Chicago Safe Start

STRATEGIC PLAN 2001-2005

OJJDP

November 30, 2001

City of Chicago
Richard M. Daley
Mayor

Department of Public Health
John L. Wilhelm, M.D.
Commissioner

19975

Table of Contents Page

1. Abstract

KEY FINDINGS

1. Violence is chronic in the target communities.
2. In the designated Chicago Safe Start districts, Englewood and Pullman, of the 18,992 children under age 5, approximately 13,000 children (68%) have heard a gunshot, 2,600 (14%) have witnessed someone attacked with a knife, and 1,300 (7%) were present when someone was shot.
3. Alcohol and substance abuse is chronic in the target communities and frequently linked to violence.
4. Most service providers are not aware of the impact of exposure to violence or how to identify children who have been exposed.
5. Few providers who come into contact with children are currently equipped to intervene with children exposed to violence.
6. There are limited specialized intervention and treatment resources addressing children's exposure to violence.
7. The issue of children's exposure to violence has had limited focus as a public policy priority.

SAFE START GOALS

GOAL I: Children who have been exposed to violence or are at risk of exposure will be identified by organizations (formal or informal) that interact with or serve children.

GOAL II: Child-serving systems and service providers will implement a formalized and coordinated response for initial intervention and referral for children exposed to violence.

GOAL III: The intervention and treatment system will have sufficient capability and capacity to seamlessly serve children who have been exposed to violence and their families.

GOAL IV: The issue of children's exposure to violence will be the subject of sustained attention and action by policy-makers.

GOAL V: Chicago Safe Start will partner with other violence prevention and reduction initiatives to reduce overall exposure to violence for at-risk children.

SAFE START STRATEGIES

1. Increase awareness by the public, first responders (police, fire department, emergency room personnel, etc.), child- and family-serving organizations (public and non-profit), community-based organizations, and policy-makers of the impact of exposure to violence on young children.

2. Establish a Training Institute for professionals who work with children on how to identify and intervene with children exposed to violence and to serve as a general resource on the issue of exposure to violence in Illinois.

3. Establish expectation and provide training to enable first responders and others who work with children and families to identify children who have been exposed to violence.

4. Develop capacity of the Domestic Violence Help Line to serve as a referral link for first responders working with families exposed to violence.

5. Focus policy and funding streams to provide training in the child welfare, domestic violence, substance abuse, and child care systems to provide initial intervention services for children exposed and to make appropriate referrals for family support and/or mental health services as needed.

6. Create a Family Support Services Network in the target communities to provide a non-threatening, asset-based approach to intervene for families whose children have been or are at risk of exposure to violence.

7. Target Chicago Safe Start resources toward and advocate expanding mental health service capacity for children in need of services.

8. Develop data collection and analytic capacity to understand the impact of children's exposure and families' access to services and to widely disseminate findings among key policy-makers.

9. Partner with other violence prevention and reduction efforts and other efforts system-wide that enhance services for children at risk of or exposed to violence.

2. Vision Statement

Children who are at risk of or who have been exposed to violence are supported by caregivers, families and communities to ameliorate the effects of such exposure.

- Caregivers, families, system and community service providers are aware of the impact of exposure to violence on young children, know the signs and symptoms, and how to help or get help.
- A full continuum of coordinated services is available at the community level to address the range of needs that children and families may have.
- The government and private sector institutions and systems that interact with children recognize their role in serving children exposed to violence and collaborate with other organizations to provide a seamless system of care.

3. Planning Process

Chicago Safe Start conducted assessment and planning activities through a two-phased process. Phase I began in June 2000 and concluded in October 2000; Phase II began in June 2001 and concluded in October 2001. The activities of each phase are detailed below.

3.1 Phase I

The Phase I planning process followed the general outline provided in the original proposal. Where departures from the outline were made, we did so intentionally to provide additional layers of detail to the design and framework and to address issues that were unanticipated during the proposal development process.

Because the project director did not officially start until July 10, 2000, the Director of the Office of Violence Prevention initiated initial assessment activities during the months of May and June following the commencement of the grant period. These initial activities included identifying key organizations in the two target districts and meeting with organizational and community leaders. Fortunately, the Chicago Safe Start project was able to build upon the infrastructure and commitment of the Chicago Violence Prevention Strategic Plan (CVPSP) work groups [now Prevent Violence! Chicago] and thus had an immediate structure within which to work.

The Oversight Committee of the CVPSP and other participants interested in the issue of children's exposure to violence attended the first Chicago Safe Start Council meeting in late June, 2000, to outline the approach for the community assessment process, discuss the role and function of work groups, and to meet the new project director. Following the first Chicago Safe Start cross-site meeting in Washington, D.C., the project director began the process of one-on-one interviews with key system leaders, community leaders, and community organization leaders. Because the CVPSP contained vast quantitative data and policy and legislative information relevant to Chicago Safe Start, the assessment process initially focused on building relationships and gaining qualitative insights. Please see Appendix A for the individual interview tool utilized during this aspect of the assessment process and Appendix B for a list of all individuals interviewed.

In late July 2000, the second Council meeting was held. The Council's membership tripled to about 100 people, from its beginnings in the committed cadre who had worked on the CVPSP to include numerous community residents, organizations, and key system leaders. Representatives were targeted at all levels within organizations: leadership, mid-level supervisors and front-line workers. [Please refer to Appendix C for a current list of Council members.] The agenda included a brief presentation on asset-based community development and then the Council broke into three work groups to last for the duration of the assessment process: Assessment, Information Systems/Evaluation, and Best Practices. Please see Appendix D for materials used at this meeting.

In late August, the Project Coordinator was hired.

During the next 10 weeks, the three work groups met independently. The Assessment work group, staffed by the Project Director, met every other week to report on findings and

outreach, while IS/Evaluation, staffed by the Local Evaluator, met twice to examine data practices at each major system agency (e.g., police, courts, child welfare). Best Practices, staffed by the Project Coordinator, also met twice, to review in a general sense three of the major national models applicable to Chicago Safe Start: the Child Development Community Policing program, Betsy McAllister Groves' Child Witness to Violence program at Boston Medical Center, and Joy Osofsky's Violence Intervention Project at LSU Medical Center.

Also during this time, the Project Director and Coordinator led 10 focus groups, 5 in each community, with an average of 10 attendees at each. Please see Appendix A for the interview tool used at each focus group. The two staff also continued individual interviews, and began to update and expand upon the quantitative data presented in the CVPSP.

Quantitative data sources included:

- Numerous publications from the Epidemiology Department of the Chicago Department of Public Health (CDPH)
- Program statistics from CDPH programs, including WIC
- Harvard's Project on Human Development in Chicago Neighborhoods
- Chicago Police Department
- Children's Memorial Hospital's Child Health Data Lab
- Illinois Department of Child and Family Services
- City of Chicago Domestic Violence Help Line
- Mayor's Office on Domestic Violence
- Chicago Department of Human Services (child care and Head Start)
- Illinois Facilities Fund
- Ounce of Prevention Fund
- Cook County Circuit Court System – specifically Child Protection, Juvenile Delinquency and Domestic Relations Courts
- Chicago Metropolitan Battered Women's Network
- Mayor's Office on Substance Abuse
- Illinois Department of Human Services, Offices of Mental Health and of Alcohol and Substance Abuse
- Illinois Department of Public Health
- U.S. Census 1990
- Numerous community organizations

In addition, staff conducted extensive literature searches on early violence prevention, children's exposure to violence, and programmatic models to keep current in research, program implementation and policy development.

The staff used the interview process at this juncture also to clarify and research both micro- and macro-level policy issues in the major relevant systems.

In mid-October, 2000, the Council met to review the assessment findings to date. The presentation of assessment findings covered the following processes:

- The qualitative process focused on analyzing three types of data:
    - System and community assets and resources

  - System and community visions for an ideal neighborhood
  - System and community-identified gaps in current resources and adequacy of existing services
- The goals of the qualitative process were to:
  - Identify and assess the availability of programs for children five and younger
  - Determine the range of services available for victims of domestic violence and their children
  - Identify the prevention, intervention and treatment services for families
  - Develop relationships and partnerships with churches, individuals, system leaders, local agencies and community organizations
  - Assess adequacy of systems' ability to identify children exposed to violence
- The goals of the quantitative process were to:
  - Identify and assess existing assets and resources, both organizational and human
  - Identify potential partners for Chicago Safe Start policy and service initiatives
  - Define areas of focus and priority based on community- and system-specific data

The Council discussed the assessment findings, posed questions for additional research, and then broke into four new work groups for the planning phase:

- Prevention
- Intervention
- Systems/Policies
- Public Awareness

Please see Appendix E for materials used at the October 2000 meeting.

Each work group was chaired by a Council member, and met separately over the next four weeks to develop priorities based on the assessment findings.

Each work group's identified priorities were presented to the full Council for feedback and discussion at the next Council meeting in mid-November. Based on these priorities, the staff then began crafting the details of the action plan, goals and objectives, and intended outcomes. Please refer to Appendix F for information regarding the development of each work group's priorities, as well as materials from the November 2000 Council meeting.

In early December 2000, the Best Practices work group reviewed a matrix of model programs, policies and curricula, as developed by the Chicago Safe Start staff, and matched them with the identified priorities. The staff conducted program site visits and interviews to further inform decisions made regarding service expansion.

The Public Awareness work group began meeting to determine a process for developing and implementing an education campaign on the impact of exposure to violence on young children.

On December 15, 2000, the draft strategic plan was distributed to a small group of key partners for review and comment, and the final draft was sent on January 15, 2001 to the

full Council (about 300 people) for feedback. Both the strategic and implementation plans were submitted to OJJDP on February 15, 2001.

3.2 Phase II

Following receipt of OJJDP's written feedback in late May 2001, the project staff devised a detailed work plan to address each of OJJDP's concerns. In addition, a strategic planning consultant was retained to assist in fleshing out the assessment process.

The following matrix details the process followed during this phase:

ACTIVITY/TASK	RESPONSIBLE	TIMELINE	COMMENT
I. Expand community needs assessment to inform service integration program design			
A. Review/analyze key community data	Consultant/Policy Intern	July 2 – July 18	
1. Reassess demographic, crime, health, mental health, substance abuse, child abuse/neglect, domestic violence, service utilization and other data to determine risk factors present in each community.	Consultant/Policy Intern	July 2 – July 18	Key data, instruments, and sources to be included in an Appendix
a. Compile existing data	Consultant/Policy Intern		
b. Identify any additional data to collect (from existing sources)	Consultant/Policy Intern		
c. Based on analysis of data, develop profile of risk factors for each community, identifying as detailed as possible the types, extent, and sources of exposure to violence for children	Consultant/Policy Intern		
2. Reassess community resources, family strengths, and other protective factors that can help prevent or ameliorate the effects of exposure to violence.	Consultant/Policy Intern	July 2 – July 18	
a. Review existing data collected through focus groups, surveys, and community networking activities.	Julie Consultant/Policy Intern		
b. Gather additional, targeted information from community, as needed, to develop complete understanding of protective factors.	Julie/Helen Consultant/Policy Intern		
c. Summarize, for each community, profile of protective factors (resources/services, environmental assets, networks/organizing activities, individual/family strengths.	Julie/Helen Consultant/Policy Intern		
B. Define target population	Julie/Consultant/Policy Intern	July 13 – July 18	
1. Estimate number of children in each community who are at-risk for exposure to violence. Include assessment of type of violence, extent, frequency, proximity, etc.	Julie/Consultant/Policy Intern	July 13 – July 18	
2. Determine access to protective factors/services.	Julie/Consultant/Policy Intern	July 13 – 18	
3. Determine number of children/families to be reached in each community	Julie/Consultant/Policy Intern	July 13 – 18	
II. Review community assessment data and complete service mapping to analyze community capacity to identify and serve children exposed to violence.		July 23 – Aug 15	
A. Assess community service capacity			
1. Identify strengths/resources/programs currently in place to assist in/support/reinforce/build on delivery of services for children exposed	Julie/Helen	July 9 – Aug 15	
2. Identify resources/programs to be	Julie/Helen	July 9 – Aug 15	

ACTIVITY/TASK	RESPONSIBLE	TIMELINE	COMMENT
added/ changed/opportunities for collaboration			
3. Identify community readiness for program implementation (understanding of program goals/knowledge of impact of violence exposure, etc.)	Helen	July 15 – Aug 15	
a. Continue community networking activities and information sharing to gather qualitative data on readiness			
b. Use before/after survey instrument to measure increased readiness after community networking activities			
4. Identify gaps or other barriers in targeted communities that may limit effectiveness or services to children exposed, such as capacity issues, mismatch, access to information, etc.	Consultant/Julie/Helen	July 9 – Aug 15	
B. List strategies needed to overcome gaps, including opportunities for collaboration, relevant program areas on which to build, etc.	Consultant/Julie/Helen	July 9 – Aug 15	
III. Strengthen service integration program design, including intervention/treatment model, based on community assessment and policy analysis findings			
A. Convene subcommittee of experts to review community assessment and research-based practice models for applicability to Illinois	Julie		
1. Identify appropriate experts	Julie/Consultant	June 29	
2. Schedule working meeting	Julie	July 2	Meeting date week of 7/23 NOTE: subsequent 7/23 dates will be modified once meeting is set
a. Present findings of community needs assessment (I, above)	Consultant	July 18	Mailing to go 7/18
b. Share briefing materials from other programs	Policy Intern	July 18	
c. Ask participants to share own practices that are research based best practices	Service Integration Program Design Team members	July 23	
d. Ask Abi and Dennis to participate	Julie	June 29	
3. Identify policies/practices/financial structures currently in place that help/hinder seamless system for children exposed to violence	Consultant	July 23 – Aug 15	Build on data collection and work done by planning workgroups
4. Identify findings from community assessment that suggest gaps/barriers to be addressed by program design	Service Integration Program Design Team Consultant	July 23 – Aug 15	
5. Refine program design	Service Integration Program Design Team	July 23 – Aug 15	

ACTIVITY/TASK	RESPONSIBLE	TIMELINE	COMMENT
	Support from Consultant/Clinical Intern		
a. Define child/family/community outcomes			
b. Identify all points of identification and access for exposed children			
c. Develop continuum of services, including prevention, intervention, and treatment			
d. Refine clinical intervention/treatment (establish frequency, duration, etc. of contact, based on research/experience)			
e. Identify service delivery partners (government, non-gov't), including program responsibilities, partnerships/collaborations, expansion of services, etc.			
f. Develop preliminary list of policy/system issues for implementation			
6. Develop management/administrative structure (e.g. if crisis intervention team to be established)	Service Integration Program Design Team Support from Consultant/Clinical Intern	July 23 – Aug 15	
a. Identify levels of staffing, supervision to reach and serve target population			
b. Identify sources of staff, supervision (e.g. designated from existing programs)			
c. Develop professional development needs			
d. Develop preliminary data collection/integration plan			
B. Draft program design description/illustrate design, emphasizing linkages to community assessment findings.	As above	Aug 15 -Aug 22	
IV. Identify and build linkages to existing state, county, and city government and other systems ("system mapping") to implement program design and lead to systemic change		Aug 15 – Sept 15	
A. Establish Systems Advisory Board of senior administrators to assess impact of implementing model and to facilitate change in policy/practice (on on-going basis, once implementation occurs)	Julie/Consultant	July 23	
B. Assess impact on relevant systems of implementing model: what changes are needed at the frontline/supervision in practice, what policy/protocol changes are needed, where is collaboration useful, how to build on CVPSP,	Systems Advisory Board/Consultant	Aug 15 – Sept 15; then on-going	Also on-going feedback loop, once implementation begins

ACTIVITY/TASK	RESPONSIBLE	TIMELINE	COMMENT
etc.			
C. List strategies needed to achieve implementation	Systems Advisory Board/Consultant	Aug 15 – Sept 15	
D. Conduct comprehensive fiscal analysis of relevant systems to be impacted by program implementation; develop appropriate strategies	Systems Advisory Board/Consultant /Policy Intern	July 23 – Sept 15	Staff work begins in July
1. Identify sources of funds for program implementation, (cash and in-kind) especially redirecting existing resources to build institutional investment			
2. Identify new funding opportunities			
3. Evaluate whether foundation funds can be sought for targeted components			
E. Develop data integration model	Systems Board/Data Consultant	July 23 – Sept 15	Staff work begins in July
F. Establish ownership for model migration to on-going system at conclusion of Chicago Safe Start demonstration	Systems Board/Consultant	Aug 15 – Sept 15	
1. Identify administrative responsibility			
2. Identify on-going fiscal support			
3. Develop migration plan (staffing, management, etc.)			
G. Create/Migrate to Senior Advisor Oversight Board	Julie/Consultant	Sept 15	Build from Steering Committee; expand as needed
1. Identify senior policy makers and advisors to advocate at the highest levels of state, county, and city government for policy, fiscal, and legislative changes		Sept 1	
2. Share program design for review/establish support		Sept 15	
3. Keep informed throughout planning and implementation to build on-going support		Sept 15 – on-going	
4. Involve in key advocacy points, e.g. securing additional funds, legislative support, etc.		Sept 15 – on – going	
V. Develop evaluation methodology for success of model	Rise	Aug 15 – Sept 15	
A. Link methodology to child/family/community outcomes specified			
B. Develop evaluation strategy for each component of model; consider clinical, satisfaction, utilization, and other measures.			
C. Incorporate feedback loop to continuous program improvement, informing each participating organization			

ACTIVITY/TASK	RESPONSIBLE	TIMELINE	COMMENT
VI. Refine vision/goals/objectives/ implementation strategies		Aug 15 – Sept 15	From work of Program Design Team and System Advisory Board
A. Refine vision to reflect system and policy change goals reflected in program design	Julie/Consultant		
B. Develop refined goals and detailed, measurable objectives that are outcome-based and clearly derive from community assessment, program design, system analysis, and for program evaluation design	Julie/Consultant		
C. Develop detailed strategies for achieving the goals/objectives.	Julie/Consultant		
1. Strategies will cover the entire five-year timeframe.			
2. Strategies will contain detail on specific activities to be undertaken.			
3. Strategies will be priorities to reflect strategic implementation over the five-year period (or implementation phase, as appropriate).			
VII. Review and Share comprehensive model			Includes model, systems linkages, evaluation component, community impact
A. Hold individual meetings with key stakeholders for feedback	Julie/Consultant	Sept 15 – Oct 15	
B. Incorporate feedback from individuals into model	Julie	Sept 15 – Oct 15	
C. Present model to broad stakeholder group	Julie/Consultant	Oct 1	On or about
1. Invite OJJDP			
2. Solicit final feedback/buy-in			
VIII. Draft revised Strategic Plan Document and Implementation Plan			
A. Develop preliminary draft sections, as steps above completed	As assigned lead responsibility, above	Sept – Oct 1	
1. Submit preliminary draft sections to Abi/Dennis and OJJDP for early review	Julie	Sept, as completed	
2. Submit preliminary draft to community partners, Council, etc.	Julie	Oct 1	
B. Compile draft document and submit for review.	Julie/Consultant	Nov 1	
C. Finalize document and submit	Julie/Consultant	Nov. 30	

Highlights of Phase II include the September 24 meeting convened by the Chief of Human Infrastructure from the Mayor's Office with high-level system representatives from city, county and state agencies. This group became the Implementation Advisory work group.

We held a roundtable luncheon in mid-October with Dr. Steven Marans of the Yale Child Study Center/National Center for Children Exposed to Violence and New Haven's Assistant Chief of Police Douglas Macdonald to discuss the Child Development-Community Policing model and how it could be adapted to a city of Chicago's size and scope.

Another highlight was the Office of Violence Prevention recognition award breakfast held on October 30, with the Mayor, the State's Attorney and other key leaders in attendance.

The entire Council met on November 7 to review the draft strategic and implementation plans and discuss the Chicago Safe Start model.

This document is the result of the Phase II planning process, which built on the work of Phase I.

4. Defined Target Area and Population

4.1 Chicago and Target Area

The Chicago Safe Start project is initially focusing on two south side Chicago Police Department Districts: 5 ("Pullman") and 7 ("Englewood") that have a combined population of 217,710.[1] These communities are within the City of Chicago, which has 2.9 million residents; there are a total of 5.37 million residents in Cook County. According to the 2000 Census, Chicago's overall racial composition is 42% White, 36.8% Black, 4.3% Asian, and 13.7% Other. The Hispanic/Latino population is 26% of Chicago's total population, a 28% increase over the 1990 census. Approximately 7.5% of Chicago's population is under age five and 29% are under age 20. Nineteen percent of all Chicago households with children are female-headed, compared to households that are in two-parent, married families with children that comprise only 17% of all households.[2] (Please refer to Appendix G for a map of the designated areas within the City of Chicago.)

4.2 Two Districts – Target Population

Police District 5 ("Pullman") consists of four community areas: Pullman, West Pullman, Roseland and Riverdale. Police District 7 ("Englewood") is comprised of two community areas, Englewood and West Englewood.[3] These two police districts are not contiguous to one another but both are on the south side of Chicago.

The Pullman district is on the far south side of Chicago and starts approximately 7 miles south of downtown Chicago and extends south 14 miles from downtown. The oldest area (Riverdale) was settled in the 1840s, mostly by farmers and laborers. World War II stimulated growth and increased industrial activity. In 1945, the Chicago Housing Authority

[1] At the point of production, the 2000 census figures available to the City of Chicago only covered actual population numbers and racial distribution. Accordingly, unless indicated otherwise, we have relied on 1990 census data and updated population data provided by the City of Chicago.

[2] US Census Bureau, Census 2000.

[3] More than 60 years ago a research committee at the University of Chicago divided the city into 75 community areas based upon social, cultural and geographic factors. Since 1960, two additional community areas have been added. Demographic and health information on these 77 community areas is useful to many community-based organizations, planners, hospitals, universities, and other groups. Our Chicago Safe Start community areas include 6 of these 77 community areas.

completed construction of Altgeld Gardens, providing a low-cost housing development that was expanded in 1954. Today, Riverdale has a higher concentration of subsidized housing than most Chicago neighborhoods, and is a poor community (with a 33% unemployment rate) with the youngest population in all of Chicago. Lacking typical urban infrastructure (shopping district, recreation, etc.) most residents must go north to West Pullman or Roseland for services.

Sections of the Pullman district (Pullman, West Pullman) originated as a planned model industrial town, conceived and built by railroad car manufacturer George Pullman. Developed in 1880, workers moved into rented properties in 1881. The town and all its facilities were owned and operated by the Pullman Company. Most of the earliest residents were German, Irish, Scottish and English. During the next three decades, as the south side working class neighborhoods expanded, Pullman was absorbed into the contiguous city. During the 1950s, whites began to move out of Pullman, but the out-migration was offset by a high postwar birth rate. During the 1960s, a major demographic shift transformed the community as more whites relocated elsewhere as African-Americans settled in the community from the areas north. Most residents have always worked outside of these communities.

During the 1950s and 1970s, African-Americans viewed the Roseland community as an escape from the overcrowded areas to the north where they could come and buy a home and have a future. The median income for Roseland is the highest of all six Chicago Safe Start communities (1989- $31,000), with 60% of housing units single-family dwellings and two-thirds owner occupied. Roseland is a community with resources, but many problems as well. The absence of a revival of the south side industrial base affects all four communities that comprise the Pullman district.[4]

Today Pullman Police District 5 has a population of 116,504 and is 95% African-American. The number of children ages 0 to 5 in the Pullman district is 11,152 or approximately 10% of the Pullman district's total population.[5]

The Englewood (comprised of Englewood and West Englewood) police district is north of the Pullman district, located approximately 7 to 8 miles south of downtown and is geographically smaller than Pullman but with a similar population size, or 101,206 residents. Englewood's earliest development (1840s) came because of railroads that laid tracks in the area. Because of the elevated and interurban transit lines that moved people across the city, in the early 1900s, Englewood shopping districts were easily accessible and the second busiest commercial area in Chicago. In the 1920s, Swedish, Irish, and Germans dominated the population. Only 2% were African American that had lived in Englewood since before the Civil War (and Englewood had been a terminal for the Underground Railroad). Population shifts after World War II coincided with events that led to a decline in Englewood's prosperity. Racial changes led to an exodus of white residents and new competitive shopping centers were built after the war in south suburban communities. Observations in recent decades revealed a community caught in a downward spiral. With characteristics of

[4] Chicago Fact Book Consortium, University of Illinois at Chicago. Local Community Fact Book: Chicago Metropolitan Area 1995. Historical references to Chicago Safe Start areas are derived from this book.
[5] Ibid.

a dysfunctional community, not unexpectedly, growing gang activities and violence is commonplace, resulting in a citywide record number of homicides in the last several years.

Today, Englewood Police District 7 has a population of 101,206 and is 98% African-American. The number of children ages 0 to 5 in the Englewood district is 11,684 or approximately 12% of the Englewood district's total population.[6]

4.2.1. Demographic, Socioeconomic & Health Factors

The two Chicago Safe Start districts share many similarities despite their historical and neighborhood differences. The majority of the time we will report the data by combining the data of the two police districts ("Chicago Safe Start area"), except when there are notable differences between police districts (Pullman and Englewood) or community areas (Pullman, West Pullman, Roseland, Riverdale, Englewood, West Englewood).

Currently the total population for the combined Chicago Safe Start area is 217,710, 97% of which is African-American. Slightly more than half of the population, 112,941 (52%), live at or below 200% of the federal poverty level (FPL) and an astonishing 29% or 63,362 residents live at or below 100% of the FPL. Of those living below the poverty level, 28,573 are children under the age of 18. Of the 77 Chicago community areas, Riverdale is ranked the 5th highest number of children in families living below the poverty level. The median household income in Chicago is $26,301; in the Chicago Safe Start area the median ranged from a low of $6,401 (Riverdale) and $13,243 (Englewood) to $31,699 in West Pullman.[7]

According to a study by the Chicago Department of Planning conducted in 1999, there are 281,757 0-5 year olds living in the City of Chicago. The age distribution of the Chicago Safe Start area is predominately young with 32% of the population is below the age of 18. Our target population of children 0 to 5 totals 22,836 children out of a population of 217,710, or 10% of the total population.

EXHIBIT 1 — Chicago Safe Start TARGET POPULATION

	Under 1	1 to 2	3 and 4	5 years	Total 0 to 5
Pullman District 5					
Roseland	758	1,617	1,676	753	4,804
Pullman	141	266	241	169	817
West Pullman	587	1,307	1,265	577	3,736
Riverdale	298	663	510	324	1,795
Englewood District 7					
Englewood	839	2,095	1,912	933	5,779
West Englewood	861	2,233	1,699	1,112	5,905
TOTAL	3,484	8,181	7,303	3,868	22,836

Source: Local Community Fact Book: Chicago Metropolitan Area. 1995

[6] Ibid.

[7] City of Chicago, Department of Public Health. Community Area Health Inventory, 1996-1998. Volume 1: Demographic and Health Profiles. Volume 2: Rankings. May 2000

Unless stated otherwise, all demographic, health, and population data comes from these two sources.

These financially shaky communities are also predominately comprised of households headed by women, with children present, who are without husbands. The percentage of residents on public aid in the Riverdale community is 53.8% (ranked 1st city-wide) followed by Englewood, at 41.1%, ranked 7th. Overall, in the Chicago Safe Start area, there are 70,684 residents receiving some form of public aid, or 38% of the total population, which is more than 50% of the rate for City of Chicago, as documented in Exhibit 2.

EXHIBIT 2	SAFE START AREAS Total population = 217,710		CHICAGO Total population = 2,783,726	
	Number	Percentage	Number	Percentage
Residents below 200% FPL	112,941	51.9%	1,126,617	40.5%
Residents below 100% FPL	63,362	29.1%	592,298	21.3%
Childhood poverty (under 18)	28,574	40.4	240,968	33.9%
Female headed households	17,375		133,146	
On Public Aid	70,684*	32.5%	569,357	20.5%
Persons over 25 years, not high school graduates	46,272	38%	593,126	34%

Source: Community Area Health Inventory, 1996-1998 Volume 1: Demographic & Health Profiles May 2000
** Updated 1999 data*

Many of the children in the Chicago Safe Start area are born to teenage mothers. Of the 3,936 average annual births (averaged years 1996-1998) in the Chicago Safe Start area, 29%, or 1,149, births were to mothers under age 20. Citywide, the percentage of teen births for the same time period was 18.2%. In Illinois, in 1998, there were 22,632 births to teens (12. 5% of all births). Of those births, 2% (462) were to girls between the ages of 10 and 14. Of those aged 15-17, there were 37% or 8,286 births and 61% of the births were to teen moms that were 18 and 19 years old. In the City of Chicago during 1998 there were 8,637 births to teen mothers; of those, 214 (or almost half of the statewide total) were born to girls under age 15. Children born to teenage mothers are more likely to suffer from developmental, physical, mental, behavioral, and emotional problems. In addition, teen parents typically complete less school than their peers, have larger families, earn lower incomes, and possess minimal parenting skills.

EXHIBIT 3	ILLINOIS Total births = 182,503		CHICAGO Total births = 50,542	
	Number	% of Teen Births	Number	% of Teen Births
Ages 10 - 14	462	2.0%	214	2.5%
Ages 15 - 17	8,286	36.6%	3,205	37.1%
Ages 18 - 19	13,884	61.3%	5,218	60.4%
Teen births (ages 10-19)	22,632	12.4% total births	8,637	17.1% total births

Source: Illinois Department of Public Health, Health Statistics, 1998.

The Chicago Safe Start community areas not only have a higher teen birth rate (29%) than the city (17%) or the state (12.4%), but 75% of children in the Englewood district are born to unwed mothers, and 58% in the Pullman district. Moreover, these areas report infant health and birth outcomes that are worse than the city average. The Chicago Department of Public Health tracks births to women who received no prenatal care. Prenatal care helps reduce the risk of infant mortality, babies born at low birth weight and a host of other life-limiting problems that may arise during a child's development. In the City of Chicago, 3.1% of deliveries were to women without prenatal care. In West Englewood, 7.6% of all births were to women lacking prenatal care or almost two and half times the rate for the city as a whole. Within the Chicago Safe Start communities, 4.5% of the women did not receive prenatal care. In addition, there were 596 (of the 3,936 births) low birth weight babies (less than 2500 grams). Babies born at low birth weight are at greater risk of death and disabilities including developmental delays, cerebral palsy, and seizure disorders. As a widely recognized health indicator, infant mortality is often linked to poor health care, inadequate nutrition, and meager living conditions. The infant mortality rate in Riverdale was 27.1, an astonishing rate when compared to the citywide rate of 10.8.

The designated Chicago Safe Start community areas also have some of the highest rates of HIV/AIDS in Chicago. As of September 2000 (most recent data available), there have been 1,209 identified HIV cases in Districts 5 and 7, of which 486 are still living with HIV. In Englewood and West Englewood the HIV rate is 41 cases per 100,000 and 40 per 100,000, respectively. This compares to a citywide rate of HIV of 28 per 100,000.

Deaths from cirrhosis of the liver also provide clues about the severity of alcoholism in each community. The rates of cirrhosis of the liver are also higher in Englewood (21 per 100,000) and West Englewood (20 per 100,000) than citywide (13 per 100,000). Reliable data on the use and abuse of alcohol and other drugs is difficult to obtain. The Communities Empowered to Prevent Alcohol and Drug Abuse (CEPADA) program has extrapolated from a national study to determine that 6% of all deaths in Chicago were attributable to alcohol, 2% to other drugs, and 17% to tobacco. A variety of indicators are used to make these estimates, such as area liquor sales, injury/accident rates, homicide/arrest statistics, and admission to treatment facilities. According to CEPADA, 24% of total deaths in the Chicago Safe Start communities were attributable to alcohol or other drugs.

In summary, the Chicago Safe Start area is African-American, with over half of its residents living in female-headed households and at or below 200% of the FPL, and with 30% of births to teenage girls. Health status indicators also reveal a community with high infant mortality, higher than average low birth weight babies and mothers without any prenatal care. The rates of HIV, and drug and alcohol use are higher than for the city as a whole. Overall, the Chicago Safe Start area is faced with an array of day-to-day survival problems in addition to the violence threatening these communities as described below.

4.2.2 Violence Data

Violence is the leading cause of death in Chicago.[8] The number of violent crimes in Chicago is significant. During 1995, based on the Chicago Police Department Crime System files,

[8] Department of Public Health. Chicago Violence Prevention Strategic Plan. 1998.

Chicago ranked ninth out of forty-three cities with populations of over 350,000 or more. For the same year, Chicago ranked sixth in the robbery rate (calculated per 100,000 residents) and fifth for aggravated assault. Given these crime rates, the likelihood of children witnessing or experiencing violence is high.[9]

The City of Chicago's police department calculates an "Overall Violent Crime Rate" (combines homicide, sexual assault, and other violent crimes) for the 77 community areas within its jurisdiction. Four of the six Chicago Safe Start community areas ranked in the top 20 in 1996, the last year data were available.[10] Rankings are determined by calculating the rate per 100,000 residents, not the number of crimes committed.

EXHIBIT 4 — OVERALL VIOLENT CRIME 1995-1996[11]

	NUMBER	RATE per 100,000	CITYWIDE RANK
City of Chicago	215,040	7,725	
Pullman District 5			
Roseland	5,072	8,977	26
Pullman	908	9,712	18
West Pullman	3,532	8,863	28
Riverdale	1,326	12,254	13
Englewood District 7			
Englewood	6,157	12,712	10
West Englewood	6,942	13,155	8
TOTAL	23,937		

In the Chicago Safe Start area, there were 23,937 violent crimes committed in one year (1996) or 11% of the total violent crimes citywide, though the Chicago Safe Start area only contains 8% of the total population. When we look at the Englewood district, the statistics are particularly distressing. The average city rate of 7,725 crimes per 100,000 residents is contrasted to 13,155 (West Englewood) and 12,712 (Englewood) per 100,000 residents, an alarming rate of violent crime.

When we look at violent crimes committed against children ages 13 and younger, we see a similar pattern. Englewood and West Englewood rank 5th and 6th (out of 77 community areas) in the City of Chicago.

EXHIBIT 5 — OVERALL VIOLENT CRIMES AGAINST CHILDREN AGES 13 & YOUNGER 1995-1996

	NUMBER	RATE per 100,000	CITYWIDE RANK
City of Chicago	11,410	1,992	

[9] City of Chicago Department of Human Services. Community Assessment Head Start. September 1999

[10] Chicago Police Department Crime System Files of all violent crimes reported to the police; processed and analyzed by the Chicago Department of Public Health. (Six percent of all violent crime victims are not included due to inaccurate addresses.)

[11] Because the numbers and rates for the above measures rely on reported data, one must consider the possibility of underreporting. Therefore, the Chicago Department of Health believes these figures must be interpreted as minimum estimates of the true case numbers and rate.

EXHIBIT 5

OVERALL VIOLENT CRIMES AGAINST CHILDREN AGES 13 & YOUNGER 1995-1996

	NUMBER	RATE per 100,000	CITYWIDE RANK
Pullman District 5			
Roseland	311	2,690	11
Pullman	30	1,550	44
West Pullman	238	2,454	18
Riverdale	91	2,273	22
Englewood District 7			
Englewood	378	2,863	6
West Englewood	406	2,905	5
TOTAL	1,454		

Source: Chicago Police Department Crime System Files of all violent crimes reported to the police; processed and analyzed by the Chicago Department of Public Health

The 1,454 violent crimes committed against children ages 13 and younger in the Chicago Safe Start area represents 13% of the total for the City of Chicago. When we look at homicides in the Chicago, the average annual number (calculated years 1996-1998) was 755 deaths. In the Chicago Safe Start area, there were 97 homicides during the same time period. Fifty-one of those occurred in Englewood and West Englewood, and there were 23 deaths in Roseland. The Illinois Department of Public Health reports gun-related deaths of children by Illinois county. For the three-year reporting period, 1994-1997 (most recent data available), there were 1,007 gun related deaths of children under the age of 19. For Cook County, which includes the City of Chicago, there were 748 gun related deaths of children for the same time period or 74% of the state's total.

Children who live in the Chicago Safe Start area have a greater chance of witnessing or even experiencing gang related violence. Chicago has an extensive gang community with a high prevalence of gang activity and violence. According to the Chicago Police Department's Gang Investigation Section, Gang Analytical Program, in the first seven months of 1999 (January 1 - July 31) there were 10,208 counts of gang related crimes in Chicago. Gang violence affects all aspects of life in these communities.

The statistics reported above are confirmed by a survey conducted by Harvard University's Project on Human Development in Chicago's Neighborhoods, a comprehensive longitudinal study. The Chicago Safe Start area was included in the distribution of this 25 question survey to parents with children ages six and younger, a portion of the research project. It was designed to assess children's exposure to violence.

EXHIBIT 6

CHILDREN'S EXPOSURE TO VIOLENCE AGES SIX & UNDER

	ENGLEWOOD	PULLMAN
Number of children in sample	51	121
During lifetime child heard gun shot(s)	76.6%	62.8%

During lifetime child was present when someone was shot	10%	3.5%
During lifetime, child witnessed somebody attacked with a knife	23.3%	4.6%
During lifetime, child witnessed someone shoved, kicked, punched	46.7%	52.3%

Source: Harvard University, Project on Human Development in Chicago's Neighborhoods 1995

Although startling, it is worth highlighting that in the Chicago Safe Start area are communities whose children are exposed to chronic violence and thus live in fear. When 67% of the children ages 0 – 6 in the Chicago Safe Start area have heard a gun shot(s), we have an exceptionally violent community.

An extensive analysis was conducted recently examining injuries experienced by children in Illinois. Based on hospital records and trauma registry data in Illinois, the Children's Memorial Medical Center estimates that on average, 42 per 100,000 children age 18 and younger required hospitalization as a result of firearm injuries from 1992-1995. During this time period, of the 3,849 trauma registry patients, 86% had been injured as a result of an assault (defined as injuries inflicted by another person with the intent to injure, harm or kill, including child battering and rape), 9% had sustained an unintentional injury and 2% had attempted suicide. [12]

Domestic violence is also a significant problem for Chicago families, including those in the Chicago Safe Start area. Because children are often exposed to violence by witnessing domestic violence between adults, it is important to analyze the prevalence in the Chicago Safe Start area. The Chicago Department of Public Health tracks domestic violence against all women age 18 and older. Defined as violent crimes reported to police that have been perpetrated by a present boyfriend or a present or former husband, this indicator is reported in both number of incidents and rate expressed per 100,000 women age 18 and older. In the six community areas, Riverdale is ranked 3rd citywide, followed by Englewood (5th) and West Englewood (8th) as documented below.

EXHIBIT 7

DOMESTIC VIOLENCE AGAINST WOMEN
AGE 18 & OLDER 1996-1998
Average annual number, rate, rank

	NUMBER	RATE per 100,000	CITYWIDE RANK
City of Chicago	38,069	3,480	
Pullman District 5			
Roseland	843	3,688	30
Pullman	110	2,844	40
West Pullman	1,428	7,397	8
Riverdale	392	10,302	3
Englewood District 7			
Englewood	1,474	8,132	5

[12] Children's Memorial Medical Center – Data & Policy Program Report, 1997;2(1).

West Englewood	1,428	7,397	8
TOTAL	5,675		

Source: Community Area Health Inventory, 1996-1998 Volume 1: Demographic & Health Profiles May 2000

Despite the fact that the Chicago Safe Start area represents 8% of Chicago's total population, it contains 15% of all domestic violence reports to the Chicago Police Department. In addition, according to the Chicago Police Department, in 1998 there were 17,960 calls dispatched to Englewood for domestic violence disturbances; in Pullman there were 12,600 calls dispatched. It is also widely known that the number of calls to the police is not an accurate reflection of the true number of incidents, widely believed to be much higher. Domestic violence profoundly affects entire families and hinders a child's development. Studies have found that children who witness violence in the home are more prone to emotional and behavioral disturbances, are less able to learn, and are at a higher risk to experience abuse themselves.

The City's Domestic Violence Help Line shows the need for domestic violence-related services and the vast numbers of children exposed to violence in the home. The Help Line data presented here are reported by zip code, with a fairly close match between the Chicago Safe Start area and the four zip codes shown in Exhibit 4. The time period covered is eighteen months from January 1999 to the end of June 2000. While some 11% of all callers do not report their zip codes, these numbers do begin to give scope to the need for help. These numbers also only reflect those who were willing, able and ready to reach out for assistance. With these limits in mind, the Help Line shows that there were 334 callers from Englewood and 351 from Pullman, or just over one percent of households in each district, compared to just under 1 percent of households citywide calling for assistance.

EXHIBIT 8

VICTIM CALLERS to the CHICAGO DOMESTIC VIOLENCE HELPLINE
JANUARY 1999 TO JUNE 2000 (18 months)

	Englewood (60621, 60636)	Pullman (60628, 60643)	Citywide
Victim callers	334	351	9,197
Victim callers with children	175	166	4,446
Number of children 0-5 living with victim callers	200	166	–
Households	28,525	34,105	1,020,911

Source: Mayor's Office on Domestic Violence

For the 685 victim callers from these two communities, Exhibit 9 documents the types of services that were requested. Of a total of 1,002 services (up to two services are recorded per caller) there were 421 (42%) requests for shelter, 298 (30%) requests for legal aid, 194 (19%) for counseling, 43 (4%) for information only, and 46 (5%) for all other services, which includes specific requests for help for children.

EXHIBIT 9

Services Requests to the Chicago Domestic Violence Help Line, in the Englewood and Pullman Districts January 1999 to June 2000 (18 months)

	Number	Percentage
Shelter	421	42%
Legal Services/Advocacy	298	30%
Counseling	194	19%
Information Only	43	4%
Other (includes services for children)	46	5%
Total	1,002	100%

Source: Mayor's Office on Domestic Violence

Approximately half of the callers in these zip codes reported having children, and some gave the children's ages, showing that there were a minimum of 200 children aged five and under in Englewood and 166 in Pullman who may have been exposed to domestic violence in their homes.

A study that estimated the prevalence of domestic violence against women attending Chicago Department of Public Health clinics found that nearly half of the more than 1,400 women surveyed had been abused at least once in their lives; 34% had been abused physically, 18% sexually and 32% verbally abused by someone close to them. Within the previous year, 19% had been physically abused.[13]

Although the number of child abuse and neglect cases has been declining, incidences of abuse and neglect continue to plague Chicago's children. Between FY 91 and FY 95, the number of calls statewide to the Department of Children and Family Services ("DCFS") child abuse hotline increased by 41.5%, which resulted in a 43.4% increase in the number of children taken into custody. In 1995, Illinois had the highest rate of children in substitute care in the nation.[14] Since that time most state child welfare systems have continued to grow. This is no longer true in Illinois and the rate of children in state care is rapidly moving toward the national median. In FY 2000 (ending June 30, 2000), Child Abuse Hotline staff responded to 306,818 calls involving possible abuse or neglect. In FY 1998 there were 46,125 children is substitute care and by FY 2001 (ending June 30, 2001) there were 27,330 children in substitute care. In FY 2000, DCFS logged 40,858 child abuse and neglect reports in Cook County of which 11,151 were substantiated, meaning that investigators found credible evidence that child abuse or neglect had occurred. In 1999 there were 8,369 children in Cook County in substitute care (living with relative, foster parents or group homes).[15]

[13] Chicago Department of Public Health. The Prevalence of Domestic Violence Among Women Attending Clinics. 1995.
[14] Peddle, Nancy, Ph.D. Current Trends in Child Abuse Prevention, Reporting and Fatalities: The 1999 Fifty State Survey. National Center on Child Abuse Prevention Research. April 2001.
[15] IL Department of Children & Family Services.

DCFS data for fiscal year 2000 (the last full year available) show that approximately 532 children in Englewood and 466 in Pullman were substantiated for child abuse and/or neglect. This reflects a rate of 15.2 indicated reports of child abuse for every 1,000 children in Englewood and 10.8 per 1,000 in Pullman. [16]

The long-term consequences of violence have been documented in multiple studies of victims of child abuse and neglect. The findings indicate that these children experience problems with physical, social and emotional development. Women studied with a history of physical or sexual abuse during childhood, when compared to women who reported never having experienced abuse, women victims of child abuse were more likely to have adult health problems including physical symptoms, psychological problems and substance abuse problems.[17]

Establishing prevalence, analyzing trends, and identifying demographic, socioeconomic and other factors associated with violence, are necessary first steps in the process of developing, implementing and evaluating strategies for prevention and intervention.

5. Community Assessment

The community assessment was conducted by drawing upon numerous sources of quantitative and qualitative data. Chicago Safe Start staff conducted over 150 interviews with community activists and organizations, city and state staff, and numerous policy experts statewide. Additionally, 10 focus groups of community residents and leaders were conducted, five in each Chicago Safe Start district. (For the data-gathering tool, see Appendix A. For a list of interviewed participants, see Appendix B.) Finally, several community-wide meetings were held. The primary quantitative data sources were the City of Chicago and the State of Illinois various data sets, referenced as footnotes throughout this document.

5.1 Service Mapping – Target Areas

The Chicago Safe Start districts do not currently have services specifically geared to address the symptoms of children ages 0 – 5 who have been exposed to violence. There are, however, numerous services available to children and families that range from childcare to health care, including many other services that address community needs. Please refer to Appendix G for maps of services in the Englewood and Pullman districts.

In the Englewood district, there are many different community activist and community-based organizations. There are approximately 260 churches and organized clergy organizations, domestic violence/homeless shelters, numerous advocacy and civic organizations including arts programming, after-school care, and recreational programs. The matrix below outlines the major organizations, services offered, hours of operation, transportation services and existing client capacity, when known.

---

[16] Ibid., Office of the Research Director, Performance Outcome Indicators, July 2001 Update, LAN 86 (Pullman), LAN 79 (Englewood)

[17] McClauley J, Kern DE, et al. Clinical Characteristics of Women with a History of Childhood Abuse: Unhealed Wounds. JAMA 1997; 277:1362-1368.

EXHIBIT 10

Agency/ Organization	Services Provided	Eligibility Requirements	Transportation Provided?	Hours of Service	Capacity/ Availability
ABJ Community Services	DCFS-contracted social services	DCFS referrals	Bus cards	M-F, 9-5	NA
Abraham Lincoln Center	Head Start, Child Care	Parents must be working or going to school	No	M-F, 7-6	NA
Ada S. McKinley Community Services	Head Start, Child Care	Parents must be working or going to school	Bus cards	M-F, 9-5	NA
Boulevard Arts Center	Creative arts programs (dance, theater, music); after-school programs; training program for parents and youth	Open to community residents	No	M-F 3-7	Serves 1500 children per year, ages 6 and up
BRASS Foundation	Counseling for youth; substance abuse treatment	DCFS, DHS, hospital and/or court referrals	Bus cards	M-F, 9-5	35 children in youth counseling, ages 13-18 in treatment, one-week waiting list
Centers for New Horizons	Child Care, Early Child Care	Parents must be working or in school	No	M-F, 7-7	NA
Children's Home and Aid Society	Child Care, DCFS provider, case management, independent living	DCFS, other referrals	Yes	24 hours per day, 7 days per week	DCFS availability: serves 224 children in child care
ChildServ	Support services for children and families	Referrals	No	M-F, 9-5	Early Head Start has 30 families; PEPP has 60. Serves over 150 children, ages 0-3 / Waiting list no longer than 30 days
Clara's House	Homeless shelter	50 beds	Yes	24 hours	Serves 50 community residents; waiting list changes daily
Community Mental Health Council	Mental health services	Referral	No	M-F, 9-5	3,286 clients monthly in all programs, residential and outpatient/ No wait list due to centralized intake, but variable wait lists depending on programs
Englewood Community Conservation Council	Advocates for community and city government investment	NA	NA	NA	NA
Free Peoples Clinic	Provides health care as well as	None	No	M-F, 6 am - 9 pm	Capacity is 5,000, but currently serves 3,000

EXHIBIT 10

Agency/ Organization	Services Provided	Eligibility Requirements	Transportation Provided?	Hours of Service	Capacity/ Availability
	job training and other support services				adults & children. 10% of 3,000 is children ages few weeks old – 18 years / No wait list for medical services
Harris YWCA	Provides sexual assault and domestic violence services	Referral from network of hospitals, courts	No	Advocates available 24 hours/day	RISE children's center annual targets 350 children ages 3-17 for sexual assault treatment services. Currently serve 150.
Imagine Englewood If	Brings together all those interested in seeing Englewood become a safer, healthier community	NA	NA	NA	Partners with 5 organizations; served 10 organizations this past year.
Kennedy-King College Child Care	Provides odd hour child care services	Parents must be working or going to school; sliding scale fees	No	M-F, 7:30 am–5:30 pm; 2:30 pm-12: 30 am	Day program serves up to 75 children ages 3-5. Extended day program serves up to 75 children ages 2-12. Serves up to 150 children total / Wait for entrance into day program could be up to a year. No wait list for extended day program.
Maria Shelter	Homeless shelter	None	No	24 hours	40 beds
Metropolitan Family Services	Provides a wide array of prevention and reduction services, including counseling, parent training, home visiting, domestic violence prevention and intervention, and grandfamily support	DCFS, court and community referrals	No	M-F, 9-5	Clients usually wait up to 2 months, depending on the specific counseling program
Neighborhood Housing Services	Provides outreach, counseling and referrals to children and families	Resident of community	No	NA	NA
Reach Out and	Provides	Homeless – only	No	24 hours	Serves and average of

EXHIBIT 10

Agency/ Organization	Services Provided	Eligibility Requirements	Transportation Provided?	Hours of Service	Capacity/ Availability
Touch	outreach, counseling and referrals for children and families	have 18 beds			92 – 100 children in the community. Currently, there are about 20-25 children in counseling. Headcount of children changes daily / Wait list N/A
Englewood Neighborhood Health Center, CDPH	Provides basic health and mental health care services	None	No	M-F 9-5	
Solace Place/St. Joseph's of Carondelet Youth Center	Residential youth center promoting positive youth development, support, education	Referrals from Probation Court, DCFS	Bus cards	24 hour residential facility	Serves 29 children in residential and 40 children in schools; therapy & counseling / Usually no wait list, but occasionally the wait is up to 2 weeks
St. Bernard's Hospital	Community-based institution providing health and mental health care	None	No	24 hours	NA

In the Pullman district, there are some major non-profit organizations and churches, a large YMCA, a Catholic Charities organization, and Metropolitan Family Services. The Salem Baptist Church, one of the largest churches in the City of Chicago, is located in Pullman, and offers a wide range of programming, including a recent mission of investing in housing. The matrix below outlines some of the major organizations, services offered, hours of operation, transportation services and existing client capacity, when known.

