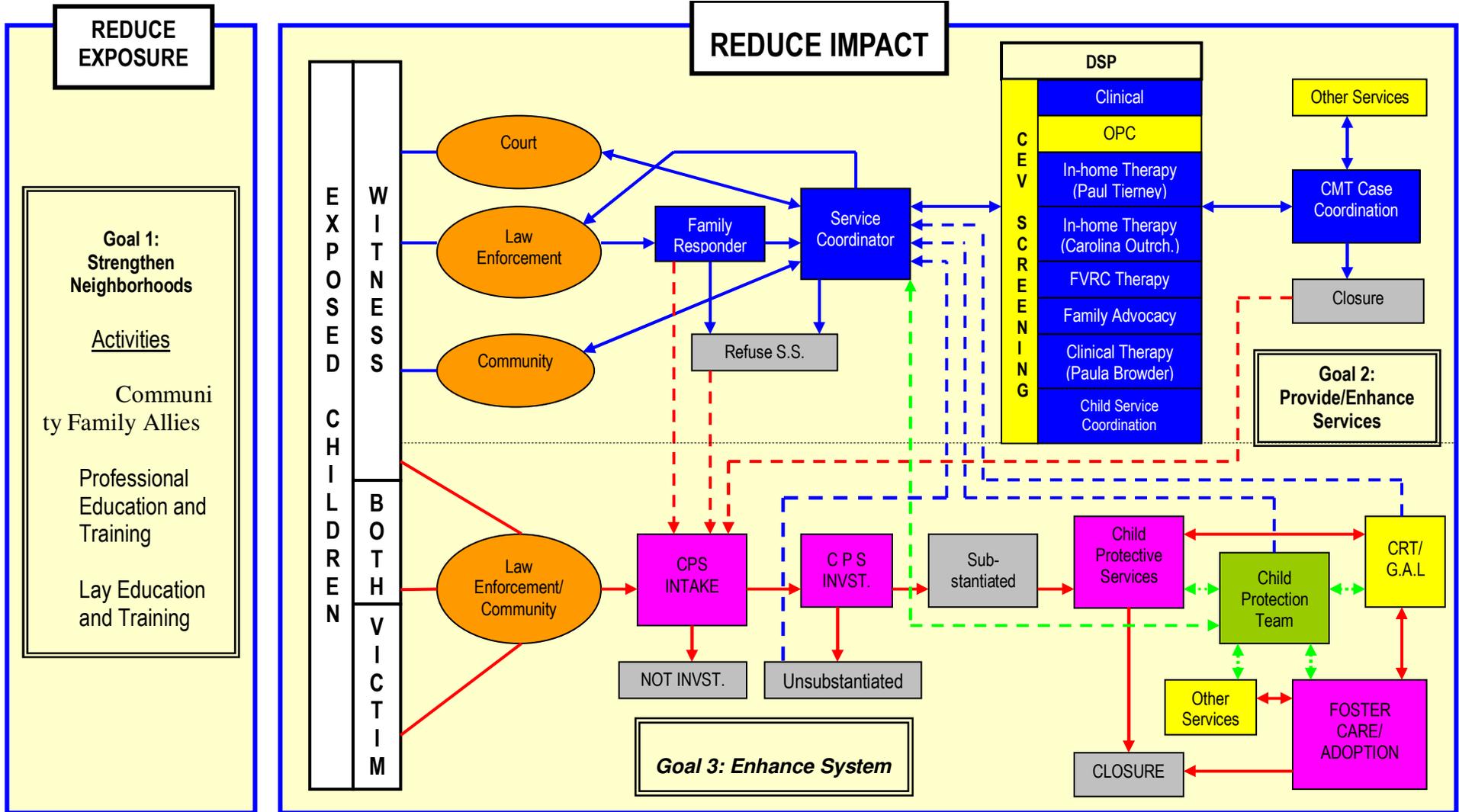
**Exhibit III-B**  
**Chatham County Definition of the Type of Violence that Requires**  
**Professional Intervention**

Professionals and community members in Chatham County agreed that professional intervention is necessary if a child experiences or witnesses any of the following:

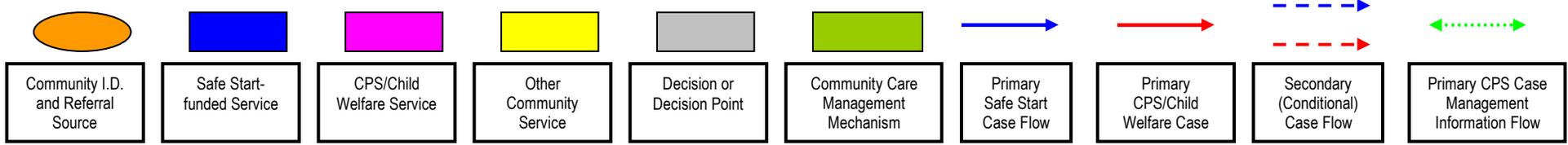
- Persistent verbal or physical harassment, such as bullying and threatening, toward the child or others in the child's environment;
- Punching with a closed fist;
- Hitting with an open hand with enough force to physically move any body part of the victim;
- Physical contact of any type that is hurtful to the victim and/or leaves a mark or indication that lasts more than 12 to 24 hours, but may not require medical attention;
- Throwing objects at people and destruction of property around people;
- Threatening serious violence (including homicide and suicide), threatening with weapons, or display of weapons associated with violent language and/or behavior;
- Sexual harassment (inappropriate touching and/or sexual language);
- Sexual abuse as defined by NC statute;
- Child exposure to violent sexual activity, including pornography; and
- Animal abuse.

# Exhibit III-C

## Chatham County Safe Start Service Delivery Model



→ TIME →



## **Exhibit III-D**

### **Chatham County Safe Start Intervention Research**

#### **Overview**

The Chatham County Safe Start (CCSS) funded nine direct service providers from the Chatham County Health Department, Family Violence and Rape Crisis Center, Chatham Counseling, Carolina Outreach, and two private practices to provide intervention services to reduce the impact of exposure to violence on children and their families. To evaluate the effectiveness of the services, each of which used different intervention models, single-subject data for 37 cases were collected by five providers (three from the Family Violence and Rape Crisis Center, one in private practice, and one from Carolina Outreach) and analyzed by the CCSS local evaluator. Only five of the nine service providers funded by the CCSS provided single-subject research data because it was difficult to consistently obtain data from veteran counselors and service providers who were resistant to incorporating single-subject research into their existing treatment strategies and case management. The data collection methods and results are discussed in further detail below.

#### **Method**

The local evaluator trained direct service providers to design and implement a single-subject study for each intervention model, to enter their single-subject data into an Excel database, and to conduct the graphical analysis of single-subject data needed to inform clinical or case decision-making using simple math. Additionally, technical assistance for single-subject research design was integrated into Case Management Team meetings.

Interventions were implemented at the family and individual level to reduce risk factors for family violence, while increasing protective factors. Of the 56 cases for which single-subject research data were collected, 37 included sufficient data to conduct an analysis of case objectives. Of the cases reviewed for the research study, 27 were closed and therefore included sufficient information about functioning before, during, and after the intervention; ten were open cases and therefore included information about functioning only before and during the intervention.

#### **Sample**

Cases consisted of parents and children, with a range of one to three clients per case ( $M=1.3$ ). Hispanic mothers less than 30 years of age with exposure to domestic violence were the most frequently identified adult clients. Services funded by the CCSS that were evaluated using the single-subject research design included:

- In-home family counseling and parent education provided by the Family Advocacy Program of the Family Violence and Rape Crisis Center;

- Individual child therapy provided by the Bilingual Child Therapy Program of the Family Violence and Rape Crisis Center;
- Family, couples, and/or child therapy provided by the Bilingual Couples and Family Therapy Program of the Family Violence and Rape Crisis Center;
- Individual adult and/or child therapy provided by the Carolina Outreach organization, a private provider; and
- Multi-systemic therapy provided to families by the Intensive Home-based Therapy Program, a private provider.

## Procedure

Single-subject research design was used to evaluate the effectiveness of services, because each service was based on a different model of practice and was focused on a certain set of effects or types of client. Data on case goals were collected for a minimum of seven data points in three phases: (1) prior to the intervention, (2) during the course of the intervention, and (3) following the termination of the intervention.

Direct service providers collected information on the most important intervention goals (e.g., improve the child's mental health), objectives by goals (e.g., reduce traumatic rage), and each objective's indicator or measure (e.g., mother's weekly count of the number of child's tantrums). Additionally, client demographic information and descriptive information on services received were recorded by direct service providers.

The data for each phase were entered into Excel, and a line graph was generated to show changes in indicators over time. To confirm the belief that the intervention was successful in changing the desired behavior (e.g., number of child's tantrums), service providers also plotted a trend line for each period of research.

The local evaluator conducted two additional analyses to confirm the service providers' findings:

- Linear regression, a statistical technique performed using SPSS, to identify any relationship between the frequency of the behavior (e.g., child's tantrums) and the passage of time; and
- A review of the written case materials to determine if any changes in the client's life corresponded with the observed changes in behavior.

## **Results**

Service providers reported a total of 52 case goals, including improvement in: child behavior management (33%), child mental health (19%), adult interpersonal relationships (13%), adult mental health (13%), parenting confidence (11%), adult/child interpersonal relationships (4%), communication (4%), and child safety (2%). To meet those goals, service providers reported 96 objectives. The most frequently reported objectives were reduction in negative behavior (29%); increase in positive interpersonal interactions

(8%), emotional expressiveness (7%), and parenting confidence (6%); and reduction in worry related to PTSD (5%), sleep disturbance related to PTSD (5%), and anger (4%).

Clients completed 75 of the objectives successfully (78%), a statistically significant finding.<sup>10</sup> A chi-square analysis revealed that the success of clients was not contingent on their age, ethnicity, gender, family role, goal, counselor, type of exposure, number of counselor contacts, and/or whether or not the case had been closed.

## **Discussion**

The results suggest that services funded by the CCSS increased children's resilience and reduced dysfunction when they received at least nine sessions of an intervention. However, threats to validity and limitation of the study make it difficult to establish a causal link between the services funded by the CCSS and a positive change in target conditions. Three possible threats to the validity of the study are: (1) selection bias due to the fact that intervention research participants were those that completed enough intervention sessions to participate in the study, (2) measurement bias due to the fact that parents collected the majority of the data, and (3) bias created by single-subject design. Additionally, the use of multiple interventions did not allow researchers to isolate the effects of concurrent interventions or environmental conditions, thus limiting the power of the results.

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<sup>10</sup> Statistical significance was at the <p0.01 level. Statistical significance at the <p0.01 level suggests that is highly unlikely (less than a 1% chance) that the improvement occurred by chance.

# IV

## Chicago Safe Start Initiative

### 1. Overview

Chicago Safe Start (CSS) was developed and implemented using a collaborative approach involving community residents, community organizations, and city and state agencies serving children six years and younger and their families. The initiative focused on the Roseland/Pullman and Englewood communities, the 5<sup>th</sup> and 7<sup>th</sup> police districts in Chicago, respectively. A major component of the effort was the strategic use of its Implementation Advisory Board (IAB) to ensure progress in enhancing the service delivery system. Collaborating agencies and community residents represented on the IAB contributed to the success of CSS by serving on formal teams, councils and subcommittees that mirrored the components of the CSS service delivery system. The CSS training curriculum was a key strategy used to enhance the community's capacity for responding to children exposed to violence. Other key strategies used to create a more responsive system of care included working with the Chicago Police Department, the Chicago Fire Department, and the City of Chicago's Domestic Violence Helpline to make it possible for these agencies to identify children exposed to domestic and community violence and refer them to appropriate services. Services appropriate for children exposed to violence were provided by Metropolitan Family Services (in the Roseland/Pullman community) and by

Family Focus and the Community Mental Health Council (in the Englewood community) as well as by service providers located in six Safe from the Start sites. These service providers also implemented referral and recruitment protocols within their own agencies to link children and families to CSS services. These two main strategies were identified as "Incident-Based" and "Symptom-Based" methods for increasing access to CSS services.

The two main strategies described above for increasing access to CSS services (i.e., referrals from first responders and inter/intra-agency referrals) were identified as "incident-based" and "symptom-based" methods. In total, the following numbers of children were identified, referred for services, and assessed for needs (Chicago Safe Start Initiative, 2003; Chicago Safe Start Initiative, 2004a; Chicago Safe Start Initiative, 2005a):<sup>1</sup>

- **1,386** children exposed to violence were identified between 2003 and 2005;
- **923** children were referred to CSS services between 2004 and 2005; and
- **474** children were screened by CSS providers between 2004 and 2005.

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<sup>1</sup> These figures were compiled from Progress Reports (2003-2005) submitted by Chicago Safe Start to the Office of Juvenile Justice and Delinquency Prevention.

A subset of children and families agreed to participate in research that allowed CSS staff and its local evaluator to examine improvement in child and caregiver outcomes. Research findings indicated that children and caregivers benefited in many ways from Safe Start services (e.g., case management, therapy, parenting skills training, family support services). Specifically, additional exposure to violence was reduced for a majority of children, children expressed fewer trauma symptoms, and caregiver functioning improved.

After federal funding ends, key components of Chicago Safe Start will continue through state and local funding and institutionalization efforts with CSS partners. For example, the Illinois Violence Prevention Authority will sustain direct services to children exposed to violence in the CSS communities. In addition, the Chicago Department of Public Health has committed to support two CSS staff positions. Finally, the CSS “incubator approach” will leave a legacy of CSS-specific programming within other agency programs.

### **1.1 Mission**

Chicago Safe Start’s mission was to prevent and reduce the impact of exposure to violence on children ages five and younger. The grantee’s goal was to improve access, delivery and quality of services through a balance of prevention and intervention efforts. Chicago Safe Start focused on education and new kinds of collaborations among city and state service agencies, community organizations and residents (Chicago Safe Start Initiative, n.d.). How

did the Chicago Safe Start grantee accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in the following sections, and a timeline of major events is attached (IV-A).

### **1.2 Chicago, (Roseland/Pullman and Greater Englewood Communities), Illinois**

Chicago Safe Start was planned and implemented within the unique context of the Roseland/Pullman and Greater Englewood communities of Chicago. The following snapshot of these two communities is intended to help others interested in replicating Safe Start to compare their own communities to Roseland/Pullman and Greater Englewood (Chicago Safe Start Initiative, 2005, p. 4; U.S. Census Bureau, n.d.).

Roseland, one of Chicago’s 77 community areas, is located on the far south side of the city and includes the neighborhoods of Roseland, Fernwood and Princeton Park. The area encompasses 4.85 square miles and is home to 52,723 residents (a 6.7% decrease from 1990), according to the 2000 U.S. Census. Pullman, a community area adjacent to Roseland, includes the neighborhoods of Pullman and Cottage Grove Heights, and covers an area of 4.85 square miles with 8,921 residents. African Americans make up 95% of the two combined areas: 20% of families and 38% of children five years and younger live below the federally defined poverty level. These figures are reflected in a median household income of \$36,291 for the average family of three.

Also on Chicago's south side, the Englewood and Hamilton Park neighborhoods make up the Englewood community area. Ninety-eight percent of the nearly 3,000 Englewood residents are African American, living in an area of 3.09 square miles. The median income for an Englewood household is \$22,884, with 34% of families and 50% of the children five years and younger living in poverty. The average family size in Englewood is four.

## **2. Contextual Conditions**

Chicago Safe Start was developed and implemented in a city that considers violence prevention an important public agenda item. Historically and currently, Chicago has invested resources in preventing family and community violence and enhancing early childhood mental health services. Monetary investment in various prevention programs reflects political and public support for this issue. The CSS was able to build upon this infrastructure and further this political agenda by expanding the focus to include young children exposed to violence.

CSS evolved also in the context of two low-income communities that place children at high risk of exposure to violence, given their high rates of violent crime and domestic violence as compared to the overall rates in the city of Chicago. Despite relatively high rates of violence, however, the Roseland/Pullman and Greater Englewood communities are cohesive, with many long-term residents and active community leaders invested in organizing residents to respond to

community violence. Working with these local community leaders facilitated CSS's entry into two communities that generally distrust federally funded programs.

### ***2.1 Political and Economic Context***

Legislation and administrative policies. The Ounce of Prevention Fund (OPF) invests in children through innovative direct service and research, while Voices of Illinois Children (VIC) works with families, communities, and policymakers to ensure that all children grow up healthy, nurtured, safe, and well educated. In 2002, these two organizations combined efforts under a new initiative, the Illinois Children's Mental Health Partnership. CSS staff joined the board of this partnership in 2002 and took on the role of educating these agencies on the impact of violence on children five years and younger, and advocating for mental health services to address the needs of these children (Chicago Safe Start Initiative, 2005, p. 3).

Support of political leaders. The Futures for Kids Advisory Board, chaired by Illinois' First Lady in 2003, took as one of its main areas of focus children's mental health. The board formed a subcommittee to look at this issue, with particular sensitivity to the linkages between mental health services, juvenile delinquency, and early exposure to violence. In the 2003 budget year, Futures for Kids was successful in securing \$2.0 million in mental health services for youth leaving juvenile detention centers, bringing its three-year total of new funding to \$6.0 million. Chicago Safe Start, through joint

members on the Steering Committee and the Future for Kids Advisory Board, as well as through direct participation on the children's mental health subcommittee, helped advance the goal of increasing access to mental health service for children (Chicago Safe Start Initiative, 2005, p. 3).

In addition, the following state, local, and private budgets support programming for children exposed to violence in Illinois and Chicago (Chicago Safe Start Initiative, 2005, p. 4):

- In August 2001, the Chicago Department of Children and Family Services (DCFS) funded services to prevent the co-occurrence of child abuse and domestic violence, specifically recognizing the needs of children who witness domestic violence. The Child Abuse Prevention Fund, a tax check-off program, is currently in the second year of funding 12 such service programs statewide. In 2005, approximately \$580,000 was used to serve a population experiencing domestic violence and child abuse concurrently;
- The Illinois Violence Prevention Authority (IVPA) provides \$500,000 in funding annually to nine sites providing services to children exposed to violence. The CSS received IVPA funding as one of those sites;
- In the current fiscal year, the Illinois Coalition Against Domestic Violence received \$207,000 to provide counseling and other services to children and

an additional \$1.1 million for children's therapy;

- The city of Chicago provides \$2.0 million each year through Community Development Block Grant funds to support the Family Violence Initiative. The grant language was modified in 2004 to include expectations that 2005 grantees would train staff on issues of children exposed to violence; and
- The Illinois Department of Health and Human Services provides more than \$23 million dollars to support domestic violence shelters and related services. Twenty two million dollars come out of state general revenue funds, and an additional \$1 million in special services funds are acquired through a tax form check-off that allows tax payers to designate a portion of their refund to this fund.

Chicago Safe Start (CSS) staff leveraged this political and economic environment in the city of Chicago and the state of Illinois by placing the needs of children exposed to violence on the public agenda. For example, CSS staff collaborated with the Illinois Violence Prevention Authority (IVPA) to advocate for passage of the Illinois Children's Mental Health Act of 2003 (Chicago Safe Start Initiative, 2005, p. 14).<sup>2</sup> This act ensures that schools 1) regard social and emotional development as integral to the mission of schools and a critical component of student academic

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<sup>2</sup> These perceptions were shared during the October 4 and 5, 2004, and October 6 and 7, 2005 site visits conducted by the Safe Start Demonstration Project National Evaluation Team.

readiness and school success and 2) take concrete steps to address students' social and emotional development. The passing of the act helped emphasize the importance of addressing issues of children exposed to violence by 1) helping to de-stigmatize mental health; 2) highlighting the need for addressing the mental health of children, including those exposed to violence; and 3) potentially tapping into service systems to help identify and refer children exposed to violence.

## **2.2 Social Context**

The social context in which Chicago Safe Start (CSS) evolved both challenged and facilitated the achievement of its goals. On the one hand, the CSS served two low-income communities with high rates of violent crimes and domestic violence compared to those Chicago overall. The rates of family violence per 1,000 residents for Roseland/Pullman and Greater Englewood are 27.5 and 40, respectively, greatly exceeding the overall rate of 15.9 violent crimes per 1,000 residents in the city of Chicago as a whole (Chicago Safe Start Initiative, 2005, p. 5 & 19). Related challenges in these communities are associated with the vestiges of individually mediated, internalized, and institutional racism – challenges characteristic of urban, predominantly African American communities across the United States. Racism permeates individuals, families, groups, and systems throughout these communities, and impacts employment, education, and health opportunities, contributing to increases in family and community violence. An outgrowth of this racism is stigmatization of such communities in the media. By

emphasizing the violence in low-income, urban, predominantly African American communities, the media play an important role in perpetuating the cycle of racism, escalating violence, and stigmatization that these communities experience.

For historical reasons, the Roseland/Pullman and Greater Englewood communities mistrust and suspect members of the Chicago Police Department and the Department of Children and Family Services. Incidents of police brutality abound in these communities. In addition, the Department of Children and Family Services removes children from the home and terminates parental rights at the highest rates among African American families in Chicago: these families have the lowest rates in Illinois for parent-child reunification. Ninety-five percent of children removed from their homes in Chicago are African American (Pardo, 1999). As predominately African American communities, Roseland/Pullman and Englewood have undoubtedly experienced removal of children from homes and termination of parental rights, as well as police brutality, leading to mistrust and suspicion of government agencies. Albeit warranted, this mistrust and suspicion creates challenges for large federal government projects like Chicago Safe Start (CSS) to gain entry into the community.

On the other hand, the positive social supports and networks within the Roseland/Pullman and Englewood communities provide a buffer to counteract the numerous challenges these communities face, including steady increases in violence. For example,

many families have lived in the Roseland/Pullman and Englewood communities for generations, contributing to community cohesion. This cohesion has supported a long history of community member involvement in local change efforts, through collaborative relationships with established local service provider agencies. For example, an indicator of cohesion in the two communities is member involvement in Local Area Networks (LANs) which are responsible for developing community-based services for children and adolescents within their local geographic area (Chicago Safe Start Initiative, 2005, p. 4). Through the Chicago Department of Public Health (CDPH), the Roseland/Pullman and Englewood communities also have local health facility management boards that solicit consumer participation and leadership. Dedicated participants in both CSS districts are committed maintaining this work (e.g., determining health resource allocation and utilization), with or without continuing government support (Chicago Safe Start Initiative, 2005, p. 4).

A political, economic, and social context with such tremendous challenges, as well as opportunities, called for a well-defined, effective service delivery system for the identification, referral, and treatment of children exposed to violence. To develop such a system, the CSS was able to build upon the long history of service provision by mental health agencies such as Family Focus, Metropolitan Family Services, and Community Mental Health Council, Inc. These providers, along with collaborative community members and CSS's community-oriented focus

helped overcome barriers to community access. This community capacity is addressed in the next section.

### **3. Community Capacity**

Because of the cohesion among members of the Roseland/Pullman and Englewood communities and their history of collaborating willingly and effectively with local area providers, the CSS faced minimal challenge to incorporating issues of children exposed to violence into the community agenda. In addition, the CSS lead agency, the Chicago Department of Public Health, had significant experience in leading participatory community-wide planning processes. For example, CDPH led the "Prevent Violence, Chicago!" strategic planning project from 1996 to 2002, to establish a framework for a comprehensive citywide approach to violence prevention programs. This initiative provided the framework through which Chicago Safe Start was funded and implemented (Chicago Safe Start Initiative, 2005, p. 5). In other words, the Roseland/Pullman and Greater Englewood communities were, in many ways, poised for a community-based initiative such as CSS.

Additional capacities included several children's mental health programs. At least 14 outpatient and eight inpatient mental health facilities in Chicago are able to provide some level of mental health services to children. Services for families experiencing violence include 67 domestic violence programs, as well as 31 intervention programs for male perpetrators. Funding for victims of family violence in Illinois has been relatively stable, though

minimally adequate (Chicago Safe Start Initiative, 2005, p. 7).

Despite these important resources, several gaps in services and barriers to access existed throughout the state. For example, prior to CSS, children exposed to violence received little attention from mental health providers. In addition, without a specific diagnosis, mental health services were generally not available to children six years and younger. Structured interventions following exposure to violence and trauma were inconsistent and uncoordinated across systems; to date, agencies still have not implemented standards for services for children exposed to violence. Finally, prior to CSS, formal functional relationships between mental health and family support service providers were inconsistent.

### **3.1 Integrated Assistance**

Local training and technical assistance. Chicago Safe Start staff increased the community's capacity (e.g., knowledge, skills, resources, relationships) to respond to children exposed to violence. Training and technical assistance were the most common strategies used to develop the capacity of the agencies and individuals affiliated with CSS. These trainings led to the enhancement of capacity not only within the collaborative agencies and communities served by the CSS, but also in communities and agencies throughout the city of Chicago and the state of Illinois. The extensive training component of CSS enhanced the skills of its partners through providing education on a myriad of topics related to children exposed to violence and their families.

A large portion of the training was organized through the CSS annual training calendar. Trainees included staff or members of child and youth service agencies, social service agencies, the courts, faith communities, and other relevant services and programs. The training curriculum had five modules: 1) building public awareness about children exposed to violence, 2) understanding the effects of exposure to violence on children's development 3) defining the role of culture in children exposed to violence 4) responding to children exposed to violence and 5) a practicum component focused on opportunities to intervene with families in crisis.

Components of these modules were fully or partially incorporated into all CSS training sessions.<sup>3</sup> Other activities include seminars, train-the-trainer efforts, and public awareness training sessions. From the start of the project through October 31, 2005, Chicago Safe Start staff conducted 61 CSS training sessions for 1,778 participants, three seminars for 395 participants, ten train-the-trainer activities for 27 participants, and 252 public awareness training sessions for 5,592 participants -- a total of 326 trainings for 7,792 participants<sup>3</sup>. See Table 1 for a summary of the number sessions offered and the number of participants (Chicago Safe Start Initiative, 2005, p. 4).

**Table 1.**  
**Chicago Safe Start Training Sessions**

Session	Number	Number of
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<sup>3</sup> These models were shared by participants during the October 6 and 7, 2005 site visit conducted by the Start to the Safe Start Demonstration Project National Evaluation Team.

Type	of Sessions	Participants
CSS Training	61	1,779
Seminars	3	395
Train-the-Trainer	10	27
Public Awareness Training	252	5,592
<b>Total</b>	<b>326</b>	<b>7,793</b>

Of the 1,779 participants in CSS training sessions, 96% of those who attended workshops of 30 minutes or longer and 75% of those who attended brief 15-minute presentations stated that, after the training, they could define exposure to violence, identify three impacts of exposure to violence on children, and help a child exposed to violence. In addition, 96% of total participants (workshop or brief session) agreed or strongly agreed with the statement, "I know what action to take to help a child exposed to violence." Of participants attending seminars, 92% reported that they could define exposure, identify its impacts and help exposed children; and 93% agreed or strongly agreed with the statement "I plan to become involved with efforts to help children exposed to violence." Eighty-five percent of participants stated that they fully intended to complete personal action plans to address children exposed to violence. More than 18 months after participation in a CSS education session, the number of participants who agreed or strongly agreed that they could a) define exposure, b) describe three ways it impacts children, and c) take appropriate action to help, remained above the immediate post-session target level of 85%. After the same elapsed time, most respondents (79%) also reported that

they were doing more personally to address children exposed to violence than they had done before the session. Finally, of 87 caregivers trained, 28 completed training evaluations. Of these 28, 93% reported that they could define exposure to violence, describe how exposure impacts children, and take action to help exposed children (Chicago Safe Start Initiative, 2005, p. 9).

National training and technical assistance. The CSS received training and technical assistance from the following national providers (Chicago Safe Start Initiative, 2005, p. 10):

- Abner Bowles/Kwesi Rollins, on sustainability
- James Lewis, on first responder and direct services
- Jane Glover, on literature and other resources
- Serena Hubert, on court action
- Patricia Van Horn, on case consultation/direct services

In 2005,<sup>4</sup> the Chicago Safe Start grantee also received technical assistance from the Institute for Community Peace (ICP) around strategic planning and collaboration with its partner agencies. ICP helped CSS staff to gauge its partners' sense of connectedness and satisfaction with the present course of the initiative, and interviewed key partners to help maximize the strength and function of CSS. One significant change that came out of the ICP assistance was the decision to replace CSS staff with

<sup>4</sup> This information was obtained shared by participants during the October 6 and 7, 2005 site visit conducted by the Safe Start Demonstration Project National Evaluation Team.

service providers as conveners and facilitators of the Community Councils in the Englewood and Roseland communities. Another significant change was the development of the Sustainability Committee as part of the Implementation Advisory Board. Through its strategic planning efforts, this subcommittee developed strategies that will sustain the CSS mission and vision beyond the federal funding period.

Chicago Safe Start staff leveraged the capacities of target communities, especially the existing platforms of violence prevention programs and collaborative partnerships, to further increase the capacity of service providers and caregivers. The ways in which CSS staff and partners worked together to create a comprehensive system of care responsive to children exposed to violence is described next.

#### **4. Community Engagement and Collaboration**

Chicago Safe Start (CSS) was a collaboration of community residents, community organizations, and city and state agencies responsible for serving or caring for children six years and younger. CSS staff and partners worked to expand and enhance the service delivery system to reduce the impact of exposure to violence on young children and their families through an Implementation Advisory Board and workgroups. Agencies involved included: Chicago Metropolis 2020 (n.d.)<sup>5</sup>, the Mayor's Office on Domestic

Violence, the Illinois Violence Prevention Authority, the Domestic Violence Mental Health Policy Initiative, Chicago Police Department, Chicago Public Schools, Illinois Department of Children and Family Services, Chicago Department of Child and Youth Services, Commission on Children and Violence, Partnership for Quality Child Care, Chicago Department of Public Health, LaRabida Hospital, Chicago Department of Human Services, Chicago Metro Association for the Education of Young Children - Commission on Children and Violence, University of Illinois - School of Social Work, Children's Home and Aid Society, Cook County Circuit Court - Child Protection Division, State's Attorney's Office, and Public Guardian's Office (Chicago Safe Start Initiative, 2005, p. 10).

The role of the Implementation Advisory Board was to ensure progress of the implementation plan by enhancing the service delivery system and developing and implementing strategies to influence system-wide change at the level of service provision. The IAB was established in 2002, replacing the prior CSS Steering Committee. Agencies with leadership and decision-making roles on the IAB were Chicago Metropolis 2020, the Chicago Police Department, the

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from traffic congestion to early childhood, with cooperation from the region's business, civic, government and its resident sectors to ensure that the Chicago region is a place where people want to work and live. The organization has been active in addressing early childhood education by convening the Early Care and Education Assembly (along with the Governor's Office), engaging business and civic leaders in early childhood public policy issues, and working with the local and state governments to address early childhood matters.

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<sup>5</sup> Chicago Metropolis 2020 is a non-profit organization started by the Commercial Club of Chicago. The purpose of Chicago Metropolis 2020 is to address regional challenges, ranging

Juvenile Court, the Mayor's Office on Domestic Violence, and the Illinois Violence Prevention Authority.

The IAB was made up of six implementation teams: 1) Direct Service Team, 2) First Responder Team, 3) Training Collaborative Team, 4) Data and Evaluation Team, 5) Public Awareness and Education Team, and 6) Court Action Team. The IAB also included the Englewood and Roseland Community Councils and two ad-hoc subcommittees: the Sustainability Committee and the City Group on Children Exposed to Violence. A description of the teams, councils, and ad hoc subcommittees follows Chicago Safe Start Initiative (2004c, p. 17):

- **Direct Service Implementation Team** developed and implemented a core program plan that defined the components of the family support services and mental health services provided under Safe Start. The team focused on the clarification of interventions, the tracking and achievement of impacts, increasing referrals and outreach, building partnerships with consumers and providers and the development of overall program sustainability.
- **First Responder – Incident Based Implementation Team** developed the detailed procedures and protocols for first responders to identify children at domestic violence and community violence (non-domestic) scenes and participated in developing procedures for linking these children and their

families to family support and/or mental health services, as appropriate. This team also was responsible for the development and oversight of the incident-based response system, made up of the first responder protocol; Domestic Violence Helpline referral card distribution; Helpline capacity development; and linkages between domestic violence and family support services, and emergency room and mental health/family support partners. Officers from the Chicago Police Department and the Chicago Fire Department Emergency Medical Services (EMS) are first on the scene of a domestic violence incident. Under the incident-based response system, these officers were responsible for referring affected family members to the Helpline, where they could access information about children exposed to violence.

- **Training Collaborative Implementation Team** identified, recruited, and collaborated with potential institutional partners to carry out research, training, and capacity building for service providers and first responders. The team emphasized knowledge and skill development driven by research findings, and also engaged in program evaluation and seeking resources for sustainability.
- **Data and Evaluation Implementation Team** provided consultation and support to the local evaluator team, ensuring

that appropriate process, outcome, and systems change data collection opportunities were identified, and that the data were collected and evaluated. This team also reviewed data collection instruments, supported the development of evaluation reports, and partnered with other pertinent evaluation-based initiatives to expand the programming and policy knowledge base around children exposed to violence. For example, the team was responsible for revising the evaluation logic model to achieve greater alignment with the CSS vision.

- **Public Awareness and Education Implementation Team** implemented campaigns to increase knowledge of the problem of children exposed to violence and of resources to treat or prevent violence exposure; these campaigns had the secondary goals of influencing public policy development and encouraging the existing system to respond to the needs of young children exposed to violence. For example, in collaboration with the Battered Women's Network, the Public Awareness and Education Team contributed to a children's art and photo exhibit during Domestic Violence Awareness Month.
- **Court Action Implementation Team** identified and advanced specific programs and policy development around children exposed to violence across

various offices and initiatives related to local courts (e.g., professional development, advocacy for increased capacity in services, refinement of court-related processes). The Court Action Team arranged training on CSS provider services for all child protection judges during one of their standing judges meetings. This also guided the identification and tracking of data underscoring the impact of exposure and intervention.

- **Community Councils - Englewood and Pullman** promoted public awareness, consumer engagement, service development and referral, as well as training consumers and professionals in the two Chicago Safe Start communities. A recent change in the councils was the replacement of CSS staff with CSS service providers as conveners and facilitators of council meetings.
- **Sustainability Committee** developed the overall sustainability plan, the funding strategy, and strategies to ensure institutional support of Safe Start.
- **City Group on Children Exposed to Violence** consisted of 1) staff of city and state agencies and community organizations and 2) community residents affiliated with CSS. City group members served on these teams, councils and subcommittees with a level of

involvement based on interest and areas of expertise.

In 2005, Chicago Safe Start staff increased its involvement with other organizations in the Chicago area working on issues related to children exposed to violence. For example, CSS service providers joined CSS staff on the Illinois Violence Prevention Authority board to work with the IVPA on its Safe from the Start initiative.<sup>6</sup> Safe from the Start coalitions were modeled after the Safe Start Demonstration Project.

CSS staff members and collaborative partners also served on the following leadership boards associated with children exposed to violence and their families: The Mayor's Office on Domestic Violence; the Illinois Teen Dating Violence Strategic Planning Board; Greater Englewood Health Advisory Board; Greater Roseland District Health Council; Developing Communities Project, Inc. Area-wide Taskforce; Chicago Police Department 5<sup>th</sup> and 7<sup>th</sup> District Domestic Violence Sub-Committees; and the Healthcare Consortium of Illinois (Chicago Safe Start Initiative, 2005, p. 20).

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<sup>6</sup> The Illinois Safe from the Start program was launched in 2001 with the goal of providing comprehensive support for very young children (five years and younger) who have been exposed to violence. For purposes of this program, children who have been exposed to violence include victims of abuse, neglect, or maltreatment; and children who have witnessed domestic violence, sexual assault, or other violent crimes. Six sites across Illinois with Safe from the Start coalitions received funding to plan and implement the program; all of these sites are now actively addressing the problem of children exposed to violence in their home and/or communities.

CSS was instrumental in fostering effective community engagement and collaboration among its staff, local provider agencies and members of the Roseland/Pullman and Englewood communities. Through its Implementation Advisory Board, CSS took advantage of existing linkages poised to formalize a system to help identify, assess and provide treatment for children exposed to violence and their families. The next section discusses in detail how this formalized system worked.

## **5. Systems Change Activities**

Chicago Safe Start staff and partners improved organizational identification and response protocols, coordinated and integrated services, enhanced services through training and engaged in several community awareness efforts to create a more responsive system of care for children exposed to violence. A central component of the CSS effort was the development of a service delivery pathway with both incident-based and symptom-based methods for identifying children exposed to violence was created as a central component of CSS (see IV-B). These system change activities are described in more detail below.

### ***5.1 Development of Policies, Procedures, and Protocols***

Several organizations modified their protocols to better identify children exposed to violence and refer them to CSS services. Specific examples include:

- Police in the Englewood and Pullman districts changed their protocol for responding to domestic violence incidents to include identification and referral of children exposed to violence;
- The city of Chicago's Domestic Violence Helpline (Helpline) modified its protocols to accept calls for services for children exposed to community violence and added CSS direct service agencies to its resources database;
- Family Focus and the Community Mental Health Council (both in Englewood) instituted referral/recruitment protocols. These agencies now not only track referrals within their individual agencies, but also keep track of referrals that they make to each other. Cross-agency referrals are made because the two agencies provide unique services: Family Focus provides family support services and CMHC provides mental health services. Recruitment from within existing caseloads also increases access to service providers trained to help children exposed to violence;
- The Safer Foundation (n.d.)<sup>7</sup> modified its management information system to include specific questions about children exposed to violence in order to guide referral for parenting education;
- The Chicago Department of Public Health and Maternal and Child Health clinics are refining their data collection around caring for young children and screening for children exposed to violence;
- Metropolitan Family Services streamlined its intake process, moving from a system in which CSS-related screening was shared across several staff members to one in which a full-time social worker began fields and screens all CSS cases. This procedural change led to more accurate information gathering and facilitated potential follow-up with clients; and
- Family Focus sends a counselor, once a week, to the Chicago Department of Human Services to conduct screening for children exposed to violence among Temporary Assistance for Needy Families (TANF) recipients. TANF provides a captive audience for Family Focus, linking receipt of assistance stipends to completion of a class on children exposed to violence.

These changes increased the likelihood that children exposed to violence would be identified and referred to CSS providers.

## ***5.2 Service Coordination and Integration***

CSS staff and partners developed two methods for improving service delivery. In the first method (i.e., incident-based response system), first responders from the Chicago Police Department and the Chicago Fire

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<sup>7</sup> The Safer Foundation is a private non-profit organization that helps ex-offenders help themselves stay out of prison and turn their lives around through re-entry services, monitoring, and training.

Department Emergency Medical Services EMS provided contact cards to families in domestic violence situations. These cards contained contact information for the Domestic Violence Helpline. Families who contacted the Helpline were referred to CSS service providers or traditional domestic violence service providers, who then fed the referrals to CSS staff to record the information for tracking purposes. Incident-based responders also began to refer cases directly to service providers. One challenge in this system, however, was the elapsed time between identification of a child by an incident-based responder and referral to a service provider. During this time lapse, families could be lost in the system, due to changes in addresses or phone number, or because the family moved on to address more pressing needs and/or lost a sense of urgency regarding mental health services after the crisis situation ended. This delay impeded the seamless flow of the service delivery system.

The second method for service delivery was symptom-based. This method involved community providers such as social service agencies, school administrators and teachers, and daycare center staff. Community members also formed a part of this system (i.e., community members could identify and refer children, as well). Symptom-based responders were trained to identify children exposed to violence in their immediate environment and refer them to CSS service providers. For example, Metropolitan Family Services, which houses both family support and mental health services divisions, incorporated a process that led to sharing of cases between these divisions. This change aided in improved identification, referral

and appropriate treatment within the agency (i.e., families received family support services, mental health services, or both, as needed). The CSS also supported the once weekly placement of a mental health worker from the Community Mental Health Council at Family Focus. This practice increased the likelihood of continuity in services for families, and, thus, the likelihood of continuation of services.

### ***5.3 New, Enhanced, and Expanded Programming***

Several agencies adopted training on issues of children exposed to violence to increase the ability of their service providers to recognize and respond to the specialized needs of these children. Specific examples include (Chicago Safe Start Initiative, 2005, p. 14 & 16):

- In 2005, the Chicago Department of Children and Youth Services implemented systemwide training for Head Start workers on children exposed to violence issues;
- The 2005 Community Development Block Grants for the Family Violence Initiative included expectations that its grantees would receive training on children exposed to violence;
- The Illinois Association of Family Childcare intends to develop training on children exposed to violence for all its members in 2006; and
- The CSS collaborative trained Helpline staff to effectively identify and refer children exposed to violence in the context of domestic violence calls. Helpline staff also received

training to identify and refer children exposed to community violence.

#### **5.4 Community Awareness**

A local marketing agency provided its services pro bono to the Chicago Safe Start grantee to develop a public awareness campaign focused on children exposed to violence. The products of this campaign included a video to educate police and EMS first responders on how to better respond to situations encountered in their work. The title of the video is “Responding to Child Victims and Witnesses - Improving Case Outcomes.” The agency also helped produce a video for parents with an accompanying storybook for children to share with their families. The storybook provides information on issues of children exposed to violence and a resource list of mental health providers and child-serving agencies.

Community members provided input on marketing materials throughout the production process. This involvement included feedback to the marketing agency on the training video for first responders. The dissemination of these materials to child-serving agencies and community members promoted the CSS ’s goal of increasing community awareness of children exposed to violence.

The CSS also helped to increase community awareness through its involvement in a variety of activities such as local parades, including the Bud Billiken Parade (an annual African American event) and the Englewood community Back-to-School Parade. CSS staff participated in the

Roseland/Pullman Annual Family Fun Day and sponsored educational forums targeting potential agency partners during National Domestic Violence Awareness Month. CSS staff participation in all of these community activities included the distribution of balloons, t-shirts, bookmarks, and other promotional materials with CSS information. A banner displayed year round at the Chicago Pedway also helped to improve community awareness.

Additionally, the following efforts provided opportunities for educating community residents, local businesses and community organizations:

- 2,500 door hangers displaying information about domestic violence and children exposed to violence were distributed door-to-door in the community (Chicago Safe Start Initiative, 2005, p. 17),
- 2,000 flyers about children exposed to violence and CSS resources were distributed (Chicago Safe Start Initiative, 2005, p. 17),
- Posters were displayed in community organizations and childcare centers,
- Five community health and safety fairs (Happy Healthy Kids Fests) were held,
- Workshops on children exposed to violence were conducted in the community,
- Presentations about children exposed to violence were made at social service agencies,
- ABC-7 aired a two-part series on children exposed to violence, and

- CAN-TV aired a program on children exposed to violence along with Prevent Child Abuse America.

In current awareness efforts, CSS direct service agencies are in the process of developing “CSS Ambassadors” from their past client base and other sources to help promote CSS in their communities. In addition, local CSS councils will develop community action plans (2006) to engage residents in response to specific violent events to help underscore the lack of acceptance of these events and their impact on everyone, especially young children.

Through these systems change activities, Chicago Safe Start designed and implemented an effective plan to identify, refer, assess, and treat children exposed to violence and their families. As a result of these activities, the following were accomplished (Chicago Safe Start Initiative, 2003; Chicago Safe Start Initiative, 2004a; Chicago Safe Start Initiative, 2005a):

- **1,386** children exposed to violence were identified between 2003 and 2005;
- **923** children were referred to CSS services between 2004 and 2005; and
- **474** children were screened by CSS providers between 2004 and 2005.

The CSS ’s formalized procedures for identification, referral, assessment and treatment of children six years and younger, coupled with mechanisms designed to embed its vision into the organizational structure of its partners and the mindset of

community members, led to institutional change at the system , agency, point-of-service, and community levels. Institutional change is addressed in the next section.

## 6. Institutionalization of Change

The mission and goals of CSS were institutionalized through the adoption of protocols by several organizations. These various protocols, described in detail in the preceding section, help to ensure the identification of children exposed to violence and referral to service providers trained to respond appropriately. In addition, CSS developed a “co-facilitation” model, or an “incubator” approach, to sustaining CSS practices and services. This model partnered CSS staff with other program staff to implement CSS-specific programming within other agencies (Chicago Safe Start Initiative, 2005, p. 23). Through training and technical assistance, CSS staff helped these “incubator” agencies integrate policies and procedures into their overall organizational structure, to guide the direction of efforts addressing children exposed to violence. The success of this approach was due in part to the inclusion of training as part of service provider agreements. Under these agreements, providers were obligated to work on multi-year plans to train clinical and counseling staff, facilitate in-house planning groups, and identify and include other satellite offices in the training. For example, through CSS train-the-trainer activities, Metropolitan Family Services has integrated identification and assessment of children exposed to violence into its six regional

sites as a result of its association with CSS in the Pullman community. Similarly, Family Focus integrated assessment instruments for children exposed to violence across its seven direct service centers in Chicago and surrounding suburbs.

Funding from other sources was obtained to continue key components of CSS, as well. CSS staff secured funding from the Illinois Violence Prevention Authority to sustain direct services to children exposed to violence in the target communities. The Chicago Department of Public Health committed to support two CSS staff positions (the education coordinator and the implementation coordinator) after federal support ceases; support for a third position is under discussion. The Department of Children and Youth Services committed \$100,000 to expand children exposed to violence training and materials to Head Start and early care providers in 2005 and 2006. The Department of Children and Family Services funded the collaborative in the amount of \$125,000 to produce the children exposed to violence awareness and response cartoon (2005; (Chicago Safe Start Initiative, 2005, p. 17).

## **7. Increased Community Supports**

Families and children exposed to violence have greater access to appropriate services as a result of CSS. All CSS trainings and materials provided families with resource information. The police and Helpline staff became important points of entry into services. The number of service providers in the target communities and citywide that are now capable of recognizing symptoms

associated with exposure to violence and responding to them effectively increased due to CSS programming and training efforts. Co-location of a CSS staff person within many of the city-, county-, and state- level clinics/programs in the community increased awareness of children exposed to violence and referrals to services. CSS service providers also expanded within-agency referral/recruitment into CSS programs (Chicago Safe Start Initiative, 2005, p. 18).

## **8. Reduced Exposure and Impact of Exposure to Violence**

Outcome data indicate that children and their caregivers significantly benefited from CSS services. These findings are described in detail in IV-C and are briefly summarized here.

Several instruments were used to assess exposure to violence and the impact of CSS services on reducing the impact of exposure to violence for participating families. Services included intake/assessment, case management, information and referral, service plan development, case collaboration, family support services, parenting skills education, individual adult therapy, crisis intervention, group therapy, and family therapy.

Therapists noted that 66% of children in services had no significant additional exposure to violence after treatment began, 24% did have additional significant exposure, and the remaining 10% of the children had unknown additional exposure (generally

because they prematurely terminated from treatment). Also according to therapists, parenting skills increased, such that caregivers were more aware of the effects of violence on children and were better able to manage the effects of exposure to violence for both their children and themselves.

Caregivers reported observing fewer trauma symptoms among their children post-intervention than they did pre-intervention. The decrease in symptoms was statistically significant for older children, though not for younger children.

Therapists' ratings indicated small, but significant improvements in child outcomes. Greatest improvement was seen in the ability to identify feelings, decrease in overall symptoms, improved pro-social skills, and improved management of anger and aggression. Children improved least in the area of posttraumatic stress disorder (PTSD) symptoms.

Therapists' ratings indicated significant improvement in caregivers' functioning as a result of treatment, as well. Following the intervention, caregivers showed significant improvements in their knowledge of children's exposure to violence, overall family functioning, understanding of children's appropriate developmental behavior, ability to take care of their own mental health needs following exposure to violence, and parenting skills. Caregivers improved least in the areas of supportive relationships and environmental stability.

The data also showed that caregivers improve more when services

were delivered in the home, and that children with no additional exposure to violence improved significantly more than children with continuing exposure. The more sessions children and caregivers attended, the more both improved. Children improved the most when services focused on identifying and expressing feelings, community violence, safety planning, or conflict resolution skills. Children improved the least when services focused on sexual abuse, media violence, or dealing with separation. When services for caregivers focused on appropriate discipline, parent-child communication skills, building a support system, or community violence, caregivers improved the most. When services for caregivers focused on safety planning or media violence, caregivers improved the least (Chicago Safe Start Initiative, 2005, p. 33).

## 9. Conclusion

The planning and implementation of Chicago Safe Start achieved a high degree of success as a result of two supportive and cohesive communities; local agencies that took the necessary steps to address issues related to children exposed to violence and their families; and a well funded, community-oriented governing body. With the further assets of an extensive and strategic collaboration plan, a training curriculum, and a community awareness effort that targeted key community and agency stakeholders, the CSS tapped into the existing strengths of the Roseland/Pullman and Englewood communities to establish a formal system of identifying, referring, assessing and treating children exposed to violence and their families. Without a

supportive and cohesive community, local agencies would not have participated in the development of a service delivery system capable of responding to children exposed to violence. Children and their caregivers significantly benefited from CSS services, including experiencing a reduction in exposure to violence while participating in services. The greatest challenge the CSS faced was counteracting the high levels of domestic and community violence in the two communities. Efforts are in place to

promote the CSS vision and mission and expand it to other areas of Chicago and throughout Illinois. These efforts include a comprehensive training curriculum and a capacity building mechanism that helped “incubate” the CSS vision within the structure of several organizations crucial for meeting the needs of children exposed to violence and their families. The CSS will leave a positive legacy in the Roseland/Pullman and Englewood communities.

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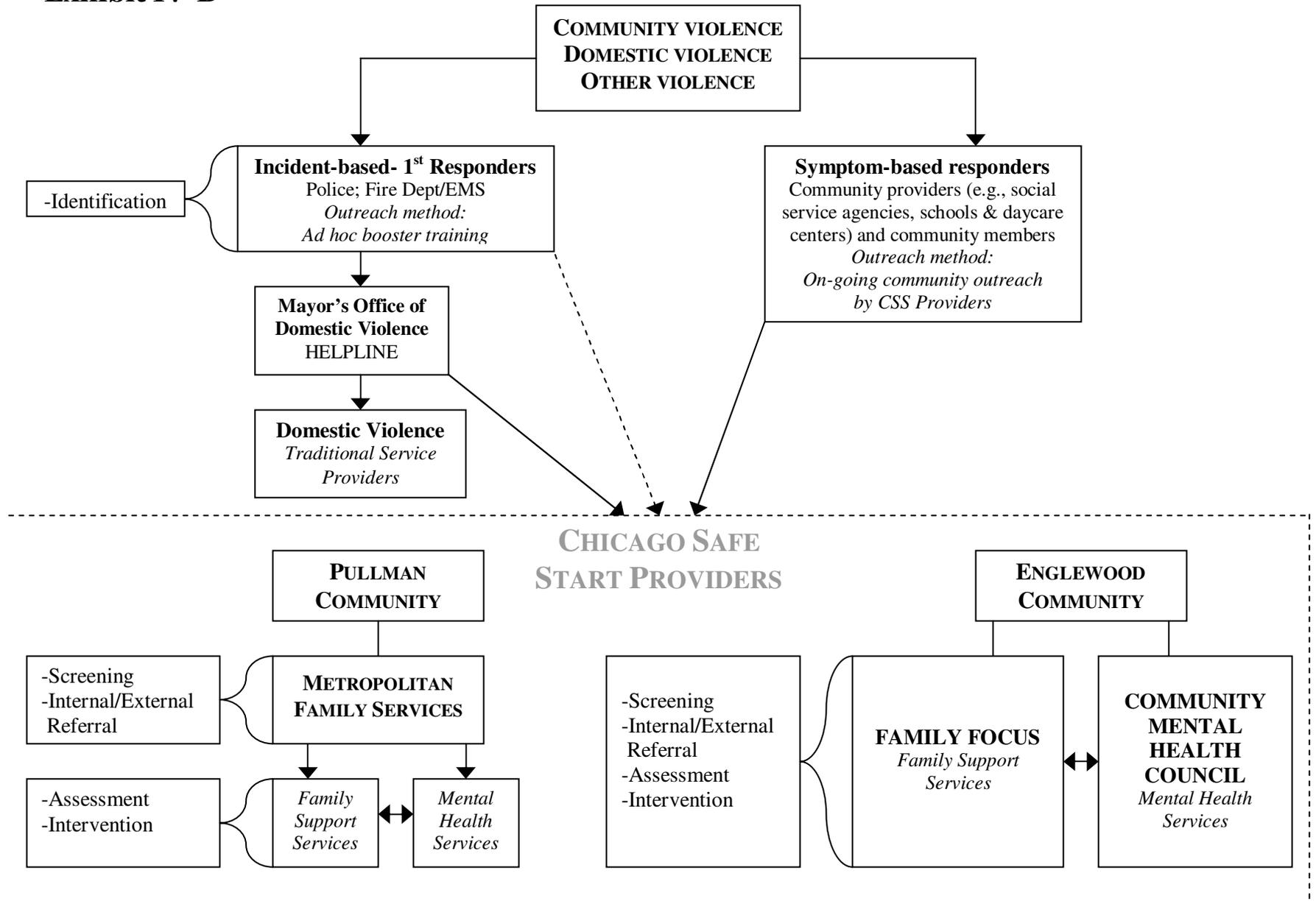
**Exhibit IV-A**  
**Timeline of Chicago Safe Start Initiative Activities and Milestones**

Major Milestones	1/00-6/00	7/00-12/00	1/01-6/01	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
Project Director position filled	✓											
Project Coordinator position filled		✓										
Community Needs Assessment		✓										
Public Awareness Campaign			✓	✓							✓	✓
Created initial CSS training curriculum				✓								
Two coordinator positions filled (education & implementation)					✓							
Implementation Advisory Board and workgroups <sup>25</sup>					✓	✓	✓	✓	✓	✓	✓	✓
Incident- and Symptom-Based Response System Monitoring					✓	✓	✓	✓	✓	✓	✓	✓
Intervention Research Report: Family Outcomes Pilot and Full Study					✓	✓	✓	✓				
Tier II funding awarded									✓			
Sustainability Plan Complete									✓			
Train-the-trainer training								✓	✓	✓	✓	✓
Roseland Safe Start Council forum												✓
Completed the preliminary draft of the CSS training curriculum												✓

Sources: Local Evaluation Report Form : 2004 and 2005; Evaluation Plan 2004; Progress Reports: January-June 2002; July-December 2003; January-June 2004; July-December 2004; January-June 2005; and July-December 2005

<sup>25</sup> The Internal Advisory Board and workgroups consist of the following: Chicago Metropolis 2020, the Mayor's Office on Domestic Violence, the Illinois Violence Prevention Authority, the Domestic Violence Mental Health Policy Initiative, Chicago Police Department, Chicago Public Schools, Illinois Department of Children & Family Services, Chicago Department of Child & Youth Services, Commission on Children & Violence, Partnership for Quality Child Care, Chicago Department of Public Health, LaRabida Hospital, Chicago Department of Human Services, Chicago Metro Association for the Education of Youth Children – Commission on Child & Violence, Mayor's Office, University of Illinois – School of Social Work, Children's Home and Aid Society, Cook County Circuit Court – Child Protection Division, State's Attorney Office, Public Guardian's Office. Source: LERF 2005 (p. 10).

