



**Case Study**

**Chicago  
Safe Start Initiative  
2000 – 2005**

***September 2006***



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Development of Community**

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## Executive Summary

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

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

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

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

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

majority of children, children expressed fewer trauma symptoms, and caregiver functioning improved.

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

## 1. Introduction

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

A theory of change was developed for the Safe Start Demonstration Project. In essence, it was expected that collaborative planning and implementation of system change activities would strengthen communities in ways that would prevent young children from being exposed to violence and reduce the impact of exposure for those who were. More specifically, *contextual conditions* (political, economic, and social) were expected to influence project planning and implementation. For example, the incidence and prevalence of child maltreatment or community violence might affect public awareness of related issues. Related to these contextual conditions are *community capacities* (the quantity and quality of service providers trained to work with young children, for example), also expected to impact project planning and implementation. According to the theory of change, community capacity would most directly affect *assessment and planning* as well as *community engagement and collaboration*. Communities with relatively large numbers of qualified professionals, for instance, might be in a better position to reach out to the existing service provider network and engage providers in assessment and planning processes. The capacity to conduct an assessment of community needs and resources was expected to be greatly influenced by the availability of *local assistance*, the ability to access *national assistance*, and the availability of accurate community data. Partnerships were to be formed to plan and initially implement a number of *system change activities*. These activities were expected to change practice across organizations, within organizations, and at the point of direct services. The system changes achieved were expected to be continued, or *institutionalized*, in the form of service coordination and integration and improved service delivery. In turn, the result of continued system changes would be *increased community supports* for young children exposed to violence such that *fewer children would be exposed to violence and the impact of exposure would be reduced*.

This interim case study report describes how Chicago Safe Start changed its community to reduce the impact of exposure to violence on young children. The analysis is based on the National Evaluation Team's site visit reports (Association for the Study and Development of Community, 2005; Association for the Study and Development of Community, 2006), the site's local evaluation report form (Chicago Safe Start Initiative, 2004b; Chicago Safe Start Initiative, 2005b), and information the National Evaluation

Team obtained from site documents (e.g., progress reports, implementation plans, strategic plans, and other materials). The report is organized according to the Safe Start Demonstration Project theory of change and covers the first five years of the Chicago Safe Start initiative. It will ultimately be used to create a cross-case (site) study report. Core questions used to guide the analysis include:

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

Chicago Safe Start's mission was to prevent and reduce the impact of exposure to violence on children ages five and younger. The grantee's goal was to improve access, delivery and quality of services through a balance of prevention and intervention efforts. Chicago Safe Start focused on education and new kinds of collaborations among city and state service agencies, community organizations and residents (Chicago Safe Start Initiative, n.d.). How did the Chicago Safe Start grantee accomplish this mission and with what success? What factors contributed to and impeded success? These questions are addressed in the following sections, and a timeline of major events is attached (Appendix A).

### ***1.1 Roseland/Pullman and Greater Englewood Communities***

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

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

Also on Chicago's south side, the Englewood and Hamilton Park neighborhoods make up the Englewood community area. Ninety-eight percent of the nearly 3,000 Englewood residents are African American, living in an area of 3.09 square miles. The

median income for an Englewood household is \$22,884, with 34% of families and 50% of the children five years and younger living in poverty. The average family size in Englewood is four.

## **2. Contextual Conditions**

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

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

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

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

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

advance the goal of increasing access to mental health service for children (Chicago Safe Start Initiative, 2005, p. 3).

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

- In August 2001, the Chicago Department of Children and Family Services (DCFS) funded services to prevent the co-occurrence of child abuse and domestic violence, specifically recognizing the needs of children who witness domestic violence. The Child Abuse Prevention Fund, a tax check-off program, is currently in the second year of funding 12 such service programs statewide. In 2005, approximately \$580,000 was used to serve a population experiencing domestic violence and child abuse concurrently;
- The Illinois Violence Prevention Authority (IVPA) provides \$500,000 in funding annually to nine sites providing services to children exposed to violence. The CSS received IVPA funding as one of those sites;
- In the current fiscal year, the Illinois Coalition Against Domestic Violence received \$207,000 to provide counseling and other services to children and an additional \$1.1 million for children's therapy;
- The city of Chicago provides \$2.0 million each year through Community Development Block Grant funds to support the Family Violence Initiative. The grant language was modified in 2004 to include expectations that 2005 grantees would train staff on issues of children exposed to violence; and
- The Illinois Department of Health and Human Services provides more than \$23 million dollars to support domestic violence shelters and related services. Twenty two million dollars come out of state general revenue funds, and an additional \$1 million in special services funds are acquired through a tax form check-off that allows tax payers to designate a portion of their refund to this fund.

