

Safe Start Initiative: Demonstration Project

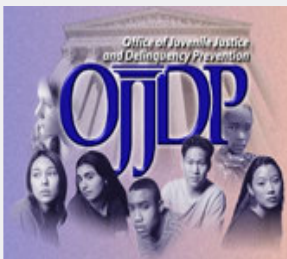
Phase I Case Studies III (2006) Report #2007-1

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Association for the Study and Development of Community

438 N. Frederick Avenue, Suite 315
Gaithersburg, MD 20877
301-519-0722 voice
301-519-0724 fax
www.capablecommunity.com



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Preface

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

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

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

Bridgeport Safe Start Initiative
Bridgeport, Connecticut

Rochester Safe Start Initiative
Rochester, New York

Chicago Safe Start Initiative
Chicago, Illinois

San Francisco SafeStart Initiative
San Francisco, California

Pinellas Safe Start Initiative
Pinellas County, Florida

Sitka Safe Start Initiative
Sitka, Alaska

Zuni Safe Start Initiative
Pueblo of Zuni, New Mexico

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Introduction

Service providers in 11 communities nationwide had the opportunity to build systems of care for children exposed to violence as part of the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Safe Start Initiative. Over the course of Phase I of the initiative (the Safe Start Demonstration Project), practitioners from multiple sectors enhanced local service delivery systems for young children exposed to violence¹ or at high risk of exposure, along with their families and caregivers. Each grantee was expected to improve upon existing service delivery systems by making them both more comprehensive and more responsive. As part of these broader systems changes, grantees were expected to provide children and families with services and interventions that are research-based; appropriate for young children exposed to family and community violence; holistic (e.g., capable of meeting multiple needs of children and families); and capable of providing a continuum of care including early identification, treatment, referrals, and follow-up.

Edleson (2006) proposed a system of care for children exposed to domestic

violence,² in which service providers would work together to create more responsive care. Structurally, Edleson's proposed system would include not only child protective services and the courts, but also a range of community-based service providers. Functionally, the system would provide a continuum of care, capable of responding to children's differentiated responses to both direct violence exposure (e.g., child abuse) and indirect exposure (e.g., witnessing domestic violence). This continuum would include prevention, identification and referral, assessment and service planning, and service provision.

Building systems of care was a primary goal of the Safe Start Demonstration Project; these final case study reports focus exclusively on the system of care for children exposed to violence developed, implemented, and institutionalized by the seven continuing local Safe Start initiatives during the grant period. The analysis is based primarily on the National Evaluation Team's visit to each site in 2006 (Association for the Study and Development of Community, 2006c, 2006d, 2006e, 2006f, 2006g, 2006h, 2006i), six site's local evaluation report forms³ (Bridgeport Safe Start Initiative, 2006; Chicago Safe Start Initiative, 2006; Pinellas Safe Start Initiative, 2006; Pueblo of Zuni Safe Start Initiative, 2006; Rochester Safe Start Initiative, 2006; Sitka Safe Start Initiative, 2006),

¹ According to the Office of Juvenile Justice and Delinquency Prevention, "exposure to violence" means being a victim of abuse, neglect, or maltreatment or a witness to domestic violence or other violent crime (Federal Register Notice, Vol. 64, No. 64/Monday, April 5, 1999, p. 16556). Preliminary analyses of the Safe Start evaluation outcome database indicate that the two most common types of violence exposure identified were "punching/hitting" (20.5%) and "verbal/stalking" (24%) (Association for the Study and Development of Community, 2006a, p.7).

² Edleson (2006) uses the term "domestic violence" solely in reference to adult-to-adult domestic violence.

³ The National Evaluation Team used the local evaluation report forms to collect data about each demonstration site in a standard format, which facilitated cross-site comparisons and analysis. The sections of the report form are based on the Safe Start program framework.

each site's 2005 case study report (Association for the Study and Development of Community, 2006b), and information obtained from site documents (e.g., progress reports and other materials). Core evaluation questions used to guide the analysis include:

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

Each case study begins with a brief overview of the site's local system of care for young children exposed to violence. Included in each site's overview are final figures for the number of children identified, assessed, and referred for services because of exposure to violence. Safe Start Demonstration sites were required to report these numbers twice a year in semi-annual progress reports. As described in the National Evaluation Team's 2004 Annual Process Evaluation (Association for the Study and Development of Community, 2005), however, these data are difficult to compare across sites for various reasons.

Most fundamentally, "identified," "assessed," and "referred" were defined differently across grantees. For example, in some sites, "assessed" was defined as a comprehensive mental health assessment conducted by a clinician; in other sites, "assessed" children were those who underwent 1) an initial

screening for exposure to violence by family advocates or 2) an initial screening, via an instrument or question on an intake form, that formally "identified" the child as exposed to violence. Similarly, some sites defined "referred" as referred *to* Safe Start services; in other sites, "referred" meant referred *from* Safe Start services to other services.

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

Each overview also includes, as available, data from a Safe Start evaluation outcome database created as part of the national evaluation. To populate this database, service providers asked caregivers several questions about the nature and extent of their child's exposure to violence; because providers did not collect this information consistently across sites, however, data on these variables are not provided for all sites.

Following each site's overview, the evaluation questions are addressed in more detail. Each case study concludes with a summary of the accomplishments of the demonstration site with regard to developing and improving service system points of entry, access, and quality for children exposed to violence and their families.

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I

Bridgeport, Connecticut, Safe Start Initiative

1. Overview of Bridgeport System of Care

To respond systematically to the needs of children exposed to violence and their families in Bridgeport, The Center for Women and Families contracted with Child FIRST and the Bridgeport area office of the Department of Children and Families. The Center for Women and Families and Child FIRST created additional partnerships with other community-based organizations to create a comprehensive system of care for this population. [See Exhibit I for a model of the Bridgeport Safe Start Initiative's (BSSI) system of care for children exposed to violence.]

Under this system of care, court advocates working for The Center for Women and Families screen children exposed or "at risk" for exposure to family violence and refer them for domestic violence support services, as well as clinical mental health services. Women and children living in The Center for Women and Family's Safe House were eligible to receive clinical mental health services from Child FIRST clinicians for one year. Although Child FIRST clinicians are no longer providing clinical mental health services for women and children living in the safe house, an in-house staff clinician has continued to provide these services.

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

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

Child FIRST provides wrap-around services to children five years and younger at risk for developmental delays for various reasons, including exposure to violence in the home. These services are provided both in Child FIRST's hospital-based center as well as in families' homes. To identify children exposed to violence, Child FIRST developed a tool now used in all pediatric settings within Bridgeport

Hospital to screen for a variety of developmental issues, including domestic violence exposure. A positive response to the self-administered domestic violence question results in immediate referral to Child FIRST for further assessment.

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

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

- **818** young children exposed to violence were identified¹ by mental health workers using a standardized tool, court personnel, domestic violence personnel, police, or early childhood educators;
- **454** children and families were assessed for violence exposure using a standard protocol developed by BSSI;² and
- **649** children identified as exposed to violence were referred to support

¹ Each child is “identified” through a report or observation that the child was present during a violent event (heard or seen) and/or has been the victim of a violent event, including child abuse or neglect (Bridgeport Safe Start Initiative, 2006).

² Only children with written releases of information are included in this count (Bridgeport Safe Start Initiative, 2006).

services documented in a BSSI family plan.³

A Safe Start evaluation outcome database was created as part of the national evaluation. This database includes “exposure to violence” variables (e.g., type of exposure). Although this information was not collected consistently across grantees or for all children assessed by BSSI service providers, specific information about the type of violence exposure was documented for 640 children identified as exposed to violence in Bridgeport, as follows:

- 59% of children witnessed (heard and/or saw) a violent event, but were not the intended victim;
- 7% of the children were physically injured as the intended victim of violence;
- 1% of the children were physically injured, but not the intended victim;
- For 5% of the children, service providers categorized the violent event to which the child was exposed as “other;” And
- For 10% of the children, the type of violence exposure was unknown.

Finally, information about the effectiveness of Child FIRST program services for children exposed to family violence was obtained for a subset of families and children. Three instruments were used to assess children’s exposure to violence, trauma-related symptoms, and parental stress. The Traumatic

³ Referred services may include services that address the needs of the child and/or the family. This count includes only children with written releases of information who received Safe Start-sponsored services (Bridgeport Safe Start Initiative, 2006).

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

Discussed next in greater detail is each component of the BSSI system of care for children exposed to violence, along with the reason for its development. (See also Exhibit I.)

1.1 Multiple opportunities to identify children exposed to violence and refer them to appropriate services

In Bridgeport during the Safe Start grant period, court advocates identified the greatest number of children exposed or at risk for exposure to family violence (Horton, Galifoco, Heye, et al., 2006); once identified, families were referred to domestic violence support services at The Center for Women and Families. Child FIRST clinicians and the clinician participating in the School-Based Health Center Mental Health Pilot Program (described in Section 1.2) also identified a large number of new cases of children exposed to violence. Screening for

children's exposure to violence in early childcare settings, particularly among children exhibiting social-emotional and/or behavioral difficulties, was found to be a promising practice for identifying children who have not yet presented to the service system (Horton, Galifoco, Heye, et al., 2006). Finally, findings from the screening project piloted in the Bridgeport area office of the Department of Children and Families demonstrate that child protection workers can be effective screeners for domestic violence and children's exposure (Horton, Galifoco, Heye, et al., 2006).

As part of the Bridgeport Safe Start Initiative, the following agencies developed policies to screen for young children's exposure to violence: Child FIRST, Bridgeport Hospital Pediatric Clinic, Bridgeport School-Based Health Centers, Bridgeport School Readiness Programs, and the Bridgeport area office of the Department for Children and Families. For example (Bridgeport Safe Start Initiative, 2006):

- Child FIRST developed a screening tool now used in all pediatric settings within Bridgeport Hospital to screen families for a variety of developmental issues including domestic violence exposure. A positive response to the self-administered domestic violence question results in immediate referral to Child FIRST for further assessment;
- Child FIRST mental health consultants working in Bridgeport early care settings began to utilize a screening form to assess for exposure to violence in the home;
- All school-based health centers participated in a pilot screening

effort on exposure to violence and intimate partner violence. As a result of these efforts, questions on these topics have been integrated into the health centers' standard screening tools;

- The Bridgeport area office of the Department of Children and Families implemented a domestic violence screening protocol for use by all child protection workers involved in investigating allegations of abuse and neglect; and
- The Center for Women and Families adopted the practice of screening all clients for the effect of violence on their children.

1.2 Early intervention, intervention, and treatment options for children at risk of exposure or exposed to violence

Child FIRST provides wrap-around services to children five years and younger at risk of developmental delays for various reasons, including exposure to violence in the home. Services include developmental screenings, child and family therapy, and care coordination. Evaluation research findings indicate that participants in Child FIRST services had decreased exposure to traumatic events, decreased trauma symptoms, and decreased parenting stress at discharge as compared to baseline (Bridgeport Safe Start Initiative, 2006).

Based on this evidence of success, the Bridgeport Safe Start grantee funded a School-Based Health Center Mental Health Pilot Program to expand the community's capacity to deliver holistic and home-based services, including clinical mental health services, to children exposed to violence.

Elementary school children and teen parents were the focus of this pilot program; one site visit participant described the school-based health centers as "portals of entry for kids who are not going to be noticed in other systems." Although both Child FIRST and school-based health centers also provide center-based services, home-based services represent an important service delivery enhancement.

In addition to supporting the above service delivery model, the Bridgeport Safe Start grantee was able to demonstrate effective integration of services across and within organizations. The Center for Women and Families, for example, integrated domestic violence support services with clinical mental health services, a significant accomplishment given that domestic violence advocates historically have viewed the therapeutic process as re-victimizing for women. The center now has a clinician on staff to provide mental health services to women and children identified through the Child Advocate and Court Program or through the Family Violence Outreach Project. This clinician, whose position⁴ was created as part of a mental health service pilot program, also works with families in The Center for Women and Family's Safe House. This internal capacity proved critical as many families were lost to the system when referred to other mental health agencies; offering mental health services within the center made

⁴ Bridgeport Safe Start funded the mental health clinician from April 2006 to March 2007. New funds from the Florence Burton Foundation were garnered to cover half of the position starting in April 2007. Several other proposals have been submitted to cover the other half of the position.

sense given that families were already coming for other services.

As an example of service integration across agencies, The Center for Women and Family's Safe House developed a partnership with Child FIRST, creating the center's first program component from outside the domestic violence sector. Again, this was significant in that many domestic violence advocates historically have not acknowledged the negative impact that exposure has on children.

Three site visit participants discussed the long-term goal of creating an outpatient mental health clinic at The Center for Women and Families as a way to provide 1) more clinical services to families and 2) professional development opportunities for court advocates (e.g., clinicians would work with advocates on screening and referring). While the commitment to continue providing these services is encouraging, two potential obstacles may impede realization of this goal. First, the barriers associated with screening and referring in the court setting discussed below (section 2) will need to be addressed to ensure successful referrals to clinical services. Second, engaging families in center-based services may be difficult, particularly in light of the findings on home-based services (also discussed below).

Integrating the expertise of domestic violence providers and child protection workers in the Bridgeport area office of the Department of Children and Families is another example of a successful service integration model supported by the Bridgeport Safe Start grantee. With

domestic violence training, consultation, and a screening protocol, child protection workers were able to substantiate domestic violence in a greater number of initial abuse and neglect cases, thereby helping workers link caregivers to needed services and reducing the likelihood of repeated substantiation of domestic violence within the same family.

The Bridgeport grantee also supported embedding mental health expertise in early childhood education and care settings, a final example of successful service integration. In this model, a Child FIRST clinician provides classroom consultation to early childhood educators; care providers; and, in some cases, parents. The consultant also provides services to individual children or groups of children as needed. With the help of the mental health consultant, early childhood educators and care providers are better able to identify and refer children exposed to violence, as well as managing these children more effectively within the early childhood setting.

Substantial Safe Start funds were dedicated to increasing 1) the number of clinical mental health providers capable of serving young children exposed to violence and 2) the number of children able to receive appropriate services. Increasing the availability of children's mental health services in the community proved insufficient, however, to engage and retain children exposed to violence and their families in these services. In fact, many Safe Start-funded mental health service slots were significantly underutilized, in part because families experiencing violence require a

combination of mental health and social services, as well as care coordination. Engaging and retaining these families in services requires effective service delivery and integration vehicles to address multiple family needs; in Bridgeport, providing services in the home was found to be a particularly effective service delivery model.

When provided in the context of domestic violence, clinical services themselves require adaptation, toward a multi-faceted and often sequenced approach. Families experiencing violence require stabilization and safety planning before they can be engaged in a therapeutic process. In addition, a parent's psychological needs and resources (e.g., empathic ability, depression, substance abuse, general emotional availability to the child) must be addressed before the parent can be engaged in addressing the parent-child relationship, an equally critical focus of clinical treatment. Finally, children must be allowed to express the feelings evoked by exposure to violence and tell their stories of violence exposure to remove the element of secrecy; to ensure safety and promote healing, children, as well as parents, must be taught strategies to cope with the feelings they identify and experience.

1.3 Mechanisms for building the capacity of service providers to respond appropriately to children exposed to violence and their families

The Bridgeport grantee experienced challenges in finding clinicians and other service providers qualified to work with young children exposed to violence and families experiencing domestic violence;

as a result, increasing both community awareness of children exposed to violence and the ability of service providers to respond effectively was critical to enhancing Bridgeport's service delivery system for this population.

Safe Start trainings offered service providers the opportunity to network and learn about other organizations, which facilitated the referral process for families. Training also increased community awareness of domestic violence and its impact on children. Safe Start resources professionalized The Center for Women and Families' Community Education Unit, which "raised the bar" and increased the organization's credibility in the community as an expert on domestic violence and its impact on children. Technical assistance equipped various service providers (e.g., court personnel, child protection workers, early childhood educators and care providers) with the knowledge and skills needed to serve children exposed to violence and their families.

From 2002 to 2005, the Bridgeport Safe Start grantee provided 129 training sessions, free to Bridgeport service providers. Staff from 381 organizations attended, for a total of 1,938 participants (Bridgeport Safe Start Initiative, 2005). In 2006, 1,200 persons representing 141 agencies participated in trainings (Bridgeport Safe Start Initiative, 2006).⁵ Trainings included two-hour workshops, intensive skill-based trainings, and technical assistance in the form of supervision and consultation workshops.

⁵ The figures provided on the number of training participants are duplicated.

A training model for clinicians was implemented with modest success. Initially, four clinicians were trained on early childhood/development, domestic violence, and the impact of domestic violence on children.⁶ The agencies in which these clinicians worked did not fully support serving children exposed to violence, and it is not clear whether or not these clinicians are still practicing in Bridgeport. Modifications were made and the model was implemented again in 2006, with the training of 23 clinicians. Intentional efforts to provide supervision and peer networking opportunities were built into the revised training model, with the goal of sustaining this clinical capacity in the community.

Also in 2006, the Bridgeport grantee developed new training to address the needs identified in the Family Engagement Study undertaken by BSSI and the PARK project in 2005. This training, which teaches cultural competence and customer service for social service providers, has been well received in the community. The Bridgeport grantee supported implementation of the training both on a community level and as in-service modules in the two largest service agencies in Bridgeport (Bridgeport Safe Start Initiative, 2006).

Finally, BSSI undertook a training assessment to guide The Center for Women and Families in sustaining their Community Education Unit (which provides many of the Safe Start trainings) and experimented with new training modalities (e.g., multiple-session trainings for licensed professionals) to ensure that training

continues to evolve to meet the needs of providers (Bridgeport Safe Start Initiative, 2006). The training assessment found that the Community Education Unit might consider experimenting with fee-for-service trainings to ensure sustainability; experimentation along these lines is ongoing.

2. Challenges and Needed Improvements to the Bridgeport System of Care for Children Exposed to Violence

Several challenges impeded the development and implementation of a complete system of care for children exposed to violence in Bridgeport.

Not all settings are ideal for screening for domestic violence and exposure to violence. Implementation of screening and referral services raised questions of where to screen parents and who should administer screening protocols. Site visit (2006) participants provided the following examples of how failing to consider these questions carefully can present barriers to universal screening:

- Screening all parents involved in the civil and criminal court systems for domestic violence is challenging for several reasons:
 - Parents are in crisis and often focused on addressing the incident that brought them to court, rather than the impact of the incident on their children, especially very young children;
 - Parents involved in the justice system often have concerns about possible links among court

⁶ Some clinicians attended multiple sessions, and some clinicians attended only one session.

