

Pediatric Care Settings

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Case Scenarios and Analyses

Scenarios

From a pediatric health clinic. Mrs. G. brings 10-year-old Alan in with the complaint that he is having difficulty sleeping at night, wakes up tired in the morning, and refuses to go to school. After a brief physical exam looking for signs of metabolic change, increased heart rate, or weight loss, the pediatrician wonders about stress or some change in the family and asks

whether anything upsetting happened recently. Mrs. G. replies that robbers attempted to break into their house 2 weeks ago. The pediatrician asks about the incident, addressing some questions to Alan and some to Mrs. G. The pediatrician learns that the attempted break-in occurred in Alan's room where someone tried to force a window open. Alan describes waking up and seeing a face at the window. He screamed for his mother, who came in and told him that he must have had a bad dream. However, the next morning, the family found evidence of the attempted break-in. Alan talks about his bad dreams, his fears that another attempted robbery would happen, and his general feeling of being unsafe. Mrs. G. says that she had not heard some of these details because she had thought it best not to talk about the incident; she hoped that Alan would forget about what happened. However, she now realizes that her son cannot forget about it.

From a public health home-visiting program for new parents. On her initial home visit to Anna, an 18-year-old first-time mother of an 11-month-old baby, the nurse home visitor asks Anna routine questions about safety in her home and in her community. Anna appears uncomfortable with these questions and changes the subject. At the next visit, the nurse, having noted Anna's discomfort with the subject in the previous visit, asks how she and the baby's father handle disagreements. Anna becomes quiet and

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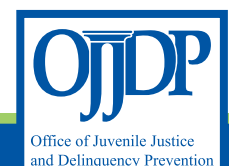
An electronic version of this publication can be found on the Web at www.safestartcenter.org.

The Safe Start Center Series on Children Exposed to Violence

Each Issue Brief in the series explains the importance of addressing exposure to violence to ensure the well-being of children from birth to age 18 in all systems that interact with vulnerable children and families. Through the use of literature reviews, case scenarios, and analyses of data, the Issue Briefs translate lessons learned from research and program practices into actions that can effectively prevent or reduce the negative impact of exposure to violence.

Issue Brief #2 translates emerging research and program practice into action steps for practitioners in pediatric care settings to design and implement programs that meet the needs of children who are exposed to violence.¹ The goal is to build the capacity of practitioners in these settings to offer sensitive, timely, and appropriate interventions that enhance children's safety, promote their resilience, and ensure their well-being. (For a complete list of Issue Briefs, see the box on page 8.)

¹In this Issue Brief, "pediatric care settings" include not only inpatient and outpatient healthcare delivery systems, but also public and preventive healthcare settings such as Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs and home-visiting programs.



says that they argue a lot. The nurse asks whether the arguments ever escalate to physical fights. Anna pulls up her sleeves and shows the nurse bruises on her arms caused by the baby's father. Anna is reluctant to talk about the bruises, saying that she fears that her baby might be removed from her care by child protective services (CPS).

Analyses

Both cases underscore the important role that health-care practitioners can play in identifying children who are exposed to violence and supporting parents as they respond to their children's needs. They also demonstrate the importance of routine inquiry during a pediatric care visit about safety and exposure to violence in the home.

Opportunities for intervention in the pediatric health clinic. During the visit the pediatrician encourages the mother and son to talk about what happened and to devise a plan so that Alan can feel safer. Together, they decide that Alan will move into the spare bedroom that is near his parents' bedroom. Alan says that this move will help him sleep better. A followup visit is scheduled for 2 weeks. Mrs. G. and the pediatrician decide that, if Alan's sleeping patterns do not improve, a referral for counseling will be made. By the time the pediatrician sees Alan and Mrs. G. 2 weeks later, the situation has improved.

The pediatrician's careful interview helps both Mrs. G. and Alan. The mother learns important information that helps her understand her child's symptoms. The child's experience is validated for him, and he is reassured that adults understand his reactions and fears. The thorough interview with Alan not only yields more information about what had happened, but also educates Mrs. G. about the power of this frightening experience on her son's life.