Chicago Safe Start (CSS) staff leveraged this political and economic environment in the city of Chicago and the state of Illinois by placing the needs of children exposed to violence on the public agenda. For example, CSS staff collaborated with the Illinois Violence Prevention Authority (IVPA) to advocate for passage of the Illinois Children's Mental Health Act of 2003 (Chicago Safe Start Initiative, 2005, p. 14).<sup>2</sup> This act ensures that schools 1) regard social and emotional development as integral to the mission of schools and a critical component of student academic readiness and school success and 2) take concrete steps to address students' social and emotional development. The passing of the act helped emphasize the importance of addressing issues of children exposed to violence by 1) helping to de-stigmatize mental health; 2) highlighting the need for addressing the mental health of children, including those exposed to violence; and 3) potentially tapping into service systems to help identify and refer children exposed to violence.

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

## **2.2 Social Context**

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

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

On the other hand, the positive social supports and networks within the Roseland/Pullman and Englewood communities provide a buffer to counteract the numerous challenges these communities face, including steady increases in violence. For example, many families have lived in the Roseland/Pullman and Englewood communities for generations, contributing to community cohesion. This cohesion has supported a long history of community member involvement in local change efforts, through collaborative relationships with established local service provider agencies. For example, an indicator of cohesion in the two communities is member involvement in Local Area Networks (LANs) which are responsible for developing community-based services for children and adolescents within their local geographic area (Chicago Safe Start Initiative, 2005, p. 4). Through the Chicago Department of Public Health (CDPH), the Roseland/Pullman and Englewood communities also have local health facility management boards that solicit consumer participation and leadership. Dedicated participants in both CSS districts are

committed maintaining this work (e.g., determining health resource allocation and utilization), with or without continuing government support (Chicago Safe Start Initiative, 2005, p. 4).

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

### **3. Community Capacity**

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

Additional capacities included several children's mental health programs. At least 14 outpatient and eight inpatient mental health facilities in Chicago are able to provide some level of mental health services to children. Services for families experiencing violence include 67 domestic violence programs, as well as 31 intervention programs for male perpetrators. Funding for victims of family violence in Illinois has been relatively stable, though minimally adequate (Chicago Safe Start Initiative, 2005, p. 7).

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

### **3.1 Integrated Assistance**

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

A large portion of the training was organized through the CSS annual training calendar. Trainees included staff or members of child and youth service agencies, social service agencies, the courts, faith communities, and other relevant services and programs. The training curriculum had five modules: 1) building public awareness about children exposed to violence, 2) understanding the effects of exposure to violence on children's development 3) defining the role of culture in children exposed to violence 4) responding to children exposed to violence and 5) a practicum component focused on opportunities to intervene with families in crisis. Components of these modules were fully or partially incorporated into all CSS training sessions.<sup>3</sup> Other activities include seminars, train-the-trainer efforts, and public awareness training sessions. From the start of the project through October 31, 2005, Chicago Safe Start staff conducted 61 CSS training sessions for 1,778 participants, three seminars for 395 participants, ten train-the-trainer activities for 27 participants, and 252 public awareness training sessions for 5,592 participants -- a total of 326 trainings for 7,792 participants<sup>3</sup>. See Table 1 for a summary of the number sessions offered and the number of participants (Chicago Safe Start Initiative, 2005, p. 4).