EXHIBIT 11

Agency/ Organization	Services Provided	Eligibility Requirements	Transportation Provided?	Hours of Service	Capacity/ Availability
Ada S. McKinley Community Services	Child Care, After School program	Parents must be working or going to school	No	M-F, 7-6, 2-midnight	After school: 3-4 years old Child Care: 6 weeks – 5 years old Night care: 2-5 years old Head Start: 3-5 years old
Agape Center	Family services	None	No		NA
Altgeld Health Center	Health care	None	No		NA
Am I My Brother's Keeper	Post-incarceration support				
BAGS	Mentoring				

EXHIBIT 11

Agency/ Organization	Services Provided	Eligibility Requirements	Transportation Provided?	Hours of Service	Capacity/ Availability
Foundation	tutoring, sports				
Bethany Christian Services	Foster care, crisis pregnancy counseling, adoption				
Blanton	Head Start, child care			M-F 8:30-11:30 am, 12:30-3:30 pm	68 children
Centers for New Horizons	Child Care, Head Start	Parents must be working or going to school	No	M-F, 7-6	Child Care: 90
Central Baptist Family Services					
Chicago State University Child Care	Child Care, Head Start	Parents must be working or going to school; sliding scale fees	No	M-F, 7-5:30	Child Care: 2-4 year olds Head Start: 3-5 year olds Total of 160 children served
Chicago Youth Centers, Altgeld/Murray and Roseland Community Centers	Child Care, Head Start	Parents must be working or in school	No	M-F 7:30-5:30	Full day: 3-5 year olds, does accept children with disabilities; capacity is 15. Half day: 3-5 year olds, also accepts with disabilities; capacity is 34
Center for Community Health Services	Case management, mental health, WIC, child care, teen parent classes, substance abuse	None	No		
Community Learning Center	Child Care, Head Start			M-F 6:30-5:45	Child care: 65 slots, ages 2-6 Head Start: 88 slots, ages 3-5
Community Supportive Living Systems	Housing for people living with HIV/AIDS	DCFS wards of the state	Yes		
Developing Communities Project	Counseling for parents and children	None	No	M, Th 6-8, T, W 6-8	Two counselors who work with children while mother is in counseling; 20-25 children.
Family Rescue Community	Transitional housing	None	No		

EXHIBIT 11

Agency/ Organization	Services Provided	Eligibility Requirements	Transportation Provided?	Hours of Service	Capacity/ Availability
Outreach	emergency domestic violence shelter, child counseling, court advocates				
Ford Center for Adolescent Parenting Programs (Catholic Charities)		Ages 13-18, resident of community area	Yes	M-F, 9-5	
Garden Medical Center	Family health care				
Greater Roseland YMCA	Child Care, After School programs			Summer: M-F 7-6; M-F 2-6	Year round: 52 slots, 5-13 years old
HealthCare Consortium of Illinois	Links for DCFS wards with health and mental health care	DCFS wards of the state	Yes	24/7	
Joseph/Oakland	Head Start, Child Care			M-F 8:30-11:30 am, 12:30-3:30 pm, 6-6	73 children
LAMMB Shelter	Transitional housing, social service referrals, etc.	CDHS referral	No	M-F, 9-5	50 families allowed to stay up to 120 days.
Metropolitan Family Services	Provides a wide array of prevention and reduction services, including counseling, parent training, home visiting, domestic violence prevention and intervention, and grandfamily support	None	No	M-F 9-5, evening hours by appt	
Neighborhood Housing Services	Rebuild low and moderate income areas	None	No	M-F 9-5, Saturdays by appt	
Olive-Harvey	Child Care	For night care:		M-F 7:30-	60 slots each in day

EXHIBIT 11

Agency/ Organization	Services Provided	Eligibility Requirements	Transportation Provided?	Hours of Service	Capacity/ Availability
College		parent is student and taking night classes		5:30 and 6:30-9:30	and night child care, ages 3-5
Rainbows	Peer grief support for youth				
Roseland Neighborhood Health Center	Health and mental health care				
Sisters Keepers	Support for women returning from prison				
Southside Help Center	After school programs, counseling	None	Bus cards for students	M-F 9-5:30, extended hours for high school students	Summer day camp serves 32 youth; substance abuse and violence prevention program targets 100 youth per school year; life skill development program targets 100 youth per school year; after school program serves 58 youth; peer leadership program serves 24 youth
Southwest Women Working Together/Amani House	Domestic violence shelter, Child Care				36 beds
Soweto	Family planning, case management				
Trinity United	Child Care, Head Start			M-F 7-5:30	Child care: 89 slots ages 6 weeks to 5 years Head Start: 34 slots
V&J Child Care	Child Care			M-F 6-5:30	70 children, licensed for 87
West Pullman Medical Center	Health care				

Citywide, there are numerous organizations and agencies involved in violence prevention, reduction, and others that provide services to victims and perpetrators. A brief summary description appears below.

EXHIBIT 12

All Our Kids: Birth to Three Networks – Catholic Charities – various social

local networks to ensure that children ages three and younger and their families have the opportunity to receive needed services	services
Chapin Hall Center for Children, University of Chicago – policy research and evaluation center	Chicago Metropolis 2020 – region-wide policy group engaging business leaders and policymakers on improving the region in issues including violence prevention and juvenile justice
Chicago Metropolitan Battered Women's Network – coalition of domestic violence service providers	Chicago Public Schools, Cradle to Classroom – provides enriching activities to young children of teenage parents while supporting the parents to finish high school
Chicago Public Schools, Parents as Teachers First – recruits and trains parents to serve as tutors and mentors to other parents, focusing on enrichment activities for children	Children's Memorial Hospital and Medical Center – first responder curriculum; Safe Homes and Havens; Effective Black Parenting; Child Data Lab
Community Mental Health Council, Institute for the Prevention of Violence – comprehensive, culturally-sensitive research, advocacy and training on prevention, intervention and community-strengthening services	Domestic Violence and Mental Health Policy Initiative – broad collaboration spearheaded by Cook County Hospital to determine modes of effective system integration and collaboration
Erikson Institute – nationally recognized provider of early childhood development training and research	Greater Englewood Healthy Start Initiative – targeted infant mortality reduction program based at the Englewood Neighborhood Health Center
La Rabida Children's Hospital, Child Witness to Violence Intervention – training curriculum and screening protocol for health care professionals to identify children and their families who are at risk of or already exposed to violence	Metropolitan Family Services Legal Aid Bureau – provides support in family law issues and has special domestic violence team.
Ounce of Prevention Fund – invests in children and families through innovative direct service and research	Project on Human Development in Chicago Neighborhoods, Harvard University – major interdisciplinary study aimed at deepening society's understanding of the causes and pathways of juvenile delinquency, adult crime, substance abuse and violence.
Union League Boys and Girls Clubs – safe and positive youth development activities	United Way, First Call for Help – links callers with community-based resources throughout Chicago

While there are no services currently invested explicitly or directly in exposure to violence in the Chicago Safe Start districts or citywide there are key system and other agencies that are direct providers of services for children and families at risk. These systems and agencies have potential points of intervention for the Chicago Safe Start project and are elucidated below.

5.1.1 Department of Children and Family Services

DCFS is among the nation's largest state child welfare agencies. DCFS has the responsibility of investigating allegations of child abuse and neglect as well as providing family preservation services directly or indirectly through contracted agencies. Placing a child in substitute care - a foster family home, group home or institution - is not intended as a permanent living arrangement but to protect the child with the ultimate goal of returning the child to the parents or to a permanent living situation.

DCFS has contracted with 1,700 private providers of services ranging from foster care placement to counseling services. There are several of these agencies in the Chicago Safe Start area (Please see matrices on pages 25-32 for listing of organizations in Chicago Safe Start community areas; Appendix G for maps).

Staff training and continuing education have become top priorities for the agency, particularly as they have moved towards a decentralized system. All DCFS supervisors and line staff are now required to attend six weeks of clinical practice retraining. This training differs from prior efforts in that the emphasis is on making critical decisions, using structured decision-making tools, and influencing family behavior. Training methods are now experiential and interactive. In addition, DCFS is also working to increase the training of private agency workers.

DCFS has appointed a Domestic Violence Liaison within the past year who works with the domestic violence advocacy and provider community to reduce the potential for children to be removed unnecessarily from a home due to a mother's own victimization and resulting "failure to protect" her children from harm. The domestic violence community views this as a major step forward.

The major point of access for Chicago Safe Start may be to include our curriculum in the DCFS training of staff, substitute care givers, and private agency staff with a goal of raising consciousness about the issue of exposure to violence on young children as well as equipping them to recognize symptoms in children exposed to violence and to make appropriate referrals.

5.1.2 Police/ Courts - Child Protective, Domestic, Juvenile Delinquency

The law enforcement and legal systems in Chicago have been affected by changing views of violence. Starting with the police and continuing through the court system, practice around issues of domestic violence, in particular, have changed dramatically in recent years. The development of collaborations with victim advocacy groups to achieve appropriate and consistent policies of response among police, courts and social service agencies is an important beginning.

Chicago's law enforcement and legal systems are made up of city, county and state agencies, each of which can be considered a complex system unto itself.

Chicago Police Department

The second largest police force in the country is in the City of Chicago. With over 16,000 Chicago Police Department (CPD) employees (including 13,500 sworn police officers) for the delivery of services the department divides the city into five areas of command and 25 districts. Two of the 25 districts represent the Chicago Safe Start area. In District 5, Pullman, there are approximately 290 police officers and District 7, Englewood, has around 390 officers.

The centerpiece for CPD in recent years has been the Community Alternative Policing Strategy program (CAPS). The organizing principle is that police and community residents need to work together to solve the problems in the community. Partnership takes place at both the beat and district level. Each district has an advisory committee of community leaders that help identify issues and set broad priorities.

The CPD has also undertaken a number of initiatives regarding domestic violence. Within CPD, a Domestic Violence Operations Coordinator has been charged with developing training and ensuring consistency and uniformity in CPD's response to victims of domestic violence. This has been accomplished through:

- Appointment of Domestic Violence Liaison officers to help develop and strengthen linkages between beat officers, victims, and community based service providers
- Enhanced domestic violence trainings, including a 28-hour (well above the state-mandated seven hours) *Family Violence Workshop* for recruits that addresses child abuse, elder abuse and domestic violence
- Development of a response protocol
- Response to officer-involved incidents
- Improved analysis and mapping of high-risk locations

Potential points of intervention for Chicago Safe Start may include building off of the domestic violence successes to include the recognition of exposure to violence on young children by developing an agreed upon protocol when responding to domestic violence calls.

Cook County State's Attorney

The State's Attorney's Office created a separate Juvenile Justice Bureau in 1997 with 2 divisions: child abuse and neglect, and juvenile delinquency. This 96-member group is headed by a Senior Assistant State's Attorney and all staff attend mandatory weekly training sessions on child protection laws, child development, community policing, DCFS structure and policy, parenting, social service agencies and drug treatment options. The State's Attorney's Office also has a domestic violence unit created by the State's Attorney to prosecute stalking, domestic battery, and other domestic violence cases. It consists of 22 prosecutors and victim assistance specialists. This unit works closely with advocacy groups to ensure the victims get the help they need.

Domestic Violence Court

In the City of Chicago, three court systems are involved in the handling of partner abuse cases. The vast majority of criminal charges for domestic abuse are misdemeanor charges, all of which are heard in a single court building. A range of specialized services for victims of domestic violence is based in this facility, and all clerical and legal staffs are specially trained on domestic violence.

The Domestic Violence Court has a Children's Room on the first floor of the building. The Room was established in June of 1998. Hours of operation are daily from 8:30 a.m. to 4:30 p.m. The Children's Advocacy Clinic is located adjacent to the Children's Room, and began providing services in October/November of 1999, run through the Office of the Chief Judge. Appointments for either individual or family counseling can be scheduled at 9:00 a.m. or 1:00 p.m. everyday. The Children's Room acts as a childcare center while the victim's case proceeds on the second floor of the Court. The children partake in games, movies and arts and crafts. Singers, musicians, storytellers and drama teams visit the Room to entertain the children, as well. The Children's Advocacy Clinic conducts mental health and case management assessment through the efforts of an on-staff therapist and case manager.

Felony domestic violence cases are heard in Criminal Court. There are two felony-level State's Attorneys that specifically prosecute domestic violence cases, but many cases are not assigned to them due to caseloads beyond their capacity.

The third court is the Domestic Relations division of the civil court. A victim may choose to get a civil order of protection in conjunction with a domestic relations proceeding, such as a divorce.

A potential point of intervention for identifying young children that may have been exposed to domestic violence is through the Children's Room in Domestic Violence Court. By training the workers to identify the symptoms of exposure to violence in young children, they may be able to make referrals to the Chicago Safe Start network of providers in the Chicago Safe Start districts. Furthermore, as Chicago Safe Start expands to include other areas of the City, the referral database could be expanded.

Juvenile Court

Over 100 years ago, Illinois was the first state to create a separate court system for the consideration of juveniles, in recognition of the fact that children are developmentally different from adults and those differences should be taken into account.

The Cook County Juvenile Detention Center is responsible for holding youth that are awaiting hearing in the juvenile or criminal courts (90%) or holding some youth prior to entering the Department of Corrections (10%). All youth in the center receive 5.5 hours a day of on-site academic instruction, as well as after school programs such as art programs, 4H, Girl Scouts, Music, Theatre, etc. The average daily census is about 450 youth.

The ability of the Court system's ability to address primary prevention may be somewhat limited by the fact that they see youth after they have allegedly committed some act of delinquency. However, a potential point of intervention may be to train judges and other

staff to make referrals after identifying siblings or children of the juveniles brought before them that may have been exposed to violence.

5.1.3 Domestic Violence & Homeless Shelters and Services

The Mayor of the City of Chicago created the Mayor's Office on Domestic Violence (MODV). MODV's mission is to ensure a coordinated and comprehensive community response to domestic violence in Chicago. In partnership with the Mayor's Domestic Violence Advocacy Coordinating Council, MODV provides planning and monitoring for a multi-disciplinary, multi-system approach to promote effective intervention and prevention of domestic violence in Chicago. The goal of this process is to create conditions that ensure that victims are provided with effective protection and support and that perpetrators are held accountable for violent acts. MODV houses and funds the Citywide DV Help Line, a 24-hour, multilingual, toll-free service which links DV victims and their children with shelter, counseling, legal services and other ancillary services. A key feature of the Help Line is that the caller can be linked with needed services by keeping the caller on the line while determining availability with the most appropriate provider. The Help Line serves as an up-to-date clearinghouse for service availability. MODV also employs a full-time community organizer in Englewood and as of July 1, 2001, MODV has a full-time organizer in Pullman.

As part of their broader research, Harvard University's Project on Human Development in Chicago's Neighborhoods conducted a small sample survey in our two police districts 5 & 7 to parents with children ages six and younger. The results revealed that 23.5% of the primary caregivers surveyed were victimized by partner violence in the last year in Pullman and 26.1% in Englewood.[18]

Chicago's partner abuse victim services are provided by a diverse array of independent, community-based agencies and programs organized around a central mission of meeting the needs of victims and their families. Current counts estimate at least 44 agencies providing services to Chicago victims, one-fifth of whom provide services at multiple sites throughout the city.[19] These providers are geographically distributed throughout 33 of the City's 77 community areas; of note, however, is that victim service providers are situated in only nine (38%) of the 24 community areas with the highest reported rates of domestic violence against women.[20] These agencies deliver services to both the general population of partner abuse victims as well as specific groups, such as women with disabilities and of specific cultures and races.

In the city, there are six shelters specifically devoted to serving women and child victims of domestic violence; four of these receive CDHS funding; one is in the Chicago Safe Start area. A service assessment by the Chicago Domestic Violence Advocacy Coordinating Council indicates that the city's six domestic violence shelters provide a total of 211 beds. State service reports show that five of these six shelters served 1,923 domestic violence clients for 43,538 nights in FY 1996.[21] Centralized intake for some domestic violence shelters

---

[18] Harvard's Project on Human Development in Chicago Neighborhoods

[19] CDPH Epidemiology Program. *Rates of Domestic Violence Against Adult Women Reported to the Police and Location of Services, Chicago, 1995-96*; Mayor's Office on Domestic Violence, *Assessment of the Current Response to Domestic Violence in Chicago*, 1997.

[20] CDPH.

[21] MODV, 10/1997.

occurs through CDHS, which also tracks bed availability and provides emergency transportation to Chicago shelters.

5.1.4 Chicago Public Schools/Child Care/Head Start

The Chicago Public Schools (CPS) serve approximately 435,470 children (September 2000) in 491 elementary and 92 high schools, which accounts for 21.4% of all public school children in the state. The children are distributed across pre-school through secondary education.

- 19,067 Pre-School
- 2,726 Pre-School Special Education
- 33,733 Kindergarten
- 283,755 Elementary (grades 1-8)
- 96,189 Secondary

Most students (85.6%) come from low-income families (compared to 34% statewide) and more than 13.8% have limited English proficiency. Forty nine percent of the students are African American, 14.9% are Latino, 34.1% are White, 1.9% is Asian/Pacific Islander and .3% is Native American. [22]

CPS offers several early childhood programs for our targeted age group. An innovative home-based program for preschool children who are not enrolled in early childhood education programs, *Parents as Teachers First*, coordinates home, school, and community programs to provide learning activities for children aged 3-5. The program is designed to foster and nurture child development in language, cognitive intelligence and social skills. The program serves approximately 10,000 children. The *Cradle to Classroom* program is intended as an indirect violence prevention initiative that combines the efforts of parents, staff, the health department, and local hospitals to provide services to 4,000 pregnant and parenting teens in 75 high schools in the city. The program also works directly with infants (*Child Find*) to identify those that may be cognitively, socially or emotionally at risk and provide them with opportunities for healthy development through Early Intervention Services. These programs are aimed at decreasing the dropout rate, improving parenting skills and preparing young children to enter school.

In the Chicago Safe Start district of Englewood there are 22 elementary schools (Pre-K or K through 8th) and there are 18 elementary schools in Pullman.

In Chicago, as elsewhere across the country, child care services vary by type, settings, missions, affiliations and levels of formality. The broad array of child care services includes, but is not limited to: privately owned for-profit care, publicly-funded early childhood education (Head Start) and pre-kindergarten programs, respite care, night care on-site at factories or hospitals, and care given by relatives or family friends on an as-needed basis. The scope of services offered through childcare is also variable. Services may range from purely custodial, to more comprehensive services designed to provide children with a head start on development, school-based learning and socialization, combining linkages to health and nutritional services and social services for family members.

[22] Chicago Public School website 2001. www.cps.k12.il.us

For FY 2000 there were an estimated 46,405 publicly funded child development slots for 0 to 5 year olds in Chicago. These include programs in Head Start, Child Care, and Pre-Kindergarten and Child Parent Centers operated by the Chicago Public Schools. Of these 46,405 slots, 14,717 (33.9%) are under the jurisdiction of Head Start; 20,116 (43.3%) are under the jurisdiction of Chicago Public Schools; and 10,572 (22.8%) represent Child Care programs. The allotted slots for child care only for 0 to 5 year olds was 12,293 in FY 2000 funded by both Chicago and Illinois Departments of Human Services. In addition, Chicago has 575 Early Head Start slots.

In the Chicago Safe Start districts there are many child development programs as documented below.

EXHIBIT 13

Pre-K, Head Start, Child Care & Other child development sites

	Englewood #	Pullman #
State Pre-K sites	18	15
Head Start sites (CDPH & other)	8	5
Child Care (private & public funded)	4	18
CPS Child Parent Centers	1	1
Other child development sites	9	6

Source: Chicago Department Human Services, 2000

(For map of locations, see Appendix G)

A potential point of intervention for Chicago Safe Start may be the training of childcare and other staff that work with the Chicago Safe Start target population in the potential ramifications of exposure to violence on young children.

5.1.5 Health Care

Chicago's health care system consists of a diverse array of primary and specialty care providers, operating under a range of organizational structures and delivering care in a variety of settings. Approximately 6,400 physicians practice medicine throughout Chicago's communities. There are 42 acute care and rehabilitative hospitals in the Chicago area including private, non-profit and government-sponsored facilities.

Mirroring national trends that affect health care financing, we have seen increased consolidation of health care providers. This has increased competitive pressure upon local providers and has resulted in a dwindling of resources available for those unable to pay for health care. A growing number of uninsured both nationally and locally exacerbates this situation.

Primary care is generally recognized as a critical access point to health services and is a particularly important element of a city's health care response to violence. In addition, trauma centers (emergency room care) are vital sites in a system designed to address

issues of violence, particularly in a city the size of Chicago. There are eight hospitals that are designated as Level 1 Trauma Centers, indicating they are equipped to handle the most severely injured patients. Most of the trauma patients in the Chicago Safe Start designated areas are seen at Cook County Hospital and Christ Hospital and Medical Center.

Primary Care

In the public sector, the Chicago Department of Public Health and the Cook County Bureau of Health Services are major providers of outpatient care, each operating primary care clinics with services ranging from maternal and child health to more comprehensive primary care. These are supplemented by over 60 community health centers, owned and operated by freestanding community boards, which are supported through a combination of public and private grants and government reimbursement.

Despite the apparent abundance of providers in Chicago, it is noteworthy that 26 of Chicago's 77 community areas have been designated as Health Professional Shortage Areas (indicating a serious shortage of primary care providers for the size of the population). Four of our six Chicago Safe Start community areas are health professional shortage areas (Englewood, West Englewood, Pullman and Roseland) and the more difficult federal designation – Medically Underserved Area (calculates physician to population ratios in addition to factoring in health status indicators) has been granted to Englewood, Roseland and Riverdale.

The Chicago Department of Public Health operates 8 community health centers, two of which are in the Chicago Safe Start target area. These health centers provide a wide range of maternal and child health services, including some specialized, targeted projects, such as an Englewood Pregnancy Gain Initiative, Roseland Breastfeeding Challenge, Home Instruction Program for Preschool Youngsters and WIC services. In addition, the CDPH operates a public health nurse home visitation service for mothers and infants identified as at-risk and it runs a state funded Chicago Family Case Management Program that serves pregnant women infants up to age two.

There are three non-profit free-standing community health centers in the Chicago Safe Start target communities, all of which offer a comprehensive array of federally mandated services. Unfortunately, none of the 30 Cook County operated clinics are located in the Chicago Safe Start area. Chicago Safe Start could build on the existing primary care network to increase awareness of children's exposure and to ensure appropriate referrals for service are made.

Hospitals

As previously mentioned, there are two Level 1 Trauma Centers that patients from the Chicago Safe Start area utilize (physically located outside of the Chicago Safe Start community) in addition to two community hospitals located within the boundaries, St. Bernard's Hospital and Roseland Hospital.

Cook County Hospital is the largest Level 1 Trauma Center serving Chicago and the Chicago Safe Start area. Domestic violence and child abuse are critical problems in the hospital, with estimates that 30% of the women seen in the ER/trauma units have experienced victimization at some point; additionally, child abuse is the third most common discharge

diagnosis in the Department of Pediatrics. Screening for domestic violence victimization occurs routinely in the ER, trauma units, and OB/GYN department. Staff is also taught to assess domestic violence through observing children, thus acknowledging the link between child abuse and the abuse of women. Cook County began the City's first domestic violence crisis intervention project offering services on-site and through referral. When abuse is identified, clients are informed of the available services (crisis intervention, counseling, legal information, access to emergency shelter, etc.), and linked, if desired, to an on-site advocate that schedules or refers for services.

Chicago Safe Start could potentially build upon the violence and domestic violence efforts that are already underway to train staff to understand the importance of recognizing and intervening when children are exposed to violence, either at the time of the incident or as symptoms began to develop.

5.1.6 Mental Health/Substance Abuse Services

Mental health services in Chicago are delivered through three types of programming: community mental health services, emotional support services as components of other programs, and services from independent providers.

In addition to services that are primarily funded for the seriously and persistently mentally ill, Chicago offers a variety of agencies and programs that provide psychosocial counseling and support to individuals and families. Within the City of Chicago, there are more than 400 freestanding programs that provide some level of psychosocial care to individuals and families; many of these serve specific population groups, including the elderly, people living with disabilities, lesbian, bisexual and gay adults and adolescents, and the homeless.[23] Chicago residents are served by four Illinois Office of Mental Health and Developmental Disability (OMHDD)-funded psychiatric hospitals: Chicago Read, Elgin, Madden and Tinley Park Mental Health Centers. These are in addition to many privately operated in-patient facilities reimbursed through Medicaid and other forms of insurance.

Mental health practitioners may include psychiatrists, psychologists, social workers, professional counselors, and marriage and family therapists. The Illinois Psychiatric Society estimates that of their member psychiatrists, 1,700 are from Chicago.[24] While estimates of other licensed mental health professionals are not available for the City of Chicago, the Illinois Department of Professional Regulation reports that within Cook County, 1,911 psychologists, 3,880 clinical social workers, 183 professional counselors and 141 marriage and family therapists hold active professional licenses.

OMHDD-funded mental health services are primarily dedicated to the provision of care for individuals who meet the criteria of seriously and persistently mentally ill. Those who do not meet such criteria includes all individuals and families that require emotional and psychosocial support across a broad range of situations, from crisis and situational assistance to ongoing mental health care. For this larger and more diverse group of potential clients that do not benefit from a coordinated mechanism of assessment and

[23] United Way, *Human Care Services Directory, 1998-1999.*
[24] Illinois Psychiatric Society, January 2000.

referral, they must rely on insurance coverage or self-pay to finance care, and they receive little or no public education on the benefits of psychosocial and emotional support, and may not be aware that support is available. All of these factors, in conjunction with a negligible public funding to providing care for the general population limit the availability of mental health support for Chicago residents.

The Chicago Department of Health operates 16 mental health centers throughout the city, 2 of which are within our Chicago Safe Start target area. These behavioral health clinics provide services for chronically mentally ill adults and currently do not have the resources or trained staff to provide pediatric or other family-oriented services.

According to the CDHS 1998 Program Information Report, only 586 children in city funded Head Start programs were referred for mental health treatment, and only 475 received treatment citywide.

OMHDD and Medicaid fund outpatient clinic services for providers that are Medicaid certified mental health providers. In the Chicago Safe Start target area there are only two community based mental health organizations that receive state funding to provide services to children. In Englewood, the Community Mental Health Council receives $420,000 in block grant monies annually provide mental health services to children and adolescents (designated for ages 3-17). The organization dedicates 6.34 clinical trained FTEs to their child and adolescent outpatient program. In addition, they staff a BRIDGE program (1.4 FTE) that is linked to the Chicago Public Schools to work on this juvenile justice program. In Pullman, the South Central organization receives $367,679 from the state and has 5 FTEs dedicated to providing outpatient child and adolescent mental health services for 9 community areas, including the four Chicago Safe Start target communities.

The substance abuse treatment system in Chicago is operated by a wide range of private providers who are supported by public funds, client fees, and insurance. The Illinois Department of Human Services' Office of Alcoholism and Substance Abuse (OASA) licenses and oversees the publicly-funded treatment facilities. There are 110 OASA licensed primary treatment providers operating 178 sites in Chicago in addition to 10 licensed recovery homes. According to OASA, approximately 50,000 Chicago residents were provided treatment services in Chicago in 1996. (These figures do not include persons treated in private hospitals even if public funds paid for that treatment.) OASA estimates that the unmet need for treatment in the state is about 90%.

The special needs of women and youth are addressed by several substance abuse treatment programs in Chicago. A total of 16 agencies provide services specifically to the needs of women and their children. Two of these are residential programs that allow women to bring their children to reside with them during in-patient treatment. The relationship between violence and substance abuse has been well documented. A 1995 national profile of clients in publicly funded women's treatment programs demonstrated that 67% of them had been victims of domestic violence and 82% were chronically addicted and unemployed.[25] Other data indicate that closer to 100% of those in treatment have some

[25] City of Chicago Violence Prevention Strategic Plan. 1998.

history of sexual or physical abuse. Substance use among women involved in the child welfare system provides additional insights into the co-existence of problems of substance use and abuse and neglect. A joint study conducted by DCFS (child welfare) and OASA in Illinois revealed that 46% of the female DCFS population is estimated to be in some need of substance abuse treatment compared to only 4.2% of adult women in the general population.

In the Chicago Safe Start target area, in FY2000 there were 5,321 patients served through OASA-funded programs. The number of patients served per 10,000 was 210 in the Chicago Safe Start communities, compared to 122 per 10,000 in Cook County as a whole. The number served was extremely high in Englewood (279), Roseland (271), and West Englewood (248). The types of substance abuse services utilized by the 5,321 patients were:

- 41% received outpatient services
- 20% were in residential rehabilitation
- 16% were in detoxification
- The remaining received residential outpatient care, case management, and intensive outpatient services.

Source: Illinois Dept. of Human Services, Office of Alcohol and Substance Abuse: Official Statistics for Chicago Safe Start communities.

As previously stated, the link between substance abuse and violence is well documented. A potential point of intervention is to reach the parents and children through training the substance abuse staff to understand and recognize the impact of violence upon children who have been exposed and to make an appropriate referral for services.

5.2 Resources Currently Invested in Exposure to Violence

Illinois currently spends over $15 billion annually to support the state's medical assistance, income support, child and community care, and other health and social services programs. Unlike many states, Illinois operates its public assistance and social service system through a network of state offices, located in various communities. Funds generally are not passed through to local counties or communities for administration, although the state makes extensive use of non-governmental organizations/non-profit service providers to assist in the delivery of services. The state, too, is generally the designated recipient of federal funds. Because of this unique funding structure, our analysis focuses primarily on state-level funding streams and policies to understand what resources are currently invested in (or not invested in!) exposure to violence. Where significant local funding is available, we highlight this, also.

5.2.1 Domestic Violence

The State of Illinois Department of Human Services provides over $23 million in support of domestic violence shelter and other services. This includes $22 million of state general revenue funds and an additional $1 million in special services funds which come from a tax form check-off that allows tax payers to designate a portion of their tax refund for this fund. In FY 2001, state funding supported 67 domestic violence programs, serving 113,700 clients (88,000 adults and 25,700 children) and providing 17,800 hours of prevention and

outreach to 253,800 community members. In addition, IDHS funds 31 intervention programs for male perpetrators.

In Spring, 2001, IDHS commissioned a survey of the funded domestic violence service providers to understand more about the services provided to children of victims. Fifty-six percent of the agencies responded to the survey, describing 115 programs serving children. The data is summarized in a report prepared by Paul A. Schewe and the University of Illinois-Chicago Domestic Violence and Sexual Assault Evaluation Team. The information here is taken from that report.

- On average, agencies have 1.6 full-time equivalent staff providing children's services, with the range being from 0.1 to 4.
- Programs were categorized as either Individual Services, Small Groups, Family Counseling, Day Care, or Other.
- 31% of the programs described were small group counseling, with 95% of the responding agencies offering at least one small group intervention program.
- Individual interventions represented another 31% of the programs offered.
- Family counseling represented 17% of the programs, and 15% were services such as tutoring, prevention services, and parenting education. Day care represented the final 6% of programs for children.
- "The age range most frequently targeted was 6 to 10 year-olds, followed by 11 to 17 year olds, three to five year-olds, and newborn to three year-olds."

As can be seen from the survey, children's services are frequently part of the comprehensive array of services offered by DHS-funded shelter and service providers. However, DHS does not require that children's service be offered nor does it earmark a portion of the funding for children's services. Therefore, it is up to the service providers applying for state funds to determine, based on their own assessment of need and resource availability, the extent to which they will offer children's services. Moreover, the survey revealed that very young children, the Chicago Safe Start target group, are the least often targeted for services. Finally, where additional information was collected on the specific curricula used (for small groups), only one-third of the respondents used a specific intervention manual or curricula. Approximately 30% indicated that their services were completely individualized. Interestingly, services provided to a mother-child dyad are not tracked in the state's data collection system, nor were such services captured in the survey instrument. These are important findings that inform our strategies and action plan, described later in this document.

The state also distributes two pools of federal funds that support services to victims of domestic violence: Victims of Crime Act program and the Violence Against Women Act program. In Illinois, these funds are distributed through the Illinois Criminal Justice Information Authority. The Victims of Crime Act (VOCA) program provides approximately $15 million annually to Illinois to support victim advocacy and other direct services for victims of sexual assault, domestic violence, child abuse, and other groups identified as underserved victims of crimes. A portion of the VOCA funds has been designated each year for children's services. In the current fiscal year, $207,000 has been provided to the Illinois Coalition Against Domestic Violence to provide counseling and other services to children and an additional $1.1 million for children's therapy. These funds were allocated to 50 programs

throughout the state. The state uses a multidisciplinary process to determine the portion of the VOCA funds to be used for children of domestic violence victims. The Domestic Violence community has been advocating increasing the funds available and is optimistic that they may receive an increase in future years.

The Violence Against Women Act program (VAWA, now called "STOP"– Services Training Prosecutors Officers) provides formula grants to support law enforcement efforts, strengthen services, or improve the criminal justice response to women victims of crime. In Illinois these funds are used to support (1) expansion of services to women who are victims of sexual assault or domestic violence; (2) improved training for law enforcement officers and the establishment of protocols for handling sexual assault and domestic violence reports; (2) improved training for prosecutors and the establishment of protocols for handling sexual assault and domestic violence cases; and (4) promotion of multidisciplinary training programs for criminal justice agencies and health care systems. Thirty percent of the funds must be designated for victim services; 25% for prosecution, 25% for law enforcement, 5% for the courts, and 15% is discretionary. Approximately $5 million is made available each year in Illinois. Approximately $600,000 was granted to the Illinois Coalition Against Domestic Violence for services statewide. While transitional shelter services can be funded through this grant program, funds must be used for adult female victims of domestic violence and cannot be set aside for children's services; thus the STOP program has limited applicability to Chicago Safe Start at this time.

The City of Chicago provides $2.0 million each year through Community Development Block Grant funds to support the Family Violence Initiative. The Initiative, a partnership of the City Departments of Health, Human Services, and Aging, the Mayor's Office of Workforce Development, and the Mayor's Office of Domestic Violence, provides funding on a competitive basis in the areas of parenting, substance abuse prevention, job training/placement, among other program areas. Coordinated through the Mayor's Office of Domestic Violence, each program must include services relating to domestic violence. For example, the CDPH-funded parenting program must include domestic violence prevention programming, such as identifying and building healthy relationships. Similarly, substance abuse prevention programs must highlight the link between domestic violence and substance abuse. Even job training/placement programs must have the capacity to respond to participants identifying domestic violence as a barrier to securing a job. Children's services are not currently an explicit part of the Family Violence Initiative funding stream, but Chicago Safe Start could pursue a review and enhancement of the current proposal process to incorporate children's exposure to violence.

5.2.2 Child Welfare

The Illinois Department of Children and Family Services is one of the few child welfare agencies in the country that is both state-administered and has state-delivered services. It is also the largest agency in the country, either public or private, that is accredited by the Council on Accreditation of Services for Families and Children. The DCFS hotline receives approximately 307,000 calls each year, of which approximately 62,000 are accepted as reports.[26] Approximately 9,500 families will be served in their homes (Intact Family Cases)

and approximately 26,000 children are currently in substitute care placements. There are approximately 12,000 licensed foster homes in Cook County.

In FY 02, DCFS's total budget is approximately $1.4 billion, of which $927.2 million are state general revenue funds, $470.7 are other state funds, and $20.7 are federal funds. Programmatically, $118.4 million supports protective services investigations; $274.6 million supports adoption and guardianship services; $87.6 million supports family maintenance; $881.2 supports family reunification and substitute care services; and $56.7 million for other support services.

While the Department supports a wide array of services for children who are abused and/or neglected, our particular focus for Chicago Safe Start is in two areas: funding which supports counseling and auxiliary services, and training. Approximately $30 million is spent each year to support counseling services for children, making DCFS the main funder of children's outpatient mental health services in the state. These funds support children in intact families and children in substitute care who need counseling or other therapeutic services related to their victimization. Currently, the standard program plan for counseling services does not make a distinction for therapeutic services required for exposure to violence as opposed to those required as a victim of violence.

In addition, DCFS spends approximately $30 million annually to provide training to foster parents, relative caregivers, child welfare workers, child protection investigators, supervisors, and other DCFS and private agency staff. The Department employs more than 800 child welfare caseworkers, 550 child protection investigators, and 50 caseworkers monitoring private agency cases. The curricula reflect best practices of the Child Welfare League of America and others, and is provided through the state's public university system. Current training, however, does not provide specific guidance for addressing children's needs related to exposure to violence. We see this as a program area for Chicago Safe Start to target.

In August 2001 DCFS issued a RFP to "Prevent the Co-Occurrence of Child Abuse and Domestic Violence" for services beginning in January 2002. Approximately $500,000, in grants of $30,000 to $50,000, is being made available statewide from the Child Abuse Prevention Fund, a tax check-off program that allows taxpayers to donate a portion of their tax refund to the fund. This is the first year these funds have been targeted to domestic violence and child abuse services. Significantly, the RFP recognizes the needs of children who witness domestic violence, explicitly seeking (emphasis added):

- Programs for children who have witnessed domestic violence in their home to help them develop self-esteem, coping mechanisms and to identify methods for getting help;

- Programs for pregnant and/or parenting teens or young women that address avoidance strategies regarding family violence and child safety;

- Parenting programs for perpetrators or victims of domestic violence that focus on the psychological damage done to children who witnessed domestic violence;

- Separate parenting programs for perpetrators or victims of domestic violence which focus on the risk of physical injury to children who are present during a domestic violence incident;

- Programs in domestic violence shelters and other community based agencies which help mothers understand the child maltreatment effects, both physiological and psychological, on children who witness repeated incidents of domestic violence; and

- Programs for parents who are victims of domestic violence and abuse drugs/alcohol, with a focus on identifying the connection of such issues to neglect.

Chicago Safe Start is pleased that DCFS has taken this step and, as described later in the Action Plan, will work with DCFS to ensure funded programs help fulfill the goals of Chicago Safe Start.

5.2.3 Child Care/Early Childhood Education Services

The Illinois State Board of Education spends approximately $180 million annually for early childhood education services, through the Early Childhood Block Grant program. The Block Grant supports three early childhood initiatives: Pre-kindergarten Program for Children At Risk of Academic Failure; Model Early Childhood Parental Training Program, and Prevention Initiative Programs Offering Coordinated Services to At-Risk Children and Their Families. Statute requires that 8% of the funds be used for programs for children from birth to age 3. It is instructive to review the program specifications (included in the most recent RFP, issued in March, 2001) for each of the initiatives because it illustrates the potential for increasing the focus on and resources for exposure to violence.

The Parental Training Initiative requires seven areas of instruction and training:

1. Child growth and development, including prenatal development;
2. Childbirth and child care
3. Family structure, function, and management;
4. Prenatal and postnatal care for mothers and infants;
5. Prevention of child abuse;
6. The physical, mental, emotional, social, economic, and psychological aspects of interpersonal and family relationships; and
7. Parenting skill development.

These seven areas, particularly numbers 1,5,6, and 7, provide wonderful opportunities for ensuring appropriate services for children exposed to violence and we anticipate that providers who would target their services to children exposed to violence could be candidates for funding under future rounds of the Block Grant. However, we also see that many more children who are exposed to violence could be impacted if the State Board made exposure to violence an explicit part of the seven areas of instruction and training; then *all* applicants would be required to incorporate services. This is a gap we try to fill through the strategies and action plan outlined later in this document.

The Prevention Initiative program is also an area which is a natural ally for serving children exposed to violence. The program targets at-risk infants and toddlers and their families and aims to provide families "knowledge about and skills in child-rearing practices, health care, educational growth and positive adult/child interactions. Through these coordinated services, parents should become better prepared to provide for the developmental needs of their children" (RFP, p. 6). Again, while Prevention Initiative funds may be a source for providers we wish to encourage to serve children exposed to violence in the target communities, we believe we can have a greater impact by incorporating into the guidelines at the state level the requirement that exposure to violence be addressed in *all* funded programs.

The Pre-Kindergarten Initiative funds programs for children who are identified through a screening process to be at risk of academic failure. The program is made up of two components—a screening component and an educational program.

Screening for Pre-Kindergarten is to be developed and implemented in cooperation with other screening programs operating in a local school district, such as Head Start, Early Intervention, Child and Family Connections, Child Find. Screening instruments are required to measure child's development in specific areas: vocabulary, visual-motor integration, language and speech development, English proficiency, fine and gross motor skills, social skills and cognitive development. Screening must also include a parent interview to gain a summary of the child's health history and social development. It may also include questions about the parent's education level, employment, income and age; the number of children in the household; and the number of school-aged siblings experience academic difficulty. Vision and hearing screening is also required. Teaching staffs are also required to be involved in the screening process. We see this screening opportunity for at-risk children as a wonderful opportunity to incorporate screening for children exposed to violence. As described later in the Plan, we are proposing to incorporate into existing screening instruments for Child Find, Early Intervention, and Head Start questions that will reveal a child's exposure to violence. We believe it is an appropriate subset of questions that can reveal the impact on a child's development and should inform subsequent services. At a broader level, we have outlined strategies for incorporating screening for exposure in all components of the Block grant programs.

The Educational Program of Pre-Kindergarten is matched to the results of the screen. It must also include parent education and involvement, provide student progress plans, include a language and literacy development component, and be linked to other services and resources in the community. Again, although services for exposure to violence are not included in the program requirements now, we believe Chicago Safe Start can encourage these fundamental changes and significantly change the system of services available for children.

The Chicago Public Schools has a large Early Childhood Education program, which is funded through the Illinois State Board of Education through the Block Grant programs described above and other pass-through federal funds. Child Find services are funded through the State to screen children 0 – 5 for developmental delays that may require Early Intervention services. The Schools' Cradle to Classroom program provides services for

4,000 pregnant or parenting teens in 75 high schools in the City. It is funded through the State Pre-Kindergarten program, described above, and offers child care services (including linkages to Early Head Start and Head Start programs), family advocacy services, health, nutrition, and other services to ensure these young mothers and their children develop safe and strong families. Because of the significant number of teen parents in the Chicago Safe Start target communities and the potential risk of exposure to violence for children of teen parents, Chicago Safe Start has developed strategies to work closely with the Chicago Public Schools and the Cradle to Classroom program. These strategies are outlined in the Action Plan.

Head Start and Early Head Start serve nearly 12,300 children annually in Chicago. The federal Program Performance Standards for Head Start and Early Head Start are quite rigorous and detail the program components that must be included. Several of these components are particularly important for Chicago Safe Start and justify our focus on Head Start programs as an avenue for identification, intervention and referral for appropriate services. First, program staff works with parents to develop Individualized Family Partnership Agreements, which outline the goals, strengths, necessary services and supports for each family. Head Start programs are expected to assist families in accessing identified services. The standards specifically reference access to counseling for mental health issues "that place families at risk, such as substance abuse, child abuse and neglect, and domestic violence." Moreover, the standards have a very strong mental health services component, requiring providers to work with parents to:

- Solicit parental information, observations and concerns about their child's mental health;
- Share staff observations of their child and discuss and anticipate with parents the child's behavior and development, including separation and attachment issues;
- Discuss and identify with parents appropriate responses to the child's behavior;
- Discuss how to strengthen nurturing, supportive environments and relationships in the home and at the program;
- Help parents to better understand mental health issues; and
- Support parents; participation in any needed mental health interventions (Performance Standard 1304.24(a)(1)(i-iv).

Head Start and Early Head Start programs also are required to have an active parent education program. In the area of mental health education, agencies are required to have:

- A variety of group opportunities for parents and program staff to identify and discuss issues related to child mental health;
- Individual opportunities for parents to discuss mental health issues related to their child and family with program staff;
- The active involvement of parents in planning and implementing any mental health interventions for their children (Performance Standard 1304.40(f)(4)(i-iii)

Because of Head Start's strong focus on child development and its explicit effort to enhance children's mental wellness through parent education, close involvement with children, and linkages to mental health professionals, Chicago Safe Start believes that these agencies will be important partners in identifying and ensuring services are provided

to children exposed to violence. As described in the Action Plan, Chicago Safe Start will work with Early Head Start and Head Start providers to incorporate the issue of exposure to violence in their already extensive mental health programming and ensure that the mental health consultation they are currently receiving is effective for children exposed, and/or link the programs to mental health providers who are part of the Chicago Safe Start network. For children needing a lesser level of intervention, linkages to Family Support will also be part of the menu of services Chicago Safe Start will bring to the Head Start network.

5.2.4 Mental Health Services

Illinois is in the lower third of all states in its expenditures on mental health services for children, and funds no services for children under three years old. Approximately $60 million is appropriated annually for child and adolescent mental health services, for children from 3 to 17 years old, with $17 million from federal Community Mental Health Services Block Grant funds in FY 02. Approximately one-third of the total, or $20 million is designated for services to children with serious mental illness and placed in state mental health facilities. Overall, state funds for children's mental health has stayed level over the past several years, with the exception of $6.0 million added over the past three years to fund assessment and linkage to services for youth leaving juvenile detention centers.

Medicaid funding is available for services under the Medicaid Rehabilitation Option or the Medicaid Clinic Option for Medicaid certified providers and Medicaid-eligible clients. The MRO/MCO services include clinic services:

- Screening, diagnosis, and assessment
- Testing
- Psychotherapy
- Prescriptions and medication monitoring
- Somatic treatments
- Partial hospitalization
- Emergency care
- Consultation and Education.

MRO/MCO also fund Community Services:

- Day Treatment
- In-Home Services
- Collateral Services
- Therapeutic Foster Care
- Early Intervention Services
- Crisis Programs
- Some Residential Services.

The Department of Children and Family Services makes extensive use of the MRO/MCO to fund intensive services for seriously emotionally disturbed children who are wards of the state. Other than for DCFS wards, Medicaid has not been extensively used to develop or fund intensive services. This is an area Chicago Safe Start will work with others who have expertise to develop a strategy for expanding mental health services for children in Illinois.

5.2.5 Substance Abuse Treatment Services

Illinois funds substance abuse treatment services through the Office of Alcoholism and Substance Abuse within the state Department of Human Services. OASA's FY 02 budget of $232.6 million is funded through a mix of federal and state funds, including the federal Alcoholism and Substance Abuse Block Grant ($61.9 million) and Alcoholism and Substance Abuse fund ($16.6 million) and state General Revenue Funds, Youth Drug Abuse Prevention Funds ($.6 million), Youth Alcoholism and Substance Abuse Prevention Fund ($1.2 million), Drug Treatment Fund ($3.5 million), among others.

OASA has taken a number of steps to focus on the specific treatment needs of women, including a focus on family. They have established a Committee on Women's Alcoholism and Substance Abuse Treatment, which issues a bi-annual plan for women's services. Over the past several years, they have been instrumental in broadening the perspective in the treatment community from the woman as the client alone to the woman in the context of her family. Initially, this meant adding childcare services to treatment programs and now is expanding to include a broader focus on the family as a whole.

At several of the OASA-funded treatment sites, TANF funds have been used to enhance programming in the on-site childcare centers. The centers offer various curricula for violence and substance abuse prevention for the children while the parent is receiving treatment services. TANF funds have also been used more broadly to enhance treatment services for women receiving TANF. Approximately $8.0 million is appropriated each year to support the enhanced childcare programs, recovery homes for women and children, and clinical services in local DHS offices.

OASA has also allocated $600,000 for a pilot program on domestic violence and substance abuse, the Domestic Violence and Substance Abuse Initiative. Under this pilot, four sites have received funds to co-locate substance abuse treatment and domestic violence shelter services. Women who enter either program are screened for domestic violence or substance abuse (depending on which program they begin with), receive an assessment, and receive integrated services on-site. DV and treatment professionals jointly conduct domestic violence/alcoholism and substance abuse groups and individual services are provided by a treatment professional who has received at a minimum the 40 hours of required domestic violence training. OASA has found that the co-location of staff and the joint work has lead to increased understanding across treatment systems and has helped break down system barriers.

Significantly, each of the pilot sites is required to provide early intervention/violence prevention services for the children of the women receiving services. This is an important step the state has taken in recognizing the importance of identifying at-risk children through the treatment system. Indeed, the Initiative has found that 70% of the women receiving alcoholism and substance abuse treatment screen positive for domestic violence and 50% of the women in domestic violence shelters screen positive for alcoholism or substance abuse. Thus, Chicago Safe Start believes that it is important to use the treatment system to reach children who may be exposed to violence.

OASA also operates the Project SAFE program, which began as a federally-funded demonstration program in the mid-1980s and now is operated at 23 sites throughout the state. It is a partnership program for women and their children referred from the child welfare system. Each of the funded sites operates under a specific Project SAFE model, which includes four program components: parenting training, joint staffings between DCFS and the treatment provider; specialized training for the treatment provider; and outreach by women in recovery to other women to help keep them engaged in the treatment program. While Project SAFE sites are not funded to directly provide services for the children of the women involved in treatment, its focus on parenting does suggest a broader recognition of the family context. Chicago Safe Start can build on this recognition.