- advocates, the Department of Children and Families, and other court personnel, making full disclosure of children's exposure difficult;
- Court advocates have a high volume of clients, making comprehensive assessment and follow-up challenging; and
 - Court advocate offices in the courthouse do not provide the privacy needed to discuss a child's exposure to domestic violence.
- In primary pediatric care settings, the level of trust and familiarity between pediatrician and parent is often insufficient to encourage disclosure of domestic violence and children's exposure. Furthermore, many pediatricians do not have the social work support staff needed to manage referrals to appropriate services.
 - School-based settings surface challenges associated with a child's identifying the issue of domestic violence. When a child discloses, the family may experience greater challenges to acknowledging the problem than if the parent were asked to disclose. Questions about the veracity of a child's disclosure also can arise when a parent is not present during disclosure. Bridgeport Safe Start partners, therefore, have made efforts to have discussions with parents or a joint meeting with parent and child.

Insufficient service infrastructure for children six years and younger prohibited full implementation of a system of care for very young children exposed to violence. Prior to BSSI, the

Bridgeport service system included few clinical providers with the skills to address domestic violence and its impact on very young children. Overall, the community had few child-focused clinical services, with long waiting lists for children in need of mental health services. Partnership between the largest provider of children's mental health services in Bridgeport (Child FIRST) and the Bridgeport Safe Start grantee failed to achieve systems change; with few alternatives for children's mental health services in the community, the Bridgeport grantee therefore struggled to transform the system of care for children exposed to violence. As one site visit participant put it, "programs are as good as the agency." Simply funding more mental health service slots within existing agencies proved insufficient to change the system of care; new approaches to service delivery and service integration were necessary to engage and retain families in mental health services.

Evaluation tools were perceived by many clinical practitioners as impeding service delivery. Specifically, the "Safe Start tools" (e.g., the Trauma Symptom Checklist for Young Children) were a burden for families to complete once, let alone more than once, as well as too complex and long for a non-mental health clinician to administer. According to several site visit participants, as many as four visits with families were often needed to complete the full assessment process. Evaluation tools therefore needed to be shorter, with clear protocols for administration.

Political corruption and city personnel turnover in Bridgeport resulted in a loss of project momentum and fewer

points of entry into the service delivery system. When OJJDP staff visited Bridgeport during the Safe Start selection process, both the chief administrative officer (CAO) for the city of Bridgeport and the director of central grants expressed strong support for the project. During the early years of the project, however, the CAO and director of central grants both left their positions, which then remained vacant for some time. Also during these years, the FBI began an investigation of the mayor of Bridgeport and other administrative and political officials for racketeering and other crimes. The mayor was eventually tried and found guilty, receiving a nine-year sentence. A state senator from Bridgeport and the governor of Connecticut also were indicted for various crimes during the course of the Safe Start Demonstration Project; both were found guilty and sent to prison. The chaos this created in the city, along with the loss of key supporters from the administration, negatively impacted the engagement of the city during key developments in the local Safe Start project.

In addition, the Bridgeport chief of police, who was not supportive of BSSI, resigned after learning the police commission was not going to renew his contract. The acting chief subsequently appointed by the mayor was alleged to have a history of domestic violence. Because law enforcement provides such an important screening and referral source for children's exposure to violence, these issues within the police department created a significant barrier to serving children and families.

More recently, however, the new police commissioner has shown support for

issues of children's exposure to violence, including a track record of support for child-focused programs [e.g., implementing Child Development-Community Policing (CD-CP)⁷ in New Haven] and interest in partnering with The Center for Women and Families (i.e., inviting center personnel to the police academy for training and using their resources to refer families to services).

3. Summary of Accomplishments

During the Safe Start grant period, children exposed to family violence in Bridgeport, Connecticut, were most typically identified by The Center for Women and Families' court advocates during court arraignment (Horton, Galifoco, Heye, et al., 2006); domestic violence service providers, therefore, provide an important point of entry into the system of care. Clinical mental health providers also effectively identified young children exposed to violence. In addition, BSSI demonstrated that child protection workers can be effective screeners for domestic violence and children's exposure. Finally, screening for children's exposure to violence in early childcare settings, particularly among children exhibiting social-emotional and/or behavioral difficulties, emerged as a promising practice for identifying children who have not yet presented to the service system.

⁷ For a complete description of the Child Development-Community Policing program, visit the National Center for Children Exposed to Violence website (www.ncccev.org).

The service delivery models represented by Child FIRST, the School-Based Health Center Mental Health Pilot Program, the mental health pilot program at The Center for Women and Families, and the center's court advocate program support the importance of providing families in crisis with services immediately. These service delivery models further illustrate that bringing services *to* families, by being present in court or visiting family homes, can increase the likelihood that families will participate in offered services. The work of the Bridgeport grantee also demonstrates that families experiencing domestic violence require stabilization and safety planning before they can be engaged in a therapeutic process. In addition, parents' psychological needs and resources (e.g., empathic ability, depression, substance abuse, general emotional availability to the child) must be addressed before a parent can be engaged in improving the parent-child relationship, an equally critical focus of clinical treatment.

The Bridgeport Safe Start Initiative continues to help families experiencing domestic violence in several ways. Child FIRST will continue to provide services to the Bridgeport community by screening for domestic violence and offering families a range of center- and home- based services. The Center for Women and Families will continue to have a clinician on staff, who will work with families at the center's Safe House, as well as with families who come to the center for other domestic violence support services. The BSSI project director is working to find resources to

sustain the School-Based Health Centers Mental Health Pilot Program, currently scheduled to end in March 2007. Families involved with the Bridgeport area office of the Department of Children and Families will continue to be screened for domestic violence, and Bridgeport's service providers will continue to have access to training on issues of children exposed to violence and domestic violence through The Center for Women and Families. There are plans to disseminate screening tools developed and tested by BSSI for use in a variety of settings via fact sheets or brochures. Despite challenges, therefore, several components of BSSI will continue in the community after federal funding ends, and the system of care for children exposed to violence established by BSSI will persist.

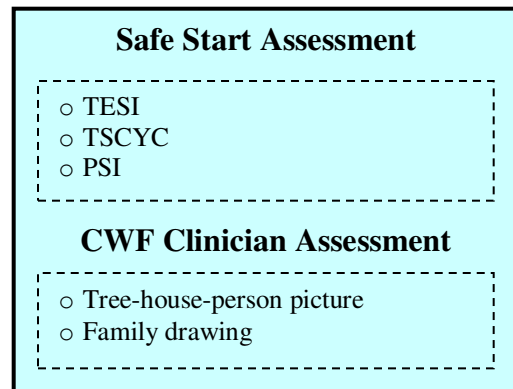
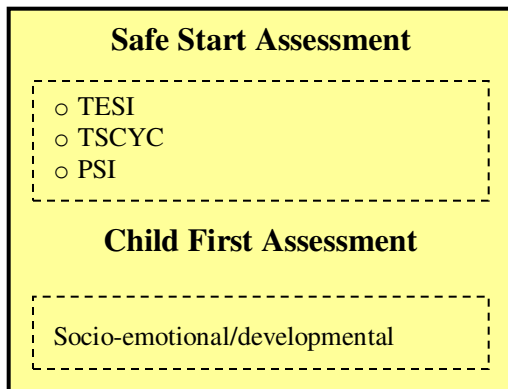
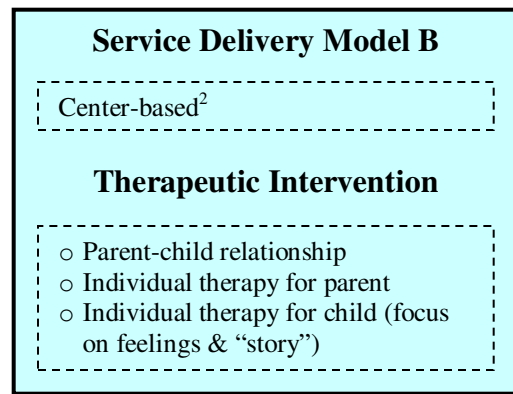
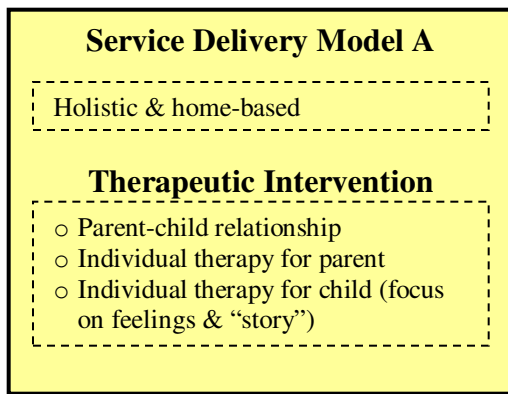
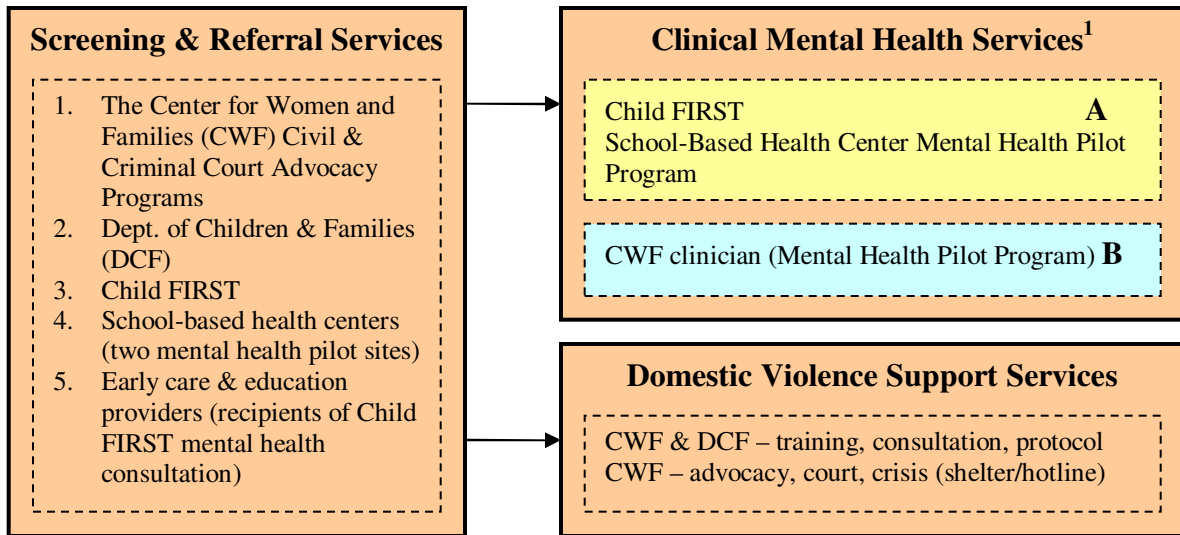
The Bridgeport Safe Start Initiative's accomplishments inform the field in several ways. First, BSSI's experience demonstrates that multiple sectors serving families with young children experiencing violence or at high risk of exposure can successfully identify this population and help families access needed services; to do so, local agencies and organizations must develop and implement identification and referral protocols for children's exposure to violence. Second, delivering services to families experiencing domestic violence in ways most convenient for the family facilitates participation in recommended treatment. Lastly, families experiencing domestic violence typically require a range of support services, including but not limited to therapeutic services.

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Exhibit I

**Bridgeport Safe Start Initiative
System of Care for Children Exposed to Violence**



¹ Please note that both of these programs offer center-based services as well. An important service delivery enhancement, however, is the capacity to serve families at home.

² Please note that families referred to mental health services are already participating in other programs at The Center for Women and Families.

II

Chicago, Illinois, Safe Start Initiative

1. Overview of Chicago System of Care

In the Chicago Safe Start (CSS) system of care for young children exposed to violence, the infrastructure consists of the police department (in the Englewood and Calumet districts¹), the fire department and emergency medical services (EMS, in the Englewood and Calumet districts), Metropolitan Family Services, and Family Focus.² This core structure derives support from the Mayor's Office of Domestic Violence and several community service providers (discussed in more detail in section 1.1). First-responder organizations (e.g., police, fire, EMS) and community providers serve as points of entry into the Pullman and Calumet service delivery systems; several of these agencies modified their protocols and practices during the Safe Start grant period to better identify children exposed to violence and refer them to appropriate services. The primary service providers for children identified by these agencies are Metropolitan Family Services and Family Focus, both of which provide mental health and family support services.

¹ The Calumet police district serves four community areas including Pullman.

² In 2006, family support and mental health services were combined under one agency and co-located within a health clinic in the Englewood community.

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

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

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

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

Discussed next in greater detail is each component of the CSS system of care for children exposed to violence, along with the reason for its development. (See also Exhibit II).

1.1 Multiple opportunities to identify children exposed to violence and refer them to appropriate services

In the Chicago Safe Start system of care, identification of children's exposure to violence occurs through either first responders (i.e., police department, fire department, emergency medical services) or symptom-based responders (e.g., teachers, day care centers, community members). After identification of violence exposure, the first responder discusses the effects of exposure with the family and also discusses the availability of services. The family may then call the Domestic Violence Helpline, ask to be contacted by service providers at a later date, or refuse further services. In all instances, the family receives a Safe Start referral card with phone numbers for available Safe Start services.

This identification/referral structure was developed because first responders are the individuals within the service system who have the most contact with young children potentially exposed to violence; for example, police officers are the individuals most likely to respond first to the scene of a violent incident.

According to 2006 site visit participants, police made 193 referrals to Safe Start during 2005, and first responders made 35 referrals during the first six months of 2006 (Association for the Study and Development of Community, 2006b). From 2003 to 2006, police officers distributed CSS information to 989 families involved in a violent incident (Chicago Safe Start Initiative, 2006b).

To enable identification and referral of children who do not encounter first responders, Chicago Safe Start trainers teach symptom-based responders to identify symptoms of children's exposure to violence. The training curriculum consists of 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's exposure 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 are fully or partially incorporated into all Chicago Safe Start training sessions (Association for the Study and Development of Community, 2006a). The training curriculum is provided to community service providers such as domestic violence service providers, social service agencies, local community health and mental health clinics, schools, and childcare providers. All who receive the

training are equipped with referral information to provide families with phone numbers of Safe Start providers; these providers receive the aforementioned training in addition to 40-hour domestic violence training. According to 2006 site visit participants, symptom-based responders made 296 referrals to Safe Start in 2005 and 131 referrals during the first six months of 2006 (Association for the Study and Development of Community, 2006b). The 131 symptom-based referrals in 2006 included 103 intra-agency referrals from Metropolitan Family Services (Association for the Study and Development of Community, 2006b).

During the Safe Start grant period, several first responder and symptom-based responder organizations modified their protocols to better identify children exposed to violence and refer them to Chicago Safe Start services (Association for the Study and Development of Community, 2006a, 2006b), for example:

- The Chicago Police Department in the Englewood and Calumet districts modified protocols for responding to domestic and community violence incidents to include identification and referral of children exposed to violence;
- The city of Chicago's Domestic Violence Helpline modified protocols to accept calls for services for children exposed to community violence and added Chicago Safe Start direct service agencies to its resources database;
- Both Family Focus and Metropolitan Family Services integrated three children-exposed-to-violence screening questions into their

respective intakes (Chicago Safe Start Initiative, 2006b);

- Metropolitan Family Services streamlined its intake process, moving from a system in which several staff members shared responsibility for screening children for violence exposure, to one in which a full-time social worker screens all incoming cases. This procedural change has led to more accurate information gathering and has facilitated potential follow-up with clients; and
- The Safer Foundation (n.d.)³ modified its management information system to include specific questions about children exposed to violence, to guide referrals for parenting education.

1.2 Assessment, treatment and support services, and referrals to other services by clinicians

The two primary service providers for Chicago Safe Start are Metropolitan Family Services (serving the Roseland/Pullman/West Pullman/Riverdale communities) and Family Focus (serving the Englewood/West Englewood communities). A member of the Chicago metropolitan community for over 150 years, Metropolitan Family Services serves 55,000 families annually (Metropolitan Family Services, n.d.), with the goal of helping families become strong, stable, and self-sufficient. Family Focus, present in the Chicago metropolitan area for 30 years, serves

³ 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.

11,000 families annually (Family Focus, n.d.), with the mission of promoting the wellbeing of children by supporting and strengthening families and their communities. Both service provider agencies require staff working with Chicago Safe Start to receive 40-hour domestic violence training (Chicago Safe Start Initiative, 2006a).

Both agencies provide comprehensive services to meet the needs of children and caregivers. Family Focus develops an individualized service plan for the child and/or family and provides services such as parent-child interaction educational groups, family therapy, adult support groups, and home visits; a mental health consultant serves the mental health needs of children and families. At Metropolitan Family Services, families are offered group counseling and therapy, family therapy, and individual services; a licensed clinical social worker provides infant mental health services.

These Chicago Safe Start service providers engage families by offering integrated, holistic services in credible, convenient settings; both agencies are large, well-established, and respected within their communities. Site visit (2006) participants stated that working with well-established agencies facilitated the process of providing Safe Start services to families, because such agencies have established databases, protocols, and other resources beneficial for children exposed to violence and their families. In addition, the co-location of mental health and family support services increases accessibility of services to families. For example, Family Focus (as of summer 2006) co-located their mental health and family

support services;⁴ providers stated that co-locating services helped increase the number of families seeking and retaining mental health services, as co-location both minimizes the potential stigma of seeking mental health services and increases accessibility of these services.

1.3 Mechanisms for building the capacity of service providers to respond appropriately to children exposed to violence and their families

Chicago Safe Start's extensive training and outreach helped provide a foundation for building a system of care for children exposed to violence. As described above, CSS developed a five-module training curriculum on children's exposure to violence, designed to benefit all service providers—from Head Start providers, to "incubator" grantees (see below), to the police department, to other entities (e.g., attendees at the Latino 2006 Mental Health Conference in Chicago). The curriculum will continue to be used throughout the Chicago Department of Public Health (CDPH) and in future trainings conducted by the CDPH's Office of Violence Prevention, which hosts Chicago Safe Start. Other CSS training activities have included seminars, train-the-trainer efforts, and public awareness training sessions.

From the start of the project through August 31, 2006, Chicago Safe Start staff conducted 429 events to increase awareness of children's exposure to

⁴ Metropolitan Family Services has offered co-located mental health and family services from the inception of CSS.

violence; see Table 1 for a breakdown of the number and type of training events conducted (Chicago Safe Start Initiative, 2006a). In total, **8,860** professionals,

parents, and other community members have participated in CSS training and public awareness activities (Chicago Safe Start Initiative, 2006b).

