Spokane Safe Start Progress Report 1/1/02 – 6/30/02

1. Collaborative Strength

Strengths:

Our positive outlook on this element of Spokane's Initiative has not changed. We seem to continue to experience success within the framework of established and developing relationships as long as we maintain a focus on developing opportunity.

A major development internal to the project was the decision of the Principal Investigator to build a single entity within the university devoted to the creation of capacity to do developmental research in the area of violence exposure. The Child and Family Research Institute (CAFRI) was approved through all channels with exception of the faculty senate which will review the application in September.

The Goals, Objectives and Action Steps outlined in the original Strategic and Implementation Plan were a reflection of shared beliefs about work that needed to be done despite the absence of a dedicated infrastructure to move the work forward. It has been clear that the major bureaucracies, with the possible exception of the local public health agency, had little capacity or interest to move thinking beyond the institutional constraint that exists in categorical systems. The problems associated with the majority of CEV do not meet the categorical requirements of any system and invite the imagination and courage of individuals to develop out-of-the-box approaches to describe and address the needs of these largely unidentified and invisible victims. Further, a major challenge is to avoid the temptation to create a new box or structure that proscribes "an appropriate" response. In effect, the work we proposed and committed to complete 16 months ago was based on a belief that as a collective we could create a multi-faceted experimental response simultaneous to developing an information analysis capacity that would eventually inform and drive policy. Though the creation of CAFRI was not part of stated developmental objectives, its existence has become central to the achievement of collaborative goals and actions.

In addition to the creation of CAFRI, relationships with those who worked on the initial planning of the Initiative continue to grow and change as opportunities are discovered.

A significant outcome of our relationship with Head Start/Early Head Start was the development of a proposal to HHS to create and track developmental outcomes over a four year period. Early responses indicate the proposal was reviewed favorably with a specific decision expected in late August. If funded, a major portion of the proposal includes the establishment of assessment, intake and tracking protocols for CEV and the creation of clinical linkages with the mental health system.

The CAFRI collaboration with the Spokane County Domestic Violence Consortium resulted in the development of a proposal to CDC/OSHA to study, quantify,

and address issues associated with domestic violence that affects the work place. Associated Industries, a 440-member organization representing nearly 15,000 employees, requested assistance in creating capacity to assist employers in responding to DV. Once funded, CAFRI will propose that part of a DV response by employers with employees will include orientation and training related to CEV as it impacts employee work performance and job satisfaction. This work is to be developmental over four years.

Over the last eight months, CAFRI and the Juvenile Court have discussed creating a more unified approach to the comparatively small number of CEV who are referred to it by the child welfare system. Under the leadership of the court Administrator, judges/commissioners, public defenders, GALs, Assistant Attorneys General, child welfare personnel and service providers began meeting regularly in April to discover a mutual vision and agreed methods to increase effectiveness with this population. Safe Start provided and continues to provide technical assistance and training and is participating with this effort. Assuming the effort to create a unified, local policy structure on behalf of dependent children is successful, we will work to create similar impacts for older children who are referred into the system.

The work with the mental health and chemical dependency systems continues. The time associated with achieving action steps is significantly more protracted then anticipated but incremental progress is noted. In fall, we will implement a surveillance strategy for children ages 0-13 who are referred into the system in preparation for the creation of an MIS that will institutional surveillance for CEV. Further, as we develop this report, the local Title XIX authority is in discussion with service providers about dedicating $120K/year to CEV on a pilot basis at least to the end of the Safe Start grant. Decision making related to continuation and expansion of funding will depend the completion of the Safe Start research and the demonstrated efficacy of the approach.

The clinical collaboration with law enforcement continues to function smoothly. More than 80 referrals have been received and activity is being documented in the process evaluation and the case study. The formal research protocol will be implemented in September.

Developmental work with COPS/SCOPES on behalf of our interest in seeing citizens at the neighborhood level assume some responsibility for child safety is continuing. In early fall we will implement formal training with volunteers and staff of COPS/SCOPES stations and will seek to involve representatives from community centers and schools. We intend to seek direct involvement of local citizens and neighborhood-based institutions at the end of the training and to involve them in the creation of action plans for neighborhood development. We have budgeted $25K to create a granting capacity for COPS/SCOPES groups who will make specific commitments to create and implement actions to provide increased safety and responsiveness at the neighborhood level to CEV and their families.

Weaknesses:

We do not see any fundamental weaknesses in our collaborative strategies.

Challenges:

The assortment of challenges we face have not changed. Washington State continues to face major budgetary/revenue woes that will impact the states capacity to provide service during the biennial legislative session in January 2003. At the time of the last report it appeared that the current level deficit would be $1.25B; however as of late January 2002 the deficit grew to $1.6B. Early forecasts for 2003 projected an additional deficit of $.9B but media has reported the projected deficit to be approaching $1.4B. Though economists have continued to report that the state economy has "bottomed out", they also continue to project large mid-term deficits. Any notion of State level participation in funding for Safe Start in the short and mid-term is unrealistic. Our chief concerns relate to the integrity of current level early intervention and prevention money that, predictably, will be at greatest risk for reduction/elimination.

Lessons Learned:

The major learned lesson relates to the timing of implementation of steps in the Initiative. Though we remain confident that the majority of Action Steps are on target, the dates associated with implementation and completions are increasingly difficult to project. "Start dates" seem easier than "completion dates". The fiscal environment in which we are developing the Initiative has been and will continue to be murky. Nevertheless, our experience suggests that opportunity is not always directly shaped by fiscal environments and maintaining a posture of openness allows us to spot unforeseen opportunity. Invariably, this reality dictates that the pace of achievement or progress is uneven and difficult to predict. Added to that reality are the tasks associated with coordination of agenda, schedules and increasingly complex work plans across disparate groups who are working voluntarily with the Initiative. Work rapidly overfills available capacity and progress slows.

Increased Capacity:

The following are areas of increased capacity:

- The Spokane Network has added $220K to the Safe Start agenda as discussed in previous plans and the project is underway and moving forward.

- Additional funding requests have been made that will create additional capacity to implement portions of the Initiative.

- The Title XIX system is making a commitment of $120K/year to support CEV clinical intervention for children ages zero to six.

- Completion of action steps associated with establishment of a practicum unit has added capacity in the Spokane Valley Community Center.

Areas for Capacity Building:

We focused heavily on finding ways to assist and support movement within the Juvenile Court toward a more unified vision and coordinated response to children referred by CPS. During the last six months, the Administrator held a dependency summit that involved public defenders, AAGs, GALs, judges, child welfare staff, and service providers. His purpose was to encourage the entire group to focus on common ground on behalf of dependency/permanence issues and to begin a process where all parties would subscribe to a common set of operational and definitional processes. Following the summit, four groups formed to identify specific steps to be taken and these groups have met several times. Just prior to the summit the Administrator and Safe Start staff had a conference call with NCJFCJ staff in order to discover what levels of assistance they could provide the local effort. After telephone consult and exchange of e-mails, the NCJFCJ is working to identify dates in September to visit Spokane and develop a process that will move the community towards creation of a Model Juvenile Court. Safe Start is involved in all aspects of this discussion.

Levels of Engagement:

All parties to the Safe Start planning continue to be willing participants as necessary. The larger systems such as law enforcement, courts (the Juvenile Court in particular) public mental health/chemical dependency, public health, public universities, community colleges/Head Start, and the K-12 systems in target areas continue to be active or willing to participate when necessary.

Child welfare's involvement reflects an interest on the part of line staff and supervisors to be included in discussion and information sharing in order to stay current on referral procedures and the capacity to do some level of joint case planning. Beyond that, child welfare has all but disappeared as a major influential presence in the community. As discussed in the Strategic Plan, this system not only recommended elimination of all early intervention/prevention resources during the last session of the legislature, but it also eliminated its operational capacity to provide 24-hour emergency response. All intake services are to be centralized in Seattle/King County and a draft implementation protocol assigns emergency response duties to law enforcement. Law enforcement was not involved in discussion of this change and states it will not perform the duties as outlined in the draft protocol. A recent news article mocked this state level decision with the header "Burp 'em Danno". The major problem associated with effective work with child welfare is that decision-making seems to have been centralized in the state capitol and its local administrator rarely attends community meetings despite invitations and encouragement. While relationships with supervisory and some managerial staff continues to be good, it appears many of them are out of communication loops and have difficulty speaking to operational planning. It will be

necessary for us to await implementation of the new centralized intake system in August in order to determine opportunities for further engagement.

II. Overall Project Management

Strengths:

The management structure exists for the purpose of communication and idea generation. Given the complexity of the Initiative there are probably only two or three of us who understand the complete scope of intent, relevance and nuance associated with all planned objectives and actions. The structure is broad enough that ideas which may seem relevant and on target in the clinical world, may seem completely irrelevant to those with a broader community engagement focus and visa versa. The partners are busy and are often working over capacity resulting in occasional tensions resulting in misunderstandings that feels like a disagreement. Sufficient time is required to assure these are vetted and, if nothing else, a consensus achieved that allows for a differences in interpretation that do not interfere with overall forward movement.

The broad nature of the designated management group and the fact that contact is usually maintained outside of a full meeting format has created opportunity for the capture of ideas, typically generated outside of group interactions. Most of these have revolved around the neighborhood engagement goals. As stated elsewhere, the development of a clinical response is possibly the least complex and easiest to maintain achievement. The creation of relationships and the establishment of relevance at the sub-neighborhood level involves an incremental set of tasks that is characterized by a high level of ambiguity requiring significant development time. It is a non-linear process requiring an ability to tolerate ambiguity while maintaining and communicating a clear vision despite the fact that others may be scratching their heads at what may seem to be a lack of focus. For many involved in this Initiative, this represents new challenge and there are no templates. To date, the level of goodwill present within the initiative seems to have helped us bridge communication challenges and the strength of relationship has created an environment where agreement exists to hold misgiving in abeyance.

The major management tool currently used to bind the Initiative is the process evaluation. While data is collected regularly most of it has focused on the creation of the clinical/law enforcement response. The data is fed regularly back into management discussion and shared among clinical and law enforcement partners. It will be more difficult to capture the essence of community development and professional development work and that challenge will be addressed in the next several weeks. Without the Process Evaluation, the development of Safe Start would be a lot like attempting to properly form bones into a skeleton without ever understanding the purpose of a skeleton or having seen a completed model.

Weaknesses:

The strength of the governance structure is also its greatest weakness. A broad group of disparately interested partners agreed to work together on behalf of an unfamiliar agenda that seemed to hold great promise. The shared commitment to build capacity preceded the sharing of a common vision and we continue to build the latter as we create and discover opportunity among those involved in the overall partnership and work to communicate it elsewhere. Movement is uneven, opportunistic and non-linear. Not all partners are equally involved or equally knowledgeable. Further, though we believe all have a commitment to the concept and principles, we will not discover true commitment until the Initiative reaches a point where only a unique contribution by a particular partner will move development to the next stage. In the last six months, the local Title XIX system stepped up to demonstrate its commitment and the Juvenile Court is demonstrating its capacity to provide committed leadership. The major weakness in our Initiative is that involvement is voluntary and it therefore moves in several directions simultaneously. Since we can never accurately predict the next development or opportunity, our success or failure fundamentally depends on the creation and maintenance of a synergy that exists on behalf of children. As such, we believe our weakness is also our strength.

Challenges:

The major challenge at this point is to continue to find the resources needed to engage and provide competent evaluation/research. One of the reasons CAFRI was formed was to create an economy of scale within which resources could be moved to address multiple evaluative/research tasks. The development of grant requests and responses to RFQs, though completed outside the scope of Safe Start funds, is completely central to the creation of a capacity that can be used to support Safe Start's ongoing work. We expect this challenge to be cyclical in nature but the major one that must be addressed consistently in order to achieve goals.

Lessons Learned:

See previous Progress Report.

III. Project Design

Systems Change/Service Integration/New Enhanced, Expanded Programming

Our goals, objectives and actions steps are not divided into the discrete groups identified by the above categories. Rather, they are written and are being implemented in such a way as to compliment and support one another across developmental categories. Attempting to pull out single actions or objectives that relate to specific headings above would weaken the overall integration of Spokane's effort. And, while the same could be said about Goal 1, it is sufficiently distinct to be discussed on its own

merit under "Sustainability", as long as the reader understands that Goal 1 does not stand alone but is dependent on specific achievement across the other three.

Goal 2: Develop strategies that support the identification and engagement of families with services when risks to children do not meet existing thresholds for mandated intervention.

Objective 1: Have systems ask about violence exposure.

Action Step 1: For law enforcement, develop data collection questions and reporting to note presence of children at scenes involving family violence and unintentional injury. Develop training protocols and implement training to assure effective reporting.

At the time of implementation, law enforcement administration and Safe Start believed there was a need to add a field to their report forms to indicate the presence of children at crime scenes. Additionally, early in Phase 1 the Prosecutor's Office indicated that such a field would be useful in felony DV cases to provide this information at a glance and avoid reading through lengthy narratives. From the forms reviewed, we could not determine that this information was gathered. However, as we began to develop the case study and review data provided to us by law enforcement and clinical staff, it was evident that police routinely record this information on primary and secondary forms under the "witness" field.

Within the last month, the Spokane Police Department provided us with a database file that lists all criminal incidents in the city and county for 2000 and 2001. Prior to obtaining this file, we used the police web site to determine the scope and frequency of calls for service by neighborhood; however, the new information is significantly more complete and detailed. As we continue to work toward uniformity of data collection and continue to engage other systems in the collection of similar information, we will employ GIS technology to plot this information in order to more closely examine neighborhood impacts.

Start: July 2001 End: October 2005

Action Step 2: Establish public social service screening questions for current exposure and history of family violence. Institute universal screening as a contract requirement of publicly funded social service provider agencies. Develop training protocols and implement training to assure effective reporting.

Early in Phase 1, an agreement was reached with the county's Title XIX authority to pursue this issue with the county's support. Over the intervening months various individuals within the provider network met and concurred this was an issue worth pursuing and data collection/intake forms of various systems were examined to determine what information was being collected. Meetings occurred as schedules permitted due to the complex nature of service provider relationships and the need for

involvement of the independent quality assurance agency. In May, a general agreement was reached about questions to be asked based on the input of all parties. Estimates from providers about the number of MH and CD clients exposed to violence range from 50% to 75%.

Start: August 2000 End: October 2005

****Action Step 2A:** Implement pilot with MH and CD providers to determine violence exposure at intake.

Providers concur about the importance of determining the extent violence exposure is a pre-existing condition among clients. Most providers concur this information should be collected routinely in order to inform the larger system about the extent of this problem. Because the best information we have to date is based on estimates and the collection of this information would require extensive adjustment to the county's MIS, all those party to the discussion agree it is important to pilot the collection of this information. We have agreed to pilot the collection of this information but to restrict the population to a 0-13 group and to secure a sample of 300 voluntary respondent families. Approval must be granted by the University and state IRBs and it is expected the pilot will begin in the fall and will run for four to five months.

