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STATE FISCAL YEAR 2020 SAFE FROM THE START ANNUAL REPORT: 2001-2020

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Illinois Criminal Justice Information Authority

State Fiscal Year 2020 Safe From the Start Annual Report: 2001-2020

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Executive Summary

This evaluation report describes the assessment and service provision activities for 4,823 children predominantly ages 0 to 5, along with their siblings and caregivers, who were exposed to violence and sought treatment at one of nine Illinois Safe From the Start (SFS) program sites between July 2001 and June 2020. Treatment services included individual child and adult therapy, family therapy, support services, psychoeducation, and case management. The objectives of the evaluation were to:

- identify the characteristics and experiences of young children exposed to violence and their caregivers.
- identify the types of violence that children are exposed to.
- assess the impact of violence on young children.
- identify risk factors for children at the individual, family, and community level.
- document the identification and referral process for children exposed to violence.
- document the types of services children and their caregivers received.
- assess the impact of service provision for young children and their caregivers.

DATA COLLECTION

Data from child and caregiver assessments were collected by each site and compiled into a comprehensive database. Data on any particular assessment varied depending upon caregivers' ability to complete all of the assessment measures and/or the amount of missing data from each questionnaire. The instruments used by SFS service providers to collect assessment and service provision data included the following:

- Background Information Form (BIF).
- Child Behavior Checklist (CBCL).
- Parenting Stress Index (PSI).
- Ages and Stages Questionnaire (ASQ).
- Ages and Stages Questionnaire: Social-Emotional (ASQ:SE).
- Safe From the Start Questionnaire (SFSQ).
- Child Completion of Services Form (Child CSF).
- Caregiver Completion of Services Form (Caregiver CSF).

SFS clinicians proctored the BIF, CBCL, PSI, ASQ, ASQ:SE, and SFSQ to caregivers at intake (Time 1 [T1]; pre-intervention). After five to eight sessions (Time 2 [T2]; post-intervention), only the CBCL and PSI were required to be repeated, while repeating the ASQ, ASQ:SE, and SFSQ were optional at the clinicians' discretion.

Further, the Child and Caregiver CSFs were completed upon families' exit from services (typically after 12-16 sessions). Although additional data at later timepoints (i.e., Time 3 [T3], Time 4 [T4]) were collected for families who stayed in services longer than 12 sessions, Time 2 was the best indicator of data collection patterns and service provision outcomes. See *Appendix* for summaries of assessments collected at T1, T2, T3, and T4 from each site from state fiscal years 2002 through 2020.

KEY FINDINGS

Demographic Characteristics of Children

- Children were primarily White (35%), Black (27%), Hispanic (24%), Multi-racial (11%), Asian (< 1%), and Other (2%, e.g., American Native).
- Children identified for services were 4.9 years old on average with ages ranging from less than one month to 17 years of age.
- Children referred for SFS services were 53% male and 47% female.
- 43% of children served lived only with their mothers.

Demographic Characteristics of Caregivers

- Mothers' ages at time of assessment ranged from 15 to 71 years, with an average age of 30 years.
- Fathers' ages at time of assessment ranged from 16 to 90 years, with an average age of 33 years.
- The majority of children (52%) came from families with annual household incomes below $15,000.

Accumulation of Risk Factors

Felitti and colleagues (1998) found that persons who had experienced four or more adverse childhood experiences (ACEs), compared to those who had experienced none, had a four- to 12-fold increase in health risk for alcoholism, drug abuse, depression, and suicide. To assess ACES, caregivers were asked about their children's exposure to 22 potential risk factors. Summarized results indicated:

- Nearly all children experienced multiple risk factors at the individual, family, and community levels. The average child experienced five or more risk factors. Some of these risk factors included having a single parent (72%), their mother having an unplanned pregnancy (62%) and living in poverty (49%).

Impact of Violence on Children and Caregivers

Exposure to violence can impact children's behavioral functioning and caregivers' level of stress. Evaluators noted the following:

- Children were referred for services due to domestic violence (81%), child abuse (15%), sexual abuse (8%), community violence (7%), and for other reasons (14%), such as neglect, behavioral problems, and witnessing sexual abuse of siblings.
- Problem behaviors frequently reported at intake by caregivers about their children included clinging behavior (51%), sleep difficulties (41%), and aggression toward siblings (45%) and parents (40%).
- At intake, 20% of children were identified as at-risk for developmental delays on the ASQ.
- The ASQ:SE identified 39% of children exhibiting social-emotional concerns pre-intervention.
- CBCL data indicated 41% of children assessed at intake were experiencing significant emotional and behavioral problems.
- Caregivers reported that the most frequently occurring problems for children included externalizing behavior (actions based on conflict with others), internalizing behavior (internally focused), aggressiveness, and emotionally reactive behavior.
- Data from the Parental Stress Inventory (PSI) indicate 43% of caregivers were

experiencing significant amounts of parental stress at intake.

Provision of Services

Services offered to children and caregivers commonly involved therapies focused on improving child-parent communication skills and addressing the impacts of domestic violence. Children were specifically taught to identify and express their feelings and ways to cope with their symptoms, while caregivers were taught about the effects of childhood exposure to violence (CEV) and child development. Evaluators observed the following:

- Children attended a mean of 10 sessions. Mean numbers of sessions ranged from seven to 11 sessions across sites.
- Caregivers attended a mean of 12 sessions. Mean number of sessions ranged from 11 to 18 sessions across sites.
- Service providers reported that 63% of children and 62% of caregivers adequately participated in services.

Impact of Services

Children and caregivers who received services experienced improvements in problem behaviors and functioning. Matched pre- and post-intervention assessment data showed the following:

- Of the children previously at risk for social-emotional disorders at intake, 26% improved on the ASQ:SE after receiving services.
- In pre-intervention, 41% of children scored in the "borderline" or "clinical" range of problem behaviors on the CBCL. In post-intervention, 25% of children scored in those ranges, representing a 39% improvement on CBCL Total Problems Scores.
- Following services, the percentage of caregivers scoring at or above the borderline-clinical range on the total stress subscale of the PSI dropped from 42% to 32%, representing a 24% improvement on PSI scores.
- Following services, providers identified improvements in child functioning. Children's ability to identify feelings, overall symptoms, and children's PTSD-Intrusion were rated as most improved, and children's ability to return to school/childcare setting was rated least improved.
- Similarly, providers identified improvements in caregiver functioning. Caregivers' knowledge of the impact of traumatic events was rated by service providers as most improved and caregivers having supportive relationships was rated least improved.
- Child and caregiver outcomes were positively correlated with the number of sessions attended. The more sessions provided, the better the outcomes for both children and their caregivers.

CONCLUSION

The data indicate a significant reduction in children's emotional and behavioral symptoms and caregiver stress after receiving Safe From the Start services. These data provided an important picture of the population being referred for violence exposure, the impact of that exposure to violence, and the impact of services. Through collaborative, community-based efforts designed to help families with a variety of needs, SFS sites are making a positive impact on the lives of children exposed to violence.

Chapter 1: Introduction

Background

The goal of the Safe From the Start (SFS) program is to identify, assess, and provide services to young children 0-5 years old, and to their siblings and caregivers, who have been exposed to violence in their home and/or community. This report reflects cumulative SFS evaluation activities from July 2001 through June 2020.

SFS was the result of a national summit, *Safe From the Start: The National Summit on Children Exposed to Violence,* held in 1999 in Washington, D.C., by the U.S. Department of Justice and U.S. Department of Health and Human Services. In response, the Illinois Attorney General held an SFS Summit in 2000 to respond to the issue of young children exposed to violence in Illinois. From this summit, a working group emerged and recommended selecting demonstration sites to develop, implement, and evaluate comprehensive community models to help young children affected by violence.

The Illinois Criminal Justice Information Authority (ICJIA) assumed statewide SFS program administration from the Illinois Violence Prevention Authority in 2013 and currently supports nine sites with grant funding. The first three sites began a six-month planning phase and initiated implementation in 2001. The second trio of sites began a one-year planning phase in 2002 and implemented the program in 2003. In 2005, two sites received grant funding and began to use SFS evaluation measures in 2006. The others began serving clients in 2007 and 2008.

Unfortunately, one site in 2012 and two sites during the 2015-2017 Illinois budget impasse closed (sites 3, 4, & 11). Of the nine remaining sites supported by ICJIA, six were located in Cook County (sites 2, 6, 7, 8, 9, & 12), two were in Central Illinois (sites 1 & 10), and one was in Northern Illinois (site 5). Results presented throughout this report pertain to analyses of data collected from these nine sites.

Chapter 2: Sample Demographics

Since 2001, the nine SFS sites altogether assessed 4,823 children total using the Background Information Form (BIF) (*Table 1*). Children (anyone under 18) were an average of 4.9 years old. Of all children served, 70% were between the ages of 0 and 5 years old (*Table 2*).

Collectively, more males (53%) than females (47%) received services across sites. Racial and ethnic identities served included White (35%), Black (27%), Hispanic (24%), Multi-racial (11%), Asian (< 1%), and Other (2% e.g., American Native) (*Table 3*).

