Philadelphia Safe and Bright Futures

A Blueprint for Responding to Children Exposed to Domestic Violence in Pediatric Health Care

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Executive Summary

In recent years, increased attention has been focused on children who are impacted by violence in the home, either as direct victims or as witnesses to domestic violence. Domestic violence can be defined generally as "a pattern of assaultive and/or coercive behaviors, including physical, sexual, and emotional abuse, as well as economic coercion, that adults use against their intimate partners to gain power and control in that relationship."[1]

Research shows that even when children are not the direct targets of violence in the home, they are often significantly harmed by witnessing the occurrence of such violence. The witnessing of domestic violence can be auditory, visual, or inferred, including cases in which the child witnesses the aftermath of violence, such as cuts, bruises, broken limbs, or a parent's emotional distress. Children who witness domestic violence can suffer severe emotional and developmental difficulties similar to children who are the direct victims of abuse.[2] Witnessing domestic violence has been shown to have serious health consequences for children that may persist into adulthood.[3]

In response to this national epidemic of domestic violence, many professional organizations have developed policies recommending routine screening for domestic violence in health care environments, including pediatric office settings.

In October 2004, the Institute for Safe Families (ISF), a non-profit organization whose mission is to prevent intimate and family violence, in collaboration with Lutheran Settlement House, a local domestic violence agency, received one of twenty-two U.S. Department of Health and Human Services (HHS) two-year planning grants to develop a coordinated community response for children exposed to domestic violence. In response to the call from HSS, ISF launched the Philadelphia Safe and Bright Futures for Children and Families Initiative (SBF) whose purpose was to develop a sustainable, collaborative approach to children's exposure to domestic violence in pediatric health care.

The SBF initiative was implemented through the Philadelphia Pediatric Health Care Collaborative (Pediatric Collaborative), which ISF developed at the beginning of the project. The Pediatric Collaborative includes over 25 organizations and agencies throughout Philadelphia that directly or indirectly deal with domestic and family violence from the victim, survivor, perpetrator and child standpoint. Many of these organizations have a longstanding, working relationship with ISF. The Collaborative has focused on the prevalence of children's exposure to domestic violence, current system responses, and recommendations for future action.

The work of SBF covered a two-year period (2004-2006) and encompassed two discreet project initiatives resulting in a *Blueprint for Responding to Children Exposed to Domestic Violence in Pediatric Health Care*.

Year One (2004-2005) focused on the development and implementation of a Needs Assessment to investigate three key questions.

- What is the prevalence of children's exposure to domestic violence?
- What are current system responses to children exposed to domestic violence in Philadelphia?

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[1] Susan Schecter and Jeffrey Edleson, Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice. Reno, NV: National Council of Juvenile and Family Court Judges, 1999.
[2] ibid
[3] Edleson, J. Children's witnessing of adult domestic violence. J Interpers Violence 1999; 14:839-870.

- What are some current best practice models associated with children's exposure to domestic violence nationally?

Using a range of methodologies, including primary and secondary data collection and analysis, a comprehensive Needs Assessment was completed by the end of year one. The full Needs Assessment is available from ISF.

Year Two (2005-2006) drew upon the results of the Needs Assessment, out of which a *Blueprint for Responding to Children's Exposure to Domestic Violence* was created. Using three subcommittees to focus the work (pediatric health care, child welfare, and mental health services and systems), the second year revolved around answering one key question:

- How can we create a model system of integrated care for children exposed to domestic violence using pediatric health care as the focal point?

From this process, a set of recommendations were formulated to guide the implementation phase.