What these pilot projects also illustrate is that the main treatment funding streams do not typically permit treatment providers to provide children's services; instead, these efforts must be separately funded. Chicago Safe Start will work with the Committee on Women's Treatment, the Domestic Violence and Substance Abuse Initiative, and others to continue to expand the opportunities for the treatment system to identify and, as appropriate, serve, children exposed to violence.

5.2.6 Family Support Services

There are no designated state sources of funds specifically for Family Support Services. Many state funding streams will support Family Support programming, but the challenge for Family Support agencies is to match their services to programs for which funding is available. In particular, Chicago Safe Start is encouraging the development of Family Support Services through the Early Childhood Block Grant program (described above) and the Healthy Families program.

The Illinois Department of Human Services provides approximately $8.8 million for the Healthy Families program. The Ounce of Prevention Fund in Chicago, a leading organization for services and advocacy on behalf of children zero to five and their families, has just awarded a new contract to provide blended services under Healthy Families and Parents Too Soon to Family Focus and St. Bernard's Hospital in Englewood. The Healthy Families program targets high-risk teen parents, providing home visits, screening and assessment and parent group services. As part of the home visit, case managers will assess the family, including a focus on factors that might interfere with the parent/child relationship. If services are needed, the family will be referred for services either in a clinic setting or in a home-based setting, depending the needs of the family. Home visits are parent/child focused and designed to encourage successful communication and enjoyable interaction between parent and child. The case manager works with the young mother in developing parenting skills (helping the parent understand the child's stage of development, develop age-appropriate expectations; develop successful communication; develop parental interest and pride in child development), building healthy interpersonal relationships (linking to domestic violence services, if needed), and providing other supports.

Chicago Safe Start believes that Healthy Families provides one appropriate model of services for the target community, because it offers the flexibility to focus on the impact of exposure to violence and because of the strong focus on understanding and enhancing

the parent/child relationship, one of the key protective factors Chicago Safe Start is trying to reinforce. Our Action Plan describes our efforts to build on this program. In particular, Healthy Families has already funded a service provider in each of the Chicago Safe Start target communities. Chicago Safe Start will work with these funded providers to build on their programs.

Our Action Plan describes other efforts to secure funds for Family Support Services because it is an area not currently funded by a designated program within the state.

5.3 Priority Risk and Protective Factors

Illinois is fortunate to be the only state that has a state-level violence prevention agency. The Illinois Violence Prevention Authority was created by the Illinois Violence Prevention Act of 1995 to provide for a comprehensive, collaborative approach to violence prevention. The IVPA is co-chaired by the Illinois Attorney General and the Director of the Illinois Department of Public Health. Its members include state agency directors and appointed private sector members from the health, criminal justice, human services, education, and victim services fields. The Executive Director of the IVPA serves on the Chicago Safe Start Steering Committee, is the co-chair of the Chicago Safe Start Public Awareness Committee, and has been very active in the Chicago Safe Start planning efforts.

In January 2000, the IVPA issued its state plan, *Building a Safe Illinois: A State Plan for Violence Prevention.* A central component of the State Plan is the identification of Risk and Protective Factors. Our discussion of Priority Risk and Protective Factors is adapted from their work.

5.3.1 Risk Factors

The IVPA identifies four categories of Risk Factors that increase the likelihood that an individual will become a perpetrator of violence and three categories of Protective Factors that can offset those risks. Indeed, much of the literature on risk and protective factors comes from the violence prevention field and focuses on strategies to prevent violence. We believe, however, that much of the analysis applies to the Chicago Safe Start population. When we talk about ameliorating the impact of exposure to violence for young children, we are speaking about offsetting developmental risk and decreasing the likelihood that a child exposed will become delinquent or a perpetrator of violence later in life. Therefore, we believe that the framework presented by the IVPA is a useful one for Chicago Safe Start.

The IVPA organizes risk factors into four categories: Biological, Individual, Family, and Community.

Biological Risk Factors. There are five risk factors in this category:

- Infants born with physical disabilities
- Prenatal exposure to drugs and/or alcohol
- Prenatal/perinatal trauma
- Head injury or head trauma
- Physiological impacts on children's brains as a result of repeated exposures to violence

Two of these risk factors are of particular importance for Chicago Safe Start—prenatal exposure to drugs/alcohol and physiological impact on children's brains as a result of exposure to violence. Unfortunately, prenatal exposure to drugs/alcohol is a significant problem in the target communities. Overall in Cook County, DCFS has indicated an average of over 1,000 cases of substance-exposed infants in each of the past three years. In FY 2000 (the most recent full year data available), 14.8% of the substantiated child abuse/neglect cases in Pullman were for substance exposure (69 out of 466 indicated cases in Pullman) and 13% in Englewood (69 out of 532 indicated cases in Englewood). These reflect rates of substantiated substance exposure in FY 2000 of 1.7 per 1000 children in Pullman and 2.3 per 1000 children in Englewood. While Chicago Safe Start's main focus is to work with families of children exposed to violence, because of the significance of substance use/abuse as a risk factor, we do outline as an objective partnering with other efforts to decrease substance use, as part of a broader goal of prevention. The second risk factor, physiological impact from exposure, is the central focus of Chicago Safe Start.

Individual Risk Factors. The IVPA identifies seven factors in this area:

- Early aggressive behavior
- Poor peer interaction skills
- Low academic achievement including poor reading skills or a weak commitment to education
- Antisocial behavior, lack of willingness to comply with adult direction, rebelliousness
- Hyperactivity or attention-deficit disorder
- Involvement with a delinquent peer group
- Acquisition of attitudes, beliefs and emotional responses which support or tolerate the use of violence

We believe that for the most part, these factors apply to children who are older than the Chicago Safe Start population. What underlies our goals, however, is to ensure that the system we develop provides support for young children exposed to violence so that the individual risk factors do not develop as the children mature.

Family Risk Factors. The IVPA identifies seven risk factors in this area, as well. Most of these are central to the work of Chicago Safe Start:

- Development of weak family bonds
- Exposure to and reinforcement of violence in the home, e.g. witnessing violence, child abuse
- Poor parental supervision, harsh discipline
- Frequent conflict within the family
- Adult family members who were abused as children or have histories of violence
- Families experiencing high levels of stress
- Rigid gender role stereotyping within the family

We know from the community assessment that a significant proportion of the children in the Chicago Safe Start communities may be in families that present one or more of these risk factors. Many of the children are in teen parent families. Research has shown that

many teen parents were themselves victims of sexual abuse and national data just released shows that younger women are particularly vulnerable to domestic violence. Additionally, the target communities have high rates of child abuse and neglect, domestic violence, and community violence. These are significant risk factors that the Chicago Safe Start strategies, particularly the emphasis on building a family support services network which can reinforce parenting are designed to decrease.

Community Risk Factors. The IVPA identifies eleven community risk factors.

- Presence of gangs and drug dealing which provide violent role models and rewards for violent behavior
- Availability of drugs
- Lack of effective social and cultural organizations
- High levels of community disorganization
- High levels of transiency or mobility
- High levels of unemployment and lack of economic opportunities
- High levels of poverty
- Accessibility of firearms and other weapons
- Community norms which favor violence as a solution to problems or look favorably on drug use, use of firearms and/or crime
- Gender stereotyping and the societal attitudes that link masculinity with aggression
- Frequent exposure to media portrayals of violence

Unfortunately, as the community assessment shows, the Chicago Safe Start communities exhibit many of these risk factors, as well. The present of gangs, drug dealing, drugs and the associated violence is probably the greatest set of risk factors and the reasons Chicago Safe Start describes the children in the communities as exposed to *chronic* violence. The poverty rates and level of unemployment are significant, as is the associated transience and community disorganization. The presence of so many community risk factors informed our strategies for impacting children exposed. We focused on strategies to reinforce and expand the community infrastructure that is present. We also realized that reducing these risk factors is part of a much broader strategy than Chicago Safe Start cannot take on alone, and therefore focus on partnering with other efforts to reduce violence. The strength of our approach, too, is to build on the protective factors, which the IVPA also describes.

5.3.2 Protective Factors

The IVPA identifies three categories of Protective Factors: Individual, Family, and Community. The core of the Chicago Safe Start approach is to reinforce key protective factors through the systems and program changes we will put in place through the project and to decrease risk factors through our efforts and partnering with others. Reinforcing protective factors, coupled with efforts to decrease risk factors, is the best approach to reduce the risk of future violence, according to research. This is the approach Chicago Safe Start will use.

Individual Protective Factors. The IVPA identified four Individual Protective Factors:

- Individual attributes: an even, resilient temperament; a positive social orientation or mood; the ability to evoke positive responses in others.

- Development of effective negotiating, conflict resolution and anger management skills;
- Ability to think clearly about problems including generating alternative solutions and recognizing the consequences of actions;
- Capacity for empathy and respect for all people and their values.

Chicago Safe Start's strategy is to help young children exposed to violence *develop* these protective factors by ensuring that their developmental needs are met. This underlies our strategy to build a family support services network; to provide mental health services when children are traumatized by violence; and to ensure that all systems that work with children understand how exposure to violence can undermine children's development and what can be done to intervene.

Family Protective Factors. The IVPA identifies three Family Protective Factors:

- Healthy parent-child bonding, an investment in the future, and an understanding of right and wrong;
- Positive, sustained attachments with at least one adult family member, teacher, or other adult;
- Schools, families, and peer groups that teach children healthy beliefs and set clear standards.

Reinforcing the family protective factors is the core of our model for change, described in Section 6.1. All of our program strategies and efforts to effect system change are fundamentally designed to reinforce the caregiver's ability to protect the child from the impacts of exposure to violence. The IVPA description of the family protective factors provide the framework for what that means: supporting the child's developmental progress through healthy bonding, sustained attachments, and clear messages and support. The Family Support Services Network is designed to provide the resources families need so that they can develop these protective factors; our efforts with the other system partners are intended to improve their ability to both recognize the family as an important protective factor and to take steps to reinforce its role.

Community Protective Factors. The IVPA identifies three Community Protective Factors:

- Attachment or connection to the community, or a sense of belonging;
- Positive, sustained attachments with at least one adult family member, teacher or other adult;
- Schools, families and peer groups that teach children healthy beliefs and set clear standards.

Many of these protective factors are the same as the Family Protective Factors and Chicago Safe Start efforts will focus on these community-level factors as well. The community mentors component of the Family Support Services Network is one strategy that is designed to ensure that families whose children are at-risk because of exposure are not isolated, but rather are connected to the community through a caring relationship. The drop-in center model of the Family Support programs will ensure that families feel that they do belong to the community. System and Community resources that respond to families' needs will help ensure that sustained attachment so that families do not fall through the cracks.

5.4 Identification of Gaps in The Current System

The gaps in the current system, not surprisingly, track closely to the key assessment findings: the areas where we found the greatest problems were tied to holes in the service delivery system. These key gaps include:

- Many caregivers are not aware of the impact of exposure to violence on young children.
- Most service providers are not aware of the impact of exposure to violence or how to identify children who have been exposed.
- Few providers who come into contact with children are currently equipped to intervene with children exposed to violence.
- There are limited specialized intervention and treatment resources addressing children's exposure to violence.
- The issue of children's exposure to violence has had limited focus as a public policy priority.

Lack of Parent/Caregiver Understanding of the Impact of Exposure

During our focus groups and one-on-one interviews, we were told that many parents don't think about the repercussions of children witnessing domestic violence in their own or other family members' homes. A violent interaction between family members creates a context in which acceptable forms of conflict resolution are not valued. Further, during childhood, a caregiver or parent may have been directly victimized within his or her family of origin. In either case, the message that violence is an acceptable form of conflict resolution has been communicated and the groundwork for beliefs regarding appropriate disciplinary action laid. The result is that during our groups, there seemed to be a lack of awareness of the importance of developmental factors in children ages 0 to 5.

For those concerned parents who want to know and do more about the impact of violence on their young children and child development in general, there are insufficient resources available to them as documented in Section 5.1. During our interviews, community residents indicated a strong interest in wanting to know more about age-appropriate child development behaviors and skills as well as identifying "abnormal" child behavior. This concern extended into the childcare environment as well as the home. There was acknowledgement of the importance of teaching cooperation, respect and positive values, non-violent interaction and conflict resolution, sharing and manners (please and thank you) to both young children and families. In essence, the community assessment reveals the environment is ripe for both a public education campaign and work with families and individuals to address the issue of violence and its impact upon children.

Lack of Provider Understanding of Impact of Exposure to Violence on Young Children

A significant gap in the current system is the lack of understanding of the impact of exposure to violence on young children. Few providers and even fewer parents recognize the problem. Most think that because the children are so young, they won't understand what is happening and thus will not be affected; however, the exact opposite is usually the case. Furthermore, because of the frequency of community violence as well as domestic violence, many parents and providers interviewed view violence as the norm. Thus, because providers who regularly interact with children are not aware that exposure is an issue, many children are not appropriately identified or served.

Lack of Services for Children Exposed

As the service mapping illustrates in Section 5.1, while there are a number of services in the target communities, there are few specifically focused on serving children exposed to violence. Moreover, even those agencies who serve children frequently have not identified exposure to violence as an area for intervention. Chicago Safe Start's strategies are geared toward addressing this gap on two fronts: first, to increase all service providers; (at the individual and system levels) awareness, understanding and skills to identify and work with children exposed; and second, to expand family support and mental health services to respond directly to the needs of children and families who have been exposed to violence.

Lack of Family Support Services as Primary Gateway for Intervention

We believe that every parent would benefit from some level of skill development and that all first-time parents might be considered at some level of risk by virtue of their inexperience. In addition, in the target communities where exposure to violence is chronic, there is a growing awareness among parents and providers of the mental health needs of very young children and families, and a dearth of mental health (and substance abuse) services. However, there is also a lack of trust in the mental health profession's ability to address identified issues, voiced again and again during the focus groups, as well as the widespread stigma attached to those seeking mental health care services. A variety of personal issues, including beliefs and perceptions, may serve as barriers to seeking mental health services.

Acknowledging that with sufficient social and service supports, many emotional and mental health problems can be effectively managed, the preference of participants was to offer family support services as the primary Chicago Safe Start gateway into the continuum of prevention, intervention, and treatment. The service most desired was a "drop-in center" with a relaxed atmosphere where parents could stop by at their convenience to seek services. Developmental screenings, parent education, child play space and other "softer" interventions were felt to be initially more effective. High levels of community violence and related fears often deter residents from socializing outside their homes. Sites that offer family support services, it was expressed, would offer an option for a safe, structured activity that all families members could participate in.

Lack of Sufficient Mental Health Capacity for Specialized Treatment of Exposure to Violence

Mental health services in general and those specifically for children are a major gap in the continuum of services in Illinois. Furthermore, there is a severe shortage of staff trained to work in the field, and institutions of higher education throughout Illinois have limited coursework in infant-toddler studies. Limited capacity, driven in part by funding barriers, may be a significant barrier for persons other than the most seriously mentally ill. Public funds for mental health treatment are available for children ages 3-18, ignoring the needs of 0-2 year olds. The two city-sponsored mental health centers in the two districts are currently funded almost entirely for chronically mentally ill adults. Prevention and support services are inadequate and almost nonexistent for children. As reported by numerous interviewees, most adults, adolescents and children find they cannot access the mental health services that do exist. The two state-funded agencies in the Chicago Safe Start districts dedicate a total of 11.3 FTEs to the treatment of children ages 3-18. This is inadequate in the context of the Chicago Safe Start community that has 22,836 children ages 0 – 5 years, with half of the children during their lifetime having witnessed someone shoved, kicked, or punched,

and approximately 70% having heard a gunshot at some point. Another important barrier is posed by the system itself, including limited community outreach to get information in the hands of people who need it and referral processes that are not geared to be quickly and fully responsive.

Lack of Public Policy Attention

As the review of policies, funding streams, RFPs and contract language in Section 5.2 illustrates, exposure to violence has had limited attention as a policy issue in the service delivery realm. As a result, there are few resources dedicated to serving children and families exposed to violence. Chicago Safe Start has outlined a number of strategies to impact public policy and ensure that in the future there are dedicated funding streams, clear program and contractual expectations for services, greater access to services, and more focus on improving the outcomes for children exposed.

5.5 Analysis Of Community Strengths, Resources And Opportunities

The selected Chicago Safe Start districts contain many assets and resources, as previously outlined in Section 5.1. Both districts have strong leaders that are aware and understand the major challenges the communities are confronting. Although each district has its own unique characteristics, there are more similarities than differences when it comes to identifying opportunities for collaboration with many other organizations and entities.

Both districts share many strengths, including:

- Strong institutions with resources such as Metropolitan Family Services and Human Resource Development Initiative, as well as other social service agencies, hospitals, health clinics, churches and community organizations. (Please see Section 5.1 for a complete list.)
- History and strong spirit of community activism
- Churches
- People who have lived and/or worked in the community for a long time and are very committed to its improvement and revival.
- Substantial revitalization efforts are underway in Englewood and proposed in Pullman.
- New collaborations between churches and schools
- Both Pullman and Englewood have District Health Councils, which meet to assess community needs, train local providers, and advocate for changes

Both districts also identified similar key themes regarding their greatest concerns:

- Violence, gangs, drugs and their effects on safety
- Teen pregnancy
- Single parents
- Inadequate health care
- Weak family bonds
- Lack of understanding of how to be an effective parent
- Unemployment or underemployment
- Lack of affordable, safe housing

- Lack of affordable, quality child care

The interviews and focus groups uncovered a community that really cares about its children and families. Often referred to as a close-knit neighborhood where adults watch out for children, the Harvard University survey substantiated these findings. When surveyors asked respondents if people were willing to help their neighbors, 76% of Pullman respondents said that they strongly agreed or agreed. Eighty-two percent (Pullman) said the parents in the neighborhood generally knew each other.

EXHIBIT 14	Englewood Strongly agree or Agree	Pullman Strongly agree or Agree
Children look up to adults	61%	74%
People don't get along	16%	22%
Adults watch out for children	55%	69%
Parents know their children's friends	53%	72%
Parents in this neighborhood generally know each other	58%	82%

Source: Harvard's Project on Human Development in Chicago Neighborhoods. 1995

Chicago Safe Start believes these new relationships that cross sectors and disciplines will be a solid base from which to pursue co-funding, public/private partnerships and other innovative funding strategies to ensure Chicago Safe Start's success.

Several efforts that are particularly noteworthy are described in more detail below.

- ❖ As previously mentioned, the Chicago Police Department has trained its officers on a protocol when responding to domestic violence calls, including data collection. This presents a major opportunity for Chicago Safe Start to work closely with the CPD to expand its protocol to include the dissemination of information about the potential impact of exposure to violence on young children. In the future, we anticipate that the police will be able to track the existence of young children during their calls. In both districts, police headquarters works with the domestic violence subcommittee on organizing domestic violence awareness events. Again, Chicago Safe Start can take advantage of those forums to conduct its public awareness campaign around the issue.

- ❖ In Englewood, the *Chicago Violence Prevention Project* works with the police department as first responders when there is street gang violence. Declaring certain geographically areas *cease fire zones*, police work with residents when there is a gang incident. The project has a community presence in its prevention and intervention work. The *Greater Englewood Community and Family Task Force* works to combat violence and its social and economic impact on families.

- ❖ The Salem Baptist Church is located within Pullman, and is one of the largest churches in Chicago. They have live broadcasts of their ministry and their charismatic preacher, Reverend Meeks is well known around the country. With about a dozen full-time clergy,

the mission of Salem extends into numerous programs for the community. They operate a charter school, day care programs, after school programs, assistance for the homeless and have even hired a social worker. Additionally, they have purchased land along a vacant corridor and have begun investing in housing and other redevelopment activities. With this type of organizational infrastructure and the ability to reach a large congregation, Chicago Safe Start has a powerful vehicle through which to raise awareness specifically about exposure to violence on young children.

- Within Englewood, the Call to Clergy meets every two months, an organization of ministers that come together from around the city to work on issues of community significance. Since there are over 260 churches in Englewood alone, large and small, housed in historic structures and storefronts, it is the belief of community residents that the churches need to become more involved in the prevention and intervention of violence as it affects the entire community, not just children.

- One of the most respected community hospitals, St. Bernard's, is also in Englewood. They have applied for grant funding in collaboration with Family Focus to start providing family support services for teenage parents in Englewood. A local school, Nicholson, operates a Parents as Teachers First program, another teenage parent education initiative.

- Within City government there are several new opportunities developing. CivicNet, a new public-private initiative to create and implement a high-performance digital infrastructure throughout the City, creates significant potential for ChicagoSafeStart.net to effect broad-based system change. Construction was started this past summer, with pilot projects conducted less than a year later. Chicago Safe Start's assessment uncovered that most organizations do have Internet access, and public sites are increasing. Chicago Safe Start's web initiative will build on the foundation created by this web site (please see sections 5 and 6 for further details).

In addition, Englewood is currently targeted for $250 million redevelopment effort by the City of Chicago's Department of Planning and Economic Development. Englewood also has its own community website (www.englewoodfutures.org) which features more than 160 organizations and projects. Perhaps one of the most unique is *Imagine Englewood If*, which unites various sectors of the community to work together to achieve a communal vision of a safer, healthier, more self-sufficient neighborhood.

Pullman is economically more diverse than Englewood and is a particularly well organized in the Roseland community. With many community development organizations, such as the *Developing Communities Project*, a network of churches and other community-based organizations, tremendous collaborative potential exists with Chicago Safe Start. In addition, parts of the Pullman area are under consideration for a significant redevelopment effort by the Chicago Department of Planning and Development.

5.6 Identification of Service Barriers Among Key Service Providers

Please see discussion in Sections 5.1, 5.2 and Section 5.4.

5.7 Program & Policy Priorities for Chicago Integrated System of Care

Each of the sections throughout the Community Assessment describes a number of policy, programmatic, fiscal, or data issues that must be addressed in order to ensure that Chicago Safe Start achieves its vision that children who are at-risk of or who have been exposed to violence are supported by caregivers, families, and communities to ameliorate the effects of such exposure. As we developed the Strategic Plan, we took seriously the notion of being *strategic:* at the same time we have tried to compile all of our learning into a comprehensive assessment, we have also worked throughout the planning process to identify key policy and programmatic levers where we thought we would have the greatest impact; to identify funding streams that we were both likely to impact and that would lead to lasting change; to determine the best use Chicago Safe Start funds to seed program development until institutional funding streams could be impacted; and to find ways to ensure children and families receive needed services as soon as possible. The priorities we outline below are the result of this Chicago Safe Start Strategic Planning process.

1. Increase awareness by the public, first responders (police, fire department, emergency room personnel, etc.), child- and family-serving organizations (public and non-profit), community-based organizations, and policy-makers of the impact of exposure to violence on young children. A broad public awareness campaign in the target communities is essential to building support for the Chicago Safe Start effort, engaging families and providers in a discussion about their role identifying children exposed to violence, and in sharing information about risks of exposure to violence. Therefore, one of our strategies is to undertake a public awareness campaign.

2. Establish a Training Institute for professionals who work with children on how to identify and intervene with children exposed to violence and to serve as a general resource on the issue of exposure to violence in Illinois. We learned through the assessment that many service providers who work with children are not aware that exposure to violence is potentially a problem or what the developmental and behavioral consequences may be. Without this information, children in their care may be manifesting symptoms as a result of exposure to violence and the provider may not see them or may not know how to respond appropriately. Yet, there are specific interventions that are based on child development theory that will help offset those risks. It is vital that providers attain the skills to identify and intervene with children exposed to violence. This is not one-time training, and because of the size and scope of the child-serving systems in Chicago and Illinois, we need to develop on-going capacity for training and skill-building. A university or other institutional partner will be essential to building the capacity for this on-going training and to build the expertise in Illinois to ensure that all programs have access to the most recent research and best practices in working with children exposed.

3. Establish expectation and provide training to enable first responders and others who work with children and families to identify children who have been exposed to violence. The core strategy of the national Chicago Safe Start effort is a core component of what we will undertake in Chicago. Through work done by the Mayor's Office of Domestic Violence, police in Chicago already have a clear protocol for responding to domestic violence calls in a way that ensures that the victim is quickly linked to services and

information (through the HelpLine). We will build on this model, as we develop our own incident-based response system for children exposed to violence.

4. Develop capacity of the Domestic Violence HelpLine to serve as a referral link for first responders working with families exposed to violence. The Domestic Violence HelpLine is already a rich resource for victim families needing referral to services. Chicago Safe Start recognizes the benefit of building on the existing HelpLine—the core staff already exists and is well-trained; protocols are already in place to make and accept referrals; police and other users are familiar with the service; and using the HelpLine further links the issue of children exposed to one of the main ways children are exposed to violence. Because of these strengths, Chicago Safe Start will look to the HelpLine to play a key brokering role for a broad array of programs for children exposed to violence.

5. Focus policy and funding streams and provide training in the child welfare, domestic violence, substance abuse, and child care systems to provide initial intervention services for children exposed and to make appropriate referrals for family support and/or mental health services as needed. The multiple systems that serve families have taken a number of steps already that advance the Chicago Safe Start goals. From the domestic violence community's provision of basic children's service, to the partnerships between the substance abuse treatment community and domestic violence service providers, to child welfare's efforts to provide appropriate developmental screens, counseling and support for children victims, progress has been made. Chicago Safe Start's role in working with these systems is to further focus attention on children exposed to violence by advocating for change at the program, policy, and funding levels. Our goal is to create a consistent set of expectations about identifying and serving children exposed to violence and to ensure access to resources that can support those expectations.

6. Create a Family Support Services Network in the target communities to provide a non-threatening, asset based approach to intervene for families whose children have been or at-risk of exposure to violence. The discussion of risk and protective factors, coupled with the data and analysis of the target communities, demonstrated strongly the need for an asset-based approach to working with families and to providing basic support services that will reinforce the protective factors at the individual, family, and community level. Creating this Family Support Services Network will be a component of our Chicago Safe Start strategy.

7. Target Chicago Safe Start resources toward and advocate to expand mental health service capacity for children in need of services. The assessment findings pointed clearly to a lack of mental health service capacity for young children. A key component of our strategy must be to both quickly develop mental health services in the Chicago Safe Start target communities and to develop a long-range strategy to build a children's mental health infrastructure in Illinois.

8. Develop data collection and analytic capacity to understand the impact of children's exposure and families' access to services and widely disseminate findings among key policy-makers. Children's exposure to violence has not been on the agenda of many policy-makers; yet to ensure that children who are exposed are identified and receive appropriate services, it must be raised as a public issue. One avenue to do this is to

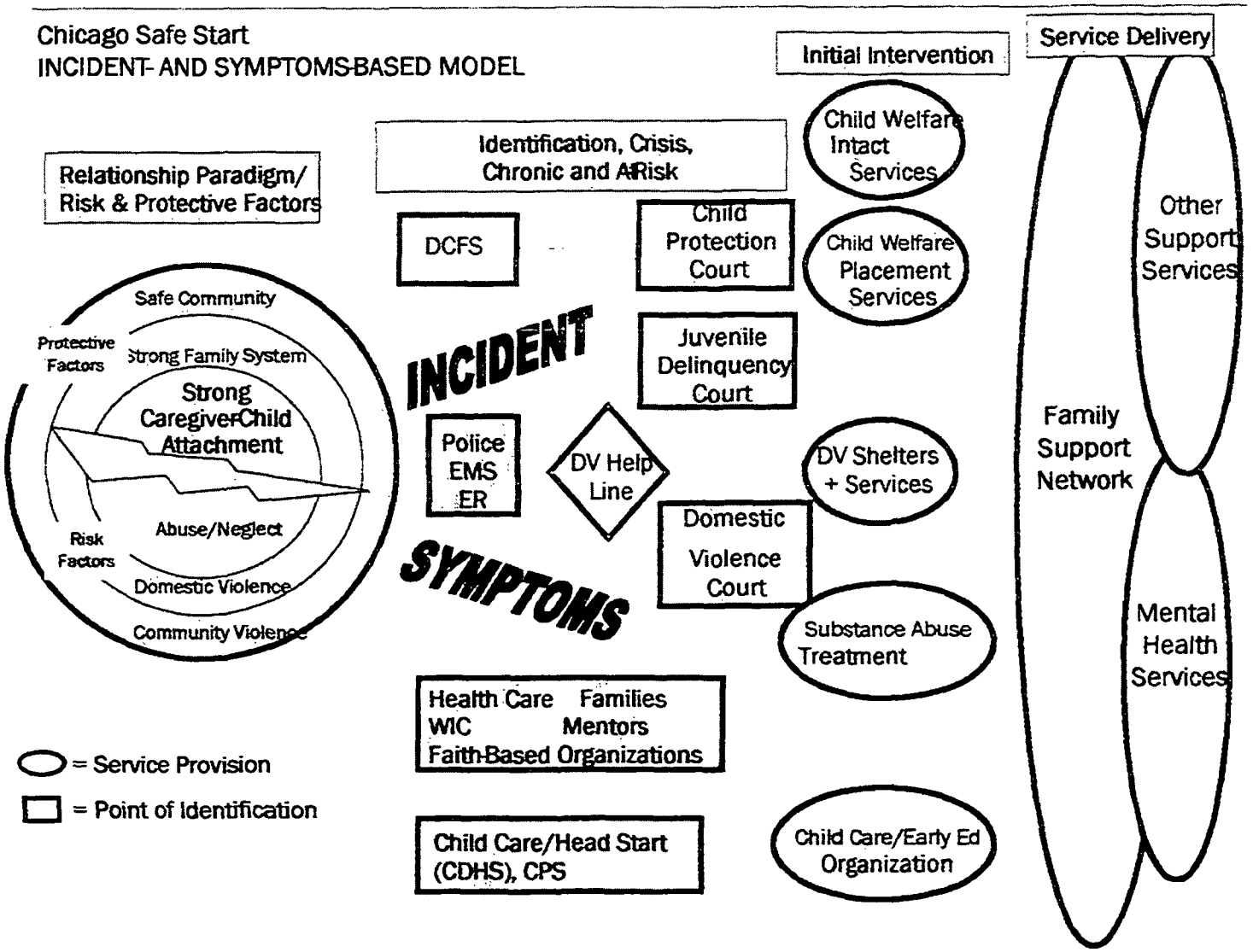
bring data and information to policy-makers to ensure that they understand the scope and extent of the problem and the policy and program changes that are needed as a result. Because so many families whose children are exposed to violence are likely already known to the public systems, considering the multiple risk factors they face (see Section 5.3), we want collect information from these systems. We also want to use the capacity of university-based research centers that already combine data from multiple systems to conduct analyses and present the findings. Fortunately, this capacity exists in Illinois and Chicago Safe Start will seek to build on it.

9. **Partner with violence prevention and reduction efforts and other efforts system-wide that enhance services for children at-risk of or exposed to violence.** Chicago Safe Start recognizes that the problem of children exposed to violence is best addressed by reducing (or eliminating) violence. We also recognize that preventing violence is a complex effort and one that Chicago Safe Start cannot and should not lead or take on alone. Therefore, we will focus our violence prevention efforts on supporting others—the Illinois Violence Prevention Authority, the Illinois Coalition for the Prevention of Violence, Prevent Violence! Chicago and the many others whose mission is violence prevention.

5.8 Description of Plan For Maintaining & Updating Assessment Findings

The following data sources will be utilized to produce an annual update on assessment findings presented in this strategic plan:

- Chicago Police Department Crime System Files, processed and analyzed by the Chicago Department of Public Health;
- Community Area Health Inventory, developed by the Chicago Department of Public Health, Epidemiology Department;
- Statistics from the Mayor's Office on Domestic Violence;
- Early Warning System Data, produced by the Chicago Police Department with the Illinois Criminal Justice Information Authority;
- Statistics from the Illinois Department of Alcohol and Substance Abuse;
- 2000 Census Tract Data, produced by the US Census Bureau;
- Local Community Fact Book: Chicago Metropolitan Area
- State Health Statistics, produced by the Illinois Department of Public Health
- Community Assessment - Head Start, produced by the Chicago Department of Human Services
- Data and Policy Program Report and Other Data Related to Young Children and Violence, produced by Children's Memorial Hospital
- Funding Stream Data from Chicago Metropolis 2020



6. Goals and Objectives for Prevention and Reduction of Impact of Exposure

6.1 Overview of Change Strategy

Chicago Safe Start's project model begins with a relationship paradigm and key risk/protective factors, and is built upon the premise that a strong attachment between caregiver and child is the most important protective factor for a young child exposed to violence. Additional protective factors include strong immediate and extended family support, and safe and supportive community resources.

Each of these levels of protective factors can be compromised by different kinds of violence. The caregiver-child attachment is damaged if there is direct child abuse or neglect. The immediate and extended family support system is affected by domestic violence. Safety and support in the community are diminished by public violence. As these protective factors are eroded, a young child's well-being can also be affected by violence in each of these realms.

The Chicago Safe Start project model focuses on two areas of intervention: children who are at risk of or have been exposed to violence are identified either through an incident-based

response or a symptoms-based response. The incident-based response is designed to intervene at the earliest point of contact when an incident of domestic violence or child abuse/neglect is reported and is built upon the police, emergency medical and child welfare emergency response systems. The symptoms-based response system is designed to enhance the capability of the existing provider community, who encounter children in the targeted age group, to identify the effects and symptoms of exposure to violence and to refer those children to needed services at the appropriate level of care. Childcare centers, Head Start, early childhood education, health care providers, substance abuse treatment providers, domestic violence service providers, WIC centers, faith-based organizations, community mentors, and family members comprise this system.

Identification, Crisis, Chronic and At-Risk

There are four broad categories of initial identification points for children exposed. First, in response to an incident of violence, either DCFS, the police, emergency medical services or a hospital emergency room would be the first point of identification. Each of these system points could be the first to respond, either on the scene or not, to a specific event of child abuse or neglect, or domestic and/or community violence. Under the Chicago Safe Start model, police officers, EMTs, or emergency room personnel in the two target areas will refer families of young children exposed to violence to the Domestic Violence Help Line, family support services or, if indicated, directly to mental health services. They will also implement a new protocol to record the demographic information and referral provided for each family.

The Domestic Violence Help Line currently serves as a tool for first responders as well as a potential point of initial identification. The Help Line's referral directory will be expanded to include resources dedicated to young children in the target communities. The Help Line already tracks demographics of callers with children as well as services requested.

In the case of an allegation of child abuse, DCFS will be the first to respond. The police may also be the first responders, but they operate under DCFS protocols. If the allegation is substantiated, then the child has prima facie been exposed to violence. Chicago Safe Start will focus on the appropriate intervention described below.

Juvenile Delinquency Court will identify teen parents and other youth who may place young children at risk of exposure due to their behavior, and provide referrals to the designated family support service provider. Relevant court staff will be trained to identify and refer, and will also implement new protocols to collect demographic data on children and families identified and referred. Child Protection Court can identify exposure to violence during proceedings and provide referrals to family support services or directly to mental health. The Court will also collect demographic and referral data for each child identified.

In a symptoms-based response, it is not a specific crisis event that precipitates identification, but symptoms or risk factors recognized by child care providers, Head Start/Early Head Start staff, school-based early childhood education, health care providers, WIC sites, community mentors, faith-based organization representatives, and/or family members. Each of these groups of people will be trained to recognize sets of behaviors and symptoms, to refer such children and their families to family support services (or directly to

mental health, if indicated). The formal system providers will also implement new protocols to collect data on children referred for services.

Initial Intervention

Initial Intervention services, under the Chicago Safe Start model, will take place through a variety of system partners that now provide little or no intervention for children exposed to violence. These include the child welfare system (for both children remaining at home and those placed in substitute care), domestic violence shelter and service system, the substance abuse treatment system, and the early childhood education and care systems.

Intact Family Services are provided by DCFS and DCFS-contracted agencies for families with an indicated allegation of abuse or neglect but the Court has determined that the child can remain safely in the home if services are provided. All Intact Family Service providers will be required to participate in training on the impact of exposure to violence on young children, what to look for, how to refer, and what they can do. They will also implement protocols to collect demographic data for each referral provided.

Placement Services are for children who cannot safely remain in their homes because of child abuse or neglect. These services are provided by DCFS and contracted agencies. Training on the impact of exposure to violence on young children, what to look for, how to refer, and what they themselves can do to help will be incorporated into existing DCFS training for foster parents and group care facilities.

Domestic violence shelters and Domestic Violence Court are additional points of secondary identification. Shelters can provide basic intervention for young children with art supplies and appropriate toys. Shelter staff and Domestic Court staff will be trained on the impact of exposure to violence on young children, what to look for, how to refer, and what they can do. They will also implement protocols to collect demographic data for each referral provided.

Child care providers, Head Start teachers, early childhood educators, health care providers, WIC staff and faith-based organization representatives will all be trained to provide basic play/art activities for children exposed as well as to refer parents to family support services, community mentors, and mental health services.

Substance abuse treatment services are another point of access, as many participants are parents of young children. Treatment center staff will be trained to include discussions on the effects of exposure to violence on young children as well as what parents can do to help their children.

Service Delivery

All points of access and identification will be trained to refer young children exposed to violence and their families to family support services in each community. All points can also refer children and families directly to mental health if indicated.

Family support services will be provided initially by a specific organization in each of the two target districts. These services will use a strength- and asset-based approach in working with parent-child interaction, enrichment activities for young children, and skill enhancement

for parents. The family support service providers will be trained to educate parents on the impact of exposure to violence on young children, what to look for, and what they can do. The providers will also be trained to provide a basic level of intervention with children and parents, including art and play activities and discussion groups. In addition, the providers will know when and how to refer to a specific mental health service provider in each of the two districts and will collect demographic data on all children identified and referred. Other referrals will be for job training, housing, and other social services.

Initially, in each of the two districts, a designated mental health provider will expand their continuum of services and the level of expertise related to children's exposure to violence. This service continuum will span a range of intensity of services, from individual psychiatric consultations and management to individual therapy with a master's level counselor to adult groups to art and play therapy for children. This continuum is based upon the four major national models in treating young children exposed to violence.

6.2 Goal I

Children who have been exposed to violence or are at risk of exposure will be identified by organizations (formal or informal) that interact with or serve children.

Children in the targeted Chicago Safe Start communities (Englewood and Pullman) are at extreme risk of exposure to violence. We learned from our assessment that the rates of violent crime in the Chicago Safe Start area are disproportionately higher than the rates for the City as a whole. Violent crimes committed against children under the age of 13 are likewise alarmingly high, with these communities representing 13% of such crimes and only 8% of the relative population. Children in these communities are known to be at a much greater risk of exposure to gang-related violence. A significant majority of children under six have heard a gunshot, or were present when someone was shot or attacked with a knife. Likewise, their risk of exposure to domestic violence is disproportionately high relative to the rest of the City, with these communities reporting over 5,600 domestic violence reports in a two-year period. Clearly, the risk of exposure to violence in these communities is so pervasive that it can be considered almost certain that most children will be exposed to violence by the time they are six years old.

Given this reality for the children in the Chicago Safe Start area, the Chicago Safe Start project determined that it is necessary to have an approach that has two essential strategies for identifying children exposed to violence. First, we plan an incident-based response system. Because there are so many reported incidents of violence, identification of children exposed to these situations must occur concomitantly with the notification to the authorities or first-response personnel. This includes first responders to community and gang-related crime such as the police, emergency medical personnel and hospital emergency room personnel; and first responders to domestic violence, including the police and Domestic Violence Help Line staff.

Second, given the pervasive and chronic nature of violence in these communities, and the overwhelming percentages of children at risk for exposure, it is necessary to identify children through a symptom-based response system. The assumption is that many of the children will go undetected by a system that only focuses on reported incidents of violence, especially

when there are so many direct victims of violence to be attended to by the existing system. We believe that exposure to violence in communities where violence is so prevalent is almost taken for granted, and that many children suffer the effects of exposure and will not be identified until they display symptoms. Therefore, a symptom-based response system is a necessary strategy to address the needs of these children.

We also know that families plagued by violence populate our court system—juvenile delinquency court, child protection court, and domestic violence court. The courts are therefore a critical system for identifying children exposed to violence.

Therefore, our first aim is to increase the identification of young children (ages 0-5) exposed to violence, and their families, through the development of an incident-based response system, a symptoms-based response system, coordination with child protection, domestic, and juvenile delinquency courts, and strategies to link informal and community networks with systems of care.

OBJECTIVE A. **Develop an incident-based response system that will identify children ages five and younger and their families who have been exposed to abuse or neglect, domestic and/or community violence.**

Chicago Safe Start will target children and families who have had reported incidents of violence, and thus the children have been exposed to violence. These reported incidents include reported incidents of community violence reported to the police and attended by emergency medical personnel; reported incidents of domestic violence focusing identification efforts on police and the Domestic Violence Help Line; and reported incidents of child abuse/neglect, focusing on the DCFS system. Toward these ends we plan to:

- Work with Chicago Police Department and the Chicago Fire Department's Emergency Medical Services to implement an identification system. The CPD and EMS are the primary first responders for an incident-based response system. As such, their level of awareness of the significance of children exposed to domestic or community violence is critical to identification of these at-risk children. Chicago Safe Start will coordinate with and build upon the MODV's work in training both the CPD and CFD personnel.

- Work with Emergency Rooms in area hospitals to implement screening, referral, and information-sharing for children exposed to violence. Where there are incidents of community violence, or domestic violence resulting in the necessity of ER services to the victim, ER personnel need to become aware that for each adult victim there may be young children at risk of exposure. ER personnel should be able to identify the situations in which young children are at risk, and to make appropriate referrals.

- Leverage capacity of the existing Domestic Violence Help Line to respond to children exposed to violence by:
    a. Screening all DV calls for children exposed,

b. Adding ability/capacity, as appropriate, to take new calls from police, EMS, and other emergency responders, and
c. Making appropriate referrals

The DV Help Line staff are first responders who are essential in identifying at-risk children and families. However, in order to respond to the anticipated increase in referrals, because of Chicago Safe Start's efforts with police, EMS, and ER personnel, the capacity of the Help Line may need to be increased.

- Coordinate with Mayor's Office of Domestic Violence, Illinois Violence Prevention Authority, and the Department of Children and Family Service in their efforts to avoid unnecessary removal from their parents of children exposed to violence. Chicago Safe Start intends to join with these city and state agencies in the effort to stem any increases in children being removed from their homes which might be due to increased identification of families at risk of having exposed their young children to violence. It is important to anticipate any negative unintended effects of increasing the identification of these families.

OBECTIVE B. **Develop a symptoms-based response system to identify children, ages five and younger, and their families, who have been exposed to violence and are manifesting some reaction.**

Statistics on the level of violence in the targeted communities show that violence is pervasive and chronic. Children are perpetually exposed to violence of many types. Much of their exposure cannot be tied to specific incidents because these incidents are either not reported, or are so frequent as to become almost a part of the fabric of life in these communities. Therefore, an incident-only approach is certain to miss many of the children who are in fact exposed to violence in these communities. Unfortunately, many of these children will only come to the attention of caregivers and service providers because they have manifested symptoms.

It is our intention to create a response system which identifies these children as well as the children identified because of their exposure to reported incidents. Strategies for identifying these children will need to focus on reaching the adults –caregivers, providers of early childhood education, and other family service providers. The strategy is to increase the awareness of these responsible adults in young children's lives to the extent that they recognize that exposure to violence puts children at risk; to be able to identify symptoms and situations that may indicate possible exposure; and to equip them with the referral processes and resources to connect these children and families with needed services. Toward these ends we plan to:

- Partner with Chicago Public Schools to incorporate screening for exposure to violence in Child Find efforts (reaches 15,000-20,000 children per year). Child Find is an early screening program conducted by the Chicago Public Schools. The purpose of the program is to screen children prior to school-age in order to identify those who may have special needs or developmental delays which can be ameliorated by early intervention prior to entering school, thereby enabling these

children to get a better start. By incorporating information and tools for screening for the effects of exposure to violence, we can reach a large number of children through an existing, wide-ranging screening program.

- Partner with CPS Cradle to Classroom program to reach teen mothers whose children are at risk of exposure to violence (reaches 6,000 children per year). Again, in partnership with the Chicago Public Schools, through their Cradle to Classroom program, we will be able to identify children who may have been exposed to violence, or who may be at risk of exposure. Targeting teen mothers, this program provides us with the unique opportunity of directly impacting the age group of parents who are predominantly the parents of young children in these communities, and whose children are potentially at greatest risk.

- Partner with CPS Youth Outreach Worker program that works with children and families exposed to violence (reaches 6,000 kids per year).

- Build capacity of Head Start, Early Head Start, and childcare providers to identify children who have been exposed. Since this age group is 0-5, many of these children will be in some form of childcare or Head Start program. The staffs of these programs do not receive information or training in regards to the effects of exposure to violence and how to identify children who may have been exposed. Chicago Safe Start will build their capacity by educating them and providing them with tools for identifying children exposed.

- Increase awareness by faith-based organizations, community-based organizations, families and community members of the risks of children's exposure to violence. A community-wide increased awareness of the impact of exposure to violence on young children can be achieved to some extent by public awareness campaigns. Additionally, however, it will be necessary to directly educate as many members of the community of adults responsible for the care of young children, as well as those that have informal, extended family relationships with them in order to be most effective at identifying the children at risk.

- Work with the Chicago Medical Society, La Rabida Children's Medical Center, community health centers, local hospitals, and other medical organizations to incorporate identification of exposure to violence in on-going professional development activities. Many of the medical and allied professionals serving children and families in these communities are so overwhelmed with the extent of direct violence and abuse of children that the issue of the effects of exposure to violence may not receive much attention. We want to incorporate this information into the ongoing professional development activities for these professionals as a way to increase the likelihood that they will identify children exposed and refer them for appropriate services.

OBJECTIVE C. Through the Child Protection, Domestic Violence, and Juvenile Delinquency Courts identify children, ages five and younger, and their families, who have been exposed to violence.

Violence is a frequent characteristic of families who come into the court system. Whether the issues are around child abuse/neglect, domestic violence, or juvenile delinquency, the courts are an integral part of any system designed to identify children who have been exposed to violence in their families or communities. In the targeted communities, the problems of these families are often so severe and long-standing that exposure of young children to violence is a secondary issue. We want to raise the level of importance of this issue in the consideration of how these cases are handled, and thereby increase the number of children identified as having been affected by violence. In order to accomplish this Chicago Safe Start plans to:

- Work with appropriate court personnel (judges, social workers, others) to ask questions regarding children's exposure to violence, to recognize signs and symptoms of exposure, and to incorporate orders for service, as appropriate. Court personnel will need to be aware of the effects of exposure to violence, and understand its significance in order to ask the necessary questions, determine if there is a possibility of risk, and follow through with appropriate referrals.

- Work with court-based childcare programs to provide basic information to families on exposure to violence and to make referrals, as appropriate. The importance of community-based childcare programs as identification resources has been addressed. The significance of court-based childcare programs is that they are linked to the system that routinely encounters families who are plagued by violence. This makes them a source for early identification of families at risk.

- Identify children at high risk through linkages with programs serving delinquent teen mothers who are on probation. We know from our assessment that the rates of teenaged motherhood in these communities are quite high (29% of the births in these communities were to mothers under age 20). We can also assume that teen mothers involved in the court system are less likely to be able to provide the strong child-caregiver bond that is required for adequate protection for children who may have been exposed to violence. Therefore, programs for delinquent teen moms are an important point of identification of children at risk.

OBJECTIVE D. Create avenues for concerned parents, family members, faith-based organizations, and informal networks to reach services for children who have been exposed to violence.

We believe that it is important for families, extended families, and informal support networks to be able to seek assistance with identifying and addressing the needs of children exposed to violence independently. For those families who do not come to the attention of first responders to incidents of violence, or who are not involved with the formal child welfare or court systems, there needs to be direct access to agencies who can assist them with understanding the effects of exposure to violence; determine if their child is experiencing

symptoms of exposure; and provide them with the necessary information and knowledge to support and protect their children. While we address the network of Family Support Services in later sections (see Goal 3, Objective A), they are a part of the identification system for self-referred families. Likewise, other "natural doors" in the locally-based community of providers become important in providing a non-threatening, non-stigmatizing availability of service to families who seek assistance on their own.

6.3 Goal II

Child-serving systems and service providers will implement a formalized and coordinated response for initial intervention and referral for children exposed to violence.

The targeted communities have many child-serving agencies, as illustrated in the maps in Appendix G and the tables in Section 5.1. The Department of Children and Family Services contracts with agencies in the Chicago Safe Start communities. Families in these communities have access to domestic violence shelters, though the capacity certainly does not meet the need. In Englewood there are approximately 40 State Pre-k, Head Start, Child Care and other child development sites. In Pullman there are about 45 such agencies. However, the number of agencies does not speak to the critical issues of their capacity to serve the needs of children exposed to violence, and their capability and competence in providing initial assessment and referral for children exposed.

Chicago Safe Start intends not to "re-create the wheel" relative to providers of children's services. Rather, the best use of the resources, and the most effective approach to the community of experienced and indigenous service providers, is to assist them in doing their jobs better in regards to children who have been exposed to violence. In order to increase their ability to respond effectively to these children, Chicago Safe Start plans to work with these agencies to increase their awareness of the impact of violence on children; to give them approaches for initial intervention with these families; and to give them skills and tools to screen for children who may be exhibiting more severe symptoms in order to refer them to appropriate family support or mental health services.

Our primary vehicle for increasing awareness, skills, and abilities to intervene with affected children is the Training Institute. Through this cadre of professional experts and university partners, we will be able to reach targeted groups of front line workers from child welfare, domestic violence, and early childhood care. We can ensure accurate and consistent information, develop and provide curricula, and develop and provide observational screening tools for use by workers coming in contact with children at risk.