**Exhibit IV-B**



## **Exhibit IV-C**

### **Chicago Safe Start Intervention Research<sup>26</sup>**

#### **Overview**

Chicago Safe Start (CSS) intervention research was designed to assess direct services (e.g., case management, counseling, family support services) to children exposed to violence and their caregivers (parents or guardians). To expand the evaluation of direct services beyond Family Focus, Metropolitan Family Services and Community Mental Health Council, CSS collaborated with a state-level violence prevention agency serving a similar population in different locations. A total of nine provider agencies, across Illinois, began providing joint reporting of direct services to children exposed to violence and their caregivers beginning in July 2004 (note: the services began earlier for both CSS and Safe from the Start). Assessments were conducted using the Child and Caregiver Completion of Services Forms which capture provider information such as therapists' credentials and experience, location and description of services provided, content of services, and therapists' ratings of outcomes for children and caregivers.

#### **Methods**

##### Sample

Three CSS sites plus six Safe from the Start sites served families using Safe Start-based treatment teams. Intake data were available for 233 children. Matched pre and post-intervention data from the CSS Questionnaire and the Trauma Symptom Checklist for Young Children (TSCYC) were available for approximately 65 children. Completion of Services Forms were available for 177 caregivers. Information from the Chicago Safe Start Intake/Screening Forms indicated that the average age of children served was 33 months old and 48% of children were female.

##### Procedures

Each CSS service provider administered the screening and assessment instruments to families before their participation in services. The TSCYC and CSS Questionnaire were completed before, during, and after intervention; and the Completion of Services Forms were completed by service providers after families terminated from services. CSS providers received monthly feedback regarding the completeness of their Safe Start case records.

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<sup>26</sup> The information summarized here is discussed in detail in the Local Evaluation Report Form (Chicago Safe Start Initiative, 2005), Section II. The local evaluator contributed significantly to the writing of this section. This information was also presented by the Chicago Safe Start local evaluator at a national evaluation meeting May 8 and 9, 2006 (Association for the Study and Development of Community, 2006).

Instruments used included:

- CSS Intake/Screening Form
- Family Referrals Form
- CSS Questionnaire
- Trauma Symptom Checklist for Young Children
- Child and Caregiver Completion of Services Forms

Impacts were assessed via the CSS Questionnaire, the TSCYC, and the Completion of Services Form. The TSCYC and the CSS Questionnaire were completed at the CSS sites only. The Child and Caregiver Completion of Services Forms were common to all sites. Family needs were identified via the Family Referrals Form, which providers used to track inter- and intra- agency referrals for additional services.

## **Results**

Pre-intervention exposure and symptoms. Sixty two percent of the children had been exposed to domestic violence, 46% had witnessed community violence, and 76% had repeated exposures to any type of violence.

The most common pre-treatment symptoms of exposure to violence were: “very protective of family members” (39%); “highly aggressive, emotional or distractible” (39%); and “often very emotional and exhibiting mood swings” (32%). For older children (between 37 and 72 months old), the following symptoms were noted most frequently: “very protective of family members” (56%); “highly aggressive, anxious, or distractible” (53%); and “cries often, very emotional, mood swings” (44%). Of note, caregiver reports indicated fewer symptoms for younger children (under 36 months) than for older children. Symptoms for younger children noted most often included: “cries often, very emotional, mood swings” (35%); “increased anxiety about separation from caregivers, increased clinginess” (32%); and “expressed fear often” (30%). The data indicated that children who had not yet completed services, or who prematurely terminated from services, were experiencing greater trauma symptoms at the time of intake. High family mobility and high stress communities were intervening factors.

Post-intervention outcomes. Therapists noted that 66% of children had no significant additional exposure to violence after treatment began, 24% did have additional significant exposure, and the remaining 10% of children had unknown additional exposure (generally because they prematurely terminated from treatment). Also according to therapists, parenting skills increased such that caregivers were more aware of the effects of violence on children and were better able to manage the effects of exposure to violence for both their children and themselves.

Caregivers reported observing fewer trauma symptoms among their children post-intervention than they did pre-intervention as measured by the TSCYC. The decrease in symptoms was statistically significant for older children, though not for younger children.

Inspection of the data from the CSS Questionnaire indicated that caregivers increased their scores on this measure; however this increase was not statistically significant. Inspection of the subscale scores revealed that increased knowledge of the impact of exposure to violence on young children was the area most impacted by intervention. Inspection of the means revealed that caregivers rated themselves well on 'self-care' and how to help their child even before services begin.

Therapists' ratings on the Child Completion of Services form indicated small, but significant improvements in child outcomes. Greatest improvement was seen in the ability to identify their feelings, a decrease in overall symptoms, improved pro-social skills, and improved management of anger and aggression. Children improved least in the area of posttraumatic stress disorder (PTSD) symptoms.

Therapists' ratings on the Caregiver Completion of Services form indicated significant improvement in caregivers' functioning as a result of treatment. Following the intervention, caregivers showed significant improvements in their knowledge of children's exposure to violence, overall family functioning, understanding of children's appropriate developmental behavior, the caregiver's ability to take care of their own mental health needs following exposure to violence, and parenting skills. Caregivers improved least in the areas of supportive relationships and environmental stability.

Other data showed that caregivers improved more when services were delivered in the home, and that children with no additional exposure to violence improved significantly more than children with continuing exposure. The more sessions children and caregivers attended, the more both improved. Children improved the most when services focused on identifying and expressing feelings, community violence, safety planning, or conflict resolution skills. Children improved the least when services focused on sexual abuse, media violence, or dealing with separation. When services for caregivers focused on appropriate discipline, parent-child communication skills, building a support system, or community violence, caregivers improved the most. When services for caregivers focused on safety planning or media violence, caregivers improved the least (Chicago Safe Start Initiative, 2003, p. 33).

Additional analyses assessed the relationship between the content and characteristics of services and outcomes for children and caregivers as measured by the Professional Summary Report sections of the Completion of Services Forms. First, the correlation between number of sessions the child and caregiver attended and the child and caregiver outcomes (e.g., the Professional Summary Report or PSR) was assessed. The number of sessions that caregivers attended was significantly correlated with both child and caregiver outcomes. As could be expected, the number of sessions a child attended was significantly correlated with child, but not caregiver, outcomes.

Next, the relationship between additional exposure to violence and outcomes was assessed. Overall, the analysis of variance was significant. Inspection of the means revealed that children with no additional exposure to violence improved the most, while children who had continued exposure to violence or for whom additional exposure to

violence was unknown (usually because these families dropped out of treatment prematurely) had little or no improvement.

Finally, in order to better understand the relationship between the content of interventions offered to children and their caregivers and the outcomes of services, a series of regression analyses were performed. First, the association between caregiver interventions and caregiver and child outcomes was examined, followed by an additional regression analysis examining the relationship between the content of services for children and child outcomes.

For the first regression analysis, the association between the number of sessions and the content of the interventions, and caregiver outcomes as measured by the PSR were assessed. Overall the model was significant ( $F(19,184)=7.95$ ,  $p<.001$ , adjusted R-square = .39), accounting for nearly 40% of the variance in caregiver PSR scores. Of the predictor variables, parent-child communication skills, appropriate discipline, and gang involvement were significantly and positively associated with caregiver PSR scores, while media violence and safety planning were significantly and inversely related to caregiver outcomes. For the second regression analysis, the association between the number of sessions and the content of the interventions, and child outcomes were assessed. Overall the model was significant ( $F(19,137)=2.15$ ,  $p<.01$ , adjusted R-square = .12), accounting for over 10% of the variance in child PSR scores. For child outcomes, the number of sessions the caregiver attended and appropriate discipline were significantly and positively associated with child PSR scores, while domestic violence and anger management skills were inversely related to child outcomes.

Finally, the association between the number and content of the child interventions, and child outcomes were assessed. Overall the model was significant ( $F(25,81)=3.88$ ,  $p<.001$ , adjusted R-square = .404), accounting for over 40% of the variance in child PSR scores. Identifying/expressing feelings, community violence, good touch/bad touch, safety planning, and decision making skills were significantly and positively associated with child PSR scores, while sexual abuse, media violence, and dealing with separation were inversely related to child outcomes.

## **Discussion**

This unique multi-site evaluation of services for children exposed to violence and their caregivers offers an interesting picture of both services and outcomes. At the conclusion of services, therapists rated caregivers as significantly improved on the PSR. To a lesser extent, therapists also rated children as significantly improved on the PSR.

The finding of positive correlations between the number of sessions attended and outcomes supports the validity of this evaluation. As could be expected, the more sessions caregivers attended, the more caregivers *and* children improved. However, the number of sessions that children attended influenced child, but not caregiver outcomes. The common sense nature of these results provide evidence for the validity of this evaluation.

Another finding that provides evidence for the validity of this evaluation is children with no additional exposure to violence improve significantly more than children who continue to be exposed to violence. This is a common sense finding that has clear implications for practice. When working with children exposed to violence, ending the children's exposure to violence should be the first goal addressed by services.

Clearly, some of the more interesting findings of this study were the results of the regression analyses. When services for *caregivers* focused on parent-child communication skills, appropriate discipline, or gang involvement, *caregivers* improved the most. This finding may indicate that when services focus on the concrete behaviors of parent-child communication and appropriate discipline, caregivers might get some immediate relief. Also, ending involvement in gangs or limited exposure to gang activity seems to also offer caregivers immediate relief. When services for *caregivers* focused on safety planning or media violence, *caregivers* improved the least. It's likely that when services focused on safety planning, the caregiver was in immediate danger from domestic violence. In these cases, slower therapeutic advances could certainly be expected. When media violence is a focus of treatment, *floor effects* might come into play where the caregivers and children might not have been experiencing serious symptoms or difficulty functioning at the start of services.

Similar to the finding for caregiver outcomes, when services for *caregivers* focused on appropriate discipline, *children* improved the most. Teaching parents appropriate ways to discipline their children appears to have benefits both for children and caregivers.

Also, when services for *caregivers* focused on domestic violence or anger management skills, *children* improved the least. Again, children might be slow to experience therapeutic gains when caregivers seek services for these types of presenting problems. Or it may be that anger management services and domestic violence services for caregivers provide little benefit for children. For adult, these services were not significantly associated with outcomes.

When services for *children* focused on identifying/expressing feelings, community violence, good touch/bad touch, safety planning, or decision making skills, *children* improved the most. These types of services should be considered when working with children exposed to violence. A focus on community violence was also positively and significantly associated with outcomes. This finding might reflect the situation that children exposed to community violence are likely to improve more quickly than children exposed to domestic violence or sexual abuse. This interpretation is supported by the finding that when services for *children* focused on sexual abuse, *children* improved the least. Similarly, "dealing with separation" was inversely associated with outcomes for children, suggesting that these issues might require longer services, more intensive services, or a different type of intervention to help children dealing with separations and losses. Keep in mind that the average number of sessions attended by children was only seven.

Clearly, one limitation of this research was that the ratings of the service providers were used to evaluate outcomes. So the service providers were essentially evaluating themselves. While the results appeared to be valid, the study would have been strengthened by an outside observer's evaluation of outcomes (perhaps the caregiver's or a teacher).

Furthermore, the implications for interventions resulting from this evaluation would have been strengthened by an experimental design where families were randomized into clearly proscribed interventions. Instead, interventions were individualized and were largely (and perhaps most appropriately) shaped by the families' presenting problems. None-the-less, this evaluation provides important information that service providers should consider when developing treatment plans for families. Interventions for caregivers addressing appropriate discipline and parent-child communication skills should be encouraged and further developed. For children, increased attention should be paid to interventions that address identifying/ expressing feelings, good touch/bad touch, safety planning, and decision making skills.

## **Summary**

### **Overall Improvement**

- At the conclusion of services, therapists rated caregivers as significantly improved on the PSR.
- To a lesser extent, therapists also rated children as significantly improved on the PSR.

### **Number of Sessions**

- The more sessions children attended, the more children improved.
- The more sessions caregivers attended, the more caregivers improved.
- The more sessions caregivers attended, the more children improved.

### **Continued Exposure to Violence**

- Children with no additional exposure to violence improve significantly more than children who continue to be exposed to violence.

### **Content of Services**

- When services for *caregivers* focused on parent-child communication skills, appropriate discipline, or gang involvement, *caregivers* improved the most.
- When services for *caregivers* focused on safety planning or media violence, *caregivers* improved the least.
- When services for *caregivers* focused on appropriate discipline, *children* improved the most.
- When services for *caregivers* focused on domestic violence or anger management skills, *children* improved the least.

- When services for *children* focused on identifying/expressing feelings, community violence, good touch/bad touch, safety planning, or decision making skills, *children* improved the most.
- When services for *children* focused on sexual abuse, media violence, or dealing with separation, *children* improved the least.

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# V

## Pinellas Safe Start Initiative

### 1. Overview

Pinellas Safe Start (PSS) was developed and implemented by building upon the county's tradition of collaboration. Key service providers likely to be accessed by families with young children exposed to violence were engaged in an assessment and planning process that resulted in a three-tiered collaboration structure and the development of an integrated service delivery model. One collaborative body, the Leadership Council, was established to provide policy and programmatic oversight for PSS. The second collaborative body, the Safe Start Partnership Center (SSPC), was formed to enhance, coordinate, and create services. The third level of collaboration involved community partners that were less directly involved in policy and programmatic oversight, but who were important to PSS's implementation due to missions overlapping with that of Safe Start.

Central to PSS was the Safe Start Partnership Center, composed of five agencies: Help-A-Child, 2-1-1 Tampa Bay Cares, The Haven, CASA, and the Pinellas County Health Department. These agencies received funding from Safe Start in response to a competitive bid to implement an integrated service delivery model as a collaborative body. Contractual responsibilities associated with Safe Start funding included using a common definition of "children exposed to violence;" implementing protocols for

systematic screening, identification, and referral of children exposed to violence and their families; providing information about children exposed to violence to parents and caregivers; contributing service data to the evaluation; and working toward a shared client information system.

The SSPC agencies brought together the perspectives and expertise of domestic violence services, child protection and related clinical services, public health (especially violence prevention and home visiting/family support), and community resource information and referral. Collectively, these agencies offered a service continuum ranging from prevention and early intervention (e.g., home visiting/family support, information about community resources) to crisis services and treatment (e.g., domestic violence and child protection services). The SSPC agencies were well positioned for early identification of children exposed to violence due to the large number of families with young children that used their services for other reasons. To fill a gap in the services of existing agencies, PSS developed and funded intensive and individualized service components (e.g., comprehensive family assessment, family support), specifically for children exposed to violence.

PSS also developed and funded (at least in part) two additional services for children exposed to violence. The Clearwater Child Development-

Community Policing (CD-CP) Program was established in Pinellas through training and technical assistance from the National Center for Children Exposed to Violence, coordinated by PSS. There was no program of this type prior to Safe Start. PSS also enhanced Coordinated Child Care by funding a Safe Start trained staff person for the existing Project Challenge program. The Safe Start consultant enhanced existing services by providing more home visits and parent support than other Project Challenge staff. Coordinated Child Care also received funding to participate in the local evaluation and to contribute data for the comparison group included in the intervention research study.

Together, the Safe Start Partnership Center, the Child Development-Community Policing Program, and Coordinated Child Care's Safe Start-enhanced Project Challenge (Enhanced Project Challenge) accomplished the following between May 2002 and December 2005 (Pinellas Safe Start Initiative, 2006)

- **8,388** young children exposed to violence were identified through Safe Start programs between May 2002 and December 2005;
- **2,406** young children exposed to violence were referred to services between May 2002 and December 2005; and
- **558** young children exposed to violence were assessed by a Safe Start Family Advocate, a CD-CP clinician, or the Project Challenge Safe Start consultant to develop appropriate support and service plans between May 2002 and December 2005.

PSS increased community awareness of children exposed to violence, increased the community's capacity to respond to these children and their families, and may have reduced parental stress through its intensive family services. Key components of PSS will continue with the support of local funding, after federal funding ends. This case study report summarizes how PSS accomplished these outcomes and under what conditions

### **1.1 Mission**

The mission of PSS was to prevent and reduce the impact of violence on young children and their families by enhancing and integrating the supports and services offered by community providers, agencies, and institutions, and by creating a community culture of valuing, caring for, and safeguarding children. How did PSS accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in the following sections, and a timeline of major events is attached (Exhibit V-A).

### **1.2 Pinellas County, Florida**

PSS was planned and implemented within the unique context of Pinellas County, Florida. The following snapshot of Pinellas County is intended to help others interested in replicating Safe Start to compare their own communities to Pinellas County.

Pinellas County is located on Florida's West Coast, bordered by the Gulf of Mexico to the west and Tampa Bay to the east. The county has a land area of 280 square miles, with an

average 3,339 residents per square mile as of 2002, making it the most densely populated county in Florida (Pinellas County Government, n.d.). According to the 2005 Census estimate, Pinellas County had a total population of 928,032 (U.S. Census Bureau, 2005). The county's population is largely European American (87% in 2000), with significant African American (9% in 2000), Hispanic or Latino (5% in 2000), and Asian (2% in 2000) populations (U.S. Census Bureau, n.d.). 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 (Pinellas Safe Start Initiative, 2005, p. 6). The median household income in most zip code areas of Pinellas County was between \$27,000 and \$36,000 in 2000; about 17% of households, however, were estimated to have incomes under \$15,000 (Pinellas Safe Start Initiative, 2005, p. 5). According to 2000 Census estimates, 71% of homes in Pinellas County were owner occupied (U.S. Census Bureau, 2000). As of September 2005, the median cost of an existing single-family home in Pinellas County was \$215,200 (Pinellas Safe Start Initiative, 2005, p. 5-6).

## **2. Contextual Conditions**

PSS was implemented within a political, economic, and social context that affected both the initiative and the broader community's response to children exposed to violence.

### **2.1 Political Context**

PSS operated within a state policy environment that mandates collaboration and coordination of services among the key sectors that serve families with young children—goals consistent with Safe Start. Florida's political context is favorable for reducing children's exposure to violence through a coordinated response to families. For example, the State of Florida has 25 Community Child Care Coordinating (4C) agencies as part of its system for providing scholarship child care for families who need help paying for child care while they work to become self-sufficient (Coordinated Child Care of Pinellas, Inc., n.d.). The 4C agencies act as a primary resource for children, families, providers, and employers; their main office is located in Pinellas County. As another example of the favorable political context in Florida, the state mandates the use of Domestic Violence-Child Protection Agreements, thereby requiring domestic violence service providers and child protection agencies to agree on how they will communicate when an allegation of abuse involves a child or parent who may be staying at a domestic violence center (Pinellas Safe Start Initiative, 2005, p. 1). The Pinellas agreement includes a specific goal to reduce the impact of violence exposure on children and calls for staff cross-training on children's exposure to violence. Furthermore, the Unified Family Court model calls for "one family-one judge," i.e., a fully integrated, comprehensive approach to handling all civil court cases involving any family member when the family is involved in a dependency case. The original Unified Family Court in Pinellas County was implemented through grant funding in 2002; since then, the unified approach has become

state recommended policy (Pinellas Safe Start Initiative, 2005, p. 1).

In contrast to the favorable political context for Safe Start, local implementation of a state mandate to privatize all child protective services and create Community-Based Care.<sup>1</sup> negatively impacted PSS's goal of coordinating agency responses to children exposed to violence. The private service provider awarded the initial service contract as lead agency for Community-Based Care in Pinellas and Pasco Counties seriously impeded the local system's ability to serve children and families in need, by operating in isolation from others in the service community. A change in the lead agency for Pinellas County's Community-Based Care in spring 2004 required considerable stakeholder time and energy; Safe Start staff was actively involved in the planning and transition process, which included changes in leadership, organization, and strategy.

More broadly, the complexity and fragmentation of the child protection system in Pinellas County created challenges for implementing an integrated service delivery strategy for children exposed to violence. The number of entities responsible for various components of service delivery helps to illustrate the complexity of the system. The Sheriff's Office investigates

child maltreatment reports. The Safe Children Coalition (which includes the lead agency for Community-Based Care and multiple service providers) provides case management, foster care, adoptions, and other child protection services. The Child Protection Team at Help-A-Child provides forensic exams and some clinical services. The State's Attorney's office prosecutes perpetrators of child abuse and neglect. A combination of public defenders and private attorneys represents families. Within this system, prevention and home-based intervention services are not formally connected with child protection services and out-of-home care. Finally, huge case loads for child protection service workers impede high quality service delivery and contribute to large numbers of children removed from their families. All of PSS's resources could have easily been consumed by efforts to improve coordination of services within the child protection system alone.

## **2.2 Economic Context<sup>2</sup>**

PSS unfolded within a relatively healthy local economic environment that supports services for children and families. The Juvenile Welfare Board (JWB) of Pinellas County, a local independent taxing authority that plans, funds, and coordinates social services for children and families, provides a secure local funding source for many human and health services in the county. In the last few years, local tax revenue has increased in Pinellas County, its municipalities, and the Juvenile Welfare Board. While the increased revenues have not resulted in increased support of

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<sup>1</sup> 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.

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<sup>2</sup> Information summarized in this section was reported in the local evaluation report form (Pinellas Safe Start Initiative, 2005, p. 3).

children's services by the County or municipalities, they have at least allowed these funding sources to remain steady, protecting some children's service providers from feeling the impact of recent trends toward reduced state funding. Many agencies and programs, however, are experiencing funding reductions; because state funding continues to be the mainstay of most child welfare programs in Pinellas County, Florida's economic conditions have a direct impact on the availability of resources for human services in the county. On the other hand, changes in recent legislation may provide new funding opportunities. For example, the Revenue Maximization Legislation now allows the Juvenile Welfare Board.

While children's services in Pinellas operate within a relatively stable funding environment, the large geographical area and complex system of services created challenges for Safe Start in developing and implementing a coordinated response to families and children exposed to violence. Differences in funding, regulation, and state and federal policy and priority create an environment in which service agencies and organizations often function in isolation from each other. These same differences create various eligibility requirements that can make it difficult for families to navigate the system and obtain needed services.

### **2.3 Social Context<sup>3</sup>**

The need for PSS remained clear throughout its implementation, as the Pinellas County community continued to

experience unacceptable rates of domestic violence and child maltreatment. In 2003, the rate of domestic violence in Pinellas County was 935 per 100,000. The Pinellas Domestic Violence Task Force estimated that for each incident of family violence reported, nine incidents go unreported. In 1999, an estimated 15% of the population of children six years and younger were exposed to violence or at high risk for exposure. Since PSS began systematic screening, more than 8,000 children six years and younger have been identified as exposed to violence. An examination of SAMIS<sup>4</sup> data from three recent fiscal years finds that over 600 participants in JWB-funded agencies reported "children exposed to violence" as the primary reason for participation in JWB-funded programs. As a final example of need for services, as of August 2005, Florida's child abuse/neglect rate was 31.5 per 1,000 children; only two other U.S. states have rates above 20 per 1,000.

The state recently announced a goal of cutting child abuse in half over the next five years, reflecting Florida's social commitment to reducing this extreme form of exposure to violence. In general, the professional community of service providers has shown its commitment to addressing the issue of violence broadly, as well the specific issues of the impact of violence on young children, through its support of PSS. It is less clear how important this issue is among the general public.

In summary, PSS unfolded within very specific contextual

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<sup>3</sup> Information summarized in this section was reported in the local evaluation report form (Pinellas Safe Start Initiative, 2005, p. 7-9).

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<sup>4</sup> SAMIS is Services and Activities Management Information System, a web-enabled reporting program for fiscal and case participant data.

conditions. In addition, Pinellas County has unique community capacities for planning and implementing an initiative such as Safe Start. A primary objective of the Safe Start Demonstration Project was to mobilize collaborative relationships for the purpose of coordinating service providers to offer a comprehensive response to families with young children exposed to violence. The service provider network in Pinellas County was prepared to do just that, and had many resources available for developing a comprehensive response. In turn, PSS was able to increase community capacity as it was implemented over time.

### **3. Community Capacity**

According to site visit (2004, 2005) participants, Pinellas County is “resource rich” and a place where there is a “history and willingness to collaborate.” The professional community, therefore, was well positioned to develop a comprehensive and coordinated response to children exposed to violence. Information provided in the 2005 Local Evaluation Report Form (pp. 10-11) supports this characterization. For example, as described above, the Juvenile Welfare Board is a secure funding source for many human and health services in Pinellas County, including PSS services. In addition, several service providers in the county share a commitment to, and expertise in, children and families, facilitating their investment in PSS (see, for example, the 2004 *2-1-1 Tampa Bay Cares Resource Guide*). Many service providers in the county (e.g., Healthy Families Pinellas, Total Family Strategies) have a long history of

collaborating to better serve children and families—a tradition PSS built upon successfully. According to 2005 site visit participants, individuals representing the organizations that implemented Safe Start programs have, in many cases, worked together over the years on various projects. In addition, many of these individuals participate in the numerous coalitions that exist in Pinellas County (e.g., Community-Based Care Coalition, Safe Children Coalition, Domestic Violence Task Force, etc.). At the county level, two major efforts to expand comprehensive community planning capacity are in the implementation stage: (1) the formation of a Health & Human Services Coordinating Council and (2) the development of a social indicator website useful for grant applications, community planning, and the general public (Pinellas Safe Start Initiative, 2005, p. 2).

#### **3.1 Training and Technical Assistance**

PSS and local partners have offered the professional community specialized training opportunities to increase their capacity to serve young children exposed to violence. Between July 2002 and December 2005, 8,302 service providers and community members received training affiliated with PSS, whether through its full training curriculum, a brief or enhanced presentation, or sponsorship (e.g., PSS paid for clinicians to receive training in Child-Parent Psychotherapy and Parent-Child Interaction Therapy; Pinellas Safe Start Initiative, 2006; Pinellas Safe Start Initiative, 2005, p. 21). Trainings provided by Safe Start staff were evaluated using surveys. On recent

surveys, 82% of 167 respondents reported that the training information would be useful to them in their work; 79% thought it would be useful to them in their personal life; 93% reported that the training was informative; and 94% reported that the training was beneficial (Pinellas Safe Start Initiative, 2005, p. 23).

In addition to training available through PSS, the Juvenile Welfare Board offers over 200 half- and full-day workshops, training sessions, conferences, and other education programs annually, a number of which are directly related to young children exposed to violence.

PSS also wrote a series of eight reports that summarize key project activities, with the goal of making these reports available to other practitioners in the community. The report series is expected to provide one source of information for service providers interested in learning about and from the Safe Start project. Safe Start reports will be made available through the National Center for Children Exposed to Violence and through the Juvenile Welfare Board's library.<sup>5</sup>

PSS worked with the National Civic League (NCL) to bring national expertise and resources to bear on local efforts to improve infant mental health and the child welfare system. The National Civic League made four site visits (November 2002, June 2003, May 2004, June 2005) for the purpose of

meeting with site staff and collaborative members to assess the site's strengths, challenges, and progress relative to training and technical assistance. PSS recently used NCL funds to bring in Alicia Lieberman and Charles Zeanah, two noted psychologists specializing in young children and trauma, as the keynote speakers for the Florida Association of Infant Mental Health conference. PSS also received technical assistance from the National Civic League for a research project: "Removal Factors in Child Welfare Cases" (Pinellas Safe Start Initiative, 2005, p. 23)

Within the context of these community conditions and through the support of local and national technical assistance, the community was engaged in the planning and implementation of PSS, and collaborative partnerships were created. How the community was engaged and the collaborative structures that resulted are discussed next.

## **4. Community Engagement and Collaboration**

Initial engagement of the professional community was achieved during the early assessment and planning phases of PSS. Community stakeholders participated in the initial community assessment that was conducted to inform planning efforts. Local agencies were also engaged in initial planning efforts through strategic planning work groups.

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<sup>5</sup> Pinellas Safe Start hopes to make reports available through the Pinellas Safe Start Initiative (n.d.), however final arrangements for the website in the future have not been confirmed.

#### **4.1 Community Engagement: Professionals<sup>6</sup>**

Safe Start grant staff, with support from JWB and many community stakeholders, conducted early assessment activities; contractual consultants conducted specific studies. Assessment of the community and local service agencies was critical to planning the implementation of PSS. One study, for example, estimated the number of Pinellas children exposed to violence or at high risk for exposure, to project the number of children likely to access services. The initial community assessment found that many children were exposed or at risk; that no systematic community response was available; and that there were many resources available in the community that could be mobilized, enhanced, and coordinated to improve the response to children and their families to reduce the impact of exposure. In recognition of these findings, the Safe Start program was designed to be countywide, to provide multiple points of entry, to link existing services, and to provide consistent messages in training and community awareness throughout the county. The Safe Start Partnership Center (SSPC; described in more detail in sections 4.3 and 5.1) was formed as a result of the community planning process.

The initial community assessment also indicated that many young children were losing child care placements due to severe behavior problems. Early childhood system representatives who participated in the

planning process suggested that some portion of these children were exhibiting behavior resulting from violence exposure. Subsequently, Coordinated Child Care added screening questions to its family needs questionnaire to help identify exposure to violence as a source of behavior problems, and PSS funded a Safe Start specialist within the early childhood.

During two phases of assessment and planning activities, local agencies were engaged through strategic planning work groups. Eleven work groups were created, with members reflecting over 113 organizational constituencies. Work groups studied the issues, contributed data, participated in program design, wrote sections of the plans, and in some cases reviewed and provided feedback on the overall PSS grant application. The frequency and duration of involvement of each work group participant differed based on expertise and resources.

The planning group's desire to inform service providers about children exposed to violence and early childhood development led to the 2001 creation of the PSS Training Curriculum and Trainer's Guide (with revisions continuing through 2006). Because PSS recognized the ongoing need for service providers and caregivers to have information about children's exposure to violence, one role of the Safe Start Partnership Center was defined as a clearinghouse for information on children exposed to violence and local resources (2002).

Overall, the first phase of assessment and planning occurred between May 1, 2000 and April 30, 2001. The second phase of assessment

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<sup>6</sup> Information summarized in this section was reported in the local evaluation report form (Pinellas Safe Start Initiative, 2005, p. 29-30).

and planning occurred between May 1, 2001 and October 31, 2002. In other words, assessment and planning continued through the initial implementation stage.

#### **4.2 Community Engagement: Parents and Caregivers**

Key findings from the PSS social marketing study conducted in 2002 indicated low levels of awareness in the community about the effects of exposure to violence, as well as about appropriate services and programs. Participants in the study (e.g., community leaders, child care providers, and parents/caregivers) expressed strong agreement that the primary sources of exposure were domestic violence and the media (Pinellas Safe Start Initiative, 2005, p. 31). The social marketing study was conducted prior to implementing any public awareness campaign; findings from the study were used to design the public awareness materials and strategies. Educating caregivers about issues of children exposed to violence was achieved through the PSS website (2003), the Public Awareness Campaign (2003), the Safe Start Partnership Center Outreach Plan (2003), education programs for parents and caregivers at high risk of perpetrating or experiencing domestic violence (2004; Batterers Intervention Program, Project Success, Alpha House, YWCA homeless shelter for families and young children), and the Community Engagement Project (2004). All of these strategies for engaging parents and caregivers continued through 2006.

Increased awareness of children exposed to violence among community members and service agencies was cited

as the single biggest achievement of PSS in 2005. According to a number of site visit (2005) participants, the community engagement component of PSS “got its legs” in 2005; this accomplishment was attributed primarily to the efforts of the community outreach coordinator and the neighborhood facilitators and ambassadors in his charge. Ambassadors and facilitators were recruited to help deliver Safe Start’s message, as well as the tools and resources necessary to reduce the number of children witnessing and impacted by violence, through presentations to community and professional groups and by building partnerships with local sponsors, philanthropists, and media outlets. As of October 31, 2005, 46 PSS ambassadors (volunteers) and five facilitators (under contract) had made 39 presentations to over 500 community members in a wide variety of community groups and organizations, including day care, early childhood education, health and social services, and civic groups. Ambassadors and facilitators reached parents and other family members through presentations at local shelters, neighborhood family centers, and churches.

#### **4.3 Collaboration<sup>7</sup>**

PSS used a three-tiered collaboration structure, allowing agencies to choose a level of involvement in the project based on their interest and commitment. The structure, composed of a Leadership Council (1), the Safe Start Partnership Center (2), and

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<sup>7</sup> Information summarized in this section was obtained through personal communication (e.g., in-person discussions, telephone conversations, email) with the Pinellas Safe Start project director.

community partners (3), was generated through a community planning process.

The most formal voluntary collaborative body was the Leadership Council, which met quarterly, and served as the official leadership and decision making group for PSS. The Leadership Council was made up of agencies with a role in the system of care for children exposed to violence (such as child protection, courts, law enforcement, and the School Board) and broad based coalitions with related missions (such as the Domestic Violence Task Force, Healthy Start Coalition, Early Learning Coalition, and Community Councils). Agency representatives were formally designated or appointed by agency senior management, and coalition representatives were designated by a constituent body of the coalition. The Council had both voting and non-voting members. Voting members approved funding requests to OJJDP, were responsible for strategic planning, determined Council membership, determined the Council's organizational structure, and decided on letters of support when pursuing funding. These members reached their decisions by consensus. Over the five year course of the grant, numerous work groups, request-for-proposal teams, and ad hoc committees formed and disbanded to address specific tasks and issues; however, products and recommendations of these groups were always brought back to the Leadership Council for action or consent. These groups included community partners and staff of funded agencies, as well as Leadership Council members.

The Safe Start Partnership Center, a funded service delivery

collaborative with contractual obligations to PSS, was a smaller collaborative within PSS comprised of a lead agency (Help-A-Child) and four other subcontracted point-of-service providers (2-1-1 Tampa Bay Cares, The Haven, CASA, and Pinellas County Health Department; each is described in more detail in section 5.1). SSPC was funded to implement an integrated service delivery model for children exposed to violence, through a request-for-proposal process. Memoranda of Understanding (MOUs) regarding partner roles and responsibilities outlined some aspects of SSPC's contractual obligations to Safe Start.

Contractual responsibilities included using a common definition of "children exposed to violence;" implementing protocols for systematic screening, identification and referral of children exposed to violence and their families; providing information about children exposed to violence to parents and caregivers; contributing service data to the evaluation; and working toward a shared client information system. Partners formally agreed to train staff in their own agencies on issues related to children exposed to violence and how to implement screening, identification, and referral protocols and provide information to families. Partners participated in interdisciplinary staffing meetings as well as informal problem solving for families with complex needs. In addition, partners developed parent education materials to be used by all agencies, and shared responsibility for meeting community education and training goals. In this way, the SSPC functioned as a central point of contact for agencies and the community for children exposed to violence, by

providing information, referrals, and training. SSPC communication and collaboration were maintained through regular meetings of management and direct service staff; the SSPC held “Partnership” meetings bimonthly and “Direct Service” meetings monthly. Two other agencies that received Safe Start funding to deliver services related to children exposed to violence often participated in SSPC meetings as well as SSPC coordinated events.

The Safe Start Leadership Council and the Juvenile Welfare Board (the lead agency for PSS) regularly reviewed the extent to which SSPC partners were meeting their contractual obligations. Partners were able to accept their contractual responsibilities due to the guidance and approval of the Leadership Council. In addition, SSPC partners received funding sufficient to allow senior-level staff to participate in interagency meetings, planning, and training.

Community partners (PSS collaborative tier 3) included organizations or individuals with missions similar to that of PSS, for example, key agencies in children’s mental health, family services, and other related sectors, as well as citizen’s groups and community leaders.

Membership within the three tiers of collaboration overlapped in some cases. The Leadership Council consisted of decision-makers from organizations, while the SSPC was made up of program managers from partnership agencies, as well as front line staff with daily operations knowledge. Community partners collaborated with PSS, but had no contractual obligations. Community

partners had looser connections to the project, and varying degrees of investment and involvement. Nevertheless, Leadership Council meetings were open to the community, allowing community partners to attend as interest dictated. Community partners could and did bring issues to the table, and input from community partners was considered in decision-making.

## 5. System Change Activities

PSS changed the service provider network by building the capacity of existing services to respond to young children exposed to violence, coordinating existing services, and creating new services to fill gaps in the network. Service integration was accomplished by creating formal partnerships among service providers (e.g., the Safe Start Partnership Center, Clearwater Child Development-Community Policing), which allowed for identifications and referrals among agencies to be coordinated and sequenced in a way that made sense for families. The SSPC received funding to develop an intensive family service component specifically geared toward assessing the impact of violence exposure and supporting families to make changes in their lives and to access other services if needed. In addition, PSS established the Clearwater Child Development-Community Policing Program through training and technical assistance, and assisted the program in securing funding for a full time coordinator. PSS also funded a Safe Start specialist to enhance Coordinated Child Care’s existing Project Challenge services, leading to the addition of a violence exposure screening question to

Coordinated Child Care's family needs assessment, and a home visit component for families identifying children exposed to violence as a concern. Integration was also accomplished through involvement of PSS in broader community efforts to coordinate responses to families experiencing domestic violence and with children exposed to this violence.

### ***5.1 Safe Start Partnership Center: An Integrated Service Delivery Model<sup>8</sup>***

Safe Start Partnership Center. The Safe Start Partnership Center was the centerpiece of PSS's approach to improving services for children exposed to violence. SSPC offered services ranging from early identification (e.g., through systematic screening by partner agencies, and information and referrals provided to families at any point of entry), to intensive and individualized family services (e.g., comprehensive assessment and family support, service coordination, and multi-disciplinary staffing when needed) for children exposed to violence, offered in the home or community setting by family advocates and a case manager housed at Help-A-Child. (See Attachment B for a model of the PSS pathways to service.)

The SSPC provides a model for coordinating the professional community's response to families with children exposed to violence or at risk of

exposure. SSPC's coordination of responses included building the capacity of service providers to identify children exposed to violence, to assess and prioritize the needs of these children and their families, and to connect families and children to the services that would best meet their needs in a sequence that made sense for the family. For example, one family might have resources such as stable housing, employment, and health insurance, making therapeutic services for the young child and parents the most appropriate referral. This family might be referred directly to a mental health provider in the community, such as Directions for Mental Health. Another family, however, might have unstable housing, lack employment and insurance, and might still be experiencing violence in the home. This family would likely be stabilized first to meet basic needs (e.g., safety plan, shelter housing if desired, etc.), and then therapeutic services might be offered. The latter family might be a good fit for the intensive family services component of SSPC.

Together, the Safe Start Partnership Center, the Child Development-Community Policing Program, and Coordinated Child Care's Safe Start-enhanced Project Challenge (Enhanced Project Challenge) accomplished the following between May 2002 and December 2005:

- **8,388** young children exposed to violence were identified through Safe Start programs between May 2002 and December 2005;
- **2,406** young children exposed to violence were referred to services between May 2002 and December 2005; and

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<sup>8</sup> Information summarized in this section was obtained during site visits (November 9 and 10, 2004, and November 14 and 15, 2005); local evaluation report form (Pinellas Safe Start Initiative, 2005a, p. 17-20), and the Semi-annual Progress Report (Pinellas Safe Start Initiative, 2005b, p. 1).

- **558** young children exposed to violence were assessed by a Safe Start Family Advocate, a CD-CP clinician, or the Project Challenge Safe Start consultant to develop appropriate support and service plans between May 2002 and December 2005.

To accomplish these outcomes, the PSS partners had to develop, enhance, and expand policies and daily practices. One key objective of the SSPC was to develop collaborative interagency protocols for identifying, referring, and providing services to children exposed to violence, and also for sharing information on client cases. The goals for identifying children were (1) to provide parents/caregivers with information about children exposed to violence and (2) to provide appropriate referrals. SSPC developed parent information materials to be used by all partner agencies; partnership agency representatives met regularly to establish common protocols for intake and referral and to work toward a shared client information system. Between 2002 and 2005, 50 policies were created, enhanced, or expanded to accomplish the goals of the Safe Start Partnership Center. For example, because of PSS, each agency in the SSPC began to identify children exposed to violence using some set of questions or information from their existing intake and/or questions added to their intake/assessment forms. The following summarizes the information and criteria that the partners used to identify children exposed to violence and to document program statistics:

- **CASA and The Haven** (the domestic violence centers). All

children six years and younger who entered shelters were assumed to be exposed or at high risk of exposure to violence and therefore were “counted” as “identified.” In addition, parents attending domestic violence support groups or other community outreach activities were asked about children six years or younger; the support group sign-in sheet was designed with a space for parents to indicate the presence of children six years or younger in the home. These children were considered exposed or at high risk of exposure and were counted. Parents were given information about children exposed to violence to ensure that identification would lead immediately to services.

- **Pinellas County Health Department.** Forms used by family home visitor staff to document various types of information gathered during the visit (e.g., risk factors and services) included a code for domestic violence and children’s exposure to violence. When domestic violence was coded, children exposed to this violence were counted in the formal “identified” tally reported to OJJDP. Parents were given information about children exposed to violence to ensure that identification would lead immediately to services.
- **2-1-1 Tampa Bay Cares.** Phone counselors followed a protocol that included questions about immediate safety issues if the initial request for information

seemed to indicate violence as a factor and the involvement of children. If domestic violence was an initial concern, counselors referred the caller to domestic violence services and counted the child (the same child would be counted again if he or she presented at a shelter). Depending on circumstances, 2-1-1 Tampa Bay Cares also referred to the SSPC or to other community programs, based on family interest, location, etc. Parents were given information about children exposed to violence to ensure that identification would lead immediately to services.

- **Help-A-Child.** The Child Protection Team reviewed child abuse reports and tallied the indicators of domestic violence in the case at first report. At this point, the tally represented statistical information only, although the Team sometimes made recommendations to child protection investigators (i.e., the Sheriff's office), based on record review. The Team also flagged cases for further follow up, including further exploration of domestic violence factors in the case and a potential referral or consultation with SSPC regarding children exposed to violence. Parents were given information about children exposed to violence to ensure that identification would lead immediately to services (except during the initial review of Child Protection Team reports).

## ***5.2 Safe Start Services for Children Exposed to Violence***

Intensive family services component of the Safe Start Partnership Center. Families with at least one child six years or younger known to be exposed to violence were referred for comprehensive assessment and family support when needs were complex and barriers to services existed that the program making the identification could not address. Families referred to the intensive and individualized service component of the SSPC typically needed additional help to sort out priorities and access services.

The intensive family services component took a holistic family approach. Families in intensive services received comprehensive assessment, crisis support, and short-term support/case management to help them sort out complex situations. Further, intensive service providers developed an individualized plan of action for each family, negotiated barriers to accessing services, and helped the family make changes in lifestyle and situation to improve child safety and well-being. The goals of intensive services were to support and strengthen parental understanding of violence exposure and its impact on the child/family, increase parental ability to address a child's needs, and help the family link with longer term supports and services that might be needed to help the family continue on a path to improve child safety and well-being. In some cases, the priorities were treatment/intervention for parents, along with appropriate child care and improved parenting skills. In other situations, the plan called for

longer term therapeutic services and specialized child care for the child.

Families that received intensive Safe Start services also were referred to other services, based on identified needs. The Safe Start Partnership Center kept records of the number of referrals made to agencies on behalf of children exposed to violence. Between October 2003 and September 2005, 210 children exposed to violence were assessed by family advocates. Each child received at least one referral for further assistance based on his or her exposure to violence. A total of 260 referrals to mental health, medical, education, and "other" services were made; 127 of these referrals (49%) resulted in the delivery of services.

Clearwater Child Development-Community Policing. Clearwater is the only Child Development-Community Policing (CD-CP) site in Florida. CD-CP was implemented in Clearwater in 2001 through training and technical assistance provided by PSS and the National Center for Children Exposed to Violence (NCCEV). Although it started on a volunteer basis, with a focus on community policing squads, CD-CP in Clearwater is now citywide, and the entire police department has received training regarding the effects of violence on children.

A team of police officers and mental health clinicians met to develop the training for the police department. The team wanted to present the information in such a way that even hardened veteran officers could relate to the experiences of children living in violent environments.

In the operation of the CD-CP, mental health clinicians from Directions for Mental Health, Inc. were paired with officers from the Clearwater Police Department. All CD-CP referrals came from police officers. Officers at the scene of a violent incident requested an on-call clinician to come to the scene, or made a referral to the CD-CP Coordinator to follow up with the family the next day. The police-mental health team provided crisis intervention and attempted to restore a sense of security for the child after a traumatic incident. Safety planning was completed with both the child and the parents. Information was provided to parents about the effects of violence on children. A brief assessment was completed to determine the needs of the child and family, and appropriate referrals were provided.

Coordinated Child Care: Enhanced Project Challenge. Coordinated Child Care (CCC) is the central agency for child care resource and referral in Pinellas County. It assists Pinellas County families with finding children care, helps low/middle income families pay for child care, provides improvement resources for child care providers, and provides other family support and education services. CCC also offers developmental screening and behavioral services, such as Project Challenge, that are open to any child in a child care program, public or private, in Pinellas County. Eligibility criteria for Project Challenge include: the child is five years or younger; the child is attending a child care program; and the child is having behavioral or emotional problems in that setting. CCC also manages child care subsidies

(scholarships) for eligible children through consolidation of public funds.

Coordinated Child Care was enhanced by the addition of a Safe Start trained staff person to the existing Project Challenge program; the Safe Start consultant improved the capacity of the system to serve children impacted by violence by providing more home visits and parent support services than other Project Challenge staff. Safe Start also has enhanced staff training for child care providers through offering regularly scheduled workshops related to children exposed to violence.

Because of PSS, Coordinated Child Care added a question to its existing family needs questionnaire, which is used at intake, eligibility re-determination, or referral to special children's services. This question asked whether the child has experienced something potentially upsetting ("such as an auto accident or family violence"). When a family responded "yes," staff followed up to confirm violence exposure, and a referral (voluntary) was made to the CCC Safe Start specialist.

### **5.3 Community Partners/Broader Network: System Enhancements and Integration<sup>9</sup>**

Early Childhood Mental Health Services. PSS, in partnership with Directions for Mental Health and the National Child Traumatic Stress

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<sup>9</sup> Information summarized in this section was obtained during site visits (November 9 and 10, 2004, and November 14 and 15, 2005); and was reported in the local evaluation report form (Pinellas Safe Start Initiative, 2005a, p. 13 & 25).

Network, offered clinicians from several agencies and private practice two extended training opportunities. Two evidence-based treatment models were taught: Child-Parent Psychotherapy and Parent-Child Interaction Therapy. Clinicians trained in these models have the capacity to respond more effectively to families affected by violence.

Domestic Violence-Child Protection Coordination. Collaboration between domestic violence victim services and child protection services has increased significantly in Pinellas County in the past five years. This has been due in large part to the efforts and involvement of PSS, and is particularly significant, given historic differences in perspective between the two service systems with regard to children's exposure to violence, the complex and somewhat ambiguous body of law, and the lack of clarity around when/if children's exposure to violence constitutes child maltreatment and what the legal response should be.

Since its inception, PSS has been actively involved with the agencies and coalitions that comprise both the county's Community-Based Care system for child welfare and the domestic violence system. For example, the Domestic Violence Task Force developed guiding principles for a coordinated community response to domestic violence cases involving children. The SSPC provides a specific example of coordination between the domestic violence and child protection systems. The county's two certified domestic violence providers (CASA and the Haven) are part of the SSPC, along with Help-a-Child, which has under its umbrella the Child Protection Team;

medical foster care; and the Exchange Club, a child abuse prevention program. The other SSPC partner, Pinellas County Health Department, is also the lead agency for several home visiting model child abuse prevention programs, under the “Healthy Start” umbrella; this includes Healthy Families Pinellas, one of the largest Healthy Families groups in America. An example of the potential benefit to children of coordination between the domestic violence and child protection systems is seen in a family with young children that enters a shelter and appears to be in need of specialized assessment and support (e.g., for children exposed to violence). Shelter staff could contact the SSPC family advocates or the case manager at Help-A-Child, to set up an initial visit with the family at the shelter within 48 hours or less. Alternatively, if the SSPC case manager at Help-A-Child was working with a family in need of domestic violence services or a consultation about domestic violence issues or legal issues, he or she could quickly connect the family with a domestic violence advocate. The CCC Safe Start specialist also worked closely with the SSPC direct services team, to connect families identified in child care settings with domestic violence services.

Batterer’s Intervention Program. In January 2004, PSS contracted with a qualified provider to offer a weekly Batterer Intervention Program (BIP) in the Pinellas County jail. The content was enhanced in collaboration with the Domestic Violence Task Force, to include information in each session about the impact of violence on children and available community resources. Because domestic violence centers receive police reports upon arrest for

domestic violence, they are able to do outreach to families of those arrested, which in turn provides opportunities to screen for children exposed to violence and to provide information and referrals to the non-battering parent.

Project Success. Project Success, an educational program operated at the jail by the Pinellas County Sheriff’s Office, is aimed at preparing mothers in jail for release. Since 2003, Safe Start has provided quarterly workshops to participants on children exposed to violence and community resources. The jail has served as an important community venue for Safe Start workshops, along with other venues likely to see exposed or at-risk children and their families (e.g., Alpha House, a program for unwed mothers; the guardian ad litem program; the YWCA homeless shelter for families with young children; Head Start).

## **6. Institutionalization of Change**

PSS accomplished several of its original objectives and as a result made several lasting changes in the service delivery system.

### **6.1 System and Agency Change**

Local funding was obtained to continue key programs (Pinellas Safe Start Initiative, 2005a, p.2). The following PSS programs were funded by the Juvenile Welfare Board or the County.

**LOCAL FUNDING TO CONTINUE CHILDREN EXPOSED TO VIOLENCE PROGRAMS THAT STARTED WITH**

OJJDP SAFE START FUNDING			
	Amount	Funder	Year Awarded
SSPC	\$296,000	JWB	FY 2005-06
CD-CP	\$70,000	JWB	FY 2004-05
CCC	\$54,000	JWB	FY 2005-06
Batterer Education	\$5,000	County/PCSO	FY 2005-06

In addition to continuation of funding, several other sources of evidence indicate the ways in which PSS has permanently changed the service provider network. The Leadership Council will continue meeting due to the importance of a coordinated response and the need to maintain an interagency advocacy for the issue. Increased referrals over two fiscal years indicate dissemination of information across agencies and within agencies regarding Safe Start and children exposed to violence. PSS not only improved awareness and knowledge about children exposed to violence and appropriate services, but also willingness to make a referral. According to key stakeholders (service providers), service delivery has improved since PSS implementation.

Eighty five percent of Key Informant Survey participants (2005) thought the service provider network's ability to identify children exposed to violence had improved since Safe Start was initiated. Ninety percent thought the network's ability to assess identified children had improved since Safe Start was initiated. And 88% thought the network's ability to make referrals for identified and assessed children had improved since Safe Start was initiated. The majority of individuals surveyed

agreed that service provision for children exposed to violence had improved since the implementation of PSS (Pinellas Safe Start Initiative, 2005c, p. 3).

### 6.2 Point of Service Change

In addition to increased service coordination and additional services for children exposed to violence, PSS has resulted in more public and private clinicians in Pinellas County trained to effectively respond to young children and their families. Clinicians trained in evidence-based models were surveyed during the summer of 2005. All respondents reported that the training had changed their practice. Child-Parent Psychotherapy trainees were asked to estimate the fraction of their current caseload in which they were implementing the model; responses ranged from 3% to 99%, with an average of 42%. Parent-Child Interaction Therapy trainees were asked to make similar estimates; responses ranged from 0% to 60 or 70%, with an average of approximately 20% (Pinellas Safe Start Initiative, 2005a, p. 14).

### 6.3 Community Change

PSS has made information about children exposed to violence and related programs more readily available. A website hosted by 2-1-1 Tampa Bay Cares promotes Safe Start messages on children exposed to violence and information on how to get help. The program tracks the number of visits to the website as an indicator of information dissemination; from the time of its launch in December 2003 through September 2005, the website received over 7,300 contacts (Pinellas Safe Start Initiative, 2005a, p. 39). Informational

materials developed for parents and caregivers are provided when parents of children exposed to violence are contacted in person. Training has provided another avenue for disseminating information about the program; training efforts appear to be effective, as a survey of 99 staff members at five local agencies found that 82% of those surveyed knew at least one method for contacting PSS (Pinellas Safe Start Initiative, 2005a, p. 44). The Safe Start Partnership Center also has provided training at local colleges and at grand rounds at a local hospital to inform staff members and students about screening for domestic violence and exposure to violence in children. In the future, the Safe Start Partnership Center will continue to function as a central point of access to information and existing community resources, as well as a source of expertise in working with families experiencing violence.