Opportunities for intervention in the home-visiting program. Anna asks the nurse whether this situation could affect her baby. The nurse seizes this opportunity to talk about how babies react to stressors in the environment and how the stress that a mother experiences might affect her baby. Anna listens intently and says that she does not want her baby to be hurt by the arguing and hitting. Together, the nurse and Anna talk about the choices that Anna has for herself and her child. Before the nurse ends the visit, she gives Anna contact information of several domestic violence agencies in the area, explains how the shelters operate, describes situations

that might warrant contacting them for help, and makes an appointment to visit Anna and her baby in 2 weeks.

The nurse's cautious questions help Anna reveal her concerns to a trusted resource who provides helpful advice. Had the nurse failed to ask about safety, she might not have learned about Anna's living situation. Anna is now equipped with information that may help prevent long-term emotional consequences for herself and her baby.

Impact of Exposure to Violence on Children

Not all children are equally affected by exposure to violence. Some children exhibit less stress or are affected for shorter periods than other children. The variables that affect the intensity and duration of a child's responses are the child's personality and temperament, whether the child knows the victim and/or perpetrator, the characteristics of the family and the quality of the parenting, the frequency of exposure, and the child's access to a parent or caregiver for support and comfort.

In general, there are three clusters of risks to children who are exposed to violence: physical injury, psychological sequelae, and interference with learning and cognition. The first and most serious risk to children and adolescents is direct injury. Children who live in homes where domestic violence occurs are likely to become direct victims of child abuse, either by the perpetrator or by the victim (Straus & Gelles, 1995). Children and adolescents who are exposed to violence are also at increased risk for symptoms of psychological conditions, including increased behavioral problems, anxiety, depression, and posttraumatic stress disorder (Edleson, 1999; Groves, 2002). Children and adolescents who witness violence, particularly chronic violence, may have increased difficulty with school performance (Margolin & Gordis, 2000; Wildin, 1991). They are frequently distractible and unfocused. They may have trouble completing a school task. Concentration may be impaired, which affects memory and ability to follow oral directions. These children may have trouble working cooperatively in groups.

In summary, children and adolescents who are exposed to violence may be affected in all areas of development. They may learn early and powerful lessons about the use of violence in interpersonal relationships. They may believe that violence is a legitimate way to exert author-

ity or express intimacy and, if the exposure is chronic or profound, may themselves learn to be aggressors.

Promising Practices For Addressing Exposure to Violence in Pediatric Settings

Pediatric care settings are perhaps the only places where children are seen at multiple points throughout their childhood and adolescence. These settings provide an opportunity to screen families for health and social risks, including exposure to violence. In addition, most parents view pediatric practitioners as important and respected authority figures. The practitioners' inquiries about exposure to violence communicate a strong message about concern for this problem. The practitioners can use their positive authority to educate parents about the impact of exposure to violence and to refer children and families to services to prevent or treat emotional or behavioral problems that may result from exposure to violence.

Universal Screening

Research on the adverse effects of child and adolescent exposure to violence (as creates a compelling case for identification of children as early as possible.. Despite the growing concern about violent behavior in children, little information in the pediatric literature identifies children's psychological trauma, other than child abuse. There is also disagreement about whether universal screening should be recommended in all pediatric care settings (Zink, Levin, Wollan, & Putnam, 2006).

Despite the number of children who are affected by child abuse and domestic or community violence, tools or protocols for systematic identification of children who are exposed to violence are not universally used in pediatric settings. Some studies show that children's exposure to violence/trauma is overlooked by the medical system, especially in children younger than age 6 (Lavigne et al., 1993; Zeigler, Greenwald, DeGuzman, & Simon, 2005). Others show that screening protocols are used more frequently in healthcare settings that serve low-income families or families of color. Focus groups of medical practitioners in urban and suburban areas revealed that suburban practitioners screened for domestic and community violence in their patient populations less frequently than did urban practitioners.

Since the publication of Henry Kempe's landmark study of abused children (Kempe, Silverman, Steele, Droegemuller, & Silver, 1962), public recognition, social policy, and medical practice have changed dramatically with regard to recognizing and responding to children who are traumatized through abuse or neglect. Pediatric practitioners are mandated reporters (see Mandated Reporting). In this role, they may use a variety of screening tools, both formal and informal, to assess for child abuse. Many hospitals have multidisciplinary child protection teams, providing specialized consultation and education to practitioners about child sexual and physical abuse.

Mandated Reporting

Many children experiencing crises or violence are also at risk for child abuse and neglect. All States have child welfare systems that receive and respond to reports of child abuse and neglect, offer services to families, provide foster homes for children who must be removed from their parents' care, and work to find permanent placements for children who cannot safely return home.