OBJECTIVE A. Increase the capacity, competence and capability of the child welfare system to intervene with children exposed to violence through abuse and neglect.

Children in the state's child welfare system whether they remain at home or are placed in some form of substitute care have been exposed to violence. While the child welfare system is particularly sensitive to the safety, counseling and developmental needs of the children in its care, it does not currently have an explicit focus on the impact of *exposure* to violence as distinct from *victimization*. Chicago Safe Start will work with DCFS to incorporate into its

policy, practices and training for caseworkers, foster parents and intact family service providers expectations and tools for dealing with children's exposure to violence.

Foster families are a particularly crucial focus for our approach involving the child welfare system. With these families, children have already been removed from their homes due to abuse and/or neglect, and foster children's exposure to violence can safely be assumed. Workers who train and counsel these families must be aware of the effects of exposure to violence in order to properly train and assist foster families in responding appropriately to these children's needs. In addition, Chicago Safe Start will support ongoing DCFS efforts to develop abuse/neglect prevention approaches for families experiencing domestic violence (through the new RFP described in Section 5.2.2), where, again, the children exposed may be overlooked in initial intervention and referral procedures.

OBJECTIVE B. **Increase ability of domestic violence shelters to provide initial intervention services for children exposed to domestic violence.**

Acknowledging the connection between domestic violence and children's exposure to violence, we are looking to the domestic violence shelters as an important access point for initial intervention and referral services. As with the other populations that we have discussed, where the primary attention of caregivers and service providers is on the victim of violence, it is necessary to raise the awareness of those who work in and administer domestic violence shelters that abused parents are not the only victims. We know from the research that children's services are frequently a part of the services provided through these shelters. However, staff may not be up to date on the best research and practices in working with children exposed. Further, linkages for referral to more formal mental health or family support services are not uniformly in place. Since this is a major system of refuge for these families, we plan to:

- Expand exposure to violence services for children in domestic violence shelters, including training staff and establishing formal linkage and referral agreements;
- Work on a systems level to assure a direct connection between domestic violence shelters and providers of mental health services to assure that children demonstrating more severe symptoms resulting from exposure receive professional treatment.

OBJECTIVE C. **Target services to teen parents involved with the Juvenile Delinquency Court.**

It has been established that, in the Chicago Safe Start area, a significant number of children at risk have parents who are teenagers. Further, teen parents involved with the Juvenile Delinquency Court are probably less likely than others to provide the strength of care-giving in the parent-child relationship that can adequately protect young children from the effects of violence exposure. Since the Juvenile Court program for teen parents is a point of identification, it follows that services for initial intervention and referral should be targeted here as well. Family Focus is one of Chicago's leading family support organizations, specializing in services to teen parents. Family Focus operates an "alternative to detention" program in conjunction with the Juvenile Court. This program will be a partner with us in this endeavor. Chicago Safe Start intends to work with Family Focus to include exposure to violence awareness information and observational screening tools to raise teen parents'

awareness of the issue and assist teen parents and Family Focus staff in determining the need for initial intervention and/or referral to other resources for children in need.

In addition, Chicago Safe Start will work with Court personnel to develop formal referral agreements for other families with teen parents to assure that they are linked with appropriate family support network service providers.

OBJECTIVE D. **Increase capacity, competence, and capability of childcare, early education, and early intervention providers to provide initial intervention services for children exposed to violence.**

Many of the children in this age group are in some form of childcare, whether home or center-based. Others are in Head Start or Early Head Start, or some other form of early intervention program sponsored independently or through the Chicago Public Schools or the Chicago Department of Human Services. We will partner with these providers to primarily do two things:

- Provide training on the effects of exposure to violence and how to provide initial intervention when symptoms present; and
- Establish a formal referral process between the childcare providers and family support services network.

We will also be engaging in systems-level activities to fully integrate children's exposure to violence in policy, contracts and funding streams. This is an important strategy to ensure that government systems and programs respond to children's exposure to violence through regular, ongoing programming and not just through special, targeted initiatives. This, we believe, is the core of systems change. This includes working with the Illinois Department of Human Services and the Chicago Department of Human Services, as well as the Illinois State Board of Education. Our aims are to advocate for dedicated funding streams which would address the need for training on exposure to violence in early childhood education and child care programs and add new services, to assure the competence of staff working with young children at risk to provide initial intervention services, and to recognize the need for referral to mental health or family support services providers.

OBJECTIVE E. **Increase capacity, competence, and capability of publicly-funded substance abuse treatment providers to recognize the link between substance abuse, violence, and the impact on children of the exposure to violence and to provide initial intervention services for children of parents undergoing substance abuse treatment.**

The research is clear on the correlation between substance abuse and interpersonal violence of all kinds. Substance abuse is recognized as a primary risk factor for exposure of children to violence. In addition, substance abuse is a debilitating factor for parents responsible for protecting children from violence and impairs their ability to recognize signs and symptoms of the effects of exposure to violence in young children. We know from our assessment that the Chicago Safe Start area is as plagued by substance abuse as it is by violence. We believe that the typical provider of substance abuse treatment is not likely to be fully aware of the effects of exposure to violence for young children, and have little or no

training on how to provide initial intervention to children suffering from those effects. We plan to:

- Increase the awareness of substance abuse treatment providers of the effects of exposure to violence and train them on how to recognize symptoms, provide initial intervention, and make referrals to mental health or family support service providers; and
- Establish a formal referral and linkage agreements between the providers of substance abuse treatment and the family support services network.

Additionally, we will be working at the state level (Illinois Department of Human Services, Office of Alcoholism and Substance Abuse) to incorporate the exposure to violence issues in funding considerations and contract expectations and effect systems change.

OBJECTIVE F. **Establish Training Institute to train on the impact of exposure to violence on young children and to build capacity to provide effective services.**

Many of our objectives and activities are directed to personnel working in key access points in the system of services available to families affected by violence. They are based on four essential strategies:

1. Increasing the awareness of exposure to violence and its effects on young children;
2. Increasing the competence and capability of those who care for and educate young children to identify those who have been exposed;
3. Increasing the competence and capability of those who care for and educate young children to provide initial intervention services;
4. Increasing their ability to recognize more severe symptoms, which require referral to family support or mental health services.

Therefore, a considerable amount of Chicago Safe Start's work in these communities involves training. Toward that end, we plan to establish a Training Institute. The Training Institute is envisioned not as a facility, but as a cadre of practitioner-partners (professionals in mental health and family support), university partners, and other experts. This cadre of training partners will be involved in working with Chicago Safe Start staff to:

1. Identify existing curricula and training modules for inclusion in existing training curricula for certain audiences (e.g. Training for child care workers, training for foster parents, etc.)
2. Develop training curricula and modules for independent training efforts (e.g. Training for mental health workers and family support workers)
3. Develop and/or identify and modify tools for observational screening of children who may display symptoms of exposure to violence;
4. Develop and/or identify and modify protocols and training support for providing initial intervention services.

It is anticipated that training and informational presentations will be conducted through any number of venues including formal education for which participants could receive CEUs; conferences and workshops for interdisciplinary training opportunities; and a speaker's bureau for on-site informational or training presentations. The Training Institute will need to

identify funding for its continuation, as it is planned to become an ongoing resource for the system of child-serving organizations in our communities.

6.4 Goal III

The intervention and treatment system will have sufficient capability and capacity to seamlessly serve children who have been exposed to violence and their families.

OBJECTIVE A. Expand capacity and strengthen capability of family support agencies to serve children and families identified as having been exposed to violence.

As described in Section 5.3, the Chicago Safe Start assessment of Risk and Protective Factors revealed that the primary protective factor is a strong caregiver-child relationship, and the core of our programmatic activities is to strengthen the ability of the caregiver to support the child who has been exposed to violence. We also learned from our assessment that a significant number of the families in our target areas are headed by young parents, indeed are single-parent families headed by young mothers. In fact, 29% of the births in the target communities are to teen parents, exceeding the statewide and citywide rates. Finally, we learned from our assessment that many families are cautious of formalized service programs and are particularly hesitant to seek mental health services. While much of our work will be to increase the capacity of existing systems to identify and provide appropriate services to families and children exposed to violence (as described in Goals I and II, above) these findings lead us to conclude that an important strategy for Chicago Safe Start is to help expand the network of Family Support Services available in the target communities.

The Family Support Services programs we will encourage—both by using Chicago Safe Start funds as seed money and by partnering with state and local government to build on-going Family Support capacity—will have a number of core components. All programs will be designed to provide a "soft" front door to reach families who might otherwise be hesitant to seek support. To reach parents, they will offer friendly, drop-in programs, workshops on topics of importance to young parents (e.g. *"The Terrible Twos"*), snacks, and, importantly, activities for parent-child interaction, where trained program staff can help identify children who may be manifesting symptoms of exposure to violence. The programs will also develop a network of Community Mentors, respected community leaders (perhaps community "grandmothers") who will help provide outreach to the young families, ensure that they stay engaged with the Family Support programs, and help model appropriate behavior.

The goal of these programs will be to build a community resource where families will feel comfortable participating in a range of activities, learn about how to be better parents (reinforcing the key protective factor of strong caregiver-child relationship), and accept advice and referral for more intensive services, if indicated. While there are no family support programs in the Englewood area and limited programs in Pullman, this model has been very successful in other similar communities in Chicago, most notably in North Lawndale, a community with demographics very similar to the Chicago Safe Start target communities.

The core components of the Family Support Services Network will include:

- Drop-In Capacity. Services will be provided in a relaxed "living room" atmosphere, where participants will feel free to stop in at any time of day to discuss problems, seek help, or receive encouragement for success. All children brought into the drop-in center will be screened to identify developmental delays or signs of exposure to violence.

- Group-Based Supports. There will be at least two models of group-based supports. The first is a less intensive program, which will build upon parents' strengths, expand parental skill portfolios, and strengthen connections among parents in the community. These groups will provide:
    - Interactive Parent-Child Centered Play Activities, appropriate to the children's developmental level and parents' interests;
    - Parent Social Time;
    - Developmental Screenings;
    - Peer Support and Advice;
    - Workshops on Topics Relevant to Parents, such as "What is Your Baby Telling You";
    - Family Literacy
    - Lending Library of Parenting Videos/Books and Children's Books and Toys;
    - Information and Referral to Community Resources
    - Field Trips.

  Under the second, more intensive model of group supports, the programs will offer specific parent-child interaction. These groups will focus on teaching parents the importance of and "how to" bond with, talk to, hold, touch, and play with their children to stimulate brain development and offset the impact of exposure to violence. Activities will also include infant massage, floor play, and dialogic reading, as developmentally appropriate. An adaptation of the nationally recognized "Baby FAST" model will be considered. The goal here will be to both enhance the parent-child interaction and to identify families where the children are particularly at-risk or demonstrating symptoms from exposure to violence. Seeing the caregiver-child interaction is essential to determining the extent to which that relationship will help ameliorate the effects of exposure or more intensive mental health services are needed.

- Home Visiting. Another core component of the Family Support Services Network model will be home visits. We are proposing to build on the *Healthy Families* national model. This model targets young, first-time mothers with the goals of promoting positive parenting, encouraging child health and development and preventing child abuse and neglect. The home visits will be used to educate parents on caring for their children and preventing violence in the home; help parents improve parenting skills, learn how to bond with their children, and understand how violence can have negative impacts on their child's development. Of course, home visits will be made only if appropriate and with due sensitivity in cases where domestic violence has been identified or is suspected.

- Linkages to Mental Health Services. Family Support Services programs will maintain linkages to a wide array of resources for families (see "Referrals to Ancillary Services,' below). Because of the importance of having access to mental health services for children exposed to violence, each program will have formal referral agreements, including guaranteed space for emergency referrals, with community mental health providers. The role of the mental health providers is described more fully under Objective B, below.

- Community Mentors. Each program will develop and coordinate a network of Community Mentors, so-called "feisty older women" who are natural community leaders and can help ensure that mothers of young children are not isolated and are linked to the Family Support Services Network. The Community Mentors may be identified through partnerships with the faith community, block clubs, service programs, or as community leaders. The Family Support Network will ensure that the Community Mentors have appropriate resources, training, and support to be effective mentors.

- General Parent Education. Parent education/outreach will be provided through education and training workshops in various community settings. Chicago Safe Start will encourage Network programs to use nationally-known models, such as MELD, or other evidence-based models that include problem-solving as a key skill. Information specific to the needs of parents and children 0 - 5 will be the focus. Parenting information, safety education, "family days" and other educational and fun activities will be provided in this outreach forum, designed to reach larger portions of the community than might participate in the drop-in program or other components. The goal will be to attract families and link them to more on-going programming, as appropriate.

- Referrals to Ancillary Services. As appropriate, Family Support programs will refer families for housing assistance, to food pantries, etc. in the community. Each program will maintain agreements or referral arrangements with appropriate community resources.

Chicago Safe Start has worked closely with several well-respected service providers to define the Family Support Services Network program model. While it is anticipated that initially the Network will begin with perhaps one or two selected providers in each community, Chicago Safe Start envisions that as demand is built, various providers will expand their service offering and use the family support model. Those that do so will join the Network, expanding resources available to families in the community, and, ultimately, communities throughout the City and State.

An important step in building an on-going Family Support Services *Network*, rather than just a program or two as part of the demonstration project, is to identify potential governmental funding sources that will support the Network over time. In our Assessment in Section 5.2, we identified several potential resource pools that are not now dedicated to exposure to violence but with appropriate providers and applications could be used to fund programs. The program model that we have outlined for the Family Support Services Network we

believe meet the criteria for funding under the Illinois State Board of Education Early Childhood Block Grant Program, in particular the Prevention Initiative, (described in Section 5.2.3) and the Department of Human Services Healthy Families program (described in Section 5.2.6).

Our strategy here is two-fold. First, as we discuss in Section 5.2.6 and in the Action Plan, an RFP has already been issued to expand the Healthy Families program to the Englewood community. Chicago Safe Start worked with community providers to develop and submit a proposal for funding that will help achieve the Chicago Safe Start goals for Family Support programming. We received notification just prior to the submission of this plan that the proposal was funded. Thus, our efforts to secure permanent funding in this area are already underway.

The second component of our strategy will be to encourage Family Support providers to apply for funding under the Early Childhood Block Grant program. These funds are typically bid by the state in the spring of each year; the amount of funding for new programs varies, but Chicago Safe Start will advocate through the legislative process for additional funds and for providers to apply for existing funds. Chicago Safe Start will also work with currently funded providers to incorporate these family support components and the Chicago Safe Start goals into their next application, again expanding the pool of providers who can become part of the Network. The longer-term, system focus of strategy of changing the RFP and contracting process to *require* services for exposure to violence as a program component is discussed under Goal II, above.

OBJECTIVE B. **Expand capacity and strengthen capability of mental health services to children and families needing more intensive support.**

We learned from our assessment that many children and families will require clinical mental health intervention to address the trauma resulting from exposure to violence. We also learned from our assessment that the capacity of the mental health system to address the needs of very young children is extremely limited. In fact, we learned that the State Office of Mental Health Services allocates *no funds* for mental health services for children under age three. As a result, there are very few mental health services available for very young children. This is among the most significant gaps that we found as we conducted our assessment and therefore we have developed a number of strategies to begin to address this need.

One of Chicago Safe Start's first steps will be to quickly expand mental health capacity in the target communities. Because there is currently no state or local funding available, we will dedicate a portion of the Chicago Safe Start resources to building this capacity. This will include working with community-based mental health providers to add appropriate staff and to refine their programming so that it is responsive to children exposed to violence.

We estimate that approximately 20% of the families who receive Family Support Services may require additional assessment or intervention services as a result of escalating or persistent symptomatic behavior. Depending on the age of the child, these symptoms may include: loss of recent developmental achievements, such as toileting; sleep disturbances;

hyper-vigilance and other changes in mood and behavior. Additional assessment and intervention may also be warranted because of on-going stressors the caregiver has experienced either as a result of victimization or other trauma that may have impacted the healthy attachment between the caregiver and child.

The specific intervention will be developed in conjunction with the selected providers, but we envision the mental health services to include at least the following program components:

- Services to Children and Families. The interventions to be established would include family sessions with caregivers and children to assess and address the impact of witnessing violence. We believe that this is a core component of the program because it will reinforce the important caregiver-child relationship and, ultimately, the caregiver's ability to protect and foster the development of the child, once services end. We envision that counselors with expertise in working with adult victims and those with expertise in working with children would partner to provide the services. Services would include appropriate evaluations and individual treatment, as needed; referral for psychiatric services, again, as needed, group services. We are considering several models for the group services, including the "Child Witness to Violence Project" developed by Betsy McAllister-Groves at the Boston Medical Center. Our focus will be to draw on research-proven interventions to apply to programs in Chicago.

- Services to Caregivers. Master's level counselors with experience in domestic violence would be available to provide counseling services to caregivers of child witnesses to domestic violence, as appropriate. Counselors would also be equipped to work with caregivers who are experiencing difficulty as a result of other types of violence.

- Infant Mental Health. A portion of the families with babies and children up to three years old may need assessment and intervention services of an infant mental health specialist. These services would be geared toward infants and younger children who are experiencing attachments and other relational difficulties with their primary caregiver as a result of exposure to violence. One model being considered is the Early Relational Assessment, designed by Roseanne Clark, which is highly regarded in the field.

- Psychiatric Services. We estimate that a small portion of the families will require the services of a child psychiatrist or an adult psychiatrist. These services will be available to families who need them, either through the providers directly or through partnerships with universities, hospitals, or private contractual arrangements.

We recognize that Chicago Safe Start can only be the seed money for the development of mental health services in the target communities and that the need is much greater in the two communities and in the State of Illinois. A key part of the work of Chicago Safe Start over the next four years will be to develop dedicated public funding streams for children's mental health services in Illinois. This effort will be part of a broader coalition working to enhance mental health services. Our work is described more fully in Goal IV, below.

A corollary problem to the lack of funding for children's mental health services is that there are few academic programs that prepare professionals for work with children exposed to violence. Chicago Safe Start will work with universities, faculty, and academic and professional associations to incorporate exposure to violence and its treatment into the curricula of social work, counseling, and other mental health professional preparation programs in an effort to ultimately increase the pool of professionals who are equipped to respond to children and families' needs.

6.5 Goal IV

The issue of children's exposure to violence will be the subject of sustained attention and action by policy-makers.

Research has only recently begun to document the negative consequence of exposure to violence and the potential linkages to future delinquency or violent behavior. Not surprisingly, a few policy-makers are only beginning to become aware, through efforts like Chicago Safe Start, of the impact of exposure and the steps that can be taken to offset that impact. We believe that an important goal for Chicago Safe Start is to increase the number of policy makers who see exposure to violence as an important issue for policy action and to shape the agenda of that policy. The strategies and objectives we outline will help us active this goal.

OBJECTIVE A. **Develop system-wide analytic capacity to understand the impact of children's exposure and families' access to services and to widely disseminate findings among key policy-makers.**

Having access to good data and analysis about the extent and impact of exposure to violence for children in Illinois is essential to persuading policy-makers that the issue is of serious concern. One of our first strategies is to build the data collection and analytic capacity that will allow us to understand the experience of children and families exposed to violence.

We will proceed on two fronts. The first will be to develop appropriate data collection tools and protocols for each component of the system that impacts children exposed to violence. These areas, such as the police when they respond to a call, the Domestic Violence HelpLine when they make a referral, the Family Support Network, and the other system and program components, will provide the basic data to inform system improvements and understand child outcomes.

Our second front will be to develop a broader analytic capacity, which will be built on the extensive resources of the Chapin Hall Center for Children Integrated Database. Chapin Hall, a children's policy research center at The University of Chicago, has been working for a number of years to bring together the data from state and local government agencies to understand the experience of children and families who receive government services. Through sophisticated matching techniques they are able to link data from various agencies to determine whether children and families have received services from multiple systems

and what services they have received. Currently, they have linked child welfare, mental health, special education, Chicago arrest, Chicago Public Schools, state employment, and a number of other system data. They are currently in the process of securing juvenile court data from the Cook County Clerk's office.

Chicago Safe Start will partner with Chapin Hall to build on this massive data set to incorporate additional data collected from Chicago Safe Start and to begin to identify the research and policy questions which might be answered based on analysis of these data. Information from these analyses will be shared broadly with policy makers to advocate, as appropriate, for changes in policies, practices, or financing.

OBJECTIVE B. **Conduct public awareness campaign targeted in Chicago Safe Start districts on the impact of exposure to violence on young children.**

This objective builds on the broad finding that the general public, service providers, and policy makers (at least prior to September 11) were not aware of the extent to which exposure to violence can be developmentally harmful to children. A key strategy for Chicago Safe Start, then, is to increase the general awareness that exposure to violence is an issue.

Our public awareness/education strategy underlies several of our other objectives. Objective A, above, describes the importance of informing public policy makers of the importance of addressing exposure to violence. A broad public awareness campaign can help make that case. We also discuss in Goal II the importance of public awareness/education as the foundation to encourage substance abuse treatment providers and some domestic violence service providers to take steps to incorporate services for exposure to violence in their programming. Based on our assessment, we found that we could not begin by offering training to the providers and expect them to provide screening or services without first generating support. The public awareness campaign is one step in that direction. Public awareness will also help build support among the first responders—police and others—who are taking on a significant role in responding to children exposed. Finally, public awareness/education is important to help families understand that their children might be reacting to exposure to violence and that they can seek help. It is another component of our strategy to provide non-threatening avenues for families to learn better how to help their children.

We were fortunate to recently have had the opportunity to meet with Dr. Marans of the Yale Child Study Center and Deputy Chief MacDonald of the New Haven Police Department, founders of the CDCP model. Throughout their conversations, they emphasized that they learned throughout the ten years that they have been operating the CDCP program. One of their key lessons, and one thing they would do differently if they were starting over, is to emphasize public education more. They felt that had they done that, they would have been able to build support for their program more quickly and might have avoided some early pitfalls. We take their comments as reinforcement of the importance of public awareness as a fundamental strategy on which to build our other activities.

OBJECTIVE C. Coalesce and mobilize a network of child- and family-serving organizations to assure system efficiency, engage in policy advocacy and promote organizational ownership of the issue.

Part of our strategy for building on-going support for the policy and program changes developed as part of the Chicago Safe Start demonstration is to build a coalition that provides leadership and that can be mobilized to provide advocacy support, information, or other resources. We envision building this coalition from the existing Chicago Safe Start Steering Committee, which is comprised of policy-makers and statewide leaders, and the Chicago Safe Start Council, which adds to the Steering Committee a broad array of service providers, community organizations, community members, families, and others with an interest in exposure to violence. (See Appendix C for a current list of the members.)

We will rely on the Steering Committee to provide senior-level leadership for fiscal, legislative, or significant policy changes, offering guidance, strategies, and access. Both Steering Committee and Council members will also work to institutionalize the commitment of their organizations to serve children who are exposed to violence by providing regular participation on either the Committee or Council; sharing information within their organization and with their parent/advisory groups; and educate their Boards about the issue.

As the Committee and Council begin this phase of their work, they will develop a clear policy agenda and a plan for action, which will be included each year in the Implementation Plan. One issue that we will encourage them to focus on is advocating for including issues of exposure to violence in the licensing and continuing education requirements of various professionals, such as social workers and counselors. This may involve working with organizations such as the National Association of Social Workers, the Council on Social Work Education, the American Psychological Association, and the Illinois Department of Professional Regulation, among others, to determine the feasibility and implications of making such changes.

OBJECTIVE D. Develop technology-based tools that will serve as a resource for policy-makers, community-based organizations, and family members about children exposed to violence.

Chicago Safe Start sees the advantage of developing technology-based tools as resources for service providers, community members, and others, as one of our strategies to increase access to information and awareness and to build an appreciation for the efficiencies of technology.

In response to requests from the Council members, we have begun to develop community web sites, to take a small step toward addressing the "digital divide." While we realize that many individual community members may not have home access to the Internet, the City of Chicago has made a commitment to providing access at public libraries, public schools, and other locations. By helping our community partners develop their own website, we can further our partnership, address one of their unmet needs, and begin to help more community members learn about the power of the Internet.

In addition to the community websites, Chicago Safe Start will use its own website, linked to the City of Chicago's KidStart website (www.chicagokidstart.org, which is being widely promoted by the City) to disseminate current research, best practices, and analysis about children exposed to violence. The importance of this web-based resource became apparent as the Office of Violence Prevention (where the Chicago Safe Start program is housed) received numerous calls after the September 11 incidents about how to talk to children.

OBJECTIVE E. **Advocate for additional children's mental health services.**

As we have highlighted throughout the Strategic Plan, Illinois' mental health services for children are underfunded. Fortunately, policymakers at the state level understand the importance of providing adequate mental health services for youth and are beginning to take steps to address the situation. Chicago Safe Start will work with other groups and organizations to encourage additional support for these services.

The Futures for Kids Advisory Board, chaired by Illinois' First Lady Lura Lynn Ryan, has taken as one of its main areas of focus children's mental health. They have recently formed a subcommittee to look at the issue, and are particularly sensitive to the linkages between mental health services, juvenile delinquency, and early exposure to violence. In fact, Futures for Kids was successful in securing an additional $2.0 million in mental health services in the current budget year for youth leaving juvenile detention centers, bringing a three-year total of new funding to $6.0 million. Chicago Safe Start, through joint members on the Steering Committee and the Futures for Kids Advisory Board and through direct participation on the subcommittee, will help advance the goal of increasing access to mental health services for children.

At least two other partnerships are organizing to increase the support for children's mental health. The Community Mental Health Council, a key provider of mental health services in the target community of Englewood, is organizing an initiative to create a children's mental health infrastructure. One component of this effort is to increase awareness among the state legislature about the need for additional services and the Futures for Kids Advisory Board and Dr. Carl Bell, Director of the Community Mental Health Council (and a member of the Advisory Board) were successful in securing Dr. Satcher to come to Illinois in late November to talk about the Surgeon General's Youth Violence Report and Public Health.

In addition, the Ounce of Prevention Fund and Voices for Illinois Children, two well-known organizations in the state, are working with interested legislators to secure additional funding for early childhood mental health services. These efforts, too, have been discussed with the Futures for Kids Advisory Board (the Executive Director of Voices is also on the Board).

Chicago Safe Start will continue to work with these partners to build an infrastructure for children's mental health in Illinois.

6.6 Goal V

Chicago Safe Start will partner with violence prevention and reduction initiatives to reduce overall exposure to violence for at-risk children.

Up to this point, the Strategic Plan has primarily outlined strategies to identify and intervene with children and families who have been exposed to violence or to change policies that impact identification or intervention. Chicago Safe Start also recognizes that the most fundamental way to offset the exposure to violence is to *prevent* violence. While we realize that Chicago Safe Start cannot be the lead organization in developing violence prevention strategies, we are fortunate that Illinois and Chicago have a number of organizations and efforts in place to prevent violence. Chicago Safe Start will partner with these existing efforts.

OBJECTIVE A. Partner with Prevent Violence! Chicago to reduce exposure to violence.

In 1996 the Chicago Department of Public Health took the lead in developing a comprehensive, broad-based strategy for preventing violence. The Chicago Violence Prevention Strategic Plan was issued in 1998 and in many ways formed the basis for Chicago's application for the Chicago Safe Start grant. Since then, the Prevent Violence! Chicago effort has focused on implementing the work described in that strategic plan. Five Committees of City agency representatives, service providers, community members, and others have been working together to make that plan a reality. Chicago Safe Start will continue to work with the PV!C efforts to decrease violence in the City.

Illinois also has the only state agency devoted to violence prevention, the Illinois Violence Prevention Authority. The Authority, co-chaired by the Director of the Illinois Department of Public Health and the Illinois Attorney General, has been in existence for five years and provides grants, technical assistance, public awareness, and other support to decrease community violence in the state. They so strongly share the goals of the Chicago Safe Start project that they have begun their own, *state-funded* pilot in four downstate communities of services for children exposed to violence. Chicago Safe Start and the IVPA have a strong working relationship. The Executive Director of the IVPA serves as the co-chair of the Chicago Safe Start Public Awareness Committee and is also a member of the Steering Committee. We have been able to work closely and will continue to work closely with them to draw on their expertise in our own program development and to assist them in advancing their violence prevention goals.

Chicago Safe Start will also assist in other community-based violence prevention efforts, particularly in the areas of gang prevention, substance abuse prevention, and parenting. We have already participated in a number of anti-violence parades, community fairs, and workshops, through the schools, community policing activities, and community activities.

We will continue to identify such opportunities to work at the state, city, and community level with others who are advancing strategies for violence prevention.

7. Action Plan

Major Implementation Activities for Year 1

The Strategic Plan and Implementation Plan include a detailed table which summarizes the goals, objectives, activities, and tasks required to implement the Chicago Safe Start vision. The table also includes the timeframes over which the various tasks will be undertaken. The purpose of this section is to provide a broad overview of the major activities, describing the rationale for the proposed timeframes.

We recognize that sequencing will be vital to ensure the effective implementation of the Chicago Safe Start program. For example, we cannot begin to train police on a protocol that requires them to call the Domestic Violence Help Line until we have prepared the Help Line to take these calls. Similarly, we cannot establish referral mechanisms if we do not have the services in place. The major activities we describe here are meant to ensure that the core components of the program are implemented in a way that makes sense. While some activities must be completed in sequence, others can be completed at the same time; these are identified in the table and below. In addition, there are a number of other activities which also begin during this period and are detailed in the implementation table, but are not discussed here because the scope is not as extensive.

These major activities also track closely to the items to be funded in the budget. The budget narrative provides a justification for the cost of each of these activities, and the two sections should be read together to gain a full picture of the Chicago Safe Start grant for the Initial Implementation phase.

Begin Development of Direct Service Programs. One of the first steps we must undertake to implement the Chicago Safe Start model is to secure the providers for the Family Support Services and mental health services components of the programs. If we increase awareness and begin training but do not have resources in place to serve the children identified, we will frustrate the first responders and families and potentially doom the program before it has begun.

We envision that the process to identify the Family Support Services providers, secure contracts, develop appropriate linkage agreements, ensure staff are hired and adequately trained, and community mentors are in place will take approximately 9 months. We see a similar timeframe to establish the mental health services as well. Thus, we will be prepared to launch the service delivery component of the program in month 10.

Establish Training/ Resource Institute. The second key component of the Chicago Safe Start model is the Training/Resource Institute. We envision the Institute playing a central and on-going role in providing training, expertise, and other resources for Chicago, and ultimately Illinois, in the area of children's exposure to violence. We think that it will be vital to have an institutional partner to house and manage the Institute to ensure that it becomes and remains a viable entity long past the conclusion of the grant program. To this end, we will use the first six months of the Initial Implementation period to identify a university or other organizational partner to house the Institute; to identify and select practitioner partners (who are essential to ensuring that the training is relevant); and to work with the Institute to select appropriate training curricula for the initial training and to establish training priorities. By

month 10, we envision that the first formal training for first responders and other priority partners will begin.

Prepare Domestic Violence HelpLine for Enhanced Role. As we begin developing referral resources and protocols for first responders and options for others to use the HelpLine, we must ensure that the HelpLine is adequately prepared for a potential influx of new calls with a particular focus on the needs of children. We will use the first six months to also ensure that the staff of the HelpLine is adequate and sufficiently trained to take on this new role. As additional training or staffing needs are identified, we will address them during months six through nine. In addition, we will ensure that the appropriate referral mechanisms are in place for the newly established Family Support Services and mental health services in the target communities and that data collection instruments that need to be developed are in place. We will be prepared to launch the use of the HelpLine for children's exposure to violence by month 10, the same time we are beginning training for the first responders and when services will become on-line with the new providers.

Prepare First Responders to Implement Identification System. In addition to the prepatory activities described above, Chicago Safe Start also has several specific tasks to undertake in order to implement the first responder incident-based identification system. These tasks include refining the protocol which will become policy and guide police activities in this area; ensuring that reporting forms are updated; modifying and providing the Violence HelpLine referral card to first responders; and, as described above, implementing training. Most of these activities will begin in month 7 and continue through month 11 so that we can launch the incident-based response system in month 12.

Establish Data Collection Support System. In addition to implementing the various identification and service components of the model, there are two essential support functions which will also take place. The first is establishing the data collection systems and protocols to ensure appropriate tracking and evaluation. The second, public awareness/education, will be described below. We have indicated above a number of places where data collection protocols and procedures will be put in place. In addition, we will work with out technical consultant and later with The Chapin Hall Center for Children to determine how the additional data to be collected through the Chicago Safe Start project can be integrated into existing databases for research and tracking purposes. These activities will take place throughout the first 12 months of implementation.

Conduct Public Awareness/Education Campaign. As can be seen in the table, much of the groundwork has already been laid for the launch of a public awareness campaign in the target communities early in 2002. This campaign will help increase awareness among family and community members and service providers about the importance of understanding the impact of exposure to violence. It will lay the groundwork for many of our identification strategies, by providing basic information prior to formal training for first responders and service providers. It will also help fuel our advocacy strategy by beginning to build momentum around exposure as a significant issue warranting public policy attention.

Begin Systems Change Activities. Many of the system change activities to implement the symptoms-based model will begin in the later months of the first year. This is done primarily

because the program components described above, establishment of the direct service programs, hotline, the Training/Resource Institute, and public awareness, are also predecessor tasks to fully implementing the symptom-based model. This is not to minimize the importance of this work, and the partners will be involved in preparing to implement changes throughout, but rather to focus on the practical timeline for getting the work done.

Legend:	
⟹	indicates timeframe over which the task will occur
X	indicates launch or implementation of key activity in month indicated
+	indicates task completed during planning phase

Key Component I: IDENTIFICATION

Gap Statement I: In the designated Chicago Safe Start districts, Englewood and Pullman, approximately 13,000 children have heard a gunshot during thier lifetime, 2,600 witnessed someone attacked with a knife, out of a population of 22,836 children under the age of 6 in these communities. Most service providers are not aware of the impact of exposure to violence or how to identify children who have been exposed.

GOAL I: Children who have been exposed to violence or are at risk of exposure will be identified by any organization (formal or informal) that interacts with or serves children.

Objective A. Develop an incident-based response system that will identify children ages five and younger and their families at the time they have been exposed to violence.

During year 2, 150 children will be identified; year 3 – 250; year 4 – 300.

Activities	Timeframes												Year 2	Year 3	Year 4	Key Partners
	1	2	3	4	5	6	7	8	9	10	11	12				
1. Work with Chicago Police Department and the Chicago Fire Department's Emergency Medical Services to implement an identification system in which first responders: a. identify whether children are present and interact with them in an appropriate manner; b. distribute the Violence Help Line card; c. call or refer the family to the Domestic Violence helpline; and d. record activities for data collection																Chicago Police Department & Chicago Fire Department
a. Refine first responder protocol to include all relevant responsibilities							⟹									
b. Ensure that updated reporting forms and data systems are developed by CPD/EMS partners							⟹									
c. Modify the Violence Help Line referral card, produce the revised card, and distribute to personnel at training and on an on-going basis							⟹									
d. Train first responders through the Training Institute to increase awareness of the impact of children's exposure to violence and on their responsibilities for implementing the protocol										⟹						
e. Implement Identification System												X				
f. Monitor CPD implementation and use of protocol. Use information generated to identify additional training or support needs												⟹	⟹	⟹		
2. Work with Emergency Rooms in target area hospitals to implement screening, referral, and information-sharing for children exposed to violence.																St. Bernard's & Cook County Hosptial
a. Develop formal linkage arrangements with the community mental health partners and the Family Support Services providers to ensure capacity to handle ER referrals.									⟹							
b. Train ER staff of hospital partners–St. Bernard's and Cook County, working with them to identify appropriate staff and training methods											⟹					
c. Make Violence Help Line referral card available to ER personnel												⟹				
d. Monitor implementation of screening and referral card distribution												⟹	⟹	⟹		
3. Build on capacity of the existing Domestic Violence Help Line to respond to children exposed to violence by: a. screening all DV calls for children exposed; b. adding ability/capacity to take new calls from police, EMS, and other emergency responders; and making appropriate referrals, as appropriate.																Domestic Violence Help Line
a. Work with Help Line provider to recruit and hire additional staff to support increase in call demand, if needed.	⟹	⟹	⟹	⟹	⟹	⟹										

b.Review Chicago Metropolitan Battered Women's Network DV Training Institute curricula for best practices for exposure to violence.															
c. Provide training through existing mechanisms to all Help Line staff on Safe Start.							→	→	→						
d. Incorporate into referral process the community mental health and family support services network								→	→						
e. Use data system to track referrals and produce data reports for feedback, implementation monitoring, and evaluation.								→	→						
f. Launch use of DV HelpLine for children's exposure to violence										X					
g. Monitor implementation. Use information to plan additional training, staffing, or other support											→	→	→	→	→
4. Coordinate with Mayor's Office of Domestic Violence, Illinois Violence Prevention Authority, and the Department of Children and Family Services in their efforts to avoid inappropriate removal from their parents of children exposed to violence.															Mayor's Offie of Domestic Violence, Illinois Violence Prevention Authority, DCFS
a. Participate in on-going dialogue to develop new protocols, policies, and practices	→	→	→	→	→	→	→	→	→						

Objective B. Develop a symptoms-based response system to identify children, ages five and younger and their families, who have been exposed to violence and are or at risk of manifesting some reaction.

During year 2 - 500 children will be identified; year 3 -900; year 4 - 1,500.

Activities/Tasks	1	2	3	4	5	6	7	8	9	10	11	12	Year 2	Year 3	Year 4	Key Partners
1. Partner with Chicago Public Schools to incorporate screening for exposure to violence in Early Intervention Child Find efforts (reaches 15,000 - 20,000 children per year).																Chicago Public Schools Child Find/Early Intervention
a. Work with CPS to update current screening instrument to include exposure to violence													→			
b. Train staff on exposure to violence and use of													→			
c. Collect data from screening													→	→	→	
d. Monitor implementation to determine additional training/support needs													→	→	→	
2. Partner with CPS Cradle to Classroom program to reach teen moms whose children are at risk of exposure to violence (reaches 4,000 teen moms)																CPS Cradle to Classroom
a. Train teachers/staff on exposure to violence, how to work with teen moms whose children are at risk, and how to screen for exposure to violence													→			
b. Monitor implementation to determine additional training/support needs.													→			
3. Partner with CPS Youth Outreach worker program that works with children and families exposed to violence (reaches 6,000 kids per year)																CPS Youth Outreach
a. Train outreach workers/staff on exposure to violence and risks to young children whose older siblings may be exposing them to violence													→			
b. Monitor implementation to determine additional training/support needs													→			
4. Build capacity of Head Start, Early Head Start, and child care providers to identify children who have been																Head Start & Early Head Start
a. Develop observation checklist to help staff identify children who may be exposed to violence										→						
b. Provide training to staff on use of checklist											→	→				
c. Monitor implementation to determine additional training/support needs													→			
5. Increase awareness by faith-based organizations,																Call to Clergy,

SEE GOAL IV, OBJECTIVE B																
6. Work with the Chicago Medical Society, community health centers, local hospitals, and other medical organizations to incorporate identification of exposure to violence in on-going professional development activities																Medical Society, La Rabida's Child Witness to Violence program, community health centers, CDPH clinics
a. Use Training Institute to develop and offer appropriate professional development workshops														→		
b. Partner with La Rabida Children's Hospital's Child Witness to Violence Program to train health care providers														→		
Objective C. Through the Child Protection, Domestic and Juvenile Delinquency Courts, identify children, ages five and younger, and their families who have been exposed to violence.	During year 3, 25 children will be identified; year 4 – 50.															
Activities/Tasks	1	2	3	4	5	6	7	8	9	10	11	12	Year 2	Year 3	Year 4	Key Partners
1. Work with appropriate court personnel (judges, social workers, others) to ask questions regarding children's exposure to violence, to recognize signs and symptoms of exposure, and to incorporate orders for service, as appropriate.																Child Protection, Domestic &Juvenile Delinquency Courts, NJFCJ
a. Coordinate efforts with NCJFCJ and consult with Presiding Judges about the best approach in the	→	→	→	→	→	→	→	→	→							
b. Review other Model Court sites for applicable practices; consider Miami Domestic Violence Court as example								→	→	→	→					
c. Develop an awareness and identification													→			
d. Implement Court identification														→	→	
2. Work with court-based child care programs, such as the Cptions for Children program, to provide basic information to families on exposure to violence and to make referrals, as appropriate.																Options for Children
a. Consult with Presiding Judges about the best approach	→	→	→	→	→	→										
b. Provide training to staff								→	→	→						
c. Ensure referral cards are made available								→	→	→						
d. Monitor implementation and provide additional training and support, as indicated											→	→	→	→	→	
3. Identify children at high risk through linkages with programs serving delinquent teen moms who are on probation																Juvenile Probation Officers, Family Focus
a. Coordinate with Family Focus evening reporting center to ensure programming for exposure to violence is incorporated	→	→	→	→	→	→										
b. Identify additional programs serving delinquent teen parents whose children might be at-risk of exposure to violence to ensure exposure to violence programming is included							→	→	→	→	→	→				
c. Monitor outcomes for further program							→	→	→	→	→	→	→	→	→	
Objective D. Create avenues for concerned parents, family-members, faith-based organizations, or informal networks to access services for children who have been exposed or are at risk of exposure	During year 1, a network will be put in place. In addition, presentations to 100 community institutions will be conducted during year 1; 200 year 2; and 300 year 3.															
Activities/Tasks	1	2	3	4	5	6	7	8	9	10	11	12	Year 2	Year 3	Year 4	Key Partners
1. Create network of Family Support Services that provide non-threatening, asset-based approach to serving families (See Goal 3, Objective A).																Metropolitan, Family Focus, other providers
2. Work with "natural doors" that families may be comfortable entering, such as through faith-based organizations, community mentors.																Churches, City Colleges, CPS, Head Start, Child Care providers, etc.
a. Conduct public awareness campaign (See Goal		X														

	1	2	3	4	5	6	7	8	9	10	11	12	Year 2	Year 3	Year 4	Key Partners
b. Develop and maintain relationships with faith-based organizations so that they can create opportunities to provide information or conduct other "soft" outreach activities to reach families at-	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	
c. Establish linkages/referral processes to Family Support and outreach by Family Support network.									→	→						
d. Maintain presence in community through forums, community fairs, violence prevention "days", parades, etc. to continue to share	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	

Key Component II: INITIAL INTERVENTION/REFERRAL

Gap Statement II: *Few providers who come into contact with children are currently equipped to intervene with children exposed to violence.*

GOAL II: Child-serving systems and service providers will implement a formalized and coordinated response for initial intervention and referral for children exposed to violence.

Objective A. Increase capacity, competence and capability of the child welfare system to intervene with children who have been exposed to violence through abuse or neglect.

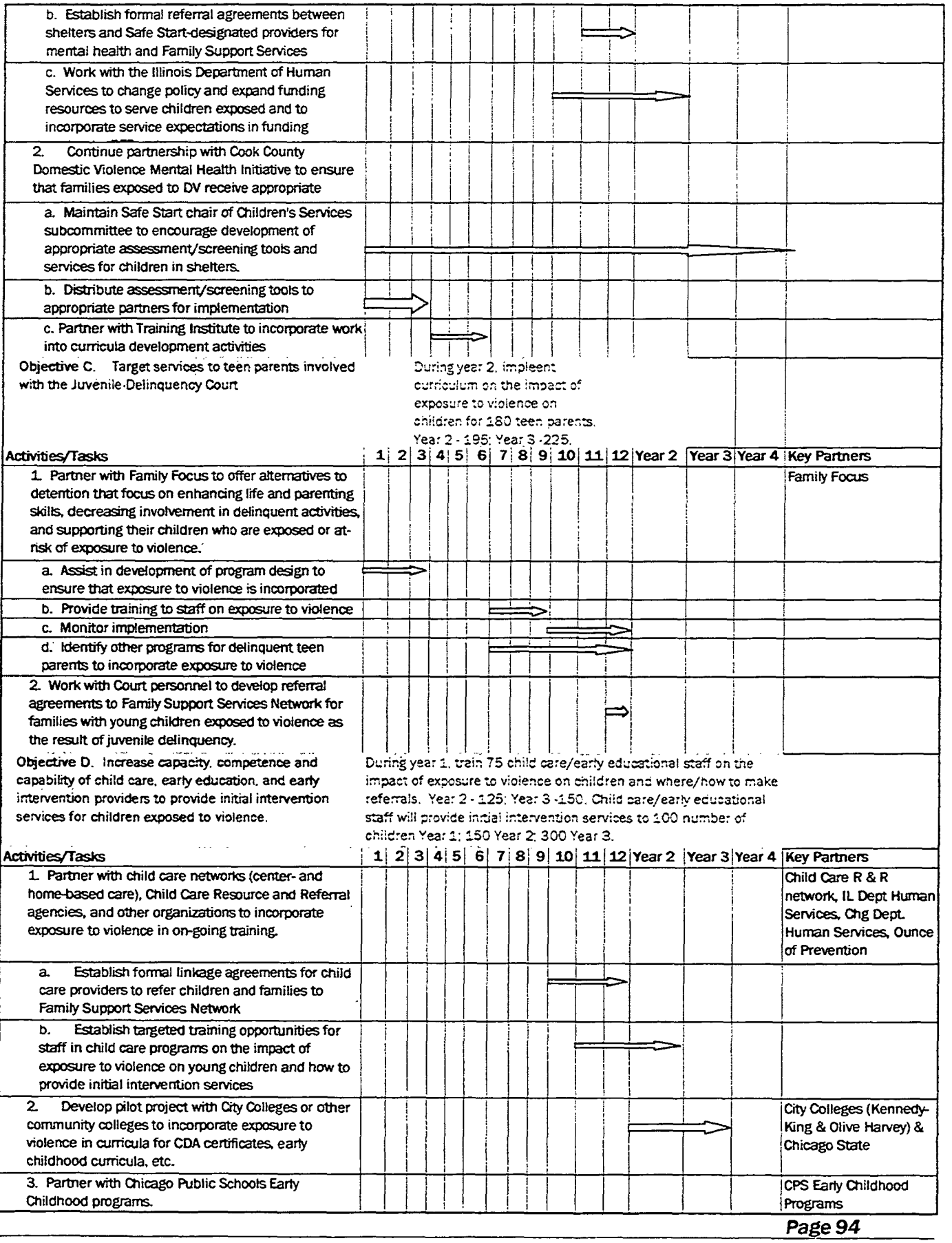
During year 2, train 150 DCFS Intact Family Service & Placement providers, parents on the impact of exposure to violence and where/how to make referrals. Year 3 - 250; Year 4 - 325.

Activities/Tasks	1	2	3	4	5	6	7	8	9	10	11	12	Year 2	Year 3	Year 4	Key Partners
1. Work with DCFS to incorporate exposure to violence in contracted services, training, and policy																Department of Children & Family Services
a. Support efforts of DCFS contract staff to incorporate into Intact Family Services contracts the expectation to provide services for children exposed or to make appropriate referrals											→	→	→			
b. Support efforts of DCFS training staff and university partners to incorporate into foster parent training and expectations appropriate intervention													→	→		
c. Work with DCFS and university partners to incorporate into training curricula and workshops for child protection staff, child welfare staff and all supervisors issues of exposure to violence (public and private agencies)											→	→	→			
d. Work with DCFS to ensure adequate counseling services/contracts are available for children suffering from exposure.											→	→	→			
2. Support DCFS efforts to develop abuse/neglect prevention efforts for children exposed to domestic violence.																DCFS
a. Participate in review of RFPs to ensure that programs that appropriately and effectively support exposure to violence are funded	+															
b. Review contract language to ensure that program plans and evaluation methods reinforce exposure to violence programming.	+															
c. Provide additional technical assistance or expertise to DCFS or service providers, as needed.		→	→	→	→	→										

Objective B. Increase ability of domestic violence shelters to provide initial intervention services for children exposed to domestic violence.