Finally, the PSS public awareness campaign has provided the community with information about children exposed to violence and where to get help, using brochures and public service announcements on both television and radio and at public events. The Tampa Bay Devil Rays partnered with PSS in public awareness events in 2004 and 2005; the Rays' support for PSS is expected to continue in the future (Pinellas Safe Start Initiative, 2005a, p. 48). The PSS Community Engagement Project provided some evidence for improved public awareness of children exposed to violence. All attendees (38 for four presentations) reported better understanding of issues related to children exposed to violence and ways to respond to children who have been exposed (Pinellas Safe Start Initiative,

2005a, p. 46-47). Although PSS did not obtain a significant level of corporate support for media buys, billboards, etc., Safe Start was able to produce high quality materials on a modest budget, and to distribute these materials via volunteers and agencies to generate some sustainability (the first priority for the campaign). The SSPC is expected to continue to provide community education and training through some of the venues and contacts identified during the grant period.

## **7. Increased Community Supports**

The support available to Pinellas County families experiencing violence has increased through OJJDP Safe Start funding; improved support will be sustained with local funding, as several Safe Start programs will continue to provide services to children exposed to violence. The Safe Start Demonstration Project may be thought of, therefore, as a community-level intervention. Important community-level changes that ultimately impact family and child well-being include changes in social norms that reduce public tolerance of exposing children to violence and changes in the service system responsible for helping families experiencing violence. An informed and responsive community is essential for improving child and family well-being. Without strong community support, both professional and public, fewer families experiencing violence are likely to receive the help they need to make a change. PSS changed the community by improving the coordination of services, enhancing the quality of services available to families with young children exposed to violence,

making additional services available to these families, and increasing public awareness of children exposed to violence.

## **8. Reduced Exposure to Violence**

The long term vision for the National Safe Start Demonstration Project and for Pinellas is that over time, with increased awareness of children exposed to violence and more preventive services, fewer children will be exposed; however, Pinellas did not anticipate, nor propose to OJJDP as an outcome, that a measurable reduction in children's exposure would result during the period of the grant. Evidence that fewer Pinellas County children are being exposed to violence because of PSS was therefore not systematically gathered. Nevertheless, preliminary evidence exists that PSS has increased public awareness of the issues associated with children's exposure to violence and how to get help.

## **9. Reduced Impact of Exposure to Violence**

Of ultimate interest are the child and family results achieved by PSS. Are families with young children exposed to violence better off because of services provided by PSS? PSS determined the effect of its specialized services on children using a comparison group study (see Attachment C for a more detailed summary of PSS's intervention research). Three groups were compared: children and families served by the SSPC intensive family services component, the Project Challenge Safe Start group, and the Project Challenge comparison group. In the two Safe Start

groups, total parental stress decreased during participation in the intervention, but the changes were not statistically significant. Information about changes in child well-being is not yet available because only five families have completed the child measure.

Given an expected influence on the well-being of both parents and their children, parents' needs and resources also were examined. As predicted, parents with more needs reported higher stress and more negative perceptions of their children. In contrast, as resources available to parents increased, their stress levels decreased, and their perceptions of their children were more positive. Generally speaking, therefore, a parent's ability to cope appeared to be related to the parent's abilities and not to his or her child's characteristics.

PSS experienced typical challenges to its research design, specifically, attrition and compliance with comparison group assignment. Families do not always participate in services long enough to meet the data collection needs of research and, even if they do, they may not agree to comply with the demands of data collection. Service providers often prioritize meeting the immediate needs of children and families over the information needs of researchers, even if the information may one day improve services.

Documentation of changes in child and family well-being for all 8,388 children identified as exposed to violence was not feasible. Tracking change for this number of children and their families would have required an unprecedented level of data coordination and sharing among service providers,

assuming that all of these families were engaged successfully in some form of intervention and participated long enough to achieve outcomes. Nor was it possible to track child and family-level outcomes for all Safe Start programs (e.g., CD-CP) and partners (e.g., CASA, The Haven, Pinellas County Health Department, 2-1-1 Tampa Bay Cares). Furthermore, it was not within the scope of the PSS evaluation or resources to evaluate child outcomes after clinicians were trained in either Child-Parent Psychotherapy or Parent-Child Interaction Therapy (Van Horn & Lieberman, 2006).<sup>10</sup> On the other hand, it was possible to examine the effectiveness of the specialized intervention components administered by Safe Start project staff at Help-A-Child and Coordinated Child Care for some children and their families.

Given that it took five years to develop the capacity and coordination among service providers to identify children exposed to violence, however, it does not seem unreasonable to think that it will take an equal amount of time for the network of providers to agree on common outcomes and to integrate the necessary data collection procedures into daily practice. In short, due to lack of the necessary data, it is not possible at this time to fully determine the impact of PSS on children and families.

## 10. Conclusion

The primary focus of this project was to change the knowledge, attitudes, and behaviors of human service professionals, to enable these

professionals, in turn, to help change the knowledge, attitudes, and behaviors of families with young children who have been exposed to violence. Change was achieved through effective leadership and capacity building, development of a central point of access to services and information, enhanced and intensive services, and securing resources for sustaining these changes. PSS's strongest achievements were the ways in which the project enhanced and integrated supports and services for families with young children exposed to violence; however, data limitations prevent definitive statements about the project's success in reducing the impact of violence exposure. The success of the public awareness campaign was commensurate with the investment of resources. The Key Informant Survey, responses of community training participants, and the number of web site visits all indicate a significant increase in awareness and concern about children exposed to violence in Pinellas County. Two challenges that PSS faces in the immediate future are establishing system-wide data sharing practices and identifying new champions for children exposed to violence as dedicated as the current leadership core in Pinellas County. The fact that Safe Start programs will continue and that PSS has been recognized by the state as a resource for coordination between the domestic violence and child protection sectors in its five-year plan to reduce child maltreatment perhaps best attest to the project's positive influence in the community over the last five years.

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<sup>10</sup> Both therapeutic models are evidence-based.

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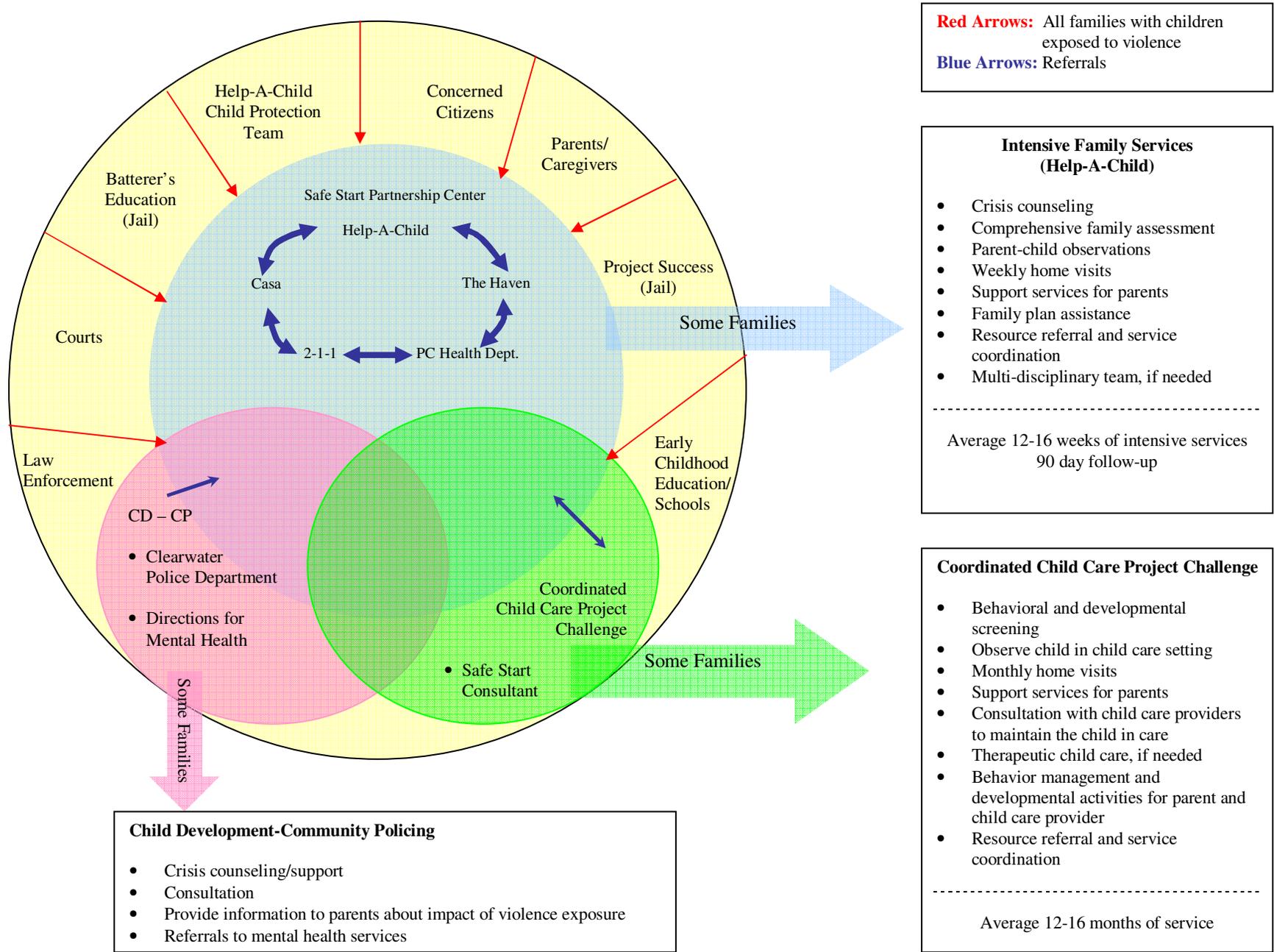
**Exhibit V-A**  
**Timeline of Pinellas Safe Start Initiative Activities and Milestones**

Major Milestones	1/01-12/01	1/02-12/02	1/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
Community assessment conducted	✓	✓					
Training Guide & Curriculum developed	✓	✓					
• Revisions on-going		✓	✓	✓	✓	✓	✓
Leadership Council (formed & ongoing)	✓	✓	✓	✓	✓	✓	✓
Development of shared information systems: SAMIS (Services and Activities Management Information System)/TBIN (Tampa Bay Information Network)				✓	✓	✓	✓
Social marketing study		✓					
CD-CP (Child Development-Community Policing Program)		✓	✓	✓	✓	✓	✓
• 31 individuals received training through the CD-CP project				✓	✓		
Safe Start Partnership Center (formed & ongoing)		✓	✓	✓	✓	✓	✓
Children's Summit			✓		✓		
Development of the Pinellas Safe Start website ( <a href="http://pinellassafestart.org">pinellassafestart.org</a> )			✓				
Project Success			✓	✓	✓	✓	✓
Help-A-Child intensive family services (formed & ongoing)			✓	✓	✓	✓	✓
• Case Worker position established							✓
Coordinated Child Care (CCC)/Enhanced Project Challenge			✓	✓	✓	✓	✓
• Contract established with CCC/Project Challenge			✓				
• CCC created a new position devoted to working with Safe Start; JWB allocated Safe Start funds for this position			✓				
• CCC Safe Start Specialist position filled			✓				
Intervention research				✓	✓	✓	✓
• Tier II measure: Temperament and Atypical Behavior Scale (TABS)					✓	✓	✓
• Tier II risk/protective factors						✓	

Major Milestones	1/01-12/01	1/02-12/02	1/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
Public awareness campaign				✓	✓		
Community engagement project				✓	✓	✓	✓
• Community Involvement and Training Coordinator position filled				✓			
• Ambassador program started with training for first 23 ambassadors				✓			
• Neighborhood facilitators hired						✓	
Batterer's Intervention Project				✓	✓	✓	
Intensive mental health services training				✓	✓		
• 13 individuals trained in parent-child interaction therapy				✓	✓		
• 16 mental health professionals trained in child-parent psychotherapy				✓	✓		
Dependency court study (factors for removal)							✓

Sources: LERF, 2004 and 2005; Progress Reports, January-July 2002, January-June 2004, July-December 2004, and July-December 2005.

Pinellas Safe Start Service Delivery Model Showing Pathways to Service



## **Exhibit V-C**

### **Pinellas Safe Start Intervention Research<sup>1</sup>**

#### **Overview**

Pinellas Safe Start's intervention research was designed to evaluate service system improvement and the impact of SSPC's intensive family services component (a home-based program) and Coordinated Child Care's Project Challenge (a childcare-based program). These two interventions were developed to reduce the impact of exposure to violence on young children. Both interventions provided families and children with comprehensive assessment and screening, behavioral observations, counseling and consultation, home visits, and resource referral and service coordination. A comparison group study was used to investigate the effects of these interventions (e.g., service provision) on children. Differences in parent stress and parent-child dynamics among three groups of children and families (two intervention groups and one comparison group) were examined. The information summarized here is discussed in detail in the 2005 Local Evaluation Report Form, Section II (pp. 3-11; pp. 20-21).

#### **Methods**

Two methods were used to conduct Pinellas Safe Start's intervention research.

##### Service System Improvement (Method 1)

##### Sample.

The sample consisted of 56 Pinellas County service providers. The largest group of respondents represented non-profit organizations that are non-faith based (45.3%). Thirty percent of respondents represented governmental agencies. Another 13.2% of respondents represented faith-based organizations, and 11.3% represented for-profit organizations. Fifty-five percent of the respondents were in management positions, and 45% were in direct service positions. Over 83% of the key informant respondents had worked for their agency for three or more years. Almost half (41%) of the respondents were employed at their agency for 10 or more years. The average length of employment was 11 years.

##### Procedures.

Key informant telephone interviews were conducted in 2002. This protocol was followed in 2005 with one modification: the questionnaire was mailed to key informants. The Key Informant Survey was sent (January 2005) to 120 stakeholders involved with the Pinellas Safe Start project. The survey asked for retrospective recall to compare the current state of services for children exposed to violence and services two years before

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<sup>1</sup> For a complete description of Pinellas Safe Start's intervention research, refer to the local evaluation report form (Pinellas Safe Start, 2005).

Safe Start was implemented. Fifty-six completed surveys were returned, for a 47% response rate.

The survey included a total of 28 questions developed to measure the contributions of Pinellas Safe Start in raising awareness of children exposed to violence and strengthening service provision for children and their families (see Appendix 1 of the 2005 Local Evaluation Report Form for a copy of the survey). Responses to three questions were used to describe service providers' perceptions of service improvement. These questions were:

**(Q 20)** What do you think of the CEV service provider network member's ability to identify children who are exposed to violence?

**(Q 21)** What do you think of the CEV service provider network member's ability to assess children who are exposed to violence once they are identified?

**(Q22)** What do you think of the CEV service provider network member's ability to make referrals for children who have been exposed to violence once they have been identified and assessed?

Response options for these questions were:

- They are much better now
- They are somewhat better now
- They are about the same now as they were
- They are somewhat worse now
- They are quite a bit worse now
- Don't know

## **Intervention Impact (Method 2)**

### Sample.

Information about the characteristics of the families that participated in the intervention research was extracted from client case files.

**Group 1** (89 families). Parents and children in Group 1 participated in SSPC's intensive family services component. A majority (77.9%) of the parents were Caucasian. Parents, on average, were 41 years old. Three-fourths of the parents had an income level below \$20,000 a year. Most parents (83.4%) had earned a high school diploma or had obtained higher levels of educational achievement. The mean number of adults in the household was 2.1. Eighty-eight percent of the parents were not married. On average, parents and children in Group 1 participated in the program for 95.65 days. Children ( $N = 44$ ) in Group 1 were predominantly Caucasian (72.7%). The average age of children in this group was 4.00 years. On average, these children had 1.31 siblings.

**Group 2** (31 families). Parents and children in Group 2 participated in Coordinated Child Care's (CCC) Enhanced Project Challenge program. The Enhanced program included a Safe Start consultant trained to help childcare providers understand the behavioral symptoms that can indicate exposure to violence. A majority (82.4%) of the parents were Caucasian. Parents, on average, were 36 years old. Sixty-one percent of the parents had an income level below \$20,000 a year. Most parents (90%) had earned a high school diploma or had obtained higher levels of educational achievement. The mean number of adults in the household was 2.1. Sixty percent of the parents were not married. On average, parents and children in Group 2 participated in the program for 342.51 days. Children ( $N = 23$ ) in Group 2 were predominantly Caucasian (60.9%). The average age of children in this group was 3.51 years. On average, these children had 1.03 siblings.

**Group 3** (4 families). Parents and children in Group 3 participated in Coordinated Child Care's (CCC) Project Challenge program. This program did not include a Safe Start consultant. All of the parents were Caucasian. Parents, on average, were 33 years old. Thirty three percent of the parents had an income level below \$20,000 a year. Most parents (83%) had earned a high school diploma or had obtained higher levels of educational achievement. The mean number of adults in the household was 2. Thirty-three percent of the parents were not married. On average, parents and children in Group 3 participated in the program for 361.51 days. Children ( $N = 4$ ) in Group 3 were all Caucasian. The average age of children in this group was 2.83 years. On average, these children had 1.25 siblings.

## Procedures

Data collection for the comparison group study began in January 2004 and ended in September 2005. The tools administered were the Parenting Stress Index (PSI), used to measure parents' total stress level based on three subscales (Parental Stress, Parent/Child Dysfunctional Interaction, Difficult Child), and the Temperament and Atypical Behavior Scale (TABS), used to measure the parent-child dynamic. The PSI was administered to parents three times: at intake, 65 days later, and 3 months after the second administration. A total of 130 parents completed the pre-test. Of these, 91 completed the mid-test, and 65 completed the post-test. The number of parents completing the full complement of PSIs was 58. Administration of the TABS began in October 2004. Only five participants completed all three administrations of the TABS. The TABS was also administered three times: at intake, 65 days later, and 3 months after the second administration.

## **Results**

### Service System Improvement

The majority of survey respondents were in agreement on the statements regarding service improvement. They believed the service provision for children exposed to violence had improved since the implementation of Pinellas Safe Start.

### Intervention Impact

Both intervention groups reported a decrease in overall parent stress after receiving services, but these changes were not statistically significant. Changes in parent-child dynamics could not be determined due to the low number of parents completing the measurement tool used to assess this outcome.

More specifically, the two intervention groups showed a reduction in the PSI scores for each of the domains (Difficult Child, Parental Distress, Parent-Child Dysfunctional Interaction) between the pre-and post-tests. However, the change was not statistically significant. It is worth noting, however, that Group 2 (Enhanced Project Challenge) scores on the PSI were above the normative range in the Difficult Child and Total Stress scores at baseline and were within the normative range at the second and third administration of the PSI.

## **Discussion**

According to Pinellas County service providers, the service system has improved since the implementation of Safe Start. Ideally, additional key stakeholder perceptions (e.g., families) would have been included in this assessment of the service system. The comparison group study had some limitations that prevented accurate data analysis. For instance, Group 3 (the comparison group) always had a significantly lower number of participants. The late administration of the TABS measurement contributed to an inability to evaluate child outcomes. Also, the sample number of participants at the end of the study was notably less than the sample number of participants at the beginning of the study. This occurred mainly because families either moved away or stopped receiving services. Despite these limiting factors, the comparison group study shows that both intervention groups reported a decrease in overall parental stress after receiving services. In addition, Group 2 families' stress levels were within the normative range after participating in Coordinated Child Care's Enhanced Project Challenge program.

## **Reference**

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# VI

## Pueblo of Zuni Safe Start Initiative

### 1. Overview

The Pueblo of Zuni was competitively selected as one of 11 Safe Start Demonstration Project sites. The Safe Start Demonstration Project is funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The goal of the project was to expand existing partnerships among service providers in key areas such as early childhood education/development, health, mental health, child welfare, family support, substance abuse prevention/intervention, domestic violence/crisis intervention, law enforcement, courts, and legal services. Each demonstration site was expected to create a comprehensive service delivery system to meet the needs of children and their families at any point of entry in the system of care. Furthermore, this comprehensive system was expected to improve the accessibility, delivery, and quality of services for children six years and younger who have been exposed to violence or are at high risk of exposure.

A theory of change was developed for the Safe Start Demonstration Project. In essence, it was expected that collaborative planning and implementation of system change activities would strengthen communities in ways that would prevent young children from being exposed to violence and reduce the impact of exposure for those who were. According to the theory, *contextual conditions* (political, economic, and social) would influence

project planning and implementation. For example, the incidence and prevalence of child maltreatment or community violence might affect public awareness of related issues. Related to these contextual conditions are *community capacities* (the number and quality of initiatives intended to improve the well-being of young children, for example), also expected to impact project planning and implementation. According to the theory, community capacity would most directly affect *assessment and planning*, as well as *community engagement and collaboration*. Communities with relatively large numbers of qualified professionals, for instance, might be in a better position to reach out to the existing service provider network and engage providers in assessment and planning processes. In addition, the capacity to conduct an assessment of community needs and resources was expected to be greatly influenced by the availability of *local assistance*, the ability to access *national assistance*, and the availability of accurate community data. Partnerships were to be formed to plan and initially implement a number of *system change activities*. These activities were expected to change practice across organizations, within organizations, and at the point of direct services. The system changes achieved were expected to be continued, or *institutionalized*, in the form of service coordination and integration and improved service delivery. In turn, the result of continued system changes would be *increased*

*community supports for young children exposed to violence such that fewer children would be exposed to violence and the impact of exposure would be reduced.*

This case study report describes how the Zuni SSI changed systems to reduce the impact of exposure to violence on young children. The analysis is based on the National Evaluation Team's site visit report (Association for the Study and Development of Community, 2004; Association for the Study and Development of Community, 2006), the site's local evaluation report form (Pueblo of Zuni Safe Start Initiative, 2005) for those two years, and other reports and information generated by the site (e.g., progress reports, implementation plans, strategic plans, and other materials). This case study report is organized according to the Safe Start Demonstration Project theory of change and covers the first four years of the Zuni SSI.

Core questions used to guide the analysis include:

- How did community conditions affect the implementation and impact of the Zuni SSI?
- How did the Zuni SSI change the community to meet the needs of children exposed to violence?
- How was the Zuni SSI institutionalized in the community?
- How did the Zuni SSI increase community support for children exposed to violence?
- How did the Zuni SSI reduce the number of children exposed to violence?

- How did the Zuni SSI reduce the impact of exposure to violence?

The mission of the Zuni SSI, spearheaded by a management team and currently located in the Division of Public Safety, was to create a culturally sensitive system to enhance child advocacy and community prevention and intervention services, to protect Zuni children exposed to violence and their families. This system will draw on traditional Zuni ways of healing and western approaches that are evidence-based (Pueblo of Zuni Safe Start Collaborative, 2005).

How did the Zuni SSI accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in the following sections, and a timeline of major events is attached (see Appendix A).

## **2. Contextual Conditions**

The Pueblo of Zuni is a rural Indian reservation, covering approximately 725 square miles in west central New Mexico and isolated from surrounding cities. Zuni is the most traditional and largest of the 19 New Mexico Pueblo tribes, with a total population of 9,311, of which 772 (8.3%) are children under the age of five (U.S. Census Bureau, 2000). The median age is 26.5 years. The main industry is the production of arts, including inlay silver jewelry, stone fetishes, and pottery (Pueblo of Zuni Tourism Department, 2005).

The Zuni people have their own language; approximately 73% of the

population reported that they spoke English less than “very well” (U.S. Census Bureau, 2000). About sixty-eight percent of the population 25 years and older had a high school degree or higher, and 5% had a bachelor’s degree or higher (U.S. Census Bureau, 2000). The median income in 1999 was \$28,000. About 44% of families had income below poverty level; half of the families were led by a female with no husband present, and with children under 18 years. Further, more than half of the population (67%) was unemployed in 1999, according to data published by the Department of the Interior Bureau of Indian Affairs (Pueblo of Zuni Safe Start Initiative, 2005).<sup>38</sup>

The closest city to the Zuni tribe is Gallup, which is 38 miles away. Tribal members must travel to Gallup for recreational activities (e.g., movies) and major supplies (e.g., food, clothing). For any major health need (e.g., surgical procedures), patients have to travel 32 miles to the nearest hospital.

The Zuni governing structure centers around a Tribal Council, consisting of the Governor, the 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. A Tribal Administrator supports the Tribal Council. The Tribal Council has been working on reorganization of the tribal government since late 2000, resulting in fewer divisions<sup>39</sup> and new directors in some

divisions. The Tribal Council’s election every four years (the last election occurred in 2002) in addition to the reorganization had both positive and negative impact on the Zuni SSI (see Section 5 for further detail).

The presence of violence is a symptom of historical trauma that has emerged within the last 20 to 30 years, after tribal members experienced years of oppression (Pueblo of Zuni Safe Start Initiative, 2005). 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 identity (Kittleson, n.d). Many Zuni leaders and residents who met with the National Evaluation Team in 2004 and 2005 expressed concern that their children would continue to lose their cultural identity and fall victim to substance abuse and domestic violence.

The Tribal Council and other members of the tribe (e.g., tribal elders, agency directors), therefore, see the conservation of tribal values as the key to diminishing Zuni children’s exposure to violence and the impact of childhood exposure to violence. These stakeholders place particular emphasis on the importance of building a strong community, whose members support each other. Understanding tribal values and tribal culture is vital to each tribal member, and especially to its future leaders (i.e., Zuni children). Therefore, the Zuni SSI provided an opportunity not only to stop the cycle of abuse, but also

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<sup>38</sup> More recent statistics were not available.

<sup>39</sup> The divisions that make up the tribal government include the Division of Administrative Services, Division of Education

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and Training Services, Division of Health Services, Division of Human Services, Division of Public Safety, Division of Housing Services, and Division of Natural Resources.

to promote Native traditions by reestablishing a holistic and accountable support system for Zuni families and children. As one agency leader said during a meeting with the National Evaluation Team in 2004, “we need to look back at where we came from to see where we are going” (Association for the Study and Development of Community, 2005).

### **3. Community Capacity**

#### ***3.1 Before the Zuni SSI***

Prior to the Zuni SSI, the capacity of the community to address the impact of exposure to violence was limited by 1) a shortage of professionals knowledgeable about issues related to early childhood exposure to violence, 2) lack of coordination across agencies that interact with children and their families, and 3) community denial of the extent of domestic violence within Zuni families.

***Shortage of knowledgeable and skilled professionals.*** Prior to the Zuni SSI, the Zuni people had access to a single licensed psychologist with expertise in early childhood trauma. This psychologist advised the Zuni SSI, but was not able to provide any clinical assistance due to other professional demands. The Zuni Comprehensive Health Center employed mental health professionals, but none who specialized in childhood trauma.

***Lack of coordination across agencies.*** The following agencies offered services to at-risk children on the Pueblo, but functioned independently:

- Zuni Entrepreneurial Enterprises, Inc. (ZEE), a nonprofit 501(c)3 organization that provides services in the Pueblo and elsewhere in southern McKinley County. ZEE assists children three years and younger at risk for or suffering from developmental delays as a result of birth defects, premature birth, or maternal substance abuse; and
- New Beginnings, which operates the only domestic violence shelter on the reservation for battered women and their children.

Other agencies and programs in contact with families experiencing violence also operated independently; these included, for example, the Division of Education and Training (housing the Temporary Assistance for Needy Families program), Social Services (housing the Family Preservation Program), and Head Start. Consequently, services were fragmented. According to several people who met with the National Evaluation Team in 2004 and 2005, turf issues affected communication and collaboration among division directors, program managers, and service providers. Domestic violence survivors who met with the National Evaluation Team in 2005 echoed this assessment.

***Community awareness of the extent of the problem.*** Domestic violence was described as a taboo issue in the community. At the individual level, the issue elicited feelings of shame. At the community level, the issue implied a loss of Native traditions and the community’s diminishing capacity to pass on its cultural assets to future

generations. The practice of Child Protective Services was to remove Zuni children from homes experiencing violence and to place them in homes outside the Pueblo, thus detaching them from their cultural roots—and strengthening the association between domestic violence and loss of cultural heritage.

### **3.2 After the Zuni SSI**

The community's capacity to identify and respond to young children exposed to violence improved as a result of the Zuni SSI.

**Knowledge about the impact of childhood exposure to violence.** Both community members and professionals (e.g., police officers, Head Start teachers) increased their knowledge of the issues of children and violence through presentations by SSI staff and experts from the National Center for Children Exposed to Violence. (See Section 6 for further explanation.)

**Coordination of services.** The Zuni SSI staff, particularly the family support services coordinator, helped coordinate services across agencies by providing a central point for receiving referrals, following up with families, and keeping referral sources updated on the status of their referred cases. Nevertheless, cross-agency collaboration remained limited; many people who met with the National Evaluation Team attributed this limitation in part to a lack of tribal policies mandating collaboration.

**Increased visibility of issues related to the impact of early childhood exposure to violence.** The SSI partners

and domestic violence survivors who met with the National Evaluation Team in 2005 reported that the general community has gained in awareness of the issues of children and violence. This was evident in the increased number of self-referrals and referrals by families and friends to the Zuni SSI, referrals by school counselors, and higher attendance at community presentations on the topic.

## **4. Integrated Assistance**

Since its inception, the Zuni SSI has received extensive technical assistance from a number of organizations contracted by the Office of Juvenile Justice and Delinquency Prevention, including the National Center for Children Exposed to Violence (NCCEV), National Council of Juvenile and Family Court Judges (NCJFCJ), National Civic League (NCL), Systems Improvement Training and Technical Assistance Project (SITTAP), and the Institute of Community Peace.

The lack of coordination across agencies, partly due to turf issues, was one of the challenges faced by the Zuni SSI staff; therefore, extensive technical assistance was sought by the staff in this area. For example, NCCEV provided assistance on the child development-community policing model, visiting the Pueblo several times to bring division directors together to collaborate on this model and to train police officers.

NCJFCJ, through the Zuni SSI, assisted in the development of the Zuni Tribal Court. More recently, in 2005, NCL engaged the Center for Network Development to conduct a feasibility study for an online case management

system for the Pueblo. SITTAP conducted training on the Indian Child Welfare Act and provided assistance to SSI staff on their intake process. SITTAP also helped the Zuni SSI with its implementation plan; provided training on sustainability; and facilitated conflict management between certain agency directors, program managers, and service providers.

Because the technical assistance was always not tailored to the unique challenges faced by a Native American community, it was not always well received by tribal agency directors. Some of the national technical assistance providers' lack of understanding of Native traditions impacted their ability to enhance the capacity of the tribe. Promising practices and approaches for helping Native children and families were based on Western standards, and the impact of historical trauma on generations of Native people was not addressed in interventions. SSI staff who met with the National Evaluation Team indicated that a significant amount of time was spent educating technical assistance providers on the Native culture and contextual conditions (e.g., SSI staff walked each new provider through the Native museum). The major challenge appeared to be finding a way to mutually engage native leaders and non-native technical assistance providers.

The Zuni SSI staff also exchanged information and received assistance from other Safe Start sites:

- The Zuni SSI adopted and adapted Chatham County Safe Start Initiative's screening protocols, consent forms, and

case management procedures, because the Zuni staff felt that Chatham County's rural characteristic most closely resembled that of the Zuni community; and

- The Washington County Safe Start Initiative staff, including a child protective services representative and the social services director from the Passamaquoddy Tribe, visited the Pueblo to share practices for responding to children exposed to violence. Zuni SSI staff, however, did not find this exchange useful, because of limited involvement on the part of Zuni division directors.

## **5. Local Agency and Community Engagement and Collaboration**

The collaboration that supported the Zuni SSI was facilitated by the involvement of 1) credible leaders and staff, 2) the initiative's function as the "glue" that held together programs across agencies, and 3) relationships with agencies that served as different entry points into the lives of Zuni children and families.

On the other hand, leadership and staff turnover, due to an unstable political and funding environment, and turf issues, challenged collaboration. As mentioned in the previous section, the Zuni SSI sought extensive technical assistance in this area.

## **5.1 Credible Leaders and Staff**

The Zuni SSI was led by a Management Team made up of higher-level leaders, including two Tribal Council members, directors of the Division of Human Services and the Division of Public Safety, the tribal administrator, the chief of police, the Social Services director, and the SSI director. The Team was supported by the Training and Technical Assistance and Public Awareness Committee, chaired by a police officer and comprised of approximately ten representatives from various community agencies. This committee oversaw activities to increase the community's awareness of issues related to childhood exposure to violence. The Policy and Procedures Committee, responsible for developing policies and procedures to guide responses to children exposed to violence, and active early on in the initiative, was no longer operational in 2005; its members had left the Pueblo. A group of managers from the Division of Human Services assumed the committee's function and, at the time of this report, was working on developing an electronic case management system.

The Zuni SSI staff believed that support from the Tribal Council and, more recently in 2005, from a tribal judge, brought credibility to the initiative. Not only was the judge a well-respected leader in the community, he had the authority to mandate batterers and victims to seek help for themselves and their children. Specific Tribal Council members were perceived as champions of the initiative; they attended meetings convened by OJJDP and supported the Zuni SSI project director.

Collaborative members also frequently commended the Zuni SSI director and the family support services coordinator for their leadership and competence in promoting collaboration, keeping all the stakeholders informed about the initiative's progress, and engaging families. The Zuni SSI director was able to build on existing relationships; her family was known for its political activism in the community. Domestic violence survivors described the family support services coordinator as approachable and trustworthy; they felt comfortable with her, and were willing to entrust their children to her care.

## **5.2 Zuni SSI's Function as the "Glue"**

Staff from partner agencies described the Zuni SSI staff as the glue that held together programs across agencies. The SSI staff used a customer service approach, frequently asking staff from other agencies "how we can help you." The family support services coordinator's effort to consistently update partner agencies on the status of their referrals reinforced the initiative's function as the "glue." According to the people who met with the National Evaluation Team, the initiative responded to needs beyond domestic violence, such as job placement, housing, and clothing.

Staff members' connections and deep knowledge of the community enabled them to provide various types of assistance to families in need, and to coordinate services to better respond to these families.

### **5.3 Relationships With Agencies That Served As Different Entry Points Into The Lives Of Zuni Children And Families**

Although Zuni Entrepreneurial Enterprises (ZEE) is located on the Pueblo, the agency's funding comes directly from the State Department of Health, Medicaid, and several 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. Therefore, the Zuni SSI's engagement of ZEE was considered a major accomplishment because it brought ZEE, a resource on the reservation but considered an outside entity, closer to the Tribal Council and other tribal programs.

Early on in the initiative, ZEE staff members were involved peripherally with the Zuni SSI; it was not until the SSI director reached out to ZEE's director that a formal memorandum of agreement between the two entities was developed. This link enabled ZEE to strengthen its connection with the Tribal Council.

Collaboration between Temporary Assistance for Needy Families (housed in the Division of Education and Training) and the Zuni SSI began when the family support services coordinator was hired in October of 2004. The services coordinator also engaged Head Start in the collaboration. The relationship between the Zuni SSI and Head Start was reinforced through the mutual participation of Head Start and SSI staff in meetings that involved professionals

serving children and families from multiple sectors. The Zuni SSI also developed relationships with the Victims of Crime Act representative, the Tribal Court, and the Family Preservation Program.

All of the above programs and agencies became referral sources for the Zuni SSI, given their frequent contact with families experiencing domestic violence.

Also noteworthy is the Zuni SSI staff involvement with the Tribal Youth Grant project in 2004. The collaboration seemed natural because 1) the two initiatives shared similar goals (i.e., to reduce violence in their community), providing a natural partnership for strengthening the community's support system for children and youth, and 2) the same agencies and decision makers involved in the Zuni SSI collaboration were involved in the Tribal Youth Grant project (e.g., directors of the Division of Human Services and the Division of Public Safety).

### **5.4 Leadership and Staff Turnover**

Leadership and staff turnover affected collaboration. From 2003 to 2005, turnover occurred in the Division of Public Safety, the Zuni Police Department, New Beginnings, the Division of Human Services, and Social Services. Such turnover had two consequences.

The location of the Zuni SSI changed three times, from an initiative under the Social Services director's supervision to an initiative under the direct supervision of the Division of

Human Services' director, and then to the Division of Public Safety in 2005. The first change was an attempt to elevate the initiative's value by placing the initiative under the direct supervision of the Division of Human Services' director, who occupied a higher position than the Social Services director in the tribal organization scheme. The second change occurred because of the heavy involvement of police officers in the initiative, making the Division of Public Safety a more natural home for the Zuni SSI. With each change of agency came new supervision; new lines of communication; and, in one instance, a new office. This instability created a sense of impermanence and diminished the initiative's capacity to grow and become institutionalized.

Improvements and policy decisions related to the Zuni SSI's sustainability were always uncertain. For example, in 2004, the director of the Division of Public Safety decided to add CDCP to the Division's budget as a line item, ensuring resources for the training of police officers and for supporting their role in identifying children exposed to violence. Police officers involved in the Zuni SSI, however, were unsure if the new Division director and police chief would maintain this commitment. A similar situation arose with leadership turnover in Social Services. The outgoing director had not supported the Zuni SSI<sup>40</sup>, and it was uncertain whether or not the new director would be supportive, affecting the role of this

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<sup>40</sup> The people who met with the National Evaluation Team gave different reasons for why the director was not supportive of the Zuni SSI. Some believed that he viewed the Zuni SSI as competing with other Social Services programs; others believed that he had a personal conflict with the Zuni SSI director.

agency as a referral source for young children exposed to violence and their families.

## **6. Systems Change Activities**

### ***6.1 Community Assessment and Planning***

During the planning phase of the Zuni SSI, a group of agency representatives came together and 1) conducted discussion groups with service providers, political and religious leaders, elders, and family members; 2) examined hospital cases involving children exposed to violence; 3) examined 911 call records for co-occurring presence of children and violence; and 4) reviewed national reports such as KidsCount and research findings on victimization published by the American Indian Development Associates in 2004 (Pueblo of Zuni Safe Start Initiative, 2004).

The information gathered and reported in the local evaluation report form (Pueblo of Zuni Safe Start Initiative, 2004) showed that:

- The majority of exposure to violence among Zuni children was related to domestic violence, even though domestic violence appeared to be underreported;
- Most domestic violence incidents were related to alcohol use or intoxication, followed by emotional stress and marital problems;
- About two thirds of the respondents to a survey conducted by the American

Indian Development Associate indicated domestic violence as a problem, while the remaining one third reported that it was “somewhat” or “maybe” a problem; and

- Slightly more than one third of the victims who responded to the survey reported that they sought help, primarily through social services, law enforcement, and/or the court system.

Discussion group participants also generated a list of risk and protective factors related to children’s exposure to violence; among them was the importance of Zuni values as a protective factor.

The Zuni SSI used the above information to emphasize the need for community awareness and action, to garner support from the Tribal Council to address children’s exposure to violence (e.g., the tribe seeks autonomy to determine how and who is certified to educate the younger generation about the Zuni language and culture), and to identify gaps in the referral and treatment process for children exposed to violence (Pueblo of Zuni Safe Start Initiative, 2005). Zuni has established a partnership with the state board of education in an effort to preserve the Zuni language. There has been no further assessment to inform the Zuni SSI.

## ***6.2 Community Action and Awareness***

The Zuni SSI invested a lot of time to increase the community’s awareness of the impact of domestic violence on young children. Without this

awareness, it was unlikely that families would seek help.

Domestic violence, however, was a taboo subject in the community; introducing the subject directly might have deterred some people from getting help. Instead, the Zuni SSI focused on inspiring the community with information about the tribe’s cultural and family traditions, and indirectly reminding the community that domestic violence violates these traditions. Several Zuni leaders claimed that Zuni youth and young adults did not know enough about their cultural roots, which they considered a protective factor against negative influences.

In 2004, two tribal elders presented frequent programs on Zuni cultural heritage; women made up the majority of those attending these programs. In 2005, these programs appeared to decrease in frequency, while presentations directly addressing domestic violence increased. This may signify a growing willingness among Zuni families to talk about domestic violence, a perception supported by people with whom the National Evaluation Team met. In total, approximately 1,200 people attended SSI-related events, presentations, and trainings in 2004 and 2005 (not accounting for people who attended events more than once).<sup>41</sup>

As part of the increasingly direct focus on domestic violence, the Zuni SSI took advantage of Domestic Violence Month in October (2005) to inundate the community with information related to domestic violence and childhood

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<sup>41</sup> Summary of events and attendees, May 18, 2006.

exposure to violence. A total of 11 events occurred, from a “domestic violence walkathon” to presentations about the effects of violence on children.

From 2004 to 2005, attendance at Zuni SSI events increased, as did referrals (including self-referrals).<sup>42</sup> This pattern may be the result of the SSI community awareness activities; a direct link could not be established.

### ***6.3 Development of Policies, Procedures, and Protocols***

The Zuni SSI influenced policies, procedures, and protocols by incorporating children exposed to violence into the tribe’s general policy on child well-being, mandating SSI services, and developing procedures for how agencies should work together to respond to children exposed to violence.

***Incorporating children exposed to violence into the tribe’s general policy on child well-being.*** The initiative played a pivotal role in revising the tribe’s policy on child well-being (i.e., the Children’s Code), which was written more than 30 years ago and did not contain any information on children’s exposure to violence. The Zuni SSI director collaborated with a judge to add information about children’s exposure to violence and child abuse and neglect to the code, and to develop a statement that services must be culturally competent and responsive to Zuni traditions. One tribal leader described the Children’s Code as “the Zuni SSI’s legacy.” The Children’s Code was distributed for public review in October 2005. The code, once approved by the community,

will set higher standards for agencies that respond to tribal children’s needs.

***Mandated services.*** Tribal judges changed their practices related to domestic violence cases by mandating that victims undergo an intake process by Zuni SSI staff within 48 hours of the arraignment. The Family Preservation Program representative reinforced this practice, also mandating her court-ordered clients to attend presentations by the initiative.

***Prescribe the way agencies work together to respond to children exposed to violence and their families.*** The initiative developed a protocol for how the police, victim advocates, and the SSI family support services coordinator should respond to a domestic violence situation. According to this protocol, police officers responding to a domestic violence call were expected to ask if children were present and to record their ages and names; however, several domestic violence survivors who met with the National Evaluation Team reported that not all police officers followed this protocol.

The Temporary Assistance for Needy Families coordinator incorporated domestic violence into the agency’s eligibility screening, such that participation in SSI services for families experiencing violence was a condition for TANF aid.

The Zuni SSI also developed a standard referral form for all agencies to use.

### ***6.4 Service Integration***

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<sup>42</sup> Summary of events and attendees, May 18, 2006

Service integration occurred initially in the form of the child development-community policing (CDCP) model. As of 2005, however, full implementation and institutionalization of CDCP remained uncertain because of leadership changes in the Division of Public Safety and the Zuni Police Department, as well as unwillingness to follow CDCP protocol, reluctance to complete more forms than necessary, and lack of support for community policing among some officers. Further, the Zuni SSI staff have been unsuccessful in retaining a mental health partner for the CDCP team. A psychologist was engaged in early 2006, but he resigned a few months later due to competing responsibilities (see next section for further details).

### ***6.5 New, Expanded, and Enhanced Programming***

The Zuni SSI established a process for identifying, referring, and assisting children exposed to violence and their families (see Appendix B). Although developed early on, this process did not become fully operational until the hiring of the family support services coordinator in late 2004 and the signing of a memorandum of agreement with Zuni Entrepreneurial Enterprises to provide clinical assistance.<sup>43</sup> The procedures for referring children exposed to violence were well defined, whereas the procedures for assessing, treating, and following up remained inadequate. This inadequacy was largely due to the lack of a licensed, SSI-dedicated mental health partner with expertise in young children exposed to violence; a psychologist hired in early

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<sup>43</sup> Note: As of the end of 2005, ZEE had not received any referrals.

2005 resigned after a few months because of other competing demands (he had retained a full-time job elsewhere, making it difficult to dedicate time to the Zuni SSI).

***Multiple points for identification and referral.*** The number of referral sources for the Zuni SSI expanded over time. By the end of 2005, at least eight agencies (New Beginnings, Head Start, schools, Tribal Court, Zuni Police Department, Zuni Comprehensive Health Center, Education and Career Development Center, and Family Preservation Program), as well as families and friends, served as referral sources. All agencies were expected to use a standard referral form developed by the Zuni SSI.

Upon receiving a referral, the family support services coordinator contacted the family to schedule an intake assessment, identify other needs (e.g., food, clothing, housing, employment), and explain the options available for help to the family and children. If necessary and appropriate, the family support services coordinator also referred the family and child to other agencies for specialized assistance, including ZEE (for children three years and younger), Zuni Comprehensive Health Center (for medical reasons), Zuni Recovery Center (for substance abuse), and the Batterers Intervention Program.

One of the strengths frequently cited by partner agency representatives was the family support services coordinator's diligence in informing them of the status of the referrals.

A total of 114 children in need of help was identified between July 2004

and December 2005. In 2005, self-referrals emerged as a referral source; Safe Start staff perceived this as a sign of willingness by Zuni families to seek help (see Table 1).

**Table 1: Number of Referrals to SSI from January until September 2005**

Zuni Police Department	18
Self-referral	4
Tribal Court	3
Social Services	2
New Beginnings	2
Other	4

*Assistance to children and families.* As previously mentioned, the child psychologist hired in January 2005 to assess and treat children exposed to violence and their families resigned in April due to other competing demands (he was a school principal and served as the SSI psychologist only after school hours and on weekends). This psychologist was initially a member of the CDCP team and had received training from the University of Oklahoma on the adaptation of Parent-Child Interactive Therapy for Native families; his resignation, therefore, left a gap in the continuum of services for young children exposed to violence and their families.

Consequently, the family support services coordinator stepped in to develop and facilitate support groups to assist domestic violence survivors and their children. She was expected to serve in this capacity until a licensed psychologist specializing in early childhood trauma was hired. She adapted and combined existing curricula designed to help children express their feelings and develop their character with

Zuni cultural traditions. She used this improved curricula with a group of eight Head Start children over a three- to six-month period. The Head Start representative described the children as excited and open to discussing their concerns with the family support services coordinator. Five adult survivors echoed this perception in their meeting with the National Evaluation Team in 2005.

The family support services coordinator also designed and conducted peer-group support for two groups of victims. Each group participated in weekly sessions for ten weeks; an average of five victims attended each session. The services coordinator frequently linked participants to housing services, career education programs, and other programs.

In general, the SSI raised awareness about how Native children should be treated by service providers, community leaders, and families. For instance, the Tribal Council has entered into discussion of the development of a tribal foster care program, to ensure that all Native children removed from their homes because of abuse and neglect remain on the Pueblo. The current practice is to place children in foster homes outside the Pueblo, thus detaching them from their cultural roots.

## **7. Institutionalization of Change**

No local resources for the Zuni SSI have been identified and developed in the Pueblo. At the time of the National Evaluation Team's site visit in 2005, Tribal Council members and SSI staff had discussed the following

possibilities: third-party reimbursement for clients, gaming fees, consolidation of funding across different divisions, and a fiscal analysis of the Social Services division's budget to determine additional sources of support for the Zuni SSI.

The changes that will be sustained are:

- Revisions to the Children's Code;
- Community awareness and understanding of the impact of childhood exposure to violence; and
- New collaborative relationships.

According to families participating in SSI support groups, the initiative sparked a change process through which community members have become more aware of domestic violence and its impact on children, and agencies have started to work together. In one person's words, "This is the beginning of something great for our children, and we have the hope to say that...the SSI opens doors for taking care of ourselves."

Tribal Council members have expressed their commitment to the SSI's values and principles; however, the sustainability of these values and principles has been hindered by:

- An unstable political environment (i.e., leadership turnover in Divisions and organizations);
- Lack of a permanent mental health resource on early childhood trauma in the Pueblo;
- Insufficient funds for sustaining the level of staffing made

possible with the federal grant (i.e., three full-time staff people); and

- Dependence on individuals and their capacities, such that knowledge about the Zuni SSI and inter-agency responses will continue to be limited to the primary liaison in each organization until protocols are institutionalized and enforced.

Despite the uncertainty of its future, the Zuni SSI has helped develop two forms of community support for young children exposed to violence and their families.

## **8. Increased Community Supports**

The Zuni SSI resulted in two forms of community support that participants described as essential to reducing domestic violence and its impact on young children:

- Site visit participants, both service recipients and service providers, reported that the SSI led to a stronger emphasis on viewing the family holistically (consistent with the Zuni culture), for example:
  - SSI helped families with needs such as clothing, household items, childcare, and transportation, in part through linking to individual donors in the community to help specific families (e.g., SSI found a donor to provide propane to a family). Even if the initiative does not continue beyond federal

funding, it is likely that the value of agencies working together to respond to a family's needs has been instilled and will continue.

- The Zuni SSI integrated the tribe's traditions and values into its presentations on domestic violence and its impact, helping families to focus on their traditional assets and to develop a sense of hope for their children's future.

## **9. Reduced Exposure to Violence**

There were no data to determine if Zuni children's exposure to violence has been reduced. Anecdotal information from the Zuni SSI service recipients who met with the National Evaluation Team reflected the belief that perpetrators of violence will be encouraged to seek help (for themselves and their families), if they understand how their behavior affects exposed children. Participants in the group sessions might reduce their children's exposure to violence after learning more about its impact.

## **10. Reduced Impact of Exposure to Violence**

There were no data to determine if the impact of exposure to violence has been reduced because the initiative has not been able to engage a mental health partner to develop an intervention. The support groups created and facilitated by the family support services coordinator was a pragmatic alternative to the resignation of the initiative's mental health partner. The impact of these

support groups were not evaluated. The impact of exposure to violence may be reduced among the children who participated in the group sessions conducted by the family support services coordinator, who taught them how to express their feelings; however, there were no supporting evidence to confirm this possibility.

## **11. Conclusion**

Site visit participants frequently described the Zuni SSI as an entity that brought services together, functioned as a broker of relationship building among agencies, and provided support services for children exposed to violence and their families. Support groups for a small number of children and adult victims were created and facilitated. Any mental health assistance beyond this for children exposed to violence, however, not available because the initiative could not retain a full-time mental health partner.

Anecdotal evidence suggests that the capacity of existing service providers in the Pueblo to respond to children exposed to violence and their families has increased. Service providers reported better understanding of the issue of childhood exposure to violence and increased knowledge of where to refer children and their families for assistance. There is some evidence that suggests that community awareness has increased as a result of the SSI (i.e., higher attendance at presentations on domestic violence and increasing self-referrals).

Zuni SSI progress thus far appears to have been facilitated by:

- The Tribal Council's commitment to stay informed and to support SSI staff;
- Staff knowledge of where to go for resources and information (e.g., Zuni cultural traditions), ability to cultivate strong relationships, and persistence in coordination and follow-up; and
- The approach of linking Zuni cultural traditions and domestic violence, making the issue more acceptable for public discussion.

Further development and institutionalization of the Zuni SSI, however, has been hindered by:

- Decades of trauma, contributing to the cycle of violence in the Pueblo and making the subject of domestic violence a continually challenging one;
- Distrust of service providers among some families because of past experiences in which they

did not receive the assistance they needed;

- Leadership and staff turnover in partner agencies and divisions; and
- Uncertain funding in the future.

The initiative was still dependent on the staff members to broker relationships and coordinate services. There was an attempt in 2004 to institutionalize the child development-community policing model; however, leadership changes in the Division of Public Safety in 2005 prevented the institutionalization.

The year 2006 will be especially critical to the Zuni SSI because of tribal elections. Depending on election results, the initiative could gain momentum and attention, or it could receive the same level of support without a major thrust in the direction of expansion and institutionalization.