Blueprint Recommendations

1. **Provide citywide training (Pediatric RADAR) for Pediatric Health Care Providers and work to institutionalize screening and intervention for domestic violence at all pediatric health care sites.**
2. **Create on-site domestic violence and mental health services in pediatric settings to respond to children exposed to domestic violence.**
3. **Increase collaboration between Pediatric Health Care Settings and Mental Health/Domestic Violence Agencies where on-site services cannot yet be implemented.**
4. **Establish the Clinical Network on Children Exposed to Domestic Violence.**
5. **Provide leadership and coordination to create a model system of integrated care for children exposed to domestic violence, with a special focus on four systems: pediatric health, mental health, child welfare, and domestic violence.**

I. Introduction

In recent years, increased attention has been focused on children who are impacted by violence in the home, either as direct victims or as witnesses to domestic violence. Domestic violence can be defined generally as "a pattern of assaultive and/or coercive behaviors, including physical, sexual, and emotional abuse, as well as economic coercion, that adults use against their intimate partners to gain power and control in that relationship."[4]

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Since 1998 the American Academy of Pediatrics (AAP) recommended intervening on behalf of battered women as an active form of child abuse prevention (AAP, 1998). Child abuse occurs in up to 70% of families in which there is abuse of adults.[7] Asking about abuse should be done in the context of improving the safety, health and well being of the entire family. The AAP recognizes that family and intimate partner violence is harmful to children and recommends that:

- Pediatricians should attempt to recognize evidence of family or intimate partner violence in the office setting.
- Pediatricians should intervene in a sensitive and skillful manner that maximizes the safety of women and child victims.
- Pediatricians should support local and national multidisciplinary efforts to recognize, treat and prevent family and intimate partner violence.[8]

Pediatric health care settings need to have a comprehensive and integrated system of services available that provide for the safety, stability and well-being of children and families identified as being involved in domestic violence and that allow for children to remain with the non-offending parent whenever possible.

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[4] Susan Schecter and Jeffrey Edleson, Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice. Reno, NV: National Council of Juvenile and Family Court Judges, 1999.
[5] ibid
[6] Edleson, J. Children's witnessing of adult domestic violence. J Interpers Violence 1999; 14:839-870.

[7] American Academy of Pediatrics (1998). The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women, *Pediatrics,* 101 (6), 1091-1092.
[8] ibid

In 1998, the American Academy of Pediatrics issued a position statement declaring, "The abuse of women is a pediatric issue." The Family Violence Prevention Fund, in partnership with the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the National Association of Nurse Practitioners issued the following statement:

> "During the past 15 years, there has been a growing recognition among health care professionals that domestic violence is a highly prevalent public health problem with devastating effects on individuals, families and communities. Most Americans are seen at some point by a health care provider, and the health care setting offers a critical opportunity for early identification and even the primary prevention of abuse. Studies show that assessing for intimate partner violence in medical settings has been effective in identifying women who are victims and that patients are not offended when asked about current or past intimate partner violence." (Groves, Augustyn, Lee & Sawires, 2004)

The work of SBF focused on how to operationalize AAP's position statement, that "the abuse of women is a pediatric issue" and bring these principles and guidelines to Philadelphia's pediatric health care settings. SBF explored how to 1) effectively train providers in pediatric settings about domestic violence; 2) screen women for domestic violence in pediatric settings; and 3) provide appropriate follow-up and response to women, men and their children who are living in the context of family violence.

II. The Process

The SBF initiative was implemented through a newly formed Philadelphia Pediatric Health Care Collaborative (Pediatric Collaborative). The Pediatric Collaborative includes over 25 organizations, health care sites and agencies throughout Philadelphia that directly or indirectly deal with domestic and family violence from the victim, survivor, perpetrator and child standpoint. The Pediatric Collaborative:

- Facilitates the exchange of information;
- Develops an increased awareness of how other systems respond to children's exposure to domestic violence; and
- Fosters and cultivates an environment in which people can work together to provide coordinated and effective services.

A: Year One—the Needs Assessment

From October 2004 to September 2005, a Needs Assessment was conducted to: 1) Determine the prevalence of children's exposure to domestic violence, based on national and local data; 2) identify gaps in current services to children exposed to family violence; and 3) identify and describe best practices associated with children's exposure to family violence.