Table 1. Number of training events sponsored by Chicago Safe Start, 2003 to August 2006

Session Type	Number of Sessions
CSS training	68
Seminars	3
Train-the-trainer	19
Public awareness training	339
Total	429

From June 2006 to March 2007, Chicago Safe Start funded “incubator programs” in five sites, to help sustain CSS practices and services. In the incubator approach, CSS staff partnered 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 incubator agencies integrate, into their overall organizational structure, policies and procedures that would guide the direction of agency efforts to address children exposed to violence. The success of this approach was due in part to the inclusion of training as part of the incubator agreement. Under these agreements, incubator agencies 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 training. Funded incubator sites were expected to have a network of at least 15 partners; each site received \$30,000 to \$50,000 to implement the incubator approach. Three incubator sites are internal Chicago Department of

Public Health entities, and two are external entities. All sites will be evaluated by the current CSS local evaluator.

CSS is in its second year of funding from Chicago Youth Services to conduct a train-the-trainer program for Head Start providers. In year one, CSS worked with 45 Head Start sites throughout Chicago. As part of the program, Head Start providers received training kits with the following resources for addressing children's exposure to violence: 1) the Safe Start five-part training curriculum, 2) additional Safe Start resource materials, 3) children’s books, and 4) posters and other violence prevention materials to share with parents. Through this program, Head Start providers are trained to identify children’s exposure to violence and refer identified children to the Head Start mental health consultant. In addition to the train-the-trainer program, Head Start providers across Chicago are offered the Safe Start five-part training on children’s exposure to violence (Chicago Safe Start Initiative, 2006b).

Two Chicago Safe Start staff positions will receive continued funding through the CDPH's Office of Violence Prevention. The director of this CDPH office has been an important advocate for Chicago Safe Start and has successfully secured funding in the city's corporate budget for the CSS implementation and education coordinators. While their positions will not focus exclusively on children's exposure to violence, this issue will continue to be a major component of their efforts.

2. Challenges and Needed Improvements to the Chicago System of Care for Children Exposed to Violence

According to site visit (2006) participants, the Chicago system of care, as conceptualized by CSS, was intended to include more extensive involvement of various community partners, including the Department of Children and Family Services (DCFS), the Chicago public schools, and the substance abuse community. Participants attributed the limited participation of these entities to the fact that they are large, multi-layered systems. Within these large systems, establishing new protocols is a lengthy and involved process, which might have delayed Safe Start's implementation (Association for the Study and Development of Community, 2006b).

Site visit participants also indicated that a helpline dedicated to children exposed to violence might have aided the referral process, by encouraging community

members to seek help for children exposed to violence of all types (e.g., community violence, in addition to domestic violence). Participants could not state with certainty the number of community members potentially deterred from calling the Domestic Violence Helpline for general violence issues, but theorized that Safe Start referrals might have been higher with a phone line dedicated to children exposed to violence.

3. Summary of Accomplishments

Chicago Safe Start increased the likelihood that children exposed to violence would be identified and referred to trained service providers. By working collaboratively with community members, CSS built upon existing community resources and partnerships to 1) develop a service system infrastructure and 2) institutionalize new practices for a comprehensive, responsive system of care to meet the needs of young children exposed to violence and their families. Chicago Safe Start was particularly effective in developing a strong working relationship with the local police department. As a result of this strong relationship, police officers received a significant amount of training on how to respond when children might have been exposed to violence. Training increased the capacity of police officers to identify children, which resulted in almost 1,000 police-based referrals to Chicago Safe Start services.

Chicago Safe Start services reduced trauma symptoms in children (as reported by caregivers), increased knowledge of the impact of exposure to

violence on children, and increased capacity of caregivers to care for themselves and their children following exposure to violence.

Chicago Safe Start's impact on the community will continue as a result of institutionalization of policies and procedures. CSS was able to sustain funding for Safe Start services through the Illinois Violence Prevention

Authority and for two Safe Start staff positions through the Chicago Department of Public Health. In addition to securing funding, Chicago Safe Start was able to embed training and protocols within the local police department, Metropolitan Family Services, Family Focus, Head Start, and the Chicago Department of Public Health.

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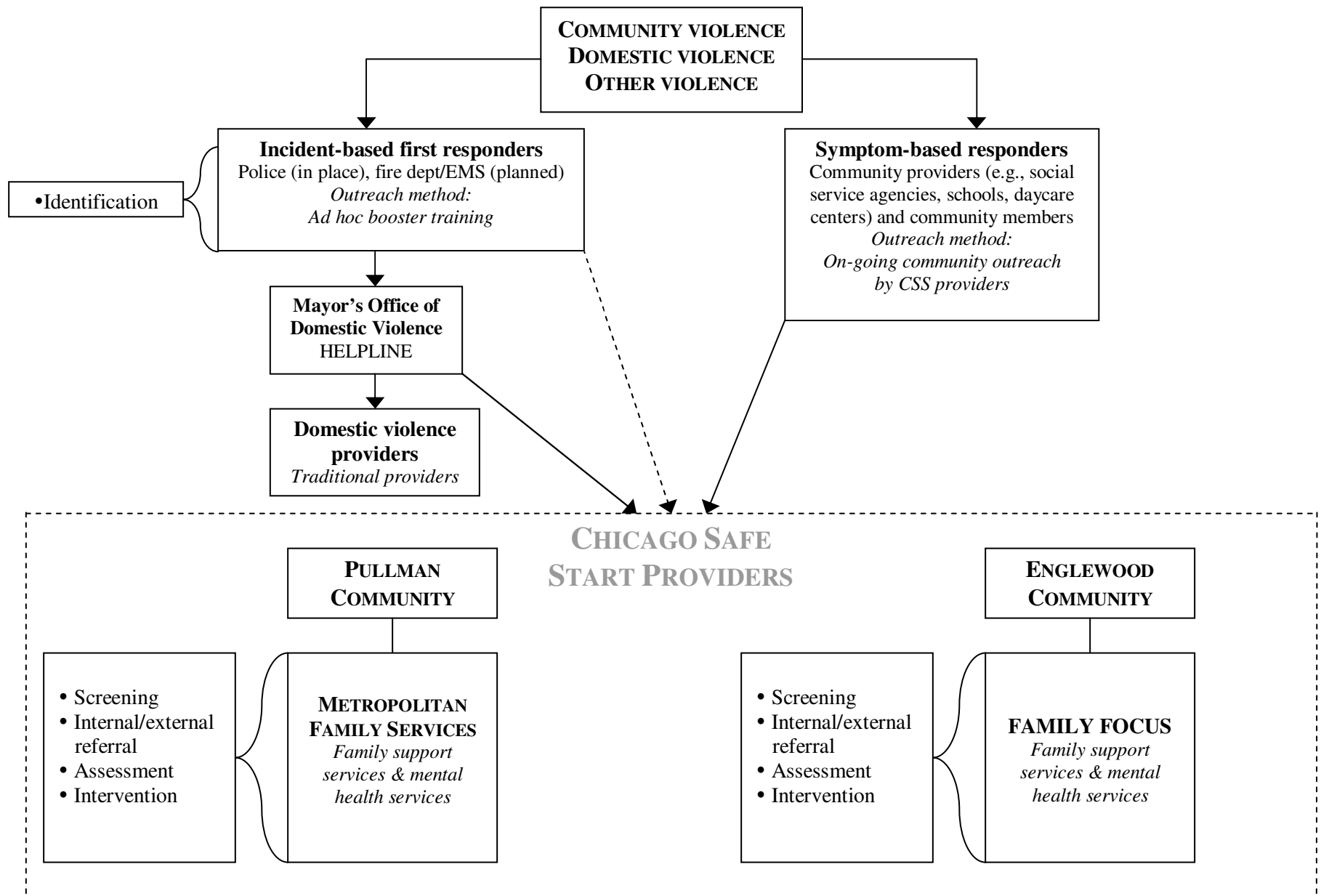
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Exhibit II

Chicago Safe Start System of Care for Children Exposed to Violence



III

Pinellas County, Florida, Safe Start Initiative

1. Overview of Pinellas County System of Care

Pinellas Safe Start's centerpiece is the Safe Start Partnership Center, a funded service delivery collaborative comprised of a lead agency (Help-A-Child) and four other subcontracted point-of-service providers (2-1-1 Tampa Bay Cares, The Haven, CASA, and Pinellas County Health Department; each is described in more detail in sections 1.2 and 1.3). During the Safe Start grant period, these five local agencies implemented policies and protocols for the identification of children exposed to violence and their families, as well as the referral of children and families to appropriate services, including Safe Start intensive family services provided by family advocates at Help-A-Child.

As another component of Pinellas Safe Start, Clearwater Police Department and Directions for Mental Health partnered to implement a modified Child Development-Community Policing program. Through this program, police officers responding to violent incidents document the presence of young children at the scene and have the option of making a referral (in which case a Directions for Mental Health clinician follows up with the family within 48 hours) or an immediate call (in which case the clinician responds to the scene immediately). Clinicians provide consenting

families with crisis intervention services, as well as referrals for any immediate or longer-term family needs, including longer-term therapy.

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

Safe Start resources also were used to bring an evidence-based therapeutic intervention appropriate for young children exposed to violence to clinicians in the community.

These new partnerships, policies, and practices were supported through training initially provided by Pinellas Safe Start and now sustained by the Juvenile Welfare Board (JWB), Pinellas Safe Start's lead agency.

Together, the Safe Start Partnership Center, the Child Development-Community Policing program, and Coordinated Child Care accomplished the following from May

2002 to November 2006 (Pinellas Safe Start, 2006a; 2006b):

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

Specific information about the type of violence exposure was documented for 441 of these children,¹ as follows (National Children Exposed to Violence Database):

- 42% of children witnessed (heard and/or saw) the violent event, but were not the intended victim;
- 6% of the children were physically injured as the intended victim of violence;
- 3% of the children were physically injured, but were not the intended victim; and
- For 4% of the children, service providers categorized the violent event as “other.” The most common type of event within the “other” category was sexual abuse.

Information about the effectiveness of Pinellas Safe Start services was obtained for a subset of families and children, by

¹ A Safe Start evaluation outcome database was created as part of the national evaluation. This database includes “exposure to violence” variables (e.g., type of exposure), but this information was not collected consistently across grantees or for all children assessed by Pinellas Safe Start service providers.

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

Discussed next in greater detail is each component of the Pinellas Safe Start system of care for children exposed to violence, along with the reason for its development. (See also Exhibit III.)

1.1 Safe Start Partnership Center: A Funded Service Delivery Collaborative and Centerpiece of the System of Care

A model for coordinating the professional community’s response to families with children exposed to violence or at risk of exposure, the Safe Start Partnership Center in Pinellas County builds the capacity of service providers to 1) identify children exposed to violence, 2) assess and prioritize the needs of these children and their families, and 3) connect families and children to services that best meet their needs in a sequence that makes sense to the family. The center was formed as a collaborative among service providers to create a single, central, visible agency for resources and services for children exposed to violence. The Safe Start Partnership Center is therefore central to Pinellas Safe Start’s development of a system of care for children exposed to violence.

The center's function and formation reflect deliberate decisions consistent with how the child and family services community conducts business in Pinellas County. The Juvenile Welfare Board developed a request for proposals for agencies interested in partnering with Safe Start, encouraging agencies to respond to the request as a collaboration. This process, typical of the way in which JWB funds organizations in the community, provided the initiative with a model for the creation of the Safe Start Partnership Center. A collaborative was a feasible structure because of the numerous service providers in Pinellas County accustomed to working collaboratively.

1.2 Multiple opportunities to identify children exposed to violence and refer them to appropriate services

The Safe Start Partnership Center developed collaborative interagency protocols for identifying and referring children exposed to violence. Each agency in the Safe Start Partnership Center began to identify children exposed to violence using existing intake/assessment forms and/or by adding relevant questions to existing forms. The following summarizes how children are identified and referred within each organization:

- The two domestic violence centers, CASA and The Haven, assume that all children six years and younger who enter shelters have been exposed or are at high risk of exposure to violence; therefore all children within this population are considered to be “identified” as exposed to violence. In addition, parents attending domestic violence support groups or other community outreach

activities are asked about children six years and younger; the support group sign-in sheet is designed with a space for parents to indicate the presence of children six years and younger in the home.

- The Pinellas County Health Department houses Healthy Families, a home-visiting initiative funded by JWB that comes in contact with thousands of families with young children (five years and younger) each year. Healthy Families staff gather and document various types of information (e.g., risk factors and service needs) during home visits; the forms used for documentation include a code for domestic violence and children’s exposure.
- If an initial request for information seems to indicate violence as a factor and involvement of children, phone counselors at the 2-1-1 Tampa Bay Cares helpline follow a protocol that includes questions about immediate safety issues. If domestic violence is a concern, counselors also refer the caller to domestic violence services and count the child as “identified” (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 refers to the Safe Start Partnership Center or to other community programs, based on family interest, location, etc. 2-1-1 Tampa Bay Cares was specifically invited to join the Safe Start Partnership Center because the agency was a recognized information and referral source within the community.
- Help-A-Child’s Child Protection Team reviews child abuse reports and tallies

indicators of domestic violence in the case at first report. At this point, the tally represents statistical information only, although the team sometimes makes recommendations to child protection investigators (i.e., sheriff's office), based strictly on record review. The team also flags cases for follow-up, including further exploration of domestic violence factors in the case and potential referral to or consultation with the Safe Start Partnership Center.

In addition to identification of children through Safe Start Partnership Center organizations, Clearwater police officers were trained to identify and document the presence of children at the scene of a violent incident. Officers may call a clinician (employed by Directions for Mental Health) to respond immediately to the scene of a violent incident, or may make a referral to the Child Development-Community Policing coordinator (also employed by Directions for Mental Health) to follow up with the family within 48 hours.

Coordinated Child Care's Safe Start consultant provides a final point of entry into services. To identify violence exposure, Coordinated Child Care added a question to its existing family needs questionnaire, used at intake, eligibility re-determination, or referral to special children's services. This question asks whether the child has experienced something potentially upsetting ("such as an auto accident or family violence"). When a family responds "yes," staff follows up to confirm violence exposure, and a voluntary referral is made to the Coordinated Child Care Safe Start consultant. Coordinated Child Care was engaged as a Safe Start partner because of

the large number of children this agency serves.

1.3 Assessment, enhanced services, and referrals to other services by family advocates, case managers, clinicians, and a child care consultant

In the Pinellas Safe Start system of care, family advocates and a case manager (employed by Help-A-Child) provide identified families with intensive and comprehensive crisis intervention services for six to 12 weeks. Referrals come from throughout the county (e.g., Safe Children Coalition, sheriff's office, police departments, child protective services, private citizens, schools), but most come from Safe Start partners and specifically the domestic violence centers. An administrative assistant refers all cases to the Safe Start case manager (Bachelor's level education), who contacts the family within 24 hours. An assessment of immediate needs is conducted over the phone and appropriate referrals are made. In some cases, Pinellas Safe Start may offer consultative services or specialized assessment for children's exposure to violence when another agency is the primary provider, and may participate in team conferences when other agencies are the lead. This collaboration with agencies outside of Safe Start is intended to reduce service duplication while also providing expertise and perspective on children exposed to violence when needed.

When Safe Start services are deemed appropriate for a referred family, the parent is seen within a week, to provide information about children's exposure to violence and Safe Start. During this meeting, parents are actively involved in determining

their immediate needs (e.g., housing, medical services, child care) and receive referrals to services to meet these needs. The need for clinical assessment is determined; if need is established, the Safe Start family advocate (Master's level education) engages with the family and starts the assessment process.

At the end of the assessment process, a family service plan is developed with service recommendations for the family. A three-month follow-up is conducted to ask parents about their ability to access resources and their satisfaction with services. The entire process is voluntary.

In the case of children identified through the Clearwater Child Development-Community Policing program, a clinician from Directions for Mental Health contacts identified families and provides brief intervention at the request of a police officer, if the parent consents. The intervention includes providing information about the effects of violence exposure on children, as well as referrals for any services the family may need, including longer-term therapy. For mental health services, families are referred to outpatient clinicians at Directions for Mental Health, an agency that specializes in early childhood trauma.

Clearwater police officers are not mandated to refer all violence incidents to the CD-CP coordinator, which results in an effective volume of referrals that emphasize quality over quantity; most referrals are made by community police officers. In all likelihood, additional clinicians and capacity at Directions for Mental Health would be required if officers were mandated to make a referral or immediate call-out in response to

the presence of children at any violent event to which they respond.

As a final entry point into services, Coordinated Child Care's Safe Start consultant receives referrals from early childhood education and care providers, as well as parents. The consultant assesses the family's needs, works with providers and parents to stabilize the child's behavior both in the classroom and at home, and makes referrals to other services as needed (e.g., therapy, housing, clothes, utilities, food, day care). The consultant typically works with 25 families per year.

Collectively, these services for children exposed to violence (i.e., services provided by the Safe Start case manager and family advocate, the CD-CP program, and the Coordinated Child Care Safe Start consultant) share the characteristics of providing a voluntary crisis intervention that 1) teaches adults to recognize that exposure to violence is an issue, 2) stabilizes the family and ensures safety, and 3) links the family to needed short-term and long-term services. Central to all of these services is relationship-building with families.

1.4 Mechanisms for building the capacity of service providers to respond appropriately to children exposed to violence and their families

The Pinellas grantee invested a portion of Safe Start funds in training clinicians to provide parent-child interaction therapy (PCIT), an evidence-based intervention appropriate for young children who have experienced trauma. Several clinicians were trained to provide PCIT early in the initiative. Over time, however, many of

these clinicians left the community, reopening the service gap that existed prior to Safe Start. More recently, a new strategy for institutionalizing knowledge within key organizations was adopted. Four clinicians with supervisory responsibilities in four different organizations (Help-A-Child/Safe Start Partnership Center, Directions for Mental Health, SunCoast Center for Community Mental Health, Family Services Center) received training to provide PCIT. These four supervisors, in turn, will train a core group of clinicians within their own organizations, with the dual goals of 1) creating an internal support system for use of the PCIT technique and 2) increasing the likelihood that PCIT expertise will remain within the organization and community over time. The Safe Start Partnership Center has become the training center for PCIT.

