Characteristics of Young Children Exposed to Violence:
The Safe Start Demonstration Project

ABSTRACT

The Safe Start Demonstration Projects, funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) under the first phase of the Safe Start initiative, were primarily designed to impact change at the systems or macro levels to reduce the incidence of and impact of exposure to violence for children age birth-6, direct services were also provided to young children and their families who were exposed to violence. The data presented in this paper come from 10 communities that submitted data regarding the characteristics of young children exposed to violence to OJJDP. These data represent families who are typically not represented in the databases of state child protective services programs, but instead have been identified by domestic violence advocates, early care and education providers, family members, court personnel, police, and other social service personnel as families with young children in need of intervention due to violence exposure. The purpose of this manuscript is to describe the characteristics of young children and their parents who seek help for psycho-social problems related to exposure to family and community violence. Results indicate that one-quarter of the children and nearly half of their parents evidenced clinical levels of stress suggesting the need to intervene at the family level as well as at the individual level when working with young children exposed to violence. The information presented, including the extent of exposure to violence, the multiple types of violence to which children are exposed, the impact of this exposure on young children and their families, and the multiple ways in which families exposed to violence come to the attention of service providers is useful for policy makers and service providers that are interested in breaking the cycle of violence by meeting the needs of the children exposed to violence and their families.
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Recent survey research indicates that more than 60% of children and youth in the United States were victims of violence or witnessed a violent event in the previous year and nearly two-thirds of these children experienced more than one victimization. Forty-six percent of the children and youth reported being the victim of an assault and 25% reported witnessing a violent event (Finkelhor, Turner, Ormrod & Hamby, 2009; Finkelhor, Turner, Ormrod, Hamby & Kracke, 2009). These rates are staggering and clearly show that exposure to violence has become part of the daily lives of our children. The purpose of this manuscript is to describe the characteristics of families that seek help for their young children’s psycho-social problems related to exposure to family and community violence. For the purposes of this manuscript, child exposure to violence can include being a direct victim as in the case of child physical and sexual abuse, to more indirect exposure that might include seeing, hearing, or otherwise being affected by violence at home or in the community.

Exposure to Domestic Violence

It is estimated that 29% of American children live in families in which intimate partner violence (IPV) has occurred during the past year (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). In 2005 an estimated 4 in 1,000 women and 1 in 1,000 men were victims of intimate partner violence (U.S. Department of Justice, 2007). Between 2001 and 2005 over 38% of the adult female victims and 21% of the adult male victims of non-lethal intimate partner violence were living in households with children under age 12 (U.S. Department of Justice, 2007). Young children are particularly at risk for exposure to family violence and its potentially lethal consequences. Data indicate that young children are disproportionately represented among children in households where domestic violence is occurring (Fantuzzo, Boruch, Beriama, Atkins & Marcus, 1997) and experience the highest rates of child abuse and neglect (US Department of Health and Human Services, 2009). Moreover, estimates of the co-occurrence of domestic violence and child abuse range between 30% and 60% (Edleson, 1999; Appel & Holden, 1998; Turner, Finkelhor & Ormrod, 2007).

Exposure to Community Violence
Children are also exposed to high rates of violence in the community and in school. Finkelhor and colleagues (2009) reported that nearly 10% of children and youth from across the US were indirect victims of community violence during the previous year. This victimization also occurs for our youngest children with 3.2% of children under the age of two and 3.6% of children between the ages of two and five exposed to community violence during the previous year (Finkelhor, et al, 2009). Data from the 2005-06 academic year demonstrates that 86% of public schools reported at least one violent crime, theft or other crime at school and 10% of boys and 6% of girls were threatened with a weapon at school (National Center for Educational Statistics, 2007). The need for a more broad-based understanding of the types of violence that young children are exposed to and their proximity to this violence is clear (Osofsky, 2003; Ehrensaft, et al., 2003; Lynch & Cicchetti, 1998; Litrownik, et al., 2003; Wolfe, et al., 2003).