During year 1, train 10 domestic violence shelter staff on impact of exposure to violence & how to make referrals. Year 2 -15; Year 3-

Activities/Tasks	1	2	3	4	5	6	7	8	9	10	11	12	Year 2	Year 3	Year 4	Key Partners
1. Implement exposure to violence services for children in shelters																Clara House, Maria, Assumption, Family Rescue Community Outreach, LAMMB shelter
a. Use Training Institute to provide specialized workshops on best practices and the most recent research, etc., for domestic violence shelter staff on impact of exposure to violence on young children.										→	→	→				


b. Establish formal referral agreements between shelters and Safe Start-designated providers for mental health and Family Support Services
c. Work with the Illinois Department of Human Services to change policy and expand funding resources to serve children exposed and to incorporate service expectations in funding
2. Continue partnership with Cook County Domestic Violence Mental Health Initiative to ensure that families exposed to DV receive appropriate
a. Maintain Safe Start chair of Children's Services subcommittee to encourage development of appropriate assessment/screening tools and services for children in shelters.
b. Distribute assessment/screening tools to appropriate partners for implementation
c. Partner with Training Institute to incorporate work into curricula development activities
Objective C. Target services to teen parents involved with the Juvenile-Delinquency Court
During year 2, impleent curriculum on the impact of exposure to violence on children for 180 teen parents. Year 2 - 195; Year 3 -225.
Activities/Tasks
1 2 3 4 5 6 7 8 9 10 11 12 Year 2 Year 3 Year 4
Key Partners
1. Partner with Family Focus to offer alternatives to detention that focus on enhancing life and parenting skills, decreasing involvement in delinquent activities, and supporting their children who are exposed or at-risk of exposure to violence.
Family Focus
a. Assist in development of program design to ensure that exposure to violence is incorporated
b. Provide training to staff on exposure to violence
c. Monitor implementation
d. Identify other programs for delinquent teen parents to incorporate exposure to violence
2. Work with Court personnel to develop referral agreements to Family Support Services Network for families with young children exposed to violence as the result of juvenile delinquency.
Objective D. Increase capacity, competence and capability of child care, early education, and early intervention providers to provide initial intervention services for children exposed to violence.
During year 1, train 75 child care/early educational staff on the impact of exposure to violence on children and where/how to make referrals. Year 2 - 125; Year 3 -150. Child care/early educational staff will provide initial intervention services to 100 number of children Year 1; 150 Year 2; 300 Year 3.
Activities/Tasks
1 2 3 4 5 6 7 8 9 10 11 12 Year 2 Year 3 Year 4
Key Partners
1. Partner with child care networks (center- and home-based care), Child Care Resource and Referral agencies, and other organizations to incorporate exposure to violence in on-going training.
Child Care R & R network, IL Dept Human Services, Chg Dept. Human Services, Ounce of Prevention
a. Establish formal linkage agreements for child care providers to refer children and families to Family Support Services Network
b. Establish targeted training opportunities for staff in child care programs on the impact of exposure to violence on young children and how to provide initial intervention services
2. Develop pilot project with City Colleges or other community colleges to incorporate exposure to violence in curricula for CDA certificates, early childhood curricula, etc.
City Colleges (Kennedy-King & Olive Harvey) & Chicago State
3. Partner with Chicago Public Schools Early Childhood programs.
CPS Early Childhood Programs

a. Implement services for children exposed in existing Early Intervention programming, including training staff and establishing referral linkages to mental health and family support services																		
b. Implement services for children exposed in Cradle to Classroom program, including training staff and establishing referral linkages to mental health and family support services																		
4. Partner with Head Start and Early Head Start programs.																		Head Start & Early Head Start providers
a. Implement services for children exposed in existing Early Intervention programming, including training staff and establishing referral linkages to mental health and family support services																		
b. Implement services for children exposed in Cradle to Classroom program, including training staff and establishing referral linkages to mental health and family support services																		
5. Change policy and funding streams to support exposure to violence services in early childhood settings.																		State & Local agencies and advocacy organizations
a. Work with the Illinois Department of Human Services and the Chicago Department of Human Services to change policy and funding streams to incorporate expectations about identifying and intervening with children exposed in child care subsidy contracts, training requirements, continuing ed requirements (start with pilot).																		
b. Work with the Illinois State Board of Education to change policy and funding streams to incorporate issues of children's exposure into Early Childhood Block Grant programs (RFPs, contracts, evaluation criteria)																		
Objective E. Increase capacity, competence and capability of publicly-funded substance-abuse treatment providers to recognize the link between substance abuse, violence, and the impact on children of the exposure to violence and to provide initial intervention services for children of parents undergoing substance abuse treatment services.	During year 2, train 20 substance abuse staff on the impact of exposure to violence on children and where/how to make referrals. Year 3 - 30; Year 4 - 45. Substance abuse partners will provide initial intervention services to 5 children Year 2: 20 Year 3: 30 Year 4.																	
Activities/Tasks	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**Year 2**	**Year 3**	**Year 4**	**Key Partners**		
1. Increase awareness among substance abuse treatment providers of the impact of exposure to violence and the role of treatment providers.																Brass Foundation, Chg Women's Treatment Center, Haymarket		
2. Partner with the Illinois Department of Human Services/Office of Alcoholism and Substance Abuse to change policy and funding streams to incorporate expectations for serving children exposed in RFP, contract, and program evaluation language.																IL Department of Human Services, Office of Acoholism & Substance Abuse		
3. Train staff on the impact of exposure to violence on young children and how to intervene.																		
4. Establish formal referral and linkage agreements between treatment providers and Family Support Services Network.																		
Objective F. Establish Training Insititute to train on the impact of exposure to violence on young children and to build capacity to provide effective services.	During year 1, training institute will be created, curriculum developed, training schedule determined. During years 2 & 3, training activities will be conducted per measures established on other objectives.																	
Activities/Tasks	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**Year 2**	**Year 3**	**Year 4**	**Key Partners**		
1. Undertake initial implementation activities.																University partner (to be identified)		

a. Identify university/organizational partner to house and support Training Institute. Secure staff, funding, contracts, as needed																
b. Identify practitioner partners (e.g. mental health staff) to collaborate in curriculum development and training																
c. Develop/refine training curricula (built on adult learning principles) for awareness, initial intervention for various populations to be trained (see Goals I, II above)																
d. Develop training priorities and schedule																
e. Compile observation checklists for initial screening by child care and other providers																
f. Implement initial training schedule							X									
2. Develop opportunities for continuing education on exposure to violence																
a. Establish schedule of conferences/workshops for information sharing among practitioners																
b. Establish a speakers' bureau to inform others about children's exposure to violence																
3. Identify funding and other on-going support needed for conclusion of Safe Start																

Key Component III: INTERVENTION/TREATMENT

Gap Statement III: Few intervention and treatment resources to address children's exposure to violence are available.

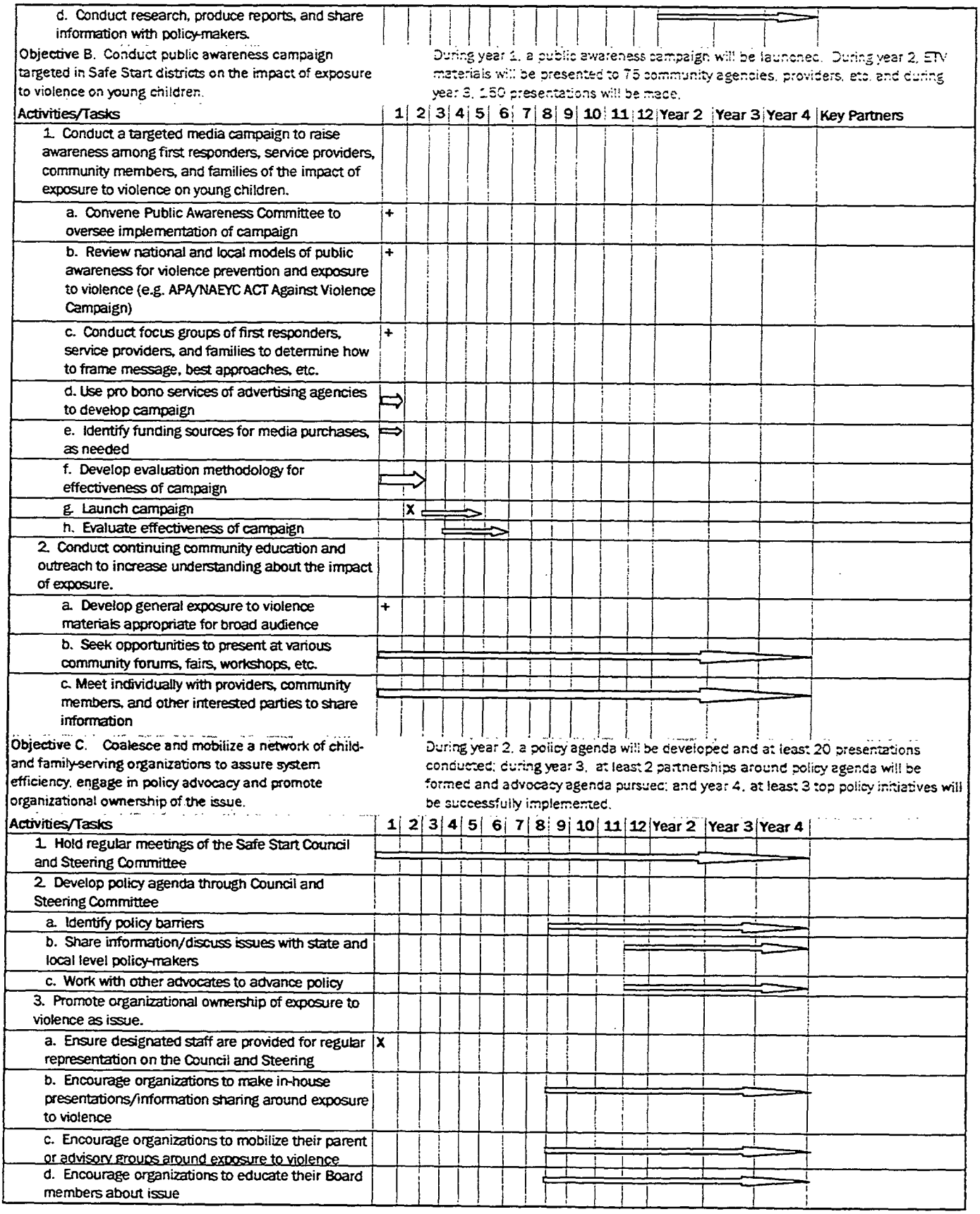
GOAL III: The intervention and treatment system will have sufficient capability and capacity to seamlessly serve children who have been exposed to violence and their families.

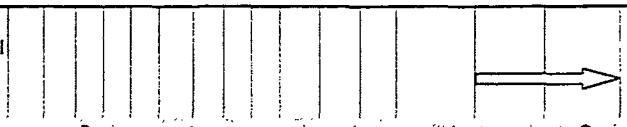
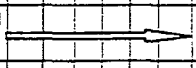
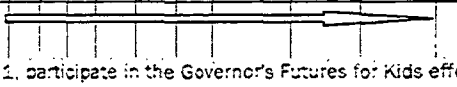
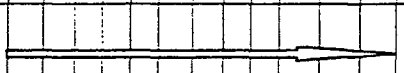
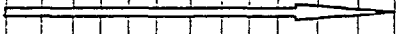
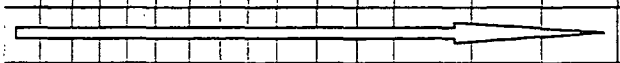
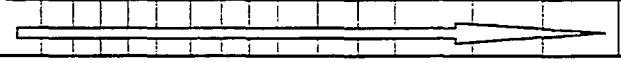
Objective A. Expand capacity and strengthen capability of family support agencies to serve children and families identified as having been exposed to

Expand the capacity of family support service providers in the Safe Start communities to serve 240 families and children in Year 2; 300 in Year 3; 400 in Year 4;

Activities/Tasks	1	2	3	4	5	6	7	8	9	10	11	12	Year 2	Year 3	Year 4	Key Partners
1. Partner with state and local government and non-profit agencies to expand capacity of Family Support Service providers in each targeted district.																Metropolitan Family Services, Commmunity Mental Health Council, others
a. Identify potential FSS providers, develop program plans, determine capacity, secure funding, secure contracts. FSS providers staff up.																
b. Establish formal linkage and referral agreements with mental health service providers to ensure continuum of care.																
c. Develop formal referral agreements for ancillary services (housing, food pantry, etc.)																
d. Use Training Insititute to train family support service providers on the impact of exposure to violence on young children and to build capacity to provide effective services.																
e. Develop network of community mentors to maintain family linkages to the family support services programs.																
f. Implement services.										X						
g. Monitor implementation to identify additional training, other support needed.																
h. Develop transition plan for phase-out of Safe Start funds.																
2. Partner with the Ounce of Prevention Fund to implement Healthy Families home visiting, infant mental health, and family support program for teen moms in target communities by aiding family support services agencies in developing proposals and																Ounce of Prevention Fund
a. Aid family support services agencies in developing proposals, securing funding that includes exposure to violence as program	+															

b. Support implementation of program by partnering with providers.	→	→	→	→	→	→											
Objective B. Expand capacity and strengthen capability of mental health services to children and families needing more intensive support.	Expand the capacity of mental health service providers in the Safe Start communities to serve an additional 75 families and children in Year 2; 100 in Year 3; 125 in Year 4.																
Activities/Tasks	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**Year 2**	**Year 3**	**Year 4**	**Key Partners**	
1. Use Safe Start funds to quickly expand capacity of mental health service providers in each district to provide a continuum of mental health services.																Metropolitan Family Services, Commmunity Mental Health Council	
a. Identify appropriate providers, develop program plans, secure contracts.	→	→	→	→	→	→											
b. Work with selected providers to refine assessment and intervention methodology.						→	→	→									
c. Develop formal referral agreements for Family Support Services and ancillary services (housing, food pantry, etc.)							→	→	→								
d. Implement services.										X							
e. Monitor implementation, using feedback to inform future training, evaluation, and support.											→	→	→	→	→		
f. Develop transition plan and secure funding for phase-out of Safe Start federal funding.														→	→		
2. Advocate for additional children's mental health services. See Goal IV.																	
3. Increase number of MH professionals who focus on children exposed by working with universities to incorporate issues and treatment of children exposed into human service curricula.																	
a. Work with the state's Futures for Kids children's mental health committee to add this item to policy agenda.	→	→	→														
b. Meet with statewide associations of social work and counseling program directors.									→	→	→	→					
c. Work with mental health professionals to develop content to be incorporated into curricula.													→	→			
d. Attend/present workshops at national meetings of social work and counseling faculty to raise awareness, share content.													→	→			
e. Meet with faculty locally to share content and encourage incorporation.													→	→	→		
f. Develop internship/practicum opportunities for students in exposure to violence. Work with faculty to reflect exposure to violence content in related practicum supervision and coursework.													→	→	→		
Gap Statement IV: The issue of children's exposure to violence has not been the focus of attention or adopted as a cross-system priority.																	
GOAL IV: The issue of children's exposure to violence will be the subject of sustained attention and action by policy-makers.																	
Objective A. Develop system-wide analytic capacity to understand the impact of children's exposure and families' access to services and to widely disseminate findings among key policy-makers.	During year 1, a contract will be put in place with an organization to conduct research. During year 2, standard reports will be produced and 2 major policy reports issued; during year 3, at least 3 reports will be issued to support policy work																
Activities/Tasks	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**Year 2**	**Year 3**	**Year 4**	**Key Partners**	
1. Develop and implement appropriate data collection and tracking protocols to monitor experience of children exposed.	→	→	→	→	→	→	→	→	→	→						Chapin Hall Center for Children	
2. Partner with The Chapin Hall Center for Children at The University of Chicago to use administrative databases to compile and analyze data collected																	
a. Develop methodology/approach for analyzing data and key research/policy questions.									→	→	→	→					
b. Secure funding for on-going research.									→	→	→	→					
c. Determine and contract with appropriate organization to conduct research.											→	→					


d. Conduct research, produce reports, and share information with policy-makers.
Objective B. Conduct public awareness campaign targeted in Safe Start districts on the impact of exposure to violence on young children.
During year 1, a public awareness campaign will be launched. During year 2, ETV materials will be presented to 75 community agencies, providers, etc. and during year 3, 150 presentations will be made.
Activities/Tasks
1 2 3 4 5 6 7 8 9 10 11 12 Year 2 Year 3 Year 4 Key Partners
1. Conduct a targeted media campaign to raise awareness among first responders, service providers, community members, and families of the impact of exposure to violence on young children.
a. Convene Public Awareness Committee to oversee implementation of campaign
b. Review national and local models of public awareness for violence prevention and exposure to violence (e.g. APA/NAEYC ACT Against Violence Campaign)
c. Conduct focus groups of first responders, service providers, and families to determine how to frame message, best approaches, etc.
d. Use pro bono services of advertising agencies to develop campaign
e. Identify funding sources for media purchases, as needed
f. Develop evaluation methodology for effectiveness of campaign
g. Launch campaign
h. Evaluate effectiveness of campaign
2. Conduct continuing community education and outreach to increase understanding about the impact of exposure.
a. Develop general exposure to violence materials appropriate for broad audience
b. Seek opportunities to present at various community forums, fairs, workshops, etc.
c. Meet individually with providers, community members, and other interested parties to share information
Objective C. Coalesce and mobilize a network of child- and family-serving organizations to assure system efficiency, engage in policy advocacy and promote organizational ownership of the issue.
During year 2, a policy agenda will be developed and at least 20 presentations conducted; during year 3, at least 2 partnerships around policy agenda will be formed and advocacy agenda pursued; and year 4, at least 3 top policy initiatives will be successfully implemented.
Activities/Tasks
1 2 3 4 5 6 7 8 9 10 11 12 Year 2 Year 3 Year 4
1. Hold regular meetings of the Safe Start Council and Steering Committee
2. Develop policy agenda through Council and Steering Committee
a. Identify policy barriers
b. Share information/discuss issues with state and local level policy-makers
c. Work with other advocates to advance policy
3. Promote organizational ownership of exposure to violence as issue.
a. Ensure designated staff are provided for regular representation on the Council and Steering
b. Encourage organizations to make in-house presentations/information sharing around exposure to violence
c. Encourage organizations to mobilize their parent or advisory groups around exposure to violence
d. Encourage organizations to educate their Board members about issue

4. Partner with local chapter of National Association of Social Workers and other child welfare professional organizations to advocate for issues of exposure into licensing and continuing education requirements.	
Objective D. Develop technology-based tools that will serve as a resource for policy-makers, community-based organizations, and family members about children	During year 1, a community web page will be launched. During year 2, the website will be fully utilized to disseminate current research, best practices and Safe Start activities; during year 3, a formal analysis on effectiveness of website will be
Activities/Tasks	1 2 3 4 5 6 7 8 9 10 11 12 Year 2 Year 3 Year 4 Key Partners
1. Create community web pages to link providers and families to information and resources.	
2. Disseminate current research, best practices, and analysis on Safe Start website.	
Objective E. Advocate for additional children's mental health services.	During year 1, participate in the Governor's Futures for Kids effort to develop statewide agenda for children's mental health, join Community Mental Health Council, and partner with Voices for Illinois Children. As initiatives are developed, strategies for years 2 and 3 will be developed.
Activities/Tasks	1 2 3 4 5 6 7 8 9 10 11 12 Year 2 Year 3 Year 4 Key Partners
1. Work through the Children's Mental Health subcommittee of the Governor's Futures for Kids Advisory Board to develop a statewide agenda for children's mental health.	 Governor's Futures for Kids Advisory Board
2. Join the Community Mental Health Council's initiative to create a children's mental health infrastructure that will dedicate public funding streams to meet the mental health needs of children exposed. (Consider Medicaid, EI, Early Childhood	 Community Mental Health Council & other advoacy groups
3. Partner with Voices for Illinois Children and the Ounce of Prevention Fund to advocate for early childhood mental health services.	 Voices for IL Children
Gap Statement V: *Violence is chronic in the target communities with approximately 23,000 violent crimes committed annually to adults and 1,400 to children ages 13 and younger (1996 data). Alcohol and substance abuse is chronic in the target communities and highly linked to violence.*	
GOAL V: Safe Start will partner with violence prevention and reduction initiatives to reduce overall exposure to violence for at-risk children.	
Objective A. Partner with Prevent Violence! Chicago to reduce exposure to violence.	 Prevent Violence! Chicago
Objective B. Support gang prevention activities in target communities such as Juvenile Gang Intervention Pilot Program in Chicago Area 1.	 Community agencies
Objective C. Support efforts to decrease substance abuse and improve parenting skills to decrease violence.	
Objective D. Partner with the Illinois Violence Prevention Authority to support statewide violence prevention	 Illinois Violence Prevention Authority

8. Plan for Measuring Progress

Chicago Safe Start has outlined a detailed work plan with specific action steps to achieve each goal. Because they are task-specific and the objectives are written as outcomes, we can determine very quickly whether we have completed our activities/tasks and achieved our objectives.

Moreover, we have detailed month-by-month timelines to ensure that we remain on track. Used with the tasks, we have a series of benchmarks to measure our implementation progress.

We have also, for each objective, defined a quantitative performance measure, which indicates, for example, the number of children to be served each year for relevant objectives.

We believe the Action Plan, because it incorporates these tools, will be an effective guide for measuring progress.

9. Training and Technical Assistance Plan

Providing training and technical assistance (TTA) on the impact of exposure to violence on young children, identification, early intervention and related services are critical components of implementing Chicago Safe Start's project model. The key areas in which TTA will be needed in order for Chicago Safe Start to provide TTA in kind include:

- Children's exposure to violence curricula
- Court initiatives
- Child welfare initiatives
- Clinical intervention models, including screening and assessment protocols
- Police-mental health partnerships

Additional areas of TTA will be identified on an ongoing basis throughout the life of the project.

We plan to leverage the following relationships to provide TTA to Chicago Safe Start staff, Council and relevant system partners:

- American Psychological Association/National Association for the Education of Young Children's ACT Against Violence Program.
- National Council of Juvenile and Family Court Judges. As Cook County's Child Protection Court is a Model Court with extensive involvement with NCJFCJ, we will work with designees from NCJFCJ
- Child Welfare League of America.
- Clinical Intervention: Marans, McAllister-Groves, Osofsky

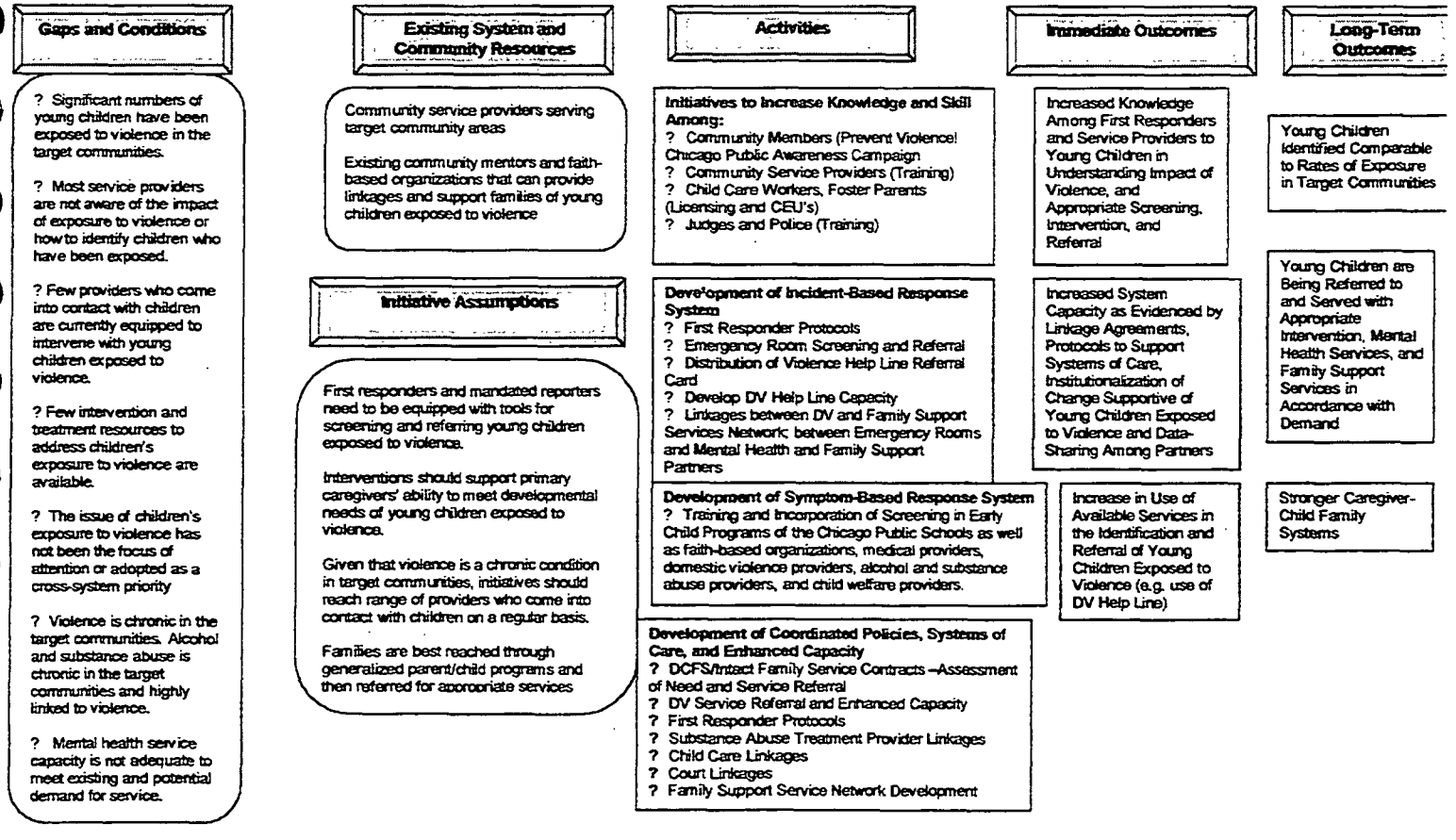
As the National Center for Children Exposed to Violence provides and coordinates training and technical assistance, NCCEV will continue to work with Chicago Safe Start to identify and facilitate training sessions, formal or informal.

10. Local Evaluation Plan

Evaluation Goals and Underlying Theory of Change

Chicago Safe Start is a project funded by the Office of Juvenile Justice and Delinquency Prevention designed to increase awareness about the impact of exposure to violence on young children ages five and younger and to reduce the impact of this exposure through coordinated system responses.

Logic Model



A Brief Summary of the Chicago Safe Start Initiative's Goals and Objectives

Described in more detail in the strategic plan, the goals of the Chicago Safe Start Initiative are as follow:

Goal I. Children who have been exposed to violence or at-risk of exposure will be identified by any organization (formal or informal) that interacts with or serves children.

This goal focuses on increasing the identification of young children (ages 0-5) exposed to violence and their families through the development of an incident-based response system, a symptoms-based response system, coordination with child protection, domestic, and juvenile delinquency courts, and strategies to link informal and community networks with systems of care.

Goal II. Child-serving systems and service providers will implement a formalized and coordinated response for initial intervention and referral for children exposed to violence.
This goals focuses on improving the initial intervention and referral of young children (ages 0-5) exposed to violence and their families through increased capacity of the child welfare system to intervene with children exposed to violence through abuse and neglect, increased capacity of domestic violence shelters, child care, early education, and early intervention providers to provide initial intervention services for children, targeted services to teen parents involved with the Juvenile Delinquency Court System, and increase capacity of substance abuse providers to identify young children exposed to violence.

Goal III. **The intervention and treatment system will have sufficient capability and capacity to seamlessly serve children who have been exposed to violence and their families.**
This goal focuses on improving the capability and capacity of the intervention and treatment system to provide seamless service to young children who have been exposed to violence and their families through expanded capacity of family support agencies and expanded capacity of mental health services.

Goal IV. **The issues of children's exposure to violence will be the subject of sustained attention and action by policy-makers.**
This goal focuses on making the issue of young children's exposure to violence the subject of sustained attention and action by policy makers through the development of system-wide analytic capacity to understand the impact of young children exposed to violence and families access to services, through public awareness campaigns in targeted communities, and through advocacy in licensure, development of statewide agenda, and funding allocations.

Goal V. **Safe Start will partner with violence prevention and reduction initiatives to reduce overall exposure to violence for at-risk children.**
This goal focuses on reducing overall exposure of at-risk children to violence through partnerships with Prevent Violence! Chicago, gang prevention activities in communities, decreased substance abuse, and improved parenting skills.

Evaluation Goals and Working Hypotheses

The goal of the evaluation of the Chicago Safe Start Initiative is to assess the impact of this initiative in achieving its stated goals and objectives. The evaluation of Chicago Safe Start will focus on:

- The capacity building initiatives

- The identification and response initiatives
- Family outcomes associated with systems and services.

Specifically, the objectives of the evaluation are to:

The capacity building initiatives

A. To assess the effectiveness of training for mandated reporters, first responders, and service providers in increasing knowledge about the identification of and appropriate response(s) for young children exposed to violence.
B. To monitor initiatives designed to increase the capacity, competence, and capability of Chicago Safe Start partners in the identification, referral and service and follow-up with young children exposed to violence and their families, specifically tracking the establishment and implementation of critical linkage agreements and fund leveraging to increase system capacity.

The identification and response initiatives

A. To assess the effectiveness of the proposed incident-based response system in identifying children ages five and younger and their families exposed to violence.
B. To assess the effectiveness of the proposed symptoms-based response system in identifying children ages five and younger and their families exposed to violence.
C. To assess the effectiveness of community and faith-based linkages in supporting a formalized and coordinated response to children exposed to violence.

Family outcomes associated with systems and services

A. To assess levels of pre- and post-intervention levels of knowledge among a sample of parents within the target communities about child development, parenting skills, and available community resources.
B. To assess changes in parent-child relationships as measured through indicators of attachment and enhanced familial protective factors such as levels of internal and external support.

The evaluation of the Chicago Safe Start initiative will focus on the following hypotheses:

The capacity and capability-building initiatives

Evaluation Hypothesis Ia:

Increased training among service providers and first responders that may include information about the stages of child development, physical and behavioral identification of children exposed to violence, and referral, intervention, and follow-up will in the short-term increase the comfort of and likelihood that service providers and first responders will identify/screen children exposed to violence and refer or intervene appropriately.

Evaluation Hypothesis Ib:

Increased efforts to enhance service capacity will mean that young children and families exposed to violence will be able to receive services that meet their needs or anticipated enrollment of 240 in family support services in the target communities and 75 young children and their families receiving mental health services in 2002 (and increasing over the duration of the grant period).

Evaluation Hypothesis Ic:

Enhanced capacity of available services, increased data sharing and enacted linkage agreements in response systems will mean more young children who have been exposed to violence and their families will receive appropriate intervention and follow-up.

The identification and response initiatives

Evaluation Hypothesis II:

Enhanced incident-based and symptoms-based response systems will mean that young children who have been exposed to violence and their families will be identified and referred for service or an anticipated 150 number of young children identified in 2002 (and increasing over the duration of the grant period).

Family outcomes associated with systems and services

Evaluation Hypothesis III:

(A sample of) Young children and families participating in services in target communities will demonstrate greater family attachment and enhanced familial protective factors in comparison to a sample drawn from the comparison communities.

Relationship Between Chicago Safe Start Initiative Goals and Evaluation Goals and Objectives		
Chicago Safe Start Initiative Goals	Evaluation Goals	Evaluation Objectives
Goal I. Children who have been exposed to violence or at-risk of exposure will be identified by any organization (formal or informal) that interacts with or serves children. *This goal focuses on increasing the identification of young children (ages 0-5) exposed to violence and their families through the development of an incident-based response system, a symptoms-based response system, coordination with child protection, domestic, and juvenile delinquency courts, and strategies to link informal and community networks with systems of care.*	I. To assess the effectiveness of capacity-building initiatives II. To assess the effectiveness of identification and response initiatives	IA. To assess the effectiveness of training for mandated reporters, first responders, and service providers in increasing knowledge about the identification of and appropriate response(s) for young children exposed to violence through pre- and post-intervention levels of knowledge among service providers around identification of young children exposed to violence. The specific indicators associated with each provider group are listed below. IA1. (Approximately) 80% of a sample (n=480) of the over six hundred police serving the target communities will have knowledge about: ■ physical and behavioral identification of children exposed to violence ■ appropriate, immediate and follow-up response ■ available community resources to support responses Additionally, assessment will include the rate at which DV cases are flagged when children are present and the rate of distribution of DV HelpLine Referral cards. IA2. (Approximately) 80% of a sample (n=60) of the current hospital/emergency department staff serving the target communities will have knowledge about:

		■ physical and behavioral identification of children exposed to violence ■ appropriate, immediate and follow-up response ■ available community resources to support responses Additionally, assessment will include the level of institutionalization and sustainability of identification initiatives. (Approximately) 80% of a sample (n= x) of providers and first responders trained in the proposed Training Institute. II C. To assess the effectiveness of community and faith-based linkages in supporting a formalized and coordinated response to children exposed to violence.
Goal II. Child-serving systems and service providers will implement a formalized and coordinated response for initial intervention and referral for children exposed to violence. *This goal focuses on improving the initial intervention and referral of young children (ages 0-5) exposed to violence and their families through increased capacity of the child welfare system to intervene with children exposed to violence through abuse and neglect, increased capacity of domestic violence shelters, child care,*	**II. To assess the effectiveness of the identification and response initiatives**	IIA. To assess the effectiveness of the proposed incident-based response system in identifying children ages five and younger and their families exposed to violence. IIB. To assess the effectiveness of the proposed symptoms-based response system in identifying children ages five and younger and their families exposed to violence. IIC. To assess the effectiveness of community and faith-based linkages in supporting a formalized and coordinated response to children exposed to violence.

early education, and early intervention providers to provide initial intervention services for children, targeted services to teen parents involved with the Juvenile Delinquency Court System, and increase capacity of substance abuse providers to identify young children exposed to violence.		
Goal III. The intervention and treatment system will have sufficient capability and capacity to seamlessly serve children who have been exposed to violence and their families. *This goals focuses on improving the capability and capacity of the intervention and treatment system to provide seamless service to young children who have been exposed to violence and their families through expanded capacity of family support agencies, expanded capacity of mental health services.*	I. To assess the effectiveness of capacity building initiatives	IB. To monitor initiatives designed to increase the capacity, competence, and capability of Chicago Safe Start partners in the identification, referral and service and follow-up with young children exposed to violence and their families, specifically tracking the establishment and implementation of critical linkage agreements and fund leveraging to increase system capacity.
Goal IV. The issues of children's exposure to violence will be the subject of sustained attention and action by policy-makers. *This goal focuses on making the issue of young children's exposure to violence the subject of sustained attention and action by policy makers through the development of system-wide analytic capacity to understand impact of initiative on young children*	I. To assess the effectiveness of capacity-building initiatives	

exposed to violence and their families, through public awareness campaigns in targeted communities, and through advocacy in licensure, development of statewide agenda, and funding allocations.		
Goal V. Safe Start will partner will violence prevention and reduction initiatives to reduce overall exposure to violence for at-risk children. *This goal focuses on reducing overall exposure of at-risk children to violence through partnerships with Prevent Violence! Chicago, gang prevention activities in communities, decreased substance abuse, and improved parenting skills.*	III. To assess family outcomes associated with systems and services	III A. and B. To assess levels of pre- and post-intervention levels of knowledge and protective factors among a sample of parents participating in the Metropolitan Family Services and the Family Focus services, especially around child development, parenting skills, and available community resources in comparison to a sample of parents from the comparison communities

II. Evaluation design and implementation

A. Overview of Evaluation Design

The following text describes the research questions that will be addressed in the examination of each evaluation hypothesis and will specify the evaluation design (sampling plans, measures, and description of related Chicago Safe Start intervention) associated with each set of hypotheses and research questions.

Parts I (the Capacity and Capability-Building Initiatives) and II (the Identification and Response Initiatives) outline the local impact assessment. The local impact assessment will look at the community, systems, and agency impacts of the Chicago Safe Start initiative and measure changes in policies, resources, practices, procedures, and other conditions including, but not limited to systems integration and a comprehensive and balanced approach to reducing the impact of children's exposure to violence.

I. The capacity and capability-building initiatives

Evaluation Hypothesis Ia:
Increased training among service providers and first responders that may include information about the stages of child development, physical and behavioral identification of children exposed to violence, and referral, intervention, and follow-up will in the short-term increase the comfort of and likelihood that service providers and first responders will identify/screen children exposed to violence and refer or intervene appropriately.

- Related research questions that will frame the evaluation include:
  What is the current practice among service providers addressing the needs of young children who are exposed to violence?

- Method, Sample, and Measures
  Two methods will be the focus of assessment of capacity and capability-building initiatives:
  - Focus Groups Around Service Provision: Two sets of focus groups will be conducted with service providers serving the needs of the target communities, one set during the initial stages of Chicago Safe Start implementation and one set towards the project period end. The initial focus group guide will focus on current practice and the follow-up focus group guide will focus on changes in practice.
    - A total of six groups of 8-10 participants each will be conducted at each of the time period (for an approximate sample size of 48-60). The groups will be drawn from existing service providers (family support services, mental health services, and educational services), community based organizations serving the communities, and community residents.
    - The following will serve as areas for exploration:
      - General understanding and perceptions on the subject of young children exposed to violence;
      - Perceptions of the technical quality of services for young children exposed to violence;

- Decision-making and management of cases of young children exposed to violence;
- Perceptions of the technical quality of services for young children exposed to violence; and,
- Perceptions of access and related issues including provider communication.

The focus groups with residents will focus on perceived resources and support in the communities and will be used to gauge changes in perceptions about the importance of issues related to young children exposed to violence.

The following will serve as areas for exploration:
General understanding and perceptions on the subject of young children exposed to violence;
Any experiences with the recognition and reaction to young children exposed to violence;
(Please note that a different plan will be implemented for health care providers in the target communities.)
The focus groups will be used to address the following activities described in the logic model:
Initiatives to increase knowledge and skill among service providers and community members and the following objectives in the Chicago Safe Start plan:

- Development of an incident-based (IA) and symptoms-based (IB) response system
- Creation of avenues for concerned parents, family members, faith-based organizations, or informal networks to access services
- Establish Training Institute (IIF)
- Expand capacity and strengthen capability of family support agencies (IIIA) and mental health services (IIIB) to serve children and families
- Conduct public awareness campaign (IVB).
- The focus group findings will be used for formative and outcome assessment purposes.
- Formative Assessment Purposes:
- Findings from the focus groups will be developed into a report for use in the refinement of the Chicago Safe Start initiatives and for the development of a service provider and consumer telephone survey.

Outcome Assessment Purposes

Findings from the focus group will serve to complement and elaborate findings from the community assessment used to structure the Chicago Safe Start initiative (and therefore provide further baseline data within the target communities) and to provide qualitative data for understanding changes associated with the Chicago Safe Start initiatives.

- Telephone Survey with Service Providers
  The Survey Research Laboratory of the University of Illinois at Chicago will be subcontracted to conduct a telephone survey with service providers about their experiences with identification and response to young children exposed to violence and their related decision-making, formal and informal

linkages/support, and their management of such cases. The main data collection will take place over a five-week period at two points in time (beginning FFY '02 and beginning FFY '05). The telephone survey sample (n=100) will be drawn from two distinct service provider group types: system agencies (e.g. those organizations affiliated with the Department of Human Services, the Chicago Department of Public Health, the Chicago Public Schools, the related Courts, and the police officers in the targeted police districts). The providers will be drawn from two primary groups from the two types of service providers: administrative staff and "front line" staff. In general, the questionnaire will include 40 closed-ended variables, five identification variables, two open-ended variables, and ten other-specify variables. The anticipated response rates are 75% for service providers and 54% for consumers (based on SRL rates for screening, cooperation, and eligibility). A small, convenience, subset of the telephone survey respondents (anticipated n=30 cases) will be involved in an embedded study in which they will be asked to track cases of young children (and their families) identified with exposure to violence as to follow-up with referrals and assessment of family outcomes.

Integration of Safe Start Initiatives: Focus on Health Care Providers and First esponders

In addition to the overall analysis with service providers, an intensive analysis will be conducted with medical providers of St. Bernard's Hospital, the Englewood Clinic,and the Roseland Neighborhood Clinic in collaboration with the Child Witness to Violence Project of LaRabida Hospital under the direction of Dr. Laura Knight-Lynn. In addition to pre-and post-training surveys, follow-up data will be collected on the extent of integration at each of these facilities of policy, procedures, and practice. The Child Witness to Violence Project will facilitate the development of interdisciplinary, implementation teams and provide training for facilitating the use of research (i.e. hospital-generated data) in changing practice.

The evaluation design will include an initial needs assessment, a questionnaire on training effectiveness, a sustainability analysis (some of the questions are outlined below) and an assessment of outcomes with comparison communities. The unit of analysis will be each medical facility (n=3) (especially given issues of staff turnover), however, data around identification and response will be collected at an individual level (anticipated sample of n=30).

- The following are a list of draft questions to assess the level of integration and sustainability of Chicago Safe Start initiatives:
- Does your department currently have a policy for addressing children who have witnessed violence?
- Does your department currently have protocols developed for addressing children who have witnessed violence?
- Presence or absence of universal screening?
- Presence of absence of assessment tools?
- Presence or absence of patient education?
- Does your hospital/department currently have linkage agreements for addressing children who have witnessed violence?

- Has your hospital/department currently identified internal resources (internal service flow) for addressing children who have witnessed violence?
- Does your hospital/department have an established training plan around issues related to children who have witnessed violence?
- Topics including hospital policy, screening, legal considerations, documentation, intervention, referral and follow-up, treatment, understanding impact of violence, etc.
- Has your hospital/department made any changes to the structure, roles, or relationships of medical personnel to better or more effectively addressing the needs of children who have witnessed violence?

Data from these questions will be used in conjunction with outcome data (identification, service and referral rates) and compared with medical practices in the comparison communities.

This model will serve as the basis for the follow-up evaluation that will be conducted with officers in the 5th and 7th Police Districts which will serve to answer the following research questions:

What is the understanding of police in the target districts of resources available to young children who are exposed to violence and their families? What is the impact of flagging in police documentation of call to home and other procedural changes on the identification and referral of young children who are exposed to violence and their families?

The Chicago Safe Start Initiative will be facilitating the development of a Training Institute. Pre-and Post- Training Surveys will be developed in conjunction with the Chicago Safe Start partners and will be developed from the first responder, the parent, and the mandated reported curricula. The surveys will assess knowledge about child development and the impacts of exposure, appropriate responses by each audience, resources available to each audience as well as measuring perceptions about efficacy and competence.

Analysis

A mean change in knowledge of 25% is anticipated to be associated with training intervention or an average of 80% knowledge at post-training depending on the training audience. Data will be reported along the following dimensions: knowledge about child development, knowledge about the impacts of exposure, knowledge about the appropriate responses by each audience, awareness of resources available to each audience, and perceptions about efficacy and competence.

Both *Evaluation Hypothesis Ib:*
Increased efforts to enhance service capacity will mean that young children and families exposed to violence will be able to receive services that meet their needs or anticipated enrollment of 240 in family support services in the target communities and 75 young children and their families receiving mental health services in 2002 (and number of additional years); and,

Evaluation Hypothesis Ic:

Enhanced capacity of available services, increased data sharing and enacted linkage agreements in response systems will mean more young children who have been exposed to violence and their families will receive appropriate intervention and follow-up;
will be assessed through system- and community-level service monitoring using the Chicago Safe Start Partner Form. During both the initial planning phase and planning phase II, the evaluator convened a group of key Chicago Safe Start partners to develop a series of shared indicators of interest and information from these meetings will be used to refine the Chicago Safe Start Partner Form and indicator checklist that will be maintained by key partners in the delivery of service to young children exposed to violence and their families.

The Identification and Response Initiatives

In order to evaluate the identification and response initiatives a system for monitoring the implementation of screening, assessment, referrals through provider reference or through self-identification promoted by referral cards (e.g. police distribution of referral cards to families on calls), actual services provided, service not provided (and reasons for not providing, e.g. lack of capacity, client refusal, requirements for service not met by client, etc.), and any follow-up.

Related research questions that will frame the evaluation include:

In ways has the Chicago Safe Start has influenced changes at the system level and at the community level for identifying, responding to and following-up with families and their young children ages five and younger who have been exposed to violence and associated family outcomes in the target communities?

Method, Sample, and Measures

The primary method for understanding the identification and response initiatives (in complement to the focus groups described earlier) is document analysis using the Chicago Safe Start Partner Activity Form. As mentioned earlier, meetings have and will continue to be convened with system- and community-level partners to develop an effective monitoring system of the ways in which the needs of young children and families are being met or not met in the target communities. The system-level representatives have and will include individuals from the Department of Children and Family Services, the Police Department, the Juvenile Delinquency and the Domestic Violence/Family Courts. The community-level representatives have and will include individuals from institutions, organizations, and agencies serving the needs of families and children ages zero to five and may include representatives from Metropolitan Family Services, YWCA, YMCA, community churches, etc. The purpose of these meetings will be to develop a core set of data types that will be collected by key stakeholders in order to monitor changes in service delivery and service quality associated with Chicago Safe Start interventions. An additional purpose will be to further develop the District Wide Organizational Networks. Organizations and agencies with a presence across both the intervention and comparison communities will be asked to serve as the key stakeholders collecting relevant service delivery and system interaction/referral data through ChicagoSafeStart.net (the Chicago Safe Start website).

Processes associated with and outcome resulting from this meeting will be monitored using the Chicago Safe Start Partner Process Form. In addition to completing process evaluation forms developed by Caliber Associates for the Safe Start Initiative, the Chicago Safe Start will complete organizational activity forms (Chicago Safe Start Partner Form) to monitor the collaborations/partnerships and targeted efforts of this local initiative. The Chicago Safe Start Partner Form is based on the National Evaluation Form (Safe Start Collaborative Members), a tool used previously by the evaluation team for assessing coalitions, and monitoring systems developed by Fawcett, et.al[27]. This form will be used to collect data at every system-level and community-level collaborative activity (i.e. planning and development meetings) to record information about the partners present, the partners' roles, the outcomes of the activity including resources generated and the audience for whom collaborative efforts were directed. Several types of community partnership activities would be recorded including community actions, community changes, planning products, services provided, media coverage, and resources generated (Fawcett 1995). A sample of the draft is included in the appendix. Data from the Chicago Safe Start Partner Form would be analyzed using cluster analysis and affiliation analysis under the oversight of a social network consultant. From the process reports, data will be collected on the types of partnerships/collaborations associated with the Chicago Safe Start Initiative, the roles of participating organizations in prevention and intervention delivery, and the resources contributed by community partners/participants. The instrument will be refined based on review of a pilot.

Additionally, representatives from each level of the incident-based and symptom-based response systems will be asked to collect information on service provision and gaps in service.
The following is a draft list of the indicators that will be tracked by representatives from these two response systems:

- Presenting Family Risk Factors
- Service Utilization
- Service Referral by Risk and Other Descriptive Variables; and,
- Case Follow-up and Outcome.

Analysis

Data from the Chicago Safe Start Partner Form would be analyzed using cluster analysis and affiliation analysis under the oversight of a social network consultant.

Changes from baseline to follow-up (including at a post-implementation data point) frequencies in the core set of data types will be compared using chi-squares to assess changes in service delivery and service quality associated with Chicago Safe Start interventions.

[27] Stephen B. Fawcett and Work Group on Health Promotion and Community Development. Work Group Evaluation Handbook: Evaluating and Supporting Community Initiatives for Health and Development. © 1993, August 1995 Edition.

Family outcomes Associated with Systems and Services outlines the intervention research. The intervention research will assess the impact of the family support service intervention on children and families.

Family outcomes associated with systems and services

Evaluation Hypothesis III:
(A sample of) Young children and families participating in services in target communities will demonstrate greater family attachment and enhanced familial protective factors in comparison to a sample drawn from the comparison communities.

Related research questions that will frame the evaluation include:

What impact will the family support initiatives have on child outcomes such as attachment, positive behavior/interactions/temperament, and behaviors related to social competence?

What impact will the family support initiatives have on family outcomes such as coping, family environment, social support, and general parenting skills?

Method, Sample, and Measures

Three organizations will provide the sample for the primary study of family outcomes: the Englewood Family Support Center, Family Focus, and Metropolitan Family Services. Head start sites in Englewood and Pullman will provide the comparison groups for two reasons: 1. parents involved with Head Start must participate in parent education to focus on the evaluation on the effectiveness of the Chicago Safe Start family support and not simply the presence or absence of a family intervention; and, 2. parents in these communities may be reasonably expected to have the same level of exposure to other Chicago Safe Start, thusly holding relatively constant the possible confounding impact. Due to the intensity of the level of intervention and assessment under consideration, a random sample is not feasible. A representative sample of a total of 30 families will be selected from the target sites, with a representative sample of 30 families from the comparison sites.

Several self-report and observational assessments are currently under consideration. A final decision about cross-site indicators will be made through meetings with the family support service providers. In addition to the selection of instruments, other factors will be discussed which may impact the evaluation. Through initial meetings with the service providers, some factors have already been identified that will influence the selection of instruments and the types of other contextual information that will need to be collected in order to develop an evaluation around family outcomes such as the availability personal and community support, inabilities of families to seek out other environments and avenues for support, reasons for entering the program and other presenting issues, etc.

Some of the instruments currently under consideration are: a modified FACES, the Parent-Child Conflict Tactics Scale, and the Family Support Scale.

Chart of Measures

Component of Local Evaluation Logic Model	Measure	Data Source
Increased knowledge among first responders and service providers to young children in understanding impact of violence, and appropriate screening, intervention, and referral	Post-training surveys Intensive Health Care Provider and Police Sustainability Interview and Document Analysis Document analysis	Police, Early Educators in Chicago Public Schools, Hospital Medical Staff, DV Providers, Alcohol and Substance Abuse Providers Police case notes Hospital tracking of identification and referral
Increased system capacity as evidenced by linkage agreements, protocols to support systems of care, institutionalization of change supportive of young children exposed to violence, and data sharing among partners	Document analysis/Chicago Safe Start Partner Form	Chicago Safe Start Partners
Increased use of available service in the identification and referral of young children exposed to violence	Document analysis/Partner Service Form (complement form to Chicago Safe Start Partner Form)	DV Help Line Records Partner Agencies, especially Family Support and Mental Health Services in Target Communities
Stronger Caregiver-Child Family Systems	Self-Administered Survey and/or Observation (currently under consideration in cooperation with partner agencies)	Parents/Caregivers Teacher/Facilitator Observation

Evaluation timeline

Emphasis of Evaluation Task	Evaluation Task	Anticipated Timeframe
Capacity and Capability-Building Initiatives	Initial Focus Groups with System Agencies, Community-Based Organization, and Resident Representatives including Refinement of Focus Group Guide, Recruitment, IRB	January – March 2002
	Follow-up Focus Groups with System Agencies, Community-Based Organization, and Resident Representatives including Refinement of Focus Group Guide, Recruitment, IRB	July – August 2005
	Baseline Telephone Survey with System- and Community-Level Service Providers	April – May 2002
	Follow-up Telephone Survey with System- and Community-Level Service Providers	May – June 2005
	Intensive Evaluation of Health Providers and Police Districts – Integration and Sustainability	Beginning in January 2002 Site Assessment Beginning in March 2002 and continuing semi-annually through October 2004
	Refinement and Pilot of Small Scale Service Monitoring System	March 2002 – May 2002 With pilot review group convening in late May and early April 2002 to discuss and develop larger scale implementation by August 2002 Reporting Quarterly from September 2002 – September 2005

Incident- and Symptom-Based Response Systems	Convene System- and Community-Level Partner Meetings to Develop, Refine, and Solidify Chicago Safe Start Partner Forms and Supplement Service Form	Beginning January 2002
	Pilot System Monitoring	See above, April 2002
	Larger Scale System Monitoring	See above, beginning August 2002 – September 2005
Family Outcomes Associated with Systems and Services	Convene Joint Meetings of Family Support Service Providers and Develop Cross-Site Indicators and Instrument	Beginning in December 2001 and continuing through the end of February 2002
	Pilot Instrument and Review Initial Findings for Instrument Refinement	February – April 2002
	Implementation of Parent-Child Outcome Instrument	Dependent on Provider Implementation of Service, anticipated Beginning July 2002 through November 2003

III. Staffing and management

Risé D. Jones, Ph.D. will oversee the management of the Chicago Safe Start Evaluation. Her resume is included in the appendix.