Background Information Form Data

Data described in this section were collected from a Background Information Form (BIF). The BIF was developed by the SFS Advisory Committee to gather demographic and background information on participating children and their families. The BIF helps tailor service provision to the individual needs and circumstances of children and their caregivers.

Table 1

Number of Children Assessed at Intake, by Site and State Fiscal Year (n = 4,823)

Site	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16*	FY 17*	FY 18	FY 19	FY 20	Total
1	55	68	62	51	43	94	53	55	44	48	39	44	44	44	43	2	35	39	25	888
2	24	36	58	50	53	50	135	89	87	31	52	38	53	66	40	8	33	64	37	1,004
5	0	2	36	64	46	51	57	110	111	59	44	46	41	32	26	0	25	40	23	813
6	0	0	0	0	5	110	59	74	88	36	40	46	44	32	31	8	23	30	28	654
7	0	1	0	0	0	46	27	34	22	39	62	46	17	26	18	0	13	21	1	373
8	0	0	0	0	0	23	32	21	38	53	34	44	26	33	20	5	22	5	17	373
9	0	0	0	0	0	0	0	56	55	71	41	30	32	30	20	0	13	11	11	370
10	0	0	0	0	0	0	0	30	23	31	26	21	18	25	6	0	34	9	15	238
12	0	0	0	0	0	0	0	5	4	18	13	4	18	6	8	0	12	12	10	110
All Sites	85	126	233	222	307	477	442	594	618	484	413	378	365	300	212	23	210	231	167	4,823

Note. *Unfunded years.

Table 2

Children's Age and Sex, by Site (n = 3,476)

Site	Average Age (Years)	*n*	Under Age 6	*n*	Female
1	4.4	541	80%	540	40%
2	4.9	635	69%	611	49%
5	4.4	512	72%	505	50%
6	6.0	536	59%	535	45%
7	5.3	313	60%	304	46%
8	5.1	322	63%	318	49%
9	4.7	347	72%	324	48%
10	3.5	205	93%	194	42%
12	4.0	85	84%	83	53%
All Sites	4.9	3,476	70%	3,414	47%

Table 3

Children's Racial-Ethnic Identity, by Region (n = 3,397)

Region	*n*	White	Black	Hispanic	Asian	Multi-Racial	Other
Cook	2,148	20%	35%	34%	.7%	8%	2%
Central IL	742	63%	14%	5%	.5%	16%	1%
Northern IL	507	58%	13%	9%	.2%	17%	3%
All Sites	3,397	35%	27%	24%	.6%	11%	2%

Note. Percentages may not equal 100 due to rounding.

Children's Home Environment

At intake, children primarily lived with their mothers (43%), their mothers and another relative (18%), both parents (14%), or their grandparents (6%) (*Figure 1*). Mothers on average were younger (30 years) than fathers (33 years) (*Table 4*).

Figure 1

Percentages of Children's Living Situations at Intake (n = 3,374)

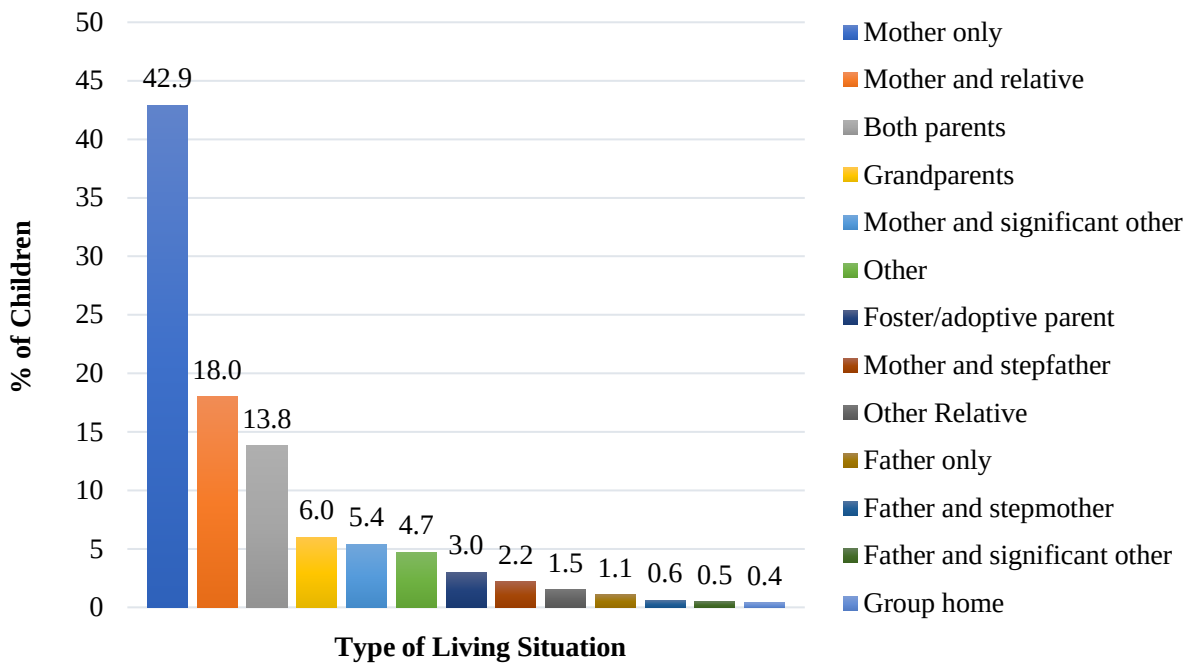


Table 4

Parent's Age

Parent	*n*	Average Age (Years)	Min.	Max.
Mother	3,304	30.1	15	71
Father	2,973	33.2	16	90

Many families rented (47%) or owned their homes (27%), while others lived with family members (10%), in shelters (8%), or in public housing (5%). Less than 1% indicated that they were homeless (*Table 5*). More than half of families (52%) had household incomes of less than $15,000 (*Table 6*).

Table 5

Children's Housing Situations, by Site (n = 3,348)

Site	*n*	Own House	Rent Home/ Apartment	Public Housing	Shelter	Homeless	With a Family Member	Other[1]
1	540	35%	37%	5%	10%	.7%	11%	2%
2	617	28%	45%	2%	10%	0%	11%	4%
5	545	28%	39%	9%	10%	.7%	11%	2%
6	512	38%	38%	0%	7%	.4%	9%	8%
7	300	26%	50%	10%	2%	.7%	11%	1%
8	282	10%	78%	5%	.4%	1%	5%	1%
9	279	10%	61%	2%	13%	.4%	13%	1%
10	201	23%	50%	8%	6%	.5%	12%	2%
12	72	17%	76%	0%	1%	0%	6%	0%
All Sites	3,348	27%	47%	5%	8%	.5%	10%	3%

Note. Percentages may not equal 100 due to rounding.

Table 6

Household Incomes, by Region (n = 3,262)

Region	*n*	$0 - 15k	$15 - 25k	$25 - 40k	$40k+	Unknown
Cook	1,999	54%	18%	12%	11%	5%
Central IL	721	47%	18%	16%	16%	3%
Northern IL	542	49%	21%	14%	14%	1%
All Sites	3,262	52%	19%	13%	13%	4%

Note. Percentages may not equal 100 due to rounding.

[1] Other housing situations included living with friends, living with parent's significant other, transitional housing, and motels/hotels.

Chapter 3: Violence Exposure and Risk Factors at Intake

Violence Exposure

Data from the BIF indicated that of the children who have experienced violence, most of them witnessed domestic violence (81%). Additionally, children were victims of child abuse (15%), sexual abuse (8%), and community violence (5%). Only 2% were witnesses of community violence and 14% were exposed to other types of violence, such as neglect and witnessing the sexual abuse of a sibling. (*Table 7*).

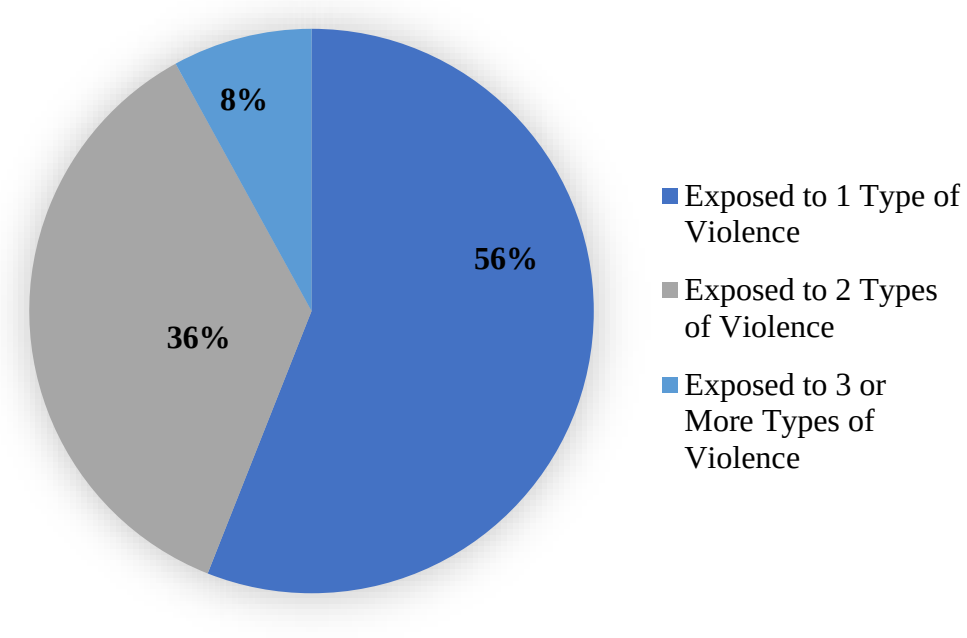
Furthermore, many children referred to services were exposed to multiple types of violence. *Figure 2* shows that 44% of caregivers at intake reported that their children had been exposed to two or more types of violence.