Domestic violence does not equal child abuse and neglect, and therefore not all cases of domestic violence must be reported to child protective services. When responding to families affected by domestic violence, it is critically important for practitioners to consider simultaneously the safety of the child and the safety of any adult victim.

State-by-State information on reporting requirements can be found at www.childwelfare.gov/systemwide/laws_policies/state.

In 1998, the American Academy of Pediatrics (AAP) published a position statement, "The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women" (AAP, 1998). The first sentence of this statement reads, "The abuse of women is a pediatric issue." The position statement presented information about the impact of domestic violence on women and children and the obstacles women face in disclosing that they are victims of domestic violence. One recommendation was that "pediatricians should attempt to recognize evidence of family or intimate partner violence in the office setting." The statement made a strong case for recognizing domestic violence but did not offer specific guidelines for screening, nor did it discuss the policy and practice challenges that

arise when practitioners implement screening protocols for exposure to domestic violence. Furthermore, it did not recognize the broad areas where children may be exposed to violence including community violence, terrorism, and war.

Major pediatric medical organizations have not endorsed a specific approach to screening for exposure to violence. However, there is strong consensus that screening for domestic violence should be routine. In 2002, the Family Violence Prevention Fund convened a panel of representatives to explore the need for systematic inquiry about domestic violence in pediatric care settings. The panel developed *Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health* (Groves, Augustyn, Lee, & Sawires, 2002). This monograph provides guidelines for asking parents and adolescents about domestic violence during pediatric visits. It recommends asking parents and adolescents about this issue in all new patient visits and once a year afterward. The monograph suggests asking the questions directly (rather than using a questionnaire) in a private room, if possible. For adolescents, it recommends asking about partner or family violence at all new visits and at health maintenance visits.

The monograph suggests that practitioners preface their questions with a rationale for why they are asking these questions and an assurance that all patients are being asked about this topic. For example, a practitioner might begin by saying, “I have begun to ask all of my patients and their parents about their family life as it affects their health and safety. May I ask you a few questions?” The specific questions depend on the relationship the practitioner has with the patient and the parent. Examples of indirect and direct questions for parents include:

- What happens when there is a disagreement with your partner or other adult in the home? (indirect)
- How do you handle this? (indirect)
- Do you feel safe in your home and/or your relationship? (direct)
- Have you been hurt or threatened by your partner? (direct)
- Do you ever feel afraid of your partner? (direct)
- Has your child ever seen a violent event in your neighborhood or house? (direct)

Other Promising Practices

- *Incorporate questions about safety in the home and community into all pediatric care visits.* It is never too early in a child’s life to inquire about exposure to violence. Whether they work in a WIC program or a pediatric clinic, practitioners can ask about safety in the home. Boston-based pediatrician, Peter Stringham, M.D., begins this discussion at each baby’s first well-child visit. He has published guidelines about how to talk with parents and children about safety and violence prevention. (Stringham, 1998). He reviews a series of brief office counseling interventions for the prevention and treatment of violence. Primary prevention strategies cover topics from safe gun storage to nonviolent handling of a potential street fight. Secondary prevention strategies deal with patients who have been injured by violence or patients who engage in street violence, weapon carrying, or dating violence.
- *Explore alternative methods of screening for exposure to domestic or community violence.* Several studies have explored the best way to screen for domestic violence in pediatric care settings. One study compared an audiotape screening questionnaire with a written screening survey for patients in an emergency department setting. Women in both groups reported that they preferred both methods to direct screening in the emergency department setting (Bair-Merritt et al., 2006). Another study focused on the use of computer-based screening, finding that computer screening has the potential to supplement current screening efforts and allows the practitioner to focus on assessment and connecting the patient with resources (Rhodes, Lauderdale, He, Howes, & Levinson, 2002). For more information on screening for exposure to domestic violence see Groves and colleagues (2002).
- *Arrange for consultation or direct services from trained social workers or domestic violence advocates.* Staff members in clinics or public health programs that have a social worker or domestic violence advocate on staff or available for consultation report that they screen frequently and with increased confidence when they know that they can link families with resources.
- The pediatric care setting should provide training on exposure to violence issues, including domestic and community violence, typical symptoms, and behavioral reactions. Training should include both

information and skills-building exercises that focus on interviewing.