The key components of the Needs Assessment included the following:

- Emergency Department study at the Children's Hospital of Philadelphia (CHOP)
- Chart audit of Philadelphia Department of Public Health (PDPH) community health centers
- Study at local university to assess college students' exposure to violence in the home
- Phone survey by local domestic violence agency among hotline callers to determine whether children's exposure to domestic violence was a concern
- Patients at four PDPH community health centers surveyed to determine the prevalence of children's exposure to domestic violence, types of childhood exposure, and needed services
- Specialized meetings and focus groups with key informants

Highlights of the Needs Assessment include the following; the full Needs Assessment is available from ISF.

Emergency Department (ED) study at the Children's Hospital of Philadelphia (CHOP)

The study done at CHOP's Emergency Department affirmed Philadelphia's high rate of domestic violence:

- 21% of women surveyed in the CHOP ED said that they had personal experience with domestic violence (n=133).
- 26% responded affirmatively to the category that they were "familiar from personal experience" (n=136).

- Preliminary results found detection rates for domestic violence “in the past year” were 10% (n=499).

The CHOP ED sees approximately 75,000 patients per year. If these questions were asked universally, family violence exposure could be detected in more than 7,000 families per year.

Philadelphia Department of Public Health - Chart Audit

1,563 pediatric charts were audited for domestic violence screening at PDPH’s 8 community health centers. The purpose of the PDPH chart audit was to gather data on prevalence of abuse and to determine the impact of training on screening by providers and detection of abuse.

- Prevalence rates for current suspected and actual abuse appear to be approximately 5% and past suspected and actual abuse appears to be approximately 36%.
- Training of pediatric providers improved detection of past abuse.

Local University Survey

- 35 Philadelphia-area college students, 24 females (68.6%) and 11 males (31.4%), completed a survey about levels of exposure, victimization, and perpetration of domestic violence.
- 20% had been exposed to some form of domestic violence as a child
- Types of exposure were pushing, grabbing, slapping, or throwing objects (20%); threatening or hurting with a knife or gun (5.7%); and kicking, biting, or hitting with something (2.9%)
- 66% of students reported victimization in their own relationships
- 29% of students reported perpetrating physical violence

Patients at 4 PDPH Community Health Centers Surveyed

- 99 women from 4 Philadelphia CHCs completed an anonymous survey
- 51% of women reported childhood exposure to domestic violence
- 61% reported experiencing IPV in their own relationship
- 29% reported that children were present during their incidents
- 55% reported that their child had been exposed to domestic violence
- 7% reported that their child was physically hurt during the fighting
- 20% reported having spoken to their health care provider about domestic violence
- 62% said they would feel comfortable discussing domestic violence with their health care provider

Phone Survey by Philadelphia Domestic Violence Agency

In July 2005, callers to a Domestic Violence hotline were asked specific questions about their children’s exposure to domestic violence.

- Of the 46 calls to a domestic violence hotline, 44 mothers voiced concerns about their children’s exposure to domestic violence; two mothers said that they had no concerns.

- Concerns included behavioral issues associated with the abuse, such as acting out and worries about the impact of exposure on children

System Stakeholder Data and Analysis

Data gathering from key stakeholders was conducted as follows: a) Two special meetings with 15 key informants; b) 24 key stakeholder interviews with staff from 14 of the participating organizations from the Pediatric Collaborative, and c) the inclusion of relevant information from the CHOP and Parenting After Violence Focus Group studies. Findings from these meetings included:

- There is agreement that pediatric health care is an extremely important setting in which to target children's exposure to domestic violence.
- Children's exposure must be addressed through a family systems perspective.
- There needs to be a spectrum of responses for families and parents who seek help through the pediatric setting.
- There needs to be more clarity regarding the relationship between the child welfare system and the pediatric settings as it relates to family violence.

