

**Strong Family Strong Community:  
A Program Plan and Evaluation Targeting Youth Violence**

By

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## **I. Introduction**

On the afternoon of Thursday, September 24, 2009 16 year-old Derrion Albert laid on the gravel, his body dented, damaged and lifeless. What transpired moments earlier was a violent altercation that started out with about ten teenagers and concluded with more than 50 youth being involved.<sup>1</sup> Caught on video, Derrion was beaten, kicked and smacked with railroad ties about a half a mile from his school.<sup>2</sup> Derrion was the third adolescent killed with in the first two months of the Chicago Public School System's (CPS) 2009 school year.<sup>3</sup> Between August 2007 and September 2009, over 70 Chicago area students had been murdered, mostly in their neighborhoods on the way to or from school.<sup>3</sup>

The death of Derrion Albert was a pivotal moment in regards to youth violence in Chicago. The community was frustrated and the national visibility of the incident forced politicians into action. Attorney General Eric H. Holder Jr. met with public school students and elected officials declaring that, "Youth violence is not a Chicago problem any more than it is a Black problem, White problem or a Hispanic problem. It is something that affects communities big and small and people of all races and all colors. It is an American problem."<sup>3 (p.1)</sup>

The purpose of this paper is to introduce a program and evaluation plan for the Strong Family Strong Community Program (SFSC), an initiative that aims to decrease youth violence in Bronzeville area of Chicago by strengthening the family unit. This paper will provide a review of the literature pertaining to youth violence prevention programs, describe the different components of the SFSC program plan and present a detailed evaluation plan.

For the purpose of this paper, violence is defined as the intentional use of physical force or power, threatened or actual, against another person or against a group or community that

results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation.<sup>4 (p.1)</sup> Within the literature, research and programs addressing youth violence typically include individuals that are between 10 and 24 years of age, though it is recognized that patterns of youth violence can begin in early childhood.<sup>4</sup>

According to a national study of students in grades in 9-12 conducted in 2003, 33% reported being in a physical fight during the preceding 12 months and 17.1% reported carrying a weapon on one or more of the 30 days preceding the survey.<sup>5</sup> Through analysis of Chicago youth violence data it has been reported that juveniles arrested for the first time at young ages were more likely to be identified as serious, violent and chronic arrestees.<sup>6</sup>

Pressures to imprison are great and efforts to prevent are rare.<sup>7</sup> Currently, there are several programs and initiatives taking place in Chicago whose missions focus on the reduction of youth violence such as Becoming A Man (B.A.M.) and We Go Together For Kids. The majority of the programs in Chicago target school aged children. However, focusing crime prevention efforts on older children or teens may cause program directors and policy makers to miss an important opportunity to intervene earlier in children's lives.<sup>7</sup>

The Strong Family Strong Community Program (SFSC) is a pediatric clinic based multi-disciplinary initiative, that aims to decrease youth violence in the Bronzeville area of Chicago by providing community based family support and education services to children of first time mothers. SFSC incorporates several strategies cited in the literature that have achieved short and long term success by targeting early childhood family risk factors. Longitudinal evidence on the development of delinquency behavior suggests that (a) early childhood programs which buffer the effects of a given delinquency risk factor should also be effective in preventing chronic

delinquency; (b) because multiple risk factors appear to have such a pronounced negative effect, early childhood programs that reduce multiple risks may be more successful in preventing chronic delinquency than are those that target only a single risk factor; and (c) the content of preventive early childhood programs should be such that they attempt to enhance parents' social support, foster positive parenting and family interactions, facilitate child cognitive development (especially verbal skills), and reduce family level and community level poverty.<sup>7</sup> The impact that SFSC seeks to accomplish include decreasing rates of youth delinquency and violence, the rates of youth arrests and incarceration and the number of youth involved in gangs in the Bronzeville community.

## **II. Review of the Literature**

### **Introduction**

The Strong Family Strong Community Program (SFSC) is a pediatric clinic based initiative that attempts to decrease youth violence by providing first time mothers with a set plan of action that will include regular pediatric visits, nurse home visits, community resources and the Chicago Child Parent Center Program. The aim of this literature review is to identify effective programs with in the literature that are similar to the SFSC program. Their design, methods, and outcomes will be reviewed and analyzed in order to recognize strengths and weaknesses that can be taken into consideration to improve the program planning, implementation and evaluation of the SFSC program.

### **Mini Systematic Review of the Literature**

#### ***Search Strategy***

The concept and methodology of the SFSC program is derived from components of the Yale Child Welfare Research Program and the Chicago Child-Parent Center Program. A computer and manual search of the literature was used to identify the references of each program and published articles that cited either program with in their bibliography. Google scholar, PubMed, and the Web of Science were used in my computer search. The search of the references and cited resources of the Yale Child Welfare Research Project generated 40 articles and the Chicago Child Parent Center Program generated 373 articles. After a brief review of several abstracts, I narrowed my search using Google Scholar searching for publications that contained both the “Yale Child Welfare Research Project” and “Chicago Child Parent Center Research Program”. This search generated over 50 references, including two review articles

Yoshikawa (1995)<sup>7</sup> and Zigler, Taussig, and Black (1992)<sup>8</sup> that evaluated over 40 programs combined.