Child Abuse and Neglect

A recent national survey revealed that 10.2% of children and youth reported being a victim of child abuse and neglect during the previous year (Finkelhor, et al., 2009). Based on data from child protective services (CPS) investigations and assessments, approximately 794,000 children were victims of child abuse and neglect in 2007 and children age birth to one year had the highest rate of victimization at 21.9 per 1000 children (U.S. Department of Health and Human Services (US DHHS), 2009). The US DHHS reports that in 2007 there were 901,807 substantiated reports of child abuse and neglect (US DHHS, 2009). However, these data are likely to underestimate the incidence of child abuse and neglect due to reliance on data from CPS reports (Alvarez, Kenny, Donahue & Carpin, 2004). Finally, based on CPS data, children under 5 years old accounted for 75.4% of children who died as the result of abuse and neglect in 2007 (US DHHS, 2009).

Impact of Violence Exposure on Children

It is important to view the impact of violence exposure on children through the lens of normal developmental progress. Domestic violence, child abuse and neglect, and community violence disrupt children’s sense of safety and security, and their normative development (Ybarra, Wilkens & Lieberman, 2007; Johnson, et al., 2002). This disruption of developmental support has effects that extend beyond physical injury, to deleterious developmental and
psychological impacts (Osofsky, 1999). Violence exposure has been linked to cognitive, emotional, behavioral, and physiological effects which interact in ways not yet fully understood.

The impact of exposure to violence for young children has been clearly documented. In the long-term, children’s exposure to violence has been linked to adult risk for mental health problems and inter-generational transmission of partner violence, with the latter being mediated by the quality of parental relationships and the development of child behavior problems (Osfosky, 2003; Capaldi & Clark, 1998; Ehrensaft, et al., 2003). Children’s exposure to community and family violence has been linked to aggressive, antisocial, and other externalizing behavior problems (e.g., Edleson, 1999; Darby, et al., 1998; Kitzmann, Gaylord, Holt & Kenny, 2003). Research has also linked child maltreatment and indirect family violence exposure and community violence exposure to internalizing problems such as depression, anxiety, and low self-esteem as well as substance abuse/dependence (Edleson, 1999; Lynch, 2003; Margolin & Gordis, 2004; Martinez & Richters, 1993).

Relationships between trauma symptoms and child maltreatment, children’s exposure to family violence, and children’s exposure to community violence are clearly documented in the research (Edelson, 1999; Lynch, 2003; Margolin & Gordis, 2000; McClosky & Walker, 2000). This relationship may in part be due to how children experience violent events. For example, Drotar and colleagues (Drotar, et al., 2003) reported that among children who had experienced domestic violence or other significant violence and were old enough to self-report, almost three-quarters perceived the violent event as a direct threat to their safety and as something over which they have little control. Several studies established a relationship between exposure to violence and cognitive delays and academic difficulties among children, with child neglect appearing to particularly have a negative impact (Edleson, 1999; Margolin & Gordis, 2000; Kitzmann, Gaylord, Holt & Kenny, 2003). Children’s violence exposure has also been tied to difficulties in relationships with peers and parents (Lynch, 2003; Margolin & Gordis, 2000). The above-mentioned emotional and behavioral difficulties of children may contribute to this, as may the emotional and behavioral difficulties of parents and caretakers who have also experienced violence (Margolin, 2005; Osofsky & Jackson, 1994). Importantly, data from the Safe Start demonstration sites (Ortega, Beauchemin & Kaniskan, 2008; Schewe, 2008; Crusto et al, 2008) and other projects (Graham-Bermann et al, 2007) indicate that direct intervention
with children and their caregivers holds considerable promise in reducing negative outcomes for children and their caregivers.

Overview of the Safe Start Initiative and the Demonstration Sites

For more than 10 years, OJJDP has been a national leader in addressing the issue of children’s exposure to violence. Under the leadership of then Deputy Attorney General Holder in June 1999, OJJDP launched the Safe Start initiative to prevent and reduce the impact of children’s exposure to violence. Safe Start is a long-range four component initiative designed to broaden knowledge about and promote community investment in evidence-based strategies for reducing the impact of children’s exposure to violence. The four components include: 1) Practice Innovation; 2) Research and Evaluation; 3) Training and Technical Assistance; and 4) Resource Development.