Table 7
Children's Violence Exposure at Intake, by Site and Type (n = 3,502)

Site	Witnessing Domestic Violence	Victim of Child Abuse	Victim of Community Violence	Witnessing Community Violence	Victim of Sexual Abuse	Other Types[2]
1	87%	28%	1%	4%	3%	9%
2	76%	16%	0%	2%	14%	18%
5	76%	10%	0%	1%	12%	16%
6	95%	9%	0%	2%	1%	5%
7	76%	13%	7%	12%	9%	13%
8	62%	11%	4%	17%	10%	27%
9	81%	12%	4%	4%	14%	12%
10	94%	15%	1%	3%	2%	11%
12	67%	9%	1%	7%	12%	35%
All Sites	81%	15%	2%	5%	8%	14%

[2] Other types include neglect, witnessing sexual abuse of sibling, suspected sexual abuse, witnessing suicide/attempted suicide or homicide, at risk for child abuse, emotional/verbal abuse, pre-natal domestic violence, witnessing family drug abuse, experiencing a traumatic event (i.e., fire incident, car accident, dog attack, homelessness, other environmental trauma), witnessing media violence, witnessing police raid of home/violent family arrests, victim of kidnapping, and other types.

Figure 2
Children Exposed to a Single or Multiple Types of Violence (n = 3,297)



Note. Children who experienced "other" types of violence were not included in this analysis.

Children's Presenting Problems

Across all types of violence exposure, the most common presenting problems described by caregivers were clinging behavior, aggression toward siblings and parents, and sleep difficulties (*Table 8*).

However, *Table 9* shows how children who were victims of different types of violence presented some symptoms more than others. For example, victims of child abuse were more likely to have problems with anxiety (46%), destructive behavior targeted toward property (35%), self-abusive behavior (21%), and to have visible injuries (15%) than children with other types of violence exposure. Victims of sexual abuse had higher rates of regressive behavior (e.g., loss of language, bedwetting, difficulty sleeping; 36%), somatic complaints (30%), depression (29%), withdrawn behavior (28%), and sexualized behavior (22%) compared to children exposed to other types of violence. Of the 46 children who were victims of community violence, half of them presented adjustment difficulties compared to the other children assessed. Those children who witnessed community violence were more likely to present fearfulness (43%) and school behavioral problems (37%) than other child victims.

Table 8

Children's Presenting Problems at Intake (n = 3,173)

Children's Presenting Problems	Children
Clinging behavior	51%
Aggression toward siblings	45%
Sleep difficulties	41%
Aggression toward parents	40%
Anxiety	37%
Fearfulness/phobias	34%
Adjustment difficulties	31%
Aggression toward peers	30%
Parent/child relationship	30%
Destructive to property	25%
Regressive behavior	22%
School behavior problems	22%
Withdrawn behavior	20%
Somatic complaints	19%
Depression	19%
Other	18%
Repetitive talk about the event	17%
Self-abusive	14%
Hopelessness	8%
Intrusive thoughts	6%
Perpetrator of sexual activity	4%
Visible injuries	4%

Table 9
Children's Presenting Problems at Intake, by Type of Violence Exposure

Children's Presenting Problems	Violence Exposure Type				
	Witnessing Domestic Violence (*n* = 2,500)	Victim of Child Abuse (*n* = 488)	Victim of Community Violence (*n* = 46)	Witnessing Community Violence (*n* = 145)	Victim of Sexual Abuse (*n* = 267)
Clinging behavior	54%	55%	59%	55%	59%
Aggression toward siblings	48%	54%	48%	38%	46%
Aggression toward parents	45%	46%	37%	37%	47%
Sleep difficulties	44%	49%	35%	46%	52%
Anxiety	41%	46%	39%	43%	45%
Fearfulness/phobias	37%	40%	41%	43%	41%
Depression	22%	27%	24%	28%	29%
Aggression toward peers	32%	33%	39%	42%	29%
School behavior problems	22%	27%	35%	37%	24%
Adjustment difficulties	31%	34%	50%	30%	36%
Withdrawn behavior	23%	27%	15%	21%	28%
Regressive behavior	24%	26%	35%	21%	36%
Hopelessness	10%	12%	17%	16%	14%
Parent/child relationship	31%	34%	37%	33%	34%
Self-abusive	16%	21%	17%	14%	21%
Destructive to property	28%	35%	33%	29%	30%
Perpetrator of sexual activity	4%	8%	2%	3%	22%
Repetitive talk about the event	18%	23%	30%	24%	24%
Somatic complaints	21%	24%	15%	28%	30%
Intrusive thoughts	6%	9%	11%	10%	11%
Visible injuries	4%	15%	11%	5%	5%

Risk Factors

Caregivers were asked to indicate whether their children had been exposed to 22 risk factors. *Table 10* shows that a child having a single parent (72%), the mother having an unplanned pregnancy (62%), living in poverty (49%), and having a father in jail (49%) were among the most commonly reported risk factors. Across all sites, children had been exposed to an average of 5.2 risk factors. Felitti and colleagues (1998) found that persons who had experienced four or more adverse childhood experiences had a 4- to 12-fold increase in health risks for alcoholism, drug abuse, depression, and suicide compared to those who had experienced none.

Table 10

Children's Risk Factors at Intake (n = 3,451)

Risk Factors	Children Exposed
Single Parent	72%
Unplanned pregnancy	62%
Poverty	49%
Father is in jail	49%
Watches violent TV and/or movies	48%
Serious medical problems	42%
No support from religious resources	40%
Mental illness: Other	36%
Mental illness: Mother	35%
Unsatisfied with living situation	31%
No community support for caregiver	31%
Harsh discipline	31%
No family support for caregiver	29%
Birth complications	24%
Exposed to use/sale of illegal drugs	23%
Guns in home	21%
Substance abuse during pregnancy	19%
No positive experiences in community	16%
Mother is in jail	16%
Child has no friends	12%
Substance abuse by mother	10%
Homeless	7%

Chapter 4: Ages & Stages Questionnaire and Ages & Stages Questionnaire: Social-Emotional

Ages & Stages Questionnaire: Baseline Results

Of the 2,004 children for whom Ages & Stages Questionnaire (ASQ) pre-intervention data were available, 20% were identified at intake as at risk for developmental delays. A total of 12% of the children displayed characteristics of being at risk in a single developmental area, 7% demonstrated being at risk in two to three developmental domains, and 2% demonstrated they were at risk in four or five domains. ASQ results indicated that children at risk showed developmental delays mostly in communication skills and fine motor abilities (*Table 11*).

Ages & Stages Questionnaire

The Ages & Stages Questionnaire (ASQ; Squires et al., 1999) provides early and accurate identification of infants and young children who are at risk for developmental delays or disorders and, therefore, may need early intervention services.

In the questionnaire, 30 items on child behaviors address five key developmental areas: communication, gross motor, fine motor, problem solving, and personal-social skills. Caregivers are asked to complete an age-appropriate ASQ, with questionnaires designed for children 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months old.

When used within a general population, the ASQ will identify developmental concerns in approximately 2.3% of children assessed (Squires et al., 1999).

Table 11

Children with Developmental Concerns at Intake, by Site and Area of Developmental Concern (n = 2,004)

Site	Children Assessed (*n*)	Area of Developmental Concern				
		Communi-cation	Gross Motor	Fine Motor	Problem Solving	Personal-Social
1	442	10%	4%	20%	7%	5%
2	321	17%	5%	11%	8%	7%
5	407	5%	1%	4%	3%	1%
6	182	16%	4%	12%	9%	5%
7	115	4%	0%	6%	4%	3%
8	150	14%	6%	15%	9%	3%
9	130	7%	2%	4%	1%	1%
10	187	9%	2%	6%	2%	3%
12	70	14%	4%	10%	9%	7%
All Sites	2,004	11%	3%	11%	6%	4%

Ages & States Questionnaire: Social-Emotional: Baseline Results

Pre-intervention Ages & Stages Questionnaire: Social-Emotional (ASQ:SE) data were available for 1,784 children (*Table 12*). Concerns about social-emotional delays were identified for 696 children (39%).

Ages & Stages Questionnaire: Social-Emotional

The Ages & Stages Questionnaire: Social-Emotional (ASQ:SE; Squires et al., 2003) questionnaire provides early and accurate identification of infants and young children who are at risk of having emotional and social disorders.

Items on the questionnaires address seven behavioral areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. The ASQ:SE is completed by caregivers. Individual questionnaires are provided to collect data on children ages 6, 12, 18, 24, 30, 36, 48, and 60 months. Questionnaires vary in length (from 19 to 33 items) depending on the age of the child.