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

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

Of the 1,779 participants in CSS training sessions, 96% of those who attended workshops of 30 minutes or longer and 75% of those who attended brief 15-minute presentations stated that, after the training, they could define exposure to violence, identify three impacts of exposure to violence on children, and help a child exposed to violence. In addition, 96% of total participants (workshop or brief session) agreed or

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

strongly agreed with the statement, I know what action to take to help a child exposed to violence.” Of participants attending seminars, 92% reported that they could define exposure, identify its impacts and help exposed children; and 93% agreed or strongly agreed with the statement “I plan to become involved with efforts to help children exposed to violence.” Eighty-five percent of participants stated that they fully intended to complete personal action plans to address children exposed to violence. More than 18 months after participation in a CSS education session, the number of participants who agreed or strongly agreed that they could a) define exposure, b) describe three ways it impacts children, and c) take appropriate action to help, remained above the immediate post-session target level of 85%. After the same elapsed time, most respondents (79%) also reported that they were doing more personally to address children exposed to violence than they had done before the session. Finally, of 87 caregivers trained, 28 completed training evaluations. Of these 28, 93% reported that they could define exposure to violence, describe how exposure impacts children, and take action to help exposed children (Chicago Safe Start Initiative, 2005, p. 9).

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

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

In 2005,<sup>4</sup> the Chicago Safe Start also received technical assistance from the Institute for Community Peace (ICP) around strategic planning and collaboration with its partner agencies. ICP helped CSS staff to gauge its partners’ sense of connectedness and satisfaction with the present course of the initiative, and interviewed key partners to help maximize the strength and function of CSS. One significant change that came out of the ICP assistance was the decision to replace CSS staff with service providers as conveners and facilitators of the Community Councils in the Englewood and Roseland communities. Another significant change was the development of the Sustainability Committee as part of the Implementation Advisory Board. Through its strategic planning efforts, this subcommittee developed strategies that will sustain the CSS mission and vision beyond the federal funding period.

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

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

## 4. Community Engagement and Collaboration

Chicago Safe Start (CSS) was a collaboration of community residents, community organizations, and city and state agencies responsible for serving or caring for children six years and younger. CSS staff and partners worked to expand and enhance the service delivery system to reduce the impact of exposure to violence on young children and their families through an Implementation Advisory Board and workgroups. Agencies involved included: Chicago Metropolis 2020 (n.d.)<sup>5</sup>, the Mayor's Office on Domestic Violence, the Illinois Violence Prevention Authority, the Domestic Violence Mental Health Policy Initiative, Chicago Police Department, Chicago Public Schools, Illinois Department of Children and Family Services, Chicago Department of Child and Youth Services, Commission on Children and Violence, Partnership for Quality Child Care, Chicago Department of Public Health, LaRabida Hospital, Chicago Department of Human Services, Chicago Metro Association for the Education of Young Children - Commission on Children and Violence, University of Illinois - School of Social Work, Children's Home and Aid Society, Cook County Circuit Court - Child Protection Division, State's Attorney's Office, and Public Guardian's Office (Chicago Safe Start Initiative, 2005, p. 10).

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

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

- **Direct Service Implementation Team** developed and implemented a core program plan that defined the components of the family support services and mental health services provided under Safe Start. The team focused on the clarification of interventions, the tracking and achievement of impacts, increasing

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<sup>5</sup> Chicago Metropolis 2020 is a non-profit organization started by the Commercial Club of Chicago. The purpose of Chicago Metropolis 2020 is to address regional challenges, ranging from traffic congestion to early childhood, with cooperation from the region's business, civic, government and its resident sectors to ensure that the Chicago region is a place where people want to work and live. The organization has been active in addressing early childhood education by convening the Early Care and Education Assembly (along with the Governor's Office), engaging business and civic leaders in early childhood public policy issues, and working with the local and state governments to address early childhood matters.