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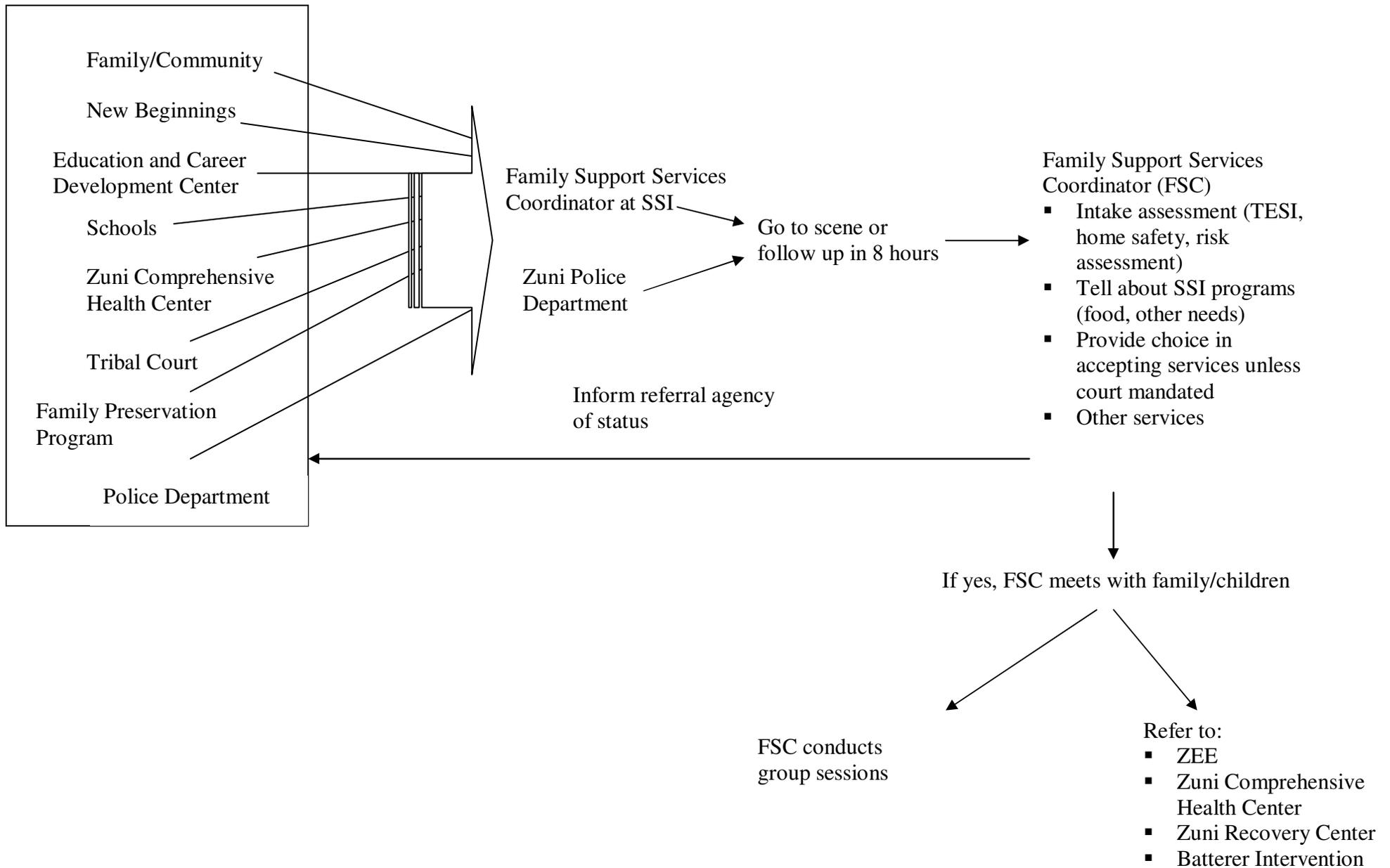
**Appendix A**  
**Timeline of Pueblo of Zuni Safe Start Initiative**  
**Activities and Milestones**

## Timeline of Pueblo of Zuni Safe Start Initiative Activities and Milestones

Major Milestones	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
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				✓		✓		
Trainings, workshops, and community presentations				✓	✓		✓	✓
Participation in Sustainability Training by the Institute for Community Peace					✓			
Training by SITTAP						✓		
Visit to NCCEV in New Haven						✓		
Collaboration initiated with the TYG project and VOCA						✓		
Family Support Services Coordinator hired						✓		
Clinician (Dr. James Sweeney) hired						✓		
Memorandum of agreement with ZEE finalized and engagement of New Beginnings started						✓		
Child psychologist hired and resigned							✓	
CDCP Institutionalized							✓	
Social Services leadership changes							✓	✓
Tribal court mandated referrals to Zuni SSI							✓	✓
Tribal Program Grant awarded								✓

Sources: LERF, 2004 and 2005; National Evaluation Case Study, 2004; and Site Visit Report 2005.

PUEBLO OF ZUNI SAFE START INITIATIVE SERVICE PATHWAY, 2005



# VII

## Rochester Safe Start Initiative

### 1. Overview

To address the issue of children's exposure to violence, the Rochester Safe Start (RSS) grantee built upon two existing community capacities: 1) extensive services with a number of initiatives focused on young children, and 2) a long history of close collaboration among government agencies and non-profits in the community.

As a community, Rochester strongly emphasizes prevention as a strategy and has invested considerable resources in the early childhood system. Children's Institute, the parent agency for RSS, promotes the social and emotional well-being of children and relies on community partnerships to inspire and implement positive public policy. Consistent with the community's priorities for young children and the expertise of the Children's Institute, the RSS committed to designing and implementing a range of initiatives that both built upon existing resources and addressed gaps in the existing system.

First, the RSS developed and implemented several nontraditional approaches (e.g., non-mental health approaches) to responding to children exposed to violence at home and in the community:

- A media campaign (Shadow of Violence), designed to increase

community responsibility for responding to children exposed to violence at home and in the community by changing community norms, attitudes and behavior;

- A training initiative based on the Shelter from the Storm curriculum, designed to focus on a range of people who serve children and families and educate them about the effects of violence and ways they can help; and
- A mentoring project (Early Childhood Education Intervention), designed to help teachers and other adults in early childhood classrooms to recognize that difficult child behaviors may be caused by exposure to violence and to provide ways of responding.

Three additional RSS interventions integrated services across disciplines:

- The SAFE Kids intervention forged a partnership between police and social workers on behalf of young children exposed to violence in the community or at home;
- The Children in Court intervention assigned domestic violence victim advocates to families in the court system.

These advocates helped to explain the impact of the legal process on the children involved and how to seek orders of protection. As part of Children in Court, the RSS also worked to implement Fast Track Supervised Visitation, a program designed for families affected by domestic violence, to reduce the amount of time families had to wait for visitations between parents and children; and

- The Mt. Hope-Foster Care intervention offered specialized mental health services to young children abused or neglected so severely that they had to be removed from their homes and placed in foster care.

The success of these interventions varied, as determined by continuous use of evaluation findings:

- Shadow of Violence
  - The media campaign was evaluated using a non-equivalent control group. Findings indicated an increase in the proportion of adults in the campaign target community who reported taking action (vs. doing nothing) after seeing a child being exposed to violence (Rochester Safe Start Initiative, 2005a, p. 54). There was no increase in such self-reported behavior in the comparison community.
  - The media campaign was also funded beyond the

federal grant period. The Rochester Ad Council approved Safe Start as a community initiative for 2005 and 2006, which will mean extensive assistance with creative and marketing approaches for phase two of the Shadow of Violence campaign. The final amount of financial support is still under discussion. The RSS also received \$1,000.00 from Target in support of phase two (Rochester Safe Start Initiative, 2005a, p. 34).

- Shelter from the Storm
  - The training initiative reached 2,313 participants between 2003 and 2005 (Rochester Safe Start Initiative, 2003; Rochester Safe Start Initiative, 2004; Rochester Safe Start Initiative, 2005b).<sup>1</sup>
  - Children's Institute obtained an AmeriCorps worker in 2004 and 2005 to provide assistance with training and logistics for Shelter from the Storm trainings (Rochester Safe Start Initiative, 2005aa, p. 34).
- Early Childhood Education Intervention

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<sup>1</sup> These figures were reported in the Progress Reports (2003-2005) submitted by Rochester Safe Start to the Office of Juvenile Justice and Delinquency Prevention.

- The mentoring project was evaluated using a randomized clinical trial design. Children in classrooms with mentors demonstrated more positive growth in their cognitive, social, and physical functioning than children in classrooms without mentors. This difference between groups of children was statistically significant (Rochester Safe Start Initiative, 2005a, p. 53).
- In 2005, the Early Childhood Education Intervention received \$148,000 from the New York State Office of Children and Family Services to provide mentoring for 30 previous control classrooms, booster sessions for 30 intervention classrooms, and training for Parent Group Leaders and Site Coordinators (Rochester Safe Start Initiative, 2005a, p. 34). This project has been expanded both in size and scope through the Early Childhood Professional Development grant from the U.S. Department of Education.
- SAFE Kids
  - SAFE Kids reached 305 children between April 2002 and February 2004, increasing the proportion of children exposed to violence who received referrals for assessment and treatment. Social workers had contact with 119 of these children, 84 of whom were classified as receiving the “highest” level of service delivery (Rochester Safe Start Initiative, 2005a, p. 47).
  - In 2005, SAFE Kids was assumed by the Society for the Protection and Care of Children (SPCC) through local grant funding and SPCC Board-designated funds (Rochester Safe Start Initiative, 2005a, p. 34).
- Children in Court
  - The Children in Court intervention increased the expertise of domestic violence advocates related to children exposed to violence, and expanded supervised visitation available both in the Domestic Violence Intensive Intervention branch of Family Court and in the new Integrated Domestic Violence Court.
  - The Alternatives for Battered Women (ABW) Child Advocate Project served 574 families with children six years and younger between May 2003 and October 2004. These families had 801 children six years and

younger and 386 children older than six. This program ended in 2005 (Rochester Safe Start Initiative, 2005a, p. 47).

- Fast Track Supervised Visitation received referrals for 53 families; 48 families accepted the referral and received supervised visits. Within these 48 families, approximately 96 parents and 70 children were served (Rochester Safe Start Initiative, 2005a, p. 47), and the average wait for service was one to two weeks as opposed to six months in the general supervised visitation program. Fast Track Supervised Visitation will be resumed through RSS in 2006.

- Mt. Hope-Foster Care
  - The Mt. Hope-Foster Care intervention served 101 young children in foster care through the Foster Care Pediatric Clinic from April 2002 to April 2004 (Rochester Safe Start Initiative, 2005a, p. 36).
  - The program was institutionalized in the community through United Way funding in 2004 (Rochester Safe Start Initiative, 2005a, p. 36).

The Rochester Safe Start grantee was able to incorporate expertise in the area of children exposed to violence into existing systems for young children. Using this overall approach, and through several specific interventions, the Rochester Safe Start grantee helped to create a community more responsive to the needs of all children, including those exposed to violence in their home and in their community. Evaluation findings further suggest that providing early childhood educators with coaching around children exposed to violence issues may be an effective way to improve all children's growth, including the growth of children who have been exposed to violence. Finally, a social marketing campaign geared toward helping children by sending messages to adults may be an effective way to change adults' behavior and expectations to support positive outcomes for children.

### **1.1 Mission**

The mission<sup>2</sup> of Rochester Safe Start was to make Rochester a community responsive to the needs of all children, especially those exposed to violence. Key goals included increasing overall awareness of the harmful effects of exposure to violence on children six years and younger; reducing the impact when children were exposed to violence; and ensuring that the community provides exposed children with all of the support and resources needed to cope, adapt, and remain healthy. Affecting the community agenda through public policy and resource allocation was also a critical goal. How did the Rochester Safe Start grantee accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in the following sections, and a timeline of major events is attached (Exhibit VII-A).

### **1.1 Rochester, New York**

Rochester Safe Start was planned and implemented within the unique context of Rochester, New York. The following snapshot of Rochester is intended to help others interested in replicating Safe Start to compare their own communities to Rochester.

The city of Rochester, with a population of 219,773<sup>3</sup> is the seat of Monroe County, and is located on the Genesee River and Lake Ontario in upstate New York (U.S. Census Bureau, n.d.). Before the rise of Silicon Valley in California, Rochester was considered a high-tech city, depending primarily on

<sup>2</sup> The mission and goals for RSS were taken from the Rochester Safe Start brochure written and designed by Idea Connections.

<sup>3</sup> The 2004 population estimate for Rochester, New York is 212,481.

Kodak and Xerox to employ its residents. In recent years, however, both Kodak and Xerox have downsized, leaving many residents unemployed;<sup>4</sup> Rochester has recently been identified as having one of the highest rates of job loss among 40 large cities. 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 or Native American descent (2.7%/0.2% and 1.3%, respectively). The remaining 44.3% of residents are European American. According to the 2000 Census, there were 24,299 children six years and younger residing in the city of Rochester. This represents a decline of 16% in this segment of the population from the 29,016 young children estimated ten years earlier.

Within the city, poverty is concentrated in the "crescent." According to the 2000 Census, median family income in ZIP codes 14608 and 14611 on the city's west side was less than one-half the national and county medians, and only three-quarters of the city median. One-third of all families in these ZIP codes had incomes below the poverty line; this fraction rose to about one-half for families with children under five years, and even higher for female householders with children under five. A high percentage of families in these areas rent, and the majority of renters spend more than 30% of their income on rent. More than one in eight properties are vacant in these areas. In ZIP code

14608, over 40% of families have no car and over 12% have no phone. In 14611, about one-third of families have no car and over 9% have no phone. By contrast, the ZIP code 14610 on the far east side is virtually all white, with high education levels, a median family income that exceeds the county median, median housing value nearly double that of the two impoverished ZIP codes, only one in twenty families in poverty, and only one in six female households with children under five in poverty.

According to the Children's Defense Fund, Rochester has the 11<sup>th</sup> highest child poverty rate of the 245 largest American cities. Child poverty has been unacceptably high in the city for a number of years, especially among some sub-populations, with a consistent 40% of all children under six years living in poverty from 1990 to 2000. Among children in married-family households, 14% were living in poverty in 2000; in single-parent families headed by males, almost one-third of children were below poverty level (an increase of 78% since 1990); and, worst of all, 59.4% of all children in female-headed households were living in poverty in 1999.

## 2. Contextual Conditions

During the planning and implementation of Rochester Safe Start, Rochester's community agenda for young children focused on preventing child abuse and neglect and promoting social and emotional well-being in early childhood. Considerable resources were invested in strengthening the early childhood system, as well as prevention services designed to keep children out of

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<sup>4</sup> These trends were discussed during the October 3 and 4, 2005 site visit with the Safe Start Demonstration Project National Evaluation Team.

foster care. Budget constraints during the life of RSS, however, created challenges in terms of enhancing and expanding services dependent on public funding. Relatively high rates of child poverty and unemployment created a social context that justified the priorities established by the community and RSS, but also created needs that would perpetually exceed capacity. This environment affected the design of Rochester Safe Start and influenced the initiative's implementation. For example, RSS was designed based on the assumption that creating a "system" of targeted services for young children exposed to violence would be largely impossible, and that incorporating expertise into existing systems would be a more successful approach (Rochester Safe Start Initiative, 2005a, p. 36).<sup>5</sup>

## **2.1 Political and Economic Context**

Protecting children from violence in the home. There is strong support for preventing child abuse and neglect in Rochester. Over the past 20 years, the child welfare system has built a diverse set of services to prevent placement in foster care. Until recently, these programs were, in theory, open to referral from the community; however, budget constraints have restricted the programs to children reported to Child Protective Services. Since 2002, the trend in number of families and children served has been downward. In addition to the formal child welfare system, Rochester has both public and private

initiatives that respond to child maltreatment (e.g., Do Right by Kids and Children's Agenda, respectively). Children's Agenda promotes home visiting by nurses and has obtained county and other funding to serve 100 high-risk families, starting in 2006.

Protecting children from community violence. Political and public intolerance of community violence is illustrated in the outgoing mayor's quick response to recent violence involving children. In 2005, the city experienced high levels of violence, with four murders of children under the age of 17, the scalding death of a toddler, and injury to a two-year old struck by a stray bullet. Violence became a critical issue in the mayoral campaign. The out-going mayor, rather than acting as a lame duck, convened citizens and organizational leaders to create a strategic plan to respond to youth violence in Rochester.

Promoting child wellness. There is growing consensus in Rochester about the importance of promoting social-emotional wellness at the early childhood level. As will be described in Section 3 of this report, Rochester has several resources dedicated to promoting healthy development in early childhood.

Political leadership and infrastructure. 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.

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<sup>5</sup> This intentional strategy was discussed during the October 3 and 4, 2005 site visit with the Safe Start Demonstration Project National Evaluation Team.

The Rochester Police Department was restructured in June 2004, with the consolidation of seven precincts into 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,<sup>6</sup> the restructuring of precincts prompted a single-minded departmental focus on successfully transitioning officers from the old system to the new one.

In spring 2005, the chief of police resigned to run for mayor, and was elected in November 2005, on a platform of public safety, education and youth support services, economic development, community development, and streamlining government. Transition teams have formed; the youth team is largely focused on teens and young adults.

Both at the state and local levels, there is recognition of the overlap between domestic violence and child abuse and the need for greater collaboration between these sectors. Despite tensions, the two systems have worked together (e.g., in the Safety First initiative<sup>7</sup>), to use a "Double Perspective" approach to children and families. Double Perspective makes the

different approaches and paradigms of child protective services and domestic violence available to both systems.

Resources for services. The county government is the primary source of funding for human services in Monroe County. Between 2002 and 2005, the county, as well as the city of Rochester, the school district, and New York state, all experienced severe budget shortfalls. Monroe County's previous and current local administrations have not supported tax increases to offset budget shortfalls. Only the sales tax rate has increased, and only by one quarter of one percent. According to site visit participants, county residents, in general, do not support tax increases.

Budget constraints have had the strongest impact on programs designed to prevent children from entering foster care (i.e., preventive services) and county support for school nurses in city schools. Constraints forced the RSS to seek nonpublic funding to support expanded and enhanced services. Constraints also generated increased tension between levels of government. From 2000 to 2003, antagonism between the county executive and the city mayor hurt the Rochester community's ability to get things done. Tensions have greatly subsided with the election of the new County Executive.

United Way funding preserved some of Rochester's prevention services, including RSS interventions, in the face of significant city and county budget cuts. Site visit (2005) participants, as well as RSS staff, described the importance of this source of funding for implementation of RSS interventions and the realization of RSS goals. As the

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<sup>6</sup> These perceptions were shared during the October 3 and 4, 2005 site visit with the Safe Start Demonstration Project National Evaluation Team.

<sup>7</sup> The Safety First initiative out-stationed a domestic violence worker on a Child Protective Services Investigation Team to provide consultation and intervention in cases in which there appeared to be co-occurring child maltreatment and domestic violence.

city (Rochester) and county (Monroe) steadily decreased their budgets for child- and family-serving organizations, agencies, and institutions, the United Way continued its financial support. This support enabled the RSS and its partners to continue to promote the social and emotional well-being of young children. United Way began its three-year funding cycle application process in mid 2005; how this will affect funding for children exposed to violence remains to be seen.

## **2.2 Social Context**

Child abuse and neglect. The Monroe County child welfare system serves at least 4,000 young children (18 years and younger) annually through Child Protective Services, Preventive Services, and Foster Care. Waits for Preventive Services vary, but can be up to a month or more. Each year, the REACH Clinic of Strong Hospital treats over 300 victims of child sexual abuse. In the fall of 2004, a Child Advocacy Center opened in Rochester. Child Protective Services, police officers, the district attorney, REACH providers, and other services are co-located in this center, to investigate cases of child sexual abuse or severe physical abuse. A Family Trauma Program at the Society for the Protection and Care of Children (SPCC) provides social work services to families in which a child has died due to abuse or neglect. What is particularly lacking in Rochester is early intervention for cases that may not be accepted as a report or indicated as a substantiated child abuse/neglect case.

Community and domestic violence. The majority of violence in Monroe County occurs in Rochester.

According to a 2004 Monroe County report,<sup>8</sup> Rochester, representing 30% of Monroe County's population, accounted for 71% of all incidents of domestic violence reported in the 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.

The level of children's exposure to community violence can only be estimated from existing data. From 1992 to 1997, Rochester saw the following annual crime rates: between 29 and 65 murders, 57 and 80 suicides, and 2,200 and 2,800 serious violent crimes (Part 1 crimes, which include murder, forcible rape, aggravated assault, and robbery). The PACE survey of parents of in-coming kindergarteners includes a series of questions on exposure to violence in the community and at home. The 2003-2004 results found that 16% of children had witnessed violence in the neighborhood and 13% had witnessed violence in the home before they entered kindergarten. This is likely an under-report (Greenberg, Lotyczewski, and Hightower, 2005). Based on these numbers, during their five preschool years, children born in 1992 had 281 chances to witness or hear about a murder, 342 chances to be affected by a suicide, and 12,773 chances to witness or hear about a serious violent event.

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<sup>8</sup> Monroe County Profile for Human Services Planning for the 2004-2007 Integrated County Planning Process.

Given the additional 24,000 family service calls to police per year (for approximately 120,000 calls over five years), it is clear that young children in Rochester live in an environment in which exposure to significant violence is extremely likely.

### 3. Community Capacity

Despite the numerous resources available in Rochester (e.g., services for children and families, strong working relationships among service providers, as discussed below), the needs of children exposed to community and family violence outstrip the capacity of the community to build a service system exclusively focused on children exposed to violence. For example, prior to RSS, existing services for mental health care for young children, including those exposed to violence, were insufficient, due to lack of therapists with specific expertise, funding streams that did not readily reimburse for mental health care for children under six, and state and local priorities that have traditionally ignored children's mental health.

As another example, the police have first contact with young children exposed to community violence, but police officers have other priorities in what are often crisis situations. Young child victims receive medical treatment, but limited social work services are available in emergency departments. Rochester does have two programs that focus on sibling survivors, but these programs tend to serve school age children rather than younger ages, and are underfunded, often relying on volunteers. There is little else targeted to

young children exposed to community violence.

Expanding the domestic violence system sufficiently to meet all needs of children exposed to violence was also deemed unfeasible at the start of RSS.

Nevertheless, site visit (2005) participants described Rochester as resource-rich and considered this an important community capacity for implementing RSS successfully; the broad array of existing services for families and children provided platforms for services to children exposed to violence and allowed Rochester Safe Start to bridge existing gaps and barriers in services.

In particular, several Rochester organizations, agencies, and institutions share a commitment to and expertise in early childhood that facilitated investment in RSS:

- Children's Institute develops and promotes prevention and early intervention programs, evaluates children's conditions and programs, conducts training for professionals, and forms community partnerships to address public policy;
- Mt. Hope Family Center is a nationally recognized research institute that has pioneered a community-supported, complete family approach to the treatment and prevention of child abuse and family violence, as well as the promotion of positive child development, the improvement of parenting skills, and the prevention of child maltreatment; and

- Society for the Protection and Care of Children provides free, home-based counseling to children and families impacted by domestic violence, as well as a safe, neutral, and supervised setting for the exchange of children whose families are court-involved because of domestic violence.

The ability of this community of child-serving groups to define a core goal (i.e., promoting the social and emotional well-being of children) was identified as a critical capacity for the implementation of RSS.

In addition, the United Way, the University of Rochester's Pediatric Links program, the REACH program at Golisano's Children's Hospital at Strong, the Rochester Police Department, and Alternatives for Battered Women contribute to the community's capacity to serve young children:

- United Way sponsors, among other projects, Success By Six, which ensures that young children are born healthy, remain healthy, and are ready to successfully enter school by age six;
- University of Rochester's Pediatric Links with the Community is a program that encourages pediatric residents to improve the health of children in their communities who lack access to care because of social or economic conditions or special health needs. Pediatric residents in this program participate in a

two-week rotation with a community health agency;

- REACH is a program that conducts psychosocial and medical evaluations of children (18 years of age and younger) for suspected sexual and/or severe physical abuse. Evaluations are conducted at the Golisano's Children's Hospital at Strong;
- The Rochester Police Department houses a Family Crisis Intervention Team (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; and
- Alternatives for Battered Women has a children's program that served 420 children of all ages in its shelter and more than 500 children from the community in 1999-2000.

Many of these organizations, agencies, and institutions collaborate with one another to better serve young children—a tradition that RSS built upon successfully. This practice of collaboration is documented in organizational and program descriptions and also was described by several site visit participants. For example:

- Assisting Children Through Transition is an “interdisciplinary” (quotes added) effort of the Children's Institute; New York's State's Unified Court Systems Seventh Judicial District; and the legal, judicial, mental health, and mediation communities to

- support children whose parents are divorcing;
- The Bivona Child Advocacy Center uses a “multidisciplinary” (quotes added) approach including Child Protective Services, Law Enforcement, REACH program at Golisano’s Children’s Hospital at Strong, Rape Crisis of Planned Parenthood, and the Monroe County District Attorney’s Office to serve young victims of sexual assault; and
  - Children’s Institute often serves as a managing partner, or in a non-management role, for efforts among agencies, families, and the community that support young children and their families in their growth and development. Almost all of the work of Children’s Institute is done in partnership; partnership is a core value of their work. Examples of community partnerships include the Rochester Early Enhancement Project, the Rochester Early Childhood Assessment Partnership, the Early Education Professional Development Project, and Rochester Safe Start.

Five additional examples of how Rochester service providers work together and with other sectors of the community (e.g., business, government) include the following:

- The Domestic Violence Consortium is a consortium of community agencies working together to address the issues of domestic violence;
- The Early Childhood Development Initiative is an initiative in Rochester/Monroe County that strives to build a community-based network of early childhood providers to promote a self-sustaining child care sector;
- The United Way’s Success By Six project encourages and facilitates collaborations and partnerships to unite community businesses, government, service providers, advocates, educators, and families;
- The Babies Can’t Wait Initiative, funded by the Robert Wood Johnson Foundation, is a cross-systems collaborative approach to incorporate knowledge from courts, child welfare, service providers, and child advocates in support of the well-being of children in the welfare system. The initiative hosts a court-based series to educate professionals about the medical, developmental, and emotional needs of young children in foster care;
- Rochester Safe Start staff are involved in other collaborative efforts in the community including the Police-Citizen Interaction Committee, the Domestic Violence Consortium, and the Pediatric Links Board; and
- Family Court has a special branch, the Domestic Violence Intensive Intervention Court (DVIIC), with a safe waiting room that houses probation staff to assist in the preparation of petitions, an ABW advocate to provide support and referral, and

Legal Aid Society representatives to provide counsel for petitioners. The University of Rochester recently received an NIMH grant to place a mental health professional in this waiting area to help with issues of trauma and stress. Staff for the DVIIC support a larger partnership and are eager to respond to needs identified by the partnership. In 2002, Monroe County became the site of an Integrated Domestic Violence (IDV) Court for families with cases pending in both family court and criminal court. RSS has provided training to court personnel and to Law Guardians to increase skills and knowledge about children exposed to violence.

In addition to their collaborative efforts in service provision, the Rochester community works together on several efforts to increase the social, emotional, and physical health of children:

- The Ad Council of Rochester is a critical resource, providing free or low-cost help with marketing, creative consultation, and distribution of media campaigns, including the RSS Shadow of Violence campaign. This local partnership of business and human services is a unique aspect of RSS;
- The Early Childhood Development Initiative is a critical “driver” of social-emotional issues in the community and has worked for more than a decade to build a

system of holistic early childhood education that addresses the whole child, as opposed to focusing primarily on cognitive development and literacy, as many other early childhood education programs do; and

- Health Action, a group of 15 community partners representing business, education, and health care sectors, was convened by the Monroe County Department of Health to “improve the health of the citizens of (Monroe County by aligning community resources to focus on selected priorities for action” Monroe County, 2006). This group releases a health “report card” on the priority area of maternal/child health, among others, and addresses this priority through the use of secondary data analysis, as well as development, implementation, and evaluation of interventions. In 2005, Health Action made a significant shift from an emphasis on physical health to prioritizing the social-emotional wellbeing of children.

In addition to the collaboration of these organizations, site visit (2005) participants discussed the important community capacity of using evidence-based practices and a data-driven approach to service delivery. Inherent to this approach is the ability to analyze data. Site visit participants gave several examples of how data can be and has been used to strengthen programs: 1) incorporation of evaluation tools into daily program operations, 2) use of data as evidence for a program’s need, 3) use of evidence of effectiveness for

prioritizing program funding, and 4) use of research to better understand the issues related to children exposed to violence.

Many site visit (2005) participants also identified Children's Institute as an important community resource instrumental to the successes of RSS.

- Children's Institute is a respected community convener with the ability to engage leaders in initiatives, including RSS. Many site visit participants cited Children's Institute's ability to find the voices in a system or community, engage a community through outreach, support existing alliances, integrate efforts to avoid duplication, and obtain community buy-in;
- Children's Institute's expertise in the social and emotional development of young children commanded the needed trust, respect, and credibility for implementing RSS interventions. Children's Institute gained community trust not only through its expertise, but also because it was perceived as having a neutral motivation for involvement in the issue of children exposed to violence, as opposed to the typically more political agendas of various advocacy groups. For example, through SAFE Kids, Children's Institute connected law enforcement and the service community—sectors with very different priorities and practices; and
- Children's Institute's commitment to evidence-based

practice has improved the quality of child and family services, including RSS interventions, by instituting an evaluation component for each of its programs. Investing resources in evaluation helps Children's Institute to dedicate limited resources to interventions with demonstrated positive impact. Evaluation findings have been used to prioritize resources dedicated to RSS interventions over time.

### ***3.1 Training and Technical Assistance***

Rochester Safe Start staff provided the professional community with a variety of training opportunities that improved capacity to respond to young children exposed to violence. For example, Shelter from the Storm training was provided throughout the life of the initiative. Mentors participating in the Early Childhood Education Intervention also received training throughout the life of the initiative (Rochester Safe Start Initiative, 2005a, p. 25).

In addition, the resource-rich community provided Rochester Safe Start with several important sources of local technical assistance. Catherine Cerulli, JD, PhD, Director of the University of Rochester Laboratory of Interpersonal Violence and Victimization (LIVV), provided local evaluation technical assistance in an effort to estimate under-reporting of the presence of children six years and younger (including prenatal children) at scenes of violence to which the Rochester Police Department responded. Dr. Cerulli and her team found massive

under-reporting. LIVV also organized the training for Law Guardians in November 2003 and has submitted papers both on that training and on a 50-state review of law and cases regarding endangering the welfare of a child as it relates to exposure to domestic violence. One valuable consequence of this work is that Dr. Cerulli now includes a discussion of children exposed to violence in all her medical and law school teaching, in addition to state training. Dr. Cerulli is also working to bring Shelter from the Storm training (module 5) to the medical community.

Furthermore, in 2005, Dr. Danielle Thomas-Taylor, a fellow in pediatrics at the University of Rochester Medical School, obtained Institutional Review Board approval for a follow-up study on the RSS sample of cases. Dr. Thomas-Taylor will screen RSS cases against the pediatric files of two hospital clinics to see what pediatricians knew about exposure to violence and, if they knew, whether they did anything.

Rochester Safe Start staff also reported several sources of national assistance that were useful for implementing the initiative (Rochester Safe Start Initiative, 2005a, p. 16-17). The Office of Juvenile Justice and Delinquency Prevention provided feedback on strategic and implementation plans that helped staff refine their strategies over time. The National Center for Children Exposed to Violence assisted with the startup and continuous improvement of the SAFE Kids intervention (described further in Section 5). The National Evaluation Team helped staff with the initiative's evaluation plan, as well as promoting useful reflection on the initiative's

strengths and challenges. Lastly, the Systems Improvement Training and Technical Assistance Project (SITTAP) provided important technical assistance around community engagement, policy initiatives, and sustainability.

## **4. Collaboration and Community Engagement**

Government agencies and non-profits in Monroe County share a long history of close collaboration; RSS grew out of the close collaborative history and working relationships among administrators and staff in various non-profit and government agencies throughout the city and county. This collaboration can be seen at all stages of the initiative's life. Success in winning the grant was the result of strong collaboration between the county health department and the Children's Institute through the Rochester Early Enhancement Project, a Children's Institute-facilitated collaborative of many local agencies that aims to increase struggling families' ability to realize their full potential. Success in sustaining RSS has been much easier than it might otherwise have been, given the network of collaborating non-profits and government agencies already in place at program inception. The structure and process of collaboration developed for the design and implementation of Rochester Safe Start is discussed next.

### **4.1 Early Assessment and Planning<sup>9</sup>**

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<sup>9</sup> Information in this section was reported in the local evaluation report form (Rochester Safe Start Initiative, 2005a, p. 22).

A community assessment, prepared by the Rochester Safe Start project coordinator with extensive assistance from staff in key organizations and agencies, was completed in August 2000 and supplemented through the work of the Center for Governmental Research, with results submitted to RSS staff in October 2000. Assessment findings identified both community strengths as potential platforms for RSS, and gaps and barriers as a basis for improving responses to children exposed to violence (Rochester Safe Start Initiative, 2005a, p. 25-26). Think tanks began the assessment/planning process and laid out a conceptual framework that stressed an ecological approach to the issue of children exposed to violence. Work groups on 1) community assets, 2) practices, and 3) evaluation were organized to complete 1) a survey of existing resources, 2) focus groups with over 130 providers and 40 family members, and 3) an assessment of existing data, respectively. A “rolling retreat” held on October 26, 2000 introduced community leaders to the concept of resilience and the impact of child abuse/neglect, domestic violence, and community violence using local experts and consultants from the National Center for Children Exposed to Violence. The second installment of the rolling retreat on October 31, 2000 presented the results of the work groups, as well as the Center for Governmental Research Community assessment, and then identified key priorities for the implementation plan. These priorities are reflected in the six interventions developed (described in more detail in Section 6).

#### **4.2 The Collaborative Council and Associated Teams: Structure and Function<sup>10</sup>**

The Safe Start Collaborative Council was responsible for decision-making about the initiative. Although basic principles were developed to guide and focus the planning of efforts within a collaborative setting, formal policies were never implemented to structure the RSS collaborative processes. Collaborative members did not vote; rather, they reached consensus on issues by allowing all members an opportunity to speak. Participation levels and intensity varied with the stage of the initiative. During the planning stage, the Collaborative Council met at least monthly, and Design Teams (described further below) met at least two or three times monthly. Attendance at all meetings was extremely high throughout the planning phase, with critical community leaders such as a United Way vice president attending almost every meeting, or at least sending someone in his stead. The RSS project director and project coordinator attended all or almost all of the planning-stage meetings, as well. The local evaluator was present for the vast majority of these meetings, and the director of the local evaluation attended on an as-needed basis. A Steering Team, consisting of the co-chairs of the Collaboration Council (i.e., counsel to the county executive and the director of the county health department) met with staff monthly to review progress, identify problems, and facilitate solutions.

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<sup>10</sup> Information in this section was reported in the local evaluation report form (Rochester Safe Start Initiative, 2005a, p. 18 & 22).

The structure of the Collaborative Council evolved based on the needs of the initiative at any given point in time. For example, at the beginning of the project, 60 to 100 people were actively involved. Some were members of the Collaboration Council; some were members of the council as well as various Planning Teams in different substantive areas; some participated only on Design Teams. By 2005, the Collaboration Council had been eliminated, to be replaced by the smaller Strategy Team as the locus of decision-making. Site visit (2005) participants indicated that this change occurred because of the need for a smaller decision-making structure capable of focusing on the components of RSS that could be sustained, and implementing these components before federal funding ended. The Strategy Team was made up of six core team members, RSS staff, and team leaders from the RSS communications, community engagement, critical interventions, and critical sectors teams. This structure facilitated decision-making but reduced the reach of RSS somewhat. Teams for key results areas (e.g., awareness) were identified and strategies outlined (Rochester Safe Start Initiative, 2005a, p. 18).

Similarly, associated teams were created and disbanded at various stages of the initiative. Planning Teams, for example, evolved into Design Teams responsible for the nuts and bolts of designing and implementing various interventions, including those targeting community norms and education, early childhood education, domestic violence, and police-mental health; the work of these teams was refined over 2001. In the first quarter of 2002, Review Teams

developed requests for proposal, reviewed applications, and recommended providers to the Collaboration Council. By Spring 2002, RSS was ready for startup of new and expanded services, and was actively beginning work on public awareness and training. Contractual arrangements were developed, and along with those, many deep partnerships with local agencies were formed and maintained. Through the implementation phase, Design Teams were consulted when issues arose, although meetings became less regular as the work of implementation began and difficulties decreased. Implementation Teams then formed for each intervention.

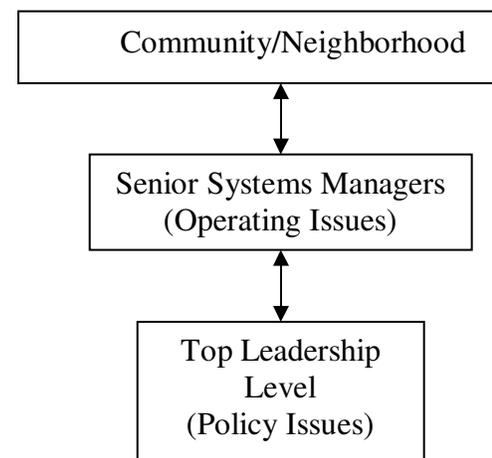
Perceived strengths and weaknesses of the Safe Start collaborative emerged during discussions with site visit (2005) participants. Collaborative strengths included:

- Children’s Institute has strong relationships with community leaders, which gave the collaborative access to important resources. For example, in 2005, a municipal official contacted Children’s Institute to manage member item money (i.e., discretionary funds). These funds were used to plan and design the Safe at Home program. The United Way and Children’s Institute continue to work collaboratively to identify funding priorities;
- Members of the Strategy Team were well positioned within their own organizations, which facilitated implementation of RSS. RSS staff strategically

engaged leaders who had decision-making authority within their organizations. These decision-makers were not, however, the public face of their organizations, and were therefore less inclined to expend the energy of the collaborative on the promotion of their own organizational agendas; and

- The three-tier structure of collaboration used by Children’s Institute/Rochester Safe Start was identified as a successful model. In the three-tier model, community needs and interests (top tier) drive the decisions of an initiative; the middle tier consists of the “doers” (e.g., deputy directors); and the bottom tier includes the highest level of leadership (e.g., mayor), required for successful implementation of an initiative. The Strategy Team operated at tier two, to make timely decisions informed by community members, but also able to impact organizational leaders. This model is shown in Figure 1.

**Figure 1. Three-Tier Collaborative Model**



One collaborative limitation was identified by some site visit (2005) participants:

- The Safe Start collaborative included a limited number of professionals working directly with families; therefore, some participants viewed the collaborative as lacking important input. The failure to create a more representative decision-making body might have hindered the investment of frontline service providers in RSS interventions. This limitation was attributed to both the Strategy Team and the earlier Collaborative Council configuration. The director of Child Welfare, a Strategy Team member, resigned in August 2005. After his resignation, the Strategy Team did not have representation from Child Welfare.

Other factors also challenged the Collaborative Council's ability to focus on implementation and sustainability efforts in 2005:

- Within Children's Institute, agency reorganization occurred, leaving the RSS project director to head both community partnerships and national services for about six months. A new director of community partnerships began in December 2005, but the transitioning of responsibilities from the RSS project director to this new director will continue for an

additional period, given the complexity of RSS and the continuing importance of the project director to RSS.

- The team that produced phase one of the Shadow of Violence campaign changed entirely over the summer of 2005. The creative director and art director left the agency to which Safe Start was assigned, and the chief executive officer of the Ad Council also left to become vice president of communications for the United Way. These changes meant orienting an entirely new team and negotiating the creative direction for phase two.

### **4.3 Community Engagement**

In the second half of 2005, the RSS began to develop its community engagement strategy in earnest. In the fall of 2005, RSS received a small planning grant from the city of Rochester through the New York State Office of Children and Family Services to focus on families affected by domestic violence in the west side of the city (Sector 3). With technical assistance from the city and from the Rochester Community Area Foundation Community Engagement program officer, the RSS began work on building relationships with two contrasting neighborhood associations by preparing an issue paper on needs, which is currently being tested through "community conversations." The need for a community organizer became apparent in 2005, and the RSS will fill a part-time contracted position in early 2006. That individual will not only complete the planning process, but will also connect with larger city anti-

violence efforts. These efforts include those of the outgoing mayor, to create a city Office of Child Safety and to coordinate public and private funding for community violence prevention efforts to build a safer and more viable community for children and youth.<sup>11</sup>

In general, Rochester Safe Start staff was less adept at engagement of residents in high crime areas than at engaging professionals in the community. Furthermore, RSS staff underestimated the extent to which some communities view domestic violence as acceptable behavior. Changing community norms around this type of violence will be more difficult than originally anticipated. The Safe at Home planning process with a local Neighborhood Empowerment Team also took longer than expected, in part due to the difficulty of finding residents interested in the project.

## 5. System Change Activities

Safe Start demonstration sites are expected to improve the system of care for young children exposed to violence by implementing a balanced, comprehensive approach, spanning five domains of system change: 1) development of policies, procedures, and protocols; 2) service integration activities; 3) resource development, identification, and reallocation; 4) new, expanded, or enhanced programming; and 5) community action and awareness activities. Rochester Safe Start staff and partners designed and implemented six core interventions that used these system

change strategies to improve the access, delivery, and quality of services for young children exposed to violence. Rochester Safe Start's overall approach to system change and specific interventions are discussed next. The interventions range from broad community awareness to narrow focus on individual children.

Rochester Safe Start was operationalized by embedding resources in existing community programs, with the goal of addressing unmet community needs. As one site visit (2005) participant stated, Rochester Safe Start "didn't develop a pipeline to therapeutic interventions." Others described RSS as seeking to raise awareness of the issue of children exposed to violence without creating additional burdens for families and service organizations. Instead, RSS staff dedicated resources to enhance ongoing efforts. One participant described the approach as follows: "Rochester Safe Start was behind the scenes pulling the strings, nice web, bringing the community together as a whole." Another participant described this strategy as "quiet infiltration." This approach is represented in Exhibit VII-B.

Rochester Safe Start staff engaged multiple sectors of the community to implement both universal and targeted system change activities. RSS staff worked with early childhood providers, the courts, the police department, and mental health providers to offer children and families universal interventions (social marketing campaign, the Early Childhood Education Intervention, community engagement/Safe at Home), as well as targeted interventions (SAFE Kids,

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<sup>11</sup> At the time of this report, this proposed idea did not appear to be on the agenda of the current city administration.

mental health services for foster care children, supervised visitation, court advocates), designed to reduce children's exposure to violence and its impact. Each of these interventions is described next.

### **5.1 Shadow of Violence Media Campaign**

RSS staff utilized the Ad Council of Rochester's expertise in social marketing to conduct a public awareness campaign designed to mobilize adults in the community to respond to children exposed to violence at home and in the community. Campaign components included a television commercial; print ads; and at a grass-roots level, posters, brochures, and door hangers for distribution at churches, community centers, businesses, and homes. Most site visit (2005) participants identified increasing community awareness of issues related to children's exposure to violence as an important accomplishment of RSS.

The Shadow of Violence Campaign was an innovation, not only for Rochester but also more broadly. Based on academic literature reviews conducted by RSS staff and National Center for Children Exposed to Violence Resource Center librarians, the Shadow campaign was the first of its type.

### **5.2 Training Initiative<sup>12</sup>**

RSS staff and partners concluded that the domestic violence system could not be expanded sufficiently to meet all needs. This conclusion provided the impetus for the training initiative that consisted of three components: 1) Shelter from the Storm (1-2 day trainings on children exposed to domestic violence), 2) conferences, and 3) presentations. These components created a unique approach to training that created two training streams: clinical and nonclinical. The bulk of training participants have attended conference and presentations. The training initiative reached 2,313 participants between 2003 and 2005 (Rochester Safe Start Initiative, 2003; Rochester Safe Start Initiative, 2004; Rochester Safe Start Initiative, 2005b).<sup>13</sup> In 2006 the focus of presentations will shift from staff to community residents.

### **5.3 Early Childhood Education Intervention**

An initiative focused on early childhood should, logically, work within the system that sees the most children six years and younger outside the family. Early childhood programs in Rochester have increasing contact with children three to five years of age. At the age of two, 49% of the city's children are in center or family care. By age three, 55% of children are enrolled in child care; by age four, that percentage increases to 70%. Other estimates put the percentage of four-year-olds in child care at over 80% (Rochester Safe Start Initiative, 2005a, p. 11). Based on these numbers and, more importantly, the evidence that

<sup>12</sup> For a full description of the trainings provided, see the local evaluation report form, 2005 (Rochester Safe Start Initiative, 2005a, p. 14-15).

<sup>13</sup> This figure was compiled from Progress Reports (2003-2005) submitted by Rochester Safe Start to the Office of Juvenile Justice and Delinquency Prevention.

high quality early childhood education is a strong protective factor for at-risk children, the RSS committed to enhancing the ability of early childhood educators to respond to children exposed to violence. Mentoring was a key part of this quality improvement system.

The Early Childhood Education Intervention was universal, with all children—and therefore all those exposed to violence—receiving the intervention indirectly through their teachers. This was a new approach in Rochester, and in general in the field of children exposed to violence. Mentors supported teachers by working with children not fully engaged in the group learning process and by providing teachers with a variety of support. Mentors supported and assisted teachers by providing them with educational materials and other resources on the behavioral signs that can indicate exposure to violence, consulting with them on issues such as classroom setup, observing child and adult behavior in the classroom, providing insight on child-parent interactions in the classroom, taking teachers on guided observations of model classrooms, and modeling strategies and techniques to assist teacher. Additionally, teachers suggested referral services or personally referred children to appropriate service providers. Collaboration, therefore, was inherent in the mentor process.

During the summer of 2004, RSS staff developed a protocol manual for participants in the Early Childhood Education Intervention. 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 were most effective and how other methods could 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.

#### **5.4 SAFE Kids Program**

Although a variant of an existing program (child development-community policing, developed by New Haven and Yale), SAFE Kids was new to Rochester. The program forged a partnership between police and social workers (employed by the Society for the Protection and Care of Children), on behalf of young children exposed to violence in the community or home. SAFE Kids increased police identification of children exposed to violence at the scene of community or domestic violence calls, bringing many children who might not otherwise have received services into the network of resources available for children exposed to violence in the community.

From the outset, the SAFE Kids project included case consultation meetings among SPCC, the Rochester Police Department, and the Family Crisis Intervention Team. The RSS coordinator attended these meetings, and the RSS administrative assistant maintained files of cases and took meeting minutes on general issues. Child Protective Services, the Mobile Crisis Mental Health Team from Strong Hospital, and on occasion other providers attended these meetings, as

well. At meetings, each new case was presented and next steps were identified.

SAFE Kids did not achieve 24-hour crisis response in the vast majority of cases, because of delays in referral by police officers. In early 2005, SPCC provided one social worker, without round-the-clock backup, to police officers, but suspended this aspect of the program during June and July (2005), after a key SPCC staff person resigned. A SAFE Kids memorandum of agreement documents the relationship among SPCC, the Rochester Police Department, and FACIT. Should SAFE Kids continue, an update will be needed to reflect the revised structure.

There were mixed perceptions about the success of this program among site visit (2005) participants. From program inception in March 2002 to February 2004, SAFE Kids responded to 130 incidents involving 305 children. During the second 12 months of that 24-month period (i.e., during the period for which accurate data on service delivery are available), social workers had contact with (and thus could be considered to have served) 119 children. Eighty-four of these children were classified as receiving the “highest” level of service delivery (i.e., contact between the social worker and both the child exposed to violence and the involved family; Rochester Safe Start Initiative, 2005a, p. 47).

### **5.5 Children in Court Program**

The Children in Court program was an innovation in Rochester, and included two projects: the Alternatives for Battered Women Child Advocate

Project and Fast Track Supervised Visitation.

Between May 2003 and October 2004, the ABW Child Advocate Project served 574 families with children six years and younger. These families were involved in either Integrated Domestic Violence Court or Domestic Violence Intensive Intervention Court, and had 801 children six years and younger and 386 children older than six. All families received court advocacy services in DVIIC and/or IDV. Additionally, all families were informed of ABW services and a variety of community-based services. Families were specifically asked at intake about early childhood and health services for their children, and referrals were made as needed. Additionally, families could access ABW’s partnership with the Legal Aid Society of Rochester for civil legal services (Rochester Safe Start Initiative, 2005a, p. 47). The advocate project ended in 2005, because a separate ABW advocate made less sense than ensuring expertise in children exposed to violence among all court advocates.

Fast Track Supervised Visitation, provided by the Society for the Protection and Care of Children, offered expedited visitation services for court-involved families experiencing domestic violence that physically endangered their children. During visitation, non-custodial parents received coaching on appropriate parenting behavior. Both parents were taught how to focus on and prioritize their children’s needs. The program received referrals for 53 families, and 48 families acted upon and received supervised visits. This translated to approximately 96 parents and 70 children served. Among these

families, the average wait for service was one to two weeks, as opposed to six months in the general supervised visitation program (Rochester Safe Start Initiative, 2005a, p. 47). Based on results described in the final report on the Fast Track project, the RSS agreed to fund and rigorously evaluate this approach to supervised visitation; that project will begin in 2006.

Through Children in Court, ABW and SPCC met regularly, primarily to review program development and problem-solve, but also to confer on specific families. This process ended with the completion of the project.

### **5.6 Mt. Hope-Foster Care Intervention**

The Mt. Hope-Foster Care intervention was an expansion of Mt. Hope's well-known approach to helping children facing serious difficulties, especially child abuse and neglect. The program provided young children in foster care ready access to rapid assessment; contextual assessment (observing and analyzing behaviors in different settings to understand differential symptoms); consultation with the foster care worker, foster parents, and bioparents; and child therapy. Mt. Hope reached 101 children between April 2002 and April 2004 (Rochester Safe Start Initiative, 2005a, p. 36). Case sharing and collaboration among the Mt. Hope therapist, foster care worker, and Foster Care Pediatric Clinic were on a child-by-child basis. No regular mechanism for case consultation was used in the project.

### **5.7 Domestic Violence Consortium Protocols**

The Domestic Violence Consortium developed child-focused protocols for handling cases of domestic violence for service providers and the courts in 2005; protocols for law enforcement and the district attorney had been developed previously. RSS staff contributed the child piece to the service provider protocols and is involved in development of training. RSS staff also helped obtain buy-in for implementation of the protocols. The Domestic Violence Consortium planned to audit implementation of the protocols, but was not awarded funding needed for that effort; the consortium is applying again and is positioned to conduct the audits in 2006-2007. In the meantime, the county has provided bridge funding for the Domestic Violence Consortium to continue its efforts at implementing the protocols.

## **6. Institutionalization of Change**

Rochester Safe Start accomplished many of its original objectives and as a result made several lasting changes in the service delivery system.

### **6.1 System and Agency Change<sup>14</sup>**

The protocols developed by the Domestic Violence Consortium for law enforcement, the district attorney, the courts, and service providers represent

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<sup>14</sup> Information in this section was reported in the local evaluation report form (Rochester Safe Start Initiative, 2005a, p. 32).

change at both the system and agency levels, as each system begins to focus on how children are affected by exposure to violence. RSS staff advocated for a section in the service providers protocol dealing with children exposed to violence, and took leadership in drafting that section. RSS staff was also active in planning for the invitational conference in October 2004 and the general conference in May 2005, where education and training on how to implement the protocols took place.

In addition, RSS staff contributed to improving mandated reporter training through the Do Right by Kids initiative, which resulted in greater openness of the local child abuse hotline to provide consultation for child-related incidents that do not rise to the level of a mandated report. The SAFE Kids protocol developed in spring 2004 also represents an important agency-level change. The institutionalization of Mt. Hope-Foster Care interventions ensures the provision of mental health care for children in foster care under the age of six. This change is both a point-of-service and an institutional change.

## **6.2 Point-of-Service Change**<sup>15</sup>

The Rochester Safe Start Training Initiative increased the expertise of over 500 clinical and non-clinical providers of services to young children, through Shelter from the Storm, as well as providing other training to over 1,000 additional attorneys, police, court personnel, and early childhood providers. Feedback from the Shelter from the Storm training

evaluation suggests that information in the curriculum was new and useful to participants. Efforts to institutionalize Shelter from the Storm included development of co-sponsorship, calculation of a cost structure, and preparation of an application for support from the New York State Office of Children and Family Services, as well as plans for incorporation within at least two major systems in 2005. Evaluation of the Law Guardian training resulted in a more intensive training on interviewing children, as well as 1) a column in the newspaper of record for attorneys, and 2) a review of the literature on adult learning as it relates to increasing attorney expertise on children exposed to violence, which will affect the training provided to Law Guardians in the 7th Judicial District.

In the future, the New York State Office of Children and Family Services, rather than Safe Start, will fund the Early Childhood Education Intervention. A screening tool was developed simultaneously to, but not as part of, the intervention as part of the other community work on children. The intervention and screening tool development were a parallel process, clearly impacting one another. The screening questions have been incorporated into PACE, a form completed by the parents of all incoming kindergarteners in the Rochester City School District. In addition, the mentoring system has institutionalized a set of training materials for mentors on knowledge and skills in responding to children exposed to violence. The cadre of mentors who worked with 35 classrooms for 18 months is now working with 30 more to increase teachers' skills in responding to children

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<sup>15</sup> Information in this section was reported in the local evaluation report form (Rochester Safe Start Initiative, 2005a, p. 32).

exposed to violence. The expertise developed through RSS will be infused into a larger Early Childhood Professional Development grant that will provide 26 mentors for infant/toddler as well as preschool early childhood programs.

### **6.3 Community Change<sup>16</sup>**

Changing adults' knowledge, attitudes, behavior, and expectations of themselves and others can contribute to positive outcomes for children exposed to violence. A link between social marketing and child outcomes is not a common finding in the academic literature, if only because there have been few social marketing campaigns geared toward helping children by sending messages to adults, evaluated in valid ways, and published. Evaluation of the Rochester Safe Start Shadow of Violence campaign showed an increase in the proportion of adults in the campaign target community who reported responding after seeing a child being exposed to violence. Among survey respondents who had been bystanders to children exposed to violence in the previous six months, common actions taken by those who responded to the exposure included listening to the child's story, comforting the child, contacting the authorities (police and/or Child Protective Services), calling Lifeline, and other appropriate responses. There was not an increase in such self-reported behavior in the comparison community.

## **7. Increased Community Supports**

Rochester Safe Start successfully obtained funding for key service components:

- In 2005, the Early Childhood Education Intervention received \$148,000 from the New York State Office of Children and Family Services to provide mentoring to 30 prior control classrooms, booster sessions for 30 intervention classrooms, and training for Parent Group Leaders and Site Coordinators. In 2006, mentors will be transitioned to the Early Education Professional Development grant. The training developed through Safe Start is now provided to all mentors;
- In 2005, SAFE Kids was assumed by the Society for the Protection and Care of Children through local grant funding and SPCC Board-designated funds. SPCC has approached the county executive, the Red Cross, and others for on-going funding support in subsequent years;
- In April 2004, the United Way picked up the Mt. Hope Family Center services for young children in foster care; and
- Fast Track Supervised Visitation could be replicated as a national model if evaluation findings support its ability to reduce the impact of children's exposure to violence.

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<sup>16</sup> Information in this section was reported in the local evaluation report form (Rochester Safe Start Initiative, 2005a, p. 33).