Start: October 2002 End: April 2003

****Action Step 2B**: Incorporate findings from the pilot into the county's MIS and institutionalize screening.

The pilot study will ensure the acquisition of experience in the development of questions, training in-take personnel to ask the questions, and fine-tune the process used to collect the information. The county planned to put its new MIS on line in July 2002 but implementation was delayed due to a variety of issues including changes in the state's process requirements. The July 2003 MIS should provide ample time for pilot testing questions, training personnel, and data analysis. Once the data is analyzed and we make final determination about questions to be asked we will develop appropriate training for involved intake staff throughout the system. We will develop on ongoing capacity to analyze this data as it relates to diagnosis and treatment for clients who penetrate the CD and MH systems.

Start: October 2002 End: October 2005

Action Step 3. Develop and implement family violence screening questions as part of universal screening for all families accessing Head Start services.

Multiple conversations with the Head Start/Early Head Start systems over the preceding eighteen months produced agreement that this assessment information was essential to the tracking of outcomes. A decision was made to delay formal work on this agenda due to changes in leadership of the Head Start program in January 2002 and

the significant need to tie the development of new screening protocols into work related to the development of national outcomes. Head Start and CAFRI have now submitted a request to HHS/Head Start for funds to create developmental measures for enrolled children. Part of that proposal includes the creation of screening and assessment questions that target CEV issues. Once a new HS/EHS director is appointed, discussion about this issue will resume and we expect formal work will begin again. If proposal is funded, formal work will begin in November 2002.

Start: September 2002 End: October 2005

Action Step 4: Explore introduction of domestic violence screening items into current statewide risk assessment screening protocol with the Juvenile Court.

The local Juvenile Court Administrator requested assistance in application of the state Risk Assessment Screening to issues associated with CEV. In examining that protocol with the director of the Guardian Ad Litem program, we concur with him that it is probably not used or applied systematically. The protocol is lengthy and there is only one relevant CEV question. In exploring issues related to screening juvenile offenders, most probation officers view violence exposure as a one of several conditions juvenile offenders experience as children and that by the time they are placed under supervision they experienced chronic exposure. Further, there are virtually no "trauma reduction" services to utilize with any offenders, particularly those with longstanding family violence histories. We have agreed the best way to approach this issue is through discussion about the creation of "model courts". All involved in this discussion agree that if there could be an intervention then it would then make sense to systematically ask the questions and explore responses.

Start: July 2001 End: October 2005

****Action Step 5:** In collaboration with the Juvenile Court Administrator, use Safe Start resources to support the development of a Model Juvenile Court.

During the months of December 2001 and January 2002, multiple discussions took place where concern was expressed about a lack of unity among major players involved in the Juvenile Court dependency process. The administrator felt the lack of a more closely scripted unified approach among the parties was due to an absence of shared vision and leadership. Judges and commissioners were concerned about the length of time involved in finding permanence for children and the tensions that seemed to exist among child welfare, public defenders, GALS, and service providers. In March, a Dependency Summit was called among the leaders and their primary staff. Agreement was reached to seek assistance in developing a vision and action plan toward the creation of a Model Court. The administrator and Safe Start staff consulted with NCJFCJ and accepted their offer of consultation assistance sometime after the Safe Start cross-site meeting. That consultation is being scheduled and we expect a site visit by the end of summer and the creation of an action plan to follow.

Start: January 2002 End: October 2005

Objective 2: Increase professional competence in identification and assessment.

Action Step 1: Establish officer training programs in the Spokane Police Department to address typical and atypical child development.

Beginning in January Safe Start will conduct a two hour child development training to service to all officers within the Spokane Police Department. After the original eight sessions of orientation to Safe Start for LE personnel, the Chief indicated his interest in having his officers receive this training so they are prepared with the best possible information when they respond to scenes in which children may be traumatized. We expect the Sheriff's Department to request similar training. Based on the last round of LE in-service trainings provided by Safe Start, we expect delivery of this training to require about 20 hours per department.

Start: January 2003 End: June 2003

Action Step 2: Develop staff development in-service programs for Head Start staff in identification and assessment of family violence exposure.

This training has been provided on request. Once a Head Start Director is appointed, we expect the delivery of this training to be formalized and regularly scheduled. If the proposal to HHS is funded, this training will be incorporated into the staff development/in-service training program. Further, we plan to incorporate *DC: 0-3* into this training and invite the participation of mental health's clinical consultants to Head Start.

Start: September 2001 End: October 2005

Action Step 3: Partner with the Spokane County Domestic Violence Consortium in the development and delivery of supervisor training to address the impact of family violence on employees in general business and industry settings.

CAFRI has written a proposal to CDC and OSHA to develop interventions in the work place related to family violence. This proposal was written in partnership with the SCDVC and Associated Industries of Spokane. Associated Industries (AI) is a 440 member organization with an employee base of about 15,000. They have requested assistance in developing a safe response to family violence that extends to the workplace and to provide supervisory training in the delivery of such an intervention. A recent survey of 150 of AI's members resulted in a 69% approval of this proposal. Further, 25% of respondents could recall an instance of family violence among employees in the last five years. It is interesting to note that of employers who had encountered a DV incident in the previous 2 years, 82% were interested in participation. If funded, developmental work on this grant will begin immediately.

Start: October 2002 End: October 2007

Objective 3: Increase professional competence in engaging families in a response/service/access.

Action Step 1: Develop and implement annual professional development plans for each of the primary sectors (e.g. mental health, substance abuse, education, health) addressing children exposed to violence. Work in coordination with SCDVC on coordination of planning schedule and partnership.

As we developed this step with community partners, no one anticipated the level of difficulty associated with it. While the SCDVC organizes and provides at least one annual training related to this issue, that training falls short of the creation of specific annual professional development plans for specific sectors. During the last year, we have determined that accomplishment of this step depends on the gathering of data related to the occurrence and prevalence of CEV among sector-specific client groups. To that end, we are developing a pilot study of CD and MH clients and are attempting to develop pilots within the education system. Further, we believe DC 0 – 3 training across sectors will assist in raising awareness levels. In addition, the creation of an integrated data analysis capacity across sectors will work in service of this effort. During the next year, we will continue to work in each of these arenas as stated elsewhere in this plan and as other opportunities arise.

Start: March 2003 End: October 2005

Action Step 2: Develop annual staff development goals with primary sectors and specific agencies to define targeted professional competencies regarding children exposed to violence.

Achievement of this step is partially dependent on the previous step. Higher education is better able to anticipate demand for professional development and provide leadership in that area. Eastern Washington University has asked Safe Start to participate with them in a review of its MSW curriculum and to assist in the development of course offerings that address the issue of CEV. This effort is scheduled to begin in mid summer and extend through winter quarter and Safe Start will participate as requested.

Start: September 2002 End: October 2005

****Action Step 2A:** Create regular cycles of multi-agency/training discussion of CEV, targeted to designated line staff.

The lead agency partnership has convened a clinical study group made up of 13 individual line staff from MH, CD, Safe Start, early childhood, and hospitals. The group meets twice monthly to engage in detailed reviews of active CEV cases to promote learning among the individuals and agencies present. This study group will work

together for nine months and is using the *Shelter from the Storm* curriculum. At that point, group membership will rotate and others will be involved. We anticipate that those who have participated throughout the nine months will be prepared to begin their own study groups among staff within their agencies.

Start: June 2002 End: October 2005

Action Step 3: Provide consultation to systems and agencies on implementation of their staff development plans related to children and families exposed to violence.

Safe Start has had discussion with multiple agencies about the CEV agenda and has spoken at a variety of community meetings related to this issue. Our goal has been to raise awareness, connect groups to community resources, and to work to organize a more comprehensive approach. To date we have worked closely with law enforcement, the entire mental health system, the juvenile justice community, Head Start and some sectors within child welfare. Feedback indicates that all systems are frustrated by the lack of funding to address this issue more comprehensively. It is one thing to have some level of resource to respond to CEV well after a child has entered a defining agency, but quite another to engage funding streams about an interest in early intervention. Clearly, multiple agency leaders and practitioners are increasingly aware of the critical need to respond earlier. As awareness builds, we anticipate that pressure within systems will build to increase capacity.

Start: September 2001 End: October 2005

Objective 4: Increase resources that support professional engagement.

Action Step 1: Decentralize professional services to neighborhood level to reduce service access barriers to families. Develop annual plans that specify objectives for decentralization of services.

Our original plan called for the development of a five teams of two practitioners to participate in the crisis response and engagement/case management activities. Upon review of the budget, we were convinced that it made more sense to hire five very experienced clinical staff and to pay higher salaries to attract them. While we were successful in hiring high quality clinical staff and placing them in neighborhood-based agencies, we limited our capacity to conduct outreach work in neighborhoods and to provide greater case management and direct community engagement on behalf of particular families and children. To that end, we have attempted to create a capacity by using practicum students to bridge this gap and have only been marginally successful. During the next several months, we will review our capacity to provide some of these neighborhood-based connecting/transitional services to families through the Safe Start clinicians.

Although the mental health system decentralized some of its resources to elementary schools, it is not an integrated presence in neighborhoods. Though some

services are provided from satellite offices, it cannot be said that these are truly neighborhood based. While those who participated in Safe Start planning concur decentralization of services is critical to engagement, many agency personnel seem concerned about the safety and liability issues associated with the delivery of services in homes. While the notion of decentralizing access to services is accepted by many as an article of faith from the community development literature, such a move will require a major change in agency strategic thinking and cost accounting. Further, the role of clinical staff in the delivery of services beyond the point of identification and basic engagement will have to become clearer in order to challenge institutional arguments about the provision of clinical services within the framework of an office.
Start: July 2001 End: Ongoing beyond 2005

Action Step 2: Implement Spokane Child Development Community Policing as summarized in the Strategic Plan.

This action step is implemented.

Start: February 2001 End: December 2001

Action Step 3: Establish ongoing structured discussion with primary sectors that develop specific plans for reallocation of staff resources to violence exposure, identification, engagement, and response strategies.

This discussion has been structured and ongoing with the mental health system since July 2001 when it was clear that budget barriers would have to be addressed before discussion could continue. In May 2002, most of the immediate budget questions were answered and a discussion was convened about the commitment of two or three Title XIX funded FTE's to sustain the Safe Start clinical intervention. That decision-making process is currently unfolding. Originally, we had discussed the possibility of making a case to child welfare to pilot the decentralization of CPS staff but postponed that discussion until budget decisions were made. As stated elsewhere in this report, child welfare is in the process of eliminating local after hours CPS response and attempted to eliminate its own contracted early intervention programs that were already decentralized in public health and schools. At this point, we are working to prepare a rationale for why they should continue the decentralization of two FTE's at Casey Family Partners and continue to fund its contracts for decentralized outreach services within schools. While we are cautiously optimistic about a favorable decision for MH funding, we will be engaged in a delaying action with child welfare over the next several months.

Start: July 2001 End: October 2005

Action Step 4: Develop funding applications to expand engagement strategies.

As discussed elsewhere in this plan, multiple applications have been submitted to expand Safe Start engagement strategies.

Start: March 2002 End: October 2005

****Action Step 4A**: Secure local funding for and pilot Title XIX support of CEV services for children ages zero to six in both CD and MH.

We are in the process of discussion related to piloting the use of two or three FTE's funded out of CD and MH to support engagement and linkage strategies for families referred into Safe Start's clinical intervention. Data gained from the research and the process evaluation will justify continuation/expansion of this commitment in order to help sustain the intervention beyond the life of the grant.

Start: August 2002 End: October 2005

****Action Step 4B**: CAFRI will develop a proposal to pilot the use of the *DC: 0-3* system in order to create capacity to serve larger numbers of CEV ages zero to six. Use of the system will assist in the study and determination of prevalence rates and will create capacity within the CD and MH systems to provide appropriate treatment to families.

Start: November 2002 End: October 2005

Action Step 5: Develop political, educational and advocacy functions that address allocation of resources to identification and engagement functions regarding children and families exposed to violence.

We are working to create a capacity to develop and analyze information from multiple systems engaged with CEV issues and are engaged in strategic discussion about state-level funding decisions in preparation for the upcoming legislative session. Spokane's strategies build on one another, are iterative, and are opportunistic. For example, using the SESS data, we have supported CFP's request to the Casey Family Program to continue their funding relationship for the next five years; that decision is pending. Further, our partners have relationships with two senior state senators, one who is the chair of the Senate Budget Committee and the other, the head of the minority party. Both are either sympathetic to issues associated with larger "child welfare" issues or are supportive of the private non-profit agencies that deliver these services. In the last session of the legislature, these two individuals built a fence around the early intervention programs proposed for elimination by the governor.

At the local level, the Juvenile Court Administrator and influential judges are supportive of the development of a model court as a means to bring greater unanimity of vision and leadership among all parties to children who are involved in that system. From a process standpoint, we share a belief that development of capacity within the court where accountability is the fundamental responsibility of the judiciary will create change in the larger system. Opportunities will be present as each step in the process unfolds.

Objective 5: Develop community/neighborhood institutional ability to identify and engage.

Action Step 1: Work with COPS and SCOPE programs to develop volunteer resident-based programs that support crisis response capacity for families exposed to violence.

This step has been difficult to implement and while we believe it to be sound philosophically, it is clear that COPS and SCOPE are not structured to lend its direct support to a CEV agenda except in a very general way. These substations are not staffed after 7 PM and volunteers are not available to officers during high incident periods. In many circumstances, safety of volunteers is a paramount concern. Moreover, as we have discussed this issue with various COP shops, volunteers invariably ask us what we would like them to do. In fact, we do not have an answer because we have not found any model of neighborhood engagement that works when it is proposed or developed by people outside the neighborhood. Rather our approach has been to discuss the issue and prevalence within neighborhoods and to offer our assistance in exploring ideas. The SCDVC has agreed to work with us to do CEV training for board members and volunteers of the COPS and SCOPE shops. This is an activity we will discuss and work to organize over the summer and will commence implementation in the fall. After greater orientation to the issue, we will again offer assistance in exploring individual neighborhood responses.
Start: August 2002 End: July 2003

Action Step 2: Develop and implement community training for volunteers associated with peer-based social service activities that serve families exposed to violence.

Invitations to the trainings discussed above will be made to staff working in community centers, churches, and other potential support systems within neighborhoods.

Action Step 3: Develop and implement training for staff in local early childhood, health, school and community based youth programs to address family violence recognition.

This step builds on the previous two steps and will be implemented in sequence.

Start: July 2003 End: October 2005

Action Step 4: Develop strength based parenting, educational and recreational programs that increases social involvement opportunities for adults and children in families exposed to violence.

The Spokane School District (District 81) has launched an initiative to turn middle schools into centers for family activity and the delivery of family support services. This

initiative is funded under Schools for the 21st Century and is a major supporter to the Safe Start Initiative as the director of that program was a participant in Safe Start planning discussion. He agrees that once established it would be possible to develop a process for identifying and linking families into CEV services while providing local support to those families from within the schools.