Additional Pinellas Safe Start training accomplishments include the following:

- **1,464** individuals participated in two- to three- hour workshops following the curriculum documented in the Pinellas Safe Start Trainer's Guide from July 2002 to June 2006 (Pinellas Safe Start, 2006a; 2006b).
- **59** agencies were represented at these workshops (Pinellas Safe Start, 2006a; 2006b).
- **6,572** individuals participated in 1) brief presentations on the Safe Start Partnership Center and children's exposure to violence, 2) domestic violence workshops enhanced with information about children exposed to violence, or 3) conferences or advanced trainings presented or sponsored by Pinellas Safe Start from July 2002 to 2005 (Pinellas Safe Start, 2006b).

2. Challenges and Needed Improvements to the Pinellas County System of Care for Children Exposed to Violence

Service providers described several challenges to creating a system of care for children exposed to violence, as well as improvements needed to make their system more comprehensive and responsive. To fully develop a system of care for children exposed to violence, additional stakeholder groups need to be more involved. In addition, all community members must be willing to speak up on behalf of children if they suspect exposure to violence (i.e., speak directly to the parent or speak to someone else, depending on the suspected situation). Finally, ensuring voluntary participation in Safe Start services remains a challenge.

Different organizational mandates and philosophical orientations limited the participation of certain stakeholders in Pinellas Safe Start. The following groups have been involved in planning and training components of the initiative, but have not established more in-depth partnerships with Safe Start:

- Safe Children Coalition (child welfare). Within the child welfare system, this coalition was created to develop a more coordinated response to domestic violence when children are present, a goal requiring significant consensus-building given the philosophical differences among stakeholders.² During

² These philosophical differences are discussed in more detail in last year's case study report

the seven years of the Safe Start grant, the child welfare system was reorganized twice, resulting in turnover that inhibited involvement in Pinellas Safe Start. Furthermore, the child welfare system has inadequate resources for its large volume of cases, leaving little room to dedicate resources (e.g., staff) to Safe Start.

- Law enforcement (e.g., Largo and St. Petersburg police departments). Developing partnerships between law enforcement and social services requires a considerable investment of resources to bridge the differences in culture and mandates. Moreover, Pinellas County has a number of different law enforcement agencies; developing one program (i.e., CD-CP) to respond to jurisdictions with varying policies and procedures is a challenge, as partnerships between police and mental health providers generally rely on protocols specific to jurisdictional context.
- Judicial system. Developing partnerships between courts and community services also requires considerable attention to bridging differences in culture and mandates. In addition, critics view the participation of judges in community coalitions as too close to advocacy and not in keeping with judicial ethics of impartiality. Judges' schedules present a further challenge, in terms of their attendance at community meetings. Finally, during the Safe Start grant period, the juvenile court in Pinellas County reorganized to become a unified

family court, in which judges rotate and change roles (i.e., they do not oversee juvenile or domestic violence cases, in a dedicated way, long enough to make effective Safe Start partners).

A final group of stakeholders, the faith community, remained relatively uninvolved in Pinellas Safe Start, possibly because meaningful roles for this group were not clearly defined. Increased involvement of all four of these groups is perceived as important to creating a comprehensive and seamless system of care throughout the county.

Ensuring voluntary participation in Safe Start services is central to developing a high-quality system of care for children exposed to violence, but was not always feasible. While a majority of families participated voluntarily in Pinellas Safe Start services,³ several site visit participants expressed concern regarding the minority of families referred as part of a child protective services case plan or dependency case court order. In situations such as these, families may not have perceived their participation in Safe Start services as genuinely voluntary. A central tenant of working with families experiencing violence is to protect them from further coercion, including systemic coercion in the form of mandating services as part of a plan to maintain parental rights. A high-quality system of care for children exposed to violence must be capable of providing parents the opportunity to

³ According to the Pinellas Safe Start project director, the Safe Start Partnership Center program coordinator has reported that more than half of referred families have been referred by the two domestic violence centers in Pinellas County and that families have participated in services on a completely voluntary basis.

(Association for the Study and Development of Community, 2006).

participate fully in decisions about what services and supports are most appropriate for meeting their family's needs.

Developing and maintaining the system of care's capacity to provide appropriate services at sufficient scale is challenging.

As discussed above, several clinicians were trained to provide PCIT early in the initiative. Over time, many of these clinicians left the community, reopening the service gap that existed prior to Safe Start. While a new strategy for institutionalizing knowledge of the PCIT technique has been implemented, some site visit participants expressed concern that available services are still inadequate to meet the community's need. As an additional example, Directions for Mental Health providers are trained to offer child-parent psychotherapy (CPT), another evidence-based model for trauma intervention with young children; however, this agency remains the only one in the county with the capacity to provide CPT. Both PCIT and CPT are relatively new models, require a lot of training, and are not available to many families outside of San Francisco, California.⁴ New models such as these may require time to establish themselves in a community and may require periodic "boosters" to sustain.

Some site visit participants also expressed concern that assessment and referral services have become synonymous with meeting the needs of families. Instead, these participants believe, families need less assessment and more case work/case management. Longer-term services typically require more resources, however, and can be difficult to

⁴ One of the developers of these trauma interventions, Dr. Patricia Van Horn, works in San Francisco where most of those trained to offer the model are located.

sustain even if initial resources can be found (as in the example of PCIT).

Direct service providers often lack a systems perspective, which may limit the system of care's capacity to provide needed services. Some direct service providers who participated in the site visit described their services as duplicating those of other providers. Furthermore, all direct service providers expressed the belief that resources would be better spent by increasing funding to their particular agencies (i.e., rather than also funding services seen as duplicative), to provide services to more children and families. What this perspective lacks is the recognition that service overlap and/or duplication may be necessary, given the relative lack of services for children exposed to violence. Particularly in an area the size of Pinellas County, having Safe Start services available in a variety of organizations located throughout the county is important to ensure access to services for all families in need. Alternatively, if services are not, in fact, duplicative, referrals to appropriate services may not be occurring.

Instilling a systems perspective, or even a more fundamental understanding of the similarities and differences among services appropriate for children exposed to violence, requires continuous education and training efforts. These efforts require resources. A related challenge to the system of care, therefore, is achieving balance between investing resources in educating service providers about the system and training them to provide needed services.

Keeping the Juvenile Welfare Board informed about Safe Start—just one of many programs funded by JWB—in a mutually beneficial manner was not a

straightforward process. Over the course of six years that included turnover in the JWB board of directors, shifts in priority areas, and realignment of departments, determining which and how much Safe Start information to share with the Juvenile Welfare Board was at times challenging. For example, at least two site visit participants stated that, in retrospect, they would have approached the Juvenile Welfare Board earlier for funding allocations, given the amount of information-sharing that was required to obtain fiscal support of key Safe Start services. According to other participants, data obtained early in the initiative was not used with the Juvenile Welfare Board as effectively as it might have been to demonstrate progress and impact. New initiatives, therefore, should give thought to how, when, and how much information to share with potential funders and decision makers over the life of a project.

The CD-CP program has not expanded to other law enforcement jurisdictions in Pinellas County, primarily due to philosophical and fiscal barriers.

Jurisdictions other than Clearwater may be less oriented toward providing families with services. In addition, Pinellas County's social service network currently does not have the capacity to respond to a county-wide CD-CP program.

3. Summary of Accomplishments

Pinellas Safe Start accomplished several goals, including raising community awareness of children's exposure to violence by increasing discussion and understanding of the issue and training large numbers of

service provider staff on how to respond. The following describes additional accomplishments in Pinellas County.

Several organizations regularly screen children for exposure to violence in Pinellas County. Children exposed to violence in Pinellas County are most typically identified by members of the Safe Start Partnership Center, in particular, the domestic violence agency partners (personal communication with Pinellas Safe Start project director; January 8, 2007). Law enforcement officials also are an important point of entry into the system for children exposed to violence, with officers of the Clearwater Police Department selectively referring children and their families to mental health clinicians. Finally, screening for violence exposure among children in day care settings, particularly children exhibiting behavioral problems, is an effective way to identify children exposed to violence.

Services appropriate for children exposed to violence and their families are available in Pinellas County. Coordinated, holistic services offered in convenient locations effectively engage Pinellas County families. Family advocates, for example, partner with case managers to connect with families quickly and assess all family needs; families determine the order in which clinical and non-clinical needs will be met. Assessment and treatment offered as part of the intensive family services component of Pinellas Safe Start occur largely in families' homes. Mental health clinicians, partnered with police officers, provide consenting families with crisis counseling at the scene of a violent event. The Coordinated Child Care Safe Start consultant provides assessment and intervention services to families in the child care setting or at home.

The system of care for children exposed to violence established by Pinellas Safe Start continues to be supported by the Juvenile Welfare Board. Pinellas Safe Start services continue through local support from the Juvenile Welfare Board (Pinellas Safe Start, 2006a; 2006c). Policies and policy advocacy for children exposed to violence have been established and will continue, along with training on the impact of children's exposure to violence and public awareness and community education activities (Pinellas Safe Start, 2006a; 2006c).

Pinellas Safe Start's accomplishments inform the field in several ways. First, multiple sectors that serve families with young children experiencing violence or at high risk of violence exposure can successfully identify families in need and

help these families access services; to do so, local agencies and organizations must develop and implement identification and referral protocols for children's exposure to violence (Pinellas Safe Start, 2006a, p.4). Second, integrated service delivery designed for the convenience of families facilitates participation in recommended interventions and treatment. Third, investing resources in interventions proven to be effective with young children exposed to violence and their families increases the quality of services available to this population. Finally, families experiencing violence typically require a range of support services, including but not limited to therapeutic services, and need to participate fully in decisions about what services and supports are most appropriate for meeting their needs.

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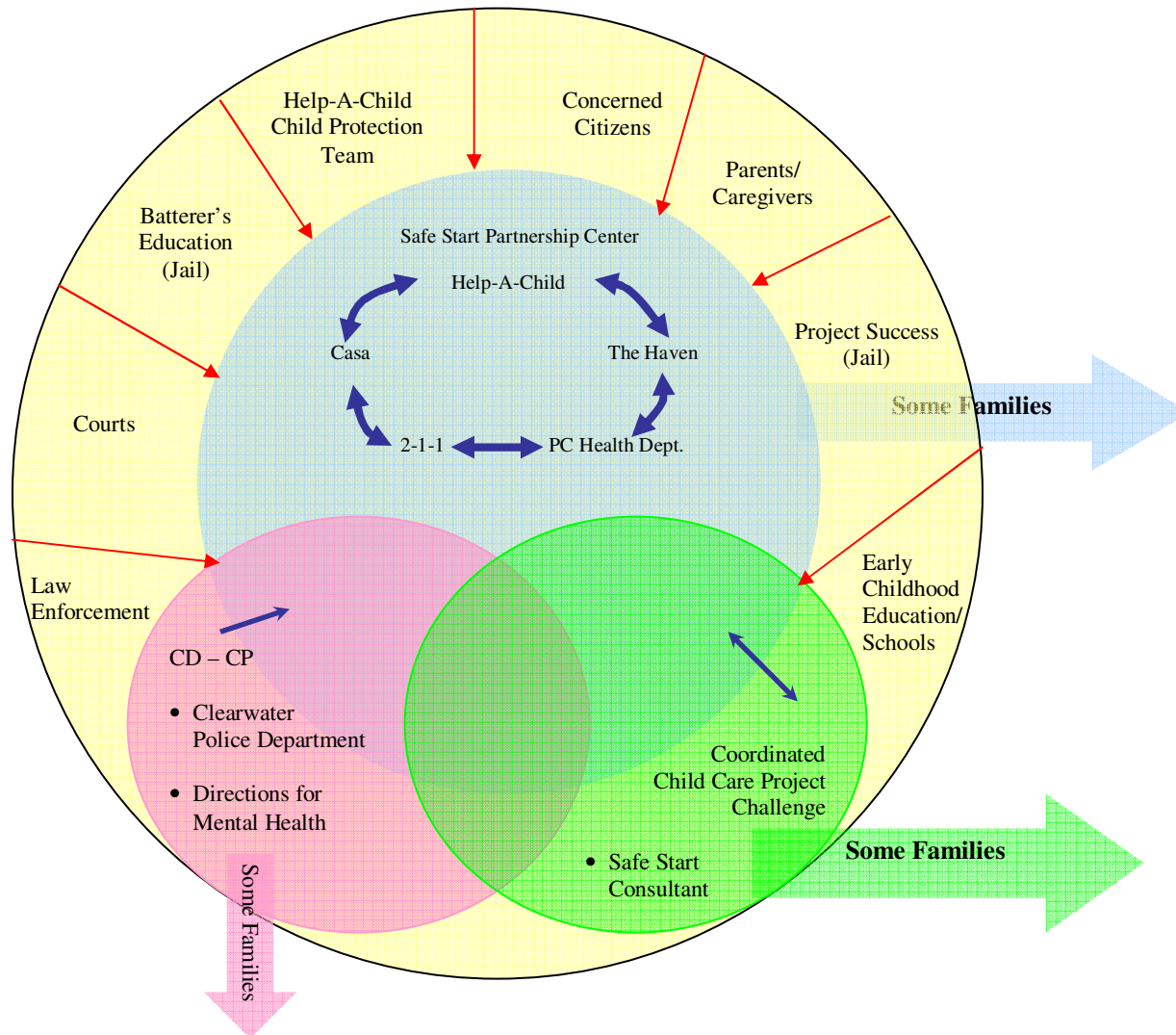
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Exhibit III

Pinellas Safe Start System of Care for Children Exposed to Violence



Red Arrows: All families with children exposed to violence
Blue Arrows: Referrals

Intensive Family Services (Help-A-Child)

- Crisis counseling
- Comprehensive family assessment
- Parent-child observations
- Weekly home visits
- Support services for parents
- Family plan assistance
- Resource referral and service coordination
- Multi-disciplinary team, if needed

Average 12-16 weeks of intensive services
 90 day follow-up

Coordinated Child Care Project Challenge

- Behavioral and developmental screening
- Observation of child in child care setting
- Monthly home visits
- Support services for parents
- Consultation with child care providers to maintain the child in care
- Therapeutic child care, if needed
- Behavior management and developmental activities for parent and child care provider
- Resource referral and service coordination

Average 12-16 months of service

Child Development-Community Policing

- Crisis counseling/support
- Consultation
- Provision of information to parents about impact of violence exposure
- Referrals to mental health services

IV

Pueblo of Zuni, New Mexico, Safe Start Initiative

1. Overview of Pueblo of Zuni System of Care

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

- Pueblo of Zuni Education Career Development Center/Temporary Assistance for Needy Families/General Assistance (5 referrals);
- Pueblo of Zuni Tribal Court (4);
- Pueblo of Zuni Tribal Social Services (4);
- Pueblo of Zuni Police Department (3);
- New Beginning (domestic violence shelter; 3);
- Pueblo of Zuni Public Schools, including Head Start (1);
- Zuni Entrepreneurial Enterprise (0);
- Zuni Recovery Center (0); and
- Indian Health Services Mental Health Services (0).

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

During the grant period, Zuni Safe Start accessed national technical assistance and used the knowledge acquired to provide local trainings and presentations about the impact of exposure to violence

¹ ZEE is a nonprofit 501(c)3 organization that provides services in the pueblo and elsewhere in southern McKinley County. ZEE assists children three years and younger at risk for or suffering development delays as a result of birth defects, premature birth, or maternal substance abuse.

on young children. The family service coordinator continues to provide presentations on the impact of exposure to violence on young children, but no one is currently accessing national technical assistance on children's exposure to violence.

Discussed next in greater detail is each component of the Zuni Safe Start system of care for children exposed to violence, along with the reason for its development. (See also Exhibit IV.)

1.1 Multiple opportunities to identify children exposed to violence and refer them to appropriate services

While Zuni Safe Start has a standard referral form available for agencies to use, many service providers use their own identification/referral process. For instance, an agency may add a question about children's exposure to violence to existing intake forms, or may make a referral to Safe Start based upon observation of a family (e.g., a social services representative may make a referral if he/she works with a family experiencing domestic violence, and young children are present). When referring children to Zuni Safe Start services, the police department uses the standard referral form.

During the Safe Start grant period, tribal judges changed their practices related to domestic violence cases by mandating that victims participate in a Zuni Safe Start intake process within 48 hours of arraignment. Similarly, the Family Preservation Program² representative mandates that her court-ordered clients

² The Family Preservation Program is part of Pueblo of Zuni Tribal Social Services.

attend Zuni Safe Start presentations to learn more about the impact of violence exposure on children. Finally, the Temporary Assistance for Needy Families coordinator incorporated domestic violence into the agency's eligibility screening, such that families experiencing violence must participate in Zuni Safe Start services to qualify for benefits.

In addition to new screening and referral procedures, Zuni Safe Start staff developed a domestic violence response protocol for police, victim advocates, and the Zuni Safe Start family services coordinator. Under this protocol, police officers responding to a domestic violence call are expected to ask about the presence of children and record the ages and names of any children present; however, according to information obtained during 2005 site visits, not all police officers followed this protocol. The protocol states that children exposed to violence should be referred to Safe Start for services, but does not specify the services to be provided.

1.2 Assessment, counseling, and referrals to other services by the Zuni Safe Start family services coordinator

After the Zuni Safe Start family services coordinator receives a referral, she contacts the family to schedule an intake assessment, identify other needs (e.g., food, clothing, housing, employment), and explain options for help available to the family and children. According to the family services coordinator, approximately 75% of families agree to services. If the family refuses Zuni Safe Start services, the family services coordinator completes a referral acknowledgement form to inform the

referring agency that the family refused services.

If the family agrees to Safe Start services, the family services coordinator completes the intake form, conducts an assessment with the family (using the Traumatic Events Screening Inventory), and completes a linkage form. The linkage form, coupled with the assessment, allows the family services coordinator to refer families to Zuni Safe Start partner agencies for services including, but not limited to, housing and general assistance. If the child has other needs (e.g., health needs) the family services coordinator refers the child to the appropriate partner agency. Likewise, if the child has severe mental health needs, the child is referred to a clinical psychologist with Indian Health Services. All families who elect to receive Zuni Safe Start services are seen by the family services coordinator.

The family services coordinator also facilitates support groups to assist domestic violence survivors and their children and help bridge communication gaps between children and parents; she is expected to serve in this capacity until a licensed psychologist specializing in early childhood trauma is hired. She has adapted the *In My House Prevention* curriculum by Change Companies to help children express their feelings and develop their character in accordance with Zuni cultural traditions. While there are no prescribed number of sessions in which children or adults participate, children five years and younger typically receive one session a week for three months. Children six years and older, depending upon their comfort level, may receive more sessions. Case notes are kept on each child, but child

improvement outcomes are not measured.