RSS continued its relationship with the Ad Council and is seeking additional support for community education:

- The Ad Council approved Safe Start as a community initiative for 2005 and 2006. This approval will provide extensive assistance with creative and marketing approaches for phase two of the Shadow of Violence campaign;
- Application for additional assistance for phase two of the Shadow of Violence campaign was made to the federal Office of Victims of Crime. This application was not funded; and
- RSS received \$1,000 from Target in support of phase two of the Shadow of Violence campaign.

RSS community partners will continue to advocate for reducing children's exposure to violence beyond federal funding. United Way now recognizes that violence is an issue that touches all of its project areas. More specific to sustaining RSS, the United Way plans to work with Children's Institute/RSS staff on sustaining the "Safe Start Initiative infrastructure" (e.g., staff positions). The Domestic Violence Consortium will continue to keep the community aware of the impact of domestic violence, on both adult and child victims. Individuals who participated in and provided Shelter from the Storm training will continue to offer their knowledge and awareness of children exposed to violence to those with whom they work within the community.

Despite these important changes in community support for children exposed to violence and their families, there remain gaps and barriers to accessing and receiving services specific for exposure to violence in Rochester:

- Systems do not systematically identify children exposed to violence;
- Multiple points of entry mean a child may or may not receive services. Are protocols in place that ensure referral for and connection with services from any point of entry into the system? Evidence from local studies and from case reviews suggests that referral processes vary considerably across points of entry; and
- Access to services is an issue that extends beyond Rochester Safe Start; RSS staff must link with larger community efforts designed to improve access to needed services.

## 8. Reduced Exposure to Violence<sup>17</sup>

Rochester Safe Start interventions were not designed to reduce exposure to violence in the sense of primary prevention, nor did evaluations designed to assess program implementation focus on this outcome. Early intervention was the primary goal of RSS interventions. Nevertheless, there are several programs and initiatives

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<sup>17</sup> Information in this section was reported in the local evaluation report form (Rochester Safe Start Initiative, 2005a, p. 37-38).

underway in Rochester that have the potential to reduce exposure to violence:

- In fall 2004, the Rochester Police Department developed an initiative to identify homes in which six or more domestic violence incidents have occurred. Officers and the Family Crisis Intervention Team approach these families to offer services and warn the perpetrator in hopes of reducing further violence. As of yet, no outcome data are available;
- The ACT program is aimed at helping parents and others in close contact with children to teach children nonviolent problem-solving. RSS community assessment identified child-on-child violence as a key issue, and this is one effort to address that problem. The ACT curriculum was developed by the American Psychological Association and the National Association for the Education of Young Children. RSS participated in the initial national launch of training trainers. No outcome data on actual prevention of violence are likely to be collected;
- Alternatives for Battered Women is maintaining its children's program in the shelter, and the Society for the Protection and Care of Children is maintaining its Family Violence Program. Family Court and Integrated Domestic Violence Court have maintained their services. Batterers intervention programs in Rochester include children exposed to violence components,

but are having difficulty obtaining referrals;

- Mt. Hope Family Center has received a federal grant to study domestic violence and young children. Project FUTURE focuses on toddlers (23 to 25 months) to look at the impact of domestic violence; however, this is a research study rather than the study of a program; and
- Mt. Hope Family Center also received a federal grant to study maternal depression and attachment and provide services to depressed mothers. These services are likely to prevent neglect of infants, providing another resource for young families.

## 9. Reduced Impact of Exposure to Violence<sup>18</sup>

As described in Section 3 of this report, the Rochester Safe Start grantee systematically used evaluation data to monitor and improve its various interventions. Process evaluation findings were used to improve upon or eliminate interventions over the life of the initiative. The evaluations of the Shadow of Violence campaign and the Early Childhood Education Intervention were the only evaluations designed to assess intervention outcomes. Neither was designed to examine a reduced impact of exposure to violence; rather, changes in community norms and classroom-level changes in child development, respectively, were the focus of these evaluations. These evaluations are described in more detail

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<sup>18</sup> Information in this section was reported in the local evaluation report form (Rochester Safe Start Initiative, 2005a, p. 39-40).

in Exhibit VII-C and are summarized briefly here.

### **9.1 Shadow of Violence Evaluation**

This evaluation employed a non-equivalent control group design, in which the control group was a high-crime portion of Buffalo similar to the treatment group (Rochester's "crescent of violence"). Four hundred random digit dialing interviews were conducted in each city, both pre- and post-intervention, for a total sample size of 1,600. The evaluation measured achievement of five objectives: increased awareness, increased knowledge of impact, and three changes in norms. Findings indicated an increase in the proportion of adults in the campaign target community who reported acting after seeing a child being exposed to violence. There was not an increase in this behavior in the comparison community. A second, very similar ad campaign and study will commence in early 2006.

### **9.2 Early Childhood Education Intervention Evaluation**

This evaluation employed a randomized clinical trial design. The data set consists of 615 observations, for children whose parents consented to provide data on exposure to and symptoms of violence at each program year's start. Teachers in these observations remained constant (with the exception of teachers lost to attrition and replaced), while children in the observations changed from year one to year two. Data sources included parents, teachers, RSS, and Rochester Early Childhood Assessment Partnership.

Children in classrooms with mentors demonstrated more positive growth in their cognitive, social, and physical functioning than children in classrooms without mentors. This difference was statistically significant.

## **10. Conclusion**

Rochester Safe Start staff and partners successfully implemented and sustained some of its critical interventions. Making the shift to sustainability planning, which also involved implementing new projects (i.e., Safe at Home, evaluation designs), during a year of internal changes and uncertainty with regard to federal funding, was challenging. Rochester Safe Start staff, Children's Institute staff, and their community partners strengthened Rochester's response to children exposed to violence and their families through trusting relationships, engaged leadership, and skilled staff dedicated to the mission of Safe Start. Additionally, the use of evidence-based practices and evaluation data was integral to the development and modification of the community response. RSS intentionally focused on building the capacity of existing service providers as opposed to developing new systems. Using a behind-the-scenes strategy, RSS staff was less concerned about name or brand recognition and more invested in helping other organizations, agencies, and institutions develop the knowledge, skills, awareness, and relationships needed to address the issue of children exposed to violence.

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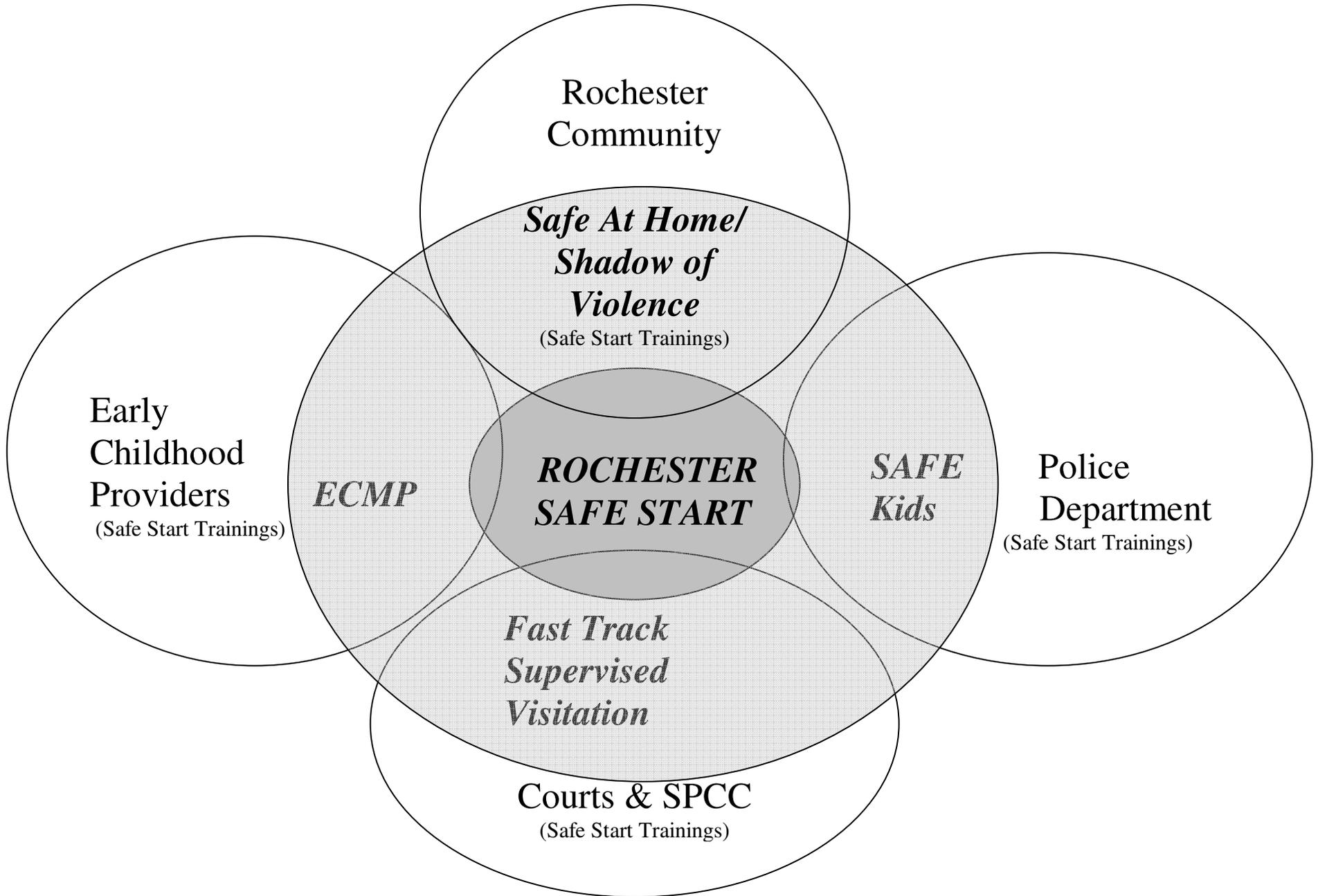
**Exhibit VII-A**  
**Timeline of Rochester Safe Start Initiative Activities and Milestones**

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	1/05-6/05	7/05-12/05
<i>Shadow of Violence</i> media campaign		✓	✓	✓				
<ul style="list-style-type: none"> <li>Received Telly award for <i>Shadow of Violence</i> public service announcement</li> </ul>					✓			
<ul style="list-style-type: none"> <li>Approved for an additional year as a community initiative for the Ad Council of Rochester</li> </ul>							✓	
<i>Training Initiative</i> for children exposed to violence				✓	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>“Babies Can’t Wait” series</li> </ul>				✓	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>Law Guardians Training implemented</li> </ul>				✓				
<ul style="list-style-type: none"> <li>Law Guardians Training developed into a monthly column series in the <i>Daily Record</i></li> </ul>					✓	✓	✓	✓
<i>Early Childhood Education Intervention</i>				✓	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>Development of consultant/mentor protocol manual</li> </ul>						✓		
<ul style="list-style-type: none"> <li>Early Childhood Education Intervention incorporated into the Early Educators Professional Development grant</li> </ul>								✓
<i>SAFE Kids</i> intervention	✓	✓	✓	✓	✓	✓		
<ul style="list-style-type: none"> <li>Creation of <i>SAFE Kids</i> Memorandum of Agreement</li> </ul>					✓			
<ul style="list-style-type: none"> <li><i>SAFE Kids</i> incorporated into the Family Violence Program of the Society for the Protection &amp; Care of Children (SPCC)</li> </ul>							✓	
<i>Children in Court</i> initiative			✓	✓	✓	✓		

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	1/05-6/05	7/05-12/05
Mt. Hope Family Center <i>Child in Context</i> intervention				✓	✓			
• Received United Way funding to continue program					✓			
Pilot training on children exposed to violence for probation officers						✓		
Safe at Home community engagement planning process								✓

Sources: Rochester Progress Reports: January-June 2004, July-December 2004, January-June 2005, July-December 2005; Rochester Safe Start Highlights: 2004 and Looking Ahead, February 2005, March 2005, April 2005, May 2005, June and July 2005, August 2005; Rochester Local Evaluation Form: 2004, 2005.

ROCHESTER SAFE START SERVICE DELIVERY MODEL



## **Exhibit VII-C**

### **Rochester Safe Start Intervention Research**

#### **Overview**

The Rochester Safe Start (RSS) grantee used various methods as part of its intervention research. However, the only two interventions that were evaluated using a comparison design were the Shadow of Violence media campaign and the Early Childhood Education Intervention. For purposes of this case study, these two evaluations are highlighted. The Shadow of Violence campaign aimed at changing community norms and attitudes. The message was simple: *Children are harmed by witnessing violence...and the community can help.* The campaign components included a television commercial; print ads; and at a grass-roots level, posters, brochures, and door hangers for distribution at churches, community centers, businesses, and homes. The Early Childhood Education Intervention mentored teachers and other adults in early childhood classrooms to recognize that difficult child behaviors may be caused by exposure to violence. Mentors also guided adults to create environments, both physical and psychological, that are supportive for children who have witnessed violence. For example, mentors showed teachers classroom layouts that children find reassuring, helped teachers structure their school day in a familiar and comforting fashion, and offered techniques for encouraging withdrawn children to open up about their feelings and for responding to children who act aggressively.

#### **Methods**

The Shadow of Violence evaluation employed a non-equivalent control group design, in which the control group was a high-crime portion of Buffalo similar to the treatment group (Rochester's crescent area).

The Early Childhood Education Intervention evaluation used a randomized control group design, in which mentors were randomly assigned to classrooms.

#### **Sample:**

The Shadow of Violence sample: Four hundred random digit dialing interviews were conducted in each city, both pre- and post-intervention, for a total sample size of 1,600.

The Early Childhood Education Intervention sample: The Early Childhood Education Intervention targeted 65 preschool classrooms and had a sample size of 615 children.

#### **Procedures:**

Shadow of Violence Campaign. Random digit dialing was used to survey residents. The evaluation measured achievement of five objectives: increased awareness,

increased knowledge of impact, and three changes in norms. Multivariate survey-weighted logistic regression analysis was employed. STATA (a common survey logit program) was the statistical software package employed to analyze the survey data.

Early Childhood Education Intervention. Data for the Early Childhood Education Intervention were collected between 2002 and 2004 by parents, teachers, Rochester Safe Start, and the Rochester Early Childhood Assessment Partnership. Two standardized instruments were used to assess the impact of violence on young children: the Teacher-Child Rating Scale (T-CRS) and the Child Observation Record (COR). The T-CRS measures the child's socio-emotional behavior by assessing the child's task orientation, behavior control, assertiveness, and peer social skills. The COR assesses a child's development and progress in different educational areas, and helps teachers construct a profile of the child. Data were analyzed using hierarchical linear modeling, which controls for shared variance (e.g., differences in classrooms are statistically separated from differences in children's outcomes). Furthermore, a parent survey was administered pre-intervention to assess exposure to violence and symptoms related to exposure to violence. These data were then analyzed to study a child's level of exposure to violence and the symptoms associated with exposure.

## **Results**

Shadow of Violence. The statistically significant and substantively large increase in reported activity by adult bystanders to children exposed to violence (discussed above) constitutes an increase in a very important protective factor. Subsequent multivariate analysis using logistic regression indicates that post-campaign Rochester respondents who reported being a bystander to a child exposed to violence were over ten times more likely than other reported bystanders (i.e., pre-campaign in Rochester and pre- and post-campaign in Buffalo) to act (i.e., odds ratio on variable that interacts city and time point is 10.2;  $p=0.009$ ).

Early Childhood Education Intervention. Parents of 1,934 children, 88% of whom were kindergartners, completed the parent survey for the 2003-2004 school year. Results showed that 16% of the children had witnessed violence in their community and 13% had witnessed violence at home.

Results obtained using the T-CRS instruments revealed no differences in scores between intervention and control groups. However, the COR instrument results showed positive changes post-intervention on all three subscales of the COR. Additionally, positive changes were observed in the total scores for treatment versus control groups. A 0.66 estimated effect size for the difference in the total COR growth suggests that mentors were successful in supporting teachers so that they were able to provide positive learning environments that helped children's progress.

## **Discussion**

Intervention research findings suggest that a media campaign and a mentoring model can be effective ways of intervening on behalf of young children exposed to violence. An effective social marketing campaign may be able to influence adult norms and attitudes, such that adults intervene when children have been exposed to violence. Such intervention is likely to contribute to more positive outcomes for children exposed to violence if norms and attitudes are changed for a significant numbers of adults in a community. In addition, providing early childhood educators with coaching and mentoring support can help children through their teachers. Initial evaluation findings suggest that focusing on the key adults in children's lives is a powerful way to promote wellness in early childhood.

# VIII

## San Francisco SafeStart

### 1. Overview

Prior to the San Francisco SafeStart initiative, the city and county of San Francisco had limited data on children exposed to violence, inadequate capacity (knowledge, skills, and resources) for responding to the specific needs of these children, and an incomplete continuum of support and fragmented services for this special population. Guided by its Advisory Council of 28 to 31 representatives from ten sectors,<sup>1</sup> SafeStart worked to address these limitations by 1) increasing the effectiveness of services by training point-of-service providers on how best to respond to children exposed to violence; 2) preventing childhood exposure to violence by sensitizing the public to the issue; 3) reducing the impact of exposure by providing early intervention and treatment; and 4) improving systems by promoting a core set of values, beliefs, and practices for responding to young children exposed to violence.

The Advisory Council, chaired by the presiding judge for the San Francisco Unified Family Court, consisted of influential leaders who were well respected in the community and in positions to affect decision-making and policies. A Steering Committee of nine people who served as the Advisory Council's executive committee,

along with several standing and ad hoc committees that focused on specific issues (e.g., evaluation, public education, batterer intervention, sustainability, and cultural competence), supported the Council. This structure enabled all stakeholders to participate according to their availability, functions, and interests.

The Advisory Council had another unique feature: the Parent Team, which functioned as a committee. This team, made up of five people who had experienced violence in their lives, ensured that SafeStart strategies were informed by the perspectives of families affected by violence, in addition to those of service providers and other professionals. The Parent Team developed a mentoring program through which its members mentored eight domestic violence survivors to support other survivors and speak publicly about violence and its impact on young children.

To increase the effectiveness of services by training point-of-service providers on how best to respond to children exposed to violence (SafeStart goal #1), the San Francisco SafeStart grantee conducted three annual SafeStart Academies, three annual conferences, and several trainings to specific groups (e.g., the school district). Over 3,000 people have attended at least one SafeStart training event (Fox & Mayer, 2005).

SafeStart's second goal, to sensitize the public to the issue of childhood exposure to violence and its impact, was accomplished through a 2004 public

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<sup>1</sup> The sectors included child welfare, law enforcement, family court, domestic violence, batterer intervention, health and behavioral health, education, early childcare, youth development, and community-based family support services.

education campaign with the theme, “You’re Not Just Hitting Her—Domestic Violence Hurts Children Too.” The campaign, co-sponsored by the Saint Francis Memorial Hospital and the California Attorney General’s Office, distributed 30,000 flyers to every elementary school, child development program, and Head Start program throughout the city. Graphics were placed inside 300 buses, on the rear of 50 buses, and on 30 bus shelters. The campaign was covered on four television stations and five radio stations, and in three local newspapers.

To reduce the impact of exposure by providing early intervention and treatment (goal #3), the SafeStart grantee used a multi-prong strategy that 1) built upon and expanded the existing infrastructure of six family resource centers<sup>2</sup> (FRCs) by funding one family advocate position in each center,<sup>3</sup> 2) established a Service Delivery Team made up of point-of-service providers as the primary mechanism for service coordination, and 3) funded three clinician positions (two full-time and one part-time).

Family resource centers, conveniently located in different

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<sup>2</sup> [Family resource centers](#) collaborate with local agencies and help many parents, families, and children access information about early intervention services. Some of the FRCs operate as independent sites in community settings; others are based in regional centers, local education agencies, public health facilities, or hospitals. One of the six SafeStart-funded centers was not a family resource center; it was a public health center that provides behavioral health services rather than family support approaches (case management, advocacy). This center, however, had the same contractual obligations to SafeStart as the other true family support agencies; hence, it was treated just like a family resource center.

<sup>3</sup> A senior staff person from each family resource center served on the Advisory Council, while the family advocates were involved in the Service Delivery Team.

neighborhoods throughout the city, provide parent-to-parent support, peer counseling and home visits, information and referral, parent education, and support services in different languages. They have staff members who share cultural characteristics with the families in the neighborhood; hence, families are more likely to go to the centers than to a mental health clinic for help. All but one family resource center has the capacity to provide behavioral health services, as well. To further increase the likelihood of identifying children exposed to violence and link services, SafeStart also funded one liaison in the police department and another in family court, and established a dedicated telephone line for SafeStart (“the Support Line”).

The Service Delivery Team consisted of the six FRC family advocates, the two SafeStart liaisons, the Support Line coordinator, a representative from Child Protective Services, a domestic violence victim advocate, an adult probation officer, two to three behavioral health service providers, and two child trauma and child development specialists. The team planned and coordinated its responses to a child and his/her family, ensuring that the child and family received all the support needed (e.g., batterer intervention, treatment, parenting support, and/or shelter). Children exposed to violence could receive treatment from the behavioral health specialists in the family resource centers, SafeStart’s clinicians, other clinicians available through the Department of Public Health Behavioral Health Services, or the Child Trauma Research Project (a joint endeavor of the University of California San Francisco’s Department of Psychiatry and the San Francisco General Hospital).

From the time of its establishment through October 31, 2005, the SafeStart

Support Line received a total of 408 calls, 262 of which were referred to SafeStart services (San Francisco SafeStart Initiative, 2005a). The Service Delivery Team served a total of 351 families and 702 children (Fox & Mayer, 2005).

Further, Service Delivery Team members were expected to attend the annual SafeStart Academies and conferences to continuously improve their knowledge and skills. They were offered opportunities to attend trainings outside of SafeStart; some members took advantage of these opportunities. Their specialized knowledge made them consultants and trainers within their home agencies for issues related to children's exposure to violence. By the end of 2005, they had provided over 169 hours of formal training to 990 people across their home agencies (San Francisco SafeStart Initiative, 2005a).

To improve systems by promoting a core set of values, beliefs, and practices for responding to young children exposed to violence (goal #4), SafeStart's staff, with assistance from its partners, developed eight policies; a ninth policy was being developed at the time of this case study. These policies, developed and continuously refined by the Service Delivery Team and Parent Team, were distributed to SafeStart partners and other agencies to guide their response to children exposed to violence and their families. SafeStart staff also created a manual, "Core Values, Practices, and Beliefs for Responding to Children Exposed to Violence," which will be available on CD-ROM in 2006.

Finally, SafeStart helped generate new knowledge about the characteristics of young children in the city exposed to violence, their families, and the response to their needs. A database of over 500 cases

was developed, police reports of domestic violence crimes were examined, and 238 batterer intervention program participants were surveyed. A study of child welfare and family court practices related to families experiencing domestic violence will be released in early 2006. The grantee used its research findings to increase the awareness of service providers, advocates, policymakers, and the wider community about the magnitude of the problem, and to encourage them to identify and refer children exposed to violence.

The San Francisco SafeStart helped promote the understanding that no single system or agency can adequately respond to the needs of children exposed to violence. Instead, a multi-system solution is required. This solution, however, surfaces tensions associated with differences in the way various disciplines and sectors respond to children and families (e.g., police, child protective services, domestic violence victim advocates). The racial, ethnic, and cultural diversity of San Francisco also require linguistic and cultural competence among services providers; there were few professionals trained to help young children exposed to violence, and even fewer with the linguistic and cultural competency necessary to help children from diverse backgrounds.

In summary, SafeStart laid the foundation for changing systems to further improve the support for young children exposed not only to domestic violence, but possibly community violence, as well (the latter form violence, however, was not addressed to the same extent as domestic violence). The future of the initiative was uncertain at the time of this report. Decisions made in 2004 about sustainability were "being called into question" (San Francisco SafeStart Initiative, 2005b).

Nevertheless, federal and local funds will continue to support the initiative until mid-2007. The Advisory Council and a subgroup of its members met several times in fall 2005 to develop a sustainability plan, which was anticipated to be in place by the beginning of 2006. The clearest strategy at the time of this report was the dissemination of the SafeStart model through the “Core Values, Practices, and Beliefs for Responding to Children Exposed to Violence” manual.

### **1.1 Mission**

The mission of the San Francisco SafeStart, spearheaded by its Advisory Council and located in the San Francisco Department of Children, Youth, and Their Families (DCYF), was to “change existing systems to ensure that every child raised in the city and county of San Francisco will live free from violence.” SafeStart’s goals were to 1) increase effectiveness of services by training point-of-service providers on how best to respond to children exposed to violence; 2) prevent childhood exposure to violence by sensitizing the public to the issue; 3) reduce the impact of exposure by providing early intervention and treatment; and 4) improve systems by promoting a core set of values, beliefs, and practices for responding to young children exposed to violence. SafeStart’s priority was to keep families together (Fox & Mayer, 2005).

How did SafeStart accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in the following sections, and a timeline of major events is attached (Exhibit VIII-A).

## **2. Contextual Conditions**

While children five years and younger make up a relatively small percentage of San Francisco’s total population (5.3% in 2004) compared to other Bay area cities, a study sponsored by the San Francisco SafeStart found that 15% to 20% of children six years and younger are exposed to violence every year (White & Shields, 2003). Another study showed that 17,000 elementary school students could be exposed to 600 crimes annually (Fox, 2005a). The level of violence in San Francisco was at its peak in 2005, compared to the previous ten years (San Francisco SafeStart Initiative, 2005c).

Poverty also affects families and children in San Francisco. Approximately 7% of families and 13% of children ages 5 to 17 lived below the poverty level in 2003 (San Francisco SafeStart Initiative, 2005c). The majority of these families and children were of African American, Latino, or Asian descent.

On the other hand, San Francisco has seen numerous initiatives and legislation intended to promote children’s well-being, such as:

- The Children’s Fund<sup>4</sup> and California’s Proposition 10 funds;<sup>5</sup>
- The Greenbook Initiative, a joint initiative of the U.S. Departments of

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<sup>4</sup> For every \$100 of property tax, three cents are allocated to The Children’s Fund. The Fund, managed by the San Francisco Department of Children, Youth, and Their Families, provides support to organizations in the public, private, and nonprofit sectors to develop innovative programs for children and youth (Department of Children, Youth, and Their Families, 2003).

<sup>5</sup> Also known as the California Children and Families First Act of 1998, this Proposition imposed an additional surtax of 50 cents per cigarette pack and increased the tax on other tobacco products (cigars, chewing tobacco, pipe tobacco, etc.) by the equivalent of one dollar per pack.

Justice and Health and Human Services, designed to improve the quality of services provided by local jurisdictions to families threatened by domestic violence or child maltreatment or abuse, for which the city and county of San Francisco are one of six demonstration sites;

- The Children’s System of Care, intended to reform service delivery systems for seriously emotionally disturbed children to reduce their out-of-home placement;
- Starting Points Initiative, which established the Early Childhood Interagency Council to guide the development and implementation of a citywide strategic plan to improve services for children five years and younger;
- Safe Havens Supervised Visitation and Safe Exchange Initiative, housed in the Department of Children, Youth, and Their Families, which creates safe places for visitation with and exchange of child victims of domestic violence, abuse, sexual assault, or stalking;
- Justice and Courage, a public/private collaborative to address recommendations made by the City Attorney’s Office regarding the city’s domestic violence response systems (San Francisco SafeStart Initiative, 2005c); and
- The Community Response Network, another collaborative led by the Department of Children, Youth, and Their Families, responsible for the development and implementation of a comprehensive community response to gang and youth violence in three neighborhoods (San Francisco SafeStart Initiative, 2005c).

In 2005, Mayor Gavin Newsom considered establishing an Office of Violence Prevention to coordinate all ongoing and related violence prevention efforts. More recently, in January 2006, a law (AB 1179) was passed to fine retailers \$1,000 for selling violent video games to minors.

All of these initiatives created a favorable context in the city for promoting issues of children’s exposure to violence. None, however, conflicted or competed with the San Francisco SafeStart, according to the majority of SafeStart collaborative members (Association for the Study and Development of Community, 2005c). Instead, the San Francisco SafeStart grantee was able to use the existing momentum as a catalyst to maintain and sharpen the focus on young children exposed to violence.

Factors that helped connect the San Francisco to other, related initiatives in the city and county included SafeStart’s location in the Department of Children, Youth, and Their Families (which leads initiatives in the city related to children); engagement of various agency leaders (described in more detail in Section 5), and staff and collaborative members’ relationships (e.g., collaborative members who served on advisory committees for other initiatives).

### 3. Community Capacity

Despite the many organizations and initiatives focused on young children's well-being, the community's capacity to support young children exposed to violence was limited. SafeStart's goals and strategies were intended to address these limitations.

***Knowledge about children exposed to violence and its impact.*** Prior to SafeStart, San Francisco had few data on children exposed to violence, including incidence, demographic characteristics, or nature of exposure. There were no legal requirements, procedures, or infrastructure for collecting such data (Fox & Mayer, 2005). Without such data, these children's needs went undetected, and the public was not fully aware of the impact of their exposure to violence. Consequently, programs and initiatives meant to support exposed children and their families were likely inadequate in design. SafeStart addressed this limitation through a public education campaign in 2004, and by sponsoring several studies about children's exposure to violence.

***Knowledge and skills specifically related to young children exposed to violence.*** Many agencies and initiatives in San Francisco are dedicated to ensuring children's well-being. Prior to SafeStart, however, none specialized in the impact of childhood exposure to violence, with the exception of the Child Trauma Research Project,<sup>6</sup> which, alone, had limited capacity to address the needs of all children exposed to violence in San Francisco. There were

also few professionals trained to help this population, and even fewer with the linguistic and cultural competency to serve the racially and culturally diverse families in San Francisco (Association for the Study and Development of Community, 2005c).

The San Francisco SafeStart began to fill the gap in knowledge and skills by offering extensive training on the impact of childhood exposure to violence to a wide range of professionals. (See Section 6.2 for further description of the trainings.)

***Continuum of support and services for young children exposed to domestic violence and their families.*** The traditional response to children exposed to violence and their families was fragmented. Support networks trusted by families (e.g., family resource centers, faith groups, teachers, childcare providers) were not connected to mental health services and shelters capable of providing expert assistance. Criminal and family court orders sometimes conflicted. Batterer intervention programs and domestic violence victim advocates focused on different members of the family.

Additionally, first-time domestic violence victims require different support from victims who experience such violence regularly, according to point-of-service staff who met with the National Evaluation Team in 2004 and 2005. The former may be less ready to leave the batterer and go to a shelter; in such cases, counseling and other family support assistance may be the best solution. On the other hand, a victim who is ready to move on and live an improved life without violence may need help transitioning into her/his new community and family. San Francisco's systems were not prepared to provide the support appropriate for victims at different stages of

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<sup>6</sup> A joint endeavor of the University of California San Francisco's Department of Psychiatry and the San Francisco General Hospital, the Child Trauma Research Project serves children six years and younger and their families who have been involved in domestic violence.

readiness for change and in need of different types of help.

The San Francisco SafeStart grantee brought together different systems to coordinate their response to children exposed to violence and their families through 1) a diverse Advisory Council made up of agency leaders and policymakers, 2) a Service Delivery Team made up of point-of-service providers (described in more detail in Section 5.1), 3) hiring and placement of a SafeStart liaison in the police department and family court, 4) contracting of family resource centers<sup>7</sup> (FRCs) and other providers (whose family advocates and mental health service providers were part of the Service Delivery Team) to provide family support and behavioral health services, and 4) establishment of a designated telephone line for SafeStart-related inquiries and referrals (“the Support Line”). These improvements (discussed in detail in Sections 5 and 6) linked agencies and services to one another to share information about service gaps, as well as the status of particular cases. SafeStart staff also developed formal policies to encourage less fragmented services and more uniform responses to children exposed to violence across systems (see Section 6 for further information about policies).

#### 4. Integrated Assistance

The San Francisco SafeStart grantee was able to garner local and national resources for a wide range of support, which

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<sup>7</sup> Family resource centers collaborate with local agencies and help many parents, families, and children access information about early intervention services. Some of the FRCs operate as independent sites in community settings; others are based in regional centers, local education agencies, public health facilities, or hospitals.

helped the initiative generate and disseminate new knowledge about the impact of children’s exposure to violence, and to expand the number of local professionals who knew about the issue.

As examples of local resources on young children’s exposure to violence from which the initiative benefited:

- The Child Trauma Research Project training director (also an assistant clinical professor at the University of California San Francisco) provided ongoing case consultation to the initiative’s Service Delivery Team, ensuring that the team’s point-of-service providers learned about the impact of childhood exposure to violence and how to respond to the needs of exposed children and their families;
- Two local psychologists were engaged by SafeStart to conduct trainings in 2005 on “vicarious trauma” (the negative effects on service providers who work with traumatized clients over time; Shields, 2006); and
- The Greater Bay Area Child Abuse Prevention Coalition and the San Francisco Child Abuse Council/TALKLine partnered with SafeStart to conduct a presentation about “Working with Sexually Aggressive Children and Their Families” in late 2005 (Shields, 2006).

Service Delivery Team members, who were consistent beneficiaries of the above training and technical assistance, served, in turn, as consultants on the issue of children’s exposure to violence to other staff within their own agencies.

The SafeStart grantee also frequently built on the expertise of professionals in one sector to teach those in another sector. For example, domestic violence sector representatives provided specialized 16-hour training on domestic violence to the Service Delivery Team, and batterer intervention program representatives trained participants at a SafeStart Annual Academy about the psyche of a batterer.

With the availability of local expertise in the area of early intervention and treatment for young children exposed to violence, the San Francisco SafeStart grantee was able to take advantage of national technical assistance funded by the Office of Juvenile Justice and Delinquency Prevention for other areas of need, particularly facilitation of meetings, research, and dissemination of research findings.

For instance, the National Civic League facilitated a strategic planning meeting for the initiative's Advisory Council in 2003. The grantee also used national technical assistance funds to sponsor the SafeStart director's presentation at two conferences in 2005 and the development of a five-year capstone report about the initiative. An additional \$52,000 was obtained through the national evaluation to conduct studies of police reports of domestic violence and the presence of children at the scene, as well as current child welfare and family court practices related to families experiencing domestic violence.

The San Francisco SafeStart grantee also consulted the National Child Traumatic Stress Network and the National Center for Posttraumatic Stress Disorder to develop its annual conference in 2005 on psychological first aid (i.e., knowledge and skills to assist people with emotional distress resulting

from an accident, injury, or sudden shocking event).

## **5. Local Agency and Community Engagement and Collaboration**

The San Francisco SafeStart collaborative was characterized by:

- Representation from a wide range of sectors that serve families and children;
- A multi-level structure that enabled people in different agencies to stay involved according to their positions and functions within their respective agencies;
- A core group of committed members who facilitated the initiative's stability and progress, despite changes in the political environment and staff turnover; and
- Continued efforts to engage more agencies and organizations.

The initiative's progress was further supported by staff members who had the capacity to educate, facilitate, manage, and administer all at the same time, as well as a local evaluator who was able to provide information to aid decision-making.

Like all other Safe Start grantees, the San Francisco SafeStart grantee encountered philosophical differences in the way some agencies viewed victims and perpetrators of domestic violence, family relations, and appropriate responses to children exposed to violence and their families; these differences, however, did not impede the initiative in any major way.

### **5.1 Representation from a Wide Range of Sectors**

SafeStart's collaborative involved people from a broad range of sectors, including: child welfare, law enforcement, family court, adult probation, domestic violence, batterer intervention, health and behavioral health, education, early childcare, youth development, and community-based family support services. Representatives from six family resource centers (part of the city's community-based family support services system) were also involved in the collaborative; these centers served different racial and ethnic groups.

## **5.2 A Multi-Level Structure**

SafeStart's structure allowed its participants to have clear roles, provide input, develop relationships, and influence decisions in an organized and efficient manner.

***Oversight for planning, implementation, and evaluation.*** A fairly large and diverse Advisory Council made up of approximately 28 to 31 agency representatives was established in 2000 to oversee the planning, implementation, and evaluation of the initiative. Council members were typically people with influence in their agencies and, sometimes, across sectors, for example, agency directors or knowledgeable persons to whom others listened (the Child Trauma Research Project training director, the clinical supervisor from the Department of Public Health Behavioral Health Services, etc.). SafeStart developed memoranda of understanding with the representatives' agencies. The Honorable Donna Hitchens, presiding judge for the San Francisco Superior Court, chaired the Advisory Council from the time of its inception. Although her term was briefly interrupted in 2005 when another judge stepped into her position due to the city's

rotating policy for judges, she was expected to return as the Council's chair in 2006 when she becomes the supervising judge for the Unified Family Court. Many Council members reported that Judge Hitchens' leadership brought credibility to SafeStart (Association for the Study and Development of Community, 2005c). They also credited the SafeStart director for his ability to engage influential people and retain their involvement, even though they perceived his style to be somewhat confrontational on a few occasions. His knowledge of systems and how to navigate them were also cited as strengths (Association for the Study and Development of Community, 2005c).

After two years, Council members found it increasingly difficult to have extensive discussions about particular issues and tasks, due to the large number of members and their competing demands. To overcome this challenge, the Council's role evolved to one of issuing final approval and endorsement of decisions. A Steering Committee made up of nine self-nominated people was established in 2002 to act as the Council's executive committee. Steering Committee members included the Advisory Council chairperson, along with representatives from the Department of Public Health Behavioral Health Services; Child Trauma Research Project; Department of Children, Youth, and Their Families; Bayview-Hunters Point Family Resource Center; *manalive* (batterer intervention program); a Parent Team member (see section on "Community Engagement" for a description of the Parent Team); and SafeStart staff.

Committees also were established to enable a smaller group of members to focus on specific topics. Some of these committees were permanent (e.g., Evaluation Committee); others were

temporary, based on need (e.g., Batterer's Intervention Committee, Public Education Committee, and Committee on Sustainability).

**Service delivery.** A collaborative of point-of-service providers was created in the form of the Service Delivery Team. The team included 12 providers whose positions were funded by SafeStart,<sup>8</sup> as well as representatives from Child Protective Services, adult probation, domestic violence agencies, Department of Public Health's Community Behavioral Health Services, City College's Department of Child Development, and Child Trauma Research Project. Beginning in 2001, the Service Delivery Team met three times every month, twice for case analysis and once for policy development and training. Section 6.2 describes in more detail the Service Delivery Team's function and accomplishments. The Service Delivery Team and the Advisory Council were linked via the SafeStart staff person who facilitated the team's meetings and the Child Trauma Research Project representative. Further, senior staff from the agencies in which the 12 SafeStart-funded providers were housed participated in the Advisory Council.

**Community engagement.** The San Francisco SafeStart collaborative had another unique feature: the Parent Team, which functioned as an Advisory Council committee. This team, made up of five people who had experienced violence in their lives, ensured that SafeStart strategies were informed by the perspectives of families affected by violence, in addition to those of service providers and other

professionals. The majority of the five people were engaged through family resource centers.

In 2004, the Parent Team applied for and received a small grant from the First 5 Commission<sup>9</sup> to develop a mentoring program. Through this program, the Parent Team trained eight domestic violence survivors in communication, public speaking, facilitation skills, and how to support other survivors. The Parent Team and the mentoring program was a step forward in involving people who have experienced violence in a city-wide initiative.

The Parent Team, however, did not have a strategic and structured process for identifying mentees (i.e., recent domestic violence survivors in need of support) and was not well integrated into other SafeStart program components. Only one mentor-mentee relationship was established, though many more mentors were trained.

In late 2005, it became apparent to SafeStart staff that the Parent Team should work more closely with the Service Delivery Team, rather than the Advisory Council, because the former was better positioned to identify mentees due to its members' frequent contact with victims. A Parent Team leader will attend Service Delivery Team meetings in the future to better establish the connection.

### **5.3 Stable Leadership from a Core Group of People**

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<sup>8</sup> The funded positions included one family advocate in each of six family resource centers, one liaison in the San Francisco Police Department, one liaison in the Unified Family Court, two full-time and one part-time clinicians, and the Support Line coordinator.

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<sup>9</sup> The First 5 Commission, guided by the San Francisco Children and Families Commission, is part of a statewide movement to assist public agencies, non-profit organizations, and parent groups in providing support for children five years and younger.

Representation from a wide range of sectors (see Section 5.1) was consistent, even though representatives changed as a result of turnover in the participating agencies. A core group of people, however, was involved in SafeStart from its first or second year. This core group helped buffer the impact of leadership and staff turnover that affected the collaborative, to keep the initiative on track.

The core group included the Advisory Council chairperson (Judge Donna Hitchens), leaders from the domestic violence sector, several family resource center directors, the Department of Public Health's Behavioral Health Services representative, the current SafeStart staff members, and the local evaluator (San Francisco SafeStart Initiative, 2002; San Francisco SafeStart Initiative, 2003a). Their early and steadfast involvement was key to the initiative's progress during times of uncertainty.

For example, the director position at the Department of Children, Youth, and Their Families (lead agency for SafeStart) changed three times during SafeStart's life. During the first turnover in 2001, the department's deputy director (who remained involved with SafeStart until 2004) and a senior analyst provided interim leadership to SafeStart (San Francisco SafeStart Initiative, 2002). The senior analyst also used her evaluation knowledge to help identify and select a new local evaluator after the previous evaluator resigned from the initiative in 2001. During that same year, the SafeStart director resigned, and a new director was hired in December 2001. Had it not been for the commitment and steadfast involvement of DCYF staff and other partners who stepped in to provide continuity, these staff changes could have diverted the initiative.

## **5.4 Continued Effort to Engage Agencies**

The SafeStart grantee made continued efforts to engage agencies that were absent from the collaborative or did not have a firm commitment. For instance, in 2005, the San Francisco SafeStart staff engaged in initial dialogue with the director of the Lesbian, Gay, Bisexual, and Transgender (LGBT) Center. This dialogue grew out of the SafeStart Cultural Competence Committee<sup>10</sup> recommendation that SafeStart reach out to the gay, lesbian, bisexual, transgender, and queer community, which was not immune to domestic violence. The Children of Lesbians and Gays Everywhere (COLAGE), Our Family Coalition, and the San Francisco LGBT Community Center presented information on how to work with same-gender families to the Service Delivery Team in 2005. According to a few collaborative members interviewed by the National Evaluation Team during a site visit in December 2005, engagement of LGBT families would be difficult, because these families already have their own support system.

Although an adult probation officer participated in the SafeStart collaborative, the Adult Probation Department and SafeStart did not initially have a memorandum of agreement, primarily because the chief probation officer was not willing to sign one. When a new chief was hired, however, he immediately signed a memorandum of agreement between SafeStart and the department, allowing SafeStart family advocates in participating

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<sup>10</sup> Because of the city and county's diverse population, cultural competence issues were raised in the Advisory Council. As a result, an ad hoc committee was established in 2004 to strengthen the initiative's response to the city and county's growing diversity.

family resource centers access to probation information on adults in SafeStart client families.

Other new engagement in 2005 included:

- The involvement of a YMCA representative on the Advisory Council, as a result of the Boys and Girls Club's withdrawal from the Council because it could no longer commit the staff time needed for participation; and
- A non-SafeStart service provider on the Service Delivery Team for the first time. SafeStart goals were included in this local service provider's grant application to the First 5 Commission in 2005. The grant was awarded, and the local service provider was invited to participate in the initiative.

The SafeStart grantee continued to enjoy a cooperative relationship with the school district, providing trainings to child development program site managers, school health program staff, teachers, and parents. The SafeStart director was an active participant in the Citywide School Health Committee (Fox, 2005b). In 2005, the director received requests from over ten schools for assistance in responding to young children exposed to violence.

Faith and grassroots (e.g., neighborhood association) groups were not involved in SafeStart; however, grassroots linkages were possible through SafeStart's relationship with the family resource centers. In 2005, SafeStart staff did attempt to develop a relationship with the San Francisco Organizing Project at Bethel Baptist Church. Overall, however, outreach to these un- or under- represented groups in

SafeStart was no longer a priority in 2005, because 1) it was considered possibly too late in the process to involve them, and 2) information about SafeStart had been distributed widely enough that staff was now busy responding to inquiries for help, and no longer had the capacity for more outreach.

### ***5.5 Differences in Philosophical Orientations Toward Helping Children Exposed to Violence and Their Families***

The relationship between SafeStart and the domestic violence sector was especially challenging, though not a major impediment, throughout the initiative's lifespan. Domestic violence sector leaders contended that SafeStart's leadership did not acknowledge or support the sector's long-established infrastructure for women and children exposed to violence. (Note, however, that the original needs assessment conducted by SafeStart showed that the majority of domestic violence agencies did not have "any systematic or consistent way" for training it's staff on issues of children's exposure to violence and its impact. This finding suggested that the existing domestic violence infrastructure for children exposed to violence was insufficient (San Francisco Safe Start Initiative, 2000, p. 18). Domestic violence leaders believed that, instead of building upon and strengthening this existing infrastructure, SafeStart opted to create new services and entry points by funding family resource centers and several other providers to assist domestic violence victims.

From the SafeStart leadership perspective, the source of the tension was ideological differences between SafeStart and the domestic violence sector with regard to approaches to dealing with families experiencing violence. According to SafeStart leadership, leaders in the domestic

violence sector did not support SafeStart's decision to use multiple means to approach the problem, including batterer intervention.

Several SafeStart partners acknowledged the tension between SafeStart and the domestic violence sector; at the same time, they indicated that this tension did not prevent anyone in the domestic violence sector from participating in the Advisory Council. The SafeStart grantee continuously worked to engage the domestic violence community and acknowledged the views of domestic violence representatives in the context of Advisory Council discussions and decisions. Some partners added that the estrangement between members of the domestic violence sector and those associated with other family and child services was present prior to SafeStart. This was not unusual; in fact, many other Safe Start demonstration sites reported similar tensions within their community and collaborative because of existing stereotypes and distrust among leaders of the domestic violence prevention sector vs. leaders in the family and child services sector.

## **6. System Change Activities**

### ***6.1 Community Assessment and Planning***

The San Francisco SafeStart grantee built on existing efforts to obtain information about services available to children and families, including:

- A needs assessment of children and families every other year by the Department of Children, Youth, and Their Families;
- An annual survey of public services by the city controller's office; and

- Existing demographic information about children and families who reside in the city and county of San Francisco.

The SafeStart grantee also collected its own data about children's exposure to violence to supplement the existing information. During the planning phase, the initiative's first evaluator collaborated with local agencies to plan and conduct 15 focus groups with a variety of stakeholders, including teen parents, youth who had witnessed violence, individuals involved in substance abuse services, public housing residents, and parents and service providers of African American, Asian/Pacific Islander, and Latino descent. Additionally, 22 key informant interviews with service providers, community leaders, and agency directors were conducted. In 2003 after implementation began, the SafeStart grantee conducted a survey of parents to examine their readiness to discuss the impact of exposure to violence on their young children.

The SafeStart grantee used information such as that provided by the above agencies, as well as its own data collection efforts, the local evaluator's semi-annual reports, and the study on police reports of domestic violence crimes to inform its initial and subsequent strategic planning meetings. A committee was established to deliberately ensure the use of data in planning and strategy improvement (i.e., the evaluation committee) and its role remained prominent throughout the initiative's lifespan.

### ***6.2 Community Action and Awareness***

The San Francisco SafeStart raised awareness at three levels: public,

professionals who work with children and families, and policymakers.

***Raising the public's awareness.*** In January 2004, the SafeStart grantee launched a public education campaign with the theme, "You're Not Just Hitting Her—Domestic Violence Hurts Children Too." The campaign distributed 30,000 flyers to every elementary school, child development program, and Head Start program in the city; 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.

In addition, the campaign received coverage on four television stations and five radio stations, and in four newspapers: *San Francisco Observer*, *San Francisco Bay View*, *El Mensajero*, and *Sing Tao Daily*. All campaign materials publicized the telephone number for the SafeStart Support Line (see Section 6.4 for further explanation about the 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 (Saint Francis Memorial Hospital and California Attorney General's Office), to demonstrate their commitment to children exposed to violence by contributing funds to the campaign.

***Raising the awareness, knowledge, and skills of professionals who work with children and families.*** The San Francisco SafeStart helped professionals who work with children and families better understand issues related to exposure to violence through three annual SafeStart Academies and three annual conferences, as well as other specialized trainings.

The SafeStart Academy and conference trainings covered topics such as vicarious trauma, psychological aid, developmental disabilities, child support enforcement, and domestic violence. In some cases, experts within one field trained providers in another field. For example, at SafeStart's annual conference in 2004, batterer intervention program staff trained domestic violence advocates, while a facilitator from the Child Trauma Research Project trained batterer intervention program staff. In total, approximately 700 people attended the Academies and conferences (Association for the Study and Development of Community, 2005c; A. Fox, personal communication, March 14, 2006; San Francisco SafeStart Initiative, 2004; San Francisco SafeStart Initiative, 2005a).<sup>11</sup>

Specialized trainings that covered related topics such as transitional housing for victims of domestic violence and the neurodevelopmental impact of child maltreatment were offered to SafeStart's Service Delivery Team members<sup>12</sup> and staff of partner agencies. SafeStart also provided training through smaller, separate events when requested. For example, in 2002, a total of 111 people from different agencies, including the school district, were trained.

Service Delivery Team members, in turn, provided a total of 169 hours of formal training to 990 people, as consultants within their home agencies.

***Raising the awareness of policymakers.*** SafeStart Advisory Council

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<sup>11</sup> The trainings in 2004 serendipitously coincided with a new mandate for mental health professionals to be trained in spousal and partner abuse, which may have contributed to the high participation levels in that year.

<sup>12</sup> Over 50 training opportunities were offered (SafeStart did not track the extent to which the members took advantage of the opportunities).

members helped to educate 13 elected officials on issues related to childhood exposure to violence and the need for a public policy response. In 2004, a member of the city's Board of Supervisors granted the SafeStart director's request for a hearing on how trauma impacts a child's brain (Association for the Study and Development of Community, 2005c).

While SafeStart's public education and awareness raising efforts were not evaluated formally, anecdotal information from SafeStart partners suggests that the above activities and events directly or indirectly contributed to 1) public awareness of family violence and children exposed to violence, 2) public knowledge of available resources and professional services, and 3) visibility of children's exposure to violence as an acceptable subject of discussion. This is evident from incidents such as:

- An article by the *San Francisco Chronicle* about infant mental health in 2004;
- Over ten inquiries to SafeStart from schools, for assistance in responding to young children exposed to violence in 2005;
- A call from a faith leader to the SafeStart police liaison about a particular case;
- A fundraiser by Kate Spade (designer of women's accessories) for children exposed to violence; and
- An increased number in "show of hands" among training participants who claimed to know something about the impact of exposure to violence on young children.

### **6.3 Service Integration**

Service integration as a result of SafeStart occurred primarily through the

Service Delivery Team. Beginning with its inception in 2001, the Team met three times each month, twice for case analysis and once for policy development and training. Team members discussed cases without disclosing client names, a confidentiality policy established by SafeStart in compliance with state laws. Dr. Patricia Van Horn from the Child Trauma Research Project provided clinical assistance during case analysis. Together, Service Delivery Team members planned the best response to a child and his/her family and considered what each department could do with the family to maximize support for the child and his/her family.

Service Delivery Team members participated in the annual SafeStart Academies and conferences, and also were offered over 50 specialized trainings. Trainings were offered repeatedly and regularly because of staff turnover. According to SafeStart staff and Service Delivery Team members interviewed by the National Evaluation Team in 2004 and 2005, the majority of team members found the trainings useful, despite their repetition.

The Service Delivery Team:

- Offered 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 (e.g., 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 them to explain these procedures to clients); and
- Enabled staff from different agencies to develop relationships with each other and become allies with a

shared commitment to supporting families (e.g., when a point-of-service provider needed to review a case and no family advocate or supervisor was available, she felt comfortable calling the Child Protective Services director for consultation).

The Service Delivery Team also promoted understanding across professional cultures by providing a setting in which providers from different agencies and sectors were required to interact with each other (e.g., family advocates had to interact and deal with batterer intervention program advocates, and behavioral health clinicians had to understand what sort of information family court personnel need).

#### ***6.4 New, Enhanced, and Expanded Programming***

SafeStart's priority was to keep families together; hence, it used a family-centered approach in which all family members, including the perpetrator and adult and child victims, received help with the intent of staying as a family unit to the extent possible.

SafeStart did the following to provide early intervention and treatment to reduce the impact of exposure: 1) funded family advocate positions in six family resource centers to help identify, assess, and treat children exposed to violence and their families; 2) funded two liaisons (one in the police department and one in family court) to help identify and refer children exposed to violence and their families, and to provide information about the status of cases; 3) established the SafeStart Support Line to handle callers and make referrals; and 4) funded two full-time and one part-time

clinicians to serve families referred to SafeStart.

Initially, SafeStart focused on six neighborhoods with high rates of violence; only residents from these neighborhoods were eligible for SafeStart services. The neighborhoods were the Western Addition, Chinatown, Mission, Bayview-Hunter's Point, Visitacion Valley, and Ocean View-Merced Heights-Ingleside (OMI). The majority of family resource centers were located in these neighborhoods.

In late 2004, the Advisory Council decided to remove this eligibility criterion to 1) diminish the perception that some neighborhoods, particularly low-income and ethnic neighborhoods, were "problem" areas; 2) allow access to low-income and culturally diverse families who did not live in these neighborhoods, but were in need of services; and 3) diminish the perception that middle- and higher-income White families outside of the above neighborhoods do not experience domestic violence.