- Practitioners should have the opportunity to practice asking questions about domestic violence so that they become comfortable and familiar with the topic.
- The program or clinic should arrange for access to social work or domestic violence consultants as well as other referral resources. These consultants should be easily accessible and able to connect families with needed services.
- The program or clinic should provide clear criteria for when to refer a child or parent for specialized services. Not all children need referral for mental health services. In general, it is recommended that a practitioner make a referral for more intensive support services in the following instances (Groves, 2005):
 - » The child's symptoms have persisted for more than 3 months.
 - » The incident was particularly violent or involved the loss of a parent or caregiver.
 - » The parent or caregiver is unable to be empathetically attuned to the child.
 - » The child is in an unsafe environment.
 - » The parent is concerned and asks for a referral.

Referrals should be made to mental health specialists who are familiar with treating children who have experienced or witnessed violence; if the case involves domestic violence, the practitioner should have experience with the particular dynamics of families in which violence occurs. Specialized treatment for these children may include providing education about normal reactions to violence for the children and parent, cognitive behavioral strategies to decrease sensitivity to reminders of the violence, and/or pharmacological interventions.

Special Considerations That May Arise in Implementing Promising Practices

- *Screening with the child in the room.* Practitioners may feel uncomfortable inquiring about parental behavior or other sensitive issues in front of the

child patient, and parents may feel equally reluctant to talk freely. This dilemma applies mostly to parents with children between ages 4 and 12. Very young children do not understand the questions, and adolescents are generally seen without the parent, giving the practitioner the opportunity to inquire directly. In general, practitioners agree that it is best to talk with parents alone about sensitive topics. However, in busy practices where separation of the parent and child is impossible, it is recommended to ask general questions about safety and to follow up privately if a parent shares a concern or appears to be uncomfortable with the questions.

- *Mandated reporting and involvement with CPS.* In the course of asking about exposure to domestic or community violence, the practitioner may hear information about child abuse or risk of injury that requires a report to the CPS agency. However, exposure to domestic or community violence (without injury to the child) does not automatically require a report in most States. Pediatric practitioners must be familiar with the criteria for making a report on suspected abuse or neglect and the specific definitions of child exposure to domestic violence as child maltreatment in their State. Unless a practitioner is legally required to report all incidences of intimate partner violence to CPS, it is recommended that this decision be based on the specifics of the case and the practitioner's knowledge of the situation (see Mandated Reporting box). Sometimes, the children are not in danger; for instance, the victim has planned for their safety and is responding adequately to the children's needs or emotional reactions. In these cases, when not mandated to report to CPS, practitioners should volunteer services and provide supports if families want a voluntary report to CPS.
- *Other obstacles encountered by pediatric practitioners:*
 - » Lack of training/information
 - » Lack of time
 - » Discomfort or personal experience with interpersonal violence
 - » Lack of referral resources or consultative support.

Surmounting these obstacles requires support from administrators in the pediatric care setting to sponsor inservice trainings for all staff members.

Building the Infrastructure

- The pediatric care setting should provide training on exposure to violence issues, including domestic and community violence, typical symptoms, and behavioral reactions. Training should include both information and skills-building exercises that focus on interviewing.
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- The program or clinic should arrange for access to social work or domestic violence consultants as well as other referral resources. These consultants should be easily accessible and able to connect families with needed services.
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Additional Information/Resources

- *Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and*

Adolescent Health (Groves, Augustyn, Lee, & Sawires, 2002). This book offers specific recommendations for assessing and responding to domestic violence in child health settings. Visit www.endabuse.org/programs/healthcare/files/Pediatric.pdf.

- *Screen to End Abuse*. This 32-minute CD, produced by the Family Violence Prevention Fund, includes five clinical vignettes demonstrating techniques for screening and responding to domestic violence in primary care settings. To order, visit fvpfstore.stores.yahoo.net/screentoenda.html.

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(continued on page 8)

MOVING FROM EVIDENCE TO ACTION: The Safe Start Center Series On Children Exposed To Violence

Framework

The following are the core concepts of the Moving From Evidence to Action Series

Core concepts

Definition of exposure to violence. This Issue Brief series uses the definition of exposure to violence of the Safe Start Initiative: “direct and indirect exposure to violence in their home, school, and community.”