The questionnaire is 78% accurate at identifying children with social-emotional difficulties and 95% accurate at identifying those without social-emotional delays (Squires et al., 2003).

Ages & Stages Questionnaire: Social-Emotional: Impact of Services

As seen in *Table 12*, children at most sites experienced a decrease in behaviors indicative of social-emotional delays after receiving services. Of the 570 children for whom both pre- and post-intervention ASQ:SE scores were available, 45% of children exhibited social-emotional concerns prior to receiving services. However, 26% of children at risk for social-emotional disorders pre-intervention were no longer at-risk post-intervention.

Table 12

Children with Social-Emotional Concerns at Intake, by Site and Intervention Point (n = 1,784)

	Pre-intervention (T1)		Post-intervention (T2)	
Site	Children Assessed (*n*)	Children with Social-Emotional Concerns*	Children Assessed (*n*)	Children with Social-Emotional Concerns*
1	361	53%	131	37%
2	287	52%	98	49%
5	292	22%	51	4%
6	191	48%	71	41%
7	126	27%	36	17%
8	148	35%	49	49%
9	126	10%	23	4%
10	178	35%	82	27%
12	75	47%	29	31%
All Sites	1,784	39%	570	33%

Note. *This value was calculated by dividing the difference in number of children with developmental concerns at T1 vs. T2 by T1%, then multiplying by 100 to obtain a percent value.

Chapter 5: Child Behavior Checklist

The Child Behavior Checklist (CBCL) was designed to measure the severity of emotional and behavior problems in children. The CBCL was administered at intake (Time 1) and after five to eight sessions (Time 2). Caregivers completed a CBCL form for each child receiving services. The Total Problems score on the CBCL was an aggregated sum of scores on 99 multiple-choice items plus the highest score on any additional problems reported on an open-ended question within the checklist. Higher scores reflect greater problems.

Child Behavior Checklist: Baseline Results

Table 13 shows that of the 2,408 children across sites for whom CBCL data was available, between 5% and 17% of children scored in the borderline range and between 7% and 29% scored in the clinical range for behavior problems at intake. Overall, 41% of children had Total Problems scores in borderline or clinical ranges at intake.

Child Behavior Checklist

The Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000) is a valid and reliable measure of emotional and behavioral problems for young children. The CBCL version for children ages 1½ to 5 obtains parents' ratings of 99 problem items, plus their descriptions of problems, disabilities, what concerns them most about their child, and their child's biggest strengths.

The CBCL is comprised of seven syndrome scales: Emotionally Reactive, Anxious/Depressed, Somatic Complaints, Withdrawn, Attention Problems, Aggressive Behavior, and Sleep Problems. Derived from a combination of these scales, the CBCL can also be scored based on two broad groupings of syndromes: Internalizing and Externalizing. The grouping called internalizing refers to the set of problems experienced within the self (e.g., anxiety, withdrawn), whereas externalizing consists of problems related to conflict with other people (e.g., aggression).

Scores falling between the 93rd and 98th percentile of the normative sample are in the 'borderline' range and indicate the possibility of impaired functioning. Scores falling above the 98th percentile suggest problems that require 'clinical' intervention.

Table 13

Children with CBCL Scores in CBCL Normal, Borderline, or Clinical Ranges at Intake, by CBCL Scales (n = 2,408)

CBCL Scales	Normal	Borderline	Clinical
Syndrome Scales			
Emotionally Reactive	71%	17%	12%
Anxious/Depressed	77%	11%	12%
Somatic Complaints	85%	9%	7%
Withdrawn	79%	7%	14%
Sleep Problems	82%	5%	14%
Attention Problems	78%	9%	13%
Aggressive Behavior	73%	11%	16%
Subscales			
Internalizing Behavior	60%	12%	28%
Externalizing Behavior	60%	12%	29%
Total Problems Score	59%	10%	31%

Note. Percentages may not equal 100 due to rounding.

Table 14 shows that the percentage of children's Total Problems Scores within borderline or clinical limits ranged from 32% (Site 6) to 50% (Site 1). CBCL syndrome scales scores falling within normal limits ranged between 61% (Site 1) to 91% (Site 8), suggesting that some sites are seeing children that may demonstrate higher levels of resilience than others.

Table 14

Children with CBCL Scores in CBCL Borderline or Clinical Ranges at Intake, by Site and CBCL Scales (n = 2,408)

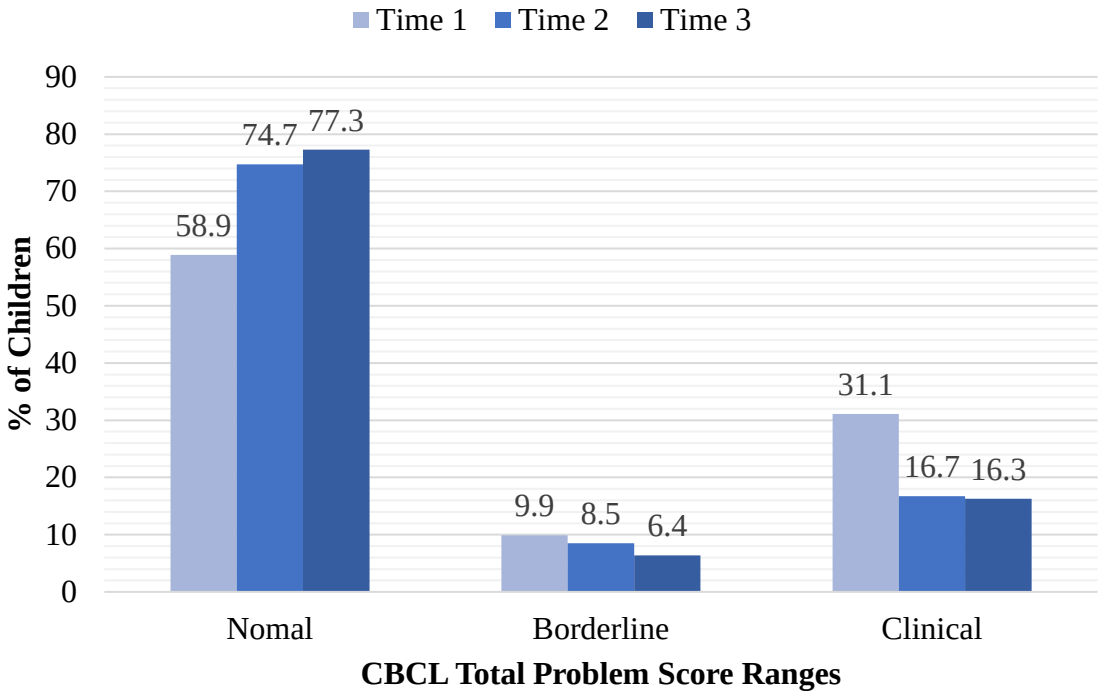
		Syndrome Scales							Subscales		
Site	Children Assessed (*n*)	Emo-tionally Reactive	Anxious/ Depressed	Somatic Complaints	With-drawn	Sleep Problems	Attention Problems	Aggress-iveness	Internal-izing	Extern-alizing	Total Problems Score
1	571	39%	31%	18%	23%	24%	26%	35%	50%	50%	50%
2	469	26%	19%	15%	21%	18%	21%	25%	40%	38%	39%
5	401	24%	19%	13%	15%	17%	21%	15%	34%	37%	36%
6	243	25%	19%	15%	20%	16%	15%	21%	34%	32%	32%
7	151	27%	24%	13%	20%	19%	35%	27%	31%	41%	38%
8	144	24%	15%	9%	20%	10%	19%	22%	31%	33%	38%
9	178	24%	26%	25%	25%	14%	38%	24%	37%	33%	37%
10	179	34%	24%	19%	20%	21%	29%	30%	43%	46%	49%
12	72	33%	28%	16%	30%	17%	18%	28%	51%	42%	44%
All Sites	2,408	29%	23%	15%	21%	19%	22%	27%	40%	40%	41%

Child Behavior Checklist: Impact of Services

Figure 3 shows the percentage of children with CBCL Total Problems Scores that fell within the normal range across sites pre- to post-intervention, indicating that caregivers observed a decrease in their children's problem behaviors. Intake data (Time 1) indicated 59% of children with CBCL Total Problems Scores fell within the normal range, 10% scored in the borderline range, and 31% scored in the clinical range. Following services, 75% of children had Total Problems Scores within the normal range, 9% were within borderline range, and 17% were within clinical range. These trends continued at Time 3, an additional time point where families in services longer than 12 sessions may be reassessed, suggesting that children's problem behaviors improve the longer they stay in services.

Figure 3

Percentages of Children with CBCL Total Problems Scores in the Normal, Borderline, and Clinical Ranges at Times 1, 2 and 3 (n = 2,408)



The percentage of children with post-intervention Total Problems Scores in the borderline or clinical ranges decreased from 41% pre-intervention to 25% post-intervention (*Table 15*). Anxiety/depression, aggressive behavior, and sleep problems decreased the most following services.