- referrals and outreach, building partnerships with consumers and providers and the development of overall program sustainability.
- **First Responder – Incident Based Implementation Team** developed the detailed procedures and protocols for first responders to identify children at domestic violence and community violence (non-domestic) scenes and participated in developing procedures for linking these children and their families to family support and/or mental health services, as appropriate. This team also was responsible for the development and oversight of the incident-based response system, made up of the first responder protocol; Domestic Violence Helpline referral card distribution; Helpline capacity development; and linkages between domestic violence and family support services, and emergency room and mental health/family support partners. Officers from the Chicago Police Department and the Chicago Fire Department Emergency Medical Services (EMS) are first on the scene of a domestic violence incident. Under the incident-based response system, these officers were responsible for referring affected family members to the Helpline, where they could access information about children exposed to violence.
  - **Training Collaborative Implementation Team** identified, recruited, and collaborated with potential institutional partners to carry out research, training, and capacity building for service providers and first responders. The team emphasized knowledge and skill development driven by research findings, and also engaged in program evaluation and seeking resources for sustainability.
  - **Data and Evaluation Implementation Team** provided consultation and support to the local evaluator team, ensuring that appropriate process, outcome, and systems change data collection opportunities were identified, and that the data were collected and evaluated. This team also reviewed data collection instruments, supported the development of evaluation reports, and partnered with other pertinent evaluation-based initiatives to expand the programming and policy knowledge base around children exposed to violence. For example, the team was responsible for revising the evaluation logic model to achieve greater alignment with the CSS vision.
  - **Public Awareness and Education Implementation Team** implemented campaigns to increase knowledge of the problem of children exposed to violence and of resources to treat or prevent violence exposure; these campaigns had the secondary goals of influencing public policy development and encouraging the existing system to respond to the needs of young children exposed to violence. For example, in collaboration with the Battered Women’s Network, the Public Awareness and Education Team contributed to a children’s art and photo exhibit during Domestic Violence Awareness Month.
  - **Court Action Implementation Team** identified and advanced specific programs and policy development around children exposed to violence across various offices and initiatives related to local courts (e.g., professional development, advocacy for increased capacity in services, refinement of court-related processes). The Court Action Team arranged training on CSS provider services for all child protection judges during one of their standing judges meetings. This

also guided the identification and tracking of data underscoring the impact of exposure and intervention.

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

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

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

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

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

## **5. Systems Change Activities**

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

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

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

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

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

Temporary Assistance for Needy Families (TANF) recipients. TANF provides a captive audience for Family Focus, linking receipt of assistance stipends to completion of a class on children exposed to violence.

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

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

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

The second method for service delivery was symptom-based. This method involved community providers such as social service agencies, school administrators and teachers, and daycare center staff. Community members also formed a part of this system (i.e., community members could identify and refer children, as well). Symptom-based responders were trained to identify children exposed to violence in their immediate environment and refer them to CSS service providers. For example, Metropolitan Family Services, which houses both family support and mental health services divisions, incorporated a process that led to sharing of cases between these divisions. This change aided in improved identification, referral and appropriate treatment within the agency (i.e., families received family support services, mental health services, or both, as needed). The CSS also supported the once weekly placement of a mental health worker from the Community Mental Health Council at Family Focus. This practice increased the likelihood of continuity in services for families, and, thus, the likelihood of continuation of services.

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

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

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

### ***5.4 Community Awareness***

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

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

The CSS also helped to increase community awareness through its involvement in a variety of activities such as local parades, including the Bud Billiken Parade (an annual African American event) and the Englewood community Back-to-School Parade. CSS staff participated in the Roseland/Pullman Annual Family Fun Day and sponsored educational forums targeting potential agency partners during National Domestic Violence Awareness Month. CSS staff participation in all of these community activities included the distribution of balloons, t-shirts, bookmarks, and other promotional

materials with CSS information. A banner displayed year round at the Chicago Pedway also helped to improve community awareness.

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

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

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

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

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

The CSS ’s formalized procedures for identification, referral, assessment and treatment of children six years and younger, coupled with mechanisms designed to embed its vision into the organizational structure of its partners and the mindset of community members, led to institutional change at the system , agency, point-of-service, and community levels. Institutional change is addressed in the next section.

## **6. Institutionalization of Change**

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

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

## **7. Increased Community Supports**

Families and children exposed to violence have greater access to appropriate services as a result of CSS. All CSS trainings and materials provided families with resource information. The police and Helpline staff became important points of entry into services. The number of service providers in the target communities and citywide that are now capable of recognizing symptoms associated with exposure to violence and responding to them effectively increased due to CSS programming and training efforts. Co-location of a CSS staff person within many of the city-, county-, and state- level clinics/programs in the community increased awareness of children exposed to violence

and referrals to services. CSS service providers also expanded within-agency referral/recruitment into CSS programs (Chicago Safe Start Initiative, 2005, p. 18).