Impact of exposure to violence. Children react to exposure to violence in different ways, and many children demonstrate remarkable resiliency. However, children’s exposure to violence has been associated with difficulties with attachment, regressive behavior, anxiety and depression, aggression and conduct problems, dating violence, delinquency, and involvement with child welfare and juvenile justice systems. And there is a strong likelihood that exposure to violence will affect children’s capacity for partnering and parenting later in life, continuing the cycle of violence into the next generation.

Risk and protective factors. The impact of children’s exposure to violence is influenced both by risk factors that increase the likelihood of a disruption in the developmental trajectories and by protective factors in the environment. These risk and protective factors depend on a child’s age and developmental level and the type and intensity of challenges present in the environment. The presence of supportive adults and/or nurturing environments provides a powerful buffer to children from the more intense stress or anxiety that may occur when children are exposed to violence.

Effective interventions. Research has documented the effectiveness of the following strategies to address the needs of vulnerable children and families—including children exposed to violence:

- Participation in *high-quality early care and education programs* can enhance physical, cognitive, and social development and promote readiness and capacity to succeed in school.
- *Early identification of and intervention with high-risk children* by early education programs and schools, pediatric and mental health programs, child welfare systems, and court and law enforcement agencies can prevent threats to healthy development by detecting and addressing emerging problems.
- For children and families already exposed to violence, *intensive intervention programs* delivered in the home and in the community can improve outcomes for children well into their adult years and can generate benefits to society that far exceed program costs.
- Outcomes improve when highly skilled practitioners provide *intensive, trauma-focused psychotherapeutic interventions* to stop the negative chain reaction following exposure to traumatic stressors (e.g., child abuse and neglect, homelessness, severe maternal depression, domestic violence). Treatment is an essential component of successful adjustments to exposure to violence, especially for children who have frequent exposures and who have complicated courses of recovery.

Guiding principles to support best practices

- The following **Safe Start** principles serve as guidelines for the development of policies, programs and specialized interventions that are effective in responding to exposure to violence.
- **Safety** of the non-offending parent and of the children **must be paramount and addressed concurrently** in cases involving domestic violence.
- Children **must be understood in the context** of their individual traits, families, and community (a **socio-ecological approach**).
- Responsibility for child’s well-being must be owned by parents, community agencies and public systems together—**CEV is everyone’s responsibility**.
- Agencies must **work together in a coordinated manner** to expand and enhance service delivery.
- Policies, programs, and services must be **developmentally appropriate, culturally competent**, and offered in the family’s preferred language.
- Programs and services need to be **evaluated rigorously** for effectiveness—efficacy is key. We must commit to continue to **learn what works**.

Behavioral and emotional problems among preschool children in pediatric primary care: Prevalence and pediatrician's recognition. *Pediatrics*, 91, 649–655.

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Moving From Evidence to Action: The Safe Start Center Series on Children Exposed to Violence

The goal of the series is to build the capacity of practitioners in a variety of different fields to offer sensitive, timely, and appropriate interventions that enhance children's safety, promote their resilience, and ensure their well-being.

Issue Brief #1: Understanding Children's Exposure to Violence

Issue Brief #2: Pediatric Care Settings

Issue Brief #3: Schools

Issue Brief #4: Child Welfare Systems

Issue Brief #5: Domestic Violence Agencies and Shelters

Issue Brief #6: Homeless Shelters, Permanent/Supportive Housing, and Transitional Housing

Issue Brief #7: Fatherhood Programs

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Safe Start Initiative

The Safe Start initiative is funded by the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP). The goal of the initiative is to increase the knowledge of and promote community investment in evidence-based strategies for preventing and reducing the impact of children's exposure to violence. Eleven demonstration sites were funded from 2000 to 2006 to create a comprehensive service delivery system to improve the accessibility, delivery, and quality of services for children exposed to violence at any point of entry. A national evaluation broadened understanding of how communities can successfully implement a comprehensive system of care with policy and practice interventions to minimize the negative consequences of exposure to violence.

Fifteen Promising Approaches pilot sites, funded in 2005, are focusing on implementing and measuring developmentally appropriate services for children exposed to violence within the context of the systems that serve them. A national evaluation of these sites will analyze the impact of specific intervention strategies on outcomes for children and families.

The Safe Start Center is a resource center designed to support the Safe Start initiative on a national level and to broaden the scope of knowledge and resources for responding to the needs of children who are exposed to violence and their families. For more information on the Safe Start initiative and Safe Start Center, visit www.safestartcenter.org.

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