Best Practices

The Needs Assessment identified programs that represented best practices for children's exposure to domestic violence. This information was used to inform the system response in Year Two.

- Project AWAKE at Children's Hospital, Boston
- The Child Witness to Violence Project at Boston Medical Center
- The Violence Intervention Program (VIP), (New Orleans Police Department, Louisiana State University, and community mental health professionals)
- The Preschool Witness to Violence Program-Child Trauma Research in San Francisco

B. Year Two: Creating the Blueprint

From October 2005 to September 2006, the Pediatric Collaborative worked on creating a *Blueprint To Respond To Children's Exposure To Domestic Violence In Pediatric Health Care*, focusing on one key question:

How can we create a model system of integrated care for children exposed to domestic violence using pediatric health care as the focal point?

In order to address this question, the Pediatric Collaborative convened three multi-disciplinary subcommittees. Subcommittees had designated leadership charged with keeping their committee on track and fulfilling the goals and objectives of the planning process. Subcommittee chairs worked closely with SBF project staff to maintain consistency in process and product.

- The *Pediatric Health Care Subcommittee* was chaired by Joel Fein, MD, MPH, Children's Hospital of Philadelphia.

- The subcommittee on *Mental Health System and Services for Children and Families* was chaired by Julie Campbell, LSW, Children's Crisis Treatment Center.

- The subcommittee on the *Role and Interaction with the Child Welfare System* was co-chaired by June Cairns, MSW, Philadelphia Department of Human Services and Rachel Fusco, PhD, University of Pennsylvania.

Using information from the needs assessment completed in Year One, the subcommittees brought together domestic violence advocates and additional experts and organizations to develop plans for system revisions and/or new services to be considered by the full Pediatric Collaborative for inclusion in the final Blueprint. The representatives of the subcommittees worked within their system to achieve acceptance of proposed changes, new services, and collaborative efforts such as cross-system training.

The charge to these subcommittees was to create, develop, and make recommendations for implementing a coordinated community response to children's exposure to domestic violence in pediatric health care. At the outset of each subcommittee deliberations, participants were given two working documents: 1) A set of "Guiding Principles" to provide a background to deliberation and approach; and 2) a set of "Operational Questions" to provide a framework for deliberations and proposed solutions.

In their deliberations, the subcommittees addressed *barriers* to identification of family violence in pediatric health settings, *gaps* identified in the service system to which families can be referred, and *challenges* in coordination of services.

Guiding Principles

- Healing begins with relationships.
- No matter what our role is, we must do what we can to stabilize environments for children and families and provide safety and security for them.
- In general, the best way to help children is to help their parents.
- We cannot do this work alone. We must create effective partnerships with other systems.
- We must learn to be comfortable with the limits of our own professions.
- Good supervision, peer support, and self-care are essential for workers in this field.
- We must look at our own attitudes toward violence as we seek to inform the attitudes of others.

Operational Questions

- How would this system best identify and respond to domestic violence?
- How would this system best respond to children being exposed to domestic violence?
- What would it take to create and implement a model program of services and resources in Philadelphia?

III: Project Outcomes

The two-year process of research and study produced the following outcomes.

- **Significant new data generated from the needs assessment on the prevalence of and response to domestic violence in Philadelphia**.

The needs assessment conducted during the first year created, for the first time, a breadth and depth of data about domestic violence and children's exposure *specific to Philadelphia*. This data not only informed the second year planning process and Blueprint development, but also ongoing work in domestic violence and children's exposure.

- **The creation of a citywide Pediatric Collaborative and subsequent formal and informal relationships and collaborations across Philadelphia.**

The creation of the Pediatric Collaborative as the mechanism for completing this work served multiple purposes. Not only did the Collaborative work intensively to complete the needs assessment and in subcommittees to create the Blueprint, but also relationships made between individuals and institutions by way of the Collaborative led to enhancement of services and activities related to children's exposure.