The Survey Research Laboratory of the University of Illinois at Chicago will be conducting the telephone survey of system-level and community-level institutions addressing the issue of young children exposed to violence in the two intervention and two comparison communities. The Survey Research Laboratory (SRL) of the University of Illinois at Chicago is a research and service unit established in 1964. It is a division of the University of Illinois at Chicago's College of Urban Planning and Public Affairs that provides survey research services to the faculty, staff, and students of the University of Illinois at Chicago and Urbana-Champaign; other academic institutions; local, state, and federal agencies; and others working in the public interest. SRL has offices on the Chicago and Urbana campuses of the University and can undertake complete survey projects from initial study design through data analysis. It can also conduct partial survey work such as sampling, questionnaire design, focus groups, data collection, and data reduction and can provide consultation on survey problems on a fee-for-service basis.

Additional consultants will be brought in who have expertise in network analysis, communication, and organizational change.

IV. Plans for reporting and utilization

The Chicago Safe Start Evaluation Staff will participate in cross-site evaluation conference calls and meetings. Additionally, the staff will submit the Safe Start Meetings, Actions, and Activities and Safe Start Collaborative Members forms for the National Evaluation of Safe Start. The Chicago Safe Start Evaluation Team will make evaluation presentations to the District-Wide Organizational Networks every six months and will work in conjunction with the Chicago Safe Start Staff to facilitate discussion, feedback, and assignments around data collection.

List of Products	Approximate Dates	Use of Information	Audience or Consumers of Information
Focus Group Findings Report	March 2002 August 2005	Development of Provider Telephone Survey Refinement of Chicago Safe Start Initiatives Qualitative Baseline Data on Systems	Chicago Safe Start Staff and Consultants Chicago Safe Start Steering Committee Chicago Safe Start Council
System Monitoring Reports	Beginning February 2002 and semi-annually through October 2005	Refinement of System Initiatives to Decrease Service Gaps and Increase Service Quality	Chicago Safe Start Staff and Consultants Chicago Safe Start partners
Reports from Telephone Survey	May 2002 June 2005	Refinement of System Initiatives to Decrease Service Gaps and Increase Service Quality	Chicago Safe Start Staff and Consultants Chicago Safe Start partners
Intervention Research Report: Family Outcomes Pilot and Full Study	Beginning April 2002 Implementation July 2002 Report December 2003	Baseline and Follow-up on Family Outcomes Refinement of Family Support Initiatives	Chicago Safe Start Staff and Consultants Family Support Partners: Metropolitan Family Services, Englewood Family Services, Family Focus Chicago Safe Start Steering Committee Chicago Safe Start

			Council
Specialized Training Reports for Health Care Providers and Police Officers	October 2004	Recommendations for Larger Scale Policy and Procedures	Chicago Safe Start Staff and Consultants Chicago Safe Start Steering Committee Chicago Safe Start Council

V. National and local capacity building efforts

The philosophy underlying the evaluation design is to create capacity among the Chicago Safe Start partners as well as a data collection infrastructure that have the potential to be sustained beyond the project period.

Listed below is a list of technical assistance and other supported anticipated to be needed during the course of the evaluation.

Building Collaborative Relationships to Foster Data Sharing and Maintenance. Limits on staff resources often make any attempt at internal evaluation overwhelming for many institutions and agencies. Training is needed on how to build relationship that facilitate the sharing of information vital to optimal system capacity and service delivery while recognizing mandated, ethical, and/or other constraints on institutional and professional exchanges of information.

Effectively Reporting Evaluation and Monitoring Findings. Training will be required in how institutions and community based organizations can report Chicago Safe Start data that takes into account various report audiences and can be used for effective program reflection, refinement, and promotion.

Utilizing Evidence Based Methods for Quality Improvement. As stated in Table II, an "Intervention and Referral Report Card" will be implemented as part of the process assessment. This technique is a type of evidence-based method designed to involve stakeholders in the process of translating research into practice. Training is needed by the evaluation team in utilizing successful TRIP (translating research into practice) models for system change. Training is needed by the collaborating partners in the process of self-assessment, action plan development, and change implementation.

Maintaining Integrity with Midcourse Corrections. Training is needed by the evaluation team, the CSS project staff and partners on the appropriateness of mid-course corrections and how to adapt action, implementation, and evaluation plans to account for such changes.

It is anticipated that the evaluation design, data management, and learning processes derived and associated with the evaluation will become institutionalized within the service system and community in the following ways:.

The data management systems developed in cooperation and collaboration with system-level and community-level partners *(e.g., those developed through co-development of common core data set strategies)* will be refined throughout the process so that the data obtained is useful, accessible, and relatively easy to maintain.

The community-level and system-level partners develop strategies *(e.g., report cards)* and structures *(e.g., district organizational networks)* for self-monitoring and evaluation that are useful for sustainability and long-term problem solving.

The community partnerships used to increase points of access to service are used for other types of needed services.

The system-level and community-level will have tools to assess partnerships in service delivery and policy implementation *(e.g. Safe Start partner form).*

The responsibilities of agencies in the process will include.

- Involvement in development of common, core data set (Data collection will be voluntary.);
- Involvement in workshops/meetings around self-monitoring and community level and system level changes;
- Assistance in gaining access to convenience samples of consumers while maintaining consumer confidentiality;
- Assistance in gaining access to provider respondents and in supporting completion of telephone surveys;
- Assistance in gaining access to provider, first responder, and parent training audiences for pre-/post-survey completion; and,
- Assistance and collaboration in all assessment design to insure communication and shared objectives.

Appendix A: Assessment Interview Tool

Interview: Associations*/Churches/Institutions/Businesses #_____
(Broach possibility of focus group if appropriate)

Name of Association: _____

Type of Association (Circle): Community-Based Church Institution Business

Respondent's Role in Association: _____

*Number of Members: _____ *Percent of Members from the Community: _____

*Meeting Frequency: _____ IF BUSINESS: Percent Clients from Community: _____

Phone: _____

Number of Years Serving Community: _____

1. Please estimate the number of associations with which you are familiar. _____
   When I say community association, I mean any organization that works both in partnership with community and is based in the community.
   Please list them:
2. Do you think that associations, institutions, businesses, etc., in [Englewood/Pullman] work together? Why or why not? *Probe to find what would help them work together better.*
3. Are you a member of another association(s) in [Englewood/Pullman]?
   Association(s):
   Leadership role:
   Active:
4. Are you a member of another association outside of [Englewood/Pullman]? If so, what role do you play?
   Association(s):
   Leadership role:
   Active:
5. What is the purpose of your association?
6. Please list the programs run by your association and the contact names/numbers associated with them. *Also ask for any literature on programs.*
7. Please estimate the number of associations your group works with/meets with?

0 1-2 3-5 6+

8. Is there a community vision? What is it? Is it united?
9. What do you think is the number one concern of residents in the [Englewood/Pullman] area?
10. What do you think is the greatest strength of the [Englewood/Pullman] community?
11. Who/what association should one meet with in [Englewood/Pullman] to implement a project for children? Who are the movers and shakers?
12. Has someone concerned about a child exposed to violence called your organization? If yes, who/what are the first three people/organizations to which you would refer this person?
13. Do you think that s/he would get the help needed? Why or why not?
14. What gaps in services for children from birth to age 5 do you see?
15. What can the City do to provide better services for children from birth to age 5 in the community?
16. What can organizations based in [Englewood/Pullman] do to provide better services for children from birth to age 5?
17. Do you have Internet access in your organization? If not, do you know of a location where you can access the Internet? Where?

Appendix A: Assessment Interview Tool

Interview: [Englewood/Pullman] Resident #_____

Member of a local church: YES NO Church name: _____

Number of Years Lived in Community: _____

1. Please estimate the number of associations in the [Englewood/Pullman] community with which you are familiar. _____
   When I say community association, I mean any organization that works both in partnership with community and is based in the community.
   Please list them:
2. Do you think that associations, institutions, businesses, etc., in [Englewood/Pullman] work together? Why or why not? *Probe to find what would help them work together better.*
3. Are you a member of an association(s) in [Englewood/Pullman]?
   Association(s):
   Leadership role:
   Active:
4. Are you a member of another association outside of [Englewood/Pullman]? If so, what role do you play?
   Association(s):
   Leadership role:
   Active:
5. Who/what association should one meet with in [Englewood/Pullman] to implement a project for children? Who are the movers and shakers in the community?
6. Is there a community vision? What is it? Is it united?
7. What do you think is the number one concern of residents in the [Englewood/Pullman] area?
8. If a friend called you whose child had just been exposed to a violent situation, who are the first three people or organizations that you would suggest s/he contact?
9. In this situation, do you think that your friend would get the help they need? If yes, why? If no, why not?

10. What can the City do to provide better services for children from birth to age 5 in [Englewood/Pullman]?
11. How can organizations based in [Englewood/Pullman] provide better services for children from birth to age 5?
12. What do you think is the gap in services for children from birth to age 5 in [Englewood/Pullman]?
13. Do you have Internet access in your home? If not, do you know of a place where you can go to access it?
14. What is the best thing about your community?

Chicago Safe Start: Community Assessment Interviewees

Name	Title	Organization	Area
Abellera, Roland	Director of Quality Management	St. Bernard's Hospital	Englewood
Al-Nurriden, Salim	Executive Director	Healthcare Consortium of Illinois	Citywide
Andrews, Dorothy	Site Director	Chicago Youth Centers Roseland	Pullman
Anger, Ida	Senior Program Director	Metropolitan Family Services	Englewood
Baker, Bridget	Director, Pastoral Care	Salem Baptist Church	Pullman
Baker, Lamont		WKKC Radio	Englewood
Banks, Cedric	Program Coordinator	Chicago Youth Centers Altgeld	Pullman
Barlowe Bell, Reaver	Director	V&J Day Care Center	Pullman
Barnes, Lynda	Case Manager, Women's Progra	Chicago Connections	Citywide
Barry, Mike	Field Service Manager	IL Dept. of Children and Family Services	Statewide
Bartik, Roberta	Commander	Youth Division, CPD	Citywide
Bell, Carl, MD	President + CEO	Community Mental Health Council	Englewood
Bell, Tom		YouthNet Director, CDHS	Citywide
Benigno-Praznowski, Li	Domestic Violence Liaison Offic	Public Housing, Chicago Police Dept.	Citywide
Betts, Daniel	Area Manager, Southeast	Chicago Park District	Englewood
Binion-Taylor, Theodor	Director, Behavioral Health	Chicago Dept. of Public Health	Citywide
Blumenfeld, Susan	Senior VP, Clinical Services	Metropolitan Family Services	Citywide
Bortey, Kera	Director	Clarence Hodges Head Start	Englewood
Bratcher, Sonya	State Coordinator	Illinois Family Violence Coordinating Coun	Statewide
Bretag, Debbie	Executive Director	IL Center for Violence Prevention	Statewide
Brewer, Karen	Consultant		Englewood
Brooks, Richard	Youth Outreach Worker	Chicago Public Schools	Englewood
Brown, Christine	Program Coordinator	Metropolitan Family Services	Pullman
Brown, Melvin	Minister		Pullman
Brown, Velma		Catholic Charities	Pullman
Burke, Danny	Representative		Englewood
Burnett, Joseph	Director	Schools First	Citywide
Butler, Rick		Pathway to Harmony	Pullman
Cain, Sharon		Alderman Austin, 34th Ward	Pullman
Callands, Deroy		Employment Resource Center	Pullman
Campbell, Falicia	Pastor	For Your Consciousness	Englewood
Campbell, Ronald	VP, Patient Care Services	St. Bernard's Hospital	Englewood
Carothers, Kathie	School Safety Coordinator	CAPS Implementation Office	Citywide
Carter-Hill, Jean	Director	Imagine Englewood If	Englewood
Clark, Leslie	Director	Roseland YouthNet	Pullman
Clemons, Deborah	Regional Administrator	Roseland Neighborhood Health Center	Pullman
Coady, Jeff		Roseland Behavioral Health Center	Pullman
Coleman, Shirley	Alderman	16th Ward	Englewood
Coleman-McKinney, Be	Outreach Coordinator	Developing Communities Project	Pullman
Collier, Ethel	Director, Violence Prevention/Ir	Chicago Public Schools	Citywide
Cooper, Ceola	Program Director	South Side Help Center	Pullman
Coversen, Maurice		Open Book	Pullman
Cox, Beverly, PhD	Professor	Kennedy-King College	Englewood
Cramer, Lina	Consultant	IL Family Partnership Network	Statewide
Crum, Christine	Legal Officer	2nd Municipal District, Circuit Court, Cook	County

Appendix B Interviewees, continued

Currie, Myrtis	Program Director	For Your Consciousness	Englewood
Curry, Milton	Director	Beautiful Zion Head Start	Englewood
Cutliffe, Dierdre	Executive Director	Rainbow House	Citywide
Daniels, Katari	Program Coordinator	Cradle to Classroom (CPS)	Pullman
Daniels, Patricia, PhD	Director	Greater Englewood Healthy Start	Englewood
Davis, Margaret	Director, Community Health	Healthcare Consortium of Illinois	Citywide
DeBonnet, Pat	Director	Greater Roseland Community Developmer	Pullman
Delehanty, Sister Joanne		St. Benedict the African	Englewood
Devine-Reed, Patricia	Director	Boulevard Arts Center	Englewood
Dixon, Derenda		Dept. of Women's Justice Services	
Dixon, Kathy		Human Resource Development Institute	Pullman
Donohue, Cathy	Program Director	Catholic Charities	Englewood
Dreakford, Cheryl	Project Director, Operations	Community Mental Health Council	Englewood
Dunlap, Cathy	Assistant to the Mayor	Mayor's Office of Intergovernmental Affair	Citywide
Dunson, Jaqueline	Director	Carey Temple Head Start	Pullman
Eason-Spears, Lisa	Youth Service Coordinator	BRASS Foundation	Englewood
Ervin, Arlene	Regional Service Representativ	Catholic Charities	Citywide
Fager, Diane	Director of Program and Policy I	Chicago Public Schools	Citywide
Farr, Belinda	Education/LAN Liaison	ABJ Community Services	Pullman
Ferguson, Gilda	Director	Family Focus Lawndale	Citywide
Finnegan, Tom	Chief of Staff, Operations	IL Dept. of Children and Family Services	Statewide
Fischer, Sunny	Executive Director	Richard H. Driehaus Foundation	Citywide
Ford, Jenefer	Executive Director	Greater Roseland YMCA	Pullman
Ford, Maurice	Commander	CPD 7th District	Englewood
Francis, Margaret	Domestic Violence Liaison	IL Dept. of Children and Family Services	Statewide
Freeman-Heron, Joyce	Area Manager, Southeast	Chicago Park District	Pullman
Fulwiley, Estell	Health Educator	ChildServ	Englewood
Gamm, Sue	Chief Specialized Services Offic	Chicago Public Schools	Citywide
Gathings, Fran	Program Manager	Metropolitan Family Services	Pullman
Gilbert, Brenda		Sheldon Heights Church of God in Christ	Pullman
Gilham, Nathaniel	Supervisor	Central Baptist Family Services	Pullman
Gills, Elder Luther	Pastor	Philadelphia Church of God in Christ	Englewood
Glen-Johnson, Lt. Mary	Community Relations	CPD 7th District	Englewood
Goode, Rhonda	Asst. State's Atty, Community Pr	Cook County State's Attorney's Office	
Goss, Andrea	Early Childhood	IL Dept. of Children and Family Services	Statewide
Goulet, Betsy	Children's Policy Advisor	IL Attorney General's Office	Statewide
Grant, Jacqueline	Program Supervisor	Generations Community Services	Pullman
Griffin, Lizzie	Director	Villa Pri Child Development	Englewood
Griffin, Nadyne	Community Health Advocate	Englewood Neighborhood Health Center	Englewood
Gross, James	Institute of Criminal Justice	Kennedy-King College	Englewood
Gugenheim, Ada Mary		Chicago Community Trust	
Hall, Deana	Investigator	CPD 5th District	Pullman
Hall, Linda		Ada S. McKinley Community Services	Pullman
Hamilton, Jan	Program Manager	Southwest Women Working Together	Pullman
Hampton, Gloria	Director	Save Our Souls	Pullman
Hampton, Tempie	Executive Director	Clara's House Shelter	Englewood
Hanes, Sgt. Doris	Community Relations	CPD 5th District	Pullman

Appendix B Interviewees, continued

Hannaway, Kevin	Assistant Director, Children's Se	Chicago Dept. of Human Services	Citywide
Hansen, Mary	Chief Operations Research Anal	Chicago Police Dept	Citywide
Hardy, Beatrice	Graphic Artist	Encouraging Creations	Pullman
Harisiedes, Jim	Child Advocacy	Children's Memorial Hospital	Citywide
Harper, Kay	Immunization Program	Chicago Dept. of Public Health	Citywide
Harris, Donnie		Human Resource Development Institute	Pullman
Hayes, Angela	Facilitator	Cradle to Classroom (CPS)	Citywide
Healy, Bridget	Asst. State's Atty, Domestic Viol	Cook County State's Attorney's Office	
Hines, Earlene		Rhema Women's Resource Center	
Hochstadt, Neil, PhD	Director, Behavioral Sciences	La Rabida Children's Hospital	Citywide
Holland, Chuck	Director of Special Projects	St. Bernard's Hospital	Englewood
Holton, John	Director, Nat'l Ctr on Child Abus	Prevent Child Abuse America	
Hoyles, Deborah	Team Leader	Metropolitan Family Services	Pullman
Hunter, Mary	Research Analyst	Chicago Police Dept	Citywide
Hylton, Ethel	Director	Alpha Temple Head Start	Englewood
Jackson, Alex	Director	Willing and Able Foundation	Pullman
Jackson, Judy	Project Manager, Englewood	Chicago Dept. of Planning and Developme	Englewood
Jackson, Kenya	Prevention Resource Developer	Prevent Child Abuse Illinois	Citywide
Jacob, Nicole		Bethany Christian Services	Pullman
James, Selene	Director, Family + Children's Se	Southwest Women Working Together	Pullman
Johnson, Cheryl	Director	Chicago Youth and Community Services	Pullman
Johnson, Cheryl	Director	Environmental Protection of Altgelt	Pullman
Johnson, Florence	Program Director	Reach Out and Touch	Englewood
Johnson, Joei	Case Manager	Catholic Charities	Pullman
Johnson, Lola	Director	Coppin Head Start	Englewood
Jones, Colleen	Senior Vice President	Metropolitan Family Services	Citywide
Jones, John Paul	Community Outreach Director	Neighborhood Capital Budget Group	Citywide
Jordan, Margaret	Director	Charles D. Joseph Head Start	Pullman
Jordan, Renee	Assistant Director	Chicago Urban Day School	Englewood
Jordan, Rev. Daryl	Children's Ministry	Salem Baptist Church	Pullman
Jordanette, Matthews	Probation Officer Supervisor	Cook County Juvenile Probation	Citywide
Joseph, Cozetta	District Manager	Chicago Dept. of Human Services	Englewood
Kelly, Peggy	Balanced + Restorative Justice	Cook County State's Attorney's Office	
Kern, Norman		Chicago Project for Violence Prevention	Citywide
Kirk, Clara	President and Founder	Clara's House Shelter	Englewood
Kirwan, Ann	Manager, 0-3 Project	Kids PEPP/Ounce of Prevention	Statewide
Klibanow, Saul	President	Pullman Bank Initiatives	Pullman
Knight-Lynn, Laura, Ph	Child Witness to Violence Progr	La Rabida Children's Hospital	Citywide
Kobierecki, Mary	Director	Roseland Behavioral Health Center	Pullman
Korfmacher, John, PhD		Erikson Institute	
Kostelny, Kathleen, PhD		Erikson Institute	
Landis, Leslie	Project Manager	Mayor's Office on Domestic Violence	Citywide
Lanfair, Sandra	Prevention Educator	Harris YWCA	Englewood
Larkin, Ruby	Executive Advisor	Pullman Bank and Trust	Pullman
LaRoche, Gwen	Director, Community Relations	Chicago Park District	Citywide
Lashley, Glenola		Englewood Community Services Office, CI	Englewood
Lassiter, Rev.		Christ Universal Temple Church	Pullman

Appendix B Interviewees, continued

LaVelle, Avis	VP, Gov't + Public Affairs	University of Chicago Hospitals and Healtr	Citywide
Lazzara, Pete	EMS Coordinator	Children's Memorial Hospital	Citywide
Limbeck, Kevin	Executive Director	Family Focus	Citywide
Linas, Jeri	Assistant Director	Mayor's Office on Domestic Violence	Citywide
Love, Joyce	Assistant Director	Chicago Project for Violence Prevention	Citywide
Love, Rev. Alvin		Lilydale First Baptist Church	Pullman
Lucas, Dennis		Highland Community Bank	Pullman
Madlock, Felicia	Therapist	Central Baptist Family Services	Pullman
Mahon-Huels, MaryAnr	Executive Director	Union League Boys & Girls Club	Citywide
Majmudar, Sharmili	Family Violence Coordinator	Metropolitan Family Services	Pullman
Marcus, Michael		Chicago Community Trust	Citywide
Martin, Sgt. Judy	Domestic Violence Coordinator	Chicago Police Dept	Citywide
Martin-Bishop, Patricia	Presiding Judge	Cook County Juvenile Court, Child Protection Division	
McCord, Joe	Manager, Community Outreach	Chicago Park District	Citywide
McCoy, William	Bishop	Am I My Brother's Keeper	Pullman
McDonald, Barbara	Deputy Superintendent	Chicago Police Dept	Citywide
McGehee, Frank	Director, Child Care Quality Proj	Harvard's Project on Human Development in Chicago	
McHugh, Mark	Site Director	Metropolitan Family Services	Englewood
McLaughlin, Jim	President	Solace Place/St. Joseph's of Carondelet Y	Englewood
McLaurin, Mattie	Facilitator	Cradle to Classroom (CPS)	Citywide
McPhilimy, Patrick	Director, Grants Management	Chicago Police Dept	Citywide
McQuaid, Lt. Michael	Youth Investigator	CPD 5th District	Pullman
Mebane, Adrian	Asst. State's Attorney, Community Prosecutions		
Merchant, Deborah		Neighborhood Housing Services	Englewood
Mercurius, Paulette	Project Coordinator	Chicago Dept. of Human Services	Citywide
Messenger, Rev.		Holy Rock Church	Englewood
Miller, Jacqueline	Training and Outreach Coordina	Chicago Abused Women's Coalition	Citywide
Mineur-Brieske, Michel	Senior Program Specialist	Chicago Park District	Citywide
Minor, Diane	Chief Administrative Officer	Chicago Park District	Citywide
Misweet, Laura	Executive Director	Free Peoples Clinic	Englewood
Moore, Clarence		Chicago Commission on Human Relations	Citywide
Moore, DeTrina	Program Director	Reach Out and Touch	Englewood
Moore, Henry	Youth Outreach Worker	Chicago Public Schools	Pullman
Morgan, Zachary	Administrator	Englewood Neighborhood Health Center	Englewood
Morris, Rob	Director of Development and Sp	Union League Boys & Girls Club	Citywide
Moy, Sybil	Community Outreach Unit	Cook County State's Attorney's Office	Citywide
Mozee, Sgt. Patrice		Chicago Police Dept	Pullman
Nelson, Rachel		Roseland Christian Homes	Pullman
Nichols, Alesia	Director	Ashland Head Start	Englewood
Nkemdi, Priscilla	Immunization Program	Chicago Dept. of Public Health	Citywide
Ogbonnaya, Benedicta	Day Care Coordinator	Human Resource Development Institute	Pullman
Ogletree, Renae	Director, Chicago for Youth	Chicago Dept. of Human Services	Citywide
Opat, Judy	Admin. Dir., Cmty Guidance Ctr	Mercy Hospital and Medical Center	Citywide
Palm, Bertina	Resident		Englewood
Payton, Willard	Pastor	New Birth Church	Englewood
Peeler, Cecelia	Community Relations	Cook County State's Attorney's Office	Citywide
Peller, John	Director of Policy	Chicago Children's Advocacy Center	Citywide

Appendix B Interviewees, continued

Peters, Patricia	Supervisor	Cook County Juvenile Probation	
Philpot, Marvin	Director	ABJ Community Services	Pullman
Poe, Billie		South Side Help Center	Pullman
Porter, Stephanie	Career Counselor	Employment Resource Center	Englewood
Powell, Diane	Director	Metropolitan Family Services	Pullman
Powell, Gregory		Lutheran Social Services	Pullman
Pullin, Ouida	Project Manager, Far South	Chicago Dept. of Planning and Developme	Pullman
Purnell, Sheila	Parent Tutor Metor	Parents as Teachers First, Nicholson Scho	Englewood
Quintenz, Sharon	Director, Child and Adolescent	IL Dept. of Human Services, Office of Men	Statewide
Redd, Juanita	Senior VP, Operations	Community Mental Health Council	Englewood
Robbins, Michael		Robbins Consulting	Citywide
Roland, Gwyn	Director	City of Chicago Domestic Violence Helplin	Citywide
Rosebuno, Ronald	Site Administrator	Catholic Charities	Englewood
Ruiz, Mark	Tattoo Program Coordinator	Access Community Health Network	Englewood
Saalik, Derrick	Coordinator	Male Responsibility Program	Englewood
Sainvilus, Marie	Youth/Teen Coordinator	Greater Roseland YMCA	Pullman
Savoy, Barbara	Director	Imani Head Start	Englewood
Schneider, Sister Mary	Director	Maria Shelter	Englewood
Schofield, Aldora	Director, Far South	Chicago Dept. of Human Services	Pullman
Schoua-Glusberg, Alisu	Project Director	Harvard's Project on Human Development	Citywide
Scott, Richard	Violence Prevention Coordinato	Cook County Dept. of Public Health	
Shaw, Barbara	Executive Director	IL Violence Prevention Authority	Statewide
Shields, Michael	Commander	CPD 5th District	Pullman
Sidote-Salyers, Nancy	Presiding Judge	2nd Municipal District, Circuit Court, Cook	County
Sinaiko, Helga	Director, King Community Cente	Chicago Dept. of Human Services	Citywide
Siola, Michael		Chicago State University	Pullman
Slutkin, Gary	Executive Director	Chicago Project for Violence Prevention	Citywide
Smith, Connie	Clinical Supervisor	BRASS Foundation	Englewood
Smith, Diane	Coordinator	Pullman CRC/Rainbows	Pullman
Smith, Lucious	Executive Director	BAGS Foundation	Pullman
Smith, Toya	Administrative Assistant	Roseland YouthNet	Pullman
Sorenson, Erin	Executive Director	Chicago Children's Advocacy Center	Citywide
Starchan, Samuel	Minister	West Pullman Church of God	Pullman
Steele, Derrolyn	Supervisor	Assumption Shelter	Pullman
Stranski, Lori	Officer	Chicago Police Dept	Citywide
Studrdivant, Johnetta	Health Coordinator	Catholic Charities	Citywide
Suggs, Hayward	Senior VP, Operations	Community Mental Health Council	Englewood
Tabb, Eric	Chief of Staff	Alderman Beale	Pullman
Taylor, Cora	Youth Outreach Worker	Chicago Public Schools	Englewood
Thomas, Evonda	Child Care Nurse Consultant	Chicago Dept. of Public Health	Citywide
Thomas, Jani	Chair	7th District Steering Committee	Englewood
Thomas, Shirene	Program Administrator	IL Dept. of Public Health, Violence Preven	Statewide
Thomas, Sybil	Assistant to the Presiding Judge	Cook County Juvenile Court, Child Protecti	Citywide
Thompson, Brenda	LCSW	Wildwood Terrace Community	Pullman
Thompson, Jewel	Chief Operating Officer	Roseland Community Hospital	Pullman
Turner, Audrey	Professor	Kennedy-King College	Englewood
Turner, Dedra		Christian Community Health Center	Pullman

Appendix B Interviewees, continued

Turner, Sandra		Marquette National Bank	Pullman
Turon, Clayton		Healthcare Consortium of Illinois	Citywide
Vega, Charlene	Pupil Support Officer	Chicago Public Schools	Citywide
Walker, B.J.	Chief, Human Infrastructure	Mayor's Office	Citywide
Walker, Mary		Roseland Community Hospital	Pullman
Walker, Noreen	Deputy Chief, Area 2	Chicago Police Dept	
Walker, Rodney	Director of Social Services	Access Community Health Network	Englewood
Warshaw, Carole, MD	Director	Domestic Violence + Mental Health Policy	Citywide
Watson, Antonio	Deacon	Antioch Baptist Church	Englewood
Welch, Cindy	Children's + Young Adult Servic	Chicago Public Library	Citywide
Welch, Jennifer	Executive Director	Chicago Metropolitan Battered Women's N	Citywide
Welch, Queen	Principal	Kohn School	Pullman
Wharton, Ken, MD	Regional Medical Director	Roseland Neighborhood Health Center	Pullman
White, Lou		Calumet Area Industrial Commission	Pullman
White, Willie		Harlan High School (CPS)	Pullman
Williams, Anthony	AmeriCorps Volunteer	BAGS Foundation	Pullman
Williams, LaDerrick	Coordinator	Roseland YouthNet	Pullman
Williams, Maurice	Chair	Neighborhood Housing Services	Pullman
Williams, Ray		Olive-Harvey College	Pullman
Wilson, Henry P.	Chairman	Englewood Community Conservation Cour	Englewood
Wilson, Officer Desiree	Domestic Violence Liaison Offic	CPD 7th District	Englewood
Wilson, Wellington	President	Kennedy-King College	Englewood
Witherspoon, Mary	Nursing Supervisor	Chicago Dept. of Public Health	Citywide
Wolff, Paula	Senior Executive	Chicago Metropolis 2020	Citywide
Woods, Elissa	School Nurse	Cradle to Classroom (CPS)	Pullman
Woodside, Deborah	Program Director	Englewood Family Health Center	Englewood
Wright, James		Roseland Neighborhood Housing Services	Pullman
Young, Sandra	Commissioner	Chicago Housing Authority	Citywide
Zasadny, Julie	Director of Communications	Voices for Illinois Children	Statewide

Appendix C: Council and Steering Committee Members

Steering Committee:

Carl Bell, MD	President and CEO	Community Mental Health Council
Patricia Martin Bishop	Presiding Judge	Cook County Circuit Court, Child Protection Division
Karen Brewer	Domestic Violence Advocate	
Tom Finnegan	Chief of Staff, Operations	IL Dept. of Children and Family Services
Sue Gamm	Chief Specialized Services Officer	Chicago Public Schools
Colleen Jones	Senior Vice President	Metropolitan Family Services
Ruby Larkin	Executive Advisor	Pullman Bank + Trust
Kevin Limbeck	Executive Director	Family Focus
Sgt. Judy Martin	Domestic Violence Coordinator	Chicago Police Dept.
Barbara Shaw	Executive Director	IL Violence Prevention Authority
Erin Sorenson	Executive Director	Chicago Children's Advocacy Center
B.J. Walker	Chief, Human Infrastructure	Mayor's Office
Noreen Walker	Deputy Chief	Chicago Police Dept.
Jennifer Welch	Executive Director	Chicago Metropolitan Battered Women's Network
John L. Wilhelm, MD	Commissioner	Chicago Dept. of Public Health
Paula Wolff*	Senior Executive	Chicago Metropolis 2020

* Chair

Appendix C
Chicago Safe Start Council

Name	Title	Organization	Area
Al-Nurriden, Salim	Executive Director	Healthcare Consortium of Illinois	Citywide
Anger, Ida	Senior Program Director	Metropolitan Family Services	Englewood
Baker, Bridget	Director, Pastoral Care	Salem Baptist Church	Pullman
Banks, Cedric	Program Coordinator	Chicago Youth Centers Altgeld	Pullman
Barlowe Bell, Reaver	Director	V&J Day Care Center	Pullman
Benigno-Praznowski, Li	Domestic Violence Liaison Offic	Public Housing, Chicago Police Dept.	Citywide
Binion-Taylor, Theodor	Director, Behavioral Health	Chicago Dept. of Public Health	Citywide
Blumenfeld, Susan	Senior VP, Clinical Services	Metropolitan Family Services	Citywide
Bortey, Kera	Director	Clarence Hodges Head Start	Englewood
Brewer, Karen	Consultant		Englewood
Brooks, Richard	Youth Outreach Worker	Chicago Public Schools	Englewood
Cain, Sharon		Alderman Austin, 34th Ward	Pullman
Campbell, Ronald	VP, Patient Care Services	St. Bernard's Hospital	Englewood
Carothers, Kathie	School Safety Coordinator	CAPS Implementation Office	Citywide
Carter-Hill, Jean	Director	Imagine Englewood If	Englewood
Clemons, Deborah	Regional Administrator	Roseland Neighborhood Health Center	Pullman
Coleman-McKinney, Be	Outreach Coordinator	Developing Communities Project	Pullman
Collier, Ethel	Director, Violence Prevention/Ir	Chicago Public Schools	Citywide
Cooper, Ceola	Program Director	South Side Help Center	Pullman
Coversen, Maurice		Open Book	Pullman
Cox, Beverly, PhD	Professor	Kennedy-King College	Englewood
Cramer, Lina	Consultant	IL Family Partnership Network	Statewide
Crum, Christine	Legal Officer	2nd Municipal District, Circuit Court, Cook County	
DeBonnet, Pat	Director	Greater Roseland Community Developmer	Pullman
Devine-Reed, Patricia	Director	Boulevard Arts Center	Englewood
Dreakford, Cheryl	Project Director, Operations	Community Mental Health Council	Englewood
Dunson, Jaqueline	Director	Carey Temple Head Start	Pullman
Eason-Spears, Lisa	Youth Service Coordinator	BRASS Foundation	Englewood
Farr, Belinda	Education/LAN Liaison	ABJ Community Services	Pullman
Ford, Maurice	Commander	CPD 7th District	Englewood
Francis, Margaret	Domestic Violence Liaison	IL Dept. of Children and Family Services	Statewide
Freeman-Heron, Joyce	Area Manager, Southeast	Chicago Park District	Pullman
Fulwiley, Estell	Health Educator	ChildServ	Englewood
Gamm, Sue	Chief Specialized Services Offic	Chicago Public Schools	Citywide
Gathings, Fran	Program Manager	Metropolitan Family Services	Pullman
Gilbert, Brenda		Sheldon Heights Church of God in Christ	Pullman
Gilham, Nathaniel	Supervisor	Central Baptist Family Services	Pullman
Gills, Elder Luther	Pastor	Philadelphia Church of God in Christ	Englewood
Glen-Johnson, Lt. Mary	Community Relations	CPD 7th District	Englewood
Grant, Jacqueline	Program Supervisor	Generations Community Services	Pullman
Griffin, Lizzie	Director	Villa Pri Child Development	Englewood
Griffin, Nadyne	Community Health Advocate	Englewood Neighborhood Health Center	Englewood
Gross, James	Institute of Criminal Justice	Kennedy-King College	Englewood
Hall, Deana	Investigator	CPD 5th District	Pullman
Hall, Linda		Ada S. McKinley Community Services	Pullman

Appendix C Council Members

Hamilton, Jan	Program Manager	Southwest Women Working Together	Pullman
Hampton, Gloria	Director	Save Our Souls	Pullman
Hampton, Tempie	Executive Director	Clara's House Shelter	Englewood
Hanes, Sgt. Doris	Community Relations	CPD 5th District	Pullman
Hardy, Beatrice	Graphic Artist	Encouraging Creations	Pullman
Harper, Kay	Immunization Program	Chicago Dept. of Public Health	Citywide
Hayes, Angela	Facilitator	Cradle to Classroom (CPS)	Citywide
Healy, Bridget	Asst. State's Atty, Domestic Viol	Cook County State's Attorney's Office	
Holland, Chuck	Director of Special Projects	St. Bernard's Hospital	Englewood
Hylton, Ethel	Director	Alpha Temple Head Start	Englewood
Jackson, Alex	Director	Willing and Able Foundation	Pullman
Jacob, Nicole		Bethany Christian Services	Pullman
James, Selene	Director, Family + Children's Se	Southwest Women Working Together	Pullman
Johnson, Cheryl	Director	Chicago Youth and Community Services	Pullman
Johnson, Cheryl	Director	Environmental Protection of Altgelt	Pullman
Johnson, Joei	Case Manager	Catholic Charities	Pullman
Johnson, Lola	Director	Coppin Head Start	Englewood
Jordan, Margaret	Director	Charles D. Joseph Head Start	Pullman
Jordan, Rev. Daryl	Children's Ministry	Salem Baptist Church	Pullman
Jordanette, Matthews	Probation Officer Supervisor	Cook County Juvenile Probation	Citywide
Joseph, Cozetta	District Manager	Chicago Dept. of Human Services	Englewood
Kelly, Peggy	Balanced + Restorative Justice	Cook County State's Attorney's Office	
Kern, Norman		Chicago Project for Violence Prevention	Citywide
Kirk, Clara	President and Founder	Clara's House Shelter	Englewood
Kirwan, Ann	Manager, 0-3 Project	Kids PEPP/Ounce of Prevention	Statewide
Klibanow, Saul	President	Pullman Bank Initiatives	Pullman
Knight-Lynn, Laura, Ph	Child Witness to Violence Progr	La Rabida Children's Hospital	Citywide
Landis, Leslie	Project Manager	Mayor's Office on Domestic Violence	Citywide
Lanfair, Sandra	Prevention Educator	Harris YWCA	Englewood
Larkin, Ruby	Executive Advisor	Pullman Bank and Trust	Pullman
Lashley, Glenola		Englewood Community Services Office, CI	Englewood
Lazzara, Pete	EMS Coordinator	Children's Memorial Hospital	Citywide
Linas, Jeri	Assistant Director	Mayor's Office on Domestic Violence	Citywide
Love, Joyce	Assistant Director	Chicago Project for Violence Prevention	Citywide
Love, Rev. Alvin		Lilydale First Baptist Church	Pullman
Madlock, Felicia	Therapist	Central Baptist Family Services	Pullman
Majmudar, Sharmili	Family Violence Coordinator	Metropolitan Family Services	Pullman
Marcus, Michael		Chicago Community Trust	Citywide
McCord, Joe	Manager, Community Outreach	Chicago Park District	Citywide
McCoy, William	Bishop	Am I My Brother's Keeper	Pullman
McGehee, Frank	Director, Child Care Quality Proj	Harvard's Project on Human Development in Chicago	
McLaurin, Mattie	Facilitator	Cradle to Classroom (CPS)	Citywide
McQuaid, Lt. Michael	Youth Investigator	CPD 5th District	Pullman
Merchant, Deborah		Neighborhood Housing Services	Englewood
Mercurius, Paulette	Project Coordinator	Chicago Dept. of Human Services	Citywide
Messenger, Rev.		Holy Rock Church	Englewood
Miller, Jacqueline	Training and Outreach Coordina	Chicago Abused Women's Coalition	Citywide

Appendix C: Council Members

Mineur-Brieske, Michel	Senior Program Specialist	Chicago Park District	Citywide
Misweet, Laura	Executive Director	Free Peoples Clinic	Englewood
Moore, DeTrina	Program Director	Reach Out and Touch	Englewood
Moore, Henry	Youth Outreach Worker	Chicago Public Schools	Pullman
Morgan, Zachary	Administrator	Englewood Neighborhood Health Center	Englewood
Morris, Rob	Director of Development and Sp	Union League Boys & Girls Club	Citywide
Moy, Sybil	Community Outreach Unit	Cook County State's Attorney's Office	Citywide
Mozee, Sgt. Patrice		Chicago Police Dept	Pullman
Ogbonnaya, Benedicta	Day Care Coordinator	Human Resource Development Institute	Pullman
Palm, Bertina	Resident		Englewood
Payton, Willard	Pastor	New Birth Church	Englewood
Peeler, Cecelia	Community Relations	Cook County State's Attorney's Office	Citywide
Peller, John	Director of Policy	Chicago Children's Advocacy Center	Citywide
Philpot, Marvin	Director	ABJ Community Services	Pullman
Powell, Diane	Director	Metropolitan Family Services	Pullman
Purnell, Sheila	Parent Tutor Metor	Parents as Teachers First, Nicholson Scho	Englewood
Quintenz, Sharon	Director, Child and Adolescent	IL Dept. of Human Services, Office of Men	Statewide
Redd, Juanita	Senior VP, Operations	Community Mental Health Council	Englewood
Robbins, Michael		Robbins Consulting	Citywide
Roland, Gwyn	Director	City of Chicago Domestic Violence Helplin	Citywide
Sainvilus, Marie	Youth/Teen Coordinator	Greater Roseland YMCA	Pullman
Savoy, Barbara	Director	Imani Head Start	Englewood
Schneider, Sister Mary	Director	Maria Shelter	Englewood
Schofield, Aldora	Director, Far South	Chicago Dept. of Human Services	Pullman
Schoua-Glusberg, Alisu	Project Director	Harvard's Project on Human Development	Citywide
Shields, Michael	Commander	CPD 5th District	Pullman
Smith, Connie	Clinical Supervisor	BRASS Foundation	Englewood
Smith, Diane	Coordinator	Pullman CRC/Rainbows	Pullman
Smith, Lucious	Executive Director	BAGS Foundation	Pullman
Starchan, Samuel	Minister	West Pullman Church of God	Pullman
Steele, Derrolyn	Supervisor	Assumption Shelter	Pullman
Stranski, Lori	Officer	Chicago Police Dept	Citywide
Studrdivant, Johnetta	Health Coordinator	Catholic Charities	Citywide
Suggs, Hayward	Senior VP, Operations	Community Mental Health Council	Englewood
Tabb, Eric	Chief of Staff	Alderman Beale	Pullman
Taylor, Cora	Youth Outreach Worker	Chicago Public Schools	Englewood
Thomas, Evonda	Child Care Nurse Consultant	Chicago Dept. of Public Health	Citywide
Thomas, Jani	Chair	7th District Steering Committee	Englewood
Thomas, Shirene	Program Administrator	IL Dept. of Public Health, Violence Preven	Statewide
Thomas, Sybil	Assistant to the Presiding Judge	Cook County Juvenile Court, Child Protecti	Citywide
Thompson, Brenda	LCSW	Wildwood Terrace Community	Pullman
Thompson, Jewel	Chief Operating Officer	Roseland Community Hospital	Pullman
Turner, Audrey	Professor	Kennedy-King College	Englewood
Turner, Dedra		Christian Community Health Center	Pullman
Turner, Sandra		Marquette National Bank	Pullman
Turon, Clayton		Healthcare Consortium of Illinois	Citywide
Vega, Charlene	Pupil Support Officer	Chicago Public Schools	Citywide

Appendix C: Council Members

Walker, Mary		Roseland Community Hospital	Pullman
Walker, Rodney	Director of Social Services	Access Community Health Network	Englewood
Warshaw, Carole, MD	Director	Domestic Violence + Mental Health Policy	Citywide
Watson, Antonio	Deacon	Antioch Baptist Church	Englewood
Welch, Cindy	Children's + Young Adult Servic	Chicago Public Library	Citywide
Welch, Jennifer	Executive Director	Chicago Metropolitan Battered Women's N	Citywide
Welch, Queen	Principal	Kohn School	Pullman
Wharton, Ken, MD	Regional Medical Director	Roseland Neighborhood Health Center	Pullman
White, Lou		Calumet Area Industrial Commission	Pullman
White, Willie		Harlan High School (CPS)	Pullman
Williams, Anthony	AmeriCorps Volunteer	BAGS Foundation	Pullman
Williams, LaDerrick	Coordinator	Roseland YouthNet	Pullman
Williams, Maurice	Chair	Neighborhood Housing Services	Pullman
Williams, Ray		Olive-Harvey College	Pullman
Wilson, Henry P.	Chairman	Englewood Community Conservation Cour	Englewood
Wilson, Officer Desiree	Domestic Violence Liaison Offic	CPD 7th District	Englewood
Wilson, Wellington	President	Kennedy-King College	Englewood
Witherspoon, Mary	Nursing Supervisor	Chicago Dept. of Public Health	Citywide
Wolff, Paula	Senior Executive	Chicago Metropolis 2020	Citywide
Woods, Elissa	School Nurse	Cradle to Classroom (CPS)	Pullman
Woodside, Deborah	Program Director	Englewood Family Health Center	Englewood
Wright, James		Roseland Neighborhood Housing Services	Pullman

Appendix D: July 2000 Council meeting materials

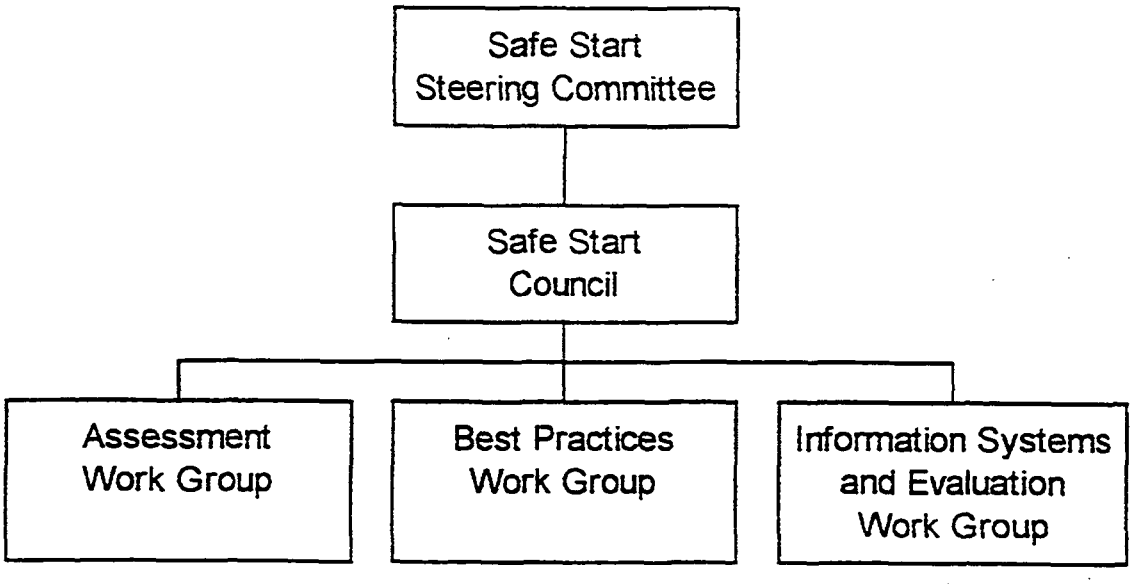
CHICAGO SAFE START INITIATIVE

July 20, 2000
DePaul Egan Urban Center
243 S. Wabash

AGENDA

12:00	Welcome Lunch
12:20	Introductions Review objectives and expected outcomes Overview of Chicago Safe Start "Through My Eyes" video
1:00	Planning and decision-making processes Vision development
3:00	Work group action plan development
4:00	Report out on work group discussions Review upcoming meeting schedule
4:30	Adjourn

Chicago Safe Start Initiative
PROJECT STRUCTURE



Please note: Work groups will likely change as the project develops and other tasks emerge.

What is Asset-Based Community Development?

Quick presentation to the Council
July 20, 2000

Needs map – shows how problems are to be addressed through deficiency-oriented policies and programs. People are told that services are the answer to their problems – develop an identity as a client.

Asset map – shows the capacities, skills and assets of a community.