Table 15

Children with CBCL Total Problems Scores in CBCL Borderline or Clinical Ranges, by CBCL Scales and Intervention Point (n = 1,021)

CBCL Scales	Pre-intervention (T1)	Post-intervention (T2)	Percentage Point Difference*	Children No Longer Showing Concerns**
Syndrome Scales				
Emotionally Reactive	31%	20%	11%	35%
Anxious/Depressed	24%	13%	11%	45%
Somatic Complaints	16%	9%	7%	44%
Withdrawn	19%	12%	7%	37%
Sleep Problems	21%	12%	9%	43%
Attention Problems	24%	15%	5%	38%
Aggressive Behavior	27%	15%	12%	44%
Subscales				
Internalizing Behavior	42%	26%	16%	38%
Externalizing Behavior	41%	26%	15%	37%
Total Problems Score	41%	25%	16%	39%

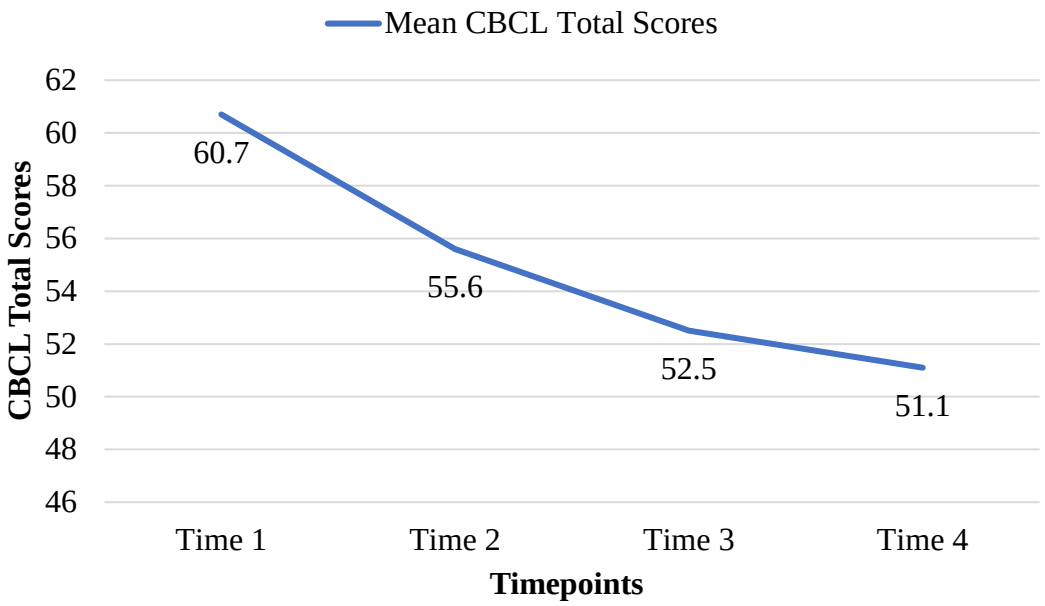
Note. *Percentage point difference refers to the difference in number of children with developmental concerns at T1 vs. T2.

**This value was calculated by dividing the percentage point difference by T1%, then multiplying by 100 to obtain a percent value.

For the 107 children for whom CBCL Total Problems Scores were available through Time 4, when providers reassessed caregivers and children 12 sessions after Time 3 (*Figure 4*), mean scores demonstrated statistically significant improvement from Time 1 to Time 2 [$t(106) = 4.74$, $p < .001$] and from Time 2 to Time 3 [$t(106) = 3.34$, $p < .001$] but not from Time 3 to Time 4 [$t(106) = 1.62$, $p = .108$]. Mean Total Problems Scores were 61 at Time 1, 56 at Time 2, 53 at Time 3, and 51 at Time 4, suggesting that children that stay in therapy continue to demonstrate behavioral and emotional benefits. A mean Total Problems Scores of 50 or less is considered within normal range (Achenbach & Rescorla, 2000). Thus, children treated for exposure to violence demonstrated CBCL Total Problems Scores decreasing to levels similar to their non-clinical, same-aged peers the longer they remained in treatment.

Figure 4

Child Improvement in Mean CBCL Total Problems Scores Over Time (n = 107)



Chapter 6: Safe From the Start Questionnaire

Service providers collected Safe From the Start Questionnaire (SFSQ) data from 2,149 caregivers pre-intervention and 900 caregivers post-intervention. Statistical analysis of the matched pre- and post-intervention SFSQ data indicated improvement in overall scores from Time 1 to Time 2 [$t(899) = 9.3$, $p < .001$] (*Table 16*). Examination of the subscales revealed that scores on caregivers' knowledge of Childhood Exposure to Violence (CEV) changed the least, while scores improved the most in the areas of self-care and ability to help their children upon CEV. Pre-intervention SFSQ average scores showed caregivers already had substantial knowledge of the effects of exposure to violence prior to receiving services.

Safe From the Start Questionnaire

The Safe From the Start Questionnaire (SFSQ) was originally developed for the Chicago Safe Start project and was designed to measure caregivers' knowledge of the effects of exposure to violence and perceptions of their ability to care for their children and themselves following exposure to violence. The SFSQ uses a Likert Scale where caregivers indicate if they strongly disagree (1), disagree (2), are not sure (3), agree (4), or strongly agree (5) to 17 statements. Higher scores reflect greater knowledge about the impact of violence on children and greater ability to care for oneself and one's child following exposure to violence.

Table 4
Caregivers' Matched SFSQ Scores, by Intervention Point (n = 900)

SFSQ Subscales	Pre-intervention (T1)	Post-intervention (T2)
Knowledge of CEV	4.38	4.45
Self-care following exposure to violence	4.08	4.26
Caregivers' ability to help their children	4.14	4.34
Total SFSQ Score	4.25	4.38

Chapter 7: Parenting Stress Index

Parenting Stress Index: Baseline Results

Table 17 shows that, at baseline, 43% of caregivers assessed had a total parental stress index score at or above the borderline range (85th-89th percentile), and 35% had a total stress index score in the clinical range (at or above the 90th percentile). In other words, majority of caregivers reported experiencing significant levels of parental stress when starting services.

Parenting Stress Inventory

The Parenting Stress Inventory (PSI; Abidin, 1995) is a valid and reliable measure of the level of stress that caregivers experience in three areas and provides an overall score.

Parental Distress: This subscale reflects the distress caregivers experience in their roles as parents. The stresses associated with this subscale include restrictions placed on other life roles because of parenting, conflict with their child's other parent, and lack of social support.

Parent-Child Dysfunctional Interaction: This subscale reflects caregivers' perceptions that their child does not meet their expectations and that their interactions with their child are not reinforcing to them as a parent. High scores suggest the parent-child relationship is threatened or has never been adequately established and indicates the need for rapid intervention. Scores above the 95th percentile suggest the potential for child abuse in the form of neglect, rejection, and physical maltreatment.

Difficult Child: This subscale focuses on behavioral characteristics that make children difficult to manage, including the temperament of the child, learned patterns of defiance, noncompliance, and demanding behavior. When both the subscales of the Parent Child Dysfunctional Interaction and the Difficult Child scores are in the clinical range, intensive therapeutic interventions may be warranted.

Total Stress: The Total Stress scale provides a measure of the overall level of parental stress.

Table 17

Caregivers with PSI Scores in PSI Borderline or Clinical Ranges at Intake, by PSI Subscale (n = 3,629)

PSI Subscales	Borderline (85th Percentile)	Clinical (90th Percentile)
Parental Distress	34%	25%
Parent-Child Dysfunctional Interaction	32%	28%
Difficult Child	43%	33%
Total Stress	43%	35%

Table 18 illustrates that across sites between 32% and 43% of caregivers receiving services scored at or above borderline level on one or more of the PSI subscales.

Table 18

Caregivers with PSI Scores at or Above PSI Borderline Range at Intake, by Site and PSI Subscale (n = 3,629)

		PSI Subscales			
Site	*n*	Parental Distress	Parent-Child Dysfunctional Interaction	Difficult Child	Total Stress
1	747	27%	30%	45%	39%
2	738	38%	40%	46%	48%
5	644	27%	26%	34%	32%
6	457	40%	40%	43%	50%
7	281	26%	26%	40%	39%
8	215	28%	28%	38%	38%
9	262	40%	42%	46%	50%
10	214	33%	27%	51%	47%
12	71	47%	30%	45%	44%
All Sites	3,629	34%	32%	43%	43%

Parenting Stress Index: Impact of Services

Table 19 shows the percentage of caregivers at or above the borderline range for each subscale and total score by site. Although all sites demonstrated improvement, it was not uncommon for some caregivers to report increased stress due to their family being in crisis or due to changing previously established family patterns or behaviors.