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

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

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

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

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

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

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

The data also showed that caregivers improve more when services were delivered in the home, and that children with no additional exposure to violence improved significantly more than children with continuing exposure. The more sessions children and caregivers attended, the more both improved. Children improved the most when

services focused on identifying and expressing feelings, community violence, safety planning, or conflict resolution skills. Children improved the least when services focused on sexual abuse, media violence, or dealing with separation. When services for caregivers focused on appropriate discipline, parent-child communication skills, building a support system, or community violence, caregivers improved the most. When services for caregivers focused on safety planning or media violence, caregivers improved the least (Chicago Safe Start Initiative, 2005, p. 33).

## **9. Conclusion**

The planning and implementation of Chicago Safe Start achieved a high degree of success as a result of two supportive and cohesive communities; local agencies that took the necessary steps to address issues related to children exposed to violence and their families; and a well funded, community-oriented governing body. With the further assets of an extensive and strategic collaboration plan, a training curriculum, and a community awareness effort that targeted key community and agency stakeholders, the CSS tapped into the existing strengths of the Roseland/Pullman and Englewood communities to establish a formal system of identifying, referring, assessing and treating children exposed to violence and their families. Without a supportive and cohesive community, local agencies would not have participated in the development of a service delivery system capable of responding to children exposed to violence. Children and their caregivers significantly benefited from CSS services, including experiencing a reduction in exposure to violence while participating in services. The greatest challenge the CSS faced was counteracting the high levels of domestic and community violence in the two communities. Efforts are in place to promote the CSS vision and mission and expand it to other areas of Chicago and throughout Illinois. These efforts include a comprehensive training curriculum and a capacity building mechanism that helped “incubate” the CSS vision within the structure of several organizations crucial for meeting the needs of children exposed to violence and their families. The CSS will leave a positive legacy in the Roseland/Pullman and Englewood communities.

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**Appendix A**  
**Timeline of Chicago Safe Start Initiative**  
**Activities and Milestones**

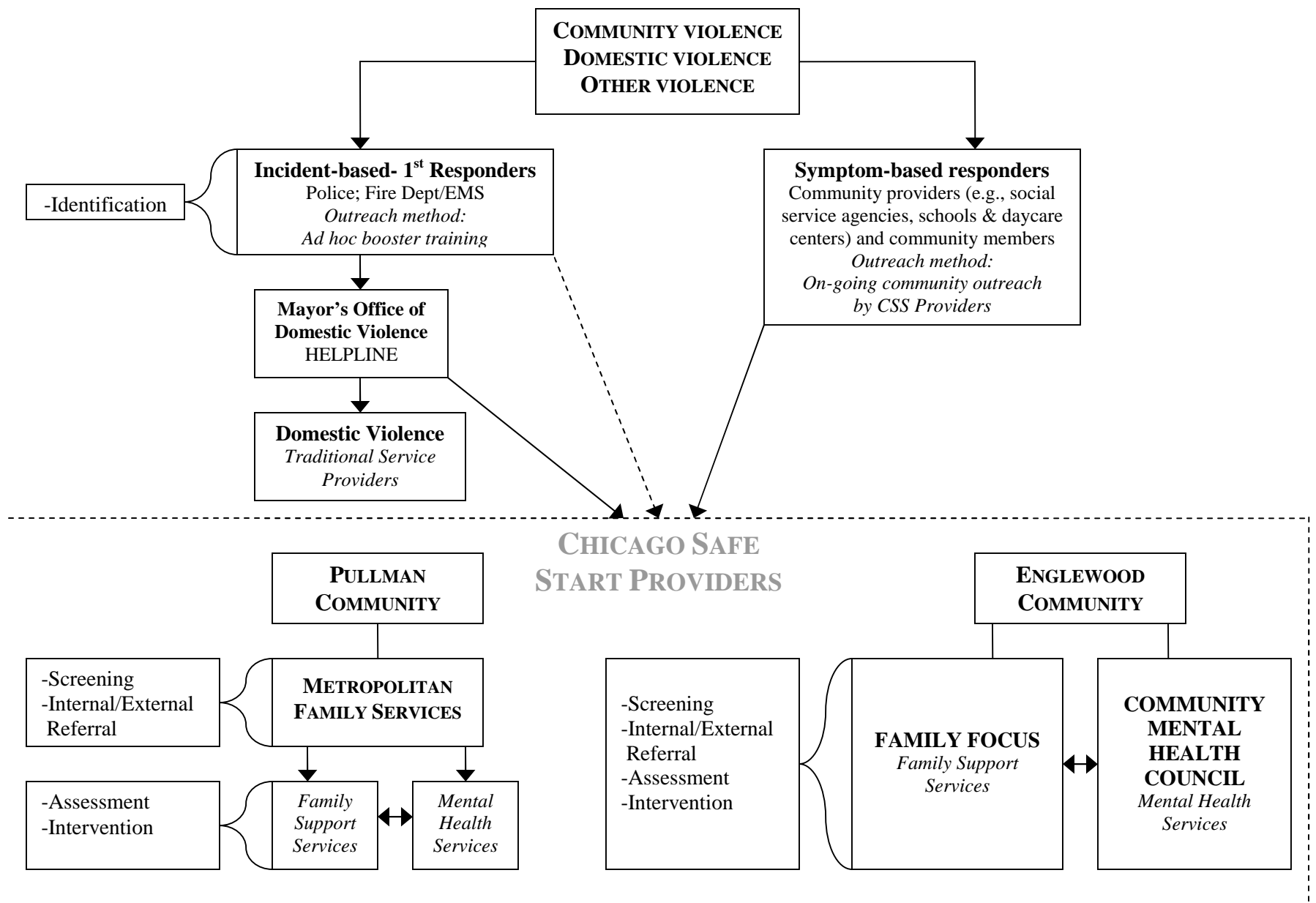
### Timeline of Chicago Safe Start Activities and Milestones