Start: October 2002 End: October 2005

Action Step 5: Develop practicum placements for MSW and MA level students in target neighborhoods to assist in outreach and support to families and volunteers.

Practicum students have been hired and placed in the Spokane Valley Community Center. They will create a capacity in that center to respond to requests for emergency services and will work to begin linking the services of three social service organizations and an elementary educational program. The development of relationships among these agencies around CEV is essential to our planning to begin exploration of neighborhood engagement in the fall. We plan to bring on three additional students in September and to have them placed in the northeast catchment area. Our strategy is to set them to work on the creation of relationships among agencies within those neighborhoods and begin to do some survey work targeted toward neighborhood engagement. They will also work to identify opportunities in COPS and SCOPE shops to integrate their neighborhood affiliations into the CEV effort.

Start: May 2002 End: June 2003

Action Step 6: Develop volunteer Safe Houses in neighborhoods to support crisis respite for children when they need to be temporarily removed from homes.

It is evident that this action is impractical. The COPS organization worked with us to explore the development of these but issues around liability, licensing, and logistics prevented clear or rapid movement. Our experience with the clinical intervention to date has not demonstrated a need for this resource. It is possible that Spokane's initiative is underdeveloped and that more focused attention on CEV issues within the neighborhood will cause this step to resurface; however to date no need has been demonstrated.

Start: January 2001 End: July 2002

Action Step 7: Extend use of family stabilization strategies around housing to reduce the impact of family violence crisis on housing and other basic needs.

Relationships have been established with the Inland Renters Association in order to create a point of mediation in the event a renting family is threatened with the loss of housing because of family violence. Relationships have also been established with school homelessness coordinators to assist in providing transitional supports for women and children who flee their residence due to violence.

Spokane's homelessness program is uneven with virtually all housing resources for homeless families available only in the city. Safe Start has been invited to participate in a county sponsored task force whose purpose is to establish resources throughout the county with new resources being made available through a small local tax on filings in the Assessor's Office.

Start: August 2002 End: January 2003

****Action Step 7A**: Develop data for presentation to the County about the need for housing assistance/stabilization for families of CEV in the Valley catchment area.

We will work with the homeless coordinators in each of the school districts to develop information about the numbers of families with school-aged children who become homeless due to family violence. This information will be presented to the county to justify the need for resources in Safe Start's Valley catchment area.

Start: September 2002 End: June 2003

Objective 6: Create Crisis Response capacity.

Action Step 1: Develop a Crisis Response Team model in partnership with law enforcement and child serving agencies in two target neighborhoods.

This step is complete. The capacity was created and the service is operational. Although complex, the development of a response capacity and getting it on line was not an especially difficult task. The development of the model of service delivery and utilizing process and evaluative data to inform the creation of an effective intervention will be an ongoing effort for the life of the grant. Collecting and analyzing data testing the efficacy of the approach will be critical to sustainability.

Start: February 2001 End: December 2005

Action Step 2: Design and implement "hot response" crisis intervention services in partnership with law enforcement.

As stated above, the initial portion of this step is complete. Ongoing development will take place through the life of the initiative.

Start: April 2001 End: October 2005

Action Step 3: Implement consultation and engagement supports with child serving agencies in the target neighborhood when a child is identified as having been a witness to violence.

After seven months of functioning primarily in a crisis response capacity, the Child Outreach Team (COT) is developing plans to advertise its service capacity to the neighborhood institutions inside their catchment areas. The goal is for the team to use its expertise in responding to referrals from agencies other then law enforcement including churches, community centers, and childcare facilities. Though we do not regard confidentiality as a barrier, it will be essential for referring agencies to understand the need to secure permission from families before making referrals.

Start: July 2002 End: October 2005

Objective 7: Develop information systems to regularly map the points of system contact and response to families exposed to violence.

Action Step 1: Develop and implement contact and screening protocols that allow for continuous update of information related to families identified for crisis contact.

In January 2002, a draft of the research protocol was completed and vetted among the clinical partner agencies and members of the Child Outreach Team (COT). Laptop computers were purchased to provide the COT with the ability to record and update contact information as it is received. Templates are being created to record information. Though information is being collected currently for purposes of an ongoing case study, we expect to implement systematic data collection in September.

Start: January 2002 End: October 2005

Action Step 2: Develop information feedback mechanisms that regularly update the program and Safe Start partners about trends in contact with full attention to confidentiality and privacy concerns.

At least three formal meetings occurred to discuss program progress, case activity, and trends. The entire partnership has met weekly to discuss clinical program development. A weekly meeting has been set with the COT and police partners to go over referral and case activity for the week and the COT meets weekly as a group for a clinical case staffing with the clinical director. Underpinning these meetings is process evaluation that provides regular and systematic feedback related to referrals, engagement, demographics, offense histories, and a host of other items relevant to oversight of the clinical portion of the project.

Start: February 2001 End: October 2005

Goal 3: Create Professional development efforts through training and technical assistance that assure broad mastery of basic skills and adoption of best practice related to violence reduction.

Objective 1: Develop higher education curricula using best practices.

Action Step 1: Develop research-based criteria to screen the literature on violence reduction and select articles and reports having scientific merit.

Our literature review is ongoing and a library of resources related to violence reduction strategies is developed. We currently have references pertaining to 24 topic areas including children's mental health, child abuse and neglect, child development, domestic violence, and risk and protective factors to name a few. The SCDVC also has a library of this type, which is used to develop presentations to community groups and policy makers.

Start: February 2001 End: October 2003

Action Step 2: Create an annotated bibliography of the scientific literature related to family violence reduction. Develop capacity for the updating of this bibliographic resource. We currently have over 600 sources cataloged in an Access database categorized by primary and secondary subject matters.

Start: January 2002 End: October 2005

Action Step 3: Develop a master course syllabus for courses(s) on violence reduction practices to be taught at the upper division level and/or graduate levels in applied psychology, nursing, social work and related programs.

We have not yet approached this action. Our first target will be the Eastern Washington University School of Social Work to discuss this need and expect to assist in the reviewing of graduate-level curriculum. Some preliminary discussion was also held with the Intercollegiate Center for Nursing Education.

Start: June 2002 End: October 2005

Action Step 4: Secure adoption of the syllabi by a minimum of two of the local universities.

See previous step.

Start: October 2002 End: 2005

Objective 2: Continuing education, professional development curriculum using best/promising practices.

Action Step 1: Establish best/promising practice criteria as it relates to identification, assessment and intervention approaches in each of the primary sectors serving children exposed to violence.

SAMSHA indicates a "best practice" in the field of children's mental health is the use of the *DC: 0-3*. However, most mental health systems view it with skepticism and

have yet to embrace this as a legitimate tool to assess and diagnose children mental health issues. However, we believe the *DC: 0-3* has significant diagnostic potential and is a legitimate tool to use in creating access for CEV in public systems and will continue to provide training for clinicians. We have presented information about this tool to the leadership in our local system to encourage consideration of its use with very young children and their families. As discussed in Goal 2, we will provide training in this area during the coming year in collaboration with Marycliff Institute.

The research plan and process evaluation may also inform us of other "best practice/promising approach" discoveries.

Start: February 2002 End: October 2005

Action Step 2: Identify and evaluate training curricula and trainers relevant to each identified best/promising practice.

This is an ongoing effort. Our first step in achievement of this action was to collaborate with the SCDVC in bringing Dr. Peter Jaffe to Spokane in March of 2001. The two day training was attended by some 300 individuals, several of which were police officers, sheriff's deputies, and child welfare workers. We are also working to identify a mentor to work with the Safe Start learning community established by CFP that meets bi-weekly. We have a capacity to connect with a mentor through video conferencing and have considered Alicia Lieberman, Jeff Edelson, Joy Osofsky, and others. CFP actually developed this mentoring approach during the last three years through its relationship with Dr. Victor Bernstein. Currently, that group is using the McAllister-Groves, *Shelter from the Storm* curriculum. We intend to collaborate with Marycliff Institute in the delivery of the DC: 0-3 training. Marycliff is working with the University of Delaware and the University of Virginia in development of the *Circle of Security*.

Start: March 2001 End: October 2003

Action Step 3: Develop a master training plan for each sector based on a planning process with each sector that identifies competencies and promising practices to pursue for training.

Our intent is to work with the Education and Training Committee of the SCDVC to achieve this step. We are already working with them to develop a CEV training to use with COP and SCOPE personnel. Both police departments are in support of this effort. The Police Department has requested child development training for all officers and that will be provided in January 2003. The mental health system is interested in working with us to assist in the delivery of the DC: 0-3 training to all child-serving clinical staff. As stated elsewhere, we are also working with Head Start to create and track developmental outcomes, which fundamentally are dependent on accurate, early assessment of CEV. Further, if EWU is successful in getting the contract to provide all

child welfare training for personnel in Eastern Washington, Safe Start will be an active participant in development of that training.

Start: May 2002 End: October 2005

Action Step 4: Develop and implement annual training plans for each sector that are integrated with the annual TTA Safe Start Plan.

This item will be address comprehensively in the coming year with the involvement of the parties mentioned above in step 3.

Start: September 2002 End: October 2005

Objective 3: Increase civil/family advocacy services.

Action Step 1: Establish consensus about best/promising practice standards as related to civil/family advocacy services.

There is little research literature regarding either family or child advocacy models. Although there are anecdotal standards for Child Advocacy Centers and other entities that do what is generally referred to as "advocacy", in the field of family violence it seems that "advocacy" is driven more by ideology than science. As such, there are a variety of advocacy approaches with victims and with witnesses, all of which have some basis in logic but none of which seem particularly well informed by good evaluation/research. To the extent there is a universal consideration in this area it is to ensure safety. We have more to learn in this arena and are not prepared to propose alternatives to existing models. We plan to continue working with the SCDVC on this step.

Start: May 2001 End: October 2005

Action Step 2: Identify and evaluate training curricula and trainers relevant to best/promising advocacy service practices.

See step 1 above.

Action Step 3: Include advocacy services in master training plan that identifies competencies and promising practices to pursue in training.

See above.

Action Step 4: Include advocacy in annual training plans for each sector that are integrated with the annual TTA Plan.

See above.

Objective 4: Increase capacity of early childhood education programs and staff to provide services to children exposed to violence.

Action Step 1: Work with early childhood representative groups to determine competencies and training objectives related to CEV.

CAFRI/Safe Start has just completed a comprehensive review of needs associated with Head Start/Early Head Start. Among these are training needs related to intake/assessment and CEV. A substantial proposal has been submitted to HHS that will fund the creation of child development outcomes research, some of which factors identification, assessment, and intervention for CEV directly into Head Start/Early Head Start programming. If funded, the work completed with HS/EHS will be shared with the broader childcare community, including the development of training to assist in broad application.

Start: January 2002 End: October 2005

Action Step 2: Work with Spokane County Domestic Violence Consortium on increasing access to and participation in STAR continuing education program for children providers. The STAR curriculum has a DV identification and response component.

The Washington Association for the Education of Young Children currently integrates the STAR curriculum into the standards it sets for certification of childcare centers. It is currently regarded as an industry standard in Washington State.
Start: August 2001 End: May 2002

Action Step 3: Determine annual training objectives that develop and deliver additional training opportunities for childcare providers to address competencies in the training plan.

We will use our relationship with HS/EHS and the developmental work discussed in step 1 as a guide for this activity.

Start: October 2002 End: October 2005

Objective 5: Influence local and state policies to increase support for family services (such as advocacy, respite care, and housing stabilization services.)

Action Step 1: Work with public elected and appointed officials to increase the support for family support programs.

Based on work between Safe Start and the Spokane Community Network, the state is considering a proposal to the legislature that will eliminate the categorical barriers with the Family Preservation Program. Local evaluation data is due to the state in June 2003.

The local public mental health authority has agreed to support a training initiative related to use of the *DC: 0-3* as an assessment tool for young children who are in need of mental health services. Agreement has also been reached to consider funding FTEs to support Safe Start's clinical work with CEV. We expect an outcome of this discussion in September 2002. Regardless of the immediate outcome, we will continue to work to convince that system about the efficacy of providing services to very young children. These FTEs will engage in direct family support work with the Safe Start population.

Safe Start has been invited to participate in formal discussion about the utilization of various housing stabilization strategies targeted to families with children who are homeless because of family violence. These discussions will begin in September 2002 with action planned for July 2003.

Safe Start is also actively working with the Breakthrough Coalition and the statewide Children's Alliance to ensure preservation of the meager fund of early intervention services that exist in Spokane. The 2003 biennial session of the state Legislature promises to be difficult and we are testing several rationale to use in launching argument to protect current resources that are actively used for CEV. We anticipate these services will be as high on the Governor's list of proposed reductions as they were during the last session.

Start: March 2002 End: 2005

Action Step 2: Work with child serving leadership to identify most useful/powerful research based arguments to influence policies in support of family support services.

Activity on behalf of this step has been ongoing. The child-serving leadership, including the Children's Alliance and Breakthrough has recognized that research-based arguments are often ineffective when used in support of program development goals unless they are accompanied by powerful anecdotes about the plight of individual children and families. Though Spokane has been reasonably successful in protecting most of the funding base for early intervention/family support services, the current crisis in state revenues equals that of the early 1980s. Significant work will be done in this area between now and May 2003 when the Legislature sends its next budget to the Governor. Our case study information will prove useful in this effort.

Start: May 2002 End: October 2005

Action Step 3: Using data developed as a result of Safe Start, encourage the City and County to increase its support of violence reduction advocacy services.

In October 2002, Safe Start in collaboration with the county's mental health authority and its subcontractors, will pilot a screening protocol study related to the incidence of violence exposure for children ages 0-13 years entering the MH system. Current estimates are that 50% to 75% of children entering the system were exposed to

chronic violence as infants and toddlers. Assuming results are as significant as we anticipate, this screening protocol will become a required data element in the county's MIS system to be implemented in July 2003. As this information is collected regularly, we will launch arguments and develop a rationale for increased Title XIX funding for young children and a change in eligibility screening.

CAFRI/Safe Start and the SCDVC are working with the Superior, District and Municipal courts to determine prosecutorial and sentencing outcomes for 1000 DV offenders. To date, we have completed 240 comprehensive file reviews and have coded and recorded the data in a database. We anticipate completion of file reviews in January 2003. This work is being overseen, rather assiduously, by prosecutors, public defenders, judges, police and others who work in the justice system. We have agreed that no data will be published unless all involved understand and concur with the questions that remain to be asked and the meaning of the data that has been collected. We fully expect that the Justice system will make specific changes in DV policy because of this new information.

Start: September 2002 End: October 2005

Action Step 4: Work with policy experts to identify most efficacious political strategies in shaping public policies.