***Family advocates dedicated to assisting children exposed to violence and their families.*** SafeStart built on and expanded the capacities of six family resource centers by funding a family advocate dedicated to addressing the impact of childhood exposure to violence at each center. Family advocates, who received extensive training on issues related to children's exposure to violence, enabled centers to provide proper support to children and their families. They also served as consultants to other center staff who came into contact with children exposed to violence and their families. One family resource center (Instituto Familiar de la Raza, see below) used SafeStart funds not only for a family advocate, but also to hire a clinician accessible to all SafeStart families.

The six family resource centers included Asian Perinatal Associates, Bayview-Hunters Point Family Resource Center, Instituto Familiar de la Raza, Urban Services YMCA, Homeless Prenatal Program, and Living in a Nonviolent Community (LINC).<sup>13</sup> These centers, located in neighborhoods throughout the city, provide parent-to-parent support, peer counseling and home visits, information and referral, parent education, and support services in different languages. The centers have staff members who share cultural characteristics with the families in the neighborhood; hence, families are more likely to go to the centers than to a mental health clinic for help. All but the Bayview-Hunters Point Family Resource Center have the capacity to provide behavioral health services; the family advocate at this center referred families to other centers or to the SafeStart clinicians.

The centers were selected through a competitive process, based on their response to a SafeStart request-for-proposal. Performance measures were based on several indicators, including the number of families served and compliance with SafeStart policies. SafeStart established a “bonus plan” to encourage the centers to serve as many families as possible. According to this plan, centers that exceeded a minimum number of families served during their first six months received a \$10,000 increment in funding for the next fiscal year. On the other hand, centers that served fewer families than the minimum

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<sup>13</sup> LINC is not a family resource center; it is a public health center associated with the University of California and the National Center of Excellence in Women's Health. LINC focuses more on public health approaches (cognitive-behavioral, therapeutic, psycho-educational), rather than family support approaches (case management, advocacy). For purposes of SafeStart, however, LINC was treated as a family resource center.

received \$10,000 less. Three centers and one center earned an increment and decrement, respectively (A. Fox, personal communication, March 26, 2006).

***SafeStart police and family court liaisons.*** The initiative funded a police liaison in the San Francisco Police Department's Domestic Violence Response Unit. This person was responsible for reviewing police reports of domestic violence cases, to ensure that police 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 family advocate and referred the victim to SafeStart services, as well as conducting police roll-call training on issues related to children exposed to violence. This position, created in 2002, lapsed into a hiatus status after the first liaison resigned in 2003. The position was not refilled until June 2004, after the police department underwent a leadership transition due to Mayor Newsom's election. After the hiring of the new liaison in 2004, police reporting of domestic violence incidents and presence of children improved (Association for the Study and Development of Community, 2005c).

SafeStart also funded a family court liaison, who was hired as a contractor in 2002 and became a full-time employee of San Francisco Superior Court in 2003. This liaison informed the Service Delivery Team of the status of SafeStart families in the court system. She also reviewed cases and identified and referred children exposed to violence to a family advocate and SafeStart services.

***SafeStart Support Line.*** The SafeStart Support Line (415-565-SAVE) began operating in November 2002; by

2003, agencies were receiving referrals through the Support Line. Also in 2003, the Support Line coordinator position transitioned from WOMAN, Inc., to the TalkLine Family Resource Center. Calls to the Support Line could be accepted by any trained counselor anywhere with a telephone and an Internet connection. The counselor who answered the call entered the caller's information into the Internet system, generating an email alert to the family advocate to whom the referral was made. The family advocate downloaded the referral and contacted the caller. The line was publicized through brochures, referral cards, Child Protective Services, and other public education campaign materials. The Support Line coordinator monitored the system and provided assistance in developing a follow-up plan for callers when requested.

***Clinicians.*** SafeStart funded two full-time clinicians and one part-time clinician; two of the three were housed in family resource centers and one in a satellite location for the Department of Public Health Community Behavioral Health Services. Along with the behavioral health service providers in five of the six family resource centers and other clinicians employed by the Department of Public Health Community Behavioral Health Services, these SafeStart clinicians were available to help SafeStart families. In 2005, both full-time clinicians resigned; by the end of 2005, their positions had not been filled.

***Process for identifying, referring, assessing, and treating children exposed to violence.*** Adult and/or child victims of domestic violence were identified through the SafeStart Support Line, the police department, family court, the Parent Team, Child Protective Services, schools, and family resource centers. Those identified

through the first six entry points were referred to a family advocate at one of the family resource centers, depending on the person's preference, cultural background and language, location of residence, and type of need.

The adult and/or child victim participated in an intake process with a SafeStart family advocate at the family resource center. The family advocate also 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.<sup>14</sup> All but one family resource center also had the capacity to provide behavioral health services. This one center referred to a behavioral health service provider at another location convenient to the victim.

Through the SafeStart Advisory Council, batterer intervention and shelter assistance also were available to families. Several family advocates reported that they often referred victims to a shelter if they believed the victim and child were in danger.

The family advocate at each family resource center determined the type and level of need based on the intake assessment. Often, the family resource center could address all needs through its menu of services (e.g., housing, employment, counseling, and parenting skill development).

Clinical intervention could be provided by:

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<sup>14</sup> All family resource centers except for LINC had the capacity to provide such support services, including parenting classes and counseling services.

- The family resource center's behavioral health specialist;
- SafeStart's clinicians; or
- Child Trauma Research Project, if the case was severe.

The family advocate also had the option of seeking assistance from the Service Delivery Team, if necessary.

The majority of children were identified through family resource centers and the Support Line. Between November 1, 2003, and October 31, 2005, the Support Line responded to 408 calls and referred 262 callers to SafeStart services; family resource centers provided services to 185 families and 367 children (Shields, 2006). The entire Service Delivery Team, which included the family advocates, SafeStart liaisons, Support Line coordinator, and SafeStart clinicians, served a total of 351 families and 702 children over the lifetime of the initiative (Fox & Mayer, 2005).

Exhibit VIII-B illustrates the path developed by the SafeStart grantee for identifying, referring, assessing, and treating children exposed to violence and their families. The strengths of the service pathway lie in the following features:

- Better coordination of service providers and agencies that respond to children exposed to violence and their families;
- Closer working relationships between family advocates and the police and family court, which made it easier to retrieve information and track cases, as well as help families navigate systems;
- A core team of people dedicated to children exposed to violence to whom other professionals and the

general public could look for assistance;

- Pooling of knowledge, skills, resources, and relationships across systems and at multiple levels (policy and point-of-service).

### ***6.5 Development of Policies, Procedures, And Protocols***

The San Francisco SafeStart staff and partners developed and distributed eight policies to guide the response of agencies to young children exposed to violence. The policies embody

SafeStart's core values, practices, and beliefs. They include:

- 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

A ninth policy, on early childhood behavioral health, was being developed at the time of writing this report. Throughout the course of the initiative, the Advisory Council and Service Delivery Team regularly reviewed and re-approved each policy, to ensure that all policies remained up-to-date.

SafeStart staff encouraged its partners and other agencies working with families and children to adopt these policies. According to the local evaluator, a total of 35 agencies adopted the policies in 2004. SafeStart staff and local evaluator did not monitor the extent to which policy adoption and implementation actually occurred (Association for the Study and Development of Community, 2005c).

SafeStart increased family access to services through a policy that required family advocates to respond 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 to 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 on how the parent or parents could assist their children) and to schedule an appointment to take place within 48 hours.

Monitoring of the family advocates' performance by the local evaluator indicated compliance with SafeStart procedures, including timeliness in their follow-up with families and creation of case management plans (Shields, 2006).

## ***6.6 Development, Identification, and Allocation of Resources***

Through the Department of Children, Youth, and Their Families, the Mayor's Office contributed \$500,000 each year to the San Francisco SafeStart for three successive years: 2004, 2005, and 2006. Between 2000 and 2003, the Children's Fund contributed \$325,000 to the initiative. In addition to these contributions, the SafeStart grantee leveraged about \$135,000 (\$120,000 from the 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) for its public education campaign.

SafeStart Advisory Council members also contributed an extensive amount of time, in-kind support, and meeting space.

## **7. Institutionalization of Change**

Changes were institutionalized at different levels and to varying degrees, as described below.

### ***7.1 System-wide and Agency Changes***

The initiative changed the way young children exposed to violence were identified, assessed, and treated by:

- Bringing together representatives from different systems that interact with young children and their families to review related policies, procedures, and practices (i.e., through the Advisory Council), and to coordinate the assistance provided to children and their families (i.e., through the Service Delivery Team);
- Enabling agency partners to view themselves as part of a support system for children exposed to violence and their families, to follow standard procedures for referring clients to the next level of assistance (e.g., from the Support Line coordinator to a family advocate to a clinician), and to share confidential case information; and
- Institutionalizing knowledge about the impact of exposure to violence on young children through the SafeStart Academies and annual conferences and the exchange of information among Service Delivery Team members, as indicated by all the collaborative members and point-of-service providers who met with the National Evaluation Team in 2004 and 2005.

Further, San Francisco Police Department officers began to document the number of children present during a domestic violence incident, along with their ages and names, and to provide the victim with SafeStart information. The SafeStart police liaison then reviewed officers' reports and followed up with families, as well. Between 2003 and 2005, SafeStart's local evaluator found that police officers' documentation of domestic violence

incidents improved significantly. The police officers were not only more diligent about submitting the required forms, the forms were generally more completed (Shields, 2006).

The Department of Public Health's Community Behavioral Health Services reorganized their clinical assessment procedures to include assessment of exposure to domestic violence as an additional determinant for the level of mental health services required.

The recent studies on 1) police reports of domestic violence and 2) family court and child welfare practices are anticipated to effect systems change in the upcoming year by identifying gaps in the system. Directors of the respective agencies will have an opportunity to consider strategies for filling the gaps.

The above changes, in turn, had an impact on the point-of-service providers who participated in the SafeStart collaborative.

## **7.2 Within Point-of-Service Providers**

Family resource center staff developed the capacity to identify and respond to the needs of children exposed to violence because of a dedicated staff person trained in related issues (i.e., the family advocate). As SafeStart partners, these centers expanded their historical support for families experiencing violence by developing a special focus on exposed children six years and younger and their families. At the same time, however, these centers experienced frequent staff turnover, causing periodic gaps in service provision for children exposed to violence and their families. The service gaps were filled once

positions were refilled, and the new staff person attended SafeStart training. Such turnover was certainly challenging for the centers; on the other hand, several collaborative members believed that outgoing staff people were able to apply SafeStart knowledge and skills in their new jobs.

Some organizations were more willing to work with people with whom they typically had not worked in the past, as a result of the collaboration promoted by SafeStart. For example, WOMAN, Inc. and other domestic violence advocacy groups were more willing to train men to deal with domestic violence.

### **7.3 Community**

The San Francisco SafeStart created a community of service providers and professionals knowledgeable about issues related to children exposed to violence and skilled in identifying and responding to these children. Between 1,000 and 1,500 people attended SafeStart trainings or were trained by SafeStart's Service Delivery Team, as mentioned in Section 6.2. Post-training evaluations of SafeStart Academies and annual conferences showed that service providers were more aware of the impact of violence on young children and believed that they were able to provide more informed services, including referrals to high-quality assistance for children and their families (White & Shields, 2005).

The larger community in the city and county of San Francisco also gained in awareness of the impact of violence on young children. This was evident through the increased number of inquiries that SafeStart staff received in 2005, particularly from schools. The 2004 public education campaign helped increase the visibility of

the issue. Another campaign will be implemented in April 2006.

## **8. Increased Community Supports**

SafeStart resulted in a community support system for children exposed to violence and their families. This system consisted of professionals, family advocates, and people who had experienced violence, including the Parent Team, Service Delivery Team, and all the agency leaders and staff participating in SafeStart's Advisory Council. Families that received support from the Service Delivery Team were satisfied with the quality of services and believed that their children were safer due to SafeStart. The families also reported that staff members were sensitive to their cultural background (religion, language, race, etc.), treated them with respect, and kept their personal information confidential. In addition, the family resource centers were conveniently located (Shields, 2006; White & Shields, 2005).

The Parent Team received and used a \$5,000 grant from the First 5 Commission to develop a parent-to-parent mentoring program. The mentoring program was established in response to a 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.

In November 2005, SafeStart staff and partners developed a manual of the initiative's materials, to disseminate the SafeStart model, beliefs, values, and guiding principles to the larger community. Over

500 copies of this document were printed, and distribution began at the end of 2005 (Shields, 2006).

## **9. Reduced Exposure to Violence**

The San Francisco SafeStart local evaluator collected data about satisfaction of families who used SafeStart services and child and family outcomes among SafeStart service recipients. Consent was obtained from families at the beginning of services, before any data were collected.

It was difficult for the local evaluator to collect uniform data for the client satisfaction survey, Child Behavior Checklist (CBCL), and behavioral health tracking form, as turnover of family advocates required ongoing training and technical assistance to orient new staff to recording these data. In 2005, a new electronic form-based system was created, requiring family advocates to “catch up” with their data entry. This hindered the local evaluator’s ability to obtain and report on client characteristics and outcomes in a timely manner (Shields, 2006).

The results reported in this section and the next reflect preliminary findings. The final findings and analysis are expected in October 2006.

Families who used SafeStart services were asked to complete a client satisfaction questionnaire upon termination of services. Of the 172 clients who consented to participating in this survey, 55 returned completed questionnaires (response rate, 32%). Preliminary survey findings showed that 94% of the respondents felt safer, and 92% agreed that their children felt safer (ETR Associates, 2006).

Further, the SafeStart local evaluator’s examination of police reports indicated that the number of calls from families rose steadily in 2004 and 2005. This might indicate decreased tolerance for domestic violence, which is a pre-condition to reduced violence and hence, reduced children’s exposure to violence. According to some police personnel, this trend may reverse in 2006, as families begin to realize the harm of exposure to violence on their children, perhaps because of SafeStart and other efforts to increase public awareness of the issue (Shields, 2006).

On the other hand, the SafeStart local evaluator also found that as domestic violence calls and arrest rates increased during 2005, the number of formal investigations of reported incidents decreased, undermining the criminal prosecution of offenders. This pattern could affect the confidence of victims and advocates in the law enforcement system’s ability to protect the former and their children. This finding reinforces the need for a more coordinated response to domestic violence victims and their children that emphasizes prevention and longer-term support, and not just crisis intervention (Shields, 2006).

## **10. Reduced Impact of Exposure to Violence**

With regard to reduced impact of exposure to violence, all 55 families who completed a questionnaire agreed that their child felt better emotionally, could better handle daily activities, and got along better with family and friends.

In addition to the client satisfaction survey, data were collected via the Child Behavior Checklist, administered by the family advocate at intake for each child aged

18 months to five years who received SafeStart services. The behavioral health service provider administered a second CBCL at the end of services. A total of 84 CBCLs had been completed by the end of 2005. SafeStart also developed a behavioral health tracking form, which was implemented in early 2005. This form tracked treatment dosage and changes in behavioral health for all children who received SafeStart behavioral health services (San Francisco SafeStart Initiative, 2005c). Analysis of family and child outcomes based on CBCLs and behavioral health tracking forms will be completed in October 2006.

## 11. Conclusion

The San Francisco SafeStart accomplished the following:

- Generated increased knowledge of the characteristics of children exposed to violence and their needs;
- Established a community of agency leaders, professionals, policymakers, and domestic violence survivors knowledgeable and skilled in responding to and assisting children exposed to violence and their families;
- Promoted information exchange across disciplines and sectors, resulting in more comprehensive knowledge of issues related to childhood exposure to violence;
- Built on an existing infrastructure of family support services and created a service pathway for identifying, referring, assessing, and serving children exposed to violence and their children; and
- Developed and distributed policies to guide agency responses to this particular population.

The above accomplishments expanded and improved the support system for children exposed to violence and their families. The extent to which SafeStart reduced children's exposure to violence and the impact of the exposure, however, remains undetermined until final analysis of findings in October 2006. Preliminary findings have been positive thus far.

The Advisory Council and SafeStart staff's leadership played a critical role in SafeStart's progress and success. Their commitment, stable participation, credibility, and influence enabled them to overcome the challenges posed by external changes and organizational differences among partners. The collaborative's formal structure also ensured a clear and systematic process for engaging partners, reviewing information, and making decisions. The majority of agencies remained committed to SafeStart throughout its lifespan, even though some agency representatives changed.

SafeStart's future remained uncertain at the time of this report. The values and principles of SafeStart may be sustained through the involvement of its staff and Advisory Council members in other efforts, and the infusion of what they learned from the initiative into these efforts. For instance, SafeStart staff and some Advisory Council members were involved in 1) redesigning the child welfare system; 2) the San Francisco Family Support Network; 3) implementation of the Mental Health Services Act; and 4) two initiative-driven efforts to develop an in-class, post-crisis response to children six years and younger exposed to community violence, and to improve cultural competency of services for same-gender couples with children exposed

to violence (San Francisco SafeStart Initiative, 2005b).

The Advisory Council met in May 2005 (27 of its members and over 20 Service Delivery Team members attended) to discuss the initiative's future. A committee on sustainability was established and met three times in the fall of 2005 to develop recommendations for the initiative's future. The Advisory Council approved proposed legislation to increase fees on birth

certificates and divorce filings to provide stable, permanent, local funding for the initiative's family support intervention. The San Francisco SafeStart Progress Report ending July 31, 2005, however, indicated uncertainty among Advisory Council members about the initiative's future direction, including whether or not it was sustainable and should continue to be located in the Department of Children, Youth, and Their Families.

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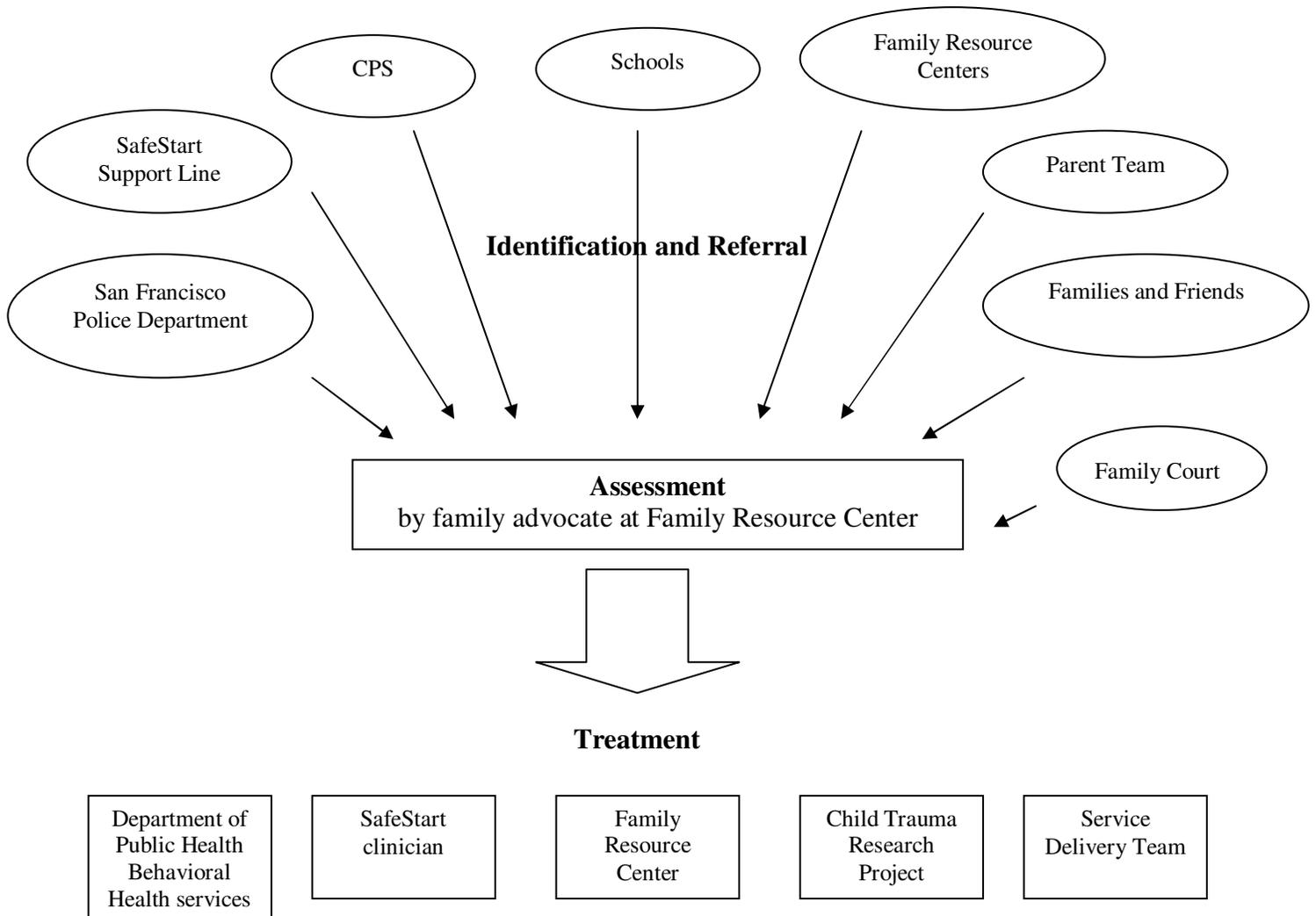
**Exhibit VIII-A**  
**Timeline of San Francisco Safe Start Initiative Activities and Milestones**

Major Milestone	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
SafeStart Advisory Council (formed & ongoing)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steering Committee (formed & ongoing)			✓	✓	✓	✓	✓	✓	✓
Parent Team (formed & ongoing )			✓	✓	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>• Parent Team Parent-to-Parent Mentoring Program</li> </ul>								✓	✓
Safe Start Service Delivery Team trainings		✓	✓	✓	✓	✓	✓	✓	✓
Safe Start Advisory Council retreats				✓				✓	
SafeStart Domestic Violence Referral & Support Line, 415-565-SAVE (established & ongoing)			✓	✓	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>• Support Line Guidebook developed and published</li> </ul>			✓						
<ul style="list-style-type: none"> <li>• Support Line Coordinator position filled</li> </ul>			✓						
<ul style="list-style-type: none"> <li>• TALK Line Family Resource Center chosen as the new service provider for the Support Line</li> </ul>					✓				
SafeStart Service Utilization Database (established & ongoing)			✓	✓	✓	✓	✓	✓	✓
Awarded local annual funding from the San Francisco Department of Children, Youth, and Their Families						✓			
Safe Start Public Education Campaign						✓	✓		
SafeStart's research report on police response to domestic violence released						✓			
SafeStart Police Liaison resigned				✓					

Major Milestone	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
SafeStart Police Liaison position filled						✓			

Sources: San Francisco Progress Reports: January – June 2002, July – December 2002, January – June 2003, July – December 2003, January – June 2004, January – June 2005; Measuring Progress, 2005; Local Evaluation Report Form, 2004 and 2005.

**Exhibit VIII-B  
San Francisco SafeStart Service Delivery Model**



# IX

## Sitka Safe Start Initiative

### 1. Overview

Prior to the Sitka Safe Start Initiative (“Sitka SSI” or “SSI”), led by the Sitka Tribe of Alaska (STA), family and child services were fragmented, with no coordinated system for identifying and serving children exposed to violence. While the SSI was intended to serve the entire Sitka community, it has focused primarily on the Native community, because of the disproportionately high incidence of domestic violence among the Native population. Its purpose was to end the cycle of violence in Native families and establish cross-agency collaboration for identifying, assessing, referring, and treating young children exposed to violence and their families.

As a result of the Sitka SSI, agencies that respond to domestic violence situations have developed and implemented protocols that describe how they work together. The Sitka SSI’s child development-community policing team (known as CID-COPS, pronounced “kid cops”), led by the Sitka Police Department, Sitkan Families Against Violence (domestic violence victim advocate and shelter), and the STA, has served as the primary referral source for the SSI, identifying 188 children from 80 families in need of help. Not all of these families and children required treatment; some were therefore referred to other agencies for specific assistance (e.g., employment and housing). Six families and their children (a total of 24

people) received treatment services from the clinician for the SSI. Parent-Child Interaction Therapy (PCIT) was the primary intervention approach.

The anticipated co-location of all family and child services for domestic violence victims within a central Family Justice Center by spring 2006 will help institutionalize the initiative’s goals after its federal funding ends. The Center would not have been possible if not for the foundation laid by the Sitka SSI (e.g., relationships, knowledge, and commitment).

The commitment of key institutional leaders to collaborate and change their procedures and practices facilitated the progress of the initiative. In addition, tangible and successful actions arising from the initiative (e.g., CID-COPS) fueled further collective action.

The implementation of treatment services, however, was delayed because of inadequate staff support to follow up with families and to coordinate all referrals from various agencies. Its primary focus on the Native community revealed problems that restricted the initiative’s progress, including: the divide between Natives and non-Natives permeating every aspect of daily life, from personal mental health to service provision; the role of historical trauma and oppression in the cycle of domestic violence among Native families; the lack of interventions tailored to the socio-

cultural context of the Native community; and the limited human resource pool in the Native community. The location of the Native community within the city of Sitka intensified these issues.

Three conditions in need of greater attention when addressing domestic violence issues and the impact of exposure on young children in a Native community are as follows: 1) friction over race, power, and cultural competency of services, which needs to be addressed to create a sustainable and coordinated system that effectively serves every child and his/her family, regardless of heritage; 2) the need for intentional design and early implementation of a healing process for Native families afflicted by violence; and 3) underdeveloped staff capacity, especially in the Native community.

### **1.1 Mission**

The mission of the Sitka SSI, spearheaded by the STA, was to end the cycle of violence in Native Sitkan families and establish cross-agency collaboration for identifying, assessing, referring, and treating young children exposed to violence and their families. How did STA accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in the following sections, and a timeline of major events is attached.

## **2. Contextual Conditions**

Located on an island, Sitka is accessible only by boat or airplane. The Sitka community is divided along non-

Native/Native lines. The non-Native community (primarily European American) and the Native community make up approximately 69% and 19% of the total population, respectively, according to the 2000 U.S. Census. The Native community is governed by a tribal council, and the rest of Sitka is governed by a municipal government. While residents from the two groups may interact because they share the same physical space, their governments, organizations, and leaders typically operate on independent and parallel paths (Sitka Safe Start Initiative, 2004).

The two groups are further divided by differences in cultural traditions, histories, and other socioeconomic characteristics (e.g., the median household income for Sitka is almost twice the income reported for the Native community alone), and mistrust of non-Native agencies is prevalent among Native citizens (Sitka Tribe of Alaska, 2005). Conversely, according to both Native and non-Native individuals who met with the National Evaluation Team, some non-Native service providers' negative perceptions about Native people inhibit their ability to provide culturally competent assistance, further fueling the latter's wariness.

The Native community has experienced decades of "historical trauma" (Dauenhauer & Dauenhauer, 1987; Whitbeck et al., 2004) as a consequence of losing their land to early Russian and European settlers; being prohibited from practicing their spiritual and cultural traditions; and subsequently, facing racism at the individual, community, and systems levels. The Native people often feel a deep sense of powerlessness. Further, the death of

every elder brings the Native language, and hence the culture, closer to extinction (Dauenhauer & Dauenhauer, 1987).

Conditions such as those described above for Native citizens can cause conflicts within the self and the community, which in turn affect a person's mental health (Nofz, 1988; U.S. Dept. of Health and Human Services, 2001). In Sitka, these effects are manifested in disproportionate rates of substance abuse and domestic violence in Native families, and a weak sense of belonging to the larger community (Association for the Study and Development of Community, 2005a; Sitka Tribe of Alaska, 2005). Because of these disproportionate rates and the role of the Sitka Tribe of Alaska (STA) as lead agency for the Sitka SSI,<sup>1</sup> the SSI has understandably focused primarily on Native children and families. The expected outcome was an end to the cycle of violence in Native families. Because of this focus and anticipated outcome, it was necessary for the initiative to include a process for healing and for addressing cultural competency issues as part of its overall strategy to reduce children's exposure to violence.

### **3. Community Capacity**

#### **3.1 Before the Sitka SSI**

**Knowledge and skills.** Before the Sitka SSI, the capacity of the Native community to address the threat of domestic violence was limited; for

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<sup>1</sup> Sitka Tribe of Alaska's Department of Social Services' director acted as the initiative's project director and oversaw the daily implementation of the grant.

example, the community did not have a single licensed or trained Native mental health professional. Clinicians were available through the SouthEast Alaska Regional Health Consortium (SEARHC);<sup>2</sup> however, these clinicians were of European descent, and their clinical interventions were perceived by the STA Social Services staff as rooted in Western approaches—neither considerate of the historical and cultural context of the Native community, nor sensitive to the multiple needs (e.g., housing, jobs) that affect Native clients.

#### ***Coordination of services.***

Further, agencies with direct and indirect contact with victims of domestic violence employed a wide array of policies and procedures related to the treatment of these victims. This assortment suggests a fragmented system of screening, assessing, referring, and treating families and children who experience violence in their homes (Alfrey, 2003). The community assessment conducted by the SSI during its planning phase confirmed the need for a continuum of coordinated services for children exposed to violence and their families.

#### ***Existing community***

**collaboratives.** There were two major existing community collaboratives intended to reduce high risk factors for children and youth (Advancing Our Community and Communities That Care). These collaboratives, however, did not have a specific focus on young

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<sup>2</sup> SEARHC is a consortium of twenty Alaska Native tribes from throughout the region that operates a hospital that serves primarily Alaskan Native and American Indian citizens, but is open to other people who are referred by a private health practitioner.

children, especially Native children, and had not generated any action, according to several agency leaders. Consequently, prior to the Sitka SSI, there had been no credible venue in the Native community for dealing with domestic violence and its impact on children.

### **3.2 After the Sitka SSI**

Since the inception of the Sitka SSI, the Native community has developed improved capacities to address domestic violence and its impact on young children by: initiating a healing process for the community; focusing attention on the impact of exposure to violence on young children and developing an initial pathway for identifying and referring these children; hiring a clinician who, although not Native, is considered familiar with Native traditions; improving relationships between non-Native and Native agencies; supporting the Sitka Police Department (SPD) in increasing its capacity to focus on violence prevention and community policing; and providing a forum for tribal and municipal government leaders to interact. The following sections describe these capacities and their development in more detail.

Four years after its inception, the Sitka SSI has not clearly succeeded in reducing Native children's exposure to violence and the impact of the exposure. The foundation for doing so, however, has been laid. The raised awareness and availability of treatment for Native families is expected to lead eventually to decreased exposure and reduced impact of exposure.

## **4. Integrated Assistance**

### **4.1 Types of Assistance Received**

Throughout the initiative, the STA received continuous assistance from the National Center for Children Exposed to Violence regarding the Child Development-Community Policing strategy,<sup>3</sup> from National Council of Juvenile and Family Court Judges about establishing a tribal court, from the Institute for Educational Leadership about overall program needs, and from the Systems Improvement Training and Technical Assistance Project about sustainability issues. The University of California Davis provided assistance regarding the PCIT model specifically. Sitka SSI staff also attended a sustainability workshop in San Diego in 2003; the workshop was facilitated and conducted by the Institute for Community Peace. These organizations and their assistance were part of the National Safe Start Demonstration Project's support system.

Aside from the expertise available from the above organizations, the Sitka SSI received technical assistance from an expert at the University of Oklahoma on adapting PCIT for Native families.

While the STA found the assistance they received valuable, some assistance providers lacked knowledge about models and approaches appropriate for Native communities, according to some STA representatives. Nonetheless, Sitka SSI staff have used the knowledge obtained to help agencies

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<sup>3</sup> The Sitka Safe Start Initiative's Child Development-Community Policing strategy is called CID-COPS (pronounced "kid cops").

in Sitka. For example, recognizing that the assessment conducted by Sitkan Families Against Violence (SAFV)<sup>4</sup> for young children exposed to violence was not age-appropriate, the STA clinician facilitated a conference call between SAFV and a domestic violence shelter in Oklahoma to help the former learn from the latter.

#### ***4.2 Additional Technical Assistance Needed***

The STA did not seek adequate technical assistance in cultural competency. In the first two years of the Sitka SSI, the TODOS Institute conducted trainings on building relationships across lines of gender, race, class, etc., and how to create more inclusive institutions. Some training participants found these trainings useful in raising their consciousness, and wished that the trainings had continued. Addressing the subject of cultural competency is critical for systems change in communities where service providers and service recipients are predominantly from the majority and minority groups, respectively. Because the Tribal Council and the municipal government recognized this need, two tribal staff member conducted a training session for the police department in early 2005. Some of the police officers responded positively to the training, and others negatively. Overall, the lack of follow-up after each of the above trainings and the inconsistent engagement of participants resulted in a loss of momentum to deal with the subject more assertively.

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<sup>4</sup> Sitkan Families Against Violence is the only advocate and shelter for domestic violence victims in Sitka.

## **5. Local Agency and Community Engagement and Collaboration**

### ***5.1 During the Planning Phase***

STA representatives invited key individuals from the mental health, domestic violence, and education sectors to form the Sitka SSI collaborative. Additional representatives from a wide variety of sectors, including law enforcement, public health, the judicial system, family and child services, substance abuse prevention and treatment, and Native cultural programs, were also invited to provide input on the strategic plan for the Sitka SSI. A community assessment was conducted in spring 2002, and the findings were used to prioritize goals and objectives. This assessment included Native and non-Native citizens. A similar assessment for Native citizens only was planned for later; it was eventually conducted in 2004 for the first time in the tribe's history.

## **5.2 During the Implementation Phase**

**Composition of collaborative.** As the SSI process shifted from planning to implementation, the core participating agencies in the collaborative were the STA, the Sitka Police Department, SEARHC, SAFV, the Office of Children's Services (OCS, formerly the Department of Family, Youth and Children), and Sitka Counseling and Prevention Services (SCAPS, which offers intervention services for batterers). School district representatives were sporadically involved. Between 2002 and 2004, the collaborative met regularly to discuss administrative issues related to the initiative.

**Function of collaborative.** The collaborative's function changed between 2004 and 2005, as 1) the number of administrative meetings decreased because of everyone's busy schedules, 2) the initiative's child development and community policing strategy (i.e., CID-COPS) developed and became the primary focus of the SSI, and 3) bimonthly case-conferencing meetings became possible with the hiring of a clinician by the STA Department of Social Services.

**Collaborative processes.** By the end of 2005, the same representatives who met for the collaborative administrative meetings also were meeting for the case-conferencing meetings; as a result, the collaborative meetings stopped. Agency representatives began to refer to the CID-COPS meetings as the SSI collaborative meetings. During the case-conferencing meetings, participants discussed new domestic violence cases,

exchanged new information about previous cases, and worked together to determine the best course of intervention for a family. People in high-level decision-making positions (i.e., Chief of Police, Director of the STA Department of Social Services, and Director of SCAPS) attended the meeting when necessary to discuss severe cases or address issues that required their input.

The relationships among agencies improved over time. Representatives of the STA Department of Social Services and representatives of SEARHC initially experienced a tense relationship because of mutual dissatisfaction with the capacities of the opposite agency to adequately serve Native children exposed to violence and their families. The tension diminished in late 2004 when the STA hired a clinician who was considered credible and knowledgeable by SEARHC clinicians. The increasing strength of the relationship between the STA and the Sitka Police Department is worth noting because it eventually led to their joint application for a *Family Justice Center* grant.<sup>5</sup> A new Chief of Police, hired in 2005, contributed significantly to the strengthening of the relationship. The new Chief not only had extensive experience working in Native communities, he also was committed to expanding the responsibilities of police officers beyond basic law enforcement to violence prevention and community support.

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<sup>5</sup> The Family Justice Center Initiative implemented by the U.S. Department of Justice supports the establishment of domestic violence victim service and support centers. These centers are expected to co-locate all services within a central place.

By the end of 2005, the case-conferencing and collaboration process was working more smoothly than ever because working together over time had allowed agency representatives to:

- Develop a better understanding of each agency's role in supporting families and children (e.g., the domestic violence victims' advocate, child protective services, and police department no longer viewed each other as "enemies," but as part of a larger support system for families and children exposed to violence);
- Increase their confidence in each other's abilities, as their collaboration generated tangible actions that benefited the community and their respective agencies (e.g., the Sitka Police Department and STA collaborated to apply for and obtain a *Family Justice Center* grant; SEARHC agreed to accept non-Native clients referred by SAFV);
- Establish clear memoranda of agreement that described how they would work collaboratively in the Sitka SSI and protect the confidentiality of the cases disclosed (ten memoranda on general participation were established, and five were developed specific to CID-COPS).

## 6. System Change Activities

Sitka SSI activities have resulted in:

- Increased awareness and dialogue about domestic violence among Native citizens;
- An initial process and procedures for identifying, referring, assessing, and to a lesser extent, treating young children exposed to violence; and
- Improved capacity of the Sitka Tribe and participating agencies (i.e., SAFV, SEARHC, SPD, OCS) to address issues related to young children exposed to violence.

### **6.1 Community Action and Awareness**

#### *Community awareness.*

Domestic violence is a painful subject for Native citizens (as described in Section 2), and many non-Native providers have limited knowledge of how the historical trauma and oppression experienced by the Native community impact the design and delivery of services. The Sitka SSI was responsible for helping Native citizens talk about the subject, and at the same time, raising the consciousness of non-Native institutions and providers to provide culturally competent services.

To start a dialogue about domestic violence among Native citizens, the Director of the STA Department of Social Services (also the director of the initiative) used her knowledge of the Native tradition of totem pole carving to raise the issue in a natural and permitted way. A group of youth told their story about domestic violence through the carving process, bringing attention to the issue and prompting participating elders to acknowledge the youth's pain. The

raising of the totem pole was a significant community event in 2005, a symbol of the community's commitment to stop the violence that affects each generation. Since the raising of the totem pole, several people have contacted the initiative's director to follow up, a sign of willingness among Tribal members to talk about their pain and begin the healing process.

**Community assessment.** As mentioned, in 2004, STA conducted the first-ever needs assessment of its community, including several questions about domestic violence and children exposed to violence. STA participants reported that these questions were included in the assessment because of the awareness raised by the Sitka SSI. Approximately 83% of the respondents indicated that domestic violence and children's exposure to it was a problem.

**Trainings.** The Sitka SSI sponsored two system-wide trainings on oppression and its impact on violence, and one training on cultural competence for the Sitka Police Department. Approximately 100 people from a variety of agencies and organizations in Sitka attended the system-wide trainings. These trainings raised the consciousness of some individuals, but did not lead to any changes in organizational policies, procedures, or practices for working with the Native community.

## **6.2 Development of Policies, Protocols, and Procedures**

The Sitka SSI has developed:

- A policy to respond to a child exposed to violence and his/her family within five days; and

- Protocols, in the form of a memorandum of agreement among STA and first-responder agencies (i.e., SPD, SAFV, SEARHC, and SCAPS), about how the agencies and their staff should work together to respond to a domestic violence situation.

## **6.3 New and Enhanced Programming**

The Sitka SSI streamlined and established an initial pathway for identifying, referring, assessing, and treating young children exposed to violence (see Figure 1). Before the initiative, standard protocols for identifying these children across agencies did not exist. Instead, individual cases were referred to SEARHC for mental health services; however, many families did not complete the full course of therapy. According to focus groups convened by the SSI, Native families had difficulty attending all of the therapy sessions because they had no childcare or transportation to the clinic, or because they had more urgent needs (e.g., finding a job, shelter). This affirmed the importance of a more holistic approach to mental health services for Native families, further motivating the STA to build its capacity to better serve its citizens.

**Identification and referral.** Identification and referral components of the care pathway were developed more rapidly than were assessment and treatment components. As described in greater detail below, procedures and practices for identifying and

referring children exposed to violence were put in place first because there was staff capacity to do so; the result was CID-COPS and the protocols related to it.

By the end of 2005, CID-COPS had identified a total of 188 children from 80 families; the number of children identified doubled from 2004 to 2005, and the average age decreased (from 8.5 years in 2004 to 7.8 years in 2005). Identified families were referred to different agencies for specific assistance. Participation of clinicians from SEARHC and SCAPS in the CID-COPS team was initially very limited because it was too expensive for these agencies to pay clinicians to be on-call after working hours. Clinicians from these agencies became more involved when case-conferencing meetings began to be scheduled during the day and not after working hours.

The relatively rapid development of the identification and referral component of the pathway was facilitated by:

- The enthusiasm of Sitka Police Department representatives and Sitka SSI staff about the potential of the child development-community policing strategy and their immediate decision to adopt it;
- The availability of technical assistance from the National Center for Children Exposed to Violence;
- The immediate assignment of representatives from SAFV and the Sitka Police Department, as

well as an SSI case manager, to the CID-COPS team;

- The Police Chief's agreement to train all police officers about CID-COPS.

To date, all police officers (except new hires in 2005), a domestic violence advocate from SAFV, and representatives from the District Attorney's Office and the Alaska State Troopers have been trained in the identification and referral pathway.

***Assessment and treatment.*** The assessment and treatment procedures and practices were established about a year later than the identification and referral pathway, after the STA Department of Social Services hired a clinician in late 2004. This clinician's expertise in child trauma and relationships and his presentation to Head Start teachers helped expand referral sources beyond the agencies directly involved in CID-COPS (i.e., SPD and SAFV). The new sources included SEARHC, SCAPS, and OCS. The clinician used primarily the PCIT model for assisting six families and their children (a total of 24 people) exposed to violence.

***Strengths of new service pathway.*** The new service pathway proved more responsive to Native families because:

- The SSI case manager, a Native, provided personal outreach to families in services, to ensure that they had transportation and childcare. Clients initially thought to be resistant to treatment began to show up regularly for appointments. The personal outreach, however,

stopped when the case manager left in mid-2004;

- The STA clinician designed the treatment plan to include two sessions per week, to enable families to complete their treatment within a shorter period of time, given that Native families typically dropped out of treatment after several weeks. Such accommodation was not possible with more traditional service providers like SEARHC;
- STA established a policy of responding within five days to a referral, whereas SEARHC responded within ten days; and
- The Healing House where treatment took place was a more familiar and accessible setting for Native families than SEARHC or SCAPS.

**Challenges.** While the Sitka SSI led to a systematic process for responding to and assisting young children exposed to violence, the successful implementation of the process has been challenged by limited staff capacity and expertise.

First, the initiative's case manager resigned in 2004; this position still had not been filled as of January 2006, because no qualified Native person had been identified. The absence of a coordinator made it difficult to attend to the daily implementation of the initiative; the initiative's project director was already stretched beyond her capacity in her role as Director of the Department of Social Services and as the only Native person in an institutional

leadership position representing the Native community's social services sector in many community-wide collaboratives. Consequently, there was no one dedicated to following up with each family to remind them of appointments and ensure that they had transportation and childcare assistance.

Second, Sitka has a limited pool of clinicians with knowledge of the impact of exposure to violence on young children. The STA clinician could manage only so many cases before he exceeded his capacity.

Third, therapeutic models that fit the historical and socio-cultural context of Native communities are lacking. The illness and conflicting schedule of a Native researcher at the University of Oklahoma who had adapted PCIT for Native families further delayed the adoption and implementation of a culturally appropriate intervention (including the training of Native paraprofessionals to deliver the intervention). Nevertheless, the STA psychologist continued to conceptualize and develop culturally appropriate intervention models, including the use of traditions such as drumming.

Finally, STA's engagement of SEARHC to provide PCIT to families fell through, which delayed the provision of treatment services. Two Native persons were trained as paraprofessionals to provide Relationship Enhancement Training (RET) during the first phase of the family treatment plan (the first 12 to 18 weeks). After completing RET, families were referred to SEARHC to complete the second phase of their treatment, which required the involvement of

certified clinicians. Families stopped going to SEARHC after a few sessions for reasons mentioned previously; consequently, STA terminated its contract with SEARHC. The paraprofessionals could not continue their assistance without the supervision of a certified clinician from SEARHC. The STA is hopeful that their clinician will train and supervise paraprofessionals after he completes the necessary requirements for certification.

### **6.4 Service Integration**

Service integration across agencies occurred in the form of case conferencing meetings twice a month (previously described in Section 4) and establishment of the Family Justice Center. The *Family Justice Center* grant, received in fall 2004, was used to remodel the Healing House (location of the STA Department of Social Services); the remodeled building will house the SPD's Domestic Violence Coordinator, the STA Department of Social Services, and other services for domestic violence victims. The successful receipt of the grant and its progress is evidence of the strengthened relationship between the STA and the Sitka Police Department, as a result of the commitment of the leaders of both institutions and their earlier collective action that benefited everyone (i.e., CID-COPS and their joint application for and receipt of the *To Encourage Arrest* grant). These efforts also have increased communication between the tribal and municipal governments, leading to a perception of the STA Tribal Council as an equal partner to the General Assembly, according to STA government staff. Prior to these grants, the STA Tribal Council was involved only in cultural

matters; now it plays a leading role in discussions about social issues.

### **6.5 Development, Identification, and Reallocation of Resources**

The *To Encourage Arrest* and *Family Justice Center* grants provided additional resources for Sitka to address issues of violence, including domestic violence. A total of \$210,000 was received in FY 2004 as part of the *To Encourage Arrest* grant. The *Family Justice Center* grant, which amounted to \$1.1 million, provided funds not only for remodeling the Healing House, but also for three new positions to work with domestic violence victims and their families, including a community outreach person. This person will be responsible for designing new public education materials. This responsibility was added to the position description after STA staff realized that there were no brochures or other educational materials geared towards Native families.

## **7. Institutionalization of Change**

### **7.1 System-Wide and Agency Changes**

There has been one system-wide change as a result of the Sitka SSI: an interagency protocol that describes how each participating agency in CID-COPS should respond to a child exposed to violence. Under the protocol, all children are expected to complete a trauma assessment administered by the STA clinician.

Changes also have occurred within agencies, including:

- All police officers are expected to participate in an annual training about CID-COPS, to increase their reporting of young children present in a domestic violence situation; and
- SAFV added issues related to children's exposure to violence to all of its training sessions.

The above practices were made possible, and will likely be sustained, because of the commitment of the agency decision-makers.

### **7.2 Point-of-Service Change**

When participating agency staff identify through their services a child exposed to violence, they are expected to refer the child to the STA clinician, along with background information about the child. This expectation has been met thus far, simply because staff now understand that the child needs help, and the procedures established by the Sitka SSI represent the best solution for the child, given the expertise of the STA clinician.

### **7.3 Community Change**

The level of knowledge of the impact of exposure to violence on young children in the Native community and within participating agencies has increased as a result of the Sitka SSI. Increased knowledge was evident in follow-up inquiries about the totem pole project to continue the dialogue that this project started, as well as increased reports of domestic violence incidents in 2005 (a sign that the community may be

less inclined to tolerate domestic violence). Trainings, case conferencing meetings, and the raising of the totem pole have contributed to this change.

## **8. Increased Community Supports**

The Sitka SSI has helped to increase community supports for services to address violence exposure through:

- Additional victim services made possible by the grant *To Encourage Arrest*, and eventually by the *Family Justice Center* grant;
- Strengthening relationships across agencies, thereby improving service coordination (i.e., CID-COPS and case-conferencing meetings);
- Bringing the issue of domestic violence to the attention of elected leaders and Native citizens (e.g., the Tribal Council agreed to include questions about domestic violence in its first tribal community needs assessment; the totem pole raising led to follow-up inquiries).
- Raising the consciousness of agencies in Sitka about the adequacy of existing services (e.g., *Advancing Our Community*, a major community collaborative in Sitka, decided to conduct a survey about existing services for young children exposed to violence and barriers to service access);
- Establishing an initial process for identifying, referring, assessing,

- and treating children exposed to violence; and
- Improving the capacity of STA to serve its own community and implement programs.

The community's improved capacity to address children's exposure to violence was reflected in the following story told by several agency leaders in 2005. A child molester was arrested, and after his arrest, 44 additional reports were made to the Sitka Police Department regarding incidents related to the same perpetrator. The Director of the STA Department of Social Services called an emergency meeting; with one day's notice, a total of 15 people representing different agencies attended the meeting. Three individuals volunteered to review existing materials (e.g., brochures) for child and adult survivors of sexual assault. Each agency also agreed to share information with the families it served (e.g., the schools set up counseling sessions for their students). According to some participants, they would not have been able to act so quickly in the past and fewer agencies would have attended the meeting. Many participants attributed the successful action to the support system established through the Sitka SSI.

## 9. Conclusion

Sitka, especially the Native community, has increased its capacity to address domestic violence and its impact on young children. Initial changes at the system, point-of-service, and community levels have occurred. Native citizens' increased awareness of the impact of exposure on young children has the potential to discourage domestic

violence, which in turn, has the potential to reduce children's exposure and ultimately, to reduce the impact of exposure.

The Sitka SSI contributed directly to the increased capacity of the Sitka Police Department and the STA to work jointly to design and develop the Family Justice Center; in applying for and implementing the *Family Justice Center* grant, these agencies implemented many of the lessons learned through the initiative about services needed and how to administer a large federal grant. A focus on the impact of exposure to violence on young children will be integrated into the Family Justice Center's mission and service delivery system.

The changes brought about by the Sitka SSI were possible because of the following conditions:

- Support from decision-makers in key agencies that have a stake in the issue (e.g., police, domestic violence victim advocate and shelter, child protective services);
- Staff knowledge and skills in mobilizing resources and relationships and initiating programming (e.g., CID-COPS and case-conferencing);
- Staff knowledge and skills in designing and providing treatment services that encourage use by Native families (e.g., location of services at the Healing House, which is more accessible and familiar to Native citizens);
- Tangible and successful collective action (e.g., through CID-COPS and the *Family*

*Justice Center* grant), which fueled further collective action; and

- A shared sense of responsibility for the problem between Native and non-Native agencies.

At the same time, the progress and full potential of the Sitka SSI were hindered by challenges common to any systems change initiative, including:

- A limited pool of local experts who specialize in childhood trauma and impact of exposure to violence on young children (e.g., the STA clinician was not hired until late 2004);
- Difficulty in initiating a community-wide dialogue about domestic violence; and
- Staff turnover (e.g., loss of the Sitka SSI coordinator).

The above challenges were exacerbated by conditions unique to a Native American community, including:

- The historical and socio-cultural context of the Sitka tribe; and
- Limited knowledge in the mental health field about interventions effective for Native American families, much less Native American children exposed to violence.

Decades of psychological, political, and economic oppression have contributed to the cycle of violence in Native families. Domestic violence elicits feelings of shame at the individual, family, and clan levels. For the Native community as a whole, the occurrence of domestic violence represents a loss of Native traditions and

the community's diminishing capacity to endow future generations with Native cultural assets.

Additionally, human resources for designing and managing any initiative are very limited in the Native community, because of low levels of education; as a result, the Sitka SSI took more time than anticipated to identify, hire, and retain Native staff and consultants (e.g., local evaluator, case manager).

An initiative that addresses domestic violence in Native communities must, therefore, design and implement a healing process as part of its programming. This strategy must consider ways to raise and discuss the issue through a process that feels safe, familiar, and natural (such as the totem pole carving project). Staff and leaders must continuously pay attention to this process to encourage and support the healing, and sustain the benefits.

In Sitka, non-Native and Native citizens cannot avoid the need to function simultaneously in each other's worlds. This creates stress for some because of prejudice on both sides. Such prejudice and negative perceptions can affect organizational cultures. From a European-dominated perception, for example, Native organizations did not run their programs in the same professional way as did non-Native agencies (e.g., Native agencies made accommodations for families who did not show up on time for their appointments, in a way that non-Native agencies would not consider part of their professional responsibility); from a Native standpoint, non-Native agencies did not run their programs in a way that

was culturally responsive and sensitive to the experiences of Native people (e.g., many families who did not show up on time for appointments could do so only with additional help with childcare and transportation).

A dialogue about power differences is essential for any systems change initiative in a community in which most service providers are from the majority group, while most service recipients are from a minority group that has experienced decades of oppression. The Sitka SSI did not have a deliberate strategy for promoting this dialogue throughout its lifespan. This limited its potential to impact the capacity of the larger community (i.e., both Native and non-Native citizens) to sustain an integrated support system for young children exposed to violence, regardless of cultural background.

Finally, the search for and adoption and adaptation of a culturally appropriate mental health intervention model for young Native children exposed to violence were time-consuming processes. The adaptation of the PCIT model by an expert at the University of Oklahoma presented the most promise; however, time constraints on the expert's part and the need to certify the STA clinician to implement the model (making it possible for him to train and supervise paraprofessionals) delayed the model's implementation. The national technical assistance providers were not fully prepared to address this gap in the field, causing the Sitka SSI staff to feel somewhat unaided.