The family services coordinator worked with approximately 50 children in 2005 (Association for the Study and Development of Community, 2006a). In 2006, the family services coordinator conducted 421 home visits, 27 office sessions, 210 group sessions (with caregivers), and ten call-outs³ (Pueblo of Zuni Safe Start Initiative, 2006).

Zuni Safe Start is well-respected within the community because it provides holistic, culturally sensitive services to clients (Association for the Study and Development of Community, 2006a, 2006b). For instance, during the 2006 site visit, community members stated that Zuni Safe Start not only provides services to help families cope with children's exposure to violence, but also addresses basic needs such as heating, housing, and food. Some of the 2006 site visit participants mentioned that the family services coordinator works with teachers to identify potential mental health problems. For instance, if a teacher has concerns about a student, the teacher speaks with the school counselor; if exposure to violence is identified, the school counselor then works with the family services coordinator to help the child. According to several 2006 site visit participants, Zuni Safe Start has raised the bar with regard to service delivery, increasing consumer expectations of other agencies in the community.

³ A call-out refers to responding to the scene of an incident with a police officer.

1.3 National training and technical assistance opportunities that built the capacity of service providers

From its inception, Zuni Safe Start 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, the National Council of Juvenile and Family Court Judges, the National Civic League, Systems Improvement Training and Technical Assistance Project, and the Institute of Community Peace. These organizations worked with service providers in Zuni to increase knowledge of 1) the issue of children's exposure to violence, 2) effective responses to this population of children, and 3) how to coordinate efforts to meet the needs of children exposed to violence more comprehensively and responsively. Zuni Safe Start staff, in turn, have made several presentations to professionals (e.g., police officers, Head Start teachers), thereby spreading knowledge of the impact of children's exposure to violence.

2. Challenges and Needed Improvement to the Pueblo of Zuni System of Care for Children Exposed to Violence

While Zuni Safe Start established important procedures and protocols for identifying, referring, and responding to children exposed to violence and their families, the initiative faced several challenges in developing a full continuum of care.

The tribal community has relatively limited professional resources, making the system of care especially vulnerable to staff turnover and departures from the community. Several Zuni Safe Start experiences illustrate this point. First, leadership and staff turnover within partner organizations impacted Zuni Safe Start's implementation. From 2003 to 2005, turnover occurred in the Division of Public Safety, the Zuni Police Department, New Beginnings, the Division of Human Services, and the Pueblo of Zuni Tribal Social Services. Consequently, the location of the initiative changed several times; the Zuni Safe Start project director, over the course of this period, reported to eight different supervisors; and the initiative eventually evolved into a stand-alone program, rather than a program within social services.

Changes within the Zuni Police Department had particularly significant negative consequences for the implementation of a key component of Zuni Safe Start. The original system of care was designed to include an adaptation of the Child Development-Community Policing program. When Zuni Safe Start began, the police chief was supportive of CD-CP, and Zuni police officers were sent to Yale University to receive training on the program. This investment of resources, however, was compromised when the supportive police chief left the department. The current police chief is not as involved in Safe Start, and most of the officers who received CD-CP program training have since left the department. As a result, the current system of care includes some police officers who are aware of Zuni Safe Start and refer to the family services

coordinator, but not all of Zuni's 15 police officers make referrals or are fully trained in CD-CP. Members of the police department reported during the 2006 site visit that more and continued training in CD-CP would provide them with the necessary knowledge of how to respond when a child has been exposed to violence.

Another programmatic challenge has been recruiting and retaining a full-time, trained, culturally competent mental health professional. Due to the lack of mental health professionals in the Zuni area, the system of care has not systematically included a full-time trained mental health clinician; Zuni Safe Start does have an on-call licensed clinical psychologist. The Zuni Tribal Council is exploring strategies to recruit additional trained mental health professional to create seamless access to mental health services within the system of care.

Finally, limited financial resources challenge sustainability. All of the 2006 site visit participants stated that a lack of continued federal funding will negatively affect Zuni Safe Start's institutionalization within the community. Participants expressed concern that Zuni Safe Start might not continue without OJJDP funding; other tribal programs might not be able to absorb Zuni Safe Start service and activities because of the limited nature of resources within the tribal community.

Coordination and communication among service providers is largely dependent on the efforts of one individual: the Zuni Safe Start family services coordinator. Site visit (2006) participants reported that Zuni Safe Start

attempted to establish a foundation of collaboration among community partners, but failed to capitalize on that foundation and has continued to lack strong partner collaboration. For instance, in 2004, Zuni Safe Start was successful in establishing a memorandum of agreement between Safe Start and Zuni Entrepreneurial Enterprises, to increase mutual referrals; to date, however, ZEE has not received or made] any referrals from or to Safe Start. Zuni Safe Start and social services also have struggled to collaborate to address children's exposure to violence, for example, with regard to informing each other of their respective work. This lack of communication has limited the identification and treatment of children exposed to violence. Communication among referring organizations remains almost entirely dependent upon the Zuni Safe Start family services coordinator (e.g., through use of the referral acknowledgement form and the linkage form). After federal funding for Safe Start ends, therefore, the coordinated response to children's exposure to violence in Zuni may be lost, unless agencies institute new policies to communicate more effectively.

In sum, site visit (2006) participants identified several needed improvements to the current system of care for children exposed to violence, including increased partner collaboration and data sharing among agencies. Some participants would like to see agencies that work with families share their case notes and any other information that may impact a particular family. Other participants would like agencies to use a standard referral form and protocol, which may lead to better communication among agencies. Two participants stated that a

permanent, central location for Zuni Safe Start would facilitate families' access to services. Finally, site visit participants stated that despite increased awareness among some community members, the community as a whole continues to deny the occurrence of domestic violence. Participants mentioned the need for more awareness work to continue to increase the number of community members who acknowledge domestic violence and its impact; community members with awareness may be more likely to seek services than individuals who remain in denial.

3. Summary of Accomplishments

Prior to Zuni Safe Start, the Pueblo of Zuni did not have a system in place to address children's exposure to violence. Zuni Safe Start worked diligently to establish a system of care responsive to the needs of children exposed to violence and their families, and helped lay a foundation of collaboration among referring agencies by establishing referral procedures (Association for the Study and Development of Community, 2006b). Through Zuni Safe Start, children exposed to violence and their families have access to a family services coordinator who provides assessment, intervention, and referral services.

The most promising indicator of Zuni Safe Start's institutionalization within the community is the Zuni Tribal Council's adoption of a revised Children's Code in 2006. The revised code incorporates language on children's exposure to violence, to emphasize the impact of violence on children's development. The code will help guide

current and future tribal programs as they relate to children. Under the direction of a committee headed by the former Safe Start project director, the Zuni Criminal Code also is being revised to promote stronger enforcement of existing criminal laws recognizing the importance of children's exposure to violence; after being elected head tribal councilwoman in late 2006,⁴ the project director stepped down from her position with Safe Start, but, through her new position, will continue to advocate for children exposed to violence and their families.

Finally, several participants in Zuni Safe Start consider its greatest accomplishments to be increasing awareness and establishing a foundation of collaboration. Prior to Zuni Safe Start, there was great shame associated with domestic violence and little open recognition of its existence. While domestic violence continues to be prevalent in Zuni, some community members now acknowledge its existence more openly, have greater knowledge of its impact on children, and are more aware of where to seek services and resources to address the problem and help their children.

⁴ This is the first time in the Pueblo of Zuni's history that a woman has been elected head of the tribal council.

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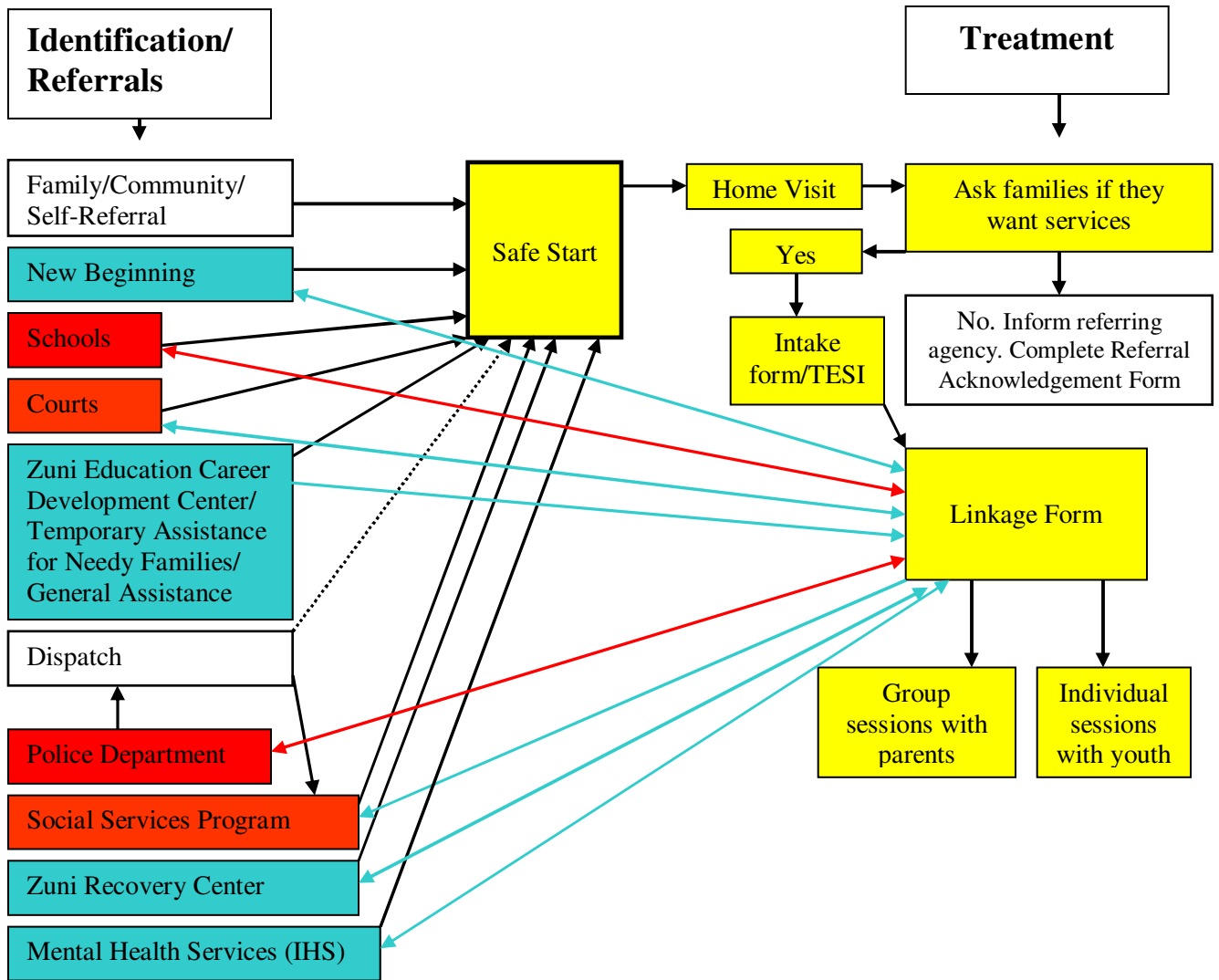
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Exhibit IV

**The Pueblo of Zuni Safe Start
System of Care for Children Exposed to Violence**



Key: Red-shaded boxes represent agencies to which Safe Start provides feedback; blue represents agencies that refer to Safe Start and receive feedback from Safe Start; and yellow represents the pathway of the Safe Start family services coordinator.

V

Rochester, New York, Safe Start Initiative

1. Overview of Rochester System of Care

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

1. A media campaign aimed at changing community norms and attitudes related to the impact of violence on children was implemented as a universal intervention. To increase campaign penetration throughout the population (e.g., among illiterate residents, residents with limited English language proficiency, or residents who do not receive publications used in the campaign), Rochester Safe Start paired the campaign with an outreach coordinator. This intervention is

2. discussed in more detail in last year's case study (Association for the Study and Development of Community, 2006a) and will not be discussed further in this case study.¹

3. The Early Childhood Mentoring Project is a second universal intervention, designed to provide early intervention to all children, including those who may be exposed to violence. Through the project, teachers and other adults in early childhood classrooms and child care settings receive coaching to recognize that difficult child behaviors may be caused by exposure to violence. A mentor manual describes procedures, roles, policies, and continuous training for mentors to help teachers adopt strategies and develop and implement action plans that support children exposed to violence.

4. The Safe Kids program² is a partnership between police and social workers designed to provide

¹ The primary focus of this final case study is the formal system of care established for children exposed to violence.

² Safe Kids is an adaptation of the Child Development-Community Policing program.

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

5. The Children in Courts program provides families with advocates who understand the impact of exposure to violence on children. These advocates not only provide legal assistance, but also can arrange for quality child care during court proceedings, as well as supervised visitation between non-custodial parents and children when appropriate.

6. The Mount Hope Family Center provides specialized mental health services to abused and neglected children placed in foster care. Clinicians at Mount Hope assess the child and offer consultation to the foster family, child care provider, and/or other caretakers. When necessary, the child receives intensive therapy.

7. The Rochester Safe Start training initiative, designed for a range of

³ The 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.

people who serve children and families, provides information on the effects of violence exposure and how to help exposed children. Mental health professionals receive specialized training on the latest therapeutic approaches, including assessment techniques and group and individual therapy. This essential capacity-building mechanism will continue through courses and training offered by the Children's Institute.

Through these interventions, 1,263 children exposed to violence were identified, assessed, and referred to support services from 2003 to 2005 (Association for the Study and Development of Community, 2006).

Discussed next in greater detail is each of these components of the RSS system of care for children exposed to violence, along with the reason for its development. (See also Exhibit V.)

1.2 Community capacity to screen for children exposed to violence

To more reliably screen for children's exposure to violence, RSS, in collaboration with Bridgeport Safe Start, developed a screening tool. As one of the first measures developed to screen for children's exposure to violence, this tool has the potential to have long-range impact on the field. In addition to development of this screening tool, screening questions have been incorporated into the Parent Appraisal of Children's Experiences (PACE), a form completed by the parents of all incoming kindergarteners in the Rochester City School District.

To infuse a focus on children into the service delivery and justice systems, RSS collaborated with the Domestic Violence Consortium to develop and institutionalize protocols that detail how to address children exposed to violence. Protocols for the county courts describe how to handle cases of domestic violence. Protocols for service providers detail how to screen, assess, treat, and refer children exposed to violence. RSS staff 1) participated in protocol development to ensure that children's needs were addressed, 2) trained court staff and service providers on the protocols, and 3) helped obtain buy-in for use of the protocols.

1.3 Two interventions to identify children exposed to violence early and provide appropriate support

Rochester Safe Start implemented the Early Childhood Mentoring Project to build the capacity of early childhood educators and care providers. This project funded mentors to support and assist early childhood teachers to 1) adopt strategies and develop and implement action plans that support children exposed to violence, 2) improve their observation skills, and 3) increase their knowledge and use of resources. To achieve these goals, mentors provided teachers with educational materials and other resources on the behavioral signs that can indicate exposure to violence, consulted with them on issues such as classroom setup, observed child and adult behavior in the classroom, provided insight on child-parent interactions in the classroom, took teachers on guided observations of model classrooms, and modeled effective strategies and techniques. Additionally, mentors encouraged

teachers to suggest referral services to parents or personally refer children to appropriate service providers. In addition to observing child behavior, teachers and mentors identified children exposed to violence through a brief survey that parents were asked to complete.

Mentoring procedures were operationalized in a manual, and the project was evaluated using a randomized clinical trial design. As compared to children in classrooms without mentors, children in classrooms with mentors demonstrated more positive growth in their cognitive, social, and physical functioning. This difference between groups of children was statistically significant (Rochester Safe Start Initiative, 2005, p. 53).

Although mentoring as a Safe Start project ended on December 31, 2005, the focus on the early childhood community at the Children's Institute has continued, with the goal of ensuring that professionals in early childhood education continue to be equipped with the skills and guidance to address a range of issues, including children's exposure to violence. Mentoring continued in 2006 with the support of an Early Education Professional Development grant, funded by the U.S. Department of Education. This funding ends in May 2007.

Mentoring also will continue through the Center-Wide Coaching Project, funded by the United Way until 2009. The coaching project is designed to improve the quality of care for children and increase the capacity and operations of five child care centers in Rochester. This effort maintains a focus on issues of

children's exposure to violence and serves each child care center in a holistic way, providing coaches for each center's director, teachers, teaching assistants, education coordinators, and other individuals in the system in need of coaching.

Several mentors who received Safe Start training continue to work in the field of early childhood education and in child care centers. Likewise, Children's Institute continues to partner with 20 urban child care centers, working with these providers on a variety of early education programs.

The Early Childhood Mentoring Project acted as a springboard for mentoring throughout the community. Mentors are now leaders in the early childhood community and are involved in state-wide conferences and trainings for non-clinical practitioners. Moreover, the community of Rochester now has trained early childhood experts, some of whom are practitioners and can return to classrooms or work with community-based organizations and local child care centers.

In Rochester, the early childhood system has contact with children three to five years of age. By the age of four, 70% to 80% of children are in child care (Rochester Safe Start Initiative, 2005). This high level of contact between the early childhood system and the young children of Rochester provided the rationale for educating early childhood teachers and child care providers to identify and appropriately support children exposed to violence; Rochester Safe Start reasoned that the capacity to support children exposed to violence could be most effectively built and sustained through such training. In

addition, the Early Childhood Mentoring Project was a natural fit with the Rochester Early Enhancement Project (REEP),⁴ a project of the Children's Institute that helped to create connections between the early childhood community and parents from the prenatal period.

Safe Kids was developed to connect children at the scene of violence to appropriate services. Rochester Safe Start funded Safe Kids to ensure regular follow-up on cases of intimate partner violence and to encourage a focus on children at the scene of a crisis. Safe Kids provided services to families through a partnership between police and social workers (employed by the Society for the Protection and Care of Children) acting on behalf of young children exposed to violence in the community or home. Under the Safe Kids protocol, Rochester police identified exposed children when called to the scene of violence, and referred these children to the SPCC for assessment and treatment. Safe Kids reached 305 children from April 2002 to February 2004, increasing the proportion of Rochester children exposed to violence who received referrals for assessment and treatment. Social workers from SPCC had contact with

⁴ The Rochester Early Enhancement Project, a partnership to support families' involvement in their young children's growth and development, consists of agencies that serve young children (e.g., family resource centers, school district, children's hospital), families, and the community. The Children's Institute is the lead agency responsible for the financial management, coordination, resource development, and evaluation of REEP. This description of REEP was taken from the Children' Institute website: <http://www.childrensinstitute.net/community/REEP/>.