The Washington State Children's Alliance has figured prominently in this effort and its leadership, a Spokane native, meets regularly with the Breakthrough Steering Committee to craft agendas and strategies. Our partners are also in regular contact with two senior state Senators from Spokane who have prominent state level leadership positions.

Start: May 2002 End: October 2005

****Action Step 4A**: To serve as the foundation for the CEV/family support agenda, The Breakthrough Steering Committee will use data/information to demonstrate to elected officials the efficacy of existing child welfare funded, early intervention programs.

This group has doubled its meeting schedule in order to develop better understanding of the various systems represented on the committee and to develop simple charts that demonstrate the connectivity and interdependence of early intervention services funded by multiple systems. The majority of these services are unique in the state and reflect more than 10 years of effort at the local level to bridge categorical funding streams. These services are also significantly less costly than those services provided by the state system. The Breakthrough Coalition is in the process of collecting the data and information to demonstrate the need for the preservation of these services and developing the rationale for using them as the foundation for creation of a system of care for CEV and their families.

Start: May 2002 End: October 2005

****Action Step 5**: Under the leadership of the Juvenile Court Administrator, provide support for the development of a Model Juvenile Court.

For some time the Juvenile Court Administrator has been frustrated at the lack of unity among parties to the dependency process, particularly as it relates to CEV children from the most seriously impaired families known to the system. Conflicts among public defenders, GALs, child welfare workers, and service providers prompted the convening of a Dependency Summit. From that summit, a consensus was reached about movement toward the creation of a Model Juvenile Court. Several consultations with Safe Start staff resulted in a telephone conference with the NCJFCJ and agreement from them to provide a consultation team to Spokane to assist in expediting the process. Those negotiations are underway and it is expected such a consultation will occur in late summer. Safe Start has agreed to provide other TTA as it may relate to judicial education and participation in seminars with the NCJFCJ. Safe Start personnel are invited to participate in the discussion of the next several steps of activity that will unfold under the auspices of the administrator and Juvenile Court judges.

Start: December 2001 End: October 2005

Goal 4: Develop integrated services for high risk families.

Objective 1: Create the CDCP/Crisis response.

Action Step 1: Develop a crisis response team model in partnership with law enforcement and child serving agencies in two target neighborhoods. Establish clear roles and responsibilities for the partnership.

The initial phase of this step was implemented in December 2001 with the first referral to the Safe Start clinical intervention. The management structure for the clinical intervention and the case study are used regularly to inform next steps in planning. While the clinical intervention is operational, the “model” is under construction and will be for the life of the Initiative. Roles and responsibilities are clear between clinical staff and law enforcement. Currently, the role of clinical staff in the area of community engagement continues to develop.

Start: December 2001 End: October 2005

Action Step 2: Complete Yale/New Haven program replication training with key staff from participating community sectors.

This step was completed in April 2001.

Action Step 3: Develop and Implement local training procedures for joint crisis response.

This step was completed in February 2002.

Action Step 4: Develop progressive protocol for use CDCP-crisis intervention in the two target communities.

Protocols have been developed with police about when to call clinical staff and how those staff will interact on the scene. Each of those incidents have been discussed at length among the management group and a case study of the first 33 referrals has been developed which assists refining interaction. Next steps include implementation of the research protocol. Each of these activities are progressive and will continue to inform initiative development.

Start: November 2001 End: October 2005

Action Step 5: Implement "hot response" crisis intervention in partnership with law enforcement, according to phased protocol.

This step is complete.

Action Step 6: Establish weekly management and problem solving for oversight of CDCP.

This has been established on three levels. WSU and the clinical partners have met weekly since September 2001 to discuss issues and plan next steps. Those meetings continue but have moved to a bi-weekly schedule over the summer months. The Child Outreach Team, police and sheriff administrative personnel, and WSU project staff met on a weekly basis to review cases, examine process and discuss overall project status. The Child Outreach Team meets weekly with the Clinical Director to do an intensive review of cases.

Start Date: October 2001 End: October 2005

Action Step 7: Implement consultation and engagement supports with child serving agencies in the target neighborhood when a child is identified as having been a witness to violence.

Now that the "hot response" clinical intervention is underway and referrals are moving through the identified process, the Child Outreach Team and the Clinical Director are working to discover how best to make connections within neighborhoods that will support families or identify other non-crisis family situations where voluntary intervention may be helpful.

Start: July 2002 End: October 2003

Actions Step 8: Establish protocols for cooperation with mandated child protection and judicial interventions when families accept CDCP services.

Multiple discussions have taken place with CPS and referrals are now moving in both directions. On two occasions, Safe Start has been the recipient of referrals when CPS staff were obligated to close their case despite the existence of persistent concern. Safe Start has received multiple referrals from public health nurses and school intervention specialists who are under contract with CPS to perform intervention services with low to moderate risk families. Within the next two weeks, Safe Staff and the CFP clinical director will meet again with CPS supervisors to continue developing a relationship and establishing boundaries.
Start: June 2001 End: October 2005

****Action Step 8A:** Design protocols for interaction with CPS as soon as possible after specific decision are made related to the centralization of Intake functions on the west side of the state.

As this plan is being written CPS is identifying how it will function and interact with local communities after its after local hours response system is eliminated and all Intake functions are centralized in Olympia, the state capital, 300 miles from Spokane. Many community agencies, including law enforcement, are awaiting information to explain this change given that implementation is slated for August 2002.

Start: July 2002 End: January 2003

Action Step 9: Design and implement data collection system for tracking contacts with respect to event characteristics, critical incidents, family characteristics and outcomes.

The final implementation of the Safe Start research will occur in September 2002. This work has been in process for nearly a year and some portions of it are underway. The data collection work discussed in this action is imbedded in the Safe Start research protocol.

Start: November 2001 End: October 2005

Objective 2: Develop and implement neighborhood services that extend the CDCP crisis intervention.

Action Step 1: Design and implement coordination of crisis response team with neighborhood volunteer activities that support the crisis resolution.

As discussed elsewhere, the COT is exploring relationship development at the neighborhood level. We are working in the Valley catchment area to create relationship and connect entities that can directly engender the development of social capital.

Additionally, the SCDVC will work with us to do volunteer training around CEV, starting with COPS/SCOPES entities and broadening into other neighborhood organizations.

Start: August 2001 End: October 2005

****Action Step 1A**: Utilize survey methods to test neighborhood awareness and interest in mobilization related to CEV.

Practicum students will be utilized in the fall to canvas specific high incident neighborhoods to conduct surveys of residents regarding domestic violence, CEV, and potential CEV prevention/early intervention strategies to occur at the neighborhood level. This technique will be utilized in both target neighborhoods.
Start: August 2002 End: April 2003

Action Step 2: Design and implement in cooperation with COPS/SCOPE, a voluntary Safe House system for children

As discussed elsewhere, this is an extraordinarily difficult step to achieve. Further, the need for a Safe House program for this population has not been supported by any of the referrals we have received to date. No further action will occur on this step until we are farther into implementation and have a more complete understanding of the needs of our target population.

Action Step 3: Create neighborhood social support services in partnership with community institutions such as parenting classes, social support groups, housing stabilization programs.

Within the next month, practicum students will begin work on this step in the Valley service area. Agencies that will be involved in this portion of the project will be the Spokane Valley Community Center, the Children's Home Society, Casey Family Partners and the West Valley School District. Some discussion has also included involvement of SCOPE shops but the role of the volunteer staffed police substations is not yet clear. We plan to examine school district information related to Millwood's high-risk population of children ages 0-5, assist in development of connections to the Spokane Valley Community Center and begin doing door-to-door survey work in this catchment area. Sometime in the fall, we plan to extend these strategies into the northeast catchment.

It has been interesting to note that multiple contacts with churches in this regard have not proven fruitful. Caucasian pastors have indicated that their ministries no longer have a neighborhood focus and that outside of the confessional, they hear and see virtually nothing related to CEV or family violence. Fewer young families attend church than ever before and in the two Safe Start catchment areas, the population of young families is highly transient. In contrast, African American pastors have reported conflicting information in this regard. We are surprised at those responses and will investigate this issue further in the coming year.

Start: January 2002 End: October 2005

Objective 3: Create assessment protocols to assess services for high risk families identified through CDCP.

Action Step 1: Develop and implement a standard assessment protocol for determining service needs in families volunteering for continued services.

This step is being implemented in context with the research protocol that will go into effect in September 2002. We are also engaged in an ongoing case study that includes data from cases referred since December 2001.

Start: November 2001 End: October 2005

Action Step 2: Develop and implement protocols for using Domestic Violence Advocacy support services for families as required.

Currently, the COT utilizes DV advocacy services available through Casey Family Partners and the YWCA; and although Spokane Safe Start initially set aside $23K in the original budget to purchase these services, we have found it unnecessary to expend the funding to purchase duplicative services. Nevertheless, during the last month referrals to Safe Start have increased exponentially and we will re-consider the issue if Safe Start referrals overwhelm the capacity to provide services of either agency.

Start: May 2001 End: October 2005

Action Step 3: Develop and implement data tracking protocols for sub-groups of children exposed to violence (i.e. domestic violence child witnessing, child neglect, unintended accident exposure).

Achievement of this step is embedded in the ongoing case study and the research protocol that will be implemented in September. To date we have seen multiple categories of trauma exposure and are tracking each.
Start: November 2001 End: October 2005

Action Step 4: Develop referral capacity and referral mechanisms for DV perpetrator treatment with voluntary family members.

During the early implementation of the crisis response model, an agreement existed between the lead service entity and a very reputable certified perpetrator treatment organization to provide assessments and treatment. However, the agency no longer employs the counselors that provided the treatment. Consequently only two referrals to the service were made.

Of greater concern is the overall capacity and ability of perpetrator treatment in the Spokane Region, as we believe larger questions exist about the integrity of services

in the area of perpetrator treatment. We believe the work CAFRI is doing with the SCDVC and the judiciary will assist in clarifying those issues and inform development work.

Start: February 2002 End: October 2005

Action Step 5: Develop and implement tracking protocols to describe assessment needs and outcomes for perpetrators in participating families.

Protocols to collect this information exist in the research design that will be implemented in September 2002.

Start: December 2001 End: October 2005

Objective 4: Expand involvement in integrated services for high-risk families.

Action Step 1: Create service linkages for families based on family need.

These linkages have been created and are operational. Our primary principle has been to engage families based on their statement and assessment of need, not based on what services are typically provided within formal systems. Most often, housing and food represent the most pressing stabilization concerns. In other portions of this report, we have discussed involvement in the development of housing resources and the creation of more accessible mental health and chemical dependency services. Our case study and process evaluation describe activity in this area to date. Successful linkages will help inform development of this step in the coming year.

Start: May 2001 End: October 2005

Action Step 2: Pilot development of a Safe Start integrated services model based on ITC service principles.

We began activity in this area in December 2001 with our first referral. The process evaluation will present data on the topic that will advise next steps as we continue to develop the model. This will continue to be a central feature of our work through the initiative.

Start: May 2001 End: October 2005

Action Step 3: Using existing integrated service programs for complex families, develop selection and referral protocols for families engaged in Safe Start/CDCP.

Two Safe Start/CDCP families have been referred into ITC services. In the month of August 2002, we will formally present to partners the second level of information available from the 33 family case study. We think that selection and referral protocols will change as volume increases, capacities change, and that utilization of

case study data will allow us to create broad guidelines for greater and more appropriate use of ITC services.

Start: May 2001 End: October 2005

Action Step 4: Development of coordinated outcomes and process evaluation efforts to examine value of ITC based services for complex families with children exposed to violence.

The implementation of the Safe Start research protocol will occur in September 2002. The process evaluation and case study are already in process. Moreover, the SESS data collection is nearly complete and will used in service of this action.
Start: May 2001 End: October 2005

IV. Ongoing Assessment and Updating the Strategic Plan

The Strategic Plan is updated and was forwarded to you.

V. Sustainability

This Section outlines activity, outcomes and accomplishments related to each goal, objective and action step. New Action Steps are designated with asterisks (**).

Goal 1: Create the long-term development of resources that supplement and eventually supplant Safe Start funds.

Objective 1: Creation of a Children's Trust

During initial meetings with the Executive Director of Foundation Northwest, we felt we had an agreement in principle to start a fund with a contribution of $20K. After the fourth meeting, he stopped returning phone calls. After consultation with our partners in United Way, we determined Foundation Northwest was only interested in partnering with Safe Start to improve the performance of private non-profit organizations but was not interested in developing a trust that could be used to fund development of best practice initiatives. Recently, as the economic situation has worsened, we are informed Foundation Northwest has become more conservative in developing partnerships with anyone at the local level. Although there were numerous attempts, action steps 1 through 5 were not implemented.

Start: May 2001 End: October 2001

Objective 2: Use of Federal Entitlement Funds

Action Step 1: Explore Utilization of Title XIX funds

There has been a lack of statewide equity in Title XIX for mental health services for very young children. We have determined that regulations structures permit use of these resources to support the treatment of CEV related problems but that new diagnostic tools must be employed to increase child and family access to these services. Changes in the funding formula are being implemented and we have an agreement to explore utilization of the *Diagnostic Classification: 0-3 (DC: 0-3)* as a tool to increase service access.

Start: August 2001 End: October 2005

****Action Step 1A**: Secure funding from the Regional Support Network to bring MH resources into the service of CEV.

We have sought commitment to use MH money to fund two FTEs to support clinical CEV work integrated to the Casey Family Partners program. If successful, we will use the Safe Start research protocol to track effectiveness and provide an analysis of outcomes.

Start: August 2002 End: October 2005

****Action Step 1B**: Create discussion with the lead service agency about development of its capacity through Title XIX mental health certification.

We will begin discussion with the lead service agency about attaining Title XIX certification to provide chemical dependency and mental health services. Though an agreement has been reached between Empire Health Services (the lead service agency's parent organization) and the Spokane Regional Health District related to chemical dependency services, it has not yet been implemented. In order to raise the level of discussion, awareness, and capacity across the mental health system related to the treatment of very young children who are CEV victims and their families, we believe exploration of Title XIX mental health certification is also an important consideration.

Start: July 2002 End: October 2005

****Action Step 1C**: Develop the use of DC 0 – 3 as a pathway to increase identification and treatment of CEV within mental health.

There is considerable interest among local MH directors for staff training in the area of *DC: 0-3*. In February, a request was made to CAFRI-Safe Start to provide such training to clinical staff in all child serving mental health agencies. In concert with Marycliff Institute, we will work to provide the training and assist providers in understanding how this classification system might be used to increase Title XIX service access for CEV and their families.

Start: 10/02 End: 10/05

Action Step 2: Identify how Head Start/Early Head Start/ECEAP and Title XX block grant funds are used locally.

We have determined that Title XX Block Grant funds are mixed and matched at the state level and are not used as a significant source of funds for these childcare programs.

Start: August 2001 End: December 2001

Action Step 3: Develop partnerships with the schools to explore utilization of the 21st Century funds to support Safe Start.