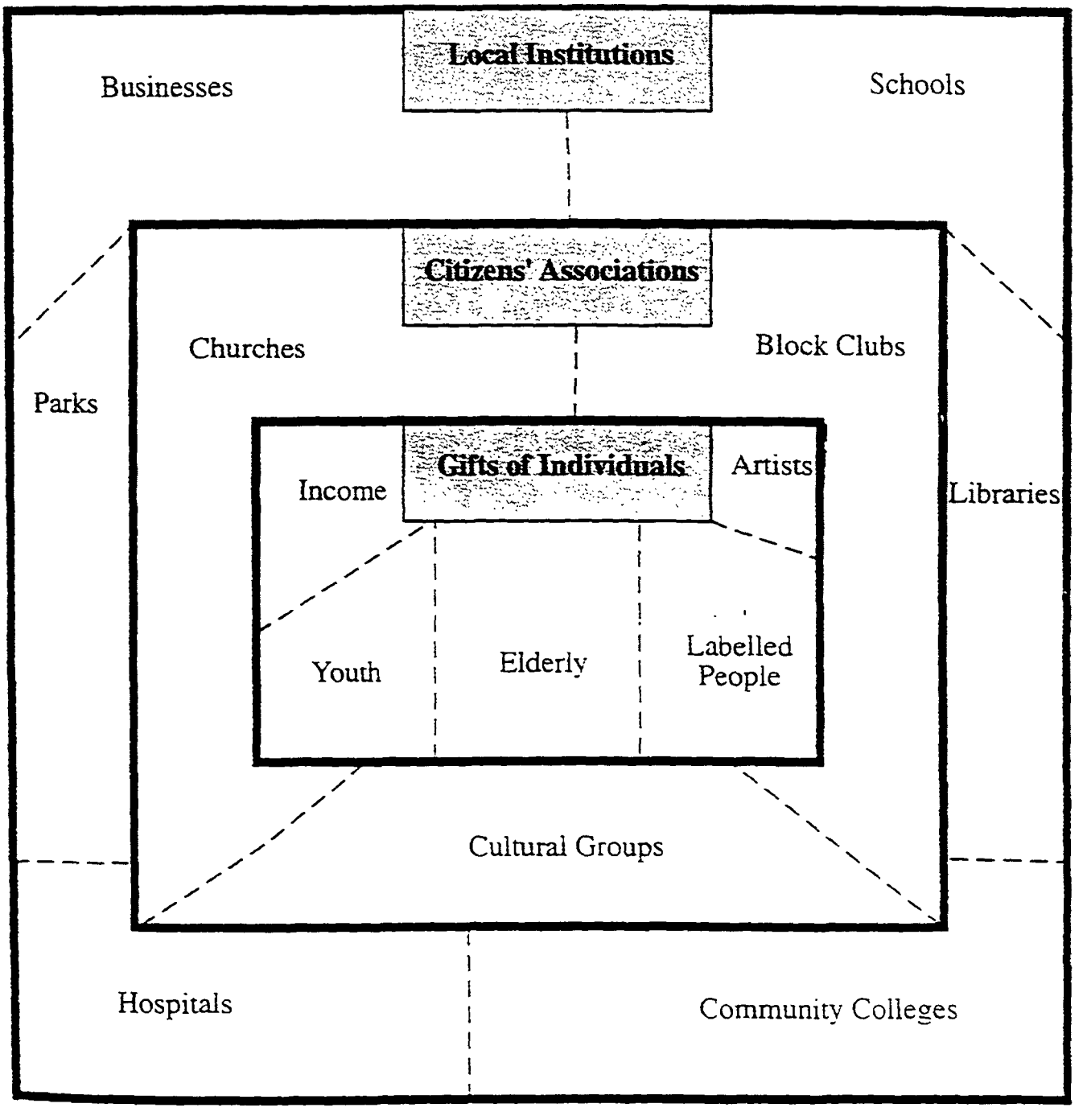
All the historic evidence indicates that significant community development happens only when local community people are committed to investing themselves and their resources in the effort.

The key to neighborhood regeneration is to locate all of the available local assets and begin connecting them with one another in ways that multiply their power and effectiveness and to begin harnessing those local institutions that are not yet available for local development purposes. New combinations, new structures of opportunity, new sources of income and control, and new possibilities for production.

The assets of a community are its individuals, associations and institutions.

This approach does not imply that communities do not often need additional outside resources. Rather, this approach simply suggests that outside resources will be much more effectively used if the local community is itself fully mobilized and invested, and if it can define the agendas for which additional resources must be obtained.

Community Assets Map



CHICAGO SAFE START WORK GROUP MEETINGS

What's the Deal with these Individual Asset Maps?

July 20, 2000

IDENTIFICATION OF RESOURCES AND CONNECTIONS THAT COULD BENEFIT OUR WORK.

- We are involved in many different things, as are those around us. Each involvement represents a potential addition to Safe Start.
- In order for Safe Start to implement the asset-based community development model, we first identify our own assets to further understand the approach and see its potential benefits.

START ANYWHERE – JOB, INTERESTS/ACTIVITIES, FAMILY/FRIENDS

- There is no prescribed order, nor is there a prescribed format. People can use the back instead or in addition to the map outline.
- We only have less than 10 minutes for this exercise, so encourage your group members to work quickly and not to think too hard about it.
- Personal interests and activities can include anything – from singing in the church choir to being a mother to two teenagers to chairing the Board of an organization.
- The interests and activities of family and friends category is included to underscore the connections we have to the work and play people close to us engage in.

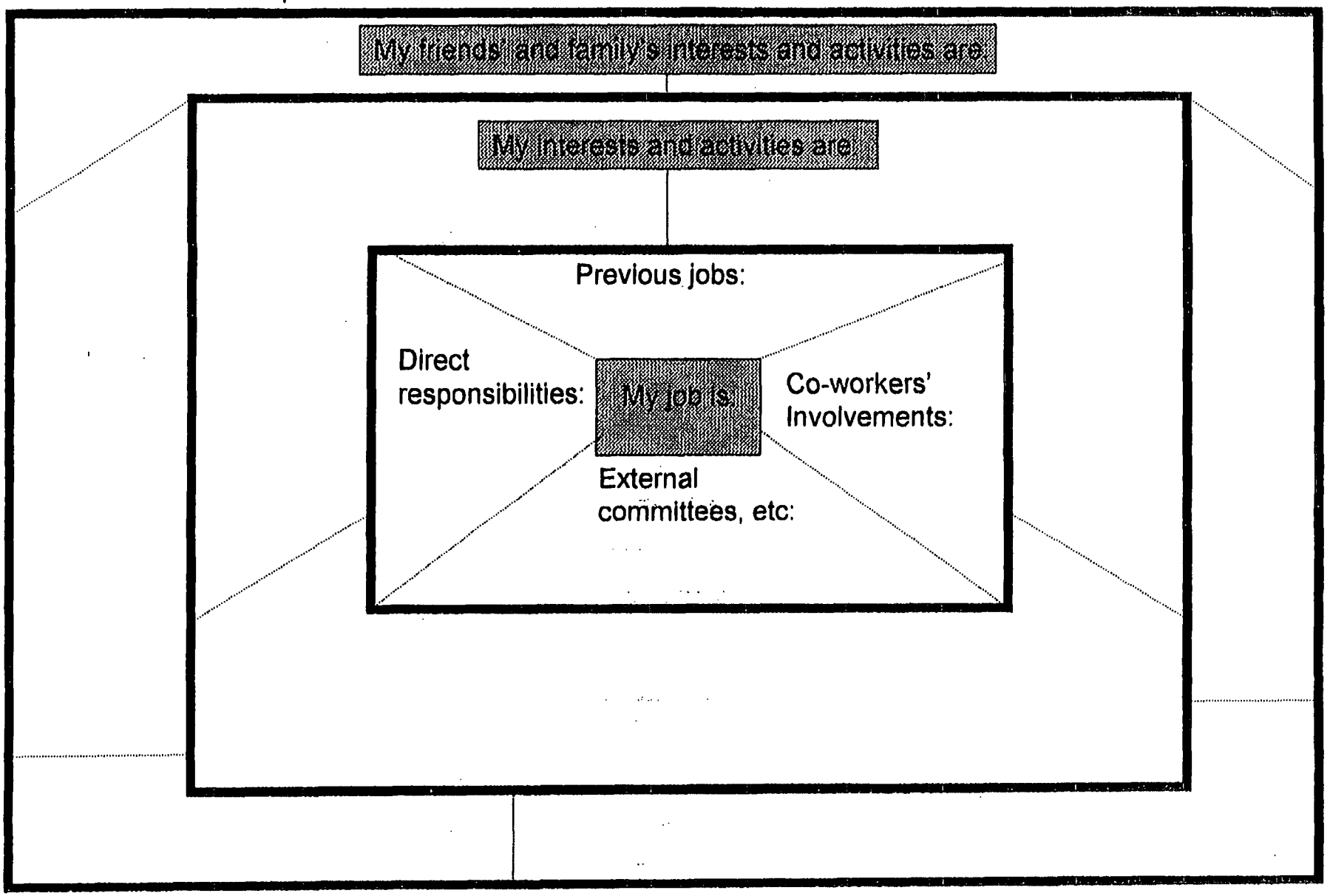
WHAT NOW?

- Group members can keep their asset maps, but you should spend a few minutes having individuals share one or two of their assets per category (e.g., job, interests/activities, family/friends).
- Discuss briefly how each individual should refer to their map in developing your group's action plan – e.g., either referring their contacts to you for us to follow up, or taking responsibility for that themselves.

CHICAGO SAFE START

Individual Assets Map

Name (optional):



CHICAGO SAFE START COUNCIL

Key Points for Work Group Meetings
July 20, 2000

ASSESSMENT
- Define team tasks and individual roles – individual asset map
- Present Kretzmann/McKnight approach and how we can use it
- Present logic model (handouts; also community assessment materials from DC)
- Develop overall action plan
- Action steps: people to interview, data to analyze, focus group plan
- Agree on upcoming meeting schedule
- Staff chair to complete reporting form

INFORMATION SYSTEMS/EVALUATION
- Define team tasks and individual roles – complete individual asset map; Need data-knowledgeable representatives from CDPH (clinics), DCFS, CPD, CPS
- Present logic model and how it is to be used as a guide throughout the project
- Develop overall action plan
- Action steps: Determine what data is collected by whom, how it is maintained, and if there are any existing system linkages to share data items
- Agree on upcoming meeting schedule
- Staff chair to complete reporting form

BEST PRACTICES
- Define team tasks (identify other effective violence prevention/systems change/child welfare programs, obtain detailed information about those programs and their applicability to Safe Start)
- Define individual roles – complete individual asset map
- Present logic model and how it is to be used as a guide throughout the project
- Action steps: define best practices (other programs serving comparable population, addressing comparable goals, that have been successful in meeting objectives) and how they are helpful to our process (spark other, new ideas)
- Develop overall action plan
- Action steps: Begin to catalog other programs to be considered resources
- Agree on upcoming meeting schedule
- Staff chair to complete reporting form

CHICAGO SAFE START
WORK GROUP REPORTING FORM

Work Group: _____

Date of Meeting: _____

Chair Name: _____

Staff Name: _____

Members in attendance: _____

_____

_____

Action Items Reported:

Task	Person(s) Responsible	Status

Discussion Items: _____

_____

_____

Next Steps:

Task	Person(s) Responsible	Other organizations involved	Due Date

CHICAGO SAFE START COUNCIL

Mark your calendars!

The NEXT MEETING is:

Monday, October 16 9:00 a.m. – 11:00 a.m.

Call Julie Sullivan, Project Director, with questions, concerns, ideas, etc.: 312-747-9396

Purpose of Safe Start

- To prevent and reduce the impact of family and community violence on young children, ages 0 to 5.

The Safe Start Vision

- To create a comprehensive service delivery system that improves the access to, delivery of, and quality of services for young children at high risk of exposure to violence or who have been exposed to violence.

Five Core Areas

- Collaborative Strength
- Systems Change
- Service Integration
- Strategic Planning (Project Design)
- Programmatic Expertise

Three Levels

- Key Leader Level (Macro)
  - Agency heads, community leaders, decision makers, policy makers, budget handlers
- Management Level
  - Internal organizational leadership, mid-level managers, internal policy makers and budget handlers
- Direct Service Level
  - Front-line leaders, street and family workers, staff, consumers

Safe Start: What it is and isn't

- Safe Start is a balanced approach between prevention, intervention and treatment
  - It is not just one
  - The vision is a comprehensive, responsive, proactive system
- Safe Start is an effort to address the impact of violence
  - It is not a general violence reduction effort

Safe Start: What it is and isn't

- Safe Start is a targeted approach for young children at high risk
  - It is not a primary or universal prevention effort
- Safe Start is for child victims, witnesses to domestic violence, and witnesses to street violence
  - It is not an effort to address general trauma or accidents

Safe Start: What it is and isn't

- Safe Start is a community-driven effort based on a data-driven assessment and planning process.
- The project builds on the existing system and leverages resources.
- This process will provide the basis and rationale for determining the appropriate balance for a comprehensive service delivery system in Chicago's diverse communities.

Strategic Plan Elements

- Vision statement
- Description of planning process
- Refined target area and population, as supported by data
- Community assessments
- Goals and objectives
- Action plan
- Plan for measuring progress
- Training and technical assistance plan
- Local evaluation plan
- Statement of collaborative planning

Goals, Objectives and Action Planning

- Goals and objectives must be outcome-focused and measurable
- Prioritized by years to be tackled/implemented
- Balanced to address the overarching framework of Safe Start – 5 core areas and 3 levels

Community Assessment

- Map current services
- Identify resources currently invested, service gaps and barriers
- Identify and prioritize risk and protective factors
- Analyze community strengths, resources and opportunities
- Analyze policies and identify program and policy priorities
- Plan for updating findings

National Approach

- Cooperative agreement
- Demonstration
- Community-driven
- Partnership
- Support
- Mutual benefit
- Best practices

Chicago Safe Start's
Data Notes.1

July 20, 2000

Each month, Chicago Safe Start's local evaluator will prepare *Data Notes* for members of the Chicago Safe Start Council. *Data Notes* will provide a brief look at recent research news and data of interest to those who are concerned with the effects of violence on young children.

This month: Two New Reports from the U.S. Dept. of Justice

1. *Intimate Partner Violence: Special Report* May 2000

Full report available at www.ojp.usdoj.gov -> BJS -> Abstracts -> Intimate Partner Violence

The Bureau of Justice Statistics of the U.S. Department of Justice issued a special trend report on intimate partner violence, commonly referred to as domestic violence. Intimate partner violence is of special concern to those interested in the well-being of children, because, as the report notes, *about 4 in 10 female victims of intimate partner violence live in households with children under age 12.* In other words, households that experience domestic violence are disproportionately likely to have young children in them.

Using information collected from the National Crime Victimization Survey and from FBI homicide data, the report had some grim but also some encouraging news. Overall, the number of women killed by an intimate partner was stable between 1976 and 1993, and then *declined* 23% between 1993 and 1997. The number of men murdered by an intimate partner fell 60% from 1976 to 1998.

The detailed picture of these homicide trends is more complex. Looking at the race of victims reveals that from 1976 to 1998, the number of black females killed by their partners dropped 45%; black males, 74%; and white males, 44%. Only white females saw no substantial decline, and in fact, from 1997 to 1998 the number of white females killed by an intimate partner *increased* 15%.

Looking at all forms of domestic violence (not just homicide), the reports states that women experienced intimate partner violence at lower rates in 1998 than in 1993. From 1993 to 1997 the rate of such violence fell from 9.8 to 7.5 per 1,000 women, and was virtually unchanged in 1998. The rate for males was relatively stable in the same period: 1.6 per 1,000 men in 1993, and 1.5 in 1998. As these rates suggest, women are far more likely than men to be the victims of intimate partner violence, accounting for 85% of the victimizations in 1998. Other data indicate that women living in households with the lowest annual household incomes experienced intimate partner violence at rates 7 times higher rates than women in households with the highest annual incomes.

HOW'S THE GOVERNMENT DOING?

R. Bruce Dold *Chicago Tribune*

July 16, 2000

There are few things government does that automatically, reflexively, touch a nerve. One of them is when government is called on to be a parent.

Fifteen years ago when I first got a look at how abused kids were treated when the government took them in, what I saw was astonishing. The Illinois Department of Children and Family Services was a vindictive, scared, secretive and clueless parent.

And those turned out to be the good old days.

By the middle of the 1990s, DCFS itself could have been charged with abuse and neglect. It was still vindictive, scared, secretive and clueless, and now it was getting absolutely overrun with children and didn't know what to do with them.

The number of abused kids rolling into the system tripled in half a decade. Newt Gingrich was talking about building orphanages around the country. The judges and lawyers and caseworkers were processing all the kids and ducking for cover in case somebody got hurt. Of course somebody got hurt. These were the days of the Keystone 19 and Clifford Triplett and Joseph Wallace. It was chaos, and they were kids.

You don't hear about those kinds of cases now, and it's not because reporters aren't willing to write about them. DCFS is a much better place than it was in the disaster days.

Last week the department announced it has been accredited by the Council on Accreditation for Children and Family Services. This is supposed to be great news. I'll take their word on that because I don't really know what it means that some outfit in New York has given DCFS its seal of approval.

The better news is that a lot of people who deal with the people at DCFS every day, the people who work in the juvenile courts and the shelter homes, say the department finally has a handle on things.

And it has results. Illinois has become the best state in the nation at putting abused kids into adoptive homes. It's doing a better job at figuring the odds—that is, fewer kids who get sent home by DCFS wind up getting beaten or burned or killed.

There's been a culture change. Better people are working there, and the people working there aren't afraid that if they raise a complaint, they'll get buried by bosses who don't want to hear any bad news.

KILLINGS CLOUDING ROSELAND COMEBACK
NEW HOUSING LIFTS COMMUNITY HOPES

By Mickey Ciokajlo
Tribune Staff Writer
July 9, 2000

Demetrius Friend was 6 years old in 1980 when his family moved to the Far South Side Chicago neighborhood of Roseland in search of a quieter, more stable life.

But as he grew up, he watched the neighborhood decline. Crime rose, and homeowners fled. Six years ago, a two-block stretch of Edbrooke Avenue, where Friend and his wife live, had 30 vacant houses.

"This was just an eyesore in the Roseland community," said Friend, who is block club president.

Today, there is a sense of resurgence. Nineteen homes have been built by Neighborhood Housing Services of Chicago on Edbrooke and around the corner on 107th Street. One block over, on South Michigan Avenue, the agency has nearly completed a $6.4 million project that will provide 40 high-quality apartments for low- and moderate-income residents.

Community leaders and residents cite the housing construction and other economic development efforts as signs that Roseland, named for the flowers grown by its Dutch settlers more than 100 years ago, will blossom again.

But even as new houses go up, abandoned structures remain a problem in the community. And the discovery since May 12 of six slain women in several of those abandoned buildings are the most vivid reminder that the community has a long way to go, residents and community leaders said.

"These killings have said that in an economically depressed environment, where drugs are free to abound, prostitution can exist and 59 liquor stores can be left open, it breeds this kind of behavior," said Rev. James T. Meeks, pastor of the 11,000-member Salem Baptist Church.

But the behavior today is not as bad as it was a decade ago, said Greg Harris, who in 1989 bought a house near 113th Street and CalumetAvenue. After years of watching men smoke drugs on the sidewalk in front of their house and seeing prostitutes ply their trade near the corner, he and his wife considered moving.

"I was sick and tired of the crime," said Harris. "I was sick and tired of the shape the community was in."

But Harris decided to stay after perceiving a new sense of community leadership. He now is chairman of the Calumet district advisory council for the community policing initiative known as CAPS.

notion of protecting the children. And they are not necessarily consistent."

He cited two recent examples: in both, the city had taken custody of children after a violent fight between their parents. And in both, the women implored him to send their children back home.

In the first, a woman with a black eye stood before him, claiming to have hurt herself by banging into a refrigerator. Her husband sounded belligerent. Their 13-year-old daughter insisted she had never witnessed any domestic violence at home. The judge suspected she had been coached.

In the second case, a woman appeared alone, her arms pocked with bruises, her face glazed by weariness. She told the judge of being terrified of her husband. She agreed to move, to take her children someplace where he would never find them.

In both cases, the judge, who under a pilot program sees all such cases in the Bronx, ultimately allowed the children to return home, but only after being assured that the women would make use of counseling and other support services, he said. In the first case, he waited a month, until the couple acknowledged that there had been a problem with violence in the home.

In some ways, these cases reflect an unintended consequence of new and arguably enlightened perspectives on domestic violence. It is now widely acknowledged that watching adults fight at home -- and especially witnessing a parent being beaten -- can scar children forever. Moreover, domestic violence can sometimes be part of a package of dysfunction at home, a red flag for egregious forms of child abuse and neglect.

"We know there's a close correlation between domestic violence and child abuse," Nicholas Scoppetta, commissioner of the Administration for Children's Services, said in an interview. "Very often where there's physical abuse of children, there's also domestic violence in the home; in particular, when there's an unrelated male in the home."

Which is why, Mr. Scoppetta said, caseworkers routinely inquire into domestic violence. The fact that one parent is

violence as part of a routine questionnaire. Ms. Tillett said, she answered candidly.

The next day, in a move that she soon realized was a grave mistake, she agreed to let the baby's father, Jamie Gray, take them home from the hospital.

City records indicate that the social worker filed a complaint to the state central register on child abuse and neglect. The next day, child welfare caseworkers, accompanied by police officers, carried away her 2-day-old son.

Ms. Tillett was charged with child neglect. "The respondents engage in acts of domestic violence in the presence of the subject child," the caseworker's report said.

Ms. Tillett was also charged with not having a crib for the baby. It did not help, she said, when she explained she was planning to move to California. She had a plane ticket in hand, she said.

It took Ms. Tillett 7 weeks to get Uganda back, as well as 19 weeks of court-ordered workshops for domestic violence victims, 10 hours of classes on being a good parent and counseling once a week. She now lives in a homeless shelter for battered women. The city child welfare agency is monitoring her case.

Like Ms. Tillett, Sharwline Nicholson said she was wholly unprepared for the arrival of the child welfare agency in her life. She, too, had separated from the father of her second child. He had never been violent until one wintry afternoon last year, when in an apparent fit of jealousy, she said, he went to her Brooklyn apartment unexpectedly, hurled whatever was in sight, and kicked and hit her so severely that her arm was broken. The baby, Destinee, was sleeping in another room; her 6-year-old son, Kendell, was in school.

The former boyfriend, Claude Barnett, fled. When the police and paramedics arrived, Ms. Nicholson said, she asked a neighbor who frequently watched her children to baby-sit until her cousin could pick them up later that day. Knowing her children would be safe, she said, she slept peacefully at Kings County Hospital that night.

The next morning, a child welfare caseworker called the hospital. "They said they had possession of my kids," Ms.

"I think the worst thing to do at that point is to remove their children," he said. "Then that person has absolutely nothing, nothing to hope for."

Tough Justice: Taking a Child When One Parent Is Battered

By SOMINI SENGUPTA 7/7/2000 p1

As the supervising judge in Bronx Family Court, Judge Clark V. Richardson spends most days presiding over one arduous decision after another -- when to sever a mother's legal ties to her child, when to throw a teenage troublemaker behind bars.

But these days there is a particularly vexing category of cases on his docket: Judge Richardson handles all of the cases in the Bronx when the city's child welfare agency has removed children from their homes because, in essence, one of their parents has been the victim of domestic abuse.

The city can take children into foster care if a parent is believed to "engage in acts of domestic violence." Its authority to do so was strengthened by a 1998 state court ruling that declared incidents of domestic violence in the presence of a child to be sufficient grounds for a charge of neglect.

In practice, Judge Richardson said, that usually means that a mother who is a victim of abuse can be accused of failing to protect her children from danger. Often, she may have done nothing wrong or negligent, but simply lacked the financial or emotional resources to leave an abusive partner.

In such cases, it falls to Judge Richardson, and other Family Court judges across the state, to decide whether those mothers get their children back, and under what terms. After all, he and other child welfare experts acknowledge, abusive partners can frequently be players in the most tragic cases of child abuse.

And so for Judge Richardson, who deals daily with disputes of law and love, violence and poverty, these cases present an especially daunting exercise in balancing interests.

"What is difficult is that you're victimizing them twice," he said of the mothers. "On the other hand, you have the

V Growing Up in a Socially Toxic Environment

James Garbarino

Introduction

Since security is vitally important for a child's well-being, when infants and
dren feel safe, they relax. When relaxed, they start to explore the environ
When a parent or other familiar person is around, a child treats the adult as a
base from which to explore the nearby space. If frightened—perhaps by a loud
or by the approach of a stranger—the child quickly retreats to the familiar p

This pattern is part of the normal development of children. It is so commo
it is used to assess the quality of children's attachment relations. Children w
not use their parents this way—showing anxiety when separated and relief
reunited—are thought to have a less than adequate attachment relationship
are "insecure" or "ambivalent" or "avoidant"). Thus, for very young childre
question of security is relatively simple. As a parent, I remember clearly the
cal experience of the clinging, wary child regarding a stranger. And I rem
sitting in airports or visiting friends and serving as a secure base for a tiny exp

Of course as children get older, their security needs are transformed. Soon
are getting on school buses and visiting friends' houses by themselves. Even
they are on the streets at night on their own. But security remains a constant
for them. Am I safe here? Will I be safe if I go there? Would I be safe then?
children do not feel safe, and in some cases, their insecurity is grounded i
This paper explores the concept of "social toxicity" with special attention to
sure to community violence as a threat to children's well being and mental h

The Concept of the Socially Toxic Environment

What I mean by the term socially toxic environment is that the social w
children, the social context in which they grow up, has become poisonous t
development. I offer this term as a parallel to the environmental movement's
sis regarding physical toxicity as a threat to human well being and survival
nature of physical toxicity is now well known, and is a matter for public poli
private concern. For example, we now know that cancer rates (e.g., breast c

and testicular cancer) reflect in part the build up of toxic substances in the physical environment—in the air, the water, the soil.

In the last ten or twenty years, some places have improved the quality of their physical environment of course, as public and professional awareness has led to changes. In the matter of recognizing, understanding, and reversing social toxicity, however, we lag far behind. We don't have a direct social equivalent to *Silent Spring*, Rachel Carson's landmark analysis of physical toxicity. Her book, published in 1953, called attention to the problem and stimulated reforms which led to public action to ban DDT and move against many of the most severe manifestations of physical toxicity in the environment.

But what are the social equivalents to lead and smoke in the air, PCBs in the water, and pesticides in the food chain? I think some social equivalents include violence, poverty, and other economic pressures on parents and their children. They include disruption of family relationships and other trauma, despair, depression, paranoia, nastiness, and alienation—all contaminants which demoralize families and communities. These are the forces in the land that contaminate the environment of children and youth. These are the elements of social toxicity (Garbarino, 1995).

Social life is more risky now than it was just 40 years ago; the level of social and cultural poison is higher. How is the environment for kids more socially toxic now than it was when I was a child? For one thing, no kid ever died from a drive-by fist fight, but the proliferation of guns among growing numbers of adolescent peer groups means that conflict and confrontation that once were settled with fists now can lead to shooting.

Let me use a personal example to illustrate this point. When I was in high school I used to write an opinion column for the school newspaper. One month I wrote an article in which I criticized the fraternities at my school, an act which led many of my peers to become angry at me. As a result, late one night I was the victim of a drive-by littering: a car pulled up and dumped garbage on the lawn of our house. The drive-by littering I experienced in 1963 was radically different from the threat faced today by a teen who angers his or her peers.

More generally, children and youth today must contend with a constant stream of messages that undermine their sense of security. If it isn't the threat of kidnapping, it's the high probability of parental divorce. If it isn't weapons at school, it's contemplating a future with dim employment opportunities.

But beyond these dramatic issues there are more, many more, that are subtle yet equally serious. High on the list is the departure of adults from the lives of kids. The lack of adult supervision and time spent doing constructive, cooperative activities are important toxic aspects of the social environment today, and compound the effects of other negative influences in the social environment for kids. Kids "home alone" are more vulnerable to every cultural poison they encounter than are children backed up by adults.

Although everyone is vulnerable to toxicity in the social environment, children (like the elderly) are the most vulnerable, just as they are among most vulnerable to physical toxicity in the environment. When airborne pollution gets really bad, who suffers first and most? Who is most vulnerable? It is the children (and our eld with asthma or other respiratory conditions who show the effects soonest and w greatest intensity. When a house is contaminated with lead or asbestos, who i greatest risk? Young children.

This analogy leads to one of the central elements of my message: As the so environment becomes more socially toxic, it is the children—particularly the m vulnerable among them—who show the effects first and worst. And who are children who will show the effects of social toxicity first and most dramatica They are the children who already have accumulated the most developmental r factors. These children already stand on the edge of life's abyss. And what fact put a child at risk? They are the stuff of talk shows and headlines and policy sen nars: absent fathers, poverty and other economic pressures, racism, addiction, e cational failure, poor physical health, family violence, and adult emotional pr lems that impair parenting.

It is the accumulation of risk factors which jeopardizes development. The pr ence of only one or two of these risk factors does not developmentally disable ch dren. Rather, it is the accumulation of three, four, or more of them (Sameroff, Sei Barocas, Zax, & Greenspan, 1987) which overwhelms the child—particularly wh these risk factors accumulate without a parallel accumulation of opportunity f tors. Once overwhelmed, children are likely to be highly sensitive to the socia toxic influences surrounding them.

As risk factors accumulate, intellectual development suffers and children c not bring to bear cognitive strength in mastering the challenges they face. Sameroff's study of 4-year-olds, children with less than three risk factors had abo average I.Q. scores of 112; children with four had below average I.Q. scores of 9

When a child's risk accumulates, he or she starts to achieve less. As a result lowered achievement, that child learns to devalue himself or herself. As a result such devaluation, that child comes to lack the reservoir of *self-esteem* he or s needs to keep positive momentum going when the going gets tough. Impaired p ent-child relations lead children to feel alienated and angry, and to reorient peers, oftentimes peers who share their feelings of abandonment or rage, and w might influence them away from socially responsible values and behavior.

Risk accumulates. Vulnerability increases. Vulnerability to what? Vulnerabil to social toxicity. Social toxicity undermines self-confidence and feelings of se worth. It squanders opportunities for positive experiences that might strength children. It erodes childhood itself. Violence and trauma are a crucial compone of social toxicity in the lives of children, and the principal focus of this chapter.

The American War Zone

Violence is a fact of life for millions of American children. Television infuses ma ery of violence into virtually every household; "real life" violence on the streets,

this conclusion upon an analysis of the role of trauma, threat, and violence on the development of children (Garbarino et. al., 1992).

Perhaps a few examples will help illuminate the effects of this gun culture on the experience of childhood. In Detroit, a young boy whose idolized teenage brother was killed in a gang-related attack was asked, "If you could have anything in the whole world, what would it be?" His answer: "A gun so I could blow away the person that killed my brother" (Marin, 1989). In California, when we asked a 9-year-old boy living in a neighborhood characterized by declining security "what would it take to make you feel safer here?" he replied simply, "If I had a gun of my own" (Garbarino, 1995). In a middle class suburb of Chicago, when we asked a classroom of 8-year-olds, "If you needed a gun could you get one?", a third of the children were able to describe in detail how they would get one. In a prison in North Carolina (Garbarino, 1995), when we asked three incarcerated teenagers about why they had done the shooting that had landed them in prison, all three replied, "what else was I supposed to do?"

We must understand the gun culture infusing the minds and hearts of American children and youth. Whether or not this cultural infusion results in actual shooting depends upon the particular circumstances of those children and youth, specifically, whether they experience an accumulation of social and psychological risk factors in the absence of compensatory opportunity factors.

The Consequences of Living in Danger

One result of violence is psychological trauma for victims, particularly children. Coping with the consequences of escalating community violence has become a major focus of our national agenda (Garbarino et. al., 1992). The emergent field of traumatic stress studies is increasingly recognizing the importance of understanding the phenomenon of post traumatic stress disorder (PTSD) as a response to childhood trauma. This follows upon the inclusion of the PTSD as a category for official diagnosis by the American Psychiatric Association. Diagnostic criteria for PTSD include re-experiencing the trauma (e.g., through recurrent dreams), numbing of responsiveness in day-to-day life, and a pattern of distorted feelings related to the traumatic experience such as feeling guilty about having survived while others did not (American Psychiatric Association, *DSM-IV*, 1994).

What is only beginning to become clear is what happens to children when the dangers they face are not distinct and single events, but rather become the fabric of their lives. This is the distinction between *acute* danger (e.g., when a deranged individual enters a normally safe school and opens fire with a rifle) and *chronic* danger (e.g., when ongoing gang warfare makes a child's streets and school a battleground in which even "innocent bystanders" are in jeopardy).

Acute danger requires a process of adjustment, either through changing the conditions of life or changing one's stance toward life events. Acute incidents of danger often simply require *situational* adjustment by normal children leading normal live fitting the traumatic event into the child's understanding of his or her situati The therapy of choice is reassurance: "You are safe again; things are back to norm

This is not to deny that post-traumatic stress disorder in children and yo exposed to acute danger may require processing over a period of months. If trauma is intense enough, it may leave permanent "psychic scars" particularly children made vulnerable because of disruptions in their primary relationships (n notably with parents). These effects include excessive sensitivity to stimuli asso ated with the trauma and diminished expectations for the future.

Chronic Danger and Its Consequences for Development

But what if there is no "post" trauma, and instead there is continuing exposure trauma? Chronic danger imposes a requirement for *developmental* adjustment. Cl dren may appear to "get used to it," but chronic danger is likely to produce reaching effects upon the child. These include chronic PTSD, alterations of p sonality, and major changes in patterns of behavior and beliefs to make some sen of ongoing danger. When these assaults occur in the context of a family or comm nity experience that results in the child feeling ashamed of his/her identity, possibilities for rage and further aggression increase.

Future orientation is important for children, and particularly adolescents, to tend to adult agendas for socialization. Trauma undermines future orientation. So observers have identified a pattern of "terminal thinking" that affects those m affected. Terminal thinking is most clearly evident when, in response to the qu tion, "What do you expect to be when you are 30 years old?" the youth answ "Dead." This outcome is most likely to take place when danger comes from soc factors that overthrow day-to-day social reality, as happens during war, or when child's neighborhood is taken over by chronic, violent crime.

The therapy of choice in situations of chronic danger is one which builds up the child's primary relationships. The goal is to create a new positive reality for t child. This new reality must be able to stand up to the "natural" conclusions tha severely traumatized child is likely to draw otherwise: "I'm weak and worthle "You can't rely upon adults," and, "The only way to be safe is to escape, or to them before they get you."

Adolescent males (i.e., the "soldiers") are the predominant casualties of neighb hoods saturated with crime, particularly gang- and drug-related crime. For the m part, children are still "innocent bystanders" or "in training" for the front lines of v lent conflict. Even when few children are actually shot, the process of adapting the threat of violence can shape their development in many, mostly negative wa

As noted earlier, surveys of youth on the southside of Chicago reveal that 25% them have witnessed a murder by the time they were 17. Studies in other Americ cities such as Washington, D.C., have confirmed and extended these findings.

may become a stable feature of personality and social ideology early in life. By age 8 patterns of aggressive behavior and "legitimization of aggression" tend to become stable, with predictability to adulthood (American Psychological Association, 1993).

Further, some adaptations to chronic danger, such as emotional withdrawal, may be socially adaptive in the short run, but become a danger to the next generation, when the individual becomes a parent. This phenomenon has been observed in studies of some families of Holocaust survivors. The emotional numbing that initially helped them to cope with life in the camps, put them at risk in the long run for emotional neglect of their own children (Danieli, 1988).

Parental adaptation to dangerous environments may produce childrearing strategies that impede normal development. For example, the parent who prohibits the child from playing outside for fear of shooting incidents, may be denying the child a chance to engage in exploratory play, as an undesirable side effect of protecting the child from assault.

Similarly, the fear felt by parents of children in high crime environments may show up as a very restrictive and punitive style of discipline (including physical assault). The parent may see it as an effort to protect the child from falling under the influence of negative forces in the neighborhood (e.g., gangs). Unfortunately, this approach is likely to have the result of heightening aggression by the child. One consequence may be difficulty in succeeding in school and other contexts that provide alternatives to the gang culture.

Another possible adaptation may be accepting violence as the modus operandi for social control (which in turn rationalizes the gang's use of violence as the dominant tactic for social influence). Holding the child back from negative forces through punitive restrictiveness is generally much less successful as a strategy than dealing with emotions openly, and promoting positive alternatives to the negative subculture feared by the parent. While understandable in the short run, such parental reliance on assault may be problematic in the long run.

In all of these examples, the adaptation is well-intentioned and may appear to be sensible and practical. It may even succeed in the immediate context as a kind of "psychosocial chemotherapy" that uses a poison in a desperate situation and at great cost, to preserve the child in the midst of the crisis of a life-threatening social environment. But its side effects may be detrimental in the long run. The problem, of course, is the social forces that create and sustain danger in the family's environment.

Beyond the direct effects of parents, the children may be involved in the process of identification with the aggressor, in which they seek to emulate those powerful aggressive individuals and groups in their environment which cause the danger in the first place (e.g., gangs in the public housing project, or enemy soldiers under conditions of war-time occupation). "If you can't beat 'em, join 'em," seems a sensible strategy for many children. As a result, hundreds of thousands of American youth routinely carry weapons to school or in their neighborhoods. It makes them *feel* safer (even if the fact of the matter is that they are more likely to be involved in a lethal confrontation as a result).

One of our major concerns is that living in chronic danger will have a nega effect on the process of moral development. One result is likely to be the sor "vendetta mentality" and "truncated" moral reasoning found among terrorists (Fic 1982). Another is the "terminal thinking" noted earlier, in which youngsters co to believe that violent death is an inevitable fact of their lives, and respond acco ingly, that is, with fatalistic violence, depression, and anti-social behavior. M terrorists, and many of our country's most violent criminals have grown up in s ations of chronic violence in which their behavior reflects the feelings of rage t often come from the experience of victimization, particularly among boys.

Families can do much to provide the emotional context for the necessary "p cessing" to make positive moral sense of danger, but it takes help from outside home. If school teachers and other adult representatives of the community are willing or unable to demonstrate and teach higher order moral reasoning, or intimidated if they try to do so, then the process of moral truncation that is "natu to situations of violent conflict will proceed unimpeded.

In Northern Ireland, for example, both Protestant and Catholic teachers fear that if they tried to engage their students in dialogue that could promote hig order moral reasoning they would be silenced by extremist elements (Conroy, 19 American urban gangs can have the same chilling effect if their threats com dominate the institutions of a community. The prosocial forces in a commu must remain in control of the schools, churches, neighborhood clubs, etc.

Children will continue to cope with difficult environments and maintain re voirs of resilience so long as parents are not pushed beyond their capacity to ab and deflect stress from children. Once that point is exceeded, however, the de opment of young children deteriorates rapidly and markedly. Reservoirs of re fence become depleted. Day-to-day care breaks down, and rates of exploitation victimization increase. Then moral development itself may be compromised.

The emerging problem of chronic gang violence poses a threat to youngs that parallels other situations in which there is a dramatic and overwhelming struction of the foundations of daily life. Erikson's (1976) study of an Appalad community devastated by flood speaks to what happens when a community l faith with itself, when parents, teachers, and other adults are demoralized and p erless. "The major problem, for adults and children alike, is that the fears haun them are prompted, not only by the memory of past terrors, but by a wholly real assessment of present dangers" (Erikson, 1976, p. 215).

What must we do? Part and parcel of any effort to make the streets and home children and youth safer is the willingness and ability of all adults to take charg themselves. Evidence from World War II and from the Middle East indicates t the level of emotional upset displayed by adults in a child's life, *not the war situa per se*, was most important in predicting the child's response (Papanek, 1972). ents who remained calm and in charge, confident and positive, were able to sh their children from much emotional harm. Teachers and other adults can play same role.

Losel, F., & Bliesener, T. (1990). Resilience in adolescence: A study on the generalizability of protective factors. In K. Hurrelmann & F. Losel (Eds.), *Health hazards in adolescence*. New York: Walter de Gruyter.

Marans, S., & Cohen, D. (1993). Children and inner-city violence: Strategies for intervention. In L. Leavitt and N. Fox Eds. *Psychological effects of war and violence on children*. (pp. 281-302). Hillsdale, NJ: Erlbaum.

Marin, C. (1989, June 21). *Grief's Children*. TV Documentary. Chicago: WMAQ.

Osofsky, J. (1995). The effects of exposure to violence on young children. *American psychologist*, 50, 782-788.

Papanek, V. (1972). *Design for the real world: Human ecology and social change*. New York: Pantheon Books.

Price J., & Desmond, S. (1987). The missing children issue: A Preliminary examination of fifth-grade students' perceptions. *American Journal of diseases of children*, *141*, 811-815.

Pynoos, R., & Nader, K. (1988). Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Traumatic stress*, *1*, 445-473.

Richters, J., & Martinez, P. (1993). The NIMH community violence project I: Children as victims of and as witnesses to violence. *Psychiatry*, 56, 7-21.

Sameroff, A., Seifer, R., Barocas, R., Zax, M., & Greenspan, S. (1987). Intelligence quotient scores of 4-year-old children: Socio-environmental risk factors. *Pediatrics*, *79*, 343-350.

Terr, L. (1990). *Too scared to cry*. New York: Harper and Row.

Vygotsky, L. (1986). *Thought and language*. Cambridge, MA: Massachusetts Institute of Technology Press.

VI Community and Domestic Violence Exposure: Effects on Development and Psychopathology

Joy D. Osofsky & Michael S. Scheeringa

Introduction

The United States is the most violent country in the industrialized world with violence having reached epidemic proportions. Many children witness violence every day of their lives in their homes or on the streets, and the impact on these children can be catastrophic. The effects of violence on children has become a public health issue requiring broad-based solutions. Homicide is the second leading cause of death among all 15-to-24-year-olds, and is now the third leading cause of death among elementary school children, ages 5 to 14 (Korchanek & Hudson, 1995). For 10- to-19 year-olds, homicide is now the second leading cause of death (Children's Defense Fund, 1996). The numbers of youth committing homicide has increased more than 150% between 1985 and 1993. The rate of known homicide offenders, ages 14 to 17, has climbed from 16.2 per 100,000 in 1990 to 19.1 per 100,000 in 1994 (Herbert, 1996). A Louis Harris poll of 2,000 teenagers from around the country (including suburban and rural areas) found that 1 in 8 youths, and almost 2 in 5 from high-violence neighborhoods, said they carried a weapon for protection. One in 9, and more than 1 in 3 in high-violence neighborhoods, said they had cut class or stayed away from school because of fear of crime (Appelbone, 1996).

Violence is defined as a use of physical force so as to damage or injure. *Trauma* is defined as a physical wound or injury or a violent emotional blow, especially one which has a lasting psychic effect (Webster Unabridged Dictionary, 1992). We have not even begun to know how many children witness violence in their homes and in the streets, although consistent evidence is available from school children in the inner cities and their caregivers indicating that as many as 90% of elementary school children in some schools have witnessed shootings, stabbings, or other violent events (Groves, Zuckerman, Marans, & Cohen, 1993; Osofsky, 1995a). Most children in elementary schools report having seen a dead body. In a survey of 6th, 8th, and 10th graders in New Haven in 1992, 40% reported witnessing at least one violent crime

Support for the first author's work reported in this chapter has been provided by the Entergy Corporation, Institute of Mental Hygiene, the Booth Bricker Fund, the Brown Foundation, the Greater New Orleans Foundation, the Frost Foundation, Bell South Mobility, the Jones Family Foundation, and anonymous donors.

City of Chicago
Richard M. Daley, Mayor

Department of Public Health

Sheila Lyne, RSM
Commissioner

333 South State Street
Chicago, Illinois 60604
(312) 747-9884
(312) 747-9888 (24 hours)
(312) 744-2960 (TTY)

http://www.ci.chi.il.us

MEMORANDUM

TO: Chicago Safe Start Council
FROM: Mary Morten, Director, Office of Violence Prevention
Julie Sullivan, Project Director
DATE: July 26, 2000
RE: Follow-up to 7/20 meeting

Thank you so much for attending the Chicago Safe Start Council meeting on July 20. We greatly appreciate your time, opinions, and ideas. Following is a summary of the current activities of each work group, the upcoming meeting schedule, and a draft of the vision statement based on ideas generated during the meeting. Enclosed please find two recent newspaper articles on Safe Start and "Children Who Witness Violence: The Hidden Victims."

CHICAGO SAFE START COMMITTEES

STEERING COMMITTEE
> 12-14 members
> Project oversight
> Policy Decisions

COUNCIL
> 50+ stakeholders
> Content decisions

ASSESSMENT WK GRP
> Qualitative - interviews
> Quantitative - data

BEST PRACTICES WK GRP
> Identify models
> Evaluate relevance
> Make recommendations

INFORMATION SYSTEMS & EVALUATION WK GRP
> Identify data collected
> Evaluation oversight

WORK GROUP ACTIVITIES

***Assessment**: Coordinating, supporting and furthering the efforts to recruit project participants, gather data and conduct interviews to inform programmatic design.*

- Identifying community contacts
- Strategizing re community forums/focus groups and questions to be asked
- Initial results of data analysis

***Best Practices**: Searching for relevant programs and models to serve as ideas for not only what intervention/prevention activities could be successful, but how they can be successful.*

- Identified 12 programs and models to explore further
- Obtaining contact info for those programs/models

***Information Systems/Evaluation**: Identifying what agencies collect what information; determining what data can be shared and how; developing plans to address gaps in data collected and for data sharing.*

- Obtaining data collection forms used at relevant partner agencies
- Determining data collection methods used at relevant partner agencies
- Recruiting needed new members from relevant partner agencies

MEETING SCHEDULE

Note: If locations are not listed, we are in the process of finalizing and will notify you as soon as we can.

Work Group Meetings

Assessment	Best Practices	Eval/Info Systems
Mon., **Aug. 7**, 3:00-4:30 Philadelphia Church of God in Christ, 1622 W. 61st St.	Tue., **Aug. 22**, 9:00-11:00	Wed., **Aug. 9**, 2:00-4:30 CDPH, 333 S. State
Tue., **Aug. 22**, 3:00-4:30		
Thu., **Sept. 7**, 3:00-4:30		
Tue., **Sept. 19**, 3:00-4:30		

STEERING COMMITTEE	FULL COUNCIL
Mon., Aug. 28, 2:00-4:00	Mon., Oct. 16, 9:00-11:00

DRAFT VISION STATEMENT FOR CHICAGO SAFE START

Please provide comments via phone, fax or email to Julie Sullivan **on or before August 21, 2000. Comments submitted after the deadline cannot be incorporated.**

Chicago Safe Start will reduce and prevent the impact of exposure to violence on children ages zero to five in the Englewood and Pullman districts. Safe Start will improve the access to, delivery and quality of services through a balance of prevention and intervention efforts, focusing on education and new kinds of relationships among city and state service agencies, community organizations and residents.

- Engage community leaders and residents
- Simplify access
- Reach out to underserved people
- Involve families
- Leverage existing resources

CONTACT INFORMATION

Please feel free to call with any questions, concerns, feedback or ideas. You can reach Julie Sullivan at 312-747-9396 or by email at sullivan_julie@cdph.org, or Mary Morten at 312-747-8787 and morten_mary@cdph.org. Both are reachable via fax at 312-747-8835.

Children Who Witness Violence

The Hidden Victims

■ James, age 4 and Angela, age 3, are walking to the store with their mother when gunfire erupts. Their mother grabs them and ducks into a store. They see a man on the street collapse in a pool of blood.

■ Nicole, age 7, hears her parents arguing in the kitchen. The fighting escalates. She hears dishes breaking and her mother screaming. She turns the volume on the television up to avoid hearing more.

Photo © Donna Ferrato

These children have several things in common: they are young; they are unintentional bystanders to frightening and potentially dangerous events; they learn important lessons about the world from these events; their emotional reactions are partially determined by the response of their parents.

In recent years, increasing attention has been paid to children as bystanders to crime and violent activity.[1] A number of studies have examined the effects on children witnessing violence. In general, we have learned that children who witness violence are also its victims, regardless of whether they suffered physical injuries. Being a bystander to violence profoundly affects a child's sense of safety and well-being and is associated with a number of poor behavioral outcomes. Programs have been created to provide services to this group of children. Legislative and public policy changes have been proposed and in some cases enacted that acknowledge the special risks for children of being bystanders to violent events.

This article provides a review of what is known about children's exposure to violence and draws the conclusion that exposure to domestic violence is the most toxic form of violence exposure for most children. The material for this article comes both from a review of pertinent studies and from the clinical findings of the Child Witness to Violence Project (CWVP) at Boston Medical Center. This mental health program for young children who witness community and domestic violence operates within the Pediatrics Department of the hospital and provides services to approximately 200 children each year.

COVER STORY

by Betsy McAlister Groves, MSW, LICSW, Director of the Child Witness to Violence Project at Boston Medical Center, Boston, Mass.

Prevalence of Children's Exposure to Violence

The discussion about children's exposure to violence begins with a review of the kinds of violence children are likely to be exposed to. Perhaps the most ubiquitous source of exposure to violence for children is television and other media (movies, video games, for example). There is little doubt that this type of violence exposure both desensitizes children (and adults) and is linked with more aggressive behavior. However, exposure to real-life violence is far more harmful for children and will be the focus of this article.

Establishing accurate numbers of children who witness violence is difficult. The challenges lie in defining the terms "exposure" and "violence" and in standardizing the age of the child in the studies. Community violence includes violence occurring on the street or in the neighborhood, drug-related violence, and gang violence. This type of violence has been strongly associated with urban and high crime areas.[2,3,4] However, the highly-publicized

continued from page 9

exposure to domestic violence appeared to be a stronger risk factor than being a direct victim of physical abuse.

Finally, several studies have attempted to delineate which aspects of a violent event are most powerful for children.[23,24] Three attributes of a violent event appear to be most harmful: the proximity of the child to the event; the extent to which the child perceives himself or a parent to be vulnerable; and whether the child knows the victim. If these attributes are then considered in the context of domestic violence, it becomes clear that the nature of domestic violence is inherently toxic for children. In situations of domestic violence, the child is likely to be close to the event and able to see and hear a great deal; the child accurately perceives that (s)he and the parent are in danger; the victim is obviously known to the child. Thus, the child is more likely to have severe symptoms and symptoms that are of longer duration.

Discussion

In summary, exposure to violence affects children in all arenas of their development: social, cognitive and emotional. Children who witness domestic violence are especially vulnerable to psychological difficulty. Their symptoms of stress are more intense and of longer duration. In addition, their caregivers may be less available to help them cope. These findings have implications for judicial practice and for public policy.

An unfortunate by-product of the increased awareness of the impact of domestic violence on children is the tendency to blame both parents for their failure to protect the child and assume the position that the child would be better off removed from the caregivers. While this response is perhaps understandable, it does not lead to sound intervention on behalf of children. In the experiences of the CWVP, the best way to help children who witness domestic violence is to assist the non-abusing parent to attain safety and to focus efforts on restoring the parent-child relationship so that the parent is better able to support and buffer the child. Sometimes, this may mean assisting a victim with legal intervention or accessing safe shelter. Sometimes, it includes giving parents information about their child's symptoms and strategizing about ways to create order, predictability and safety in the child's life. Removing a child from his/her parents is a last resort, because such loss further traumatizes the child.