As part of its Practice and Innovation effort, OJJDP funded 11 Demonstration Sites from 2000 to 2006 across the country. The sites were designed to improve the accessibility, delivery, and quality of services for children exposed to violence and their families at any point of entry. These community-level system changes helped improve outcomes for children by increasing the identification of children in need of services, improving access to services, and increasing community awareness of the impact of children’s exposure to violence. Individual and family-level outcomes included reduced trauma symptoms in children, decreased parenting stress, and improved family functioning. Community-level outcomes included improvements in systems’ (i.e., police, mental health, childcare, CPS, and domestic violence agencies) ability to identify, screen, and refer children exposed to violence, enhanced service integration, and increased public awareness (Kracke, Lamb & Hyde, 2008). In a second phase of the initiative (2005–2010), OJJDP funded 15 Promising Approaches Pilot Sites which currently are focusing on implementing and measuring developmentally appropriate services for children exposed to violence within the context of the systems that serve them. A process and outcome evaluation of these sites will increase knowledge about how specific intervention strategies affect outcomes for children and families.

The 11 Demonstration Sites consisted of communities across the country representing six urban (Baltimore, MD; Bridgeport, MA; Chicago, IL; Pinellas Co., FL; Rochester, NY; and San Francisco, CA), three rural (Chatham Co., NC; Spokane Co., WA. and Washington Co., ME), and two tribal (Sitka Tribe of Alaska and Pueblo of Zuni) communities (see Table 1 for a comparison of Safe Start Sites). Although the Safe Start Demonstration sites were
primarily working to impact change at the systems or macro levels, funding was also used to provide direct services to children and families to enhance and expand the system of care at each site. A brief description of the work at each of these demonstration sites is provided in Appendix A.

The data described in this paper are from the 10 sites that provided data regarding the characteristics of children referred for direct services due to exposure to violence. The data are descriptive in nature, providing information on the characteristics of a community-based sample of young children who were exposed to violence (e.g., age of child at exposure, types and number of exposures). It is important to note that the Safe Start sites assessed children’s exposure to violence when they were the victim (e.g., child abuse, neglect) and exposure to violence that they witnessed (e.g., domestic violence, community violence). In many cases children experienced more than one type of violence exposure making it difficult to attribute the impact of exposure to a single type of violence or incident.

Methods

All sites obtained local Institutional Review Board (IRB) approval that allowed for the collection of data at the site level and the sharing of data across sites. Descriptive information was collected by service providers (psychologists, social workers, counselors, paraprofessionals, etc.) at the sites and included demographic data (age, gender, race of child and who they reside with) and information regarding the violent event that led to referral for services. Assessments were conducted prior to families receiving services, and assessment approaches varied across sites. Instruments that were administered at two or more of the Safe Start sites included the Traumatic Events Screening Inventory-Parent Report Revised-Brief Version (Ghosh-Ippen, et al., 2002), the Trauma Symptom Checklist for Young Children (Briere, 2005), and the Parenting Stress Index Short Form (Abidin, 1995).

The Traumatic Events Screening Inventory-Parent Report Revised-Brief Version (TESI; Ghosh-Ippen, et al., 2002) is a 24-item semi-structured interview that determines a history of exposure to traumatic events in children six
years and younger. This inventory presents caregivers with a list of traumatic events and asks if the child has ever experienced them. The TESI asks about exposure to many types of trauma. One site gathered information using only the TESI items that assess family violence such as separation from a family member, kidnapping by a family member, witnessing physical fighting in the family, witnessing serious verbal threats in the family, witnessing arrest of family member, experiencing or witnessing inappropriate sexual activity, and experiencing abuse or neglect. The other TESI items include exposure to serious accidents, natural disasters, severe illness or injury of someone close, death of someone close, serious medical procedures or life threatening illnesses, mugging, animal attacks, community violence, direct exposure to war/conflict/terrorism, exposure to war/conflict/terrorism on television or radio, or exposure to other stressful events.

The Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005) is a 90-item questionnaire that was used to measure the effects of exposure to violence on young children aged 3 to 12 years. Caregivers generally completed this form before and after their child participated in Safe Start services. The TSCYC is composed of eight subscales that measure Post-traumatic Stress (PTSD) Intrusion, PTSD-Avoidance, PTSD-Arousal, Sexual Concerns, Dissociation, Anxiety, Depression, and Anger/Aggression. Because of this study’s emphasis on young children, one site shortened the scale from the original by removing those that assessed ‘sexual concerns’ ‘dissociation’ and ‘atypical responses’; therefore, only results from the remaining subscales are reported in this manuscript. Data from the TSCYC are coded on a 1 to 4 scale, where a ‘1’ indicates that the child is not experiencing that particular symptom or displaying that particular behavior and ‘4’ indicates that the child has experienced that symptom or behavior ‘very often’.