Multiple exploratory conversations have taken place across five school districts related to Safe Start and the challenge of funding intervention services for pre-school children. Exploratory discussion has also occurred with two Title XIX mental health organizations related to their partnerships with two of these districts. The Spokane Community Network committed $225K to services for the 6-12 year-old population. As such, Safe Start's partnership with Spokane Community Network resulted in a collaboration between Safe Start, Children's Home Society (CHS), the Spokane Valley Community Center (SVCC), and Lutheran Community Services. CHS has a contract relationship, supported in part by 21st Century School funds, with the West Valley School District (WVSD), and the Spokane School District to provide early intervention services to older populations of emotionally disturbed, CEV children and their families. Safe Start has provided two practicum students to assist in linking these services and to help process referrals and responses to requests for emergency support that come in to the SVCC. Safe Start meets with these agencies regularly.

Start: May 2001 October 2005

****Action Step 3A**: Create relationships with the WVSD to pilot identification of families with children in the Early Childhood Education Assistance Program (ECEAP).

Millwood School, an elementary school within the WVSD, has some 250 children ages zero to five attending on a regular basis. Counselors report in-depth knowledge about the occurrence of family violence that affects these children but has no capacity to store or transmit data electronically. During summer months, Millwood provides a bridging program for high-risk families and is the center for similar programs in three other elementary schools in that district. Safe Start will provide part-time assistance to do in school and in-home support to these families and will help link them to services. In the fall, Safe Start staff will assist in organizing a data collection and mining effort within Millwood that will result in the development of electronic systems to capture, track and report information to be used to develop need statements and case plans. In order to accomplish goals in the fall we will submit appropriate IRB proposals.

Start: July 2002 End: October 2005

****Action Step 3B**: In collaboration with the WVSD/Millwood School and the SVCC, Safe Start will design and conduct surveys, presentations, and focus groups in the Valley catchment area in order to determine capacity for community engagement at the sub- neighborhood level.

Start: November 2002 End: October 2005

Action Step 4: Establish links with the State's Title 4-E planning unit related to the development of a child welfare early intervention pilot.

Safe Start explored utilization of Title IV-E resources to create opportunities for early intervention services with a child welfare population that was at risk of placement. The state indicated that Federal Region 10 was withdrawing support from such efforts in Washington and Idaho and further indicated that workload issues within child welfare precluded the identification of populations of children who had not received a CPS investigation and had an open case.

Start: August 2001 End: February 2002

****Action Step 4A**: Safe Start will work with Eastern Washington University to develop CEV training for child welfare workers.

Discussion is under way between the state and the Washington State schools of social work to decentralize responsibility for child welfare training using Title IV-E training funds. Safe Start has been invited by Eastern Washington University to participate in this effort on behalf of the CEV agenda. Safe Start will assist in developing and delivering training to child welfare workers. Though exposure to family violence issues is covered in the current Child Welfare Academy, the topic gets only an hour of attention and is not as well developed as the literature indicates it could be. Decentralization of capacity and responsibility for this training provides opportunity to teach workers how early exposure to chronic trauma results in adaptive behaviors and poor developmental outcomes. Greater exposure to this information may influence placement/reunifications decisions.

Start: 1/03 End: 10/05

Action Step 5: Explore the use of TANF resources on behalf of eligible families served by Safe Start.

TANF personnel have been uniformly responsive to Safe Start referrals eligible for a TANF benefit and have been supportive of case planning organized to address family violence. Given the five-year time limit expires next month, Safe Start clinical staff will be vigilant about corresponding impacts on old or new referrals. If the TANF time limits become a problem, we may have to revisit our timeline and re-open this as an issue.

Start: July 2001 End: April 2002

Objective 3: Use of local and state funds to advance an agenda for children exposed to violence.

Action Step 1: Develop linkage with the Therapeutic Childcare community within target neighborhoods.

After submission of the original plan, a federal Title XIX audit of the TCC program showed deficiencies that threatened the assessment of penalties against the states child welfare agency. As child welfare realigned its regulations and began closer oversight of this program, providers throughout the region withdrew from this program due to the unanticipated cost associated with compliance. During the last legislative session, 35% of the state funds allocated for this program were eliminated. This program no longer exists in the greater Spokane region.

Start: 10/2001 End: 3/2002

Action Step 2: Establish rationale for use of Family Preservation resources with this population.

The literature on Intensive Family Preservation shows it to be an ineffective service when used as a last option in the effort to avoid a placement and preserve a family. The literature also shows this short-term intervention does not have long-term impacts as originally claimed. Safe Start has presented this information in a variety of venues. Within Washington State, use of this service is proscribed in statute along with a prescriptive methodology related to delivery.

Start: October 2001 End: June 2002

****Action Step 2A**: In partnership with the Spokane Community Network, create rationale for elimination of categorical barriers within child welfare's Family Preservation Services program.

The Spokane Community Network exists as a local entity within Washington State's (DSHS) Family Policy Council framework. Its purpose is to find ways to reduce categorical barriers within systems and between systems, and to fund small pilot programs that blend services and resources on behalf of multi-problem families. Though the Network has been recognized for its success in bringing small programs together in collaborative efforts, it is noteworthy that none of its funded programs are separated by categorical funding. The Network's current focus is the Safe Start collaboration and its categorical focus is the removal of barriers in the Family Preservation Services program. Further, a proposal to create a rationale for the removal of categorical barriers in this program was accepted by the Family Policy Council and work will continue with a final report due to the state in July 2003. Assuming the acceptance of the proposal recommendations, there will be a

presentation to the 2004 legislature for action. If successful, this initiative will accomplish the intent of Action Step 2.

Start: July 2002 End: March 2004

****Action Step 3**: Secure funding from the Juvenile court and School Districts to support Teen Peace.

Teen Peace is an intervention program targeting adolescent violence that occurs at home and at school. It has been funded for two years under a small grant from the CDC through the Spokane County Domestic Violence Consortium but the funding will lapse in October 2002. This early intervention, psycho-educational program cycles each 12 weeks and has developed an excellent reputation among probation officers, school counselors, and families. Follow-up evaluation extends over 12 months and preliminary data suggests high client and family satisfaction and a near absence of recidivism. However, there are many more referrals than capacity. The Juvenile Court is taking steps toward intervening earlier in the cycle of teen violence and has developed a stake in understanding the extent of this issue at the point of intake to its system. We will approach them about continued funding and will approach schools in context with their school anti-violence initiatives.

Start: July 2002 End: June 2003

Objective 4: Create means and activities to increase corporate engagement in increasing resources for children exposed to violence.

Action Step 1: Establish an engagement strategy in consultation with corporate community leaders to address the impact of family violence on work force preparation and retention. Conduct this work in partnership with the Spokane County Domestic Violence Consortium (SCDVC).

During the past year, we have worked closely with the SCDVC to explore options for corporate engagement. Within the last two months, formal discussion has occurred with Associated Industries, a professional organization representing some 440 employers with nearly 15,000 employees. An agreement exists to seek funding from OSHA/CDC to support the development of workplace strategies to provide support to victims of family violence particularly when violence affects the workplace. In support of that agreement, Robinson Research (with input from Dr. Blodgett) completed a survey among 110 of the employers represented by Associated Industries. The result of the survey was that 25% of respondents were able to recall an instance of family violence that affected the workplace and of these individuals, 70% were anxious to receive assistance in addressing this issue on behalf of employees. CAFRI will develop a proposal on behalf of this partnership and will organize portions of it to support Safe Start's CEV agenda. The request will be for $400K for each of five years.

Start: July 2002 End: October 2005

Objective 5: Pursuit of other grant funds.

Action Step 1: Establish a monitoring function in Safe Start that looks for program funding opportunities.

A monitoring function is established and grants have been or are being written as follows:
1. CAFRI developed a proposal to HHS in support of Head Start/Early Head Start activities to create and track developmental outcomes.
2. In partnership with Untied Way/Success by Six, the Community Colleges of Spokane and the Educational Services district, CAFRI worked in support of a proposal that provides training and educational supports to in-home childcare providers.
3. CAFRI developed an SESS extension grant to the Case Family Program in support of Child Neglect Research.
4. CAFRI is developing a proposal to OSHA as described in the previous Action Step.
5. CAFRI developed a proposal to the Early Learning Foundation in support of two private child abuse agencies to test the efficacy of parenting support programs.

This work will continue throughout the life of the Safe Start initiative. Our intent is to create local capacity, to provide research and data analysis services, to support project development, and broad system change efforts in service of a family violence and CEV agenda.
Start: May 2001 End: October 2005

Action Step 2: Establish a shared grant development capacity across the larger community systems where staff with grants development skills meet regularly and review opportunities for new funding submissions from multiple lead organizations representing the community.

The Breakthrough Steering Committee continues to review funding opportunities with this action step. Further, multiple partners who came together around Safe Start have approached CAFRI with requests to participate in the development of proposals. CAFRI/Safe Start is currently working beyond capacity.

Start: September 2001 End: October 2005

Action Step 3: Develop at least one additional grant application to national foundation or federal programs to support extension of activities in the Safe Start Strategic Plan.

This step is complete. However, in addition to those outlined above we are intending to develop and submit requests to support a data development/integration/community informatics strategy sometime within the next year. We will also pursue the development of proposals in support of interest within the leadership of the local mental health system to create a system of care specifically

targeted at young children. It is probable that such a request will address implementation of the *DC: 0-3* we have been approached to support a request to pilot interventions specifically targeted to chemically addicted pregnant women. CAFRI was also approached by law enforcement to participate in evaluation research related to Spokane's very significant methamphetamine problem especially as it relates to child witnesses. Again, in all of these efforts CAFRI's primary interest is in the development and discussion of information related to children and their families in service of an overall systems change effort.

Start: November 2001 End: October 2005

Strengths:

The challenge of fiscal sustainability has deepened. The state budget's current level deficit as of mid-January 2002 was $1.6B. A major focus of that budget among children's advocates was the targeted elimination of all early intervention and prevention services. Safe Start partners, and many others, used legislative relationships to ensure no reductions were taken in these vital budget categories. As we approach the next legislative session, a statewide group has convened to find ways to lobby on behalf of these resources in the face of more egregious reductions.

Additionally, the Family Policy Council and its Spokane Community Network committed $220K to provide CEV services to the 7-12 year old population, in tandem with Safe Start services to the younger group. Further, the local XIX authority began working actively to find ways to provide specific FTE support to the CEV effort on behalf of the Safe Start population. We will not know the outcome until the next reporting period.

CAFRI has been involved in the development of several grant requests on behalf of Safe Start objectives, particularly as they relate to corporate engagement and Head Start/Early Head Start and the CEV population. (See Strategic and Implementation Plans.)

Weaknesses:

Efforts toward sustainability are weakened by a growing bleakness in the state budget. In January 2003, economists predict legislators will face another $1.4B revenue problem. To the extent reductions are successfully targeted at early intervention/prevention services or private non-profit child and family serving agencies it is probable that our overall capacity will be weakened in the short to midterm.

Challenges:

See above.

Lessons Learned:

Sustainability of the Initiative does not entirely depend on new funding streams. Rather, we believe weight must be given to the reprioritization of funds within existing system, especially mental health and chemical dependency and it is also clear that sustainability will be negatively impacted if cuts are made in current level prevention and early intervention resources. Underpinning the entire funding debate must be a dedicated approach to the analysis of data collected by multiple systems about common clients. An assertive, community/university-based research effort is essential to inform decision-making.

Further, multi-system professional development efforts are critical to sustainability; as groups and individuals are better informed about child development, chronic trauma related to violence exposure, brain development and the overall lack of attention to these issues within the larger bureaucratic systems and their policy venues, the tenor of advocacy changes. Increasingly, local level decision makers including judges, law enforcement and private non-profit child serving agencies are impatient with the moribund nature of larger state bureaucracies.

Areas of Increased Capacity:

See Collaborative Strength above and please refer to Implementation and Strategic Plans dated July 2002.

Areas for Capacity Building

This area is covered amply in this and other documents particularly the Strategic and Implementation Plans. Throughout the next several months Safe Start personnel will participate in a growing statewide effort to save early intervention/prevention programs funded, principally, by child welfare and public health. We anticipate the child welfare system will offer up these services as first round cuts as they attempt to conserve tertiary services. On the contrary, we anticipate the public health system will work vigorously to oppose reductions in these areas. As this is being written, a small group of legislators is meeting to consider the cost of elimination of these services and is listening to community groups who oppose these reductions.

VI. Evaluation

All Goals and Objectives:

In the following evaluation report we summarize the accomplishments, challenges, and opportunities revealed in our process records in relation to particular goals, objectives, and action steps. We make a conscious effort to augment rather than repeat what has been noted by Roy Harrington in previous sections of this report. We conclude with an analysis of the strengths, weakness, challenges, lessons learned, increased capacities, and future capacity development.

Summary of the Status of Goals, Objectives, and Action Steps

Status of goal 1, objective 1, action steps 1 – 5: There was one meeting recorded during the review period pertaining to this objective. Although unsuccessful in developing a children's trust in cooperation with Foundation Northwest, we believe this to be a viable concept and therefore intend to actively pursue new opportunities with other private foundations.

Status of goal 1, objective 2, action steps 1 – 5: There were 12 meetings recorded during the review period pertaining to this objective. Additional action steps were added during the most recent iteration of the Strategic Plan to more specifically delineate tasks associated with securing Title XIX funding for CEV services. The Child Outreach Team implements action step 5, use of TANF funds on behalf of Safe Start families, as service linkage strategy.

Status of goal 1, objective 3, action steps 1-3: There was one meeting recorded pertaining to this objective during the review period. State funding no longer exists to support therapeutic child care programs, therefore it is not possible to develop linkages within the target neighborhoods.

Status of goal 1, objective 4, action steps 1-2: There were 36 meetings recorded during the review period. Activity has significantly increased in this area from the previous review period. We have nothing to add from an evaluation perspective.

Status of goal 1, objective 5, action steps 1-8: There were a total of 49 meetings pertaining to this objective during the review period. For action step one, our approach to process evaluation has been to formally record community contacts rather than internal staff actions to keep the process manageable. Therefore as an internal staff function, work regarding this action step is not formally recorded. However, we continue to research additional private and public grant opportunities and potential projects in the area of promoting children's mental health and expect to develop and submit and grant application during the next calendar year. To address action step two, we identify potential shared grant opportunities through our growing collaborative partnerships. Although we have completed action step 3, we fully expect to continue making new grant applications as opportunities arise.

Status of goal 2, objective 1, action steps 1-4: There were a total of 11 meetings during the review period pertaining to this objective.

For action step one, during our records review for the case study we found that law enforcement was routinely recording information regarding child witnesses to violence on primary and secondary forms under the "witness" field. Indeed, process evaluation further revealed that children as young as four are interviewed at the scene about the incident.