Major Milestones	1/00-6/00	7/00-12/00	1/01-6/01	7/01-12/01	1/02-6/02	7/02-12/02	1/03-6/03	7/03-12/03	1/04-6/04	7/04-12/04	1/05-6/05	7/05-12/05
Project Director position filled	✓											
Project Coordinator position filled		✓										
Community Needs Assessment		✓										
Public Awareness Campaign			✓	✓							✓	✓
Created initial CSS training curriculum				✓								
Two coordinator positions filled (education & implementation)					✓							
Implementation Advisory Board and workgroups <sup>8</sup>					✓	✓	✓	✓	✓	✓	✓	✓
Incident- and Symptom-Based Response System Monitoring					✓	✓	✓	✓	✓	✓	✓	✓
Intervention Research Report: Family Outcomes Pilot and Full Study					✓	✓	✓	✓				
Tier II funding awarded									✓			
Sustainability Plan Complete									✓			
Train-the-trainer training								✓	✓	✓	✓	✓
Roseland Safe Start Council forum												✓
Completed the preliminary draft of the CSS training curriculum												✓

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

<sup>8</sup> The Internal Advisory Board and workgroups consist of the following: Chicago Metropolis 2020, the Mayor’s Office on Domestic Violence, the Illinois Violence Prevention Authority, the Domestic Violence Mental Health Policy Initiative, Chicago Police Department, Chicago Public Schools, Illinois Department of Children & Family Services, Chicago Department of Child & Youth Services, Commission on Children & Violence, Partnership for Quality Child Care, Chicago Department of Public Health, LaRabida Hospital, Chicago Department of Human Services, Chicago Metro Association for the Education of Youth Children – Commission on Child & Violence, Mayor’s Office, University of Illinois – School of Social Work, Children’s Home and Aid Society, Cook County Circuit Court – Child Protection Division, State’s Attorney Office, Public Guardian’s Office. Source: LERF 2005 (p. 10).

**Appendix B**  
**Chicago Safe Start Service Delivery Model**



**Appendix C**  
**Chicago Safe Start Intervention Research**

# Chicago Safe Start Intervention Research<sup>9</sup>

## Overview

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

## Methods

### Sample

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

### Procedures

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

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

Instruments used included:

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

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

## **Results**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **Discussion**

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

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

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

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

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

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

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

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

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

## **Summary**

### **Overall Improvement**

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

### **Number of Sessions**

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

### **Continued Exposure to Violence**

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

### **Content of Services**

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

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

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