The Parenting Stress Index Short Form (PSI/SF; Abidin, 1995) is a 36-item parent-report questionnaire that assesses stress in the parent-child relationship for children 10 years and younger. The PSI assesses the level of stress that caregivers experience in three areas – Parental Distress, Parent-Child Dysfunctional Interaction, Difficult Child, and Total Stress. Raw scores on each subscale can range from 12 to 60. Total raw scores can range from 36 to 180. Scores above the 90th percentile are considered to be in the “clinical” range. The Parental Distress subscale reflects the distress a parent or caregiver experiences in their role as a parent. The stresses associated with this subscale are related to: restrictions placed on other life roles because of parenting; impaired sense of parenting competence;
conflict with the child’s other parent; lack of social support; and depression. The *Parent-Child Dysfunctional Interaction* subscale reflects the caregiver’s perception that their child does not meet their expectations; that their interactions with their child are not reinforcing to them as a parent; and that they experience their child as a negative factor in their life. The caregivers typically see themselves as abused or rejected by the child, feel disappointed in the child, and feel alienated from the child. High scores suggest the parent-child relationship is threatened or has never been adequately established and indicates the need for intervention. Scores above the 95th percentile suggest the potential for child abuse in the form of neglect, rejection, and physical maltreatment. The *Difficult Child* subscale focuses on behavioral characteristics that make children difficult to manage, including the temperament of the child, learned patterns of defiance, and demanding behavior. High scores by parents with children below 18 months of age suggest the child may have significant problems in self-regulatory processes. High scores for parents with children above two years of age are related to measures of child behavioral adjustment and to behavior-symptom checklists. Parents scoring high often need professional assistance. Moreover, when both the subscales of the Parent Child Dysfunctional Interaction and the Difficult Child scores are in the clinical range, intensive therapeutic interventions are usually warranted. The *Total Stress* score provides a measure of the overall level of stress related to parenting that a person is experiencing.

Cross-tabulations were conducted to summarize the descriptive data and chi square analyses were conducted on categorical variables to assess differences across sites. ANOVAs were run to identify any differences across sites on the outcome measures.

**Results**

Prior to analysis, 641 duplicates (same case number) were removed, leaving a total of 2,798 children in the dataset. Unknown and missing values were dispersed throughout the data file, occurring in almost all demographic and descriptive variables. The majority of the missing data was a result of the site choosing not to report or collect the information (e.g., Washington County did not report demographic information) or due to information not being available to service staff at the time of the intake assessment. At the time of data analysis, applicable data was drawn from ten Safe Start sites with only four available observations from Sitka Safe Start and thus the frequencies for Sitka are not shown individually, but are included for the total numbers across all sites.
Table 2 displays the demographic data by site with the number of cases listed below each site. There were significantly more male than female children ($\chi^2(1) = 33.86, p<.001$), with 56% of the sample male. Across all sites, the race/ethnicity of the children was reported as one-third African-American (32%), followed by Latino/Hispanic (25%), Caucasian (20%), Asian (4.9%) and Other (4.8%). Race was not reported for 12.4% of the sample. The frequencies within site were generally representative of their geographic locations. For instance, Chicago and Baltimore had the highest percentage of African-Americans, San Francisco the highest percentage of Latino and Asian-Americans, and Spokane the highest percentage of Caucasian participants. Most children resided in households with their biological mother (66%), while only about 21% lived with their biological father (either with or without mother also present). There was a significant difference between ethnic groups in households with a father ($\chi^2(3) = 27.59, p<.001$), with Caucasian participants having the highest percent (35%) and African Americans the lowest percent (19%) of households with father present. Age was calculated by taking the difference between interview date and birth date. About 28% of the sample is under one year old, 22% is between one and three years of age, 24% between three and five years, 20% between five and nine years old and 6% over the age of nine.