Although activity in the area of having systems ask about violence exposure (action step 2) has remained relatively constant compared to the previous review period, the implementation of this objective has been considerably slower then expected. Process evaluation has documented the complex and long process of developing a pilot protocol study (in partnership with the Title XIX MH authority and three MH/CD agencies) to screen children ages 0-13 for violence exposure at the point of intake. Process evaluation will document the steps necessary to develop and implement training protocols. Future formative evaluation efforts will concentrate on analyzing the results of this pilot study as well as possible system-wide implementation. We plan to use participant training satisfaction surveys and follow-up with a sample of participants to determine transfer of new skills to practice.

Regarding action step 3, CAFRI had a pre-existing contractual relationship with Head Start/Early Head Start and the institute recently completed a comprehensive community assessment regarding the needs of high-risk children ages zero to five and a descriptive review and analysis of the Spokane Head Start/Early Head Start as well. In cooperation with the Spokane Community Colleges system (parent agency for HS/EHS), we have developed a substantial proposal that was submitted to the Department of Health and Human Services for a five-year grant. If funded, the program will incorporate factors such as identification, assessment, and early intervention for CEV into the HS/EHS program and fund the creation of child development outcomes research. As such, we expect to address this action step through the pending grant funding from HHS

Further, we expect to develop relationships with independent childcare providers to develop continuing education programs addressing child development and the identification of children exposed to violence and trauma. As such we expect that the process evaluation will capture the planning and implementation of these steps. Action step 4 was discontinued.

Status of goal 2, objective 2, action steps 1-3: There were 26 meetings pertaining to this objective during the review period. Through process evaluation we have documented the development and implementation of an initial Safe Start training and the Immersion Training to the SPD and SCSO. This fall we will be developing an in-depth training about child development and CEV that will implement starting January 2003. Additionally, during the last round of process interviews, the law enforcement line officers and officials were complimentary about our earlier trainings and indicated that they would like additional training in child development and CEV, particularly regarding behaviors one is likely to see in a child recently exposed to violence. We plan to use participant training satisfaction surveys and follow-up with a sample of participants to determine transfer of new skills to practice.

Regarding action step 3, if the Head Start/WSU grant application is funded, staff development is intrinsic to program development and we will document accordingly. We plan to use participant training satisfaction surveys and follow-up with a sample of participants to determine transfer of new skills to practice.

Status of goal 2, objective 3, action steps 1-3: There were seven meetings recorded regarding this objective during the review period. In our process evaluation, we have documented our work with the SCDVC and tracked the development and provision of training to local law enforcement, mental health personnel, and COPs/SCOPE volunteers. We expect to continue documenting the development of CEV training curricula in cooperation with the local mental health and chemical dependency authority, West Valley School District, and Eastern Washington University. Products will include the documentation of meetings, actions, and a formal plan for each sector.

Further, the state has mandated the use of the Global Assessment Scale portion of the DC: 0-3, this is primarily a process evaluation task as there are no local agencies currently using the DC: 0-3 and we have to engage in a series of discussions and training to educate agency personnel regarding its use. We intend to document these discussions and develop plans of action for its implementation across numerous agencies. We therefore expect that activity in this area will increase during the next review period.

The implementation of action step three has been comprehensively documented within the process record numerous trainings we have given to a variety of groups including child welfare, law enforcement, Head Start/ECEAP, etc. As many public and private agencies are frustrated with the current and impending budget reductions particularly regarding early intervention, we expect that we will be increasing our consultation role in the future and will document accordingly.

Status of goal 2, objective 4, action steps 1-5: There were 20 meetings associated with this objective during this review period and activity has significantly increased compared to the previous review period although work in this area has occurred primarily through the implementation of action steps 2 and 4.

Regarding action step one, the effort to reallocate resources and decentralize staff through out-stationing strategies has been documented across community agencies. During the next review period, we intend to survey families receiving services through community agencies that shift resources to address violence exposure and barriers to service. We anticipate working with agencies to conduct anonymous surveys to determine if the participants see shifts in resources as being beneficial.

Action steps 2 and 4 have been comprehensively documented in our process records specifically in the “Meetings, Minutes, & Actions” report that is updated on a regular basis. We expect to continue documenting the ongoing work to maintain our relationship with law enforcement. Current formative evaluation efforts include process interviews with key participants as well as an ongoing case study of service delivery. Both process and formative evaluation analyses are routinely shared with the partnership and community members to garner feedback regarding program development and assist us in making necessary modifications. The draft outcome evaluation plan is currently in its third revision. We expect to finalize the draft and

submit to the WSU IRB for approval. We expect the outcome evaluation will commence this fall.

For action step 5, through process evaluation we have documented our efforts in collaboration with our partners such as the Washington State Children's Alliance to maintain the early intervention services within the current biennial state budget. In collaboration with our partners, we expect that we will continue our advocate for the preservation of early intervention funding with local and state leaders and will document accordingly. Additionally, through the Children's Alliance and the Breakthrough Steering Committee we have documented our regular contact with two senior state senators.

Status of goal 2, objective 5, action steps 1-7: There were 32 meetings pertaining to this objective during the review period, a significant increase from the previous review period.

Concerning action steps 1, 2, 3, and 6, our process record documents numerous discussions with the COPS and SCOPE leadership to determine the viability of this action step. We have found safe houses to be particularly difficult to establish because of issues with licensure, liability, safety, etc. Implementing this step has been difficult with the COPS/SCOPE volunteers because they are generally not available after 7 p.m. However, the neighborhood-based, community development aspect and neighborhood surveys of the Spokane Safe Start model will enable us to more fully address this step. Therefore, we have discontinued work on step one but will revisit later in future revisions of the strategic plan.

The process record comprehensively documents action step 5, the development of a Safe Start practicum unit and contract negotiations with Eastern Washington University. Each practicum student chronologically documents their activities which is coded and recorded in our database.

Target dates for action steps 4 and 7 fall into an upcoming calendar year.

Status of goal 2, objective 6, action steps 1-3: There were 39 meetings pertaining to this objective during the review period. This action step has been comprehensively documented in our process records specifically in the "Meetings, Minutes, & Actions" report that is updated on a regular basis. Essentially this step is complete, however, we will continue to document ongoing program maintenance and service improvements.

Status of goal 2, objective7, action steps 1-3: There were 23 contacts pertaining to this objective during the review period. The majority of these contacts consisted of meeting with our service partners and the Child Outreach Team to review and solicit feedback relating to our overall evaluation plan. Specifically, we developed protocols defining the four levels of treatment, determined when it is appropriate to introduce the research aspect of the project to clients, and mutually developed an Access database to gather pertinent intake and demographic client information. All Child Outreach

Specialists were equipped with laptop computers and we expect that the implementation of the database to occur in September 2002.

We are using triangulated data collection methods including written chronological documentation of goal and objective progress, qualitative interviews, and multiple case studies, to document and inform the Spokane Safe Start Initiative.

To this end, in February 2001, Spokane Safe Start initiated formal data collection procedures. Our purpose for using this method is to collect data at the goal and objective to ensure an ongoing, comprehensive process and formative evaluation effort. Initially we created data collection reporting forms based on the structure of our Strategic Plan goals and objectives in which the reporter documented the date, time, location, attendees and agencies, applicable goals and objectives, purpose, and action of each meeting. However, we found the use of these forms cumbersome and time consuming. Therefore, we modified our data collection strategy to a narrative format in which the reporter chronologically documents all relevant external meetings that occur in the community and simply refer to these as the "chronological notes". The reporter uses the Spokane Safe Start Action Grid, which explicates the goals, objectives, and action steps, as a guide to record and code the data prior to forwarding to the process evaluator on a monthly basis. Using the Action Grid as a guide, the process evaluator then reviews all data for consistency and accuracy and modifies and/or adds data codes as necessary. The process evaluator then enters the data into a master Access database table; the data fields reflect the requirements for process data reporting to the National Evaluation Team (NET). If necessary, the process evaluator will seek clarification from the reporter and notes the often-varying perceptions of each reporter of the same circumstance. We can then manipulate the data to create pivot tables, charts, and reports that reflect the level of activity for each goal and corresponding objectives and analyze accordingly. However, for final analysis and reporting purposes to the NET, we create a sub-table specific to the reporting period and eliminate all duplication in the numbers of contacts made for each objective.

The interview method of qualitative inquiry is a well-established in the fields of sociology and public administration (Denzin & Lincoln, 1998) and is considered an important program evaluation tool. Our objective in using this method is to gather necessary program evaluation data as well as to ensure that the process of model development is consistently informed through reflexive accounting and open communication.

Starting in December 2001 in preparation for the biannual progress report, we implemented ongoing qualitative interviews with the individual Safe Start collaborative partners. However, we interview the Child Outreach Team as a group because we believe the close, positive group dynamic engenders a greater level of data gathering. Interviews are semi-structured and open-ended to encourage participants to "brain storm" about the Spokane Safe Start model and program development. Again, using the format developed by the National Evaluation Team, we utilize a broad guideline that addresses the project's strengths, weaknesses, current challenges, future challenges,

areas of increased capacity, areas to increase future capacity, and lessons learned within the context of program replication.

Each interview is taped and transcribed by the process evaluator and organized thematically. The researcher cross compares the responses from each interview participant to determine similar patterns and themes thereby allowing us to identify positive program development trends as well as potential "red flags". For example, a seemingly innocuous comment made by one participant may take on an entirely different meaning when analyzed within the context of another participant's statements. We then report the findings back to the collaborative partners in the form of a formal presentation.

Lastly, to assess the current service provision as well as to inform the future quasi-experimental outcome evaluation and develop comprehensive data collection strategies, we have engaged in a series of retrospective data collection in the form of qualitative multiple case studies to occur at three time intervals, June 2002, December 2002, and December 2003. The purpose of these studies is to conduct an exploratory and descriptive, grounded theory analysis of the Safe Start crisis response strategy. Our intention is to establish referral patterns and common family characteristics that emerge from Safe Start archival records and staff interviews as well as to inform, improve, and refine demographic data collection. We expect to develop an Access database that will instantly code intake data collected by the COSs into a table that may be uploaded for research analysis. See the July 2002 Strategic Plan for more detail.

Status of goal 3, objective 1, action steps 1-4: There were 28 meetings pertaining to this objective with the EWU School of Social Work recorded during the review period. Regarding action steps 1 and 2, our literature review is ongoing and we have developed a library of resources regarding 24 topic areas related to domestic violence and CEV. Action steps 3 and 4 fall into an upcoming calendar year.

Status of goal 3, objective 2, action steps 1-4: There was one contact pertaining to this objective during the review. This task addresses the selection and use of curricula that increases awareness and knowledge of best practice clinical methods among practicing professionals. To this end, the DC: 0-3 is a promising practice in children's mental health and we intend to work in concert with Marycliff Institute to train mental health professionals in its use. Moreover, we are currently updating our process records to reflect the lead agency's creation of a training and mentoring program for professionals that encounter CEV. We expect to continue documenting the development of CEV training curricula in cooperation with the local mental health and chemical dependency authority, West Valley School District, and Eastern Washington University. Products will include the documentation of meetings, actions, and a formal plan for each sector.

Status of goal 3, objective 3, action steps 1-4: There was one contact pertaining to this objective during the review period. Our process evaluation reveals that we have engaged in a comprehensive search of the research literature regarding child and

domestic violence advocacy and found there is no definitively articulated model nor is there any research attesting to the efficacy of "advocacy". Moreover, it appears to us that the notion of advocacy is supported more by ideological anecdotes then by science. Because of the lack of a definitive best or even promising practice model it is impossible to establish a consensus around this concept and is therefore premature to include in our professional development curricula development.

Status of goal 3, objective 4, action step 1-3: There were 28 contacts regarding this objective during the review period that focused on identifying training needs for Head Start/Early Head Start and ECEAP staff, researching and completing a needs assessment, and developing a collaborative grant application. Action step 2 was discontinued.

Status of goal 3, objective 5, action steps 1-4: There were 22 meetings pertaining to this objective during the review period, a significant increase from the previous review period. Regarding action steps 1 and 2, we have comprehensively documented our work with the Spokane Community Network (see Goal 1) as well as our efforts to secure funding for two FTEs to address CEV within the context of Safe Start. However, we view this as an ongoing activity to advance the CEV and children's mental health agenda.

Action step 3 falls into an upcoming calendar year.

Pertaining to action step 4, through process evaluation we have documented our efforts in collaboration with our partners such as the Washington State Children's Alliance to maintain the early intervention services within the current biennial state budget. In collaboration with our partners, we expect that we will continue our advocate for the preservation of early intervention funding with local and state leaders and will document accordingly. Additionally, through the Children's Alliance and the Breakthrough Steering Committee we have documented our regular contact with two senior state senators.

Status of goal 4, objective 1, action steps 1-9: There were 46 meetings during the review period addressing this objective.

Action steps 1, 3, 5: The coordination and relationship between social service providers, (particularly Safe Start agencies) and the Spokane Police Department and Sheriff's Office continues to grow and become increasingly purposeful in the realm of child exposure to violence. The leadership of the Spokane Police Department and Spokane County Sheriff's Department are extensively invested in the project and are supportive. For example, law enforcement provided the Child Outreach Team (COT) with police radios to ensure smooth communication, unlimited access to the public safety building, police identifications, and a Safe Start mailbox. Additionally, they have been willing to work with Safe Start staff to include them in roll calls and by scheduling ongoing ride-a-longs. Law enforcement administrators are dedicated to "getting the

word out" about Safe Start to engender referrals and their presence and advisory role at the weekly case staffing has been extraordinarily beneficial to the process.

Further, both departments are committed to training all commissioned and non-commissioned officers to continuing, comprehensive training in the areas of the Spokane Safe Start model, child development, and trauma exposure. A major milestone in the development of the partnership between the police and Safe Start occurred in November 2001 with the Immersion Training, a three-day event attended by police personnel, human service providers, and crisis response staff. During the initial stage of the training, the police personnel were quite skeptical about the feasibility of the model. By the conclusion of the training, however, the police personnel and human service providers discovered many shared job characteristics and developed a mutual respect for each other. Each day's sessions concluded with additional ride-a-longs in the target areas lasting into the night. We learned that police and clinicians view trauma from very different perspectives. In some of the "low-level" domestic violence calls, police were of the opinion that a clinical response was not warranted; however, clinicians felt that in a response in those same circumstances would be beneficial. Both groups were enthusiastic about the endeavor and the training was an overwhelming success in which the outreach specialists and police shared organizational and professional cultural characteristics to benefit children exposed to violence.

Clearly, these early varying perspectives indicated that consistent communication, relationship development, and networking must occur to generate referrals and evolve analogous perspectives of the same circumstances. Therefore, throughout the first six months of service implementation a number of communication mechanisms have been successfully developed and employed to ensure the accessibility and quick response of the Child Outreach Team. First, the partnership determined that simplicity was essential to maintaining contact and created a one-number system in which officers contact an answering service who in turn contacts the on-call COS and has the capacity to patch them through directly. Unfortunately, not all officers are equipped with cell phones and the officer can contact the on-call child outreach specialist through police radio dispatch. Other methods include written referrals in the form of a police report left in Safe Start's mailbox, consistent ride-a-longs, and attendance at roll calls.