These findings about the extent to which a child may be affected by witnessing domestic violence also have important implications for custody and visitation, if the batterer is a parent.

Program offers counseling at crime scenes for kids

By Noreen S. Ahmed-Ullah
TRIBUNE STAFF WRITER

When police have responded to domestic violence reports, young children at the scene often have been handed off to relatives or the Illinois Department of Children and Family Services without any counseling for the abuse they may have witnessed.

A $670,000 grant from the U.S. Department of Justice will help Chicago change that.

With a new program that kicked off nationwide Monday, the Chicago Department of Public Health hopes to coordinate efforts so children, both victims and witnesses of violence, get immediate counseling starting at the scene of a crime from therapists and psychologists called in by police.

In Chicago, the city hopes to pilot the Safe Start program in the Pullman and Englewood communities, which together have 8.5 percent of the city's childhood poverty cases and 13 percent of female-headed households, said Mary Morten, director of the Department of Public Health's office of violence prevention.

Englewood also was chosen because it "has had a high visibility for some very violent acts," Morten said, referring serial killings and the murder of 11-year-old Ryan Harris.

Morten will assess the roles agencies, schools and police districts play and see how best to coordinate activities so children—from infants to the age of 5— who are exposed to violence do not fall through the cracks.

'One of the first times children are exposed to violence is at home, and this rocks the foundation of their lives.'
Mary Morten

"Generally, one of the first times children are exposed to violence is at home, and this rocks the foundation of their lives," Morten said. "Some times these children show very aggressive behavior that may end in their being violent in school."

Without early help, these children also will show other symptoms, such as severe emotional disturbance, substance abuse and poor school performance, said Dr. Steven Berkowitz, psychiatric coordinator for the National Center for Children Exposed to Violence, which was dedicated Monday at the Yale University School of Medicine in New Haven, Conn.

The national center will provide local communities participating in the national program with training and technical assistance for their social service agencies.

Besides Chicago, seven other cities, such as San Francisco and Spokane, Wash., have received grants to participate in the program.

Appendix E: October 2000 Council meeting materials

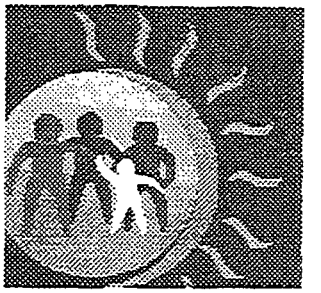
City of Chicago
Richard M. Daley, Mayor

Department of Public Health

Sheila Lyne, RSM
Commissioner

333 South State Street
Chicago, Illinois 60604
(312) 747-9884
(312) 747-9888 (24 hours)
(312) 744-2960 (TTY)
http://www.ci.chi.il.us

Chicago Safe Start
MEMORANDUM



Working Together to Help
Children Exposed to Violence

TO: Chicago Safe Start Council
FROM: Julie Sullivan
DATE: October 5, 2000
RE: Council Meeting on October 16

We look forward to seeing you at Chicago Safe Start's upcoming Council meeting on **Monday, October 16, 2000, at Metropolitan Family Services, 235 E. 103rd St. The meeting will begin promptly at 9:30 a.m. and adjourn at noon.** Please call me at (312) 747-9396 or Helen Washington at (312) 747-9406 if you have any questions. If you have not already RSVP'd, please call us immediately.

This meeting is critical in determining what Safe Start is going to be.

- The staff will present the assessment findings, which will serve as the basis for four new work groups (Prevention, Intervention, Systems/Policies, and Public Awareness)
- Each of these new work groups will determine approximately 3-5 priorities for system agencies and community organizations as Safe Start moves toward initial implementation.
- Each work group will present their priorities at the next Council meeting on November 17.

- Next, the Best Practices work group will recommend model programs, policies and curricula to implement the priorities.
- Then, the staff will draft the 18-month implementation plan and the 5-year strategic plan, which will be disseminated on Jan. 15 for your review and comment.

Please consider the following questions in preparation for the Oct. 16 Council meeting:

- What kinds of programs and policy changes do you think Safe Start should focus on? In the short term? In the long term?
  - *Example: Safe Start should focus on increasing the availability and quality of mental health services for young children (programmatic). Safe Start should work on assuring that the police are tracking whether children are present when responding to domestic violence calls (policy).*
- What do you think you need to know to be able to make programmatic and policy decisions regarding the components of Safe Start?
- What roles should each of the systems (e.g., police, DCFS, health care, mental health, domestic violence services, Courts, child care, etc.) play in prevention and intervention?
  - *Example: Safe Start should convene and lead a multi-disciplinary task force with representatives from each system to determine how to use cross-training and/or interagency agreements to bring needed expertise; e.g., the police and a social worker teaming together to respond to a domestic violence call; a DCFS caseworker teaming with a domestic violence advocate to provide more effective and comprehensive services to families.*
- What role should the community (organizations and individuals) play in prevention, intervention and public awareness?

- *Example: Safe Start should work with community leaders to mobilize intra-community resources (e.g., a "Safe House" designated every few blocks which children and mothers know is a place to go to seek solace and referrals from a volunteer neighbor). Safe Start should work with community parks, churches, and other places of social gathering to create and implement a public awareness campaign on effective child discipline and the impact of exposure to violence on young children.*

Chicago Safe Start

Council Meeting, October 16, 2000

Opening Points

- Explain and emphasize asset-based approach – assessment focused on resources and capacity
- Explain qual and quant data, systems – purpose, relevance
- Ask questions, raise issues as go along
- This information will serve as the basis for you to help determine what Safe Start will consist of – we are going to break up into new work groups to meet once or twice to determine priorities based on today's presentation
- Set framework for new work groups – balanced approach, define all, emphasize importance of participation at this point
    - Prevention
    - Intervention
    - Policies/Systems
    - Public Awareness
    - Ongoing: Best Practices, Information Systems
- Next meeting is November 17.

Chicago Safe Start

Council Meeting, Oct. 16, 2000

New Work Groups

- The Best Practices and Evaluation Work Groups will continue to exist, but will lay dormant over the next four weeks. Best Practices (with aggressive recruitment of additional members) will meet next on November 21 and December 5 to review the priorities as presented by the other work groups to the Council on Nov. 17 and select program/curriculum models to use.

- Representatives from each key system (e.g., police, DCFS, DV, mental health) will be assigned to each work group to ensure participation and input across the continuum.

- Work group chairs will also be preselected. Work groups are to set their own meeting schedule based on the deadline of Nov. 17 presentations to the full Council.

- Work groups will work from the assessment findings presented to the Council on 10/16 to identify approximately 3-5 priorities to become key components of Safe Start program and task force implementation.

Prevention

- Based on the assessment findings presented on 10/16, what are 3-5 priorities for systems change/improvement and community efforts?
- What are the roles of the police, DCFS, DV, mental health, etc. in prevention?
- We are defining prevention as both primary and secondary.

Intervention

- Based on the assessment findings presented on 10/16, what are 3-5 priorities for systems change/improvement and community efforts?
- What are the roles of the police, DCFS, DV, mental health, etc. in intervention?
- We are defining intervention as the effort (by systems and/or community organizations) to work with an individual and/or a family to break a negative cycle and provide the necessary supports to foster health and well-being.

Policies/Systems

- Based on the assessment findings presented on 10/16, what are 3-5 priorities for systems change/improvement and specific policy/protocol changes?
- What are the roles of the police, DCFS, DV, mental health, etc. within the system focusing on child and family well-being?
- What longer-term task forces need to be created to ensure optimal functioning of the system to promote child and family well-being?

Public Awareness

- Based on the assessment findings, what are 2-3 key messages to be disseminated in these two districts?
- What media would be most effective – e.g., billboards, CTA bus ads, CTA transit ads, PSAs, etc.?
- How can this public awareness campaign come to fruition – i.e., can we obtain pro bono advertising agency services?
- What should the timeframes or phases be?
- Should trainings open to the public be included in the public awareness plan?

Appendix F: November 2000 Council meeting materials

Chicago Safe Start
Planning Phase Work Groups
Priority Identification Questions

Please use the following questions, as well as any you and/or your group wish to add, to frame your discussion of potential priorities for Chicago Safe Start program and policy initiatives.

REVIEWING THE INFORMATION

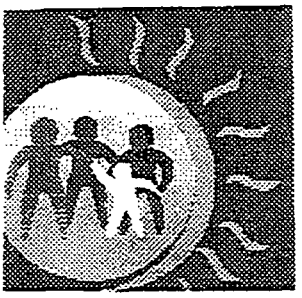
1. What information, of that presented on Oct. 16 as well as what you know, is most helpful to you in determining what the community wants in terms of child protection, family strengthening, parenting education, etc.?
2. What information, of that presented on Oct. 16 as well as what you know, is of greatest concern to you?
3. What programs and/or policy changes are most important in working towards Safe Start's mission (e.g., to prevent and reduce the impact of exposure to violence on children 0-5)?

EVALUATING OPTIONS

1. ***Implementability*** – Can a potential priority realistically be implemented? In the short term (e.g., within the first 18 months – May 2001 through November 2992)? In the long term (e.g., before the grant ends in December 2005)? Can sufficient support (and at low, medium and high levels) be garnered from the necessary organizations? Can sufficient support be earned in the community so that people will participate?
2. ***Financial feasibility*** – Can a potential priority be realistically funded – through any kinds of supporters, including city, state and federal organizations, community organizations, foundations? How would funding levels change over time?
3. ***Doing the "right" thing*** – Is a potential priority going to directly or indirectly improve the lives of children 0-5?
4. ***Asset-based*** – Does a potential priority create or leverage resources and linkages within the communities?

Chicago Safe Start
Planning Phase
Prevention Priorities

October 30, 2000



Working Together to Help
Children Exposed to Violence

Chair: Marie Sainvilus, Roseland YMCA
Attendees: Michael Robbins, Kathryn Haines, Leontyne Clemons, Rob Morris, Jennifer Gabrenya, Jennifer Ford
Staff: Helen Washington, Julie Sullivan

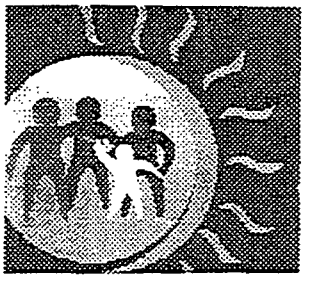
Short-Term Priorities

- Safe Start Satellites/Liaisons
  - Located in existing agencies/churches in the Englewood and Pullman districts
  - Point people for all resources for 0-5 – provide linkages and resources to community organizations, churches, schools, police and families
- Safe Start Englewood and Pullman district web sites
  - All projects, organizations, initiatives and agencies (see: www.englewoodfutures.org)
  - Union League Boys & Girls Club can help with computer access
- Regular meetings (perhaps every other month) of all community organizations
  - Improved linkages, understanding of available community resources
  - Steering committees for district web sites
- Training on child development, impact of exposure to violence, what to do
  - Child care – day care center-based, in-home, licensed and unlicensed; partnership with CDHS; parks, libraries, CPS early childhood; all mandated reporters working with the 0-5 age group
  - Parents – via churches
  - First responders – police, fire, paramedic

Long-Term Priorities

- Convene consortium of Chicago universities providing MSW and PhD (psychology) training to build capacity of mental health personnel expert in children exposed to violence
  - Begin with field practica in local organizations
  - Develop specialty certification in children exposed to violence/violence prevention
  - Seek private foundation support also
  - Partner with Carol Warshaw's mental health policy initiative as well as Ounce of Prevention/Kids PEPP work in this area
- Build network of safe havens for children in the two districts – via the City child care initiative, existing child care agencies, churches

Chicago Safe Start
Planning Phase
Intervention Priorities



Working Together to Help Children Exposed to Violence

November 9, 2000

Chair: Commander Michael Shields, District 5, Chicago Police Dept.
Attendees: Gwyn Roland, Katherine Francis, Bridget Baker, Ida Anger, Lisa Spears, Deborah Hoyles, Lt. Mike McQuaid, Kathryn Haines, Derrolyn Steele, Belinda Farr, Reaver Barlow-Bell
Staff: Julie Sullivan, Helen Washington

Priorities

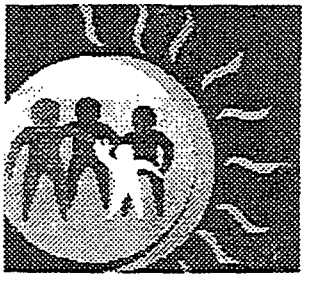
- Safe Start Englewood and Pullman district web sites
  - All projects, organizations, initiatives and agencies (see: www.englewoodfutures.org)
  - Union League Boys & Girls Club can help with computer access
- Training on impact of exposure to violence on young children and what to do about it – for day care, schools, health care, libraries, churches (Sunday School, not services)
- Parent education on available resources, effects of violence, child development at registration for day care, Head Start, kindergarten, library/park programs; prenatal/OB care at hospitals, health clinics
  - Focus on where moms of young children go in the area for baby supplies – WIC, toy stores, Target, McDonald's, White Castle
  - Public awareness messages using Blue's Clues, Rugrats, WGN-Merrie Dee
- Increase police presence around day care and Head Start locations during peak coming and going times
  - Provide map of all such sites to district commanders
- Research feasibility of providing a bus to pick up children for day care/Head Start (perhaps in partnership with Union League Boys & Girls Club)
- Regular meetings (perhaps every other month) of all community organizations
  - Improved linkages, understanding of available community resources
  - Steering committees for district web sites

Discussion Points

- Many parents afraid while coming/going to day care and Head Start; kids and teachers are afraid to go outside because of gang activity and high traffic in general
- Young parents need hands-on parenting education, not just reading from something

Chicago Safe Start
Planning Phase
Policies/Systems Priorities

October 26 and November 7, 2000



Working Together to Help
Children Exposed to Violence

Chair: Leslie Landis, Mayor's Office on Domestic Violence
Attendees: Lt. Candace Angus, Saul Klibanow, Kathryn Haines, Michelle Fugate, Frank McGehee, Alisu Schoua-Glusberg, Jennifer Welch, Sgt. Judy Martin, John Peller, Michael Tischleider
Staff: Lisa January, Julie Sullivan

Priorities

- Target children 0-5 via Juvenile Justice system – when an older child comes in, target the younger siblings for preventive services
- Convene or support existing task force with child welfare advocates, DCFS, domestic violence service providers and the Police Department regarding new protocol for police to list the children present in the home when responding to a domestic call
- Convene or support existing task force to examine current DCFS child care licensing requirements and processes and recommend improvements
  - Training requirements
  - Potential for city to contractually require city-funded child care and Head Start agencies to have Safe Start training on child development, impact of exposure to violence, what to do
- Advocate for DCFS' CERAP protocol to add documentation on number and ages of children in the home
- Advocate for DCFS to provide services for 0-5 year olds who witness violence
  - CERAP completed for each child in the home to determine services needed
  - Be clear that child will not be taken from home for witnessing violence, but referred for services in the community and follow-up
- Convene task force of substance abuse treatment providers to develop curriculum on child development, effects of exposure to violence, what parents can do and where they can go for help
- Work with existing faith community coalitions to gain support for inclusion of Safe Start child development and exposure to violence concepts in church efforts

Chicago Safe Start

COUNCIL MEETING

Discussion of Safe Start Priorities

November 16, 2000

Agenda

- **Welcome** – Claude Robinson, Uhlich Children's Center
- **Overview of Meeting** – Erin Sorenson, Chicago Children's Advocacy Center
- **Planning Process** – Helen Washington, Safe Start
- **Prevention Priorities** – Michael Robbins, Robbins Consulting
- **Intervention Priorities** – Cmdr. Michael Shields, 5th District
- **Policies/Systems Priorities** – Leslie Landis, MODV
- **Public Awareness** – Julie Sullivan, Safe Start
- **Community Outreach Update** – Helen Washington, Safe Start
- **Safe Start web sites** – Kathryn Haines, Safe Start
- **Next Steps** – Julie Sullivan, Safe Start

Planning Process

- Work groups formed at last Council meeting, Oct. 16
- Prevention, Intervention, Policies/Systems, and Public Awareness
- Each group met once or twice (see handout for discussion questions), chaired by a Council member, to identify priorities for Safe Start
- Tonight, each work group chair will present the group's priorities for the full Council to discuss

Prevention Priorities

- Short term
  - Safe Start satellites/liaisons
    - Located in existing agencies or churches in the Englewood and Pullman districts
    - Point people for all resources for 0-5-year-olds
      - Provide linkages and resources to community organizations, churches, schools, police and families
  - Safe Start Englewood and Pullman district web sites
  - Regular meetings (perhaps every other month) of all community organizations
    - Improved linkages, awareness of available resources
    - Steering committee for district web sites

Prevention Priorities

- Short term
  - Training on child development, impact of exposure to violence, what to do
    - Child care – center-based, in-home, licensed and unlicensed; partnership with CDHS; parks, libraries, CPS early childhood, all mandated reporters working with the 0-5 age group
    - Parents – primarily via churches
    - First responders – police, fire, ambulance

Prevention Priorities

- Long term
  - Convene consortium of Chicago universities providing MSW and PhD (psychology) training to build capacity of mental health personnel expert in children exposed to violence
    - Begin with field practica in community organizations
    - Develop specialty certification in children exposed to violence/violence prevention
    - Seek private foundation support, too
    - Partner with the Domestic Violence/Mental Health Policy Initiative and the Ounce of Prevention/Kids PEPP work in this area

Prevention Priorities

- Long term
  - Build network of safe havens for children in the two districts – via the Mayor's child care initiative, existing child care agencies, churches

Intervention Priorities

- Safe Start Englewood and Pullman district web sites
- Training on impact of exposure to violence on children 0-5 and what to do about it – for day care, schools, health care clinics, libraries, churches
- Parent education on available resources, effects of violence, child development
  - Registration for day care, Head Start, kindergarten, library/park programs, prenatal/OB care
  - Focus on where moms of young children go in the area for baby supplies – WIC, toy stores, Target, McDonald's

Intervention Priorities

- Increase police presence around day care and head Start locations during peak coming and going times
- Research feasibility of providing a bus to pick up children for day care/Head Start
- Regular meetings of all community organizations

Policies/Systems Priorities

- Target children 0-5 via the Juvenile Justice system – when an older child comes in, target the younger siblings for services
- Convene or support an existing task force with child welfare advocates, DCFS, domestic violence service providers and the police regarding new protocol for police to list the children present (ages) in the home when responding to a domestic call
- Convene or support an existing task force to examine current DCFS child care licensing requirements and processes and recommend improvements
  - Training requirements
  - Potential for contractual requirement for Safe Start training

Policies/Systems Priorities

- Advocate for DCFS' assessment protocol to add documentation on number and ages of children in the home
- Advocate for DCFS to provide and/or refer services for 0-5 year olds who witness violence
  - Assessment for each child in the home
  - Be clear that child will not be taken from home for witnessing violence, but referred for services in the community and follow-up

Policies/Systems Priorities

- Convene task force of substance abuse treatment providers to develop curriculum on child development, effects of exposure to violence, what parents can do and where they can go for help
- Work with existing faith community coalitions to gain support for inclusion of Safe Start child development and exposure to violence concepts in church efforts

Public Awareness

- 2-3 key messages
- Target audience(s)
- How, where, with whom
- Meet once within the next three weeks

Community Outreach

- Churches
  - Pullman – 5
  - Englewood – 4
- Schools
  - Pullman – Cradles to Classroom, Region 6
  - Englewood – Region 5 (Dec. 2000)
- Community Organizations
  - Pullman – Greater Roseland YMCA, Southside Health Consortium
  - Englewood – BRASS Foundation, Imagine Englewood If

Community Outreach

- Law Enforcement
  - Pullman – District 5, Peer Jury Planning Group
  - Englewood – District 7, Domestic Violence Candlelight Vigil
- Developing Communities Project
  - Local churches and organizations providing leadership training and education to create instruments of change in the far south side community areas

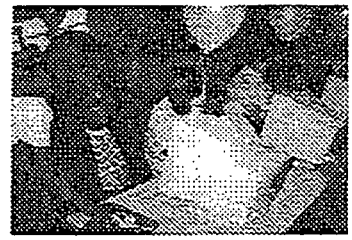
Safe Start Web Sites

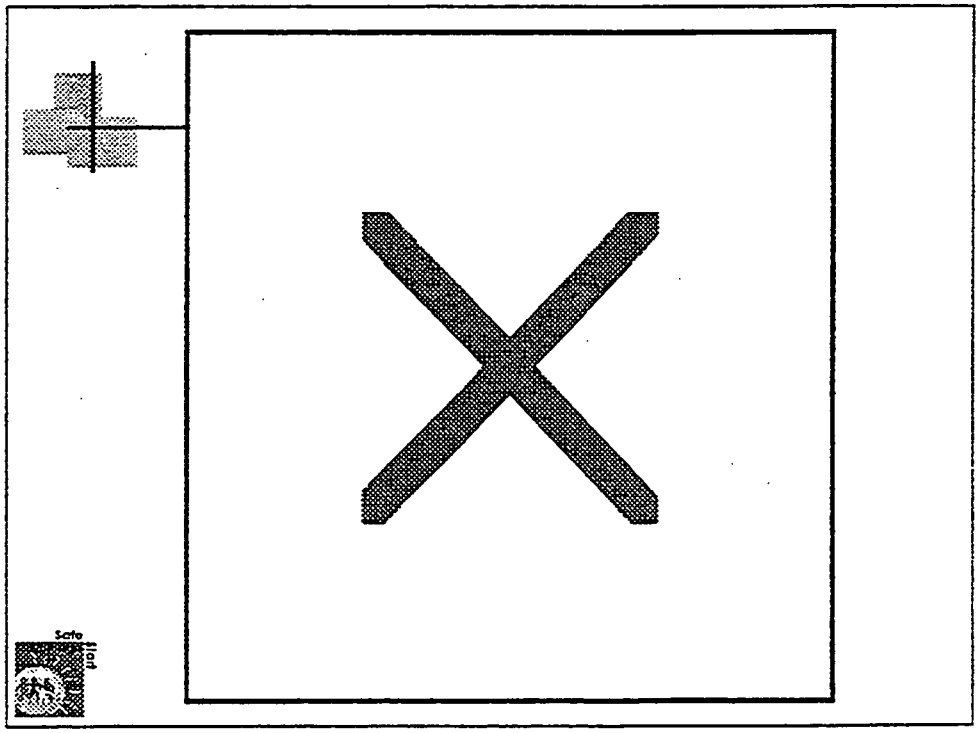
- Why a community web site?
  - Collaboration and coordination are central components of Safe Start
  - Community feedback:
    - "Once we know where all the players are and what they are doing, we can go somewhere."
    - "What we need are connections and collaboration among organizations."
  - A community web site can provide, in one place, a summary of all the services and resources available in the community

Safe Start web sites

Who has internet access in:

- Pullman district
  - Developing Communities Project
  - Pullman Bank Initiatives
  - Generations Community Services
  - Metropolitan Family Services
  - BAGS Foundation
  - Greater Roseland YMCA
  - LAMBB Shelter
  - Southwest Women Working Together
  - Ada S. McKinley, Roseland Head Start
  - Pullman Library
  - Am I My Brother's Keeper
- Englewood district
  - LIFTT – "Learning is Fun Through Technology"
  - Computer labs in the parks: Ogden, Lindblom, Hamilton, Sherwood
  - Boulevard Arts
  - Rebirth of Englewood





Next Steps

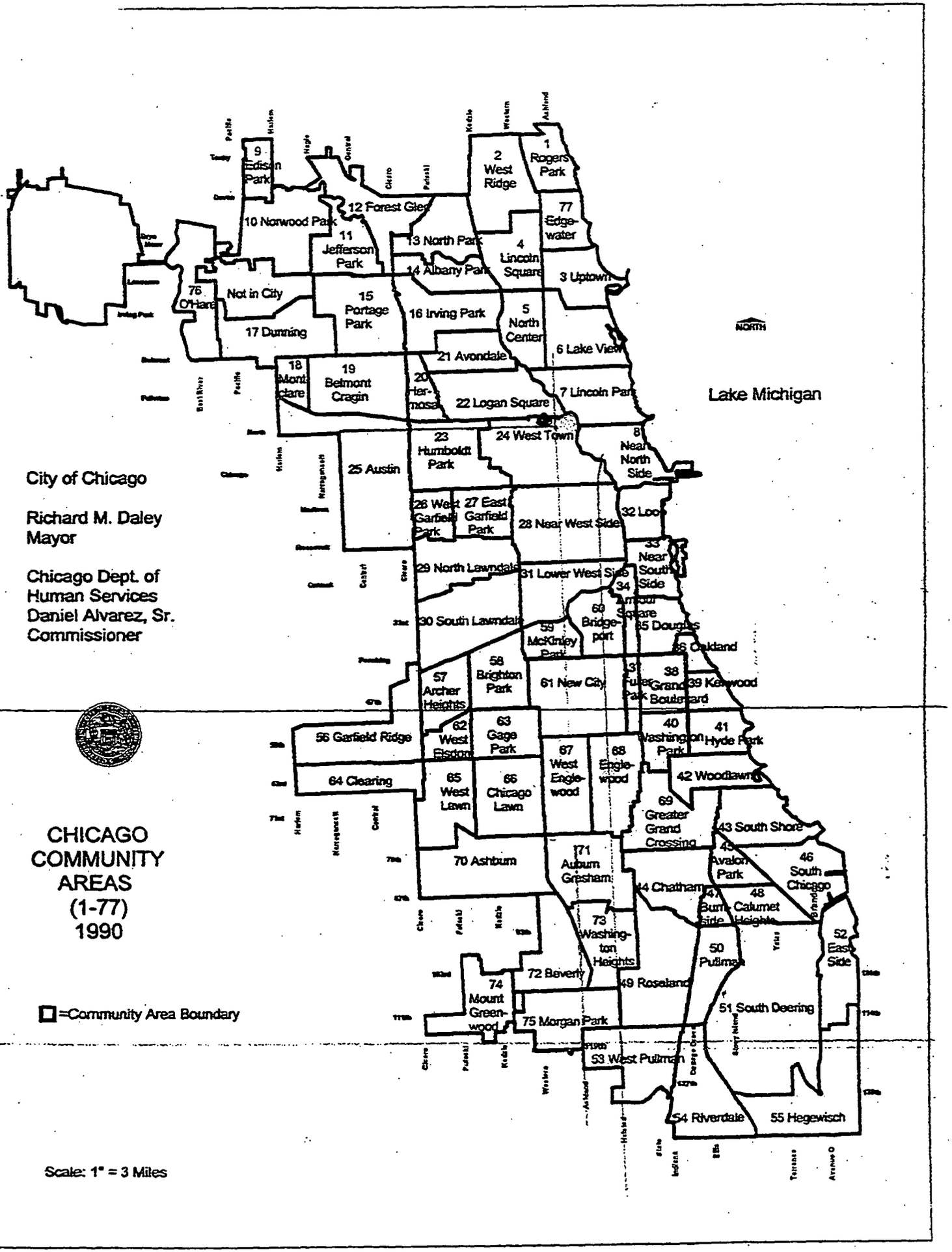
COUNCIL

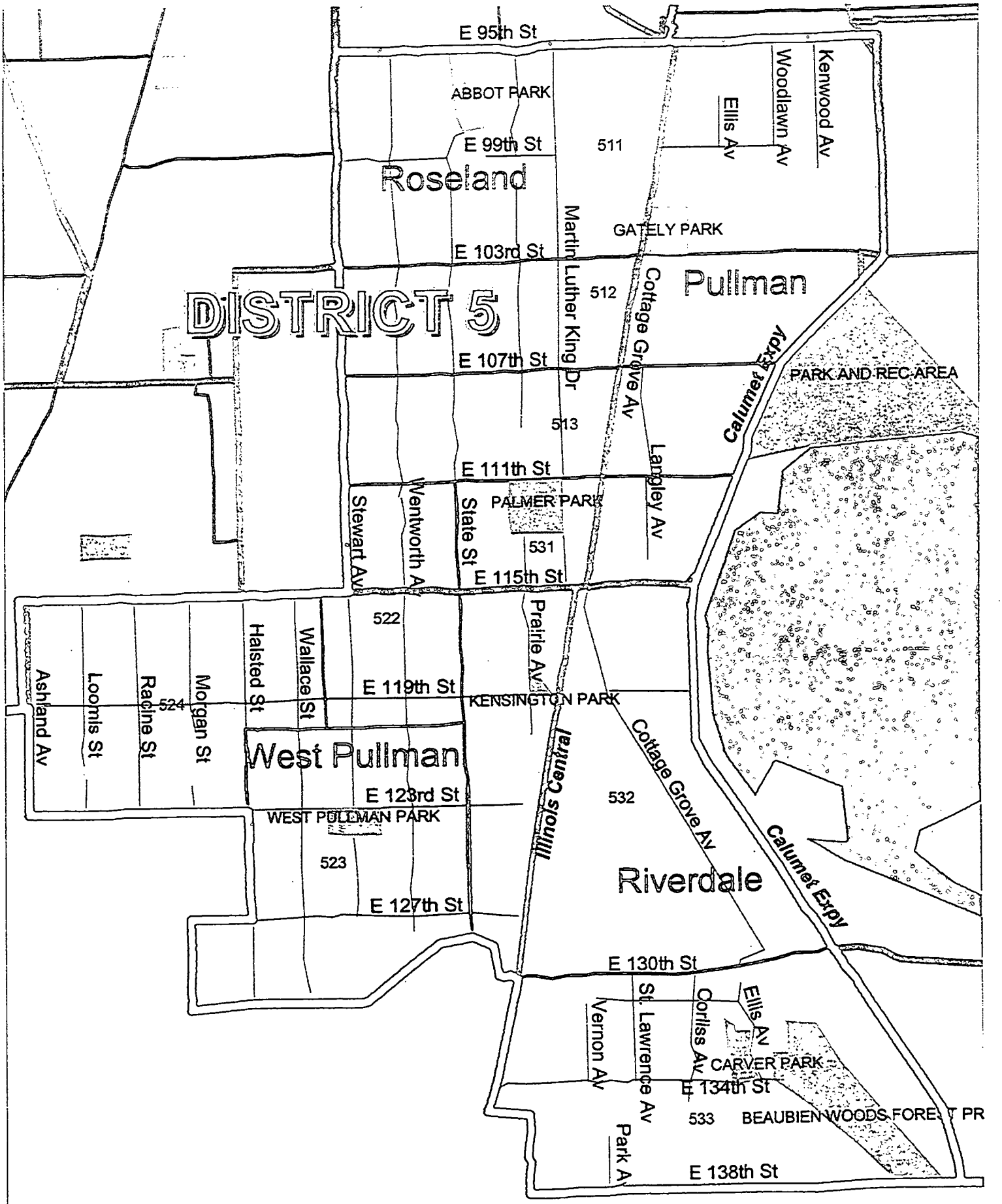
- Best Practices work group
- Public Awareness work group
- Review draft plans, provide feedback

STAFF

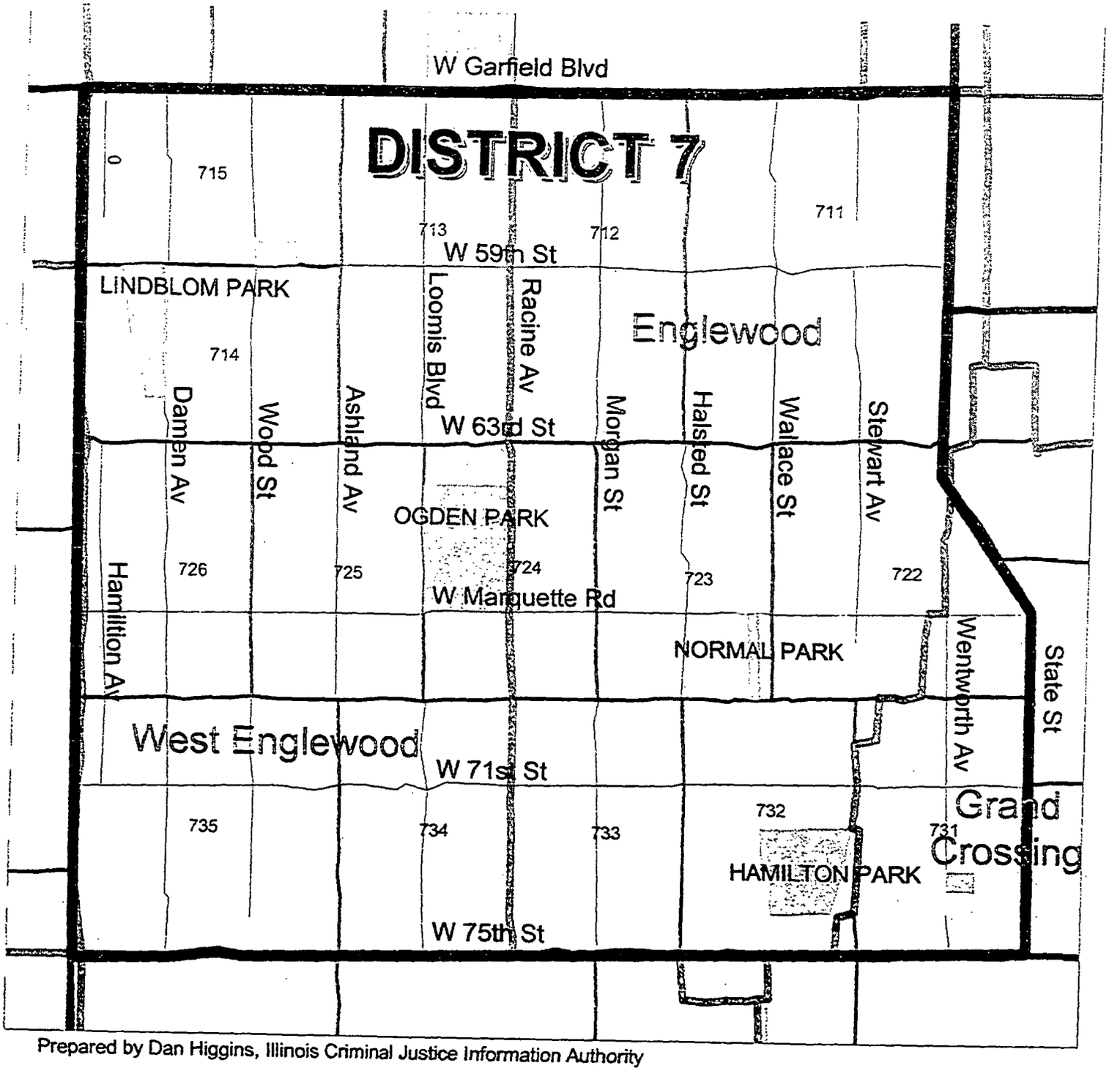
- Finalize system and policy reviews
- Distribute program and curricula matrix to Best Practices work group
- Review qualitative and quantitative data collected
- Draft plans, distribute to Council on or before Jan. 15, 2001
- Finalize plans, submit to Washington, DC on or before Feb. 15, 2001

Appendix G: Target Area Maps; CDHS Maps


City of Chicago
Richard M. Daley
Mayor
Chicago Dept. of
Human Services
Daniel Alvarez, Sr.
Commissioner
CHICAGO
COMMUNITY
AREAS
(1-77)
1990
=Community Area Boundary
Scale: 1" = 3 Miles
NORTH
Lake Michigan
1 Rogers Park
2 West Ridge
3 Uptown
4 Lincoln Square
5 North Center
6 Lake View
7 Lincoln Park
8 Near North Side
9 Edison Park
10 Norwood Park
11 Jefferson Park
12 Forest Glen
13 North Park
14 Albany Park
15 Portage Park
16 Irving Park
17 Dunning
18 Montclare
19 Belmont Cragin
20 Hermosa
21 Avondale
22 Logan Square
23 Humboldt Park
24 West Town
25 Austin
26 West Garfield Park
27 East Garfield Park
28 Near West Side
29 North Lawndale
30 South Lawndale
31 Lower West Side
32 Loop
33 Near South Side
34 Armour Square
35 Douglas
36 Oakland
37 Fuller Park
38 Grand Boulevard
39 Kenwood
40 Washington Park
41 Hyde Park
42 Woodlawn
43 South Shore
44 Chatham
45 Avalon Park
46 South Chicago
47 Burnside
48 Calumet Heights
49 Roseland
50 Pullman
51 South Deering
52 East Side
53 West Pullman
54 Riverdale
55 Hegewisch
56 Garfield Ridge
57 Archer Heights
58 Brighton Park
59 McKinley Park
60 Bridgeport
61 New City
62 West Elsdon
63 Gage Park
64 Clearing
65 West Lawn
66 Chicago Lawn
67 West Englewood
68 Englewood
69 Greater Grand Crossing
70 Ashburn
71 Auburn Gresham
72 Beverly
73 Washington Heights
74 Mount Greenwood
75 Morgan Park
76 O'Hare
77 Edgewater
Not in City

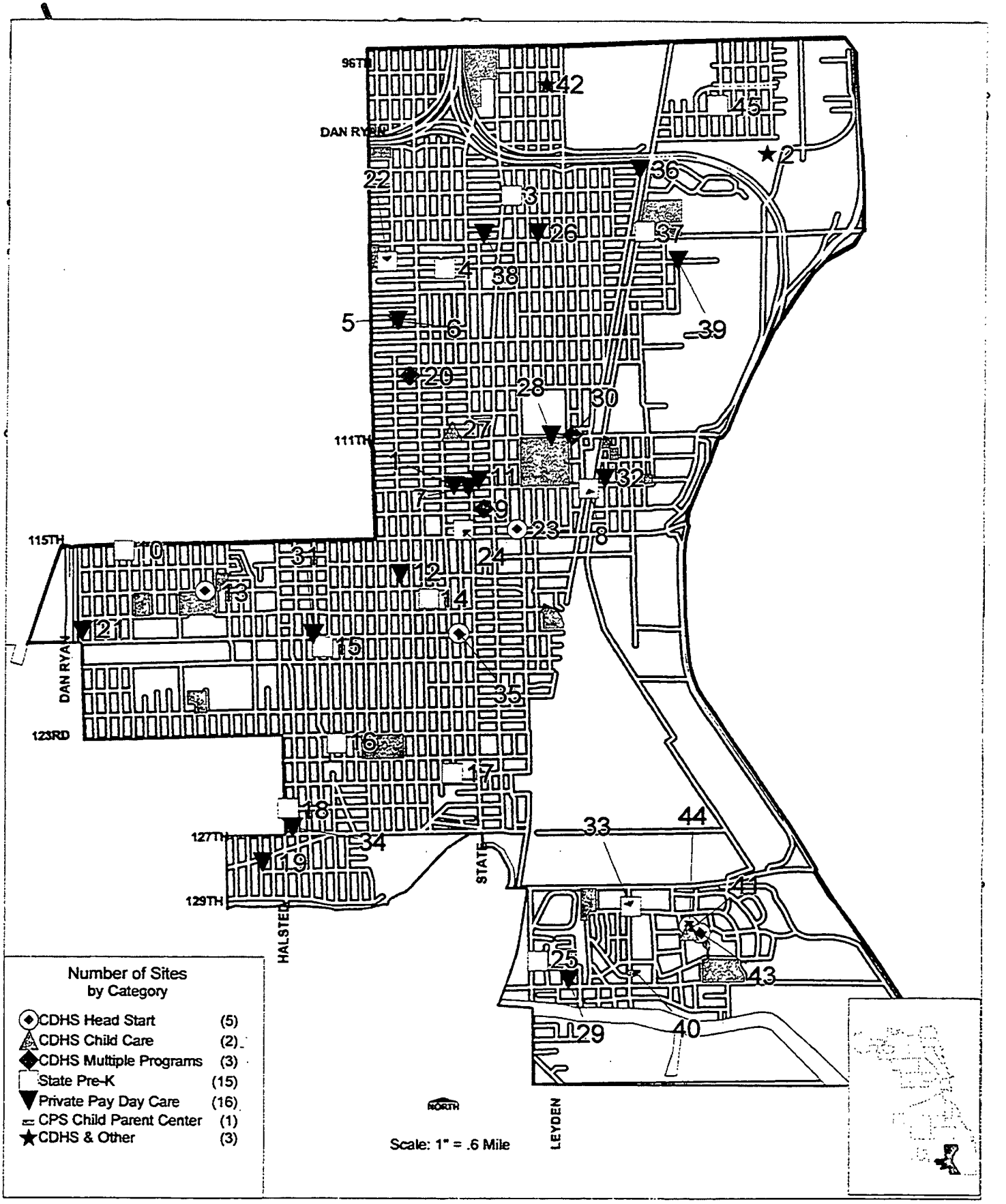


Prepared by Dan Higgins, Illinois Criminal Justice Information Authority



Prepared by Dan Higgins, Illinois Criminal Justice Information Authority

POLICE DISTRICT 01 PULLMAN-CHILD DEVELOPMENT SITES (AGES 0-5) JANUARY 2000

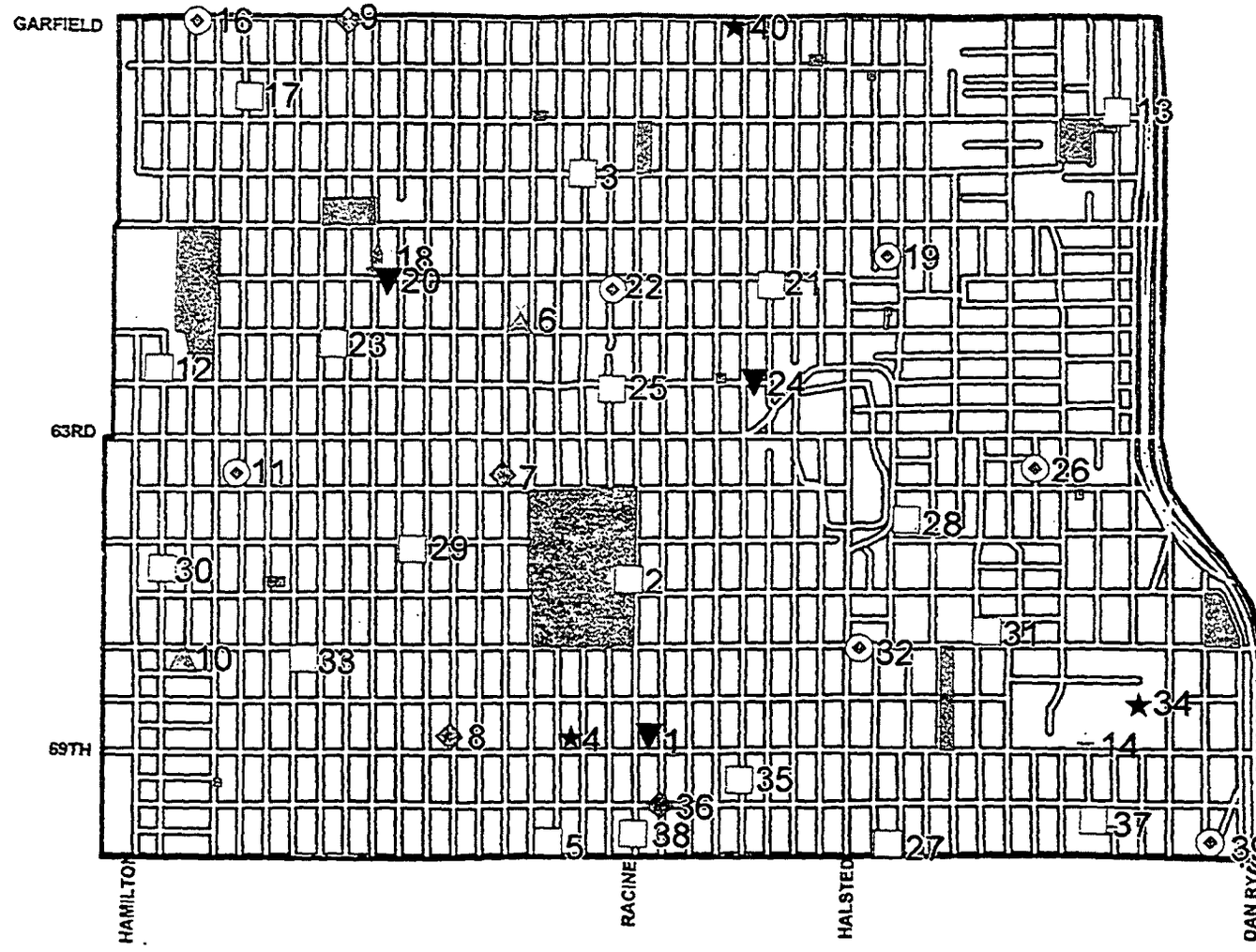


City of Chicago
Richard M. Daley
Mayor

Chicago Dept. of Human Services
Ray Vázquez
Commissioner

f:\users\hs00286\maps\othdept.\pd05ch.wor
8/20/00 R&P CM

POLICE DISTRICT 7 ENGLEWOOD-CHILD DEVELOPMENT SITES (AGES 0-5) JANUARY 2000

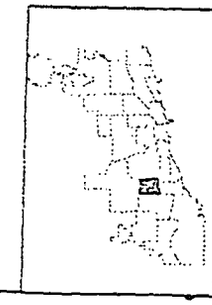


Number of Sites by Category

CDHS Head Start	(7)
CDHS Child Care	(1)
CDHS Collaboration	(1)
CDHS Multiple Programs	(4)
State Pre-K	(18)
Private Pay Day Care	(3)
CPS Child Parent Centers	(1)
Ounce of Prev. Head Start	(1)
CDHS & Other	(4)

NORTH

Scale: 1"=.4 Mile

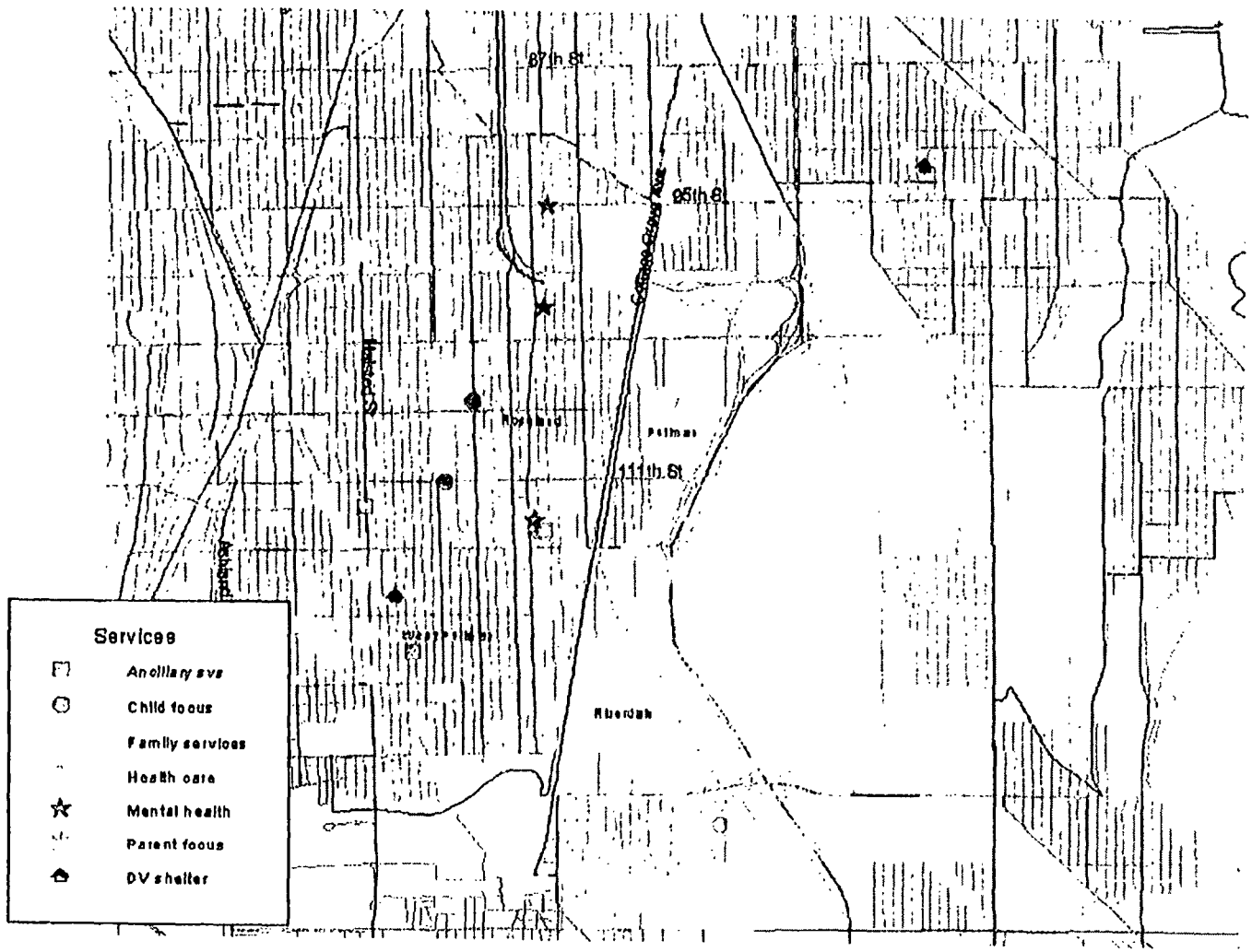


City of Chicago
Richard M. Daley
Mayor

Chicago Dept. of Human Services
Ray Vázquez
Commissioner

f:\users\hs00286\maps\othdept\pd07ch.wor
8/2000 R&P CM

Services available in the Pullman Communities



Services available in the Englewood Communities