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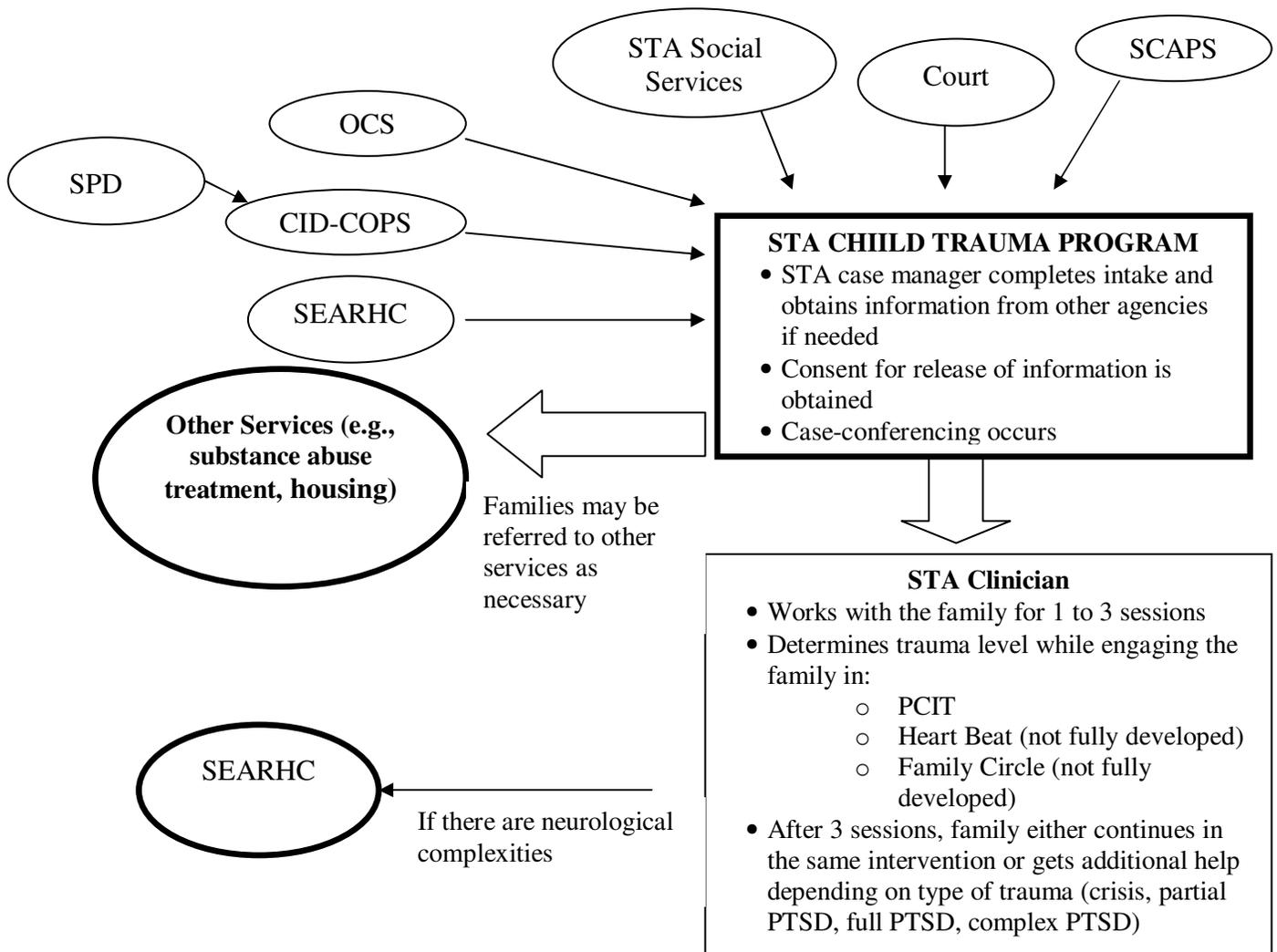
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**Exhibit IX-A**  
**Timeline of Sitka Safe Start Initiative Activities and Milestones**

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	1/05-6/05	7/05-12/05
Collaborative meetings	Monthly meetings until September 2003; first quarterly meeting occurred in December 2003				✓	✓	Monthly meetings changed to focus on case-conferencing	
Staff and other internal changes					Hired new local evaluator  Sitka SSI Coordinator left STA	Hired Social Services Deputy Director (also served as SSI clinician)		SPD DV Response Unit Coordinator resigned  SAFV liaison to the Sitka SSI resigned
Community assessment	✓					✓ (Tribal community assessment)		
Training by the TODOS Institute	✓		✓					
Cultural competency training for SPD						✓		
Technical assistance from NCCEV on CDCP			✓ (training in New Haven)	X				✓
Implementation of CID-COPS, including trainings for law enforcement officers			✓	✓	✓	✓		
Technical assistance from NCFJCF on judicial system				✓ (first Tribal Court order issued)	X			
Training for PCIT		✓ (two trainings by Univ. of California at Davis staff)		✓ staff attended PCIT conference in Sacramento	✓ (by Univ. of Oklahoma staff)	Training at Univ. of Oklahoma	Technical assistance from Dr. Subia Bigfoot at the Univ. of Oklahoma via telephone	

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	1/05-6/05	7/05-12/05
				o)				
Implementation of PCIT		✓						
New funds				<i>To Encourage Arrest grant received</i>		<i>Family Justice Center grant received</i>		

**Exhibit IX-B  
SITKA SSI Service Delivery Model**



# X

## Spokane Safe Start Initiative

### 1. Overview

Spokane Safe Start was designed to create a crisis response team to address the needs of children and families exposed to violence while integrating these families voluntarily into services, and to create a neighborhood-based capacity for early intervention. While working to achieve their vision, Spokane Safe Start staff and community partners served as a catalyst for the development of both information around the topic of children's exposure to violence and a way to bring attention to a segment of the community whose needs were not being met.

Spokane Safe Start staff identified and sought to address opportunities for systems change in what they viewed as essential child-serving sectors: mental health, law enforcement, child welfare, the dependency court system, and social service agencies involved with domestic violence and substance abuse. Systems change through early identification, coordination of services, assessment, and treatment was viewed as critical and central to realizing positive outcomes for children exposed to violence and their families in Spokane. Converging circumstances, however, principally a downturn in the economy at the state and local levels, challenged the ability of the Spokane Safe Start grantee to generate the comprehensive change needed to bring about a coordinated and sustainable system of care for children exposed to

violence. Yet, gains were made, illustrating the importance of partnerships, sector-by-sector change, and strategic purpose.

The Spokane Safe Start grantee modeled the New Haven Child Development-Community Policing (CDCP) approach and formed partnerships among law enforcement, Spokane Mental Health, Partners with Families and Children, and the NATIVE Project to form the Child Outreach Team (COT), a group of five clinicians on-call 24 hours a day and seven days a week to respond to officers who identified children exposed to violence. Through the Child Outreach Team, Spokane Safe Start identified, referred, and assessed over 700 families and over 1000 children between 2001 and 2005.

To promote sector-by-sector systems change, the Spokane Safe Start grantee collected and analyzed data relevant to the context of the system being addressed. The grantee successfully launched systems change initiatives in three key sectors of its partnership: 1) Juvenile Court through the Court Improvement Program (CIP), 2) law enforcement through the implementation of CDCP, and 3) mental health services through training and improved screening for children exposed to violence. Each of these sectors developed a protocol for identifying children exposed to violence, a process for asking the right questions of children and parents involved in a crisis (e.g.,

domestic violence) situation, and an understanding of the ways to promote change within its sector. Furthermore, between 2001 and 2005, the Spokane Safe Start grantee provided trainings for approximately 3,000 professionals in different fields such as law enforcement, mental health, and education to increase awareness and knowledge at the community level around issues of children's exposure to violence and the impact of violence in the lives of children.

Over the course of program implementation, the Spokane Safe Start grantee worked through many economic and political obstacles facing Spokane County social and mental health service providers and community residents in the past several years. Chief among these obstacles were the severe budget cuts which impacted education, child welfare, mental health, law enforcement, juvenile justice and the entire non-profit child service community. Additionally, several of the original initiative planners have either retired or left their positions, including the Spokane Police Chief and the Spokane County Sheriff, the Director of County Community Services, the Juvenile Court Administrator, the presiding Dependency Court Judge and the Director of the Spokane County Domestic Violence Consortium. Although these factors hampered the progress of sustaining a coordinated system of care for children, the Spokane Safe Start grantee successfully developed and enhanced partnerships between organizations and successfully gathered data that will impact the child and family service system in other ways.

### **1.1 Mission**

The mission of Spokane Safe Start was to prevent and reduce the impact of exposure to violence on young children and their families by enhancing and integrating the supports and services offered by community providers, agencies, and institutions, and by creating a community culture of keeping children valued, cared for, and safe. How did Spokane Safe Start accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in this report.

### **1.2 Spokane County, Washington**

Spokane County is located on the eastern border of the state of Washington, adjacent to Pend Oreille County, Whitman County, Lincoln County, and Stevens County in Washington, and to Bonner County, Kootenai County, and Benewah County in Idaho. The county spans 1,764 square miles of land, with an average of 237 residents per square mile. According to the Washington State Office of Financial Management, the estimated 2003 population of Spokane County was 428,700, with 308,756 and 119,844 residents in incorporated and unincorporated areas respectively. The population of the city of Spokane is 196,624; that of the newly incorporated city of Spokane Valley is 82,005; and that of the remainder of the county is 150,966. Spokane County (in total) is 92.1% white, 1.7% Black, 1.5% Native American/Alaskan Native, 2.2% Asian/Pacific Islander, 0.8% other, and 2.4% mixed race (U.S. Census Bureau, 2000).

According to U.S. Census Bureau (2000) estimates, approximately 27,583 children under the age of five were living in Spokane County in 2003, accounting for approximately 6.6% of the total population. The median household income for 1999 was between \$36,177 and \$41,083. Approximately 12% of the county's population lives below the poverty line, slightly more than the nation's overall percentage of 10.6%.

## **2. Contextual Conditions**

The state of Washington is divided into two distinct economic, cultural, and political regions. Western Washington is far more urban than eastern Washington and accounts for about 75% of the state's population and 40% of its land mass. The politics in the Spokane region range from conservative to libertarian, and the overall philosophy toward government can be characterized by an absence of trust and a belief that "less is more." Other political, economic, and social conditions are described below.

### **2.1 Political Context**

Prior to 2000, when Spokane Safe Start began, Spokane County lacked a community master plan for children and youth services, as well as legislative or administrative policies specifically supporting assistance to children exposed to violence, or requiring collaboration of services to help children exposed to violence. Over the course of the implementation of Spokane Safe Start, the infrastructure that did exist for the support of children and families underwent severe budget

cuts (described further in other sections of this case study). Thus, both the political and economic contexts for the implementation of Safe Start in Spokane County presented significant challenges to the success of the initiative.

The strategies that the Spokane Safe Start grantee hoped to implement were grounded in system changes supported by proactive policies for children and families, for example:

- Increased funding for key child-serving agencies, particularly children's mental health services;
- Restructuring of the child welfare system to address children's issues in a more family-friendly and less bureaucratic manner; and
- Developing the capacity of social service agencies and the court system to share data about children exposed to violence and their families across agency boundaries (Association for the Study and Development of Community, 2006, p. 6).

In an effort to create a sustainable policy foundation for addressing child and family issues, the Spokane County Children's and Adolescents Initiative was launched on September 1, 2004, as a direct outgrowth of Safe Start. Spokane County Community Services, through its Regional Support Network, tasked Washington State University and Eastern Washington University (both Safe Start university partners) with facilitating a two- to three- year process for the development of an outcome-driven, family-centered system of care for children. Although this process focused

initially on Medicaid providers and recipients, the ultimate design of the system of care was expected to accommodate the needs of all children in the Spokane County community. Various organizations and systems, both formal and informal, were to participate in the process, thus ensuring that the development of the system of care would be community-based, inclusive, and representative of all those impacted by mental health. While funding for the Initiative was provided through Spokane County Community Services, the university partners withdrew from the relationship after 14 months of work due to a 25% reduction of funding to the Spokane County's mental health system. This 25% reduction was principally taken from mental health services provided to children and families. The university partners chose to return the funds so that they could be used to support these child and family serving agencies (Spokane Safe Start Initiative, 2005, p. 14).

## **2.2 Social Context**

Spokane is the trade and cultural center of a large area of the Northwest, including the state of Washington east of the Cascade Mountains, northern Idaho, western Montana, and northeastern Oregon. Due to changes in its industrial base, Spokane has seen a growth in poverty and now has disproportionately high rates of poverty. Approximately 37% of all Spokane children live in significant economic deprivation and are clearly the poorest residents of the region (Spokane Safe Start Initiative, 2005, p. 4).

Spokane has a service-based economy, in which technology and

manufacturing play only a minimal role. Education, health, and social services are the principal sources of employment.

The city of Spokane and Spokane County operate separate law enforcement agencies. The most common crimes in the city of Spokane are larceny/theft (63.21% of all crime), burglary (18.16%), vehicle theft (10.37%), aggravated assault (5.17%), robbery (2.58%), rape (0.46%), and murder (0.04%). Approximately 16,000 incidents of domestic violence-related crime are reported to law enforcement annually in Spokane County. In fiscal year 2004, there were approximately 98,000 new requests statewide for service from the Children's Administration (Child Protective Services, Child Welfare Services, etc.), including 80,000 referrals for abuse or neglect and 18,000 voluntary requests for services. Statewide, 38,000 referrals were accepted for Child Protective Services investigation, affecting nearly 47,000 children. There were 7,300 new placements, and more than 6,800 children exited out-of-home care. Of these 6,800 children, 4,887 went home, 1,110 children were adopted, 434 children were placed in new guardianships, and 369 children had other exits (Spokane Safe Start Initiative, 2005, p. 7). Spokane County child welfare data is represents approximately 13-15% of the statewide totals.

By statute, all children with serious emotional disorders in the state of Washington are eligible for publicly funded mental health support. Unfortunately, the extension of eligibility to caregivers is not automatic, creating potential eligibility barriers for family-centered care. There is also

evidence that service rates for eligible children in Spokane lag significantly behind those of other Washington urban areas. Further, the state mental health system budget is only adequate to serve 30% of the identified child population in need of mental health services (Spokane Safe Start Initiative, 2005, p. 10).

### **2.3 Economic Context**

Economic conditions in the state of Washington can be described as tumultuous. During the implementation of Spokane Safe Start, several major economic events at the state level severely impacted the availability of resources for children and families, including:

- Reduction in state revenues impacting all early intervention capacity in social service;
- Over-expenditures in child welfare resulting in interim cuts;
- The Braam lawsuit and settlement plan; and
- Over 62,000 children in Washington State lost medical insurance (from 2003 to 2005) (Spokane Safe Start Initiative, 2005, p. 3).

At the state level, the 2005 fiscal forecast was more promising than in recent years, because increased revenue enabled the legislature to appropriate additional funding for the state reserves. However, little of that additional revenue was used to provide or restore services to children that had been cut earlier in the biennium budget. Instead, the state government focused on economic development and higher education (Spokane Safe Start Initiative, 2005, p. 2).

The cumulative effect of concurrent reductions in federal and state funding, described by some Safe Start staff as “the roof falling in,” challenged the ability of the three major Safe Start partnering sectors (substance abuse, mental health, and child advocacy) to continue to implement the vision and goals of Spokane Safe Start.

Cuts in funding had a particularly significant impact on the non-profit service delivery infrastructure in Spokane, which serves as the primary source of care for children and families. The non-profit infrastructure is heavily dependent on state and local funding. According to Safe Start staff and partners, this infrastructure can no longer provide the level of services it provided five years ago, eroding the concept of interagency interdependency (Association for the Study and Development of Community, 2006).

The bulk of the state budget shortfall disproportionately affected children’s mental health and trauma services. Spokane Mental Health, the area’s largest provider and a Safe Start subcontractor, cut 20% of its workforce (65 individuals) in 2005. Lutheran Community Services, the largest provider of children’s mental health and trauma services, experienced a 40% reduction in funding and subsequently laid off 15 therapists and eight support staff. The county eliminated all funding to provide mental health services in the schools. Other local budget cuts included the layoff of 17 city police officers and a loss of \$800,000 in Head Start funding. The Children’s Administration experienced a \$13 million budget shortfall in 2005, which

resulted in a regional budget reduction of \$3.1 million in the Spokane area. Partners with Families and Children–Spokane (PFC), the lead Safe Start contractor, incurred a \$142,000 annual reduction in funding from the Region 1 Children’s Administration, as well as a \$10,000 per month reduction in mental health funding due to other budget cuts. Together, these funding reductions hampered the functioning of PFC, which has been operating since 1988 as the only program in the region providing wraparound, family-based services to high-risk families experiencing abuse, neglect, and trauma (Spokane Safe Start Initiative, 2005, p. 4).

Local agencies have made efforts to address the cuts from state resources. In November 2005, the Spokane County Commissioners proposed a three-year (time limited), 0.1% sales tax increase, potentially raising \$6.5 million in revenue per year. Collection of the revenue, however, will not begin until July 2006 and is not expected to provide sufficient resources to fully restore mental health services.

### **3. Community Capacity**

Spokane non-profit organizations, community-based organizations, social service agencies, and research universities (Washington State University and Eastern Washington University) have historically worked together, partnering on multiple projects focused on children and families, as a result of the limited resources available in the Spokane area. Spokane has had significant success in developing local applications of integrated service treatment models for high-risk children

and families. “Integrated services” in Spokane refers to cross-disciplinary and often co-located service delivery strategies using a client-empowerment strategy referred to as Individualized and Tailored Care (ITC) (Spokane Safe Start Initiative, 2005, p. 7). This capacity was important in the development of the Spokane Safe Start service delivery model. In addition, other types of capacities supported the mission and goals of Spokane Safe Start.

#### **3.1 Spokane County Community Network**

During planning phases, the Spokane Safe Start grantee partnered with the city of Spokane and the Spokane County Community Network. Spokane maintained a relationship with a state child welfare entity known as the Family Policy Council (FPC), and was one of a diminishing number of local governments in the state to receive a small (\$220,000) two-year grant from the FPC to address generic child abuse issues among children six to 12 years of age. In administering this grant, the Spokane County Community Network chose to limit its request-for-proposal to the two Safe Start catchment areas, requiring collaborative partnerships among applicants and mandating that successful applicants identify how they would prioritize the issue of trauma exposure. As a result of the consequent funding of two partnerships, the Spokane County Community Network/Family Policy Council provided Spokane with the capacity to engage all but one of its publicly funded mental health providers into direct relationship with Safe Start. Safe Start’s relationship with the Spokane County Community Network continued to support the initiative

throughout its implementation, including providing funds to develop Teen Peace, an intervention targeting adolescents who had been victimized by and had perpetrated violence. Teen Peace was developed by the NATIVE Project, one of Spokane Safe Start's key partners.

### ***3.2 Child and Family Research Unit (Washington State University)***

The Child and Family Research Unit (CAFRU) was developed to identify and respond to opportunities for improving and expanding services in the Spokane community. CAFRU works to strengthen and nurture children and families, by conducting theoretical service outcome and public policy research that contributes to improved quality of life for children and their families (Child and Family Research Unit, n.d.).

### ***3.3 Partners with Families and Children—Spokane***

Partners with Families and Children is an accredited, hospital-based children's advocacy center that provides treatment to children and families affected by acts of child maltreatment (abuse, neglect, and exposure to drugs and violence). The organization uses a model of collaboration and partnership with other community agencies to provide the services necessary for restoring children and their families to healthy, productive lives.

### ***3.4 Spokane Mental Health***

Spokane Mental Health is a not-for-profit organization that has been serving children, families, adults, and elders throughout Spokane County since

1970. The agency provides quality treatment and rehabilitation for those with mental illness and co-occurring disorders. These services include: crisis response services; individual, family, and group therapy; case management and support; vocational rehabilitation; psychiatric and psychological services; medication management; consumer education; and a family support program to expedite access to assessment and services for families with children involved in Juvenile Court dependency proceedings. Spokane Mental Health tailors services to the unique needs and strengths of each person seeking care. Co-located partners include substance abuse staff (Spokane Mental Health, n.d.).

### ***3.5 The NATIVE Project***

The NATIVE Project is an urban Indian non-profit organization that has served Spokane County since 1989; it is the largest outpatient substance abuse program in eastern Washington for adolescents. The NATIVE Project advocates for children and families of all races, ethnicities, sexual orientations, and religions, but serves in particular as a resource on Indian issues. The organization promotes a drug- and alcohol- free lifestyle; spiritual, cultural, and traditional Native values; wellness and balance of mind, body, and spirit for each person; respect and integration of all healing paths to wellness for self and others; lifestyles that encourage and are supportive of prosperity; education; and awareness (N.A.T.I.V.E. Project, n.d.).

### **3.6 YWCA-Alternative to Domestic Violence**

The YWCA's Alternative to Domestic Violence program is the primary domestic violence service agency for Spokane County, receiving approximately 3,000 duplicated client-initiated requests for help annually. In its partnership with the courts, the YWCA has helped to provide legal advocacy to obtain approximately 700 protection orders and 1,200 no-contact orders.

### **3.7 Other Community Resources**

At the time of the development of the first strategic plan, the following were noted as strengths and resources for Spokane Safe Start:

- Spokane County Head Start is a countywide program providing early childhood education and social services through nine neighborhood sites. This county program was one of the original Early Head Start sites and continues to provide Early Head Start services under continuing grants.
- Deaconess Medical Center co-located 10 staff for mental health and substance abuse services in two school districts, representing a significant commitment of internal resources to co-location strategies and out-stationing of staff.
- The Spokane Domestic Violence Consortium is a grantee of Coordinated Community Response to Prevent Intimate Partner Violence, an initiative of the Centers for Disease Control

and Prevention (CDC). The Consortium, with a membership of over 200 professionals and organizations, is now an acknowledged leader in the region on policy and professional development efforts related to domestic violence. Part of its mission is to conduct extensive media (television, radio, print) campaigns to educate the Spokane community about family violence and children exposed to violence. Dr. Blodgett, principal investigator for Safe Start, is also principal investigator for the Domestic Violence Consortium.

- A number of noteworthy programs in Spokane use integrated service program models on smaller scales. Breakthrough for Families provides integrated services to homeless teens and their families. The West Valley School District employs Individualized and Tailored Care principles in its multidisciplinary teams for complex children. The YWCA has participated in co-location strategies with city schools for homeless children and remains a principal partner in the team strategies of the Regional Domestic Violence Team (Spokane Safe Start Initiative, 2005, p. 29).

## **4. Community Engagement and Collaboration**

Spokane Safe Start was an outgrowth of coordinated community work directed through the Breakthrough

Community Coalition. Breakthrough was formed after the brutal murder of a young teen, Rebecca Hedman, who had been living on the streets in Spokane. Breakthrough is a voluntary, informal coalition that includes participation of senior management and line staff from the principal regulatory and service agencies addressing children's issues in Spokane. Leaders from education, advocacy, and the nonprofit service sectors, as well as private citizens, also participate. Using an informal collegial strategy, Breakthrough has brought significant resources to Spokane, playing a direct role in the planning and partnerships that have garnered more than \$10,000,000 in new direct service resources for children and families over an eight-year period. Breakthrough served as the sponsoring community coalition for Spokane Safe Start, and the Breakthrough Executive Committee served as the primary advisory body for Safe Start (Spokane Safe Start Initiative, 2005, p. 8).

A formal collaborative process, however, was not the driving force for Spokane Safe Start partners and community members. Although memoranda of agreement were signed in a limited number of cases (as described below), the Spokane Safe Start grantee did not rely upon this or other typical collaborative mandates to implement change for children and families exposed to violence. Instead, the grantee relied upon data-driven decision making, information dissemination, and training to promote and fulfill Safe Start goals (Association for the Study and Development of Community, 2006). These activities are described in later sections.

The Spokane Safe Start grantee did utilize formal work groups to plan the work of the initiative to achieve its goals across seven assigned dimensions. Initially, work groups were named for the planning functions they were to serve, for example, Family Identification, Service Integration, Family Support, Professional Development, Policy, Data Integration, and Resource Development. Individuals with current or recent leadership experience associated with administering publicly funded systems served as work group facilitators. For example, the director of the Spokane County Domestic Violence Consortium provided leadership and expertise to the Service Integration Committee in the area of family support. In the area of professional development, the Dean of Eastern Washington University's School of Social Work served as group facilitator. A former director of Spokane County Corrections served as leader of the Policy Committee (Spokane Safe Start Initiative, 2005, p. 22).

Prior to Safe Start, Lutheran Community Services provided the only formal program for children exposed to domestic violence. This center-based program had the capacity to serve approximately 100 children per year. During the implementation of Spokane Safe Start, approximately 260 children per year received services.

The Spokane Safe Start grantee developed sub-contractual relationships between Washington State University and three agencies (Partners with Families and Children, NATIVE Project, and Spokane Mental Health), to provide services to children exposed to violence and their families. These types of formal

functional relationships between mental health agencies to provide services to children exposed to violence and their families did not exist prior to Spokane Safe Start.

Although federal funding for Spokane Safe Start has ended, Safe Start staff report that agencies continue to collaborate with the demonstration project, particularly by making their staff available for ongoing trainings regarding children exposed to violence and family violence. For example, the Spokane County Sheriff's Office allowed Safe Start staff to train 209 deputies during a recent quarterly in-service rotation. Similarly, a number of mental health providers requested and received training for nearly 125 clinicians. Safe Start staff plans include future training of chemical dependency professionals and paraprofessionals in treatment of children exposed to violence and family violence. Spokane Safe Start has moved into the area of early learning and has participated in developing a venue for mobilizing the private sector into partnership with child care providers around this issue. Safe start has also completed trauma training to 109 separate child care provider agencies. Further, Safe Start personnel are working with the Spokane Public Schools and the Education Services District (Spokane County) to implement the Safe Schools/Healthy Students grant where the topic of trauma has been adopted as the central organizing core priority of the program.

## **5. Community Awareness**

The community assessment and planning process initiated at the outset of

Spokane Safe Start indicated that the community had only anecdotal knowledge of children exposed to violence, and lacked a mechanism to conduct surveillance of this issue. The Spokane County Domestic Violence Consortium was chosen to serve as the entity that would provide community awareness activities regarding children exposed to violence. Over the course of the implementation of Spokane Safe Start, the Domestic Violence Consortium significantly increased its education outreach to the community, providing training and written materials to a variety of non-profit service agencies, Head Start, childcare providers, and public and parochial schools. In addition, the U.S. Department of Health and Human Services/Centers for Disease Control and Prevention awarded federal funding to the Consortium, which used these resources for community education, a small juvenile perpetrator treatment program, and a small child witness to domestic violence treatment program—all in support of the goals of Spokane Safe Start.

Indications are that community knowledge about children exposed to violence significantly increased due to the efforts of the Spokane Safe Start grantee. As a direct outcome of the grantee's community awareness and outreach activities, over 70 agencies with nearly 3,000 individuals from the fields of law enforcement, mental health, substance abuse, education, child welfare, and the justice system received training in children's exposure to violence in the state of Washington. Trainings and knowledge dissemination led to a number of collaborative partnerships, studies, and programs in

service of children exposed to violence and their families.

## **6. System Change Activities**

Spokane Safe Start staff and partners described their systems change approach as a process for sector-by-sector change based on collection and analysis of data relevant to the context of the system being addressed. The situating of Spokane Safe Start within Washington State University (viewed by the community as a “neutral convener”) allowed the staff of Safe Start to serve as conveners and facilitators of systems change. The university setting also provided the capacity for Spokane Safe Start to implement a data-based approach to systems change. Salient features of how the sector-by-sector approach was operationalized are described below.

### **6.1 Memoranda of Understanding**

Although Spokane Safe Start staff and partners did not rely heavily upon the use of formal agreements (i.e., memoranda of understanding), several strategic agreements with key child-serving agencies provided a basis for generating partners for the delivery of services to children exposed to violence and their families. Key partnership agreements were developed with Partners with Families and Children, Spokane Mental Health, and the NATIVE Project (see the section on community capacity for a description of these partnering organizations). These key partners represented the three sectors considered by Safe Start staff as essential to engage in systems change

activities. Memoranda of understanding with these partners resulted in 1) increased case sharing and collaboration between the Safe Start grantee and child welfare, 2) referrals made to the Safe Start grantee by child welfare, and 3) invitations from child welfare to Safe Start staff to participate in child protective staffing meetings, during which cases and information about clients were shared.

According to Safe Start staff, however, true partnerships and collaborations in Spokane are fostered through the long-term development and maintenance of relationships between agencies, rather than through formal memoranda, due to the fact that Spokane is a small community where one’s word and handshake are paramount, and partnerships may be characterized as being “relational” and horizontal in nature (Spokane Safe Start Initiative, 2005, p. 32).

### **6.2 Screening Studies**

To facilitate systems change, Spokane Safe Start staff developed a process of sector-specific screening studies to make the case for a focus on children exposed to violence. In addition, the screening studies provided much needed information on child and family issues in the target population, for which little current information was available. Two major studies were undertaken and are described below.

The Mental Health Family Violence Screening Study for families receiving mental health services was the first sector-based screening study undertaken by the Spokane Safe Start grantee. The study was a descriptive

study of a representative sample of families engaged in publicly funded mental health services in Spokane, designed to screen for family violence prevalence, to identify types of violence, and to identify the prevalence of child exposure to violence and associated child maltreatment—information vital to shaping a community response to the issue of children’s exposure to violence. Further, the study attempted to identify any correlation between mental health diagnosis, service utilization, and treatment outcome. Prior to the screening study, no published studies addressed the issue of the prevalence of family violence and child exposure in the history of families seeking mental health services; therapists in Spokane did not collect any data on children’s exposure to violence and collected only minimal information about domestic violence. With the inception of the study, 95% of therapists in the four main child-serving agencies (Spokane Mental Health, Family Services Spokane, Lutheran Community Services, and Children’s Home Society) began to screen clients for children’s exposure to violence. Initial analyses of the data collected indicated that the level and severity of exposure in children and their caregivers were extensive (Spokane Safe Start Initiative, 2005, p.34). Several of the therapists involved in the study stated that they were surprised by the level of violence exposure in their clients, and used this information in planning treatment interventions. The Regional Support Network planned to use the findings from the surveillance study to support a requirement for all mental health providers receiving Medicaid funding to screen for children’s exposure to violence and

domestic violence as part of their standard screening protocol.

As a result of a request from the chemical dependency (i.e., substance abuse) sector, Spokane Safe Start staff anticipated conducting a second screening study, to gather information about the presence of violence in a chemical dependent population. Spokane Safe Start staff recognized from the outset that substance abuse is a key risk factor in the lives of families with children exposed to violence, and sought independent verification of this problem in the Safe Start clinical population. Findings from the substance abuse screening study will provide data to “prove” the point that violence is an integral part of the cycle of chemical dependence and to establish substance abuse as a visible issue in the discussion of children’s exposure to violence. In addition, the screening study will provide the major system responsible for addressing substance abuse with information on how violence and violence exposure affect its population. As of December 2005, seven of the largest Spokane area chemical dependency providers receiving public funding had agreed to participate in the initial screening study to identify violence and violence exposure. CAFRU staff (at Washington State University) will provide training on intimate partner violence and children’s exposure to violence to all clinicians employed by these providers. This study is expected to have major policy and practice implications, as the public substance abuse authority and its providers already have expressed interest in having violence exposure questions permanently included in their data collection and intake assessments

(Spokane Safe Start Initiative, 2005, p34).

The Safe Start grantee's data-driven decision-making process (i.e., screening studies and tools) provided organizations and agencies with the capacity to make the case for systems change in serving children exposed to violence. The early successes of these efforts convinced Spokane Safe Start leadership and partners of the effectiveness of this approach.

### **6.3 Child Outreach Team**

Citizen groups participating in the Safe Start planning process recommended that the initiative address the ability of the Spokane community to provide crisis intervention to

reduce trauma due to violence exposure. The six-month planning process within the community generated the following themes:

- Crisis response services must be mobile and immediately available to families around-the-clock;
- Services must center on the needs of the child, but include the entire family, with safety as the paramount consideration;
- A co-located, neighborhood-based, wraparound approach should be used;
- Once safety has been established, the purpose of initial contact must be voluntary engagement with a focus on child and family assessment;
- All contacts with the family must be culturally sensitive and responsive;
- While substance abuse and mental health assessment and treatment services must be immediately available, they cannot serve as a proxy for addressing violence and its immediate impact on family members;
- Services to the primary victim and the child should be integrated; and
- Ongoing, supportive case management services must be available to the family when the family is ready to engage (Spokane Safe Start Initiative, 2005, p. 30).

As a result of the community planning process and outcomes, the Spokane Safe Start grantee developed a service delivery model in which three

major agencies provided identification of children exposed to violence: 1) law enforcement, 2) YWCA– Alternative to Domestic Violence (domestic violence shelter), and 3) Child Protective Services. (See Exhibit X-B for a diagram of the Spokane Safe Start service delivery model.) In the assessment and treatment of children exposed to violence, the Child Outreach Team (COT) played a major role. COT was composed of Safe Start collaborative partners (i.e., Partners with Families and Children, Spokane Mental Health, and the NATIVE Project). COT child outreach specialists provided early intervention services and treatment to families with young children identified by law enforcement or other community agencies. Four child outreach specialists and one part-time clinical supervisor were funded for service provision during implementation of Spokane Safe Start. Each clinician was an experienced professional in working with children and families. Child outreach specialists worked days, weekends, and flexible shifts based on client needs and calls for service. Clinicians had rotating on-call schedules to provide round-the-clock crisis-response capacity. All participation in the program was voluntary for all families. Four levels of treatment services were available: acute crisis contact, crisis intervention, engagement/brief treatment support to link clients to resources within the community, and intensive treatment support based on a wraparound treatment model.

Crisis contact involved obtaining information available from the agency (e.g., law enforcement) that identified the family for possible clinical intervention; because contact with the

COT was strictly voluntary for families, information for a large, but unknown, percentage of families was limited to what the referring agency knew and could legitimately share with the Safe Start grantee. Crisis intervention involved actions/outcomes with voluntarily engaged families to address the crisis events that brought the family to the attention of Safe Start. Following crisis intervention, some families were willing to receive ongoing support from the crisis response team specialists through an engagement/brief treatment support set of activities.

In the identification process, police officers responding to crisis calls played a key role. In most situations involving family and other violence, only the officer at the scene sees the child. Therefore, using law enforcement as the gateway for identification and referral provided Spokane Safe Start with access to families that had no prior connection with the social service system through Child Protective Services. The Safe Start grantee was initially unprepared for the types of children and families identified through law enforcement. Of the first 132 families identified, only five had CPS involvement. Most of these children and families were “invisible” because child welfare and other child serving systems are organized around legal definitions of a “problem”. The vast majority of Spokane Safe Start’s children exposed to violence were, as a result, hidden in the system. They became visible through the work of the COT whose definitions of the “problem” were not restricted to solely addressing the legal issues children and families faced (Association for the Study and Development of Community, 2006, p. 10).

The Spokane Safe Start identification process succeeded for a number of reasons. First, Spokane’s law enforcement agencies (both city and county) had a history of implementing community policing. This history, which provided entrée for Spokane Safe Start, included working with university partners to implement a Neighborhood Resource Officer program along with the S.A.R.A. (scanning, analyzing, responding, assessing) model of data analysis to improve the effectiveness of policing. Utilizing the S.A.R.A. method, Safe Start leadership worked with key leadership in both city and county law enforcement to look at Spokane 9-1-1 systems of crime reporting, to effect change in policy regarding how officers respond to domestic violence and child abuse cases. This analysis resulted in change to police officer practice when responding to family violence calls.

Second, after officers were trained on issues of children exposed to violence and how to respond to calls to protect children present during a violent incident, Safe Start leaders participated in police roll call periodically, to share accomplishments with children and families identified by police, thereby reinforcing training concepts. As one law enforcement official stated, “This education and training of police has no additional cost to the police or the program (Association for the Study and Development of Community, 2006, p. 13).” The result of the Spokane Safe Start grantee’s history, collaboration, and training was buy-in from law enforcement, particularly mid-level administration (i.e., lieutenants), who became “cheerleaders” for children exposed to violence. These mid-level

officers made significant inroads into the police culture, increasing the number of referrals by law enforcement to the Child Outreach Team.

Finally, Safe Start was instrumental in increasing the level of regard between law enforcement officers and clinical personnel. Over the course of the initiative, these groups developed mutual respect, which led to a team approach to identification, referral, and ultimately treatment of children exposed to violence. For example, to satisfy the needs of law enforcement officers, Spokane Safe Start's COT members agreed to provide response times to crisis calls "faster than a tow truck." (Association for the Study and Development of Community, 2006, p. 13). Evidence suggests that the relationship between the law enforcement and clinical sectors provided the key to success for implementation of the Spokane Safe Start service delivery model, by offering law enforcement a trusted entity to which to refer children and families.

#### **6.4 Juvenile Court System**

Restructuring of the child welfare system at the local level encountered significant barriers during the implementation of Spokane Safe Start. While Safe Start staff and partners viewed the child welfare system as an important sector to engage, they determined that critical strategies for child welfare reform would not be feasible at the time of the initial implementation of the initiative. An alternative approach to the child welfare system, however, was undertaken through 1) development of a web-based database to be shared between

Dependency Court judges and child welfare and 2) incorporating information on children's exposure to violence into the training for a recently funded statewide initiative focused on judicial leadership (i.e., the Court Improvement Project [CIP]).

An initial joint proposal of the Spokane Juvenile Court and the Spokane Child Welfare Office to the U.S. Department of Justice to develop data systems within Juvenile Court to track and support the Adoption and Safe Families Act (ASFA) implementation was unfunded. Nevertheless, CAFRU-Safe Start moved forward with a scaled down version of the original plan. Safe Start, the Child Welfare Office, and Juvenile Court pooled funds to plan and create a web-based system to enhance the capacity of judges to make more holistic decisions on behalf of children in the dependency system, where children's exposure to violence is an historical issue in Child Protective Services cases. As of this writing, Juvenile Court had completed work on a conceptual design for a web-based information system that will combine information from multiple sources involved in dependency proceedings and make that information available to judges in real time. The majority of this work was vetted with the Dependency Policy Review Committee, a group whose endorsement will be necessary to move the project toward approval and adoption. National Council of Juvenile and Family Court Judges (NCJFCJ) worked closely with Safe Start partners as a consultant to this process. While development of the database is currently on hold, future efforts to complete this project are planned.

As a by-product of the web-based database project, the Washington State Office of Administrator of Courts selected Spokane as one of its five Court Improvement Project sites. The CIP provided consultations with Serena Hulbert (NCJFC consultant), which were a major factor in the development of judicial leadership within Spokane Juvenile Court. Judges and commissioners began to embrace an enhanced role at the local level in setting standards and enforcing accountability among all parties to dependency actions. Court review schedules changed, and there was discussion of other adjustments in local court rules, intended to force more expeditious resolution of permanency goals for children in state custody. As a result of the Safe Start grantee's consultation with Juvenile Court and abuse/neglect training provided to its commissioners, the sitting judge mandated that dependency reviews change from every six months to every two months. These changes at the local level are expected to drive a similar review of current dependency policies at the state level (Spokane Safe Start Initiative, 2005, p. 33).

### **6.5 Other Systems Change Activities**

As a result of the work of the Spokane Safe Start grantee, several additional activities laid the groundwork for future systems change for children and families, particularly children exposed to violence:

- Expansion of domestic violence programming. All Safe Start child outreach specialists were trained in safety planning by a domestic violence advocate. The

Spokane County Regional Domestic Violence Team provided a significant number of referrals for Safe Start. At the time of this writing, the primary domestic violence provider in Spokane, the YWCA, was in discussion with Safe Start staff about co-location of advocacy and Safe Start services.

- Expansion of family programming. In a departure from the traditional center-based model, the Spokane Safe Start grantee provided a family-focused, child-centered program with the capacity to meet with families in their homes and in the community.
- Increased funding for children exposed to violence services. In partnership with the Safe Start grantee, the Spokane County Community Network received a \$220,000 grant from the Family Policy Council. This grant targeted children six to 12 years of age exposed to violence, and served 185 children in 61 families in 2001 and 2002. Services included counseling, tutoring, in-home visits, and respite services. Most of this work occurred in the Spokane Valley catchment area and involved partnerships with the Children's Home Society, local schools, and the Spokane Valley Community Center.

Although Spokane Safe Start staff and partners made gains in sensitizing child- and family- serving agencies to the needs of children exposed to violence and their families, the political and economic conditions in

the state of Washington, and particularly in Spokane County, could thwart these gains. During 2005, there was almost no dialogue between the state system and the community about core community concerns. Despite repeated attempts by the Safe Start grantee to engage formally with the state system, only line staff and supervisors demonstrated interest in making referrals to Safe Start. The state child welfare agency resisted engagement with a comprehensive agenda for children exposed to violence. The Children's Administration experienced a \$13 million budget shortfall, which resulted in a regional budget reduction of \$3.1 million in the Spokane area (Spokane Safe Start Initiative, 2005, p. 52). All of these factors led Spokane Safe Start staff and partners to describe the state of affairs in 2005 as a "free fall of funding" and put the future of Safe Start in limbo.

## **7. Institutionalization of Change**

Despite the “free fall of funding,” the vision for carrying out the work of Spokane Safe Start focused on continuing screening studies to assist local agencies in using data-driven decision-making, through data analysis and economic impact analysis, to create the case for sector-based systems change. Spokane Safe Start developed a product (i.e., the screening study) and tools (i.e., training) to take the work of the initiative to other sectors (specifically, early childhood education and substance abuse agencies). Evidence points to the funding of the Teen Peace program as an example of the efficacy of this approach. In addition, according to Spokane Safe Start staff and partners, this approach increased awareness within local agencies of the impact of exposure to violence on children. As a direct outcome of the Spokane Safe Start collaboration, over 70 agencies with nearly 3,000 individuals from the fields of law enforcement, mental health, substance abuse, education, child welfare, and the justice system received training in children’s exposure to violence in the state of Washington (Spokane Safe Start Initiative, 2005, p. 27). Other institutionalized changes are outlined below.

### **7.1 Point-of-Service Change**

According to Spokane Safe Start staff and partners, systems change activities at the point-of-service level (i.e., delivery of treatment for children exposed to violence) resulted in improved identification, assessment, and referral of children exposed to violence within each agency/system that

participated in Spokane Safe Start. Specifically, through the Mental Health Family Violence Screening Study described above, over 90 therapists in four agencies received training on the effects of chronic violence exposure on children and the use of an appropriate screening protocol. It is anticipated that these efforts will result in a plan to create a universal screening protocol for children’s exposure to violence within the mental health system of Spokane, allowing all children seeking services through the public mental health system to be screened for chronic violence exposure. In addition, training providers in treatment methods for children exposed to violence and their families has been identified as critical to institutionalizing change for these children and families.

Although the Spokane Safe Start grantee made significant strides within the mental health, juvenile justice, and substance abuse arenas, outside the scope of the Mental Health Family Violence Screening Study and an upcoming screening study for the chemical dependency/substance abuse system, the grantee was unable to document the extent of follow-up by staff within each agency/system (Spokane Safe Start Initiative, 2005, p. 42). Therefore, the long-term impact on children and families receiving Safe Start services cannot be determined.

### **7.2 Service Integration**

To promote service integration, the Spokane Safe Start grantee adopted several strategic approaches. Rather than attempting widespread service integration immediately, a sector-by-sector approach for systems change was

undertaken, with service integration as an endpoint. The Spokane Safe Start grantee, through its convening capacity, promoted relationship building as a means through which services could be integrated. Training served as an effective means of increasing the knowledge and awareness of children exposed to violence across categorical systems and institutionalizing a desire for increased integration. In addition, cross-agency protocols were developed.

Over 70 agencies in the Spokane region received training through Spokane Safe Start. During planning and implementation phases, the Safe Start grantee conducted three community-wide trainings/meetings; a week-long training at Yale for collaborative partners, including law enforcement; and an immersion training for clinical staff and law enforcement prior to implementation of the service delivery model. Other trainings included ongoing child witness trainings with the Domestic Violence Consortium and trainings on attachment and the developing mind. In addition, a number of mental health providers requested and received training for nearly 125 clinicians. Chemical dependency professionals and paraprofessionals also were trained in children's exposure to violence and family violence issues (Spokane Safe Start Initiative, 2005, p. 22).

The Spokane County Sheriff's Office allowed Safe Start staff to train 209 Sheriff Department employees during their quarterly in-service rotation. Additionally, all law enforcement personnel in the county and city were provided training in the purpose and use of Safe Start.

Spokane Safe Start worked to develop several multi-system protocols. The following efforts are examples of the types of multi-system protocols directed at agencies serving children and families:

- The Mental Health Family Violence Screening Study was intended to lead to the development of a universal screening protocol for children's exposure to violence within the mental health system. (See the section on systems change for a description of this screening study.)
- Despite barriers and limitations, the Spokane Safe Start grantee experienced significant success in developing local applications of integrated service treatment models for high-risk children and families. "Integrated services" in Spokane refers to cross-disciplinary and often co-located service delivery strategies using a client-empowerment strategy referred to as Individualized and Tailored Care (Spokane Safe Start Initiative, 2005, p. 28).

### **7.3 Policy Change**

While efforts to promote change at the state level were unsuccessful due to the political and economic conditions in Washington during the implementation of Spokane Safe Start, the Safe Start grantee was able to develop child- and family- friendly policies at the local level, for example:

- The Spokane Safe Start grantee was instrumental in the

development of a model juvenile court agenda and the development of a prototype for an integrated management information system for the Spokane County Juvenile Justice Administration.

- Due to Safe Start, 9-1-1 dispatch operators began to record the presence of children at domestic violence incidents and report this information to the dispatched officer. In addition, reports electronically transferred to sheriff and police dispatch were annotated to remind officers to make referrals, as appropriate, to Safe Start.
- The Juvenile Court administrator and the presiding judge adopted a policy structure for decision-making within Juvenile Court. Juvenile Court also committed to developing information systems that will be used to provide judicial officers with better information about the movement of children through the system. The collaborative relationship between the Safe Start grantee and the juvenile justice system assisted in this overall process and will be tapped to provide ongoing training and technical assistance to judicial officers within the juvenile system. In addition, Juvenile Court and child welfare agencies are working to find ways to share data related to case movement and the Adoption and Safe Families Act (ASFA) compliance. An ongoing major strategic objective for the Safe Start grantee is to convince Spokane Superior Court to end the

practice of rotating judges into Juvenile Court for one-year assignments. The current judge is committed to finding ways to work more closely with child welfare and is asserting her leadership to move the dependency agenda in that direction.

- The Office of the Administrator of Courts (OAC) database was validated, and work to analyze 1,100 prosecutions was completed. This research into prosecution/sentencing outcomes carries specific implications for decision-making among judges.

## **8. Increased Community Supports**

Prior to Spokane Safe Start, services for children living with domestic violence were limited. As a result of the work of the Spokane Safe Start grantee, all families, particularly “invisible” families, gained access to services for children exposed to violence, whenever the family is “ready” to engage in services. The Spokane Safe Start grantee also contributed to a general sense of heightened awareness of the impact of exposure to violence on children, particularly among law enforcement, clinicians, social service providers, and the judicial system.

The presence of Safe Start in the Spokane community significantly increased the availability of services to families and children affected by domestic violence. The majority of Safe Start families were previously unknown to the formal social service system, and many were unaware of the services

available to them. By contrast, the Safe Start Child Outreach Team engaged families in multiple services in the areas of trauma, mental health and counseling, substance abuse, health, education, career development, subsistence needs, domestic violence advocacy, and legal assistance.

The Safe Start grantee received referrals from law enforcement, child welfare, public health, Head Start, education, domestic violence advocates, and the justice system. The Child Outreach Team and CAFRU staff actively conducted outreach to program providers and law enforcement about Safe Start. As of this writing, Safe Start remained the only program in Spokane County specializing in serving children exposed to violence. Juvenile justice, child welfare, and Safe Start, however, have discussed the development of future programs.

Several funding opportunities resulted from the work of Spokane Safe Start staff and partners. In partnership with the Safe Start grantee, the Spokane County Community Network received a \$220,000 grant from the Family Policy Council. This grant targeted children six to 12 years of age exposed to violence, and served 185 children in 61 families in 2001 and 2002.

Leaders in the Spokane human services and law enforcement communities consistently demonstrated support for Safe Start through continued participation in community meetings. Leaders in the fields of juvenile justice, mental health, child welfare, and Spokane County committed to partnership and program development.

In fall 2002, the Child and Family Research Unit, in partnership with the Spokane County Domestic Violence Consortium, Spokane Police Department, and Spokane Sheriff's Office, received a grant from the Centers for Disease Control and Prevention to study the effects of domestic violence in the workplace; the collaboration to obtain this grant was a result of Spokane Safe Start and it funded portions of the study. More than 1,000 employee surveys were completed via a random digit dial process. Specific interest in outcomes from the National Institute of Occupational Safety and Health resulted in application for a separate grant to create a companion effort in Boise, Idaho as a control community. Dissemination of information from this study's findings will work to strengthen broader system change efforts. In addition, this study offers evidence of success in creating the means for corporate engagement in the Safe Start mission.

Evidence from the random digit dial survey demonstrated that interpersonal violence is a widespread event with significant health, employment, and legal impact in the lives of a significant minority of residents. In both Spokane and Snohomish Counties, 41% of participants reported minor children living in their household in the past 12 months. Based on estimates of lifetime prevalence and annual incidence of interpersonal violence, children in these counties live with an adult lifetime victim of interpersonal violence in an estimated 15% of households. On an annual basis, 6% to 9% of the community's households with children have an adult who has been a victim of

intimate partner violence in the past 12 months. Spokane Safe Start staff suggested that the research findings support the contention that community awareness has increased due to the media campaigns produced by the Spokane Domestic Violence Consortium.

Within the professional community, specifically among child-serving agencies, there was a significant increase in awareness of Safe Start services for children exposed to violence over the course of the initiative, as reflected in the steady increase in referrals from program inception.

## **9. Reduced Exposure to Violence**

The Child Outreach Team engaged approximately 991 children in Safe Start services between 2001 and 2005. A total of 36 families was referred to the longitudinal study; of these, 18 families participated, with only a single family completing the study. Therefore, no meaningful post-treatment data could be obtained, and there is no evidence of reduced exposure to violence. Factors that contributed to clinicians' inability to refer families to the longitudinal study are explained in Exhibit X-C.

Spokane Safe Start staff attempted to analyze outcome data from systems with some level of responsibility for the issue of family violence. While an incredible volume of data was collected, most of the data were not immediately or easily retrievable to answer the simplest of questions regarding children and families documented in the records of child- and

family- serving agencies. Safe Start staff identified that multiple systems often collected the same data for broadly disparate purposes; organization and storage problems confounded efforts to retrieve even the most common elements. While some pieces of data collected by county-administered systems (e.g., mental health) were comparatively accessible, data from corresponding systems administered at the state level (e.g., child welfare) were not accessible at all at the local level. Therefore, according to Safe Start staff, it was impossible to engage in a basic pathway analysis or aggregated descriptive study of families exposed to violence (Spokane Safe Start Initiative, 2005, p. 29).

## **10. Reduced Impact of Exposure to Violence**

Spokane was not able to study the effectiveness of its intervention approach to reduce the impact of violence exposure on children. Although the Child Outreach Team was able to engage many families in services through its voluntary engagement approach, not all of these families chose to participate in the Spokane Safe Start grantee's longitudinal study. Of 18 families referred to the study and assessed at baseline, only one completed the study. Therefore, the Spokane Safe Start grantee described this study as unsuccessful.

## 11. Conclusion

Safe Start staff and partners identified four areas of significant accomplishment:

- **Training**

- The Spokane Safe Start grantee, over its five years of implementation, trained 4,000 to 5,000 people (professionals, clinicians, and community members) on the implications of, symptoms of, and treatment options for children exposed to violence.
- The grantee implemented two full cycles of training for every law enforcement officer in the city of Spokane and Spokane County.
- Every mental health provider in Spokane County received at least three cycles of training, including five full-day trainings and one half-day training. These trainings brought together over 250 leaders in the field of children exposed to violence in Spokane and Spokane County.
- Every conference delivered by the Spokane Safe Start grantee included a planning component that followed

the goals of the Safe Start implementation plan.

- **Social Informatics Strategy**

- Spokane Safe Start leveraged its resources to gather information (e.g., needs assessment, trends, and descriptions). Analysis of community trends provided useful information about what conditions existed at the community level and established a baseline for implementing and measuring change.
- The social informatics strategy process included: 1) defining the data design process with a joint committee composed of key stakeholders, 2) systematically collecting data, and 3) using data in discussion with key stakeholders and agencies where change would be initiated.
- A social informatics strategy was perceived as the most effective means of promoting systems change in Spokane. The Spokane Safe Start grantee indicated that a dual strategy of systemic and grassroots mobilization for change was difficult to accomplish with the resources available. The

grantee anticipated a next step with greater grassroots involvement, particularly with regard to examining the early care and education sector as a gateway for identification and referral for children exposed to violence.

- The Spokane Safe Start grantee will collect six years of data on Spokane County to compare with similar sectors in western Washington, which can be used to leverage and increase state funding for children and families.

- **Adaptation and implementation of Child Development-Community Policing**

- The Spokane Safe Start grantee, according to project leaders, developed the largest single adaptation of CDCP outside of New Haven, Connecticut, primarily because Spokane and Spokane County law enforcement could not bring the same level of personnel to the application of CDCP and, therefore, implemented CDCP in a larger population with fewer law enforcement resources. Spokane Safe Start effectively implemented and adapted the CDCP model, which

successfully served as a gateway for the identification and referral of children involved in domestic violence incidents. The model garnered the support and buy-in of both senior administration and mid-level administrators within law enforcement.

- **Significant systems change**

- The Spokane Safe Start grantee successfully launched systems change initiatives in three key sectors of its partnership: 1) Juvenile Court through the Court Improvement Program, 2) law enforcement through the adaptation of CDCP, and 3) mental health services through training and improved screening for children exposed to violence. Each of these sectors developed a protocol for identifying children exposed to violence, a process for asking the right questions of children and parents involved in a crisis (e.g., domestic violence) situation, and an understanding of the ways to promote change within its sector (Association for the Study and Development of Community, 2006, pp7-9).

The Spokane Safe Start grantee received referrals for 669 families and 1,214 children between December 2001 and December 2005. Of these families, approximately 72% or 482 families and their children received services from the Child Outreach Team in the form of at least one contact. The COT only referred 36 families for participation in the longitudinal research study (7.5% of those eligible). Of these families, only 18 families participated in the outcome research.