However, the implementation of these mechanisms has not been without problems. We found that our original protocol of having the officer determine the necessity of Safe Start intervention at the point of crisis has not worked well. Essentially this protocol required the officer to observe the child and make a clinical assessment about the effects of traumatization due to violence exposure. As such, the officers frequently misinterpreted that a flat affect and withdrawal was a normal response to an incident without understanding the behavior within the broader context of violence chronicity. Consequently, the COT only received a paper referral one to two days after the incident and a major opportunity to create a rapport with the family and offer services at the point of crisis was lost. (Our preliminary data suggests that a family

will be significantly more likely to engage in services and use services for a longer period if a connection is made at the moment of the crisis.)

Moreover, during a one-month period the COT did not attend roll calls or ride-a-longs and referrals declined significantly. The partnership recognized that the responsibility to maintain the relationship with law enforcement, particularly line-level officers, rests with us. To that end, the COT scheduled regular ride-a-longs with several officers and committed to attending roll call meetings at least once per quarter. The police administration further suggested modifying the contact protocol to requiring the officers to contact Safe Start for any violent incident in which children ages 0-6 were present. Since these modifications were implemented there has been a significant increase in the number of referrals including some very high profile cases outside our target areas which have afforded us a higher level of visibility and respect within both departments.

Overall, both departments are satisfied with the commitment and professionalism of the individual child outreach specialists, their ability to work as a team and with the police, the efficiency of the response, and the quality of the interventions. One officer stated that the COT response time is "huge" and there has been only positive feedback regarding the Initiative. Prior to Safe Start Both line officers and law enforcement administrators indicated that they were unaware of how traumatic violence exposure effects the neurological and social development of children and its subsequent long-term affects on society. During recent interviews, police administrators and line-level officers offered several constructive suggestions to maintain the close relationship with law enforcement including:

- Ensure the officers are constantly aware of Safe Start and strategize to prevent under-reporting of cases by:
  - Participating in consistent ride-a-longs;
  - Attending roll call trainings;
  - Continuing to provide case updates to referring officers;
  - Creating posters and brochures for the roll call rooms; and
  - Providing Safe Start stickers with the phone number for the patrol cars.

- Educate the police about the verbal and emotional abuse aspects of domestic violence.

- Provide more training in child development issues specifically regarding a child's reaction to witnessing violence. How should the child act? What are the behavioral nuances the officers should be aware of?

- Prior to the Safe Start orientation and Immersion trainings, many officers were unaware of the number of resources available to the families within the region and Safe Start could provide training to expand this knowledge.

- Utilize the "hot board" (read by the shift sergeants at every roll call) to provide monthly summaries of Safe Start activity.

In general, the collaboration between law enforcement and social services is stronger since the implementation of the COT and is demonstrated by Lt. McGovern's recent statement that "although there has been no major conflict, if an issue did occur between law enforcement and social services we are better able to work through it now than six months ago." Nonetheless, as stated above, we recognize that it our responsibility to ensure the continuing partnership with law enforcement because otherwise, in the words of more than one officer, Safe Start "will be out of sight, out of mind". Therefore, we intend to continue to be as responsive as possible and incorporate their suggestions into the emerging model.

Action step 4: We have documented multiple discussions between Safe Start staff, the service agencies, and law enforcement regarding the development of a progressive protocol. However, we expect that as the service model develops modifications in protocols may be necessary and intend to continue documenting these discussions as necessary in the process record. Although verbal agreements have been made regarding protocols, we have not yet established formal policies and procedures. We expect that Safe Start staff will assist the lead service agency in completing this task.

Action step 6: We currently document in our process record biweekly meetings with the service partners as well as weekly clinical case reviews with the Child Outreach Team and law enforcement administrators. Although Safe Start staff meet on a weekly basis, we opted to record only external community meetings applicable to Safe Start.

Action step 7: The Child Outreach Team and its Clinical Director are currently in the process of strategizing to address this action step and we will expect to document progress in the process record. Once fully implemented, we expect to evaluate work in this area through our process interviews and case study analyses.

Action step 8: We have documented numerous discussions with CPS in the process record. The COT has made and received referrals to and from CPS. However, we expect this to be a somewhat complex process as more relationship development will need to occur before formal protocols can be developed. Process evaluation activity will focus on the developing association, the planning for protocol development, and any subsequent written procedures.

Action step 9: Formative evaluation tasks include quarterly process interviews as well as multiple case studies. We are currently in the process of using the information gained from the first case study to design an Access database and form to collect this information. We expect to implement this form this fall and the data will be primarily collected by the child outreach specialists at the time of intake and through their ongoing contacts with families. Safe Start staff will regularly review data collection procedures and modify as needed.

Status of goal 4, objective 2, action steps 1-3: There were 2 meetings pertaining to this objective during the review period. The Child Outreach Team and its Clinical Director are currently in the process of strategizing to address this action step and we will expect to document progress in the process record. Further, we will continue to document our work with the SCDVC to train volunteer organizations and will document accordingly.

Status of goal 4, objective 3, action steps 1-5: There were 18 meetings regarding this objective during the review period.

Action steps 1 and 3: We engaged in a series of meetings with the COT to review the evaluation plan and develop protocols regarding service delivery and research design and have made modifications accordingly. Formative evaluation tasks include quarterly process interviews as well as multiple case studies. We are currently in the process of using the information gained from the first case study to design an Access database and form to collect this information. We expect to implement this form this fall and the data will be primarily collected by the child outreach specialists at the time of intake and through their ongoing contacts with families. Safe Start staff will regularly review data collection procedures and modify as needed.

Action step 2: We have nothing more to add from an evaluation perspective.

Action step 4: Our attempts to establish capacity and referral mechanisms for DV perpetrator treatment are well establish in the process evaluation. We will continue to work with SCDVC and the judiciary to address narrow state perpetrator treatment guidelines and the lack of certified treatment in the Spokane region.

Action step 5: Formative evaluation tasks include quarterly process interviews with the COT as well as the implementation of multiple case studies. We are currently in the process of using the information gained from the first case study to design an Access database and form to collect this information. We expect to implement this form this fall and the data will be primarily collected by the child outreach specialists at the time of intake and through their ongoing contacts with families. Safe Start staff will regularly review data collection procedures and modify as needed.

Status of goal 4, objective 4, action steps 1-4: There were 14 meetings regarding this objective during the review period. Generally, this objective is implemented by the Child Outreach Team as a service linkage strategy. To date, only one family has been enrolled in ITC services at Casey Family Partners. To assess the current service provision as well as to inform the future quasi-experimental outcome evaluation and develop comprehensive data collection strategies, we have engaged in a series of retrospective data collection in the form of qualitative multiple case studies to occur at three time intervals, June 2002, December 2002, and December 2003. The purpose of these studies is to conduct an exploratory and descriptive, grounded theory analysis of the Safe Start crisis response strategy. Our intention is to establish referral patterns

and common family characteristics that emerge from Safe Start archival records and staff interviews as well as to inform, improve, and refine demographic data collection. We expect to develop an Access database that will instantly code intake data collected by the COSs into a table that may be uploaded for research analysis. See the July 2002 Strategic Plan for more detail.

Strengths:

The following themes were identified as strengths during the process evaluation interviews:

- Getting the children into services sooner than they normally would be.
- The continuing relationship between law enforcement and social services.
- Protocol development especially with the COT.
- The relationships have strengthened in the last three months. Although there has been no major conflict, if an issue did occur between law enforcement and social services we are better able to work through it now then six months ago.
- The response time of the COT is "huge".
- The COT also provides excellent feedback by calling the referring officer the next day and communicating "where we stand".
- The COT staff are really helpful and are good clinicians. There are no personal clashes or complaints from officers; there has only been positive feedback.
- There are no additional paperwork burdens for officers.
- The initial training was good.
- For this period, the COT is up and running – launched. There is a sense that it is working and people are engaging and talking about their kids.
- We have survived our first staff turnover. It was good for us to go through the process of hiring again, which worked well.
- Law enforcement is very committed to Safe Start which is evident in their regular attendance at the weekly clinical meeting. That would not have happened in a previous era and Mike Erp made that happen by opening the door.
- The Valley Center opened and the COT members are established in their places.
- The achievement of creating the Skill Development Group. People have been selected and are committed to clinical curriculum development and case review by experts to improve their professional development. The group is led by G. Woods and attended by staff from the following agencies: CFP, Head Start, W. Valley School District – early childhood program, NATIVE Project, SCMH, and the COT. Currently, they are using the *Safe Haven* curriculum (from Boston) to observe what works and what does not work. This dynamic has worked for CFP and will probably work differently for Safe Start and she states that she needs to be open to it taking a different path. The plan is that the COT will meet every week and the entire group every other week. The important aspect of this group is they determine their own learning curriculum and that it is multi-disciplinary. It is inevitable that it will not work like Casey's and there was a year of resistance and denial.

- The meeting at WSU (prior to the community meeting) to go through the Action Plan was instructive in terms of assessing where we are in the process. These meetings would be useful on a quarterly basis to take stock.
- There were strengths in the community meeting which was a good demonstration of broad section of the community still feeling committed. It was important for the COT to "tell some stories" and give examples of what the families are like because that is what people are curious about.
- Deborah Robbins has represented the field of domestic violence at staffings and is a good, adamant, articulate spokesperson for that point of view.
- The development of the personal relationships throughout the group which has helped to tie the mental health and chemical dependency perspectives together. All of the players have gotten to know each other better, specifically the varying perspectives and how those perspectives fit together.

Weaknesses:

The following themes were identified as strengths during the process evaluation interviews:

- There has been a drop in referrals because patrol has not been making them. This may mean the officers need constant reminding. The referral protocol should be changed from the officer determining if Safe Start should respond to the scene to having the officer call for every incident in which violence is present. In this manner the officer would discuss the incident with the clinician and the clinician can judge the seriousness of the situation.
- If the clinicians aren't regularly attending roll call or going on consistent ride-a-longs they are "out of sight, out of mind." Every three months the clinicians should revisit roll call and regularly schedule a number of ride-a-longs. (The COSs have recently scheduled a number of them.)
- The police are so immersed in the old culture, especially in regards to making paper referrals to CPS that it is difficult to get out of the mindset of equating CPS and Safe Start.
- Patrol needs to incorporate into their thinking to remember the kids and not just think in terms of suspects and witnesses.
- Within social services there are so many outside factors that affect the provision of services; for example, there are conflicts between social service agencies. Additionally, there is significant energy expended to sustain the initiative by attempting to acquire additional grant money. The constant money chase and posturing for funds takes energy away from the program and the work.
- The specialists need to engage in brokering with other systems to get the children services (e.g., outreach at the line level).
- A lot of officers forget about Safe Start and tend to compartmentalize; out of sight and out of mind.
- The small number of referrals continues to be a problem. Officers will forget about the program unless "you stick it in their face".
- Unaware of the status of the program and the follow-up on written reports.

- Would be useful to have a brochure the officers can hand out.
- Of concern is the Monday Intervention Group meeting. The suggestion that the chairs rotate has made it feel like it is a leaderless group that rambles which results in the meeting becoming focused on interpersonal relationships. There needs to be a strong leader and an agenda to make the meetings more productive. Visual tools (e.g., writing on the board) are useful. Moreover, it is disconcerting that there is a shifting population on Monday; it is not possible to have everyone present each week. The feedback loop is a weakness because not everyone is on the same page and we need to ensure that we inform those who are absent.
- Regarding the community meeting, some of the planning in the afternoon did not go very far but that may have been inevitable and is unsure of what the result of that is.
- A lot of people do not know about Safe Start and we need to get the word out to those people to generate referrals and be recognized as a resource available in the community. We could accomplish this through giving more presentations to schools and other community partners.
- It seems that Safe Start is an 8 a.m. – 5:00 p.m. response. Most of the ride-a-longs occur during the day versus after hours; currently one crisis responder is doing swing and graveyard shift ride-a-longs. We need to be "in the face" of the police and sheriff's department by developing more personal relationships with them.
- There is a lack of clarity as far as what we are doing; it seems that "we are spinning our wheels". Redefining roles will be helpful. Safe Start is such a great opportunity in which there are a variety of providers that can get to the bigger and broader mission; however, we need to be developing protocols to assist in accomplishing this.

Generally, the individuals interviewed did not believe there were any fundamental weaknesses in the Spokane Safe Start model. For the most part, they preferred to think in terms of challenges rather than weaknesses.

Challenges:

The following themes were identified as challenges during the process evaluation interviews:

- Getting patrol up to speed.
- Getting the families to follow through with services is more likely to occur if the COT responds at the time of the incident.
- Education for the police of the verbal and emotional abuse aspects of domestic violence.
- Maintaining follow-up calls to the referring officers.
- Maintaining contact with the COT.
- The Strategic Plan is an enormous undertaking. For example, It is difficult to form a conception of neighborhood development and how to get there. What are

the important steps to take and what part the COT can play in neighborhood development?

- People would love to hear the COT give presentations and would be very popular. However, it does not appear that we have much unanimity of how to put them to work. They could be useful at schools, PTA meetings, service clubs, etc. However, there could be a time management issue as crisis response is the most important aspect of the model.
- The partnership is struggling to find a way to be effective about nailing down some of those things so that everyone can act with more confidence. There is a certain amount of walking on egg shells with each other that has to do with still not having a fully trusting collaborative partnership.
- In this last period, CFP's trust with SCMH was seriously abrogated. Although Theresa is doing a fine job with Safe Start, there is not the trust in her organization that was present last year when we started Safe Start which affects the ability for the three partners to work together.
- There is a certain dynamic of tension within the Safe Start clinical collaboration. Although everyone agreed that Gary Woods would be clinical supervisor, there is still a question about the supervisory role of the other two service partners.
- The "selling" that Safe Start is beneficial to the community. We are newcomers and there is significant mistrust (e.g., LCS) that we may do harm to these families. This has been a big hurdle for the project. We need to secure more "buy in" to effectively impact and improve the larger issues.
- It has been a challenge, although not difficult, to work with the different systems as they have different expectations of employees.
- We need to ensure that we give the model enough time to develop because there is a certain amount of process that there has to be there for new program development.
- The new edicts from DOJ that we should organize ourselves around courts are disconcerting (maybe mostly for Roy) and interrupts the concept of neighborhood development that it may prove to be a bit of a distraction. Do we do a perfunctory thing to satisfy them or do we actually take this into the center of what we are doing?
- The ongoing philosophical divide with the YWCA that has less form to it then ever.
- Sensitivity to power is instructive for all of us.
- Integrating the various fields (DV, CD, etc.) into the work.
- The relationship with the three partners is a work in progress and trust has to be earned and you have to go through experiences together. Three is an awkward number because there always seems like there is an alignment of two plus one which important to keep shifting so the dynamic does not "get stuck".
- Money, money, money.