- **New knowledge on system capacity to respond to children exposed to domestic violence.**

By coming together regularly and sharing both quantitative and qualitative data, there has been a development of a collective knowledge about what each institution is currently doing to respond to children's exposure and what the capacity is of individual institutions and the system as a whole to increase their commitment to this work.

- **The development and creation of a model *Clinical Network on Children's Exposure to Domestic Violence*.**

One of the key recommendations that came out of the subcommittee work was the creation of a Clinical Network on Children's Exposure (see Section IV). As a result of this process, this network has been funded and will begin meeting regularly in the fall of 2006.

- **Buy-in and development of on-site domestic violence and child mental health resources at pediatric sites.**

The importance of on-site domestic violence and child mental health resources at pediatric sites has been recognized by SBF participants as critical to the response to children's exposure to domestic violence. Through SBF, there has been a significant growth in the understanding of that importance and the need for institutional commitment to create on-site services. Currently, there are services being developed in several sites throughout the City. In cases where it is not cost effective or efficient to have on-site personnel, the resources located at larger institutions could be available for real-time consultation and intervention. These mental health resources, if available, could also be accessed for other identified mental health needs in these institutions, such as suicidality, depression, and somatic disorders.

- **Clear consensus among stakeholders on next steps.**

While much work has been done, there is much, much more to do. This project has led to a strong sense of clarity and consensus among stakeholders on the next steps that need to be taken to enhance and improve the system's response to children exposed to domestic violence. Reaching that level of agreement was the result of a shared process and commitment that came out of the SBF initiative.

IV. Recommendations and Next Steps

After two years of focused inquiry and investigation, the stakeholders agreed on the following recommendations. While the overall recommendations apply to all pediatric health care sites, there was strong recognition that the implementation of policies, practices, training, and other responses to domestic violence will be different depending upon the institution. As such, it is important for each institution to determine the best way to meet the overall goals laid out in the Blueprint.

Recommendation One:

Train Pediatric Health Care Providers Using the RADAR Training Model

Pediatric health care settings need to establish as standard of care, policy and protocol for screening and identifying caregivers about domestic violence. To achieve this goal, pediatric health care providers can be trained to use Pediatric RADAR, a tool that has been used and studied in adult medicine and child welfare settings. **RADAR** stands for **R**outinely screen; **A**sk direct questions; **D**ocument; **A**ssess safety; **R**espond, **R**eview options, and **R**efer. The objective of Pediatric RADAR is to teach providers about the effects of domestic violence on children, how to ask their pediatric patients' female caregivers about safety as it relates to interpersonal violence, and how to respond safely and appropriately to self-reported victimization of domestic violence in their patients' families. For each setting, customized training strategies will need to be developed. Additionally, methods of screening and documentation will likely vary by site. However, key components for each site include:

- Train and provide technical assistance to health care providers on screening for domestic violence.
- Determine which method of screening and identification is appropriate to each health site: health provider screen, self-report, computer screen.
- Identify and screen high-risk patients (teens, teen parent, new mother, and obvious suspicious behavior).
- Assess health care provider understanding of the domestic violence issues, including its impact on children, the relationship between domestic violence exposure and behavioral problems, and co-morbidity with child abuse.
- Provide ways to easily document screening and findings such as written prompts on the patient encounter forms, and other internal mechanisms for better assessment and documentation.
- Provide referrals and/or a point person to refer domestic violence clients for an immediate, appropriate response.
- Establish protocol for supporting the children, such as assessment of the impact of DV, referral to specialized mental health/trauma services in appropriate cases, etc.

Recommendation Two:

Establish on-site domestic violence and mental health resources in pediatric health care settings.

On-site domestic violence and mental health services appear to be the ideal model of family centered care. Health care providers, domestic violence advocates, and child trauma specialists agree that by having someone on-site to refer families to will increase screening and identification, referrals, and services for families.