Although the law enforcement, juvenile court, public health, and substance abuse systems have embraced the Safe Start agenda, Spokane Safe Start staff and partners lack a cohesive vision for future funding and program development around the major issues affecting the healthy development of children and the capacity to support and serve their families. Outlined below are the proposed activities to be conducted by Safe Start partners to enhance the future implementation of the mission and goals of Spokane Safe Start:

- Gather information from all relevant systems to determine specific reductions to capacity, including regulatory changes that have occurred over the last five years;
- Develop a specific problem statement related to the impact of these changes on marginalized populations that share risk factors for children's exposure to violence (e.g., family violence, substance abuse, mental illness, poverty) and demonstrate how reductions in one system create specific cost shifts to other systems;
- Engage a maximum of 75 corporate and civic leaders in education and discussion of these issues, and begin the process of creating consensus about the financial impact of reductions, cost shifts, and cumulative losses to capacity and human capital;
- Create task groups made up of corporate and civic leaders whose responsibility it will be to develop models for local support and governance of social and health service support systems, which do not rely on current categorical funding for core support;
- Use data gathered by CAFRU related to Safe Start, criminal justice prosecution, workplace domestic violence, and other information developed by the Spokane Regional Health District, to demonstrate not only how the funding paradigm has changed, but also how the former paradigm for funding and categorical programming no longer fits the most current understanding of marginalized populations;
- Conduct an initial one-day conference to define core issues and create consensus about response (late January 2006); and
- Create a single plan for the development of local support and local governance of a unified funding stream to create interventions for children exposed to violence whose families share a combination of risk factors that include poverty, family violence, substance abuse, and mental illness (Spokane Safe Start Initiative, 2005, p. 20).

During the five-year implementation of Spokane Safe Start, the partners tackled critical tasks to change systems and provide services for children exposed to violence. To create long-term systems change, they implemented a sector-by-sector approach. Sector-specific data, combined with training around issues of children exposed to violence, was the basis of this approach. The major learning from this approach is the added value of gathering information for decision-making for social problem solving. Further, a sector-by-sector approach has impact across sectors, as evident in the impact of training court officers in judicial leadership on child welfare system reform.

Despite economic and political obstacles, Spokane Safe Start was able

to identify and provide services to over 1,100 children and their families. Strong relationships were developed among partnering agencies, resulting in the funding of one partner for a program focused on adolescents. In addition, Safe Start staff collected a large database of information regarding children exposed to violence.

Spokane Safe Start partners recommend that federal partners find a way to continue funding for this type of program longer, without a competitive re-granting process, particularly if projects are demonstrating success. The Safe Start partners also suggest re-ordering the priority for the discussion of children exposed to violence at the professional (clinical) and community levels (i.e., discussion at the community level should come first).

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**Exhibit X-A**  
**Timeline of Spokane Safe Start Initiative Activities and Milestones**

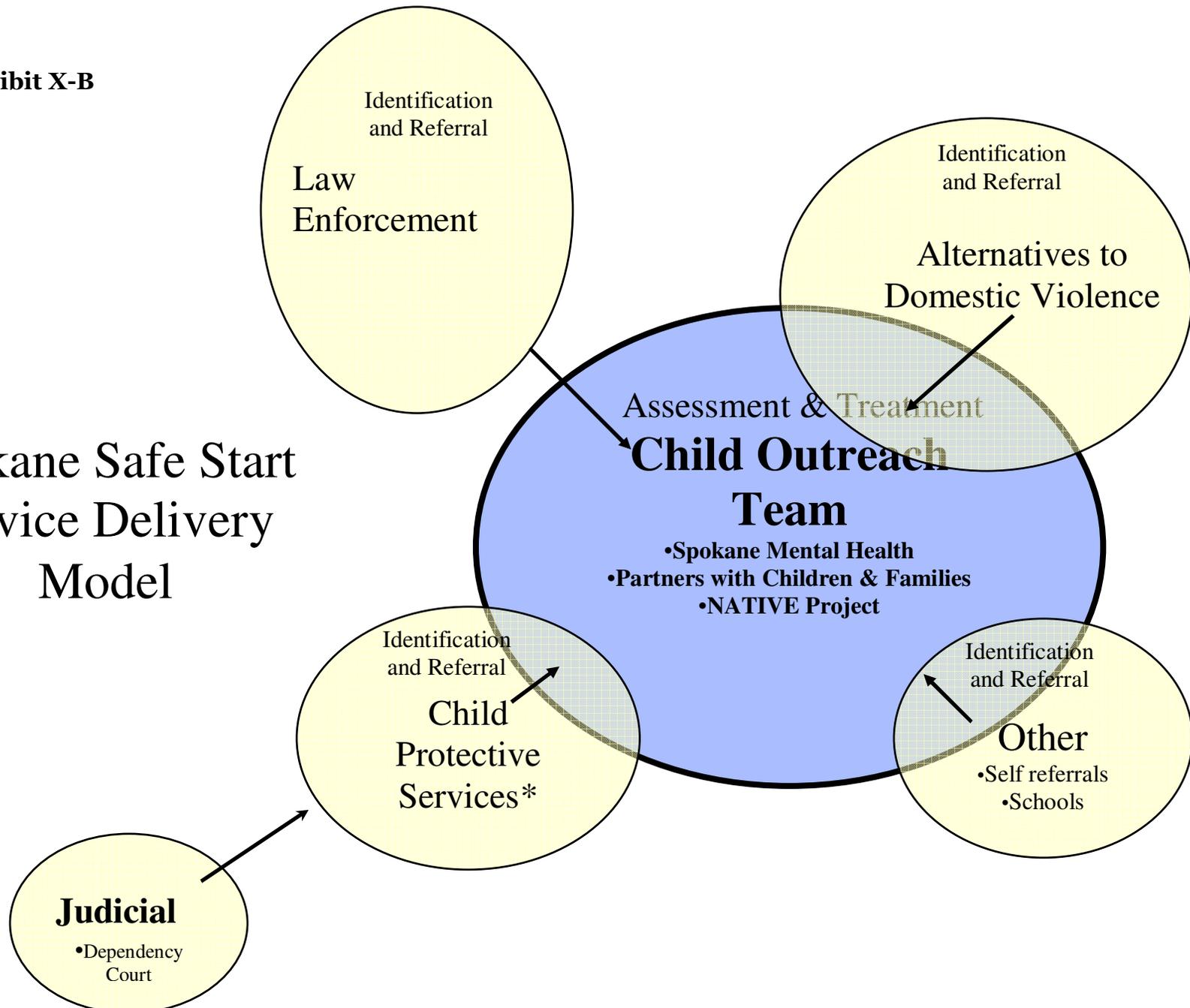
Major Milestone	1/01-6/01	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
DC: 0–3 Mental Health Staff Trainings				✓	✓	✓	✓	✓	✓	✓
Early Childhood Education Assistance Program at Millwood Elementary School				✓	✓	✓	✓	✓	✓	✓
Children Exposed to Violence Trainings for State Child Protective Services Workers					✓	✓	✓	✓	✓	✓
• Partnered with Eastern Washington University (EWU) to develop Children Exposed to Violence Training Curriculum				✓						
Stipend program created for Master of Social Work (MSW) students at EWU				✓						
Teen Peace Program				✓	✓	✓	✓			
Spokane Police Department Children Exposed to Violence Trainings					✓	✓	✓	✓	✓	✓
Case Studies of Spokane Safe Start Families			✓	✓	✓	✓				
Neighborhood Engagement Strategies (implemented & ongoing)				✓	✓	✓	✓	✓	✓	✓
Crisis Response Volunteer Resident-Based Programs				✓	✓	✓				
Crisis Response Team (formed & ongoing)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pilot Study : The Incidence of Violence Exposure for Children Ages 0-13 Years Entering the Mental Health System				✓	✓	✓				
Community Assessment Effort				✓						
The Child and Family Research Unit (CAFRU) (established & ongoing)			✓	✓	✓	✓	✓	✓	✓	✓

Major Milestone	1/01-6/01	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
Children Exposed to Violence Data Collection, Training, and Curriculum Development Initiative with the Spokane Police Department		✓	✓	✓	✓	✓	✓	✓	✓	✓
Multi-agency Trainings & Discussions of Children Exposed to Violence for Line Staff				✓	✓	✓	✓	✓	✓	✓
Male Involvement, Fathering, and Batterer Accountability Collaborative Initiative						✓	✓			
• Male Involvement Task Group formed						✓				
• Fathering Conference							✓			
Outreach Program with Spokane Domestic Violence Coalition								✓		
Entered Agreement with Spokane County's 9-1-1 Emergency Calls Dispatch Center							✓			
Mental Health Family Violence Screening Study (ongoing)								✓	✓	✓

Sources: Spokane Progress Reports, January-June 2002, July-December 2002, July-December 2003, July-December 2004, January-June 2005; Spokane Safe Start Strategic Plan, 2002; Spokane Case Study 2004; Local Evaluation Form, 2004, 2005.

**Exhibit X-B**

# Spokane Safe Start Service Delivery Model



## **Exhibit X-C**

### **Spokane Safe Start Intervention Research**

#### **Overview**

The Spokane Safe Start grantee adapted the New Haven Child Development-Community Policing (CDCP) model and established a clinical team known as the Child Outreach Team (COT). Through the COT, Spokane Safe Start funded five clinicians housed within the Spokane Safe Start partner organizations: two positions in Partners with Families and Children, two positions in Spokane Mental Health, and one position at the NATIVE Project. The COT's primary purpose was to respond to crisis calls as reported by the police and the 9-1-1 call center. The response included treatment and follow-up services to families who engaged in services voluntarily. Common treatment used by clinicians included acute crisis contact, crisis intervention, brief treatment support to link clients to resources within the community, and intensive treatment support based on a wraparound treatment model. Families were to be assessed on nine different occasions through their participation in the study: at baseline and 3, 6, 9, 12, 15, 18, 21, and 24 months after baseline.

#### **Intervention**

Families that engaged in treatment with the COT were approached by a COT clinician to participate in a follow-up longitudinal study with the Spokane Safe Start grantee. The longitudinal study sought in-depth descriptions of the impact of Safe Start services; the children and families identified through the COT; the type and intensity of the services developed for the families; and the program and participant characteristics that influenced access, acceptability, and impact of the program. Families who agreed to participate in the study received ongoing support from COT clinicians, who created a support plan for the families and engaged them in brief or intensive treatment support services.

#### **Methods**

Caregivers and children were assessed in four areas: demographic and historical information, adult affective and behavioral measures, child affective and behavioral measures, and child-caregiver relationship measures. A variety of tools were used to assess each of these areas, including: Starting Early Starting Smart (SESS); Brief Symptom Inventory; Conflict Tactics Scale; Post-Traumatic Stress Scale for Family Violence; Alcohol and Other Drugs (AOD) Screener; Addiction Severity Index; SESS Services Access Utilization and Satisfaction (SAUS) survey; Battelle Developmental Inventory; Achenbach Child Behavior Checklist (CBCL); DeGangi Infant Toddler Behavior Checklist; Social Skills Rating System; Parent-Infant Relationship Global Assessment Scale; Conflict Tactics Scale Parent-Child; Family Adaptation and Cohesion

Scales III (FACES III); Parenting Stress Inventory; Parenting Discipline Index; and HOME.

### Sample

During a four-year period, the COT referred only 36 families out of a total of 669 to the research study. Of these 36 families, only 18 participated in the study.

### Results

The COT referred only 36 families to participate in the research study. These 36 families represented only 7.5% of those eligible for the study. A total of 18 families agreed to participate in the study, receiving the baseline assessment. Only one family completed all nine assessments. Other families received assessments at the following marks: twelve families were assessed three months after baseline, five were assessed at six and nine months after baseline, six families were assessed 12 months after baseline, four were assessed 15 months after baseline, and only two families were assessed 18 and 21 months after baseline.

### **Discussion**

The Spokane Safe Start grantee pointed to the following factors that affected the low referral of families:

- Spokane Safe Start's recruitment strategies via clinicians were not effective (e.g., clinicians were requested to approach families about the study during the third or fourth visit, but most families were approached as early as the second visit);
- Many families discontinued services prior to being approached about the study; and
- Clinicians failed to understand the importance of the research for sustainability efforts.

The Spokane Safe Start grantee acknowledges that the data gathered are not sufficient to conduct statistical analysis and, as a result, the longitudinal study was not successful.

# XI

## Washington County Safe Start Initiative

### 1. Overview

Washington County Safe Start, better known as Keeping Children Safe Downeast (KCSO), has been the leader in Washington County in raising awareness around issues of children's exposure to violence. Prior to KCSO, talking about issues of domestic violence and child abuse and neglect was a taboo. The KCSO has created the foundation for systems change and service integration in Washington County by improving the way that key organizations and agencies that serve children and families work together, enhancing existing services to more effectively identify, and respond to children exposed to violence.

KCSO's efforts to improve services for children exposed to violence included identifying a point of entry into mental health treatment for children six years of age and younger. The KCSO contracted with Washington County Psychotherapy Associates (WCPA) by reserving slots for children referred for services through KCSO. These children were treated as soon as they were identified instead of being placed on a waiting list. This method was intended to improve services in various ways: 1) children were to be linked to services within 72 hours of being identified and 2) children were to be immediately seen by a clinician. However, families viewed the process as too bureaucratic and invasive of their privacy and did not

follow through, limiting the effectiveness of the intervention.

Furthermore, KCSO's goal to increase awareness of children exposed to violence was met by providing a series of trainings with the latest information on children exposed to violence for service providers, teachers, law enforcement, and community members and successfully managing several public awareness campaigns targeting parents and children throughout the community. While the results of these trainings and campaigns cannot be measured, a total of 3,779 service providers were trained and a great number of community members were reached through media vehicles such as radio announcements, posters, brochures, etc. (Keeping Children Safe Downeast, 2005a).

The KCSO was instrumental in the development and implementation of both state and local policies focused on creating community based resources for families to address children's exposure to violence. For example, both the Child Abuse Network Council and the Maine Department of Health and Human Services adopted a mandated reporter trainer curriculum statewide developed by the KCSO. Through KCSO's advocating efforts, Washington County became the second county in Maine to adopt a 211-info line. Through the support of the District Attorney's office the Passamaquoddy Tribe championed forensic interviewing as a tool for

interviewing children exposed to violence. Forensic interviewing prevents re-victimization of the child and promotes faster prosecution of the perpetrator. This tool has been accepted by law enforcement and court personnel in Washington County. Five forensic interviewing rooms have been instituted in different locations around the county.

With KCSD's funding coming to an end, its staff, board members, and collaborating partners have worked to create a sustainable plan so that the work of the KCSD will carry on. Two agencies, Regional Medical Center-Lubec and Washington Hancock Community Agency, signed a Memorandum of Understanding to manage KCSD's trainings and campaigns, search for funds to sustain KCSD, and to keep the issue of children exposed to violence at the forefront of everyone's minds.

### **1.1 Mission**

The mission of KCSD is "to advocate for, and respond to, children exposed to, or impacted by, violence by committing to, or supporting, prevention, intervention, and treatment strategies" (Keeping Children Safe Downeast, 2004). How did Washington County Safe Start accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in the following sections of this report, and a timeline of major events is attached (Exhibit XI-A).

### **1.1 Washington County, Maine<sup>1</sup>**

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<sup>1</sup> The information in this section was reported in the local evaluation report form (Keeping Children Safe Downeast, 2005b, p. 3-7).

Children Safe Downeast was planned and implemented within the unique context of Washington County, Maine. This snapshot of Washington County is intended to help others who may be interested in replicating Safe Start compare their own communities to Washington County.

Washington County, also known as "Sunrise Country," runs along the eastern shore of Maine and is the most northeastern point of the United States. Adjacent counties in Maine include Hancock County, Aroostook County, and Penobscot County, and in New Brunswick, York County and Charlotte County. With a population of about 33,941 residents, the county has a total area of 3,255 square miles of which approximately 2,568 square miles is land. There are 47 towns in Washington County, ranging from as many as 4,000 people to as low as only 10 individuals.

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 two Passamaquoddy reservation sites share a tribal council and are located in two different parts of the county (Princeton and Perry).

Approximately 8% of Washington County's population is children under six years of age. The

median household income as reported in 1999 was \$25,869 or 38% less than the median household income for the entire United States. Approximately, 14.2% of families in Washington County or 19% of the individuals in the county live below poverty level, compared to 9.2% and 12.4%, respectively, for the United States. Of the families that live below the poverty line, at least 4.2% have children under five years of age.

## **2. Contextual Conditions**

Several factors had a significant impact on the implementation of the KCSD demonstration project. Washington County differs greatly from other Maine counties. The large size, rural character and low population density of Washington County impacts service delivery, particularly services that address issues of responding to instances where children are exposed to violence. Lack of a strong economic infrastructure in Washington County contributes to increased poverty. A lack of official statewide policies regarding children exposed to domestic violence contributes to increased harm for children. Other political, social, and economic contextual conditions affecting the development and implementation of KCSD are explained below.

### ***2.1 Economic and Political Context***

Washington County is among the poorest counties in Maine and in the nation. It relies heavily on its natural resources as a base for its income. Many people work in the blueberry and cranberry fields, as well as in the fishing

and forestry industries. Many of these jobs are seasonal and depend on seasonal workers, which include immigrants, who come and go based on the need. The service sector is also a main source of income for many. People in the service sector tend to work for non-profit organizations, hospitals, health care centers, the county's university or college, and industries such as retail, transportation, and construction, among others.

As a result of statewide economic problems and changes in state level leadership, the Department of Health and Human Services (DHHS) is in the process of restructuring. As part of the restructuring process, DHHS has reduced their programming and staffing levels, resulting in overburdened staff. A decrease in state Medicaid funding further reduced resources and staffing of behavioral and mental health services for children. An example of this is the recent merge between the Department of Human Services and the Bureau of Behavioral and Developmental Services to form the Department of Health and Human Services (DHHS). Overall, it is perceived that the merging of these key social service agencies reduced the amount of resources available for all social services in Maine leading to competition between agencies for limited resources. Competition for resources has created tensions between agencies in the past, which has resulted in lack of cooperation.

## **2.2 Social Context**

Geographic isolation of Washington County families contribute to the underreporting of issues of domestic violence and children exposed to family and community violence. According to site visit (2005) participants, families in Washington County tend to be very private about their lives. Seeking help outside of the family is considered taboo. Linking families to KCSD services, therefore, was a challenge because of a resistance to reporting family violence incidents and seeking professional help from either law enforcement or child and family serving agencies.

A more recent problem in Washington County, however, has been a rapid increase in the use and abuse of prescription narcotics or OxyContin. This has exacerbated the already problematic co-occurrence of substance abuse and domestic violence because OxyContin are highly addictive and induce extremely violent behavior in users. Because the use of OxyContin has increased rapidly, statistics are not yet available; however, the Regional Medical Center at Lubec, a key partner in KCSD's collaborative, recorded that "...between 1997 and 1998-99 the clientele of the Regional Medical Center at Lubec (RMCL) substance abuse programs throughout Washington County changed from primarily alcohol abusers with 9% synthetic narcotic abusers to 39% exhibiting abuse of synthetic narcotics" (Keeping Children Safe Downeast, 2004, p. 43).

## **3. Community Capacity**

Many contextual conditions described above contribute to the lack of community capacity in Washington County. Site visit participants indicated that although there are social services for families and children, these services are located in larger towns of the county and not easily accessible. During one of KCSD's initial strategic planning meetings (2000), participants discussed the system of care that was in place in Washington County. They concluded that while families were receiving services from multiple agencies, there was a lack of communication and coordination between agencies about these families. This lack of communication and coordination often resulted in barriers to identification and treatment. Other barriers that could impede coordination included:

- Incompetent and overburdened staff
- Frequent staff turn-over
- Lack of funding
- Turf between agencies
- Lack of integrated case managements

Following this meeting, the KCSD invited key agencies to give educational presentations around the type of services they provide and the work they do, and they identified key trainings around topics of children's exposure to violence that were needed in the community. The Passamaquoddy Tribe, the largest Native American Tribe in Maine, also invited collaborative members to an educational forum where they explained the types of services available for tribal members. It was at this point that participants realized how much work they had ahead of them regarding their cultural histories and

differences, and the interface of service delivery systems on and off reservation.

Training and technical assistance was not part of KCSD's plan until collaborative members realized that it was an important factor missing in Washington County. After conducting a needs assessment, the initiative had a better understanding of the type of trainings that were needed in the county, which included: lack of understanding agency functions, effects of neglect, and parenting courses, among others. Throughout the life of the initiative, KCSD trained approximately 3,500 professionals in the fields of law enforcement, education, social work, and direct service providers in Washington County. However, the big question that lingered throughout the strategic planning process was finding out the best way to reach a community that lived in such a big area and in such isolation. KCSD achieved this with its various campaigns, such as the Blue Ribbon public awareness campaign, that involved local restaurants, as well as churches, and other local businesses. The KCSD also transmitted radio announcements that raised awareness around issues of child abuse and neglect.

Furthermore, the KCSD made available small grants for people interested in attending trainings and conferences around topics of children's exposure to violence and abuse and neglect. These small grants made it possible for three professionals to attend the Finding Words training that focused on forensic interviewing; an interviewing technique supported by Washington County's District Attorney and the Passamaquoddy Tribe as a way of preventing re-traumatization of the

child and expediting the process by which the District Attorney's office processed child abuse cases.

Throughout the project, the KCSD partnered with Rapid Response, the local first responder team for domestic violence calls, to receive training and technical assistance on Child Development-Community Policing (CD-CP) from the National Center for Children Exposed to Violence (NCCEV). James Lewis and a team from the Yale Child Study Center traveled to Washington County and met with law enforcement and first responders to discuss how CD-CP works in rural areas such as Chatham County in North Carolina. Also, the Rapid Response Team director attended a cross-site meeting in Sitka, Alaska where he met with police officers and reviewed the CD-CP program implemented in the rural city of Sitka.

In addition, in October 2003 and January 2004 the Interdisciplinary Team (IDT), KCSD's cross-disciplinary group (described in more detail in later sections), held a conference with Dr. Tom Wolff, an expert in community collaboration, development, and sustainability. In this conference the team explored its organizational capacity and structure and identified several areas that needed strengthening, such as decision-making, recruitment of new members, and making the effort to work together outside the IDT. As a result, the IDT dissolved in order to develop a subcommittee structure to support the integration of activities among KCSD service providers and incorporate Dr. Wolff's recommendations. The resulting subcommittees formed were:

- The Child Abuse Response Team (CART), which works on increasing the number of successful prosecution of child abuse cases and assuring that children are not re-traumatized by litigation processes.
- The Mental Health Collaborative (MHC), which examines the emotional and mental health impact of violence on children and families and works toward improving the referral process.
- The Multidisciplinary Team (MDT), which reviews recent child abuse cases/calls and brainstorms different ways to improve the intervention process.

#### **4. Local Agency and Community Engagement and Collaboration**

The KCSD used a diverse board combined with the subcommittee structure described above to create opportunities for child and family serving institutions to build relationships. They focused on communication and understanding among key professionals in the system of care in Washington County. The ability to bring together these key individuals was cited as the single biggest achievement of the KCSD, as captured in the words of a KCSD community partner “if we can get all the same players at the same table communicating, then the Initiative will have made a huge difference for the children in Washington County.” Engaging key child and family serving agencies and organizations, professionals, and community stakeholders was critical to the success

of the KCSD. By the end of the federal funding cycle for the KCSD, indications were that communication and understanding among key professionals in Washington County had improved and commitment to continue the project was evident (Association for the Study and Development of Community, 2005b).

Key child and family serving agencies and organizations and professionals were initially engaged through the assessment and planning phases and continued participating through the KCSD collaboration. Local professionals were also engaged through cross-disciplinary and specialized training. Community stakeholders (e.g., Washington Hancock Community Agency, Child Development Services, law enforcement) participated in the initial community assessment that was used to inform planning efforts and were engaged throughout the demonstration project through social marketing campaigns.

##### ***4.1 Engaging Key Child and Family Serving Agencies and Organizations***

The KCSD Collaborative Board consisted of 17 members and subcommittees including the Multidisciplinary Team, Child Abuse Response Team, Training

Collaboration, and Mental Health Collaboration. KCSD board membership included representation from the following sectors:

- Passamaquoddy tribe
- Child welfare
- Law enforcement
- Physical and behavioral health
- Domestic violence
- Education
- Substance abuse
- Home visiting
- Community members
- Community collaboratives

The KCSD provided a mechanism for collaborating that did not exist prior to the Safe Start Demonstration Project. The KCSD collaboration structure created opportunities for key professionals to develop the trust needed to share their concerns and frustrations and become knowledgeable about their peers responsibilities and program restrictions. This was a significant accomplishment because before Safe Start, organizations in Washington County lacked a mechanism for collaborating. An especially noteworthy accomplishment was that the KCSD developed a strong partnership with the Passamaquoddy Tribe through shared decision making and joint planning and implementation of the forensic interviewing efforts, bridging tribal and non-tribal communities of Washington County for the first time. The KCSD also held monthly Board meetings about how KCSD funds were being spent to make the financial processes of KCSD transparent to all partners. This transparency helped to create trust between KCSD collaboration partners.

The environment of collaboration and information sharing developed by the KCSD helped decrease duplication of services and brought to light gaps in services, which KCSD addressed through their systems change activities. As part of their collaborative efforts, the KCSD developed a strategic plan and used their community assessment and the diverse representation of their collaborative members to identify existing barriers to services for children and families in the community. The KCSD worked to minimize the lack of and inconsistent/inaccurate information regarding individual agency services among professionals and community members by increasing formal and informal links between agencies serving families. This increased communication identified the following barriers to and gaps in services in Washington County:

- Differences in philosophy of key organizations/agencies involved in the system of care for children and families in Washington County
- Competition and turf issues created by limited financial resources
- Lack of tribal and non-tribal agency cooperation
- Lack of knowledge about the impact and appropriate response to children exposed to violence in the community
- Misperceptions of the Department of Human Services and the court system created reluctance to report incidents of family violence involving children among mandated reporters

The KCSD planned to address these barriers to and gaps in service by developing an integrated case management system, in-home supports and parent education, and best-practices programs to enhance and expand services for children exposed to violence. KCSD's initiation of the Multidisciplinary Team, the Mental Health Collaborative team, as well as the Child Abuse Response Team established a foundation for a developing case management model currently being promoted and developed for statewide implementation by Maine's Department of Health and Human Services (DHHS). DHHS will support the piloting of a "Wraparound" model of integrated case management in the coming fiscal year (2007); a model that relies upon the collaboration of service domains represented by mental health, child protection, domestic violence advocacy, corrections, education and early child care providers. Washington County is poised to support the implementation of the Wraparound model due to the structural systems enhancements attributable to the sustained elements of the Multidisciplinary Team and the Child Abuse Response Team. These enhancements improve the Washington County's prospect of successfully developing, with the cooperation and support of DHHS, a structurally sound integrated case management system within a 2 to 3 year period.

The KCSD worked with existing home visiting programs to improve outreach to new parents by developing the "Welcome Baby Bags" resource. This effort provided informational packages, including parenting education materials and new-parent resource linkages to approximately 500 new

parents in Washington County, primarily distributed by *Family First Home Visiting Nurses*. The KCSD provided resources to other home visitors through the WIC program, and DHHS public health nurses, pediatricians, hospitals and other practitioners in the county in an effort to reach additional parents.

"Parent education" was further addressed through KCSD's support and promotion of the *Second Step Violence Prevention Curriculum* in the county's Head Start and K-3 programming. The USDOE has recognized this program as a model *intervention and prevention curriculum*. The KCSD introduced this curriculum into 25 preschools, Early Care and Education Programs, (ECEP), Family Child Care Homes (FCCH) and head start classrooms throughout Washington County. The Resource Development Center (RDC), Family Resource Center (FRC) and RMCL have committed to promoting and supporting this curriculum as it is further introduced to K-3 classrooms to sustain the effort in the coming 3-5 years. Trainers have been trained to provide on-going support to new classrooms.

The KCSD further addressed parent education by supporting Head Start and private childcare providers' development and implementation of a fatherhood curriculum for classroom teachers to address and enhance the parenting skills of fathers. The new *Fatherhood Project* serves families whose children are enrolled in county Head Start and childcare programs and is estimated to have impacted 350 families and 630 children.

#### **4.2 Engaging Professionals**

The KCSD engaged professionals from mental health, first responders, education, domestic violence, health and human services, law enforcement, faith based organizations community sectors through cross disciplinary and specialized training. As a result, 3,500 professionals in Washington County are knowledgeable about the identification of and response to children exposed to violence.

#### **4.3 Educating Parents and Community Residents**

In order to engage parents and community residents, The KCSD used social marketing campaigns to increase community awareness and knowledge about children exposed to violence and resources available for addressing this issue. KCSD social marketing campaigns included:

- A Blue Ribbon Campaign to provide information on children's exposure to violence in a variety of media including newspapers, op-ed pieces, public presentations, flyers on developmental issues (birth to six), resource information and community engagement activities. In support of the campaign the KCSD distributed wreaths with a single blue ribbon to churches and businesses to hang in support of the campaign. The campaign was begun by the Regional Medical Center-Lubec (RMCL) during 2004 and continues by popular demand.
- Distribution of informative placemats to restaurants, parent packs, baby bags, and Father's

and Mother's Day cards and other materials.

These efforts resulted in a slight increase (7% from 2003 to 2005<sup>2</sup>) in the community's perception that children's exposure to violence is a major problem in Washington County<sup>3</sup>.

The KCSD also engaged in efforts to improve the system of care for children. These activities are discussed next.

### **5. System Change Activities**

The KCSD has created the foundation for systems change and service integration in Washington County by improving the way that key child and family serving organizations work together, improving the identification and referral of children exposed to violence, and expanding and enhancing services at the local and state level. As a result, 79 children exposed to violence were identified by community agencies and referred to and treated by Washington County Psychotherapy Associates between 2003 and 2005.

Additionally, the KCSD was instrumental in establishing forensic interviewing to help keep children from being re-victimized and improve the ability of the court system to successfully prosecute child abuse cases.

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<sup>2</sup> Seven percent represents a total of 28 people.

<sup>3</sup> This information reflects the result of the follow-up telephone survey to determine the impact of these and other community engagement activities with households across Washington County.

## **5.1 Creating a Culture of Collaboration**

The KCSD was successful in changing the culture of isolation to one of collaboration, and improving communication between agencies and organizations. Site visit (2004 and 2005) participants consistently cited collaboration as an important accomplishment of KCSD. Organization and agency staff became familiar with each other's roles and responsibilities through relationship building and networking opportunities provided by the KCSD, the newly developed KCSD subcommittee structure (as previously described) and cross-disciplinary training opportunities provided by the KCSD. The process of bringing together people from different agencies and disciplines took longer than anticipated because of the long history of isolation that existed within Washington County. However, evidence indicates that after five years the culture in Washington County has changed.

For example, forensic interviewing<sup>4</sup>, championed by the Passamaquoddy Tribe, was successfully implemented and will continue beyond the federal funding cycle. Forensic interviewing focused on preventing re-

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<sup>4</sup> Forensic interviewing is an investigative process that safeguards the emotional, physical and developmental needs of the child. The investigative process includes two core components. First, investigators are trained to address the emotional, physical and developmental needs of the child while obtaining admissible evidence. Second, the interview with the child is videotaped and this recording is admissible in court. Together, these components reduce the number of times a child has to describe the traumatic event and participate in public testimony which could further traumatize the child.

traumatizing children exposed to violence. Forensic interviewing also contributed to the ability of the court system to successfully prosecute child abuse cases using the evidence provided by children through the forensic interviewing process. The use of forensic interviewing in prosecution of child abuse cases was the result of work by the KCSD and through the support of Washington County District Attorney (CART chairperson). The Passamaquoddy Tribe provided resources to help the KCSD fully implement forensic interviewing by providing a location for the interviews to be held. The adoption of forensic interviewing as a standard practice in Washington County is one of the most significant impacts resulting from the new culture of interagency collaboration created by the KCSD.

## **5.2 Improved Identification and Referral of Children Exposed to Violence**

The culture of collaboration created by the KCSD set the stage for improved identification and referral of children exposed to violence by partnering agencies. Training was used as a strategy to improve the identification and referral of children in Washington County. A total of 3,500 direct service providers were trained on how to appropriately identify and respond to children exposed to violence. As a result, 79 children exposed to violence were identified by five community agencies (Child Development Services, Head Start, Family Counseling Services, Department of Human Services, Rapid Response) and referred to Washington County Psychotherapy Associates for

assessment and services(Keeping Children Safe Downeast, 2005b). (See XI-B for a diagram of the KCSD service delivery model).

The KCSD used another key strategy to improve the identification of children exposed to violence. This strategy was the development of a mandated reporter curriculum that was adopted state-wide. The curriculum developed by the KCSD for mandated reporter trainer was adopted statewide by both the Child Abuse Network Council and Maine Department of Health and Human Services. This state-wide on-going training effort will contribute to improved identification children exposed to violence in the future.

In order to improve community members' ability to identify and respond to children exposed to violence KCSD engaged in social marketing campaigns, as previously mentioned, which consisted of the development and distribution of materials on issues related to children's exposure to violence.

### **5.3 Existing Services**

The KCSD improved existing services by infusing additional resources to enhance the number and quality of existing local services. They also used their strong leadership and working relationships with child-serving agencies to advocate and successfully implement changes in services at the state level.

At the local level, the KCSD improved the responsiveness of Washington County Psychotherapy Associates (WCPA) by funding slots for children exposed to violence. Funding

slots increased the capacity of WCPA to treat children exposed to violence through the KCSD referral process. This is important because WCPA is the largest psychiatric treatment provider in Washington County and therefore typically has a waiting list for families with a variety of mental health issues. Waiting lists for services are commonly two months or longer<sup>5</sup>. These reserved slots provided critical services more quickly for children exposed to violence.

Between May 2002 and December 2005 KCSD served approximately 5% of the children under five years of age in Washington County (Keeping Children Safe Downeast, 2005b). This represents a small number considering the KCSD estimate that approximately one third of the households in Washington County experience some sort of family violence, with media and television perceived by parents as the biggest sources of exposure. The KCSD attributes the small number to challenges created by a large county with limited resources, lack of knowledge about organizations and agencies in the community, and a limited number of agencies knowledgeable about issues related to children's exposure to violence.

The KCSD records also may not reflect the full number of referrals made to the program because some referrals for services were made without notifying

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<sup>5</sup> This information is from the Muskie Evaluation Team Washington County Mental Health Capacity Assessment Report, May 2003. The survey identified some 13 agencies that provide child mental health services in Washington County although WCPA is the largest. WCPA also may refer children for psychiatric services to providers in the city of Bangor, a two hour drive from most towns in Washington County.

KCSD. KCSD and Washington County Psychotherapy Associates tried to amend this issue by meeting with the referring agencies on several occasions and trying to improve the accountability of the referring/reporting system. However, inconsistencies between the number of families referred to services and the number of notifications of referrals KCSD received were still found.

In addition, the KCSD provided training opportunities that focused on ways to educate mental health professionals about changing referral and treatment practices which was expected to result in increased engagement of parents/caregivers with the KCSD referral process. Finally, the KCSD enhanced the capacity of local criminal justice officials by providing funds for digital cameras used for collecting evidence to support the forensic interviewing process.

At the state level, the KCSD increased the number and quality of services available in Washington County by advocating for the implementation of Maine 2-1-1. The KCSD was instrumental in the implementation of Maine 2-1-1 in Washington County, a toll free number where residents will be able to call for help or receive information regarding domestic violence and other resources for children and families. Washington County is only the second county in Maine to implement 2-1-1. This resource is especially important for Washington County because of its scarce community resources and geographical barriers to access care.

## **6. Institutionalization of Change**

System change activities implemented by the KCSD were institutionalized in Washington County in a number of ways. Most significantly, KCSD began to make inroads into the culture of isolation that existed in Washington County by bringing service providers to the table to work together. The KCSD achieved this by facilitating the Interdisciplinary Team (IDT). As described before, the IDT dissolved because of a need to form smaller sub-committees according to each agency's interest and discipline. Some of these groups still continue. The Child Abuse Response Team (CART), for example, has been working with the District Attorney in Washington and Hancock County to institutionalize forensic interviewing and set a goal to train law enforcement and child protective workers on interviewing children in Washington County and statewide. The Multidisciplinary Team (MDT) also continues to meet regularly to review old and current Child Protective Services cases. The MDT has been using the revision of cases as an educational tool to increase communication between agencies. This practice has reduced the isolation of practitioners and allowed them to participate in a cross-disciplinary approach to address the needs of children exposed to violence and their families.

### **6.1 Point of Service Change**

Originally, the KCSD did not plan to incorporate training in its strategic plan. However, after various

meetings with its collaborative, the KCSD identified a need for training service providers around issues of exposure to violence. The KCSD offered more than 20 different trainings from 2003 until 2005. More than 3700 people in the community participated in these trainings around issues of children's exposure to violence. Some of the trainings include: Forensic Digital Photography, Brain Development—formerly Baby's Blossoming Brain, Child Abuse and Neglect, Forensic Interviewing, and Impact of Media Violence, among many others.

## **6.2 System and Agency Change**

The Regional Medical Center-Lubec (RMC-L) and the Washington Hancock Community Agency (WHCA) agreed and formed a partnership to continue looking for funding for KCSD. Jointly, they wrote a five-year logic model with systems change activities, intermediate outcomes, and long term outcomes. The RMC-L is concentrating its efforts doing the community outreach component, while WHCA is responsible for the initiative as a whole and conducting the committee meetings. Both organizations have agreed to undertake the financial burden, but they are committed to write grant proposals together in order to receive more funding for the initiative.

The five-year (2005-2009) Community Sustainability Plan was developed and agreed to by collaborating agencies. The three main goals of the plan include:

- **Increase Washington County's knowledge of children exposed to violence** by continuing

community awareness activities (e.g., the Blue Ribbon Campaign), incorporating issues related to children exposed to violence in the trainings of 13-15 agencies, and promoting the 2-1-1 call center as the single point of entry to appropriate services.

- **Continue to strengthen and enhance the provider network at the local, state, tribal and county levels to sustain KCSD** by engaging various agencies including Head Start, the Department of Health and Human Services (DHHS), Family Resource Centers and Resource Development Centers. Collaboration with the Passamaquoddy Tribe will continue. Training at the state level for mandated reporters and first responders will be continued.
- **Partner with state, local, county, and tribal service providers to promote systems reform** by enhancing the understanding of children exposed to violence among key stakeholder groups including domestic violence advocates and parent. Sustainable resources will be identified. And barriers to access will continue to be addressed.

## **7. Reduced Exposure to Violence**

The KCSD identified a total of 79 children as exposed to violence between 2003 and 2005, but the KCSD funded service provider only assessed 37 children (Keeping Children Safe

Downeast, 2005b). No post-treatment data could be obtained; therefore, there is no evidence of reduced exposure to violence. Many factors contributed to clinicians' inability to collect data. For example, families' considered the assessment as an invasion of privacy and, after the first therapy, did not return for services. Also, after being identified, many families were left to contact services for appointments on their own; many opted not to go in for services. Additional factors, such as physical barriers (e.g., long travel distances, lack of transportation, weather), contributed to the site's inability to engage or retain clients in services. It can be noted, however, that narratives of play therapy in a limited number of post-assessment cases indicate that aggressive behaviors were reduced and sociability with the clinician showed improvement over time. In addition, at least one case reported improved school behavior during the multi-session play therapy intervention

KCSD, however, impacted service providers with their trainings in a very positive way. Trainings made service providers realize the impact that exposure to violence has on young children. Therefore, two agencies (RMC-L, WHCA) formed a partnership to keep finding ways to keep KCSD's legacy alive and other agencies made certain to keep meeting in their respective committees to find ways of improving the system of care for children. Understanding the issue creates an awareness within a community about the need to address children exposed to violence which may ultimately exposure.

## **8. Reduced Impact of Exposure to Violence**

The KCSD was not able to get information on impact of services offered by the Washington County Psychotherapy Associates and their families because of limited participation by families and limited buy-in and supervision of the clinicians and counselors responsible for assessing families (Keeping Children Safe Downeast, 2005b).

In regard to the clinician "buy-in", it's important to recognize that clinicians expressed (during interviews conducted by the Muskie Evaluation Team) a conflict in devoting time to administering the structured 2-3 measurement tools of the evaluation, while maintaining their primary focus on providing services to families during the initial assessment visit. In clinicians' view, addressing the presenting needs of families, often in crisis, took precedence over administering the evaluation measures to parents. Offers of assistance regarding further training by the evaluation staff on study implementation techniques did not resolve this "conflict".

After families received the initial referral for services, parents and families were left to make the linkage on their own and follow up with appointments for assessment. This process limited parental participation. Families were also required to give their consent to participate in follow-up data collection and most declined. This unwillingness also created difficulties for KCSD to access case records and required a new Institutional Review Board approval

process and lengthy legal review. This delayed the data collection significantly and by the time these issues were resolved, KCSD was only able to gain access to the last ten case records for review.

These ten records provided descriptive information about children exposed to violence in Washington County. Key descriptive information included:

- Most violent incidents occurred in the child's home
- For most violent incidents, children were witnesses and not victims
- The child's mother was the most frequently reported victim
- The child's father was the most frequently reported perpetrator

KCSD efforts did not improve the response time to refer children for assessment within 72 hours of witnessing violence. Between April 2003 and July 2005 the KCSD analyzed the referral process for 48 cases involving children ranging from two to ten years of age ( $M=4.8$ ) and it took an average of 10 days for a child to be referred for treatment. More information about KCSD's intervention research can be found in Exhibit XI-C.

## 9. Conclusions

Through trainings and community awareness campaigns, the KCSD demonstration project increased agency-based professionals and community members knowledge of the impact that exposure to violence has on children in Washington County. The KCSD has also identified the barriers to creating a coordinated system of care to identify, refer, and treat children. These barriers included the large size, rural character and low population density of Washington County. Another barrier was the stigma and invasions of privacy issues families associate with receiving mental health services. The KCSD also helped to break down an existing culture of isolation by encouraging a system of collaboration between child-serving agencies and providers that will continue after federal funding ends. In addition to a spirit of collaboration, the KCSD focused on creating permanent and lasting changes in Washington County. The KCSD was instrumental in institutionalizing effective practices and resources to help families with children that have been exposed to violence. Forensic interviewing, mandated reporter training, Maine 2-1-1, and community resources (e.g., a library) will continue to be used to reduce the exposure and impact of exposure to violence for children and families. The KCSD will also continue as outlined in their sustainability plan and as a result of KCSD's efforts, Washington County can continue to develop a stronger infrastructure to support children exposed to violence.

## 10. References

Association for the Study and Development of Community (2005a). *Site Visit Report: Washington County Safe Start Initiative January-December 2004*. Gaithersburg, MD: Author.

Association for the Study and Development of Community (2005b). *Site Visit Report: Washington County Safe Start Initiative January 1 through September 15, 2005*. Gaithersburg, MD: Author.

Keeping Children Safe Downeast (2004). *5-year community strategic plan*. Milbridge, ME: Author (Available from the Association for the Study and Development of Community).

Keeping Children Safe Downeast (2005a). *Progress report: January 1, 2005-June 30, 2005*. Milbridge, ME: Author (Available from the Association for the Study and Development of Community).

Keeping Children Safe Downeast (2005b). *Local evaluation report form*. Milbridge, ME: Author (Available from the Association for the Study and Development of Community).

**Exhibit XI-A**  
**Timeline of Washington County Safe Start Initiative Activities and Milestones**

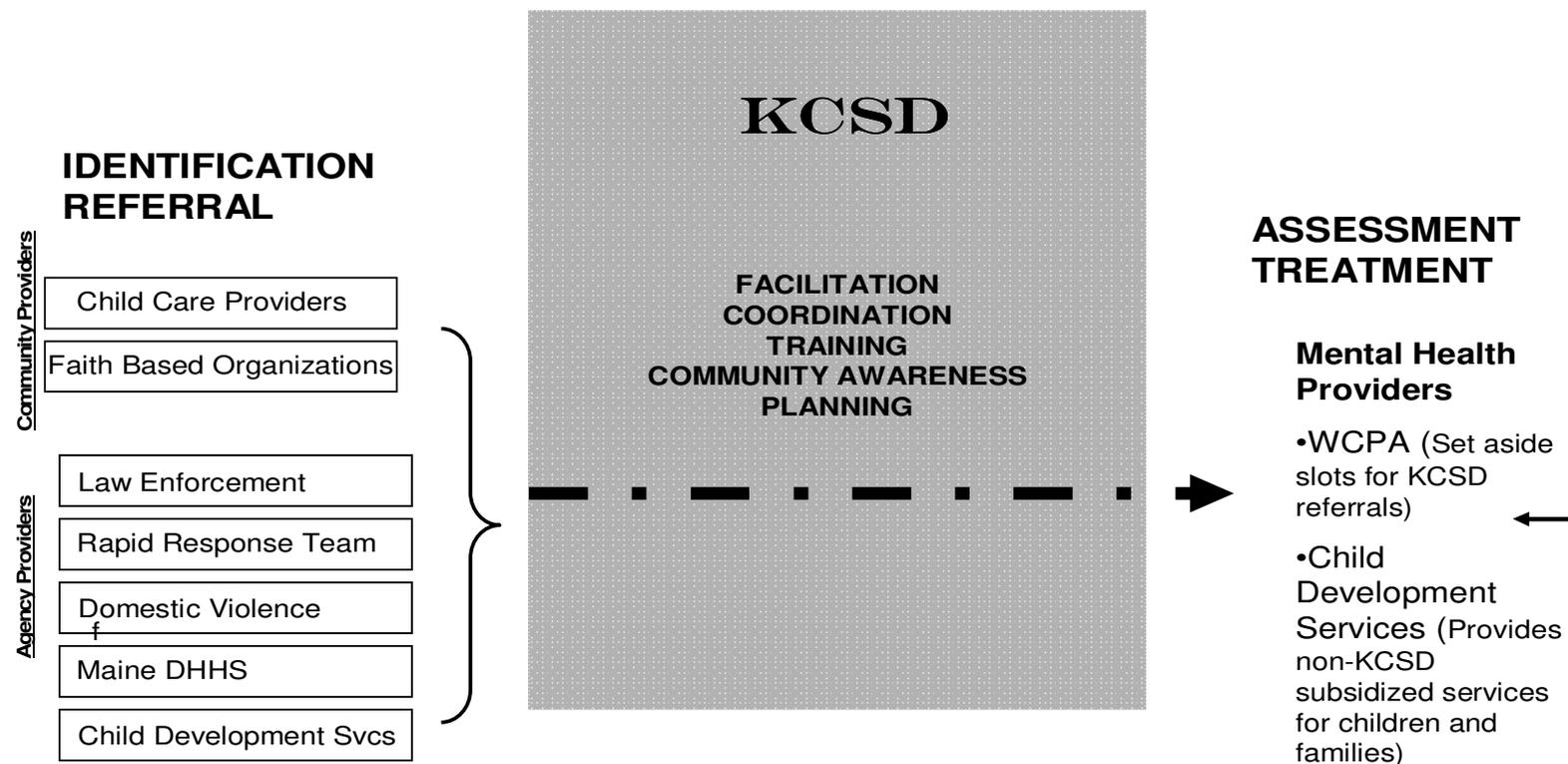
Major Milestone	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
Inter-Disciplinary Team	✓	✓	✓	✓	✓	✓			
Multi-Disciplinary Team (formed & ongoing)					✓	✓	✓	✓	✓
Child Abuse Response Team (formed & ongoing)					✓	✓	✓	✓	✓
Mental Health Collaborative (formed & ongoing)					✓	✓	✓	✓	✓
KCSD Collaborative Board (formed & ongoing)				✓	✓	✓	✓	✓	✓
KCSD Community Awareness Campaign		✓	✓	✓	✓	✓	✓	✓	✓
• April Child Abuse and Neglect Council Awareness Campaign		✓		✓		✓		✓	
• October Domestic Violence Awareness Campaign					✓		✓		✓
Second Step Violence Prevention Trainings					✓	✓	✓	✓	✓
Mental Health Assessment Pilot Project with Washington County Psychotherapy Associates (WCPA)					✓	✓	✓	✓	✓
Digital Camera Project				✓	✓	✓	✓	✓	✓
• Digital Forensic Photography Training							✓		
Training Scholarship Program	✓	✓	✓	✓	✓	✓	✓	✓	
Welcome to the World Baby Bag Program					✓	✓	✓	✓	✓
DownEast Batterer's Intervention Program (DEBIP)					✓	✓	✓	✓	✓

Major Milestone	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
Mandated Reporter Training Program			✓	✓	✓	✓	✓	✓	✓
Downeast Sexual Assault Response Team (SART):						✓	✓	✓	
Baby's Blossoming Brain Training					✓	✓	✓		
Fatherhood Training Project						✓	✓	✓	
KCSD newsletter (established & ongoing)						✓	✓	✓	✓
2-1-1 Web Database and Call Center Project								✓	✓
Head Start Training Program								✓	✓
Children Exposed To Violence (CEV) Training Program - Dr. Bruce Perry Video Series								✓	
Cross Disciplinary Training					✓	✓	✓	✓	✓
Peaceful Choices Non Violent Early Childhood Training								✓	✓
Internet Pornography Crimes Project								✓	
Rapid Response First Responder Training		✓	✓	✓	✓	✓	✓	✓	✓
Zuni/Passamaquoddy/KCSD Peer Exchange								✓	✓
KCDS Project Director resigned						✓			
Project Director Position filled						✓			
Community Educator Position filled	✓								
Community Educator resigned						✓			

Sources: Washington County Progress Reports: January – June 2002, January -June 2004, July-December 2004, and January-June 2005; Washington County Semi-Annual Progress Report: July-December 2003; Local Evaluation Form 2004, Local Evaluation Form 2005, and KCSD Semi Annual Report 2005.

**Exhibit XI-B**

# Washington County Safe Start Service Delivery Model



## **Exhibit XI-C**

### **Washington County Safe Start Intervention Research**

#### **Overview**

KCSD contracted with the Washington County Psychotherapy Associates (WCPA) to provide services to children ages zero to six that were exposed to violence in Washington County. Families who accepted treatment received up to three sessions with WCPA paid for by KCSD or they could be referred to other services depending on their needs. Play therapy was the most common treatment used by WCPA.

KCSD's intervention research was divided into two phases. Phase I tracked the referral of children and caregivers by five local agencies to WCPA that volunteered to take part of the study. Phase II intended to track the impact of the effectiveness of treatment on children and families exposed to violence. Assessment information such as the child's exposure to potentially traumatic experiences was collected at baseline. No post-intervention data were obtained, however, because most families were hesitant to accept services. For the purpose of this summary, we will only focus on Phase II of KCSD's intervention research explained in further detail below.

#### **Method**

WCPA was required to conduct an initial assessment on the child using a standardized interview protocol that incorporated the Trauma Events Screening Inventory (TESI) and the Trauma Symptoms Checklist for Young Children<sup>86</sup> (TSCYC). A post intervention assessment of the child, using the same instruments, was required as well, but no data could be obtained.

#### **Sample:**

Phase II had a sample size of 10 cases that were referred for assessment between April 8, 2005 and June 10, 2005. Information about these 10 cases included the following: Characteristics of children referred to the KCSD Pilot Assessment; Sources of referral; Potentially traumatic events and occurrences experienced by the child; and Follow up referrals and diagnoses.

#### **Procedures**

Initially, WCPA collected baseline assessment data using the interview protocols, the TESI, and the TSCYC. WCPA was also expected to collect post-intervention data. No post-intervention data were collected because parents were unwilling to participate during the initial stages of the research. In the absence of post-intervention data, WCPA agreed to de-identify the last 10 cases and gave the data to the Muskie Evaluation Team. The Muskie Evaluation team entered into no contact with children and families.

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<sup>86</sup> As reported in the LERF, "both trauma measures are parent-reported" (Keeping Children Safe Downeast, 2005b, p. 51).

## Results

Descriptive analyses were performed for the 10 cases. Of these cases, six were girls and 4 were boys. The children ranged from two to seven years of age; four children were four years old, one was two years old, two were five year olds, another two were six years of age, and one was seven years old. DHHS Child Protective Services referred 60% of the cases, while other referrals came in from the domestic violence shelter and Head Start, for a total of two referrals each. The majority of the incidents, 5 in total, occurred in the child's home, either in their usual home or in their other home if the child's parents were separated. Other incidents occurred in a relative's home, in a day care setting, or in some other unreported location. In many instances the child witnessed a domestic violence incident, but in other cases they child put him/herself in danger. The most common diagnoses were adjustment disorder, posttraumatic stress disorder, and disturbance of emotions. Play therapy was the most common treatment provided by WCPA. In one other case, the child received further counseling from Child Development Services, while in another case they therapist worked with the mother in her ability to redirect the child.

Trauma was measured with two instruments, the TESI and the TSCYC. Results showed that 71% of the children had been victims of sexual assault, another 71% had experienced the death of someone close to them, 43% experienced an attempted suicide from a person close to them, and 57% had experienced some type of media violence such as seeing war episodes or terrorism attacks. Children exposed to violence also exhibited aggressive behavior (i.e., yelling). However, other types of trauma symptoms were infrequently reported by parents in the Trauma Symptom Checklist, such as: having bad dreams (reported in one case only), crying at night or not being able to sleep (reported in one or two cases), and increased startle (reported in two cases).

## Discussion

Washington County Safe Start's intervention research was designed to analyze the treatment's effectiveness in reducing the effect and impact of children's exposure to violence through their intervention method. The data collection was not successful mainly because families were not willing to participate in the study. The data that was collected, however, provides an informative description of the characteristics of the children referred, the nature of the trauma, and the trauma symptoms presented by children.

## Reference

Keeping Children Safe Downeast (2005). *Local evaluation report form*. Milbridge, ME, AK: Author (Available from the Association for the Study and Development of Community).