119 of these children, 84 of whom were classified as receiving the “highest” level of service delivery (Rochester Safe Start Initiative, 2005, p. 47).

Although Safe Kids will not continue as originally designed, and a formal memorandum of agreement will no longer exist, the relationship between police and SPCC is continuing. The police will continue to call SPCC on behalf of children exposed to violence, and SPCC will continue to serve these children, usually within 24 hours. Police officers have increased awareness of children at the scene of a crime and of issues related to exposure to violence, and SPCC staff members have increased awareness of the challenges that police face.

Safe Kids provided an important system enhancement because the existing Rochester Police Department’s Family Crisis Intervention Team (FACIT) has only short-term involvement with families. In addition, FACIT responds to 1) a range of individuals in crisis, including those needing to notify next of kin of deceased, seriously injured, or seriously ill persons and 2) a range of situations, including homicides, fatal fires, fatal accidents, bank robberies, and other traumatic occurrences. Safe Kids, on the other hand, focused primarily on protecting children’s safety in the context of community and family violence.

1.4 Targeted interventions provided by court advocates and clinicians

Rochester Safe Start developed two interventions, located within the court system and the foster care system, for

children known to be exposed to violence.

The Children in Courts program provided children exposed to violence and their families with advocacy and intervention services. Alternatives for Battered Women (ABW) and the Society for the Protection and Care of Children, the two providers in Rochester that 2006 site visit participants identified as having the greatest capacity to work for systems change, collaborated to improve attention to children’s issues and supervised visitation processes through the Children in Courts intervention. To ensure that children’s needs (e.g., mental health needs, safety needs) were met and that issues of children’s exposure to violence were considered in Integrated Domestic Violence Court⁵ and Domestic Violence Intensive Intervention Court,⁶ ABW provided a child advocate. To improve family adjustment and reduce children’s anxiety related to long waiting times between a domestic violence incident and visitation with the offending parent, SPCC implemented Fast-Track Supervised Visitation, a program to provide expedited supervised visitation with the non-custodial parent for families experiencing domestic violence with a risk of physical danger to children.

Children in Courts increased the expertise of domestic violence advocates

⁵ Integrated Domestic Violence Court serves families with cases pending in both family court and criminal court.

⁶ Domestic Violence Intensive Intervention Court is a special branch of family court 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.

related to children exposed to violence and expanded supervised visitation available in both Domestic Violence Intensive Intervention Court and Integrated Domestic Violence Court. The ABW Child Advocate Project served 574 families with children six years and younger from May 2003 to October 2004; these families had 801 children six years and younger and 386 children older than six. Fast-Track Supervised Visitation received referrals for 53 families; 48 families accepted the referral and received supervised visits. Within these 48 families, 96 parents and approximately 70 children were served (Rochester Safe Start Initiative, 2005, p. 47), and the average wait for service was one to two weeks, as opposed to six months in the general supervised visitation program.

The dedicated child advocate is no longer in court (Rochester Safe Start Initiative, 2005, p. 47). The focus of Rochester Safe Start was to ensure that all court advocates developed some awareness of children exposed to violence; therefore, the advocate project ended in 2005 because a separate child advocate was no longer considered necessary. Funding for Fast-Track Supervised Visitation ended in February 2007, and the program will not continue. Despite concerted efforts by the Society for the Protection and Care of Children to generate referrals from judges, judges did not refer enough families to fill both a “treatment” group and a “control” group for controlled evaluation of the project. Evaluation of this project, therefore, will include a description of the children in the treatment group and a discussion of external environmental circumstances that affected the project's

research design. The evaluation is scheduled to be completed in May 2007.

Several changes to the court system will be sustained:

- The Domestic Violence Intensive Intervention Court waiting room will continue to show a video that describes the court process. Rochester Safe Start sponsored creation of this video in response to an evaluation of the court, which indicated that families feel intimidated by the court process and need an orientation to feel more comfortable. A Spanish language version of the video is being produced.
- Issues of children’s exposure to violence will continue to be presented via *Babies Can’t Wait*,⁷ an educational program that reaches hundreds of lawyers via video conference in six counties in New York. *Babies Can’t Wait* lessons are videotaped and made available online within the court system intranet, which is accessed by 16,600 court employees in 62 counties across the state.

In addition, during the Safe Start grant period, Domestic Violence Intensive Intervention Court developed a relationship with the University of

⁷ *Babies Can’t Wait*, funded by the Robert Wood Johnson Foundation, is a cross-system collaborative approach to disseminate knowledge from courts, child welfare, service providers, and child advocates in support of the wellbeing of children in the welfare system. The program hosts a court-based series to educate professionals about the medical, developmental, and emotional needs of young children in foster care.

Rochester Medical Center to offer mental health screening and assessment to court-involved families. Upon entry into the court system, the entire family is assessed to determine whether the domestic violence experience has negatively impacted the family's mental health. This process increases awareness of mental health needs, to facilitate connecting families to appropriate services. As a component of this collaboration, the National Institute for Mental Health funded the University of Rochester to place a mental health professional in the court to help with issues of trauma and stress. Although Rochester Safe Start was not directly involved in this partnership, Safe Start helped the courts develop a relationship with the university by supporting cross-training of court and university staff.

The Mount Hope Foster Care Intervention provides specialized mental health services for children in foster care. Through this intervention, young children in foster care received ready access to rapid assessment; contextual assessment (i.e., observing and analyzing behaviors in different settings to understand differential symptoms); consultation for the foster care worker, foster parents, and biological parents; and child therapy. From April 2002 to April 2004, the intervention served 101 young children in foster care (Rochester Safe Start Initiative, 2005, p. 36). Rochester Safe Start played an important role in providing bridge funding for the program, until Mount Hope was able to find a more stable and long-term source of money (i.e., the United Way) to sustain the intervention as part of the Foster Care Pediatric Clinic. Evaluation of the intervention, which relied on case

file review and anecdotal information, suggested that the intervention improved children's mental health; this evaluation was valuable in encouraging funding from the United Way.

Rochester Safe Start chose to support the Mount Hope Foster Care Intervention because:

- It was an important program in a strong institution. Mount 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.
- It was a program that needed bridge funding to continue serving a clinical population of young foster children. Bridge funding from Safe Start supported rapid contextual assessment and case sharing among therapists, foster care workers, and the Foster Care Pediatric Clinic.

1.5 Mechanisms for building the capacity of service providers to respond appropriately to children exposed to violence and their families

Because the domestic violence system could not be expanded sufficiently to meet all needs, RSS provided Shelter from the Storm training for clinical and non-clinical providers to raise community awareness and increase community capacity to respond to

children exposed to violence. Rochester Safe Start focused on increasing the capacity of agencies that have contact with children (e.g., child care centers and schools), because of the shortage of specialists available to many of these agencies. Children's Institute led this effort because they had the in-house capacity to do so, and because they could not identify an outside agency with the capacity to meet the requirements of their request for proposals to lead the effort.

From 2002 to 2005, the training initiative reached 2,704 participants (Association for the Study and Development of Community, 2006b). Shelter from the Storm was funded to continue through December 2006 and began charging a fee for training in 2007. In addition, issues of children's exposure to violence will be integrated into the training branch of the Children's Institute, the Training in Prevention System (TIPS).

2. Challenges and Needed Improvements to the Rochester System of Care for Children Exposed to Violence

Rochester Safe Start experienced the following challenges to their universal and targeted interventions and learned the following lessons.

More concentrated or staggered efforts, allowing Safe Start staff to focus on one system at a time, may have helped move more systems to a tipping point.

The breadth of systems change efforts undertaken by RSS spread staff and funding across many activities, making it difficult to push any system very far.

Likewise, the great number of simultaneous activities resulted in loss of momentum for some projects because of competition with other ongoing activities. For example, 2006 site visit participants expressed the desire for a more extensive media campaign. Along with other Safe Start grantees, Rochester Safe Start had considered the possibility of a national media campaign; however, they lacked sufficient resources and time to dedicate to expanding their campaign. Site visit participants suggested that two to three full-time Safe Start staff members would be needed to address comprehensive systems change.

The broad focus on systems change also allowed for persistent service gaps and barriers for children exposed to violence in Rochester. Despite important changes in community support for children exposed to violence and their families, therefore, Rochester still faces the following challenges:

- 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 review suggests that referral processes and their reliability 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.

Rochester Safe Start experienced these challenges firsthand. For example, despite the efforts of RSS and resources dedicated to Safe Kids, police are still not mandated, under a formal policy, to identify children at the scene of a violent incident and ensure that these children are referred to appropriate local services.

Partnerships with service delivery providers were stronger than partnerships with community residents, resulting in a stronger focus on children's exposure to domestic (vs. community) violence. More

participation from community residents would have helped Rochester Safe Start balance their focus on domestic and community violence. The systems (i.e., law enforcement, courts, treatment community) and agencies (e.g., ABW, SPCC) engaged in Rochester Safe Start have more contact with children exposed to domestic violence. Because RSS did not address community involvement from the outset, deliberate effort was required to avoid an exclusive focus on domestic violence. Rochester Safe Start's association with systems and agencies that work closely with victims of domestic violence may have confused community members about the focus of Safe Start.

Instability in funding streams and leadership in Rochester resulted in a loss of project momentum. Rochester city, county, and school district, along with New York state, all experienced severe budget shortfalls during the Safe Start grant period. County funding for programs for children exposed to violence (i.e., child welfare) and for family programs (i.e., programs for the unemployed and those on public assistance) was reduced, forcing

Rochester Safe Start to seek funding from private and nonprofit sectors. In addition, the Rochester mayor, county executive, and sheriff turned over, and the Children's Institute reorganized their infrastructure. These changes slowed the progress of Safe Start, during the time required to re-establish relationships and support for issues related to children's exposure to violence after each turnover.

3. Summary of Accomplishments

Safe Start resources were dedicated to enhance the existing service delivery system for children and families in Rochester. Despite the numerous resources available in Rochester (e.g., services for children and families, strong working relationships among service providers), relatively high rates of unemployment and related child poverty create needs that outstrip the capacity of the community to build a service system exclusively for children exposed to violence. Therefore, Rochester Safe Start focused on incorporating expertise on children's exposure to violence into existing systems for young children. Evaluation was used to improve interventions and inform important decisions about where to dedicate initiative resources. The focus on evidence-based practice and the use of evaluation data to show effectiveness and/or need for improvement encouraged agencies to embed and value activities funded by Rochester Safe Start.

Through this overall approach and several specific interventions, Rochester Safe Start helped create a community more responsive to the needs of all

children, including those exposed to violence in their home or community. Rochester Safe Start staff and partners successfully implemented and sustained several critical interventions. As a result of the continued engagement of representatives from the court system and the early childhood community, Rochester Safe Start leaves a legacy of trained leaders, who will continue

championing issues of children's exposure to violence. Evaluation findings suggest that providing early childhood educators with coaching around issues of child exposure to violence may be an effective way to improve the development of all children, including children who have been exposed to violence.

4. References

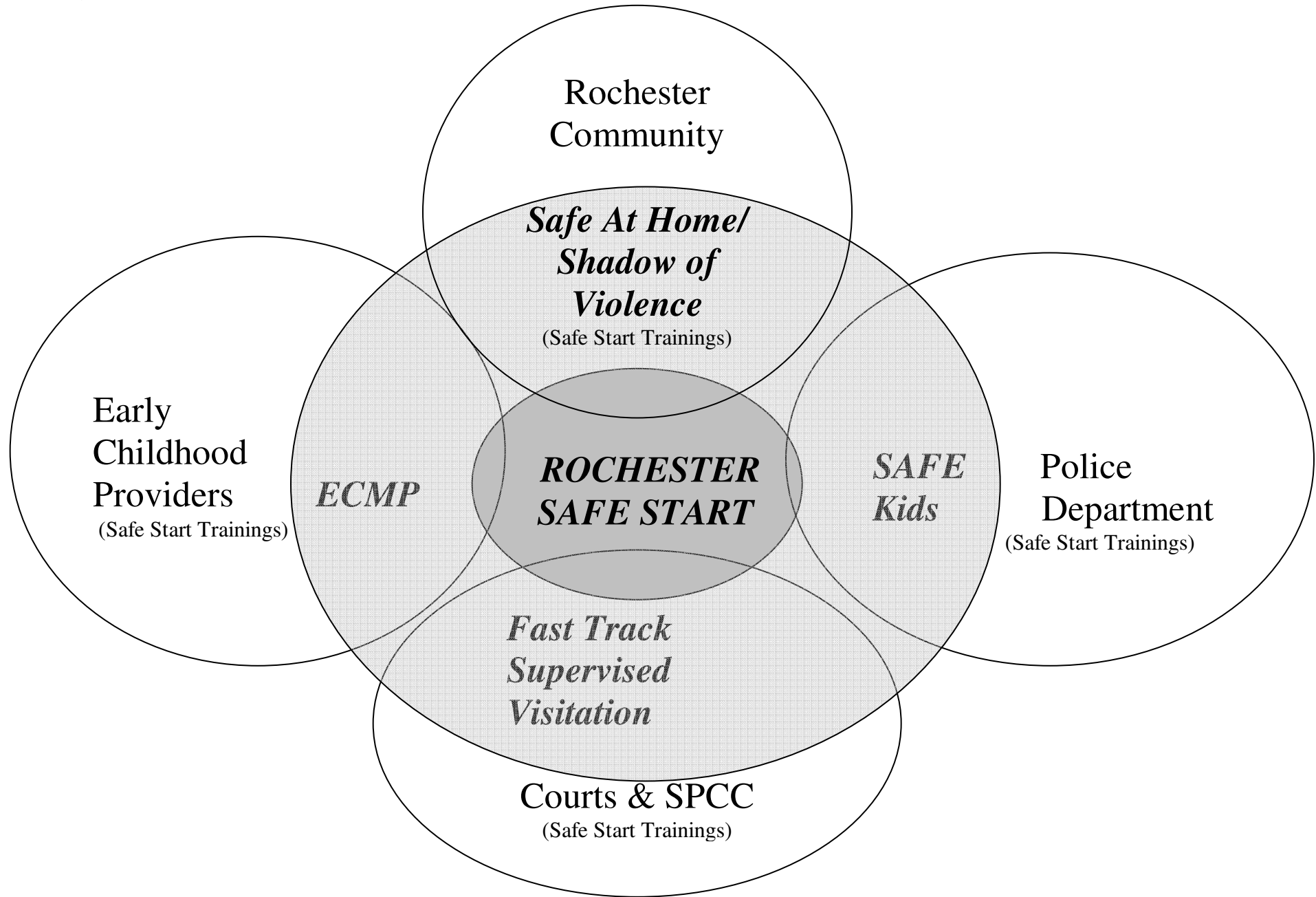
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Exhibit V

Rochester Safe Start Service Delivery Model



VI

San Francisco, California, SafeStart Initiative

1. Overview of San Francisco SafeStart System of Care

The San Francisco SafeStart system of care has two distinct components: a management/oversight component and a service delivery component. The Advisory Council and its Steering Committee, which serve as the management component, consist of influential leaders, well-respected in the community and in positions to affect decision making and policies for agencies participating in San Francisco SafeStart. The Service Delivery Team (SDT) interacts directly with children exposed to violence and their families. Together these components work to address the strategic goals of San Francisco SafeStart: 1) to increase the effectiveness of services by training point-of-service providers on how best to respond to children exposed to violence; 2) to prevent childhood exposure to violence by sensitizing the public to the issue; 3) to reduce the impact of exposure by providing early intervention and treatment; and 4) to improve service systems by promoting a core set of values, beliefs, and practices for responding to young children exposed to violence. The two-tiered structure of SafeStart not only enables the work of the Service Delivery Team to be coordinated across child- and family- serving agencies, but also has allowed for SafeStart's core principles,

policies, and protocols to be institutionalized within the community (Association for the Study and Development of Community, 2006a).

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

Children exposed to violence receive treatment from behavioral health specialists in family resource centers; if the condition is beyond the expertise of these specialists, children may be

referred to other clinicians available through the Department of Public Health Behavioral Health Services (DPHBHS) or the Child Trauma Research Project (a joint endeavor of the University of California San Francisco's Department of Psychiatry and San Francisco General Hospital). The Service Delivery Team provides case conference review and other support to professionals in SafeStart-participating agencies (Association for the Study and Development of Community, 2006a).

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

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

Further, the Service Delivery Team coordinated the following from November 2003 to October 2005:

- The Talk Line responded to **766 calls** and referred **460 callers** to SafeStart Services, and
- SafeStart family resource centers provided services (e.g., case management, assessment, and treatment) to **577 families** and **766 children** (personal communication

with SafeStart project director, March 30, 2007).

Discussed next in greater detail is each component of the San Francisco SafeStart system of care for children exposed to violence, along with the reason for its development. (See also Exhibit VI.)

1.1 SafeStart Service Delivery Team

With a central role in service integration and delivery, the San Francisco SafeStart Service Delivery Team provides a model for coordinating the professional community's response to families with children exposed to violence or at risk of exposure. The SDT addresses the third goal of SafeStart by 1) providing early intervention and treatment for children exposed to violence through an expanded infrastructure of the existing family resource centers that serve children and 2) coordinating cross-agency activities to ensure that children and families receive child- and family-focused, community-based care and treatment. The Service Delivery Team integrates services for families by helping families prioritize their needs.

The work of the Service Delivery Team is guided by nine core principles, protocols, and policies developed by SafeStart staff, with assistance from the Advisory Council and the SafeStart Parent Team. These policies, continuously refined by the Service Delivery Team and Parent Team, are distributed to SafeStart partners and other agencies to guide their response to children exposed to violence and their families and are generally available in the manual "Core Values, Practices, and

Beliefs for Responding to Children Exposed to Violence.” Each participating organization has specific functions and contributions to the operation of the SDT:

- The San Francisco Police Department (SFPD) identifies children exposed to domestic violence and refers their families to the Talk Line for additional support;
- Unified Family Court refers families to the Talk Line for additional support;
- The Talk Line, housed in the San Francisco Child Abuse Center, connects families to family resource centers, provides follow-up services to ensure that families link to services, and maintains family files for tracking purposes;
- SafeStart family resource centers provide families with case management, assessment, and treatment services;
- The Department of Public Health Behavioral Health Services provides behavioral health services for SafeStart families unable to receive needed services through a family resource center or with behavioral health needs beyond the capacity of family resource center staff;
- The Child Trauma Research Project provides clinical services for children and families experiencing severe exposure to violence and/or severe effects of exposure (e.g., physical harm to child, developmental challenges); and
- ManAlive and the Compass Family Resource Center provide consultation on batterer intervention issues (Association for the Study and Development of Community, 2006c).