A. On-Site Domestic Violence Resources

ISF, in collaboration with Lutheran Settlement House, a domestic violence agency, recently developed CAMP (Children and Moms Project), a multi-approach program that facilitates domestic violence screening at St. Christopher's Hospital for Children Ambulatory Pediatric Clinic. This project has been funded by the Children's Trust Fund. CAMP provides trainings on domestic violence for residents and attending physicians; an on-site domestic violence counselor who works specifically at the hospital; a committed and involved hospital social work department; prompts for domestic violence inquiry on the Well Child Check-up sheet; and five resident "champions" who participate in teaching and consulting to the remaining staff.

CAMP can serve as a specific model for other pediatric health care settings. Based on what has been learned from the CAMP Project at St. Christopher's Hospital for Children, the following is recommended for a domestic violence specialist in a pediatric setting:

1) Be the key person to work with the woman who identifies herself as a victim of domestic violence.
2) Work closely with social work and other related staff, committees, and other facets of the hospital/health care setting to increase overall coordination and awareness of services.
3) Assist with the development of domestic violence policy and protocol to include: definitions, guiding principles, routine assessment, intervention, documentation strategies, reporting policies, and confidentiality rules. The domestic violence advocate can serve as the liaison between the patient and medical professional.
4) Provide case consultation.
5) Provide general education and resource materials on domestic violence and the effects of domestic violence on children to staff in both in-patient and outpatient settings.
6) In collaboration with key hospital personnel, provide on-going training for both clinical and non-clinical staff related to screening and intervention for domestic violence.

B. On-site Mental Health Services

The Mental Health Subcommittee agreed that children and families affected by domestic violence are most likely to be successful in following through with mental health treatment if comprehensive mental health services for the whole family can be provided in pediatric health care settings. Ideally, this would include specialized mental health treatment for children exposed to domestic violence, women who are domestic violence victims and men who are abusive.

One potential model for delivering this kind of care would partner a pediatric health care setting with existing child and family mental health services that specialize in treating children exposed to

domestic violence. The therapist would be an employee of the mental health agency, receive supervision from that agency and carry a set caseload (1-2 days per week) at the pediatric health setting. This model would require some resolution of existing barriers to implementation, including:

1) Funding - "real" costs. Currently, reimbursement is only for the actual hour spent doing therapy and not the associated costs with providing this service at a different location.

2) Clinical needs of the consulting staff. Having a mental health provider operating away from their home agency would require appropriate mechanisms for training, ongoing supervision, and crisis consultation.

3) Issues related to record keeping, billing, liability, and CBH/OMH regulations. Currently there are fairly stringent regulations, by the state and Medical Assistance, regarding record keeping, liability, and location of services that would need to be resolved to create this model.

Achieving on-site domestic violence and child mental health services will require significant commitment from institutions. In order to promote that commitment, the following is needed:

1) Buy-in from all levels — residents, attending physicians, nursing staff, social work and management/administration.

2) At least one "champion" within each cohort of professional staff.

3) Training that addresses staff turnover and new staff.

4) Resources such as physical space, administrative support, family violence materials.

5) Negotiation with mental health systems and funders to address some of the barriers discussed above.

Recommendation Three:

Increase collaboration between Pediatric Health Care Settings and Mental Health/Domestic Violence Agencies where on-site services cannot yet be implemented.

While the ultimate goal articulated by SBF is on-site mental health and/or domestic violence services in pediatric health care settings, it is clear that this will not be achieved overnight. Pediatric settings are at varying points of readiness to establish such goals. In the meantime, there is much work that can be done to help facilitate the coordination and collaboration of services to families across settings. This includes: enhancing referrals between pediatric health care and mental health or domestic violence services, better integration of mental health services at sites where it does exist (even if not specific to domestic violence), and better understanding of the role that a pediatric health provider can play in helping families become safe.