Information regarding the violent event episodes is displayed in Table 3. The first row shows the referral source for the information. The most common named referral source was the police (15%) followed closely by the courts, child provider services, and mother. However, a large percent (19%) was referred by another source not listed. Comparing across sites, there are differences in the frequency of referral sources which were expected as Safe Start sites, by design, targeted unique populations of families including those involved with CPS, the courts or police. The next row displays what triggered the violent event. In most cases it was not known (56%), but in the cases where it was known the most common was a specific event (e.g., a call to the police for a domestic violence occurrence or a
case opening with CPS for an allegation of CAN; 21%). Interestingly, routine screening (e.g., when a child began preschool or at a medical visit) was the event that identified 10% of the children who were involved with Safe Start sites and the suspicion of an event was used to identify 4% of the child clients. The next two rows of Table 3 indicate who was injured and who perpetrated the violence. The most frequent victim of the violent event was the mother (26%), while the most frequent perpetrator was the father (31%). The child was the next most likely to be injured (9%), while the mother was the next most likely to be the perpetrator (9%). However, a large proportion of both the injured and perpetrator were unknown (19% and 20% respectively). The last row of Table 3 presents the frequencies of type of violence, where an incident may involve more than one type. Verbal threats and stalking appeared to occur most often (17%) followed closely by punching or hitting (15%). A gun or knife was involved in over 3% of the violent events. However, Rochester and San Francisco do not report the type of violence and Chicago and Washington only report certain types of events. Given the difficulty for families in reporting a young child’s exposure to violence it is most likely that the reported incidents across all sites in the last column are an underestimate of the true frequency of the types of violence experienced.

Insert Table 4 about here.

The Traumatic Events Screening Inventory (TESI) was administered in three sites; Bridgeport, Chatham, and Washington. The mean number of family violence, non-family violence, and total violent events are displayed in Table 4. Following the model presented by Crusto and her colleagues (2008), the data from the TESI is presented as 2 domains: Family Violence Events and Non-Family Violence Events. Chatham asked only those items in the family violence subscale (11 of the 24 possible events) resulting in a lower total mean compared to Bridgeport and Washington, however the Chatham score on the family violence domain is comparable to the other sites. Overall, the average number of total violent events was 3.7, with 14% of the children experiencing seven or more events. Particular items of the TESI with the highest frequencies of endorsement were ‘ever seen or hear people in family physically assault each other’ (68%), ‘separated from you or another person who child depends on’ (57%) and ‘ever known family member who was arrested, jailed, imprisoned’ (51%).
Tables 5 and 6 display the subscale means and the classification rates for three clinical levels of the Trauma Symptom Checklist for Young Children (TSCYC) subscales. The scale was administered in Bridgeport, Chicago, and Washington. The means for the subscales do not significantly differ by site except for anger aggression ($F = 5.82, p=.003$), where Bridgeport had a significantly higher mean than Chicago. The percent of children reaching the clinical level varies by subscale from 18% for anxiety to 26% for anger/aggression and posttraumatic stress total. On the other hand, for all subscales the majority of children scored below clinical range.

Tables 7 and 8 display the mean Parenting Stress Index (PSI) subscale scores and the percent classified in the clinical range for the three sites that administered the scale including Bridgeport, Pinellas, and Washington. Across the three sites, the percent classified in the clinical range varied from 40% for parental distress to 54% for difficult child. For the total score, 47% were in the clinical range (above the 90th percentile) and 25% were above the 99th percentile.

**Discussion**

Although the negative consequences of young children’s exposure to violence have been well documented in the scientific literature, a systematic understanding of the number and types of violent events that young children are exposed to is lacking. Much of the data concerning children’s exposure to violence comes from child protective service (CPS) providers, and therefore is missing the children and families exposed to violence who do not come to the attention of governmental agencies (US DHHS, 2009; Prevent Child Abuse America, 2007). The data presented in this paper come from 10 communities funded by OJJDP as part of the Safe Start demonstration project to implement systems of care to prevent the incidence and consequences of exposure to violence for children age birth to 6 years. These data represent families that have been identified by domestic violence advocates, early care and
education providers, family members, CPS, court personnel, and police as families with young children in need of intervention due to violence exposure. They represent the types of families with young children who are impacted by violence and come in contact with human service, law enforcement, early education or other helping professions as well as CPS.