Table 19

Caregivers with PSI Scores at or Above PSI Borderline Range, by Site, PSI Subscale, and Intervention Point (n = 1,662)

	Parental Distress		Parent-Child Dysfunctional Interaction		Difficult Child		Total Stress	
Site	T1	T2	T1	T2	T1	T2	T1	T2
1	25%	14%	26%	22%	43%	31%	37%	27%
2	42%	30%	44%	38%	49%	43%	50%	46%
5	28%	14%	25%	16%	36%	20%	32%	19%
6	31%	28%	38%	32%	42%	32%	47%	38%
7	24%	27%	25%	29%	44%	32%	45%	31%
8	34%	32%	33%	29%	43%	37%	43%	42%
9	35%	17%	38%	23%	39%	26%	44%	23%
10	34%	19%	24%	18%	52%	38%	48%	34%
12	43%	35%	21%	12%	42%	50%	38%	24%
All Sites	31%	22%	31%	26%	43%	32%	42%	32%

For the 1,662 caregivers for whom Time 1 and Time 2 PSI data were available, 42% had Total Stress scores in the borderline range at Time 1, whereas 32% had Total Stress scores in the borderline range at Time 2 (*Table 20*). Overall, 24% fewer caregivers fell in the borderline range following services [$t(1661) = 8.6$, $p < .001$]. Scores for Parental Distress showed the greatest improvement between Time 1 and Time 2 with a 29% change [$t(1708) = 8.6$, $p < .001$]. This data suggests that services were effective at relieving parental distress.

Table 20

Caregivers with PSI Scores at or Above PSI Borderline Range, by PSI Subscale and Intervention Point

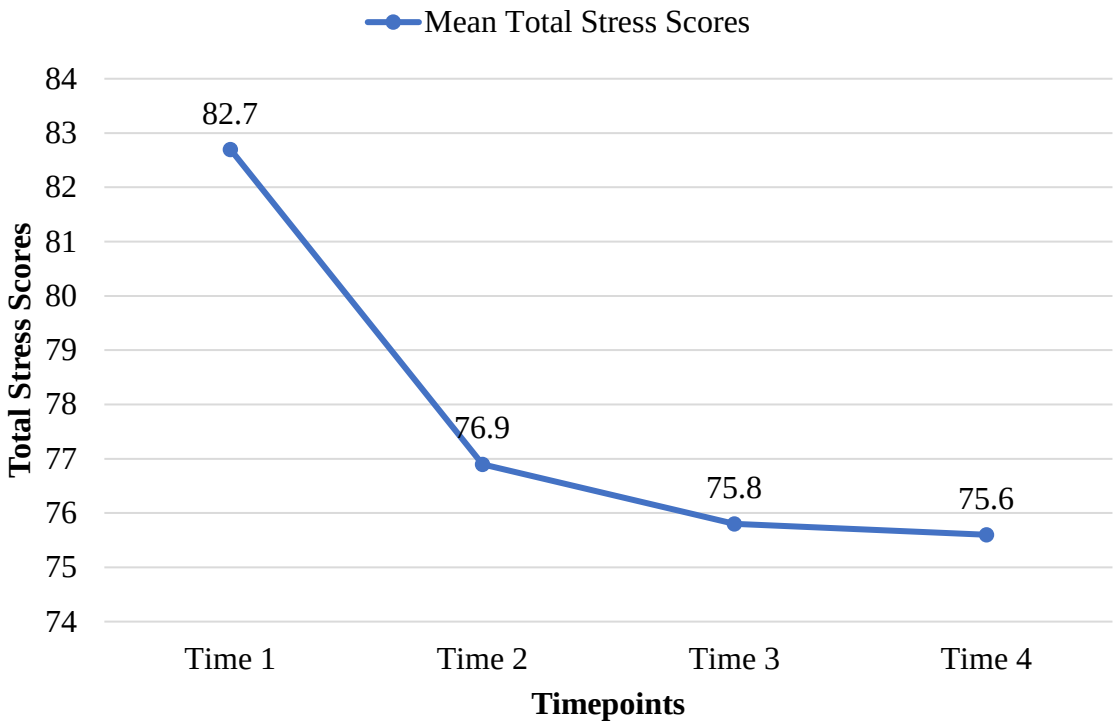
PSI Subscales	*n*	Pre-Intervention (T1)	Post-Intervention (T2)	Percentage Point Difference*	Caregivers Showing Reduced Stress**
Parental Distress	1,709	31%	22%	9%	29%
Parent-Child Dysfunctional Interaction	1,693	31%	26%	5%	16%
Difficult Child	1,685	43%	32%	11%	26%
Total Stress	1,662	42%	32%	10%	24%

Note. *Percentage point difference refers to the difference in number of children with developmental concerns at T1 vs. T2.
**This value was calculated by dividing the percentage point difference by T1%, then multiplying by 100 to obtain a percent value.

Additionally, the 163 caregivers who had PSI scores collected through Time 4 demonstrated continued improvement. *Figure 5* illustrates the decrease in mean Total Stress scores for those caregivers from Time 1 to Time 4. Mean Total Stress scores decrease from 83 at Time 1 to 76 at Time 4, thus suggesting that caregivers who stay longer in services continue to report decreased stress [$t(162) = 4.3$, $p < .001$].

Figure 5

Caregiver Improvement in Mean PSI Total Stress Scores Over Time (n = 163)



Chapter 8: Completion of Services Forms

Child Completion of Services Form

After services to a family were completed, staff at each site rated the children's improvements in 15 areas of functioning on a Professional Summary Report (PSR), a scale contained within the Completion of Services Forms (CSF). Staff rated children's improvements in each area on a scale of 1 to 4, with 1 indicating that the area of functioning declined over the course of services, 2 indicating no change, 3 indicating improvement, and 4 indicating that the child greatly improved in that area of functioning.

Table 21 shows that "Child's ability to identify feelings," "Overall symptoms," and "Child's PTSD-Intrusion" were rated by service providers as most improved, while "Child's functioning at school," "Child's impulse control," and "Child's ability to return to a school/childcare setting" were rated least improved.

Table 21

Provider Reported Child Outcomes (n = 2,440)

Child Outcomes	Mean	*SD*
Child's ability to identify feelings	3.05	.67
Child's overall symptoms	2.94	.72
Child's PTSD-Intrusion	2.91	.76
Child's PTSD-Arousal	2.88	.75
Child's PTSD-Avoidance	2.87	.77
Child's stress	2.87	.72
Child's anxiety	2.86	.72
Child's pro-social skills	2.83	.67
Child's anger/aggression	2.81	.73
Child's functioning at agency	2.80	.73
Child's functioning at home	2.80	.70
Child's depression	2.79	.72
Child's functioning at school	2.71	.73
Child's impulse control	2.71	.71
Child's ability to return to a school/childcare setting	2.62	.73

Child & Caregiver Completion of Services Forms

The Child and Caregiver Completion of Services Forms were developed by service providers from all the SFS sites in 2004. This form was completed by service providers after a child or caregiver completed their treatment plan or were no longer receiving SFS services. The forms are used to describe the services that were provided to families and the outcomes of those services from service providers' perspectives.

Caregiver Completion of Services Form

After families completed services, staff at each site rated caregivers' improvement in 10 areas of functioning (*Table 22*). Similar to the child PSR, staff rated caregiver improvement in each area of functioning on a scale of 1 to 4, with 1 indicating that the area of functioning declined for caregivers while 4 indicated that functioning improved over the course of services. "Caregiver's knowledge of the impact of traumatic events" was rated by service providers as most improved and "Caregiver's having supportive relationships" was rated least improved.

Number of Sessions

Simple correlations between the number of sessions and outcomes as measured by the PSR reveals that the more sessions children attended, the more children improved following services ($r = .25$, $p < .001$) *(Figure 6).* Similarly, the more sessions caregivers attended, the more caregivers improved ($r = .21$, $p < .001$).

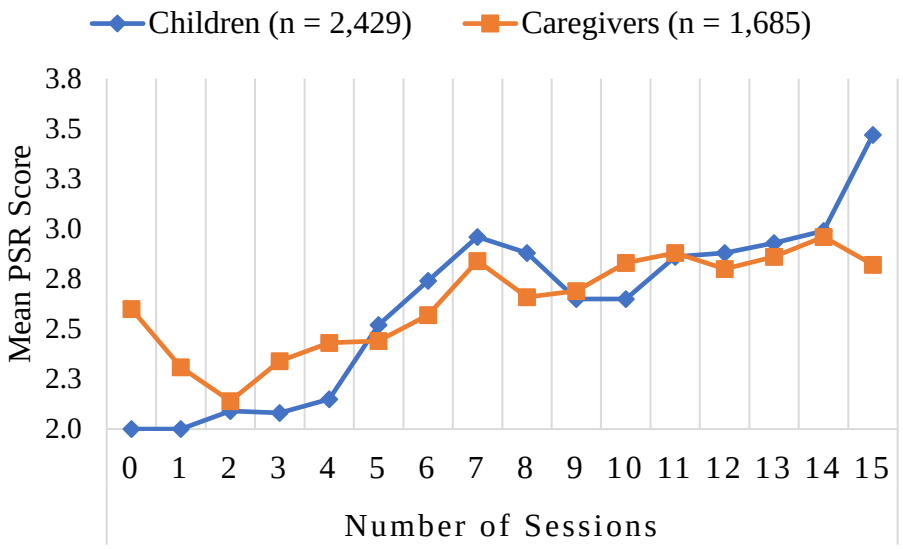
Table 22
Provider Reported Caregiver Outcomes (n = 1,691)

Caregiver Outcomes	Mean	*SD*
Caregiver's knowledge of the impact of traumatic events	3.12	.63
Caregiver's ability to listen to child talk about violence/abuse	2.90	.71
Caregiver's ability to talk to child about violence/abuse	2.90	.70
Caregiver's understanding of child's developmentally appropriate behavior	2.87	.65
Overall family functioning	2.86	.72
Caregiver's parenting skills	2.75	.67
Caregiver's ability to take care of their own psychological and emotional needs	2.74	.74
Caregiver's situation stabilized	2.73	.81
Caregiver's ability to nurture	2.71	.68
Caregiver's having supportive relationships	2.56	.70

Figure 6 also shows that of children with completed PSRs (i.e., less than two missing values on the PSR) and a recorded session number (n = 2,429), children who terminated services prior to one or two sessions experienced little or no change in outcomes. After three sessions, PSR scores generally improved with more sessions. Of caregivers with completed PSRs and a recorded session number (n = 1,685), results showed a similar pattern of improvement in PSR scores, with outcomes improving as the number of sessions increased. Improvements in outcomes were generally observed after six sessions for caregivers.