Recommendation Four:

Create a Clinical Network of Experts to Address Family Safety and Children's Exposure to Domestic Violence

The vision for the *Clinical Network on Children Exposed to Domestic Violence* emerged from the voices of children who were interviewed in ISF's focus group study. Based on the responses from children who were interviewed about their experience of growing up in the shadow of family violence, and based on the growing realization among professionals who work with children, there is a significant need to gather a network of professionals that will help expand efforts - programmatic and policy - to respond to children exposed to domestic violence. The goals and activities of such a clinical network include the following:

1) Identify and convene key stakeholders and systems that can effectively address family safety and children's exposure to domestic violence.

2) Expand the clinical expertise and improve Philadelphia's response to children exposed to domestic violence by providing specialized training to both clinical (therapists, domestic violence advocates, pediatricians, DHS) and non-clinical domestic violence service providers (police, attorneys, teachers).

3) Provide clinical supervision and support, case consultation and multi-disciplinary case discussion, which promotes invaluable cross-fertilization.

4) Serve as a "think tank" focused on systems that both support or create barriers for the treatment of children exposed to domestic violence.

5) Develop a formal standard of care and response for both the overall system, and clinical standards and/or a comprehensive family treatment model for domestic violence.

6) Identify the top five priority areas to address children's safety and exposure to domestic violence.

7) Create a three-year strategic plan for addressing and mobilizing key systems and decision makers around policies, services and interventions that can help promote safety, healing and recovery.

Recommendation Five:

Provide leadership and coordination to create a model system of integrated care for children exposed to domestic violence, with a special focus on four systems: pediatric health care, mental health, child welfare, and domestic violence.

The work of SBF has made great strides toward developing a systems response to children exposed to domestic violence. However, there still needs to be continued leadership and coordination to reach the goals set by the subcommittees and the specific recommendations contained in the Blueprint that are not yet ready for implementation because of lack of funding, need for policy and/or institutional change, or additional program planning. A continued focus that brings together the major systems involved in SBF toward moving the work forward is critical to long-term implementation and sustainability.

V. Conclusion

Domestic violence, violence that occurs between adult caregivers in the home, seems to be the most toxic form of exposure to violence for children. Furthermore, we now believe that young children are far more likely to be exposed to violence in the home than to violence on the street (Groves, B. 2002. Children who see too much. Beacon Press)

SBF has made the issue of children's exposure to domestic violence and the role that pediatric health care can play a priority in Philadelphia. Multiple agencies and systems worked together to create the Blueprint and embark on a process of envisioning a family-centered approach to children exposed to domestic violence. Leaders from each of the four key systems who participated in this process can say with a deeper understanding and commitment:

"Children's exposure to domestic violence is a pediatric health care issue."

"Children's exposure to domestic violence is child welfare issue."

"Children's exposure to domestic violence is a child mental health issue."

"Children's exposure to domestic violence is a domestic violence service systems issue."

Our work constitutes great progress toward the goal of creating a more integrated system of care for children exposed to domestic violence, because it is through a shared process and agreement that these outcomes have been achieved.

It is for the children who are living with violence that we dedicate the next decade of our work. We will work diligently toward implementing the Blueprint recommendations, nurturing individual institutions, and advocating for changes in the systems that have the ability to better address the safety and well being of families living with domestic violence.

VI. Acknowledgments

The Safe and Bright Futures initiative was made possible by funding from the U.S. Department of Health and Human Services for whose support we are deeply grateful. Thank you also to all of the agencies and individuals who participated in the needs assessment interviews, the families who were interviewed in focus groups and the many members of the Pediatric Collaborative. In particular, we want to acknowledge Sally Black, Jennifer Kolker, June Cairns, Joel Fein, Julie Campbell. A very special thank you to Lutheran Settlement House's Bi-lingual Domestic Violence Program and its Director, Ana Lisa Yoder, our co-partner on this project. Together, our community has created a shared vision for what is possible for Philadelphia's children and their families.