1.2 Identifying children exposed to violence and referring them to appropriate services

The San Francisco Police Department provides an important point of entry into the service delivery system and plays a key role in identifying and documenting children who are exposed to domestic violence incidents. Unified Family Court is also a key referral source, identifying families who are court-involved but not under court order for child protection. The Talk Line functions as a central referral mechanism to SafeStart services. Each of these organizations and their role in the system of care for children exposed to violence are described in more detail next.

The San Francisco Police Department identifies children and families and refers to SafeStart services by connecting families with the SafeStart Support Line (answered by trained Talk Line staff and volunteers). The police department’s domestic liaison, a position internally funded through SFPD resources, coordinates referrals. As a result of SafeStart training, police officers, who serve as first responders to family violence, understand the negative impact of violence exposure on children present at the scene of a domestic violence incident; officers now respond differently to domestic violence by documenting the presence of any children and referring the incident to the Talk Line as appropriate. In addition to serving as a first responder, the SFPD provides a safe place for families, where fear of continued abuse is reduced and assistance with legal issues is available.

Moreover, SFPD collects critical information to document details that

family resource centers may need for mandated reporting purposes, as they provide follow-up care and treatment for children exposed to violence and their families. The importance of documentation was underscored in a study conducted by the SafeStart local evaluator. The study reviewed 3,000 felony domestic violence files to ascertain how well police documented family incidents, particularly focusing on the documentation of family characteristics and the presence of children. The study found that police were more likely to file necessary follow-up information if they documented the presence of a child at the scene of a domestic violence incident. While the study showed that police documentation improved over the course of the Safe Start Demonstration Project, the evaluator concluded that “police could play a more significant role in the prevention of children’s exposure to violence by continuing to improve documentation practices” (Shields, 2006).

Through a court advocate position funded by SafeStart, Unified Family Court has served as an integral member of the Service Delivery Team. The court is able to command the presence of others (e.g., child-serving agency representatives, parents, court advocates) at meetings and refer families to SafeStart services. As part of the Service Delivery Team, the court advocate is able to monitor the compliance and progress of families referred for SafeStart services.

San Francisco Police Department, Unified Family Court, Child Protective Services, and other community-based agencies make referrals directly to the

SafeStart Support Line. The Support Line, described by 2006 site visit participants as the “glue” of the Service Delivery Team, merged in 2006 with the San Francisco Child Abuse Center’s Talk Line.¹¹ The merger has provided increased multi-lingual services for SafeStart families, as well as a “permanent” home for the call-in operation.

The Talk Line serves as the central referral and tracking agency for the SafeStart system of care. To connect families with care and treatment services, the Talk Line, under the guidance of the SafeStart Support Line coordinator, refers children and families to the FRC family advocate located in their neighborhood. The Support Line coordinator follows up to ensure that the family and FRC connect. Data regarding the referral are kept on file in the SafeStart referral database for future reference should a family have a need to reengage the system.

While not a member of the Service Delivery Team, Child Protective Services refers to SafeStart when children and families do not fall under their jurisdiction but are in need of services. Connecting these families to SafeStart is critical to reducing the incidence and effects of child exposure to violence. Over the course of SafeStart, Child Protective Services has worked to improve documentation of these cases, particularly with respect to participation

¹ The SafeStart Support Line was operated as an independent call-in phone line by the San Francisco Child Abuse Council. In 2006, it merged with the council’s Talk Line to provide a single contact point for child abuse and domestic violence incidents. The Talk Line now refers children exposed to violence and their families to SafeStart services.

in the San Francisco Greenbook Project on court reform for domestic violence cases.

1.3 Intervention and treatment provided by family advocates and clinicians

SafeStart funds family advocate positions in seven San Francisco family resources centers. When a child or family needs more intensive clinical treatment than can be provided by FRC staff or treatment in their native language, clinicians working for the Department of Public Health Behavioral Health Services or the Child Trauma Research Project provide the necessary specialized clinical treatment or language-specific services.

SafeStart funds family resource centers to provide case management, assessment, and treatment. These centers are considered the “heart” of the San Francisco SafeStart system of care; since the inception of SafeStart, all Service Delivery Team agencies have referred families to FRCs. Located in neighborhoods with the highest incidence of child exposure to violence, the seven centers that participate in San Francisco SafeStart provide a safe place for children and families to receive a wide array of services beyond those included in the SafeStart package (e.g., food, housing, employment). In keeping with the philosophy of SafeStart and the centers themselves, FRCs provide local capacity for accessible, family-friendly, inviting services within the community. According to family resource center advocates, FRC programs, including SafeStart, effectively retain families in services because FRC staff are able to develop strong relationships and build

trust with families. The success of utilizing FRCs for the delivery of SafeStart services has prompted the San Francisco Department of Children, Youth, and their Families (DCYF) to propose expanding the capacity of the SafeStart program from the current seven centers to all 12 DCYF-funded centers over the next budget period (2007 to 2010).

The SafeStart service delivery package administered in family resource centers includes parent-to-parent support, peer counseling and home visits, information and referral services, parent education, and mental health/behavioral health services. Support services are provided in different languages (Association for the Study and Development of Community, 2006a). Family assessment and goal assessment data are collected for each family (San Francisco SafeStart Initiative, 2005). The Child Behavior Checklist (CBCL) is administered to every SafeStart child in the family between the ages of 18 months and five years. Family advocates administer the first CBCL at intake; behavioral health clinicians administer the second CBCL at the end of behavioral health services. In addition, SafeStart developed a form to track treatment dosage and changes in behavioral health for all children receiving behavioral health services (San Francisco SafeStart Initiative, 2005).

Clinicians with the Department of Public Health Behavioral Health Services and the Child Trauma Research Project provide specialized treatment to children exposed to violence and their families. Behavioral health services are available for SafeStart families unable to receive services in a family resource center or with behavioral health needs beyond the

capacity of the local FRC case manager. A significant number of SafeStart families are non-English speaking; the Department of Public Health Behavioral Health Services provides multi-lingual services for these non-English speaking families, if that capacity is not available in the neighborhood family resource center.

1.4 Mechanisms for building the capacity of service providers to respond appropriately to children exposed to violence and their families

The director of the Child Trauma Research Project, Dr. Patricia Van Horn, brought a case-consultation process to the SafeStart Service Delivery Team. This process provides a multidisciplinary team approach to explore the “meaning of kids’ behavior” and how to support families of children exposed to violence. The process is regarded by participants as highly effective professional engagement, both strengthening clinical practice (i.e., how to think about the client) and providing support to clinicians who are themselves exposed to secondary trauma through their work. Case consultation provides an opportunity for any member of the Service Delivery Team to bring a case to the group for discussion (parental consent to discuss the case is obtained prior to case consultation); discussion is led by Dr. Van Horn, whose experience and direction are highly regarded by participants. SafeStart funds the case-consultation process (e.g., meeting logistics, materials), while a memorandum of understanding with the city of San Francisco, one source of financial support for the Child Trauma Research Project, provides for

involvement of the project and its director (i.e., Dr. Van Horn).

San Francisco SafeStart provides extensive and continuous training for Service Delivery Team members and other professionals in child-serving agencies throughout San Francisco County. Training is provided through three venues: 1) an annual SafeStart Academy, 2) conference trainings, and 3) specialized trainings on topics related to children’s exposure to violence.

The SafeStart Academy and conference trainings provide in-depth training on topics such as vicarious trauma, psychological aid, developmental disabilities, child support enforcement, and domestic violence. Cross-training also takes place in these venues. For example, domestic violence advocates may work with batterer intervention program staff to deepen understanding of each group’s key issues, approaches, and practices. Specialized training focuses on topics such as transitional housing for victims of domestic violence and the neurodevelopmental impact of child maltreatment. The San Francisco Department of Youth and Family Services will provide resources to continue to fund training through the SafeStart Academy.

From 2002 to 2005, San Francisco SafeStart provided training for **3,226 service providers and child- and family- serving professionals** (Association for the Study and Development of Community, 2006b).

2. Challenges and Needed Improvements to the San Francisco System of Care for Children Exposed to Violence

During site visits, San Francisco SafeStart participants suggested several improvements needed to create a more comprehensive system of care for children exposed to violence. For example, the San Francisco School District is viewed as an important but absent partner in the SafeStart model; greater participation of schools is seen as an important future goal. Principals in SafeStart neighborhood schools have been open to helping SafeStart staff expand awareness of children's exposure to violence among families of children that attend their school. They also have been trained to identify and refer children that may be showing signs of exposure to violence. Nevertheless, the schools have been described as a missing partner in SafeStart because they do not participate in Service Delivery Team meetings or case consultation meetings.

Site visit participants indicated several other resources needed to meet the challenge of providing services to the diverse population of children and families that use SafeStart services. Legal resources, particularly legal counsel/advice for SafeStart staff and point-of service-providers, would improve the system of care. Some children and families receiving care and treatment are actively involved in court cases surrounding a domestic violence incident; providers need assistance in understanding what can and cannot be legally discussed with these families.

Greater access to language-proficient clinicians, access to a psychiatrist or

other medical personnel who can prescribe and monitor medications, and greater capacity to provide dyadic therapy treatment were mentioned as clinical resources that would improve the current system of care. Site visit participants identified increased accessibility to therapists trained to treat children six years and younger as an additional clinical resource need.

Domestic violence issues are addressed in Service Delivery Team meetings; however, site visit participants reported a need for increased involvement of batterer intervention programs and domestic violence advocates. To connect with batterers (i.e., perpetrators) and involve batterer intervention programs, SafeStart needs to explore 1) the degree to which such connections are permissible within the boundaries of court orders and 2) where and how such connections are feasible beyond the current involvement of ManAlive (a batterer intervention program) and the Compass Family Resource Center in the Service Delivery Team.

Finally, data collection focused on program performance remains an issue for SafeStart. Developing and clarifying standard performance measures for SafeStart point-of-service providers would help determine best practices for: 1) dosage (i.e., how often should point-of-service providers meet with clients?), 2) quality assurance (i.e., what are the minimum training requirements for point-of-service staff?), and 3) case flow (i.e., how long should a case be active?). To support standard data collection will require training on the use of simple tools, along with resources to apply data-collection techniques in a culturally competent manner.

3. Summary of Accomplishments

The San Francisco SafeStart system of care has been able to: 1) generate increased knowledge of the characteristics of children exposed to violence and their needs; 2) establish 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; 3) promote information exchange across disciplines and sectors, resulting in more comprehensive knowledge of issues related to childhood exposure to violence; 4) build on an existing infrastructure of family support services and create a system of care for identifying, referring, assessing, and serving children exposed to violence and their children; and 5) develop and distribute policies to guide agency responses for children exposed to violence and their families (Association for the Study and Development of Community, 2006a).

Further, as a result of the work of the Advisory Council, the Steering Committee, and the cross-agency Service Delivery Team, there is increased capacity to address the needs of children exposed to violence and their families, specifically, 1) better coordination of service providers and agencies that respond to children exposed to violence and their families; 2) closer working relationships among family advocates, the police, and Unified Family Court, facilitating information retrieval, tracking of cases, and the provision of assistance to families in

navigating the various systems that affect their lives; and 3) the presence of a core team of professionals dedicated to children exposed to violence and able to serve as resources to other professionals and the general public. The improved capacity to pool knowledge, skills, resources, and relationships across systems and at multiple levels from policy to point of service has created a less fragmented and more cohesive system of care, thereby improving the support available to children exposed to violence and their families.

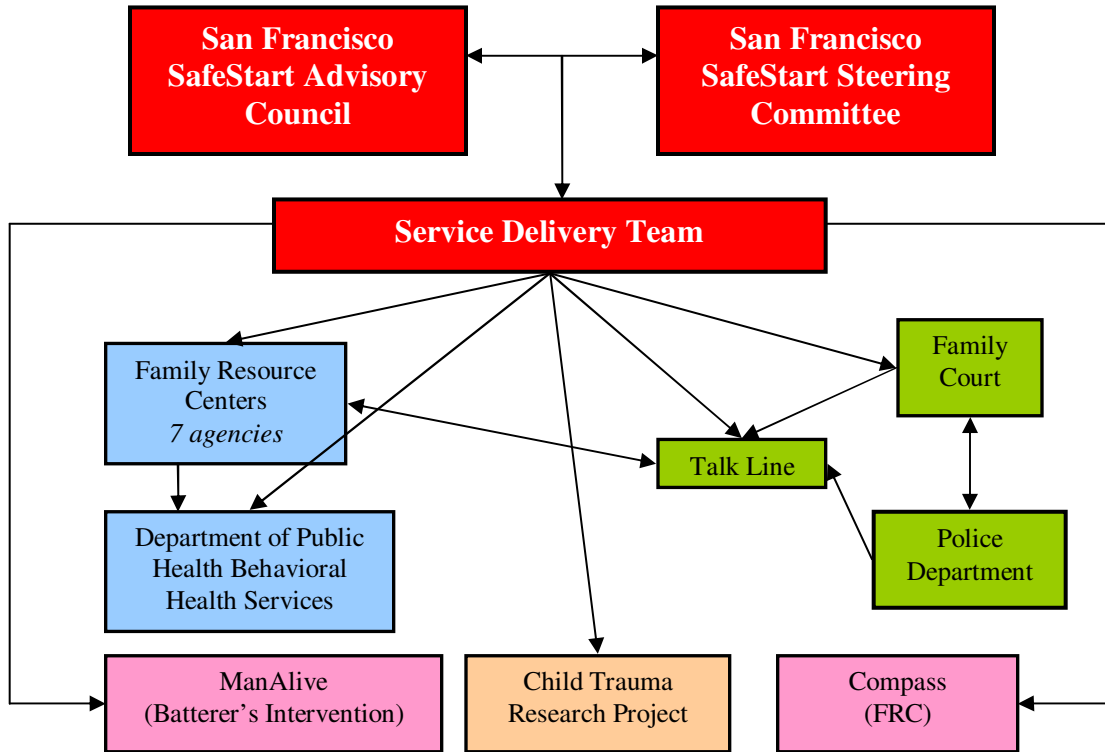
Funding to sustain the work of the SafeStart program (e.g., support to family resources centers to provide services and treatment for children exposed to violence and their families, administrative staffing costs for SafeStart) will continue through a dedicated line item in the DCYF annual budget. DCYF is the chief child-serving agency in San Francisco, providing a voice and agency in San Francisco government focused exclusively on ensuring that young people, 17 years and younger, develop in a healthy and productive manner. DCYF is the lead agency for programs related to violence prevention for young children (five years and younger) and provides significant funding to San Francisco's family resource centers, which are key participants in SafeStart's system of care. Additional services provided by law enforcement, the Department of Public Health Behavioral Health Services, and the court advocate in Unified Family Court will be sustained through the resources of their respective host agencies (Association for the Study and Development of Community, 2006c).

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Exhibit VI

San Francisco SafeStart Initiative System of Care



Key:

- Red = San Francisco SafeStart program components
- Green = Identification and referral
- Blue = Assessment and treatment
- Orange = Training and advanced clinical treatment
- Pink = Domestic violence resources (batterer intervention programs)

VII

Sitka, Alaska, Safe Start Initiative

1. Overview of Sitka System of Care

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

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

Many of these organizations interact frequently with children exposed to violence and their families, facilitating their role as points of entry into the service delivery system.

The continuum of care developed by the Sitka SSI is strongest at the points of identification and referral, as a result of informal case conferencing and Child Intervention and Development-Community Oriented Policing Services (CID-COPS). CID-COPS, an adaptation of the Child Development-Community Policing program, provides a structure within which several organizations have enhanced their function as points of entry into the system of care for children exposed to violence. Under CID-COPS protocols, the Sitka Police Department formally documents the number of children exposed to violence identified by police officers. After children exposed to violence are identified, they and their families are referred to various services. Cross-organizational referrals also occur at biweekly case conferences, during which a group of service providers, law enforcement officers, school staff, advocates, and judicial staff voluntarily meet to discuss cases of children's exposure to violence and work together to determine child and family needs.

Assessment, intervention, and treatment services are provided by a family advocate and a psychologist; however, these components of the system of care

are frequently unavailable to families due to staff turnover and absences from the community.

Discussed next in greater detail is each component of the Sika SSI system of care for children exposed to violence, along with the reason for its development (see also Exhibit VII-A).

1.1 Multiple opportunities to identify children exposed to violence and refer them to appropriate services

CID-COPS provided the organizational structure for developing identification, response, and referral processes for children exposed to violence and their families. Prior to CID-COPS, partners and point-of-service providers in the Sitka community were acutely aware of the potential impact of violence on children; only after the introduction of CID-COPS, however, were they made aware of a solution. Through CID-COPS, the Sitka SSI developed an interagency protocol to describe the role of each agency in the continuum of care for children exposed to violence, from identification to treatment to follow-up. Under the protocol, police officers are required to record the presence of children during all domestic violence responses. Each morning, the Sitka Police Department's domestic violence coordinator reviews the officers' reports and immediately informs 1) the child's school principal or counselors, to ensure the child is handled appropriately in school; 2) Sitkans Against Family Violence, to ensure the SAFV advocate visits the family's home accompanied by a police officer; and 3) the Sitka Tribe of

Alaska Department of Social Services, to ensure the department's psychologist follows up with treatment.

CID-COPS also developed a response protocol (see Exhibit VII-B), under which individuals from several organizations assumed roles in responding to children exposed to domestic violence and their families. Over time these individuals included STA Department of Social Services staff (including the psychologist), representatives from Sitka Counseling and Prevention Services, the SAFV advocate, Sitka Police Department officers, and the Office of Child Services supervisor. Their respective roles under the response protocol are described next.