Figure 6

Mean PSR Scores, by Number of Sessions and Client Type



Across all sites, caregivers attended a mean of 12 sessions (*Table 23*). Mean number of sessions for caregivers ranged from nine (Central IL) to 15 (Cook) sessions.

Across sites, children attended a mean of 10 sessions; mean number of sessions children attended ranged from seven (Northern IL) to 11 sessions (Cook).

Table 23

Client Session Descriptive Statistics, by Region and Client Type (n = 3,849)

	Children				Caregivers			
Region	*n*	Mean # of sessions	Min.	Max.	*n*	Mean # of sessions	Min.	Max.
Cook	2,149	11.1	0	100	1091	14.9	0	100
Central IL	1,007	8.0	0	70	738	9.2	0	85
Northern IL	693	7.3	0	75	434	10.6	0	78
All Sites	3,849	9.6	0	100	2,263	12.2	0	100

Note. Outliers, defined as clients with more than 100 sessions, were not included in this analysis.

Additional Exposure to Violence

Following services, staff indicated whether families were exposed to additional violence after services began. Out of 2,765 children, 19% of children were exposed to additional violence after services began. Staff also indicated that 14% of 1,920 caregivers were exposed to additional violence while participating in services. (*Table 24*).

Table 24

Clients Exposed to Violence While Participating in SFS, by Site and Client Type (n = 2,765)

Site	Children		Caregivers	
	n	Exposed to Violence	*n*	Exposed to Violence
1	555	10%	463	5%
2	540	28%	350	21%
5	489	10%	382	7%
6	309	18%	160	19%
7	218	6%	145	6%
8	196	36%	106	29%
9	256	30%	164	28%
10	172	24%	135	21%
12	30	33%	15	40%
All Sites	2,765	19%	1,920	14%

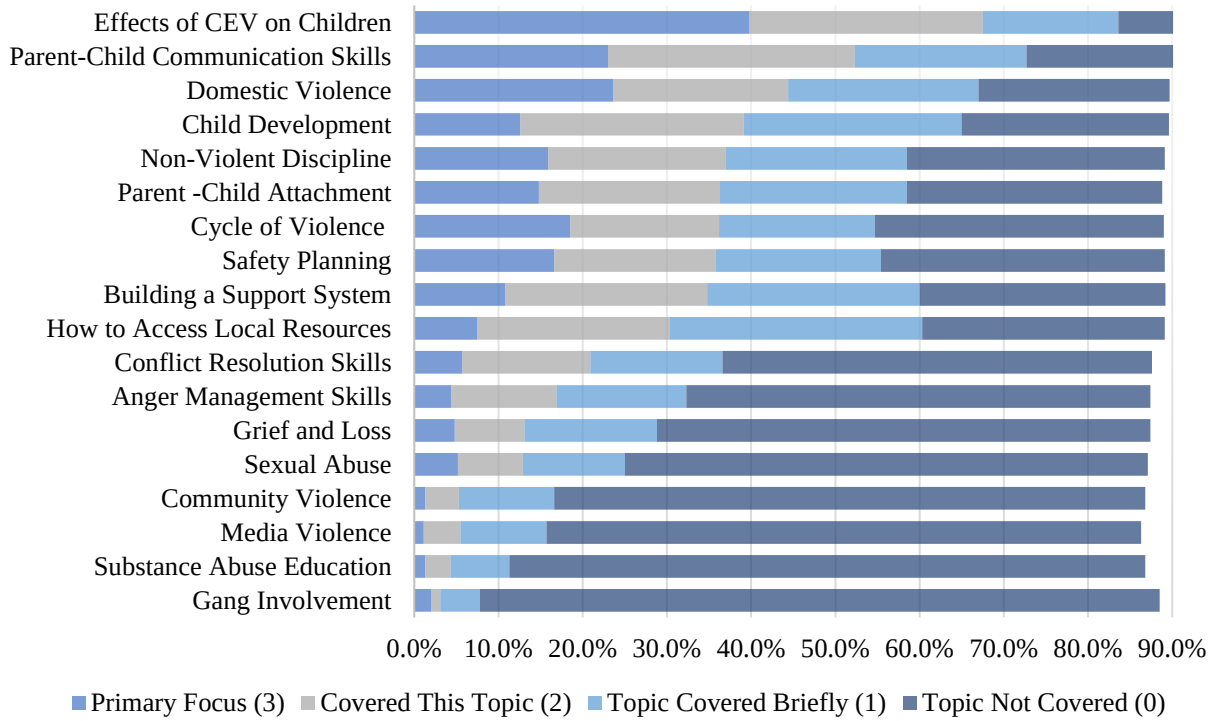
Session Topics

Staff at each site described the extent that topics were addressed in sessions by rating each topic on a scale of 0 to 3, with 0 indicating they did not address the topic and a 3 indicating the topic was a primary focus of the intervention. The effects of CEV on children, parent-child communication skills, and domestic violence were the topics most commonly addressed by service providers working with caregivers.

Topics addressed least often included substance abuse education and gang involvement (*Figure 7*). For children, identifying/expressing feelings, parent-child communication skills, and symptom reduction were the most addressed topics, while community violence and media violence were the topics least addressed *(Figure 8).*

Figure 7

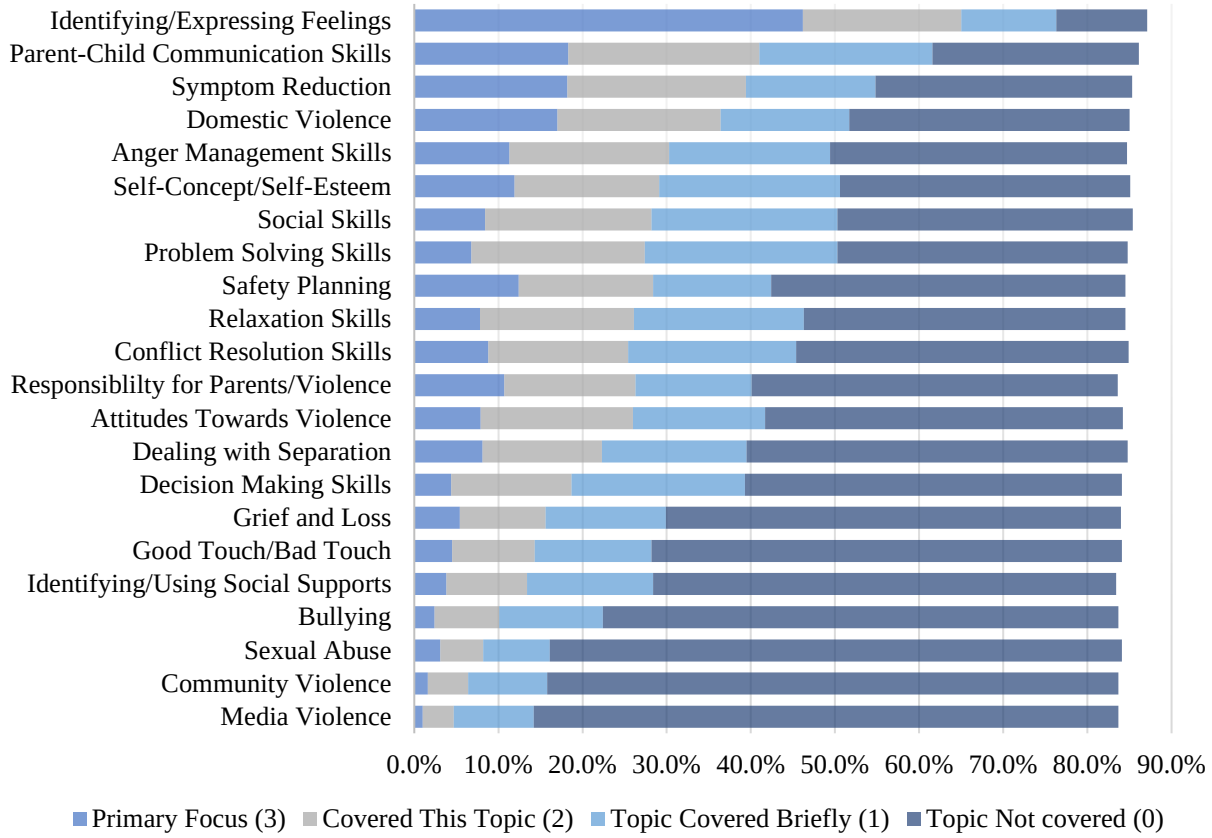
Extent Topics Addressed by Providers in Sessions with Caregivers, by Topic (n = 2,566)



Note. Caregivers who did not attend any sessions were not included in this analysis.