Lessons Learned:

The following themes were identified as lessons learned during the process evaluation interviews:

- Have one or two officers at the line level dedicated to Safe Start.
- Have the COT go to roll calls to discuss cases but keep it "bare bones" to obtain historical information.
- Call front desk and ask them to call referring officer at home if necessary to discuss a case.
- The COT must continually interact with the patrol division in both the police and sheriff's departments. They will forget until Safe Start becomes ingrained.
- The Thursday case review meetings are a "waste of time" for patrol officers. Most patrol officers have the attitude that "I've got my thing to do" and that once their reports are written their work is done and they move on.
- Follow up with the families by officers was more successful in New Haven because they have more officers and different schedules. Spokane patrol officers work four ten-hour shifts and have a very limited window of time. Grave yard officers only see people when there is a problem. Younger officers have a different work ethic in that they do not want to work overtime and are less responsible then older officers.
- The call backs to the referring officers from the COT are valuable as well; the officers get so few phone messages unless it is someone asking for something.
- Families need a lot more services other then a police response and an arrest for failing to follow up on a service. (Gets to the notion of the importance of voluntary services.)
- There are resources available to families but they may need assistance to obtain them.
- Police officers must be aware that there are resources available to them other than writing a report and sending it to the prosecutor.
- Sustained training with law enforcement is necessary.
- Everyone should have a Chris Blodgett and Roy Harrington. Chris for his brains and Roy because he knows everybody and can get people to come out. This town is sick of visioning and planning and they attend Safe Start meetings because he asks them to.
- Data collection and data integration is integral to program continuation and model development.

Areas of Increased Capacity:

The following themes were identified as areas of increased capacities during the process evaluation interviews:

- The contacts that each of the clinicians brings to the model.
- There was nothing in existence before for these families. The officers' options were limited to CPS or "cursing on the way back to the car".
- The clinicians have excellent contacts with other agencies within the city and are able to assist families in obtaining services.
- Any new resource increases capacity within the community.
- Prior to training, officers were unaware of the number of resources available to the families within the region.

Areas for Capacity Building:

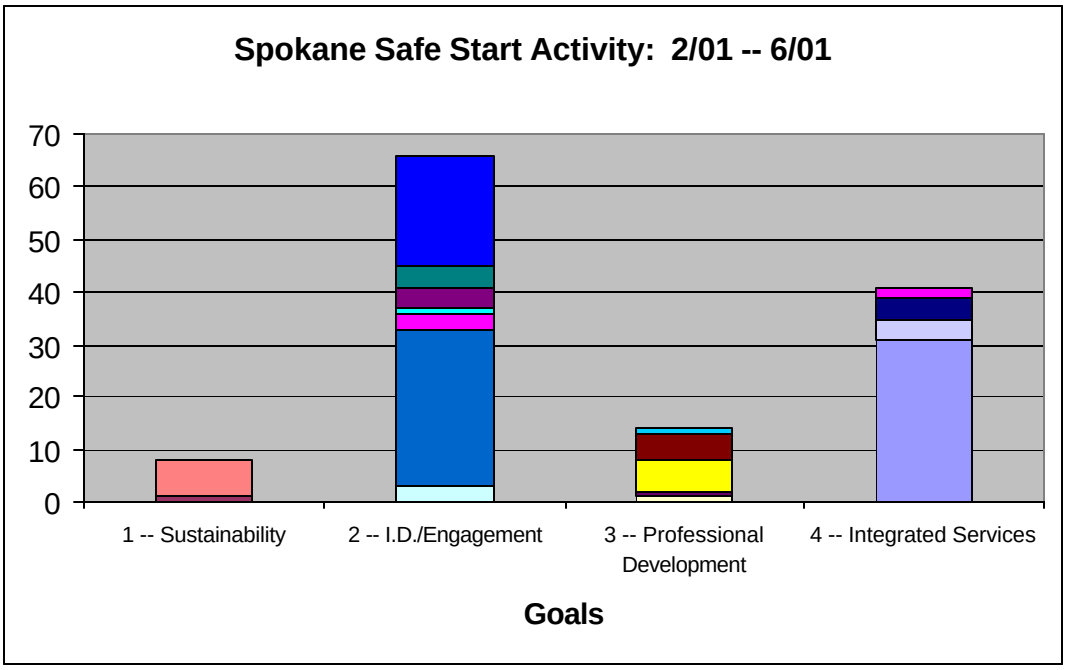
The following themes were identified as areas of areas for future capacity building during the process evaluation interviews:

- There needs to be more training in child development issues specifically regarding a child's reactions to witnessing violence. How should the child act? What are the behavioral nuances the officers should be aware of?
- Have the team/staff conduct thirty minute trainings during roll call.
- Utilize the "hot board" (read by shift sergeants at every roll call) to provide monthly summaries of Safe Start activity.
- Have the Safe Start number (general) added to the Victim's Assistance Card.
- Officers might be becoming interested more because of the mental health crisis program.

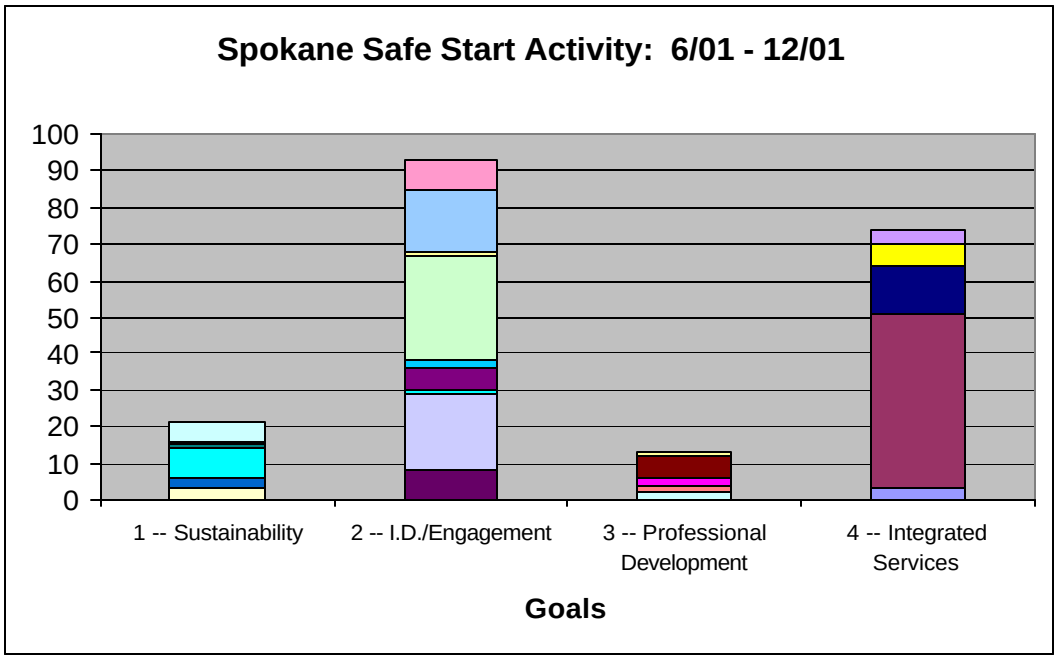
Level of Engagement:

In terms of the Strategic Plan Goals and Objectives, process observations support the conclusion that we continue to have high levels of engagement with relevant programs and agencies in achieving Goals 2 and 4. Although we document less engagement relative to Goals 1 and 3, it is clear that our activity during this review period has increased significantly in the areas of sustainability and professional development. Graphs below demonstrate our work activity over the previous three review periods; the varying colors represent the respective objectives.

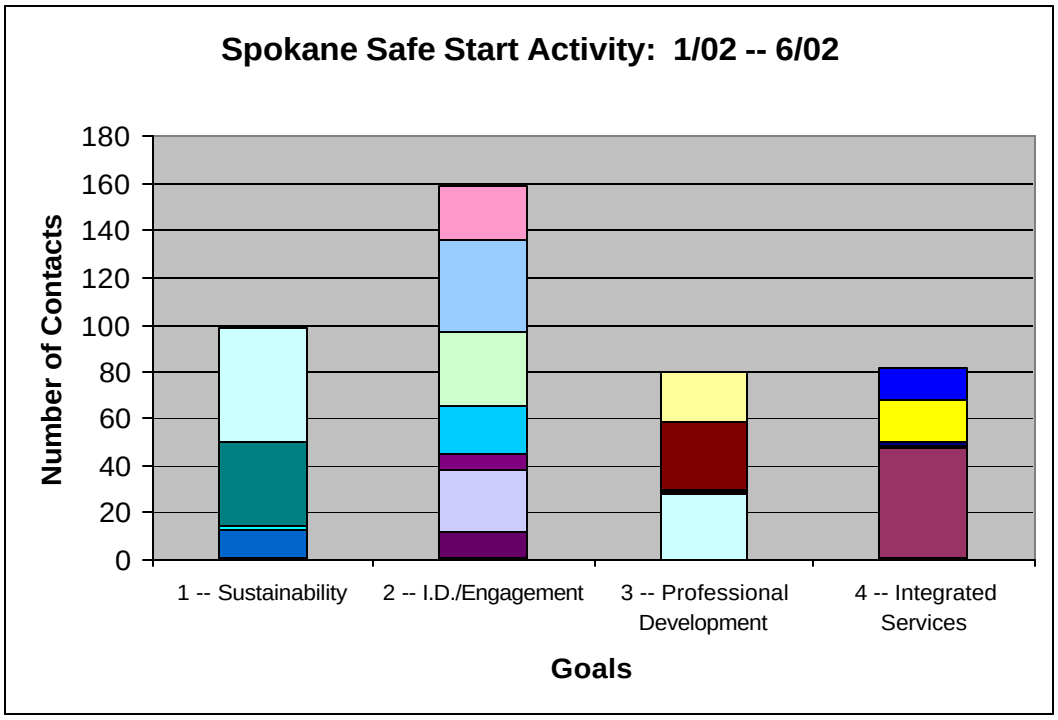
The graph below demonstrates that during the initial portion of the implementation phase (2/01 – 6/01), our efforts were clearly concentrated on the development of a crisis response capacity as the preponderance the of work focused specifically on Goal 2 – I.D./Engagement on Objective 2, I.D and Assessment and Objective 6, developing a crisis Response Model. Additionally, the concomitant work to develop a partnership with law enforcement was integral to the development a crisis response capacity and is clearly reflected in our efforts in the area of Goal 4 – Integrated Services, Objective 1, CDCP Model.



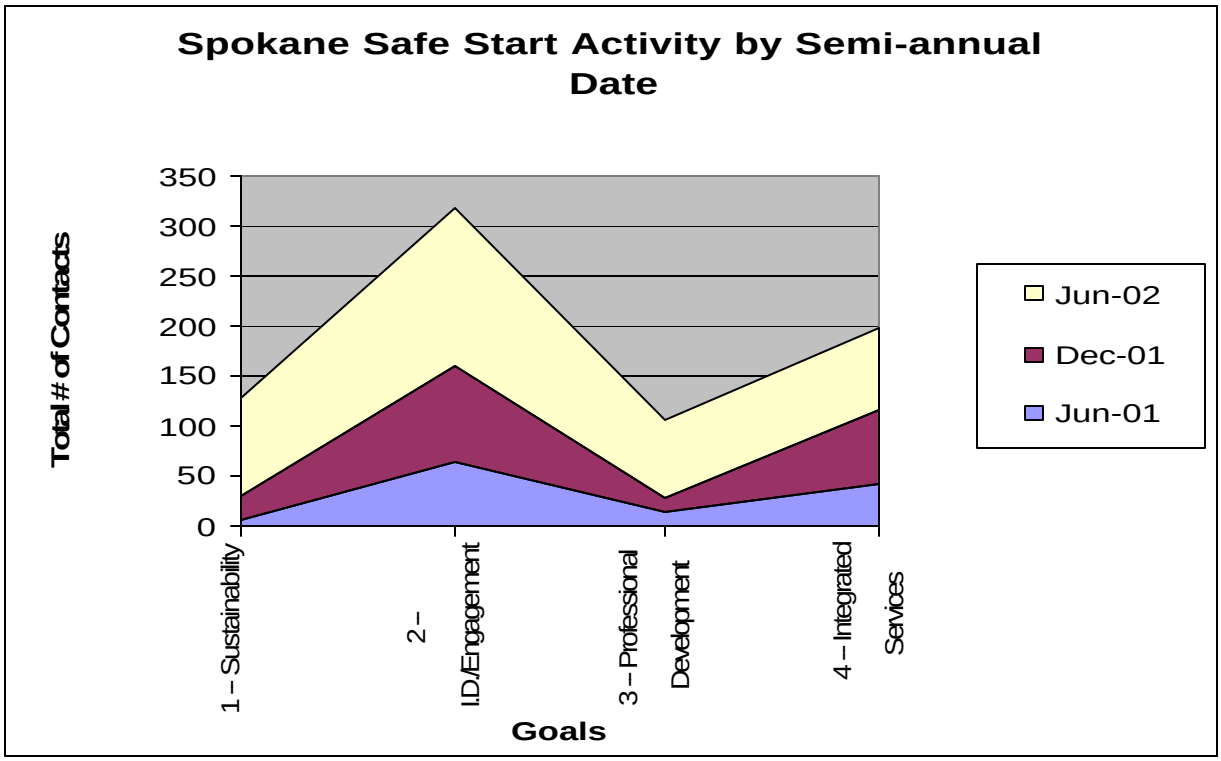
As we moved into full implementation of the model, the graph below (6/01 – 12/01) clearly indicates that although most of our energies were still concentrated on goals 2 and 4, our efforts became more distributed in that we addressed a greater number of objectives more frequently.



Now that the Spokane Safe Start model has been successfully implemented, the graph below demonstrates that during the previous six months we have turned our attention to the long-term aspects of the Strategic Plan, namely sustainability and professional development. Although the level of our activity on Goal 2 remains consistent and has even increased, our work is increasingly more distributed and proportionately more equitable in the areas of sustainability, professional development, and integrated services.



The last graph is perhaps most telling about the nature of the Spokane Initiative at this point in time. Compared to the previous two review periods, our activity and contacts have exponentially increased and over half of the contacts we have documented through process evaluation since February 2001 have occurred during the last six months. Moreover, whereas during the earlier review periods there was much duplication between data reporters, as the project expands and involves more people, organizations, and agencies duplication has significantly decreased.



Finally, the level of engagement and cooperation between all the collaborative agencies, WSU, and law enforcement is nothing short of phenomenal. The commitment of the partners and the larger community to benefit children exposed to violence is significant and we anticipate that during the next review period the agenda will continue to expand and touch many other sectors and individuals in the community. The principal challenge for the process evaluation will be to ensure that we consistently capture the ever-increasing growth of the model, its impact on the community, and its impact on children exposed to violence.