The children identified in these communities as having been exposed to violence typically live at home with one or more biological parent and are quite young. Twenty-eight percent of these nearly 3,000 children in this data set are under the age of one and another 22% are between the age of one and three, indicating that 50% of the sample is under the age of three. At this age many children are still being cared for in their homes (US Census, 2000) and therefore less likely to come to the attention of traditional service providers (daycare workers, teachers, etc.). However, given that more than half of the women and a quarter of the men who are victims of intimate partner violence live with children under the age of 12 (US Department of Justice, 2007), the courts, police, CPS, domestic violence advocates, day care providers, teachers, and other social service providers are in a position to refer young children and their families to services that can help to ameliorate the impact of violence exposure.

It is noteworthy that for 21% of the children referred, a specific event (such as police intervention) precipitated the referral and in another 10 percent, a routine screening (such as those conducted at early care and education settings) precipitated the referral indicating the value of community-wide training on the incidence and impact of exposure to violence for young children. The proximity of the perpetrator to the children is also important to consider as the closer the relationship between the child witness or victim and the perpetrator the greater impact the event will have for the child (Gelles, 1987; Gewirtz & Medhanie, 2008). In these Safe Start communities the perpetrator was more often than not a biological parent (31% fathers, 9% mothers) and the children were more often a witness (35%) than a victim (9%) of the violent event indicating that these communities were focusing beyond the recipient of violence to also look at the unintended victims, young children who are silent witnesses to these events.

On average the children in our sample had been exposed to 2.5 types of family violence events which could include witnessing physical fighting in the family, witnessing serious verbal threats in the family, witnessing a family member being arrested, separation from family members who provide care, kidnapping by a family member, experiencing or witnessing inappropriate sexual activity or experiencing abuse or neglect. Nearly two-fifths of the
children and youth surveyed by Finkelhor and colleagues (2009) reported more than one direct victimization within
the previous year and 10.9% of the children and youth reported 10 or more direct exposures to violence. A limitation
of the data from the Safe Start sites is that the age at which children were first exposed to a particular violent event or
how frequently that exposure occurred are not known. Future research should collect this information so that these
variables can be examined in relation to the impact of this exposure on young children (Kracke & Hahn, 2008). This
information will be vital in the development of screening tools and treatment methods for young children exposed to
violence and their families.

About 25% of the children impacted by violence were reported to have clinical-level symptoms of post-
traumatic stress disorder and another 12% sub-clinical levels. Likewise, about half (47%) of their mothers reported
clinical levels of stress related to parenting their child. This clearly indicates the need to intervene at the family level
when young children are exposed to violence to reduce the impact of the violence for both the children and their
primary caregivers. It will be important in future work to examine maternal outcomes beyond parenting stress in
these families as the mother may, as was the case for 25% in this sample, be a victim of violence and benefit from
supportive services. Although data to address this question were collected by some of the Safe Start sites,
methodological variability precluded our ability to examine these relationships using this cross-site data.

The eleven Safe Start demonstration projects provided an opportunity to begin to understand the extent and
types of exposure to violence for young children and the consequences of such exposure. The data on individual
characteristics of CEV provided by this initiative, although important, are limited. The national cross-site evaluation
of the Safe Start demonstration project focused on measuring systemic change across sites’ service delivery systems.
The collection of quantitative outcome data was conducted by the individual Safe Start sites because each site
strategically tailored the services to their specific local needs. Although the national evaluation team designed a
database to capture descriptive information about the children served, not all sites collected the same data. Since sites
independently chose outcome measures to document their interventions, only some of the measures overlapped
across sites.

Future work should include the collection of more specific information regarding violence exposure (age of
first exposure, number and types of exposure, proximity to perpetrator) and information about the impact of violence
exposure for children and their caretakers. The use of standardized outcome measures across all Safe Start sites will also greatly enhance the comparison and confirmation of the impact of the interventions. One limitation of this manuscript, and of the field in general, is the availability of measures of violence exposure and child functioning for very young children. As noted, 28% of the children identified by sites were under the age of one. More work is necessary to understand and assess the impact of violence exposure on these very young children. The use of standardized measures across all Safe Start sites has been incorporated into the implementation of the second phase of the Safe Start Initiative as 15 new sites pilot specific interventions. Findings from the Rand Corporation evaluation of this initiative are expected in 2010. This use of standardized outcome measures will greatly enhance the comparison and confirmation of the impact of all the Safe Start interventions. This information will enable the field to move forward toward more systematic identification, referral, and interventions to reduce the impact of violence exposure on children and their families.
References