Figure 8

Extent Topics Addressed by Providers in Sessions with Children, by Topic (n = 3,900)



Note. Children who did not attend any sessions were not included in this analysis.

Additional Service Referrals

Service providers not only directly served families exposed to violence, but also provided 1,793 internal and external referrals in the last 19 years to address additional victim needs *(Table 25).* Clients were most often referred for counseling, childcare, domestic violence services, food/clothing, educational and legal advocacy, and transportation. A total of 239 "other" referrals were provided to SFS families such as parenting support groups, crisis nursery services, and Christmas Adopt-a-Family programs.

Table 25

Referrals Provided by Staff to Clients (n = 1,793)

Primary Referrals	*n*	Other Referrals	*n*
Counseling	213	Parenting Support Group/Classes	37
Child Care	198	Crisis Nursery/Respite Services	36
DV Services	136	Christmas Adopt-a-Family/Christmas Gifts	31
Food/Clothing	127	Children's Summer Camp	16
Legal Advocacy	102	School Supplies	12
Educational Advocacy	100	Holiday Party	12
Transportation	86	Psychiatric Services/Evaluations	10
Developmental Assessment	64	Appliances/Utilities/Furniture/Gift Cards	8
Housing	63	Children's Mentoring Services	6
Rent or Utilities Assistance	52	Aging/Grandparent Support Group	6
Services for Children Over Age 6	48	Extra-Curricular Activities for Families	5
Sexual Assault Services	40	Baby Equipment (i.e., car seats)	5
Medical Advocacy	36	Children's Support Group	4
Financial Services	36	Alcoholics Anonymous	4
Temporary Shelter	27	Other Mental Health/Medical Services	3
Employment Services	24	Family Visit Center	3
Offender Services	13	Toys for Tots	3
Bilingual Services	12	DCFS	2
911	10	Doula Services	2
Substance Abuse Services	6	Recycling for Families	2
Immigration Services	6	Additional referrals (i.e., 123 Magic, books on DV and children, crisis services, Self-defense class, yoga, establishing paternity, grief support group, couple's therapy, and youth leadership conference on trauma)	32
Disability Services	5		
Primary Referrals Total	1,554	Other Referrals Total	239
Total Referrals	1,793		

Chapter 9: Conclusion

These findings reflect information gathered from 4,823 children and their caregivers who received a range of Safe From the Start program services from state fiscal years 2002 to 2020. Results indicated that most children (81%) were referred for services after witnessing domestic violence. ASQ:SE and CBCL data indicated that 41% and 50% of children, respectively, were experiencing significant emotional and behavioral problems. Additionally, 43% of all caregivers at Time 1 were experiencing significant parental stress.

Following services, improvements were indicated across all assessment scores post-intervention. Analysis of pre- and post-intervention data showed 26% (ASQ:SE) to 39% (CBCL) fewer children scored in the borderline or clinical ranges after receiving services. Twenty-four percent of caregivers had reduced stress, according to their PSI scores. Overall, providers identified improvements in child and caregiver functioning. Children's ability to identify feelings and caregiver's knowledge of the impact of CEV greatly improved.

Although Safe From the Start has proven to positively impact families exposed to violence in Illinois for almost 20 years, there are numerous challenges and opportunities for growth.

COVID-19 Impact

The COVID-19 pandemic exacerbated issues that many non-profit and community-based organizations already face. For example, low client retention has created challenges for SFS program implementation. Also, as telehealth was more widely used to provide therapy and case management, it has become more difficult for service providers to engage and keep families in services. In a 2021 needs assessment conducted by the SFS evaluators, service providers explained the reasons for such difficulties. These included diminishment of organic connection between providers and families, safety concerns on behalf of families, and a lack of online resources and technical capacities. Although some sites are transitioning back to in-person services, client retention and engagement should continue to be a priority in ongoing discussions between the evaluation team and sites.

Furthermore, as time passes and more data are collected, the pandemic's impact on families exposed to violence should be further analyzed.

Additional Challenges

Timely and complete data entry into the Safe From the Start database also has been an ongoing challenge at many sites. Data collection challenges have come at every step of the process, including gathering complete data from caregivers (especially from families with multiple children in the program) and difficulties gathering data on children whose primary caregivers change throughout their program participation. Several steps have been taken to improve the completeness of the data. In January 2021, shortly after ICJIA transitioned the SFS evaluation to ICJIA's Research & Analysis Unit from an external research partner, the evaluation team began offering training and technical assistance opportunities to SFS sites. Specifically, the ICJIA team has opened ongoing, bi-directional conversations with SFS sites to

ensure providers are consistently updated and informed about changes to evaluation processes that may impact how they deliver services to families.

Successes

One of the main successes of the SFS program has been the resiliency of sites to withstand major obstacles at the state and national level, such as the two-year Illinois budget impasse and the COVID-19 pandemic. Illinois' SFS program has served as a national model for addressing impacts related to young children's exposure to violence. The data indicate that among families who participated in the SFS program that there were significant reductions in children's symptoms and caregiver stress and an improvement in child and caregiver functioning. These data provide an important picture of the population receiving SFS services, the impact of exposure to violence on children, and the benefits of those services. With dedicated staff, updates to the evaluation protocol and client assessment tools, and continued funding, SFS can continue to serve as a model of excellence in serving young children exposed to violence and their families for years to come.

References

Abidin, R. R. (1995*). Parenting Stress Index, Third Edition: Professional Manual*. Psychological Assessment Resources, Inc.

Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for the ASEBA Preschool Forms & Profiles*. Research Center for Children Youth & Families Achenbach System of Empirically Based Assessment.

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M., Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults –The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8*

Squires, J., Bricker, D., & Twombly, E. (2003). Parent-completed screening for social emotional problems in young children: The effects of risk/disability status and gender on performance. *Infant Mental Health Journal*, *25*(1), 62-73. https://doi.org/10.1002/imhj.10084

Squires, J., Potter, L., & Bricker, D. D. (1999). *The ASQ user's guide* (2nd ed.). Brookes Publishing.

Appendix: Cumulative Data Collection Patterns

The following tables summarize all available data per measure from each site during the 19 years of the program's service provision. *Table 26* summarizes intake (BIF) and completion (CSF) data collected at each site from state fiscal years 2002 to 2020. *Table 27* presents all other assessment data available at each time point per site for the same time period.

Data indicate sites collected at most only half of Time 2 assessments compared to total assessments collected at Time 1. One reason for this could be that ASQ, ASQ:SE, and the SFSQ assessments are optional at Time 2. Additionally, families may leave before their service plans are complete, as program participation is voluntary.

Table 26

Completed BIF and CSF Forms, by Site and Client Type, from State Fiscal Years 2002-2020

Site	BIF	Child CSF (%)	Caregiver CSF
1	888	925 (104%)	602
2	1,004	761 (76%)	460
5	813	763 (94%)	459
6	654	801 (122%)	360
7	373	340 (91%)	190
8	373	350 (94%)	151
9	370	364 (98%)	192
10	238	235 (99%)	183
12	110	45 (41%)	36
All Sites	4,823	4,584 (95%)	2,633

Note. The Child CSF column indicates percentages of child completion forms per BIF. Child CSF percentages surpasses 100 when families exited the program but returned to complete treatment within three months, thus completing more than one CSF.

Table 27

Completed Assessment Forms by Site, Assessment Type, and Intervention Point, from State Fiscal Years 2002-2020

Site	ASQ Assessment Totals				ASQ:SE Assessment Totals				CBCL Assessment Totals				SFSQ Assessment Totals				PSI Assessment Totals			
	T1	T2	T3	T4	T1	T2	T3	T4	T1	T2	T3	T4	T1	T2	T3	T4	T1	T2	T3	T4
1	402	39	1	0	361	131	3	1	571	320	122	31	409	212	5	0	747	449	199	55
2	294	22	4	1	287	98	29	5	467	176	54	16	304	109	36	7	738	317	131	41
5	388	18	1	0	292	51	13	3	401	141	28	7	365	165	45	8	644	279	76	14
6	175	6	1	0	191	71	27	4	242	95	42	3	176	71	29	2	457	194	84	8
7	110	5	0	0	126	36	10	2	151	50	11	2	178	68	28	6	281	130	42	12
8	144	6	0	0	148	49	23	7	144	64	33	12	111	55	28	9	215	106	59	34
9	118	11	1	0	126	23	5	0	178	61	14	1	133	50	16	2	262	97	41	2
10	173	12	2	0	178	82	26	1	179	79	27	0	170	69	17	1	214	87	30	1
12	69	1	0	0	75	29	12	2	72	34	12	2	42	7	0	0	71	36	17	2
Total	1,873	120	10	1	1,784	570	148	25	2,405	1,020	343	74	1,888	806	204	35	3,629	1,695	679	169
All Sites	2,004				2,527				3,842				2,933				6,172			

About ICJIA

Created in 1983, the Illinois Criminal Justice Information Authority (ICJIA) is a state agency dedicated to improving the administration of criminal justice.

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