Primary responders include people who can handle the victim, children, and perpetrator at the scene of violence. Two CID-COPS responders are required to respond to each domestic violence call: one responder for the victim and

child/children and one responder for the perpetrator.¹² The police dispatcher receives all necessary background information on the perpetrator (e.g., repeated offense, violation of restraining order), the victim, and the children. Under the original response protocol, the responding police officer then picked up the on-call SAFV advocate to ride to the scene, bringing the CID-COPS bag, containing the release of information form, toys, and information about CID-COPS and the Sitka SSI. At the scene,

¹ The victim is typically a woman and the perpetrator is typically a man.

the advocate scheduled a follow-up call or visit with the family, with the goal of arranging to accompany the victim to the arraignment (if any) and ensuring that the victim would schedule an appointment with the STA psychologist. During the fall of 2006, however, differences in philosophy about arresting women during a domestic violence response emerged, and SAFV withdrew its participation in CID-COPS (though not in other Sitka SSI activities). Consequently, a counselor from SCAPS now responds with police officers to domestic violence incidents.

The OCS supervisor typically receives a report from CID-COPS the day after an incident.

From 2002 to the end of 2006, 262 children exposed to violence were identified, based primarily on police reports of domestic violence (Sitka Safe Start Initiative, 2005, 2006).² Safe Start referred the majority of children to SAFV, OCS, and the STA psychologist. A small number of additional referrals were made to SCAPS, South East Alaska Regional Health Consortium, the tribal courts, or the juvenile justice and probation officer; however, CID-COPS did not keep track of these less frequent referrals.

Secondary responders include people from organizations in the continuum of care likely to interact with a child exposed to violence. In the Sitka SSI system of care, other organizations also may identify children exposed to violence and complete forms to refer

these children to services, for example:

- SCAPS counselors and SEARHC clinicians may identify children exposed to violence while providing substance abuse or mental health treatment to parents,
- SAFV staff identify children that accompany caregivers to the SAFV domestic violence shelter,
- Case managers with OCS identify children exposed to violence as part of their work with children in need of protective services,
- Staff from the STA Department of Social Services and the Early Learning Program may learn of children exposed to violence through other agencies or individuals in the community, and
- School principals and counselors may screen for violence exposure when behavioral changes are observed in a child.

The number of children referred through these pathways, however, is not documented.

Mutual referrals also occur at biweekly case conferences, during which a group of service providers, law enforcement officers, school staff, advocates, and judicial staff voluntarily meet to discuss cases of children's exposure to violence and work together to determine child and family needs. These conferences, facilitated by a coordinator from the Sitka SSI, are considered a promising practice because they place the child and family within the larger context of systems that interact with families (Groves & Gewirtz, 2006). To ensure confidentiality of families discussed during case conferences, all participating

² This number likely included children who were identified more than once.

representatives sign a confidentiality agreement each time they enter the room.

1.2 Assessment, treatment and support services

Family advocates and psychologists provide children exposed to violence and their families with assessment and treatment services. The Sitka SSI hired a case manager to engage and retain families in clinical services. The initial case manager was a Native American citizen who provided personal outreach to families participating in parent-child interaction therapy provided by the STA psychologist, to ensure that families had transportation and childcare. This case manager left in 2004. In 2006, a new case manager was hired and assisted families through culturally based healing services. She also left the case manager position, however, to become a family advocate with the STA Department of Social Services. In her new position, the family advocate has helped several Native families and children give voice to their experiences of trauma; within three months of hire, she reportedly helped approximately 40 Native families access services. The full impact of this individual on the system of care remains to be seen; meanwhile, the Safe Start case manager position remained unfilled at the end of 2006.

Within the Sitka SSI system of care, formal assessment and treatment procedures and practices for children exposed to violence were established about a year later than the identification and referral pathway, after a psychologist was hired by the STA Department of Social Services in late 2004. This psychologist uses a series of instruments

³ to assess children's social competence, behavior problems, and development; the quality of parent and child social interaction; and major sources of stress in parent and child interactions. Treatment is provided in the form of PCIT. By the end of 2006, six families and their children (a total of 24 people) (personal communication with Safe Start staff, September 12, 2006) had received PCIT services, in significant contrast to the number of children (i.e. 262) identified and referred (Sitka Safe Start Initiative, 2005; 2006). If a child experiences physical or neurological harm, he/she is referred to SEARHC or the Sitka Community Hospital.

1.3 Mechanisms for building the capacity of service providers to respond appropriately to children exposed to violence and their families

The Sitka SSI built the capacity of service providers to respond to children exposed to violence and their families through accessing national technical assistance. The Sitka SSI sought continuous assistance offered by the Office of Juvenile Justice and Delinquency Prevention. Technical assistance providers included:

- The National Center for Children Exposed to Violence, regarding the CD-CP strategy;
- The National Counsel of Juvenile and Family Court Judges, on establishing a tribal court;

³ Assessment instruments include the Child Behavior Checklist, the Dyadic Parent-Child Interaction Coding System, the Eyberg Child Behavior Inventory, and the Parenting Stress Index.

- The Institute for Educational Leadership, on overall program needs;
- The Systems Improvement Training and Technical Assistance Project and the Institute for Community Peace, on sustainability issues; and
- University of California Davis and University of Oklahoma, on PCIT.

Through local trainings and presentations, Sitka SSI staff have shared the knowledge obtained from technical assistance providers. In addition to periodic trainings and presentations provided by SSI staff, CID-COPS provides annual training on children's exposure to violence to community members, clinicians, and law enforcement. Although technical assistance has therefore been valuable, some STA representatives reported that assistance providers lack adequate knowledge of models and approaches appropriate for Native communities.

2. Challenges and Needed Improvements to the System of Care for Children Exposed to Violence

The Sitka SSI experienced several challenges to the development and implementation of a system of care for children exposed to violence. These challenges included the Native community's⁴ experience of "historical trauma" (Whitbeck, Adams, Hoyt, & Chen, 2004), the relatively small pool of

⁴ To better understand the history and culture of Sitka's Native community, see Dauenhauer, N.M. & Dauenhauer, R. (1987). *Haa Shuká, Our Ancestors*. Seattle, WA: University of Washington Press.

Native professionals in Sitka, and the lack of culturally appropriate therapeutic interventions.

Due in part to historical trauma, Native families distrust services provided by non-Natives, limiting engagement of families in the system of care for children exposed to violence. The Native community has experienced decades of historical trauma, as a consequence of losing their land to early Russian and European settlers; being prohibited from practicing their spiritual and cultural traditions; and facing racism at the individual, community, and systems levels. Native people often feel a deep sense of powerlessness, with the death of every elder bringing the Native language, and hence the culture, closer to extinction (Dauenhauer, 1987). Due in part to their history of trauma at the hands of non-Natives, Native families distrust services provided by non-Natives. In a service delivery system with few Native professionals, such distrust creates a significant barrier to establishing a system of care for both Native and non-Native children exposed to violence.

Two major conditions hindered the assessment and treatment components of the system of care: 1) lack of Native professionals trained in early childhood trauma and 2) inadequacy of existing interventions for Native children and families. The STA psychologist (certified to use PCIT) planned to train paraprofessionals in use of the intervention; however, to become a PCIT trainer requires the completion of 14 cases. With only six cases completed at the end of 2006, the STA psychologist has not yet been able to train others.

Even if training becomes possible, the PCIT approach is problematic. Despite the Sitka SSI's efforts to adapt PCIT, the therapy is neither sufficient nor appropriate to address the impact of cross-generational abuse in Native families; this intervention focuses on the dyadic relationship between parent and child and does not take into account the extended and clan structure of tribal families. At the end of 2006, therefore, the Sitka SSI director began to work with a Native professional to develop a curriculum for clinicians and other providers working with Native Americans to teach strategies to address intergenerational trauma and unresolved grief (Sitka Safe Start Initiative, 2006). Training using this curriculum is scheduled to begin in 2007.

Sitka's relatively small population of professionals (both Native and non-Native) trained to address child trauma makes the system of care for children exposed to violence especially vulnerable to staff turnover and absences. Over the course of the Safe Start Demonstration Project, changes in staff or staff departures from Sitka, even if only temporary, impeded the provision of a complete continuum of care. For instance, the psychologist hired in 2005, with credentials in child trauma, went on sabbatical twice, each time creating a gap in services free to Native citizens and uninsured non-Native families. Native citizens had the option of accessing services through SEARHC, but their uninsured non-Native counterparts either had to pay out of pocket or forgo services altogether.

As another example, the Sitka SSI was without a case manager (to engage and retain families in clinical services) or

coordinator (to follow up with Safe Start partners to coordinate information sharing and inter-agency communication) for a relatively long period of time (2004 to 2006), because no qualified person could be identified. Case management and coordination are the backbone of any system of care for children, adolescents, and their families (Stroul & Friedman, 1996). Without personnel in these roles, families failed to keep their therapy appointments, and monitoring of the movement of families through the system of care was inconsistent. This gap temporarily weakened the system of care.

3. Summary of Accomplishments

Prior to the Sitka Safe Start Initiative, family and child services in Sitka were fragmented, with no coordinated and comprehensive system of care for children exposed to violence. Through the efforts of the Sitka SSI, such a system has been established, with particularly strong system components (i.e., CID-COPS and case conferences) for identifying children exposed to violence and referring these children to services. The Sitka SSI system of care benefits the entire Sitka community, including Native and non-Native families.

The coordination and comprehensiveness of the system of care in Sitka was further strengthened through the establishment of the Sitka Family Justice Center (FJC), which co-locates representatives from the Sitka Police Department, Sitkans Against Family Violence, and Alaska Network on Domestic Violence and Sexual Assault in one building, next to the STA Department of Social Services. A number of rooms in the Family Justice Center are

set aside for physical and mental health services, provided onsite several times a week by a Sitka Community Hospital volunteer nurse and SEARHC clinicians, respectively. As a result of the improved relationship facilitated by the Sitka SSI, the Sitka Police Department and the STA seized the opportunity to apply for the FJC grant (awarded in the amount of \$1.2 million dollars), increasing the probability of institutionalizing a focus on young children exposed to violence. The Family Justice Center is a critical capacity left behind by the initiative.

To view the legacy of the Sitka SSI more broadly: through involvement in the initiative, providers stopped viewing each other as “enemies,” and came to see one another as part of a larger support system for children exposed to violence and their families. This helped increase confidence in each other’s abilities, particularly in the case of Native and non-Native providers. The Sitka SSI helped improve the Native community’s capacity to address issues that affect its families and children and has contributed to a perception of the Tribal Council as on par with the General Assembly, which could fuel further collaboration between the Native and non-Native communities. In addition, Native families are now more willing to seek services from non-Native agencies; at the same time, services are more accessible to them through the work of the STA family advocate. Native families learned, primarily through word of mouth, that non-Native agencies (e.g., the Sitka Police Department) are friendly toward Native families and take their complaints seriously.

Particular components of the system of care are sustainable, primarily because of organizational changes, leadership support, and clear benefits to the community:

- The Sitka SSI vision and focus on young children exposed to violence and their families will continue through CID-COPS and the Family Justice Center.
- Interagency collaboration will continue, because CID-COPS and the FJC provide the structure for agencies to respond collectively to the needs of children and families. Partners are confident that they can raise sufficient funds to sustain the Family Justice Center after grant funding ends.
- CID-COPS and case conferencing will continue because of leadership support, especially from the Sitka Police Department, and because of the benefits evident to the majority of participating agencies. No funding is required to sustain case conferencing because all representatives voluntarily attend meetings.

In conclusion, the Sitka SSI established a system of care with identification and referral components that appear sturdy and long-lasting. Further improvements to the assessment and treatment components of the system are needed, however, to ensure a sustainable system of care that is truly comprehensive and responsive.

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Exhibit VII-A

Sitka Safe Start System of Care for Children Exposed to Violence

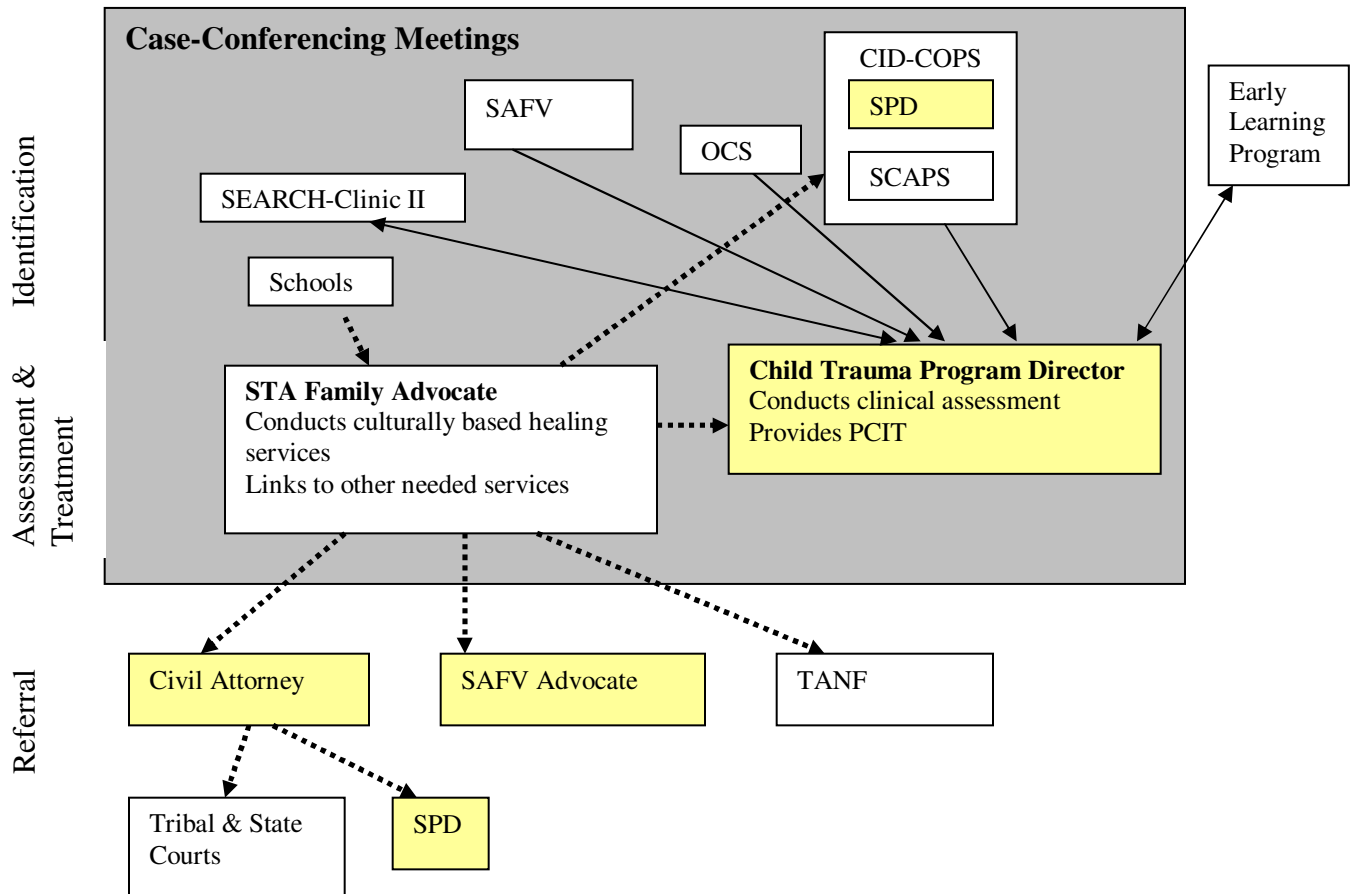


Exhibit VII-B

CID-COPS Law Enforcement Response

Sitka Police Officers will refer incidents in which children were exposed to violence and /or trauma to the CID-COPS Program. Depending on the situation, the referral can be immediate or the next day. The goal of CID-COPS is to serve families whose children have been traumatized, exposed to violence, or victimized by maltreatment or neglect. Clinicians can only respond if the offender has been removed and the scene is secured. The following are the procedures to notify the CID-COPS team.

ON SCENE OFFICER

1. The officer will notify the on-call detective when children witness or are exposed to violence or trauma. Criteria and questions that should be taken into account are:
 - A. Are children at the scene? The absence of children in the room does not imply that there are not children connected to the individuals involved in the violence.
 - B. What is the nature of the relationships of children with the significant people involved?
2. The officer will provide the following information to the on-call detective;
 - A. Number and ages of the children
 - B. Arrest status
 - C. Number and relationship of the household members on scene
 - D. summary of incident to include location of the children at the time of incident.
3. The officer will stand by until the detective and clinician arrive on scene. The officer will introduce the program, the detective and clinician to the adult of the household member.
4. If a detective is not available, the officer will standby with the clinician until they are finished.
5. On the bottom of the case report cc: to CID_COPS and Office of Children Services (OCS).
6. Patrol Officers are encouraged to be involved with the follow-up visits with the families. They are also welcomed to attend the participate in the CID-COPS case conference.

DISPATCH

1. Notify the on-call Detective with information relayed from the on-scene Officer.
2. Assist the Detective with contacting the clinician.

ON-CALL DETECTIVE

1. Evaluate the information and determine if acute response is necessary.
2. Contact clinician with information. (Clinician only responds in the offender has been removed from the scene).
3. Bring CID-COPS bag.

4. Respond to the scene if warranted.
5. Assure that family is informed of their rights of confidentiality.
6. Advise the adult in charge of the care of the child/children about the impact of exposure to violence on children.
7. Stand by to assist clinician
8. Document response.

DV DETECTIVE FOLLOW-UP

1. Detectives will explain CID-COPS purpose and ask for the victim's voluntary participation in the program. If victim agrees, responder will ask her to sign the CID-COPS release of information.
2. Accompany the Victim Service Coordinator on the follow-up home visit within one week of the incident.
3. Attend and participate CID-COPS Conferencing.

DV VICTIM SERVICE COORNIATOR (VCS) FOLLOW-UP

1. The VCS will follow-up with a home visit within one week of the incident.
2. The VCS will discuss safety planning and support services.
3. Attend and participate in CID-COPS Case Conferencing.
4. Maintain records, minutes, and signed Release of Information Forms.

Domestic Violence Unit

1. The Domestic Violence Unit will review all Domestic Violence case reported to the police department and refer cases to the CID-COPS team in which children under the age of 18 were exposed to violence and /or a pregnant woman was exposed to violence or victimized by violence.
2. The Domestic Violence Unit will notify the school if there were school age children exposed to violence.
3. The DV Unit will act as the recording agency. They will keep records of the meeting, signed release of information forms, the minutes and the list of the attendees. All records will be disposed of according to Police Department OPM.