The Yale Child Welfare Project, Chicago Child Parent Center (CPC) Program, High/Scope Perry Preschool Study, Syracuse University Family Development Research Program (FDRP), and the Houston Parent Child Development Center (PCDC) will be highlighted and analyzed in the following sections of this mini-systematic review. These programs were selected because they included at least two of the three components of the SFSC Program, which includes a medical referral/intervention, a child focused early education program, and a parent focused family support program. These projects represent the majority of the data cited in regards to early childhood preventive programs for youth violence and possess similar methods to those of the SFSC program.

### ***Promising Programs***

#### **▪ *Yale Child Welfare Research Program*<sup>7,9</sup>**

The Yale Child Welfare Program operated from 1967 to 1972 through the Yale Child Care Center in Yale-New Haven, Connecticut. The major goal of the Yale Child Welfare Project was to diminish the erosion of human potential often associated with conditions of poverty or inadequate care in the earliest years. It was a comprehensive, service centered, longitudinal, intervention project for low-income families and their children. Eighteen inner city, low income, predominantly African American first born children and their families participated in the intervention from before birth to 30 months of age. Each family was assigned a “family team” that included a pediatrician, home visitor, developmental examiner and staff from a daycare center. The intensity of the program was on average 28 home visits, 18 well care-baby exams, 8 developmental exams and optional childcare.

▪ ***Chicago Child Parent Center (CPC) Program***<sup>7, 10</sup>

Founded in 1967, the Chicago CPC is the country's second oldest federal preschool program and the oldest extended early education intervention. It is a center-based intervention that provides comprehensive educational support and family support services to economically disadvantaged children and their parents. The Chicago Public Schools currently operate 24 CPCs; 20 have services from preschool to third grade and four have services only in preschool and first and second grades. By providing a school-stable learning environment during the preschool and primary grade years in which parents are active participants, CPCs goals are to enhance the child's social and scholastic development.

The infrastructure of CPCs is subdivided into components and includes the head teacher, a child development component, a parent involvement component, school-community outreach services, and physical health/medical services. The head teacher is the program coordinator and has the responsibility of organizing and implementing program services for participant families, as well as organizing in-service trainings and workshops for classroom staff. Through the child development component, CPCs offer a half-day preschool program (three hours), full-day kindergarten program at most sites (six hours), and full-day primary – grade services (six hours).

Relatively structured, activities are designed to promote basic skills in language and reading as well as good social and psychological development. Class sizes are small and each classroom has a teacher aid. The parent involvement component requires at minimum, one-half day per week of parent involvement in the center. Parent activities include classroom volunteering, participation in school activities and opportunities for further education and training. The school-community outreach services component of CPCs provide a full-time non-instructional school-community representative for each center. He or she identifies and enrolls



families in the neighborhood who are in most educational need and conducts a home or school visit to all enrolling families. Additional visits occur on a most-in-need basis.

The school-community representative also refers families to community and social service agencies such as employment training, mental health services and welfare services. Lastly, upon entry into the program children undergo a health screening from a registered nurse on site, in addition to vision and hearing tests. In first grade the expansion program is implemented in parent elementary schools. Parent involvement does not change but program coordination is streamlined.

The CPC programs in Chicago are part of the Chicago Longitudinal Study. It seeks to determine the long-term effectiveness of a federal center based preschool and school based intervention program for urban low-income children. Follow up data from the nonrandomized matched-group cohort of 1,539 low income, mostly Black children is still being collected.

- ***High/Scope Perry Preschool Study***<sup>7, 11, 12</sup>

Investigators at the High/Scope Education Research Foundation developed this program for young children to help them avoid school failure and related problems. High/Scope Perry Preschool was a 2-year preschool education program for 3- and 4- year olds living in low-income families. Teachers had bachelor's degrees, a certification in education, and served five to six children at a time. Early education classes were scheduled four times a week for two and a half hours each. The classroom and daily schedule was arranged to support children's self-initiated learning activities, provided both small-group and large group activities and helped children engage in key experiences in child development. Home visits were used to keep parents apprised of their child's activities and encourage participation in the educational process. In addition

there were monthly small group meetings that provided opportunities for parents to exchange views and to support one another's changing perceptions of child rearing.

- ***Syracuse University Family Development Research Program (FDRP)***<sup>7, 8, 13</sup>

The Syracuse University FDRP provided educational, nutrition, health and safety, and human service resources for 108 families beginning prenatally until children reached elementary school. The major goal of the intervention was to influence and have impact on the more permanent environment of the child, the family and the home and to support parent strategies that enhance the development of the child long after the intervention concluded. The key component to this intervention was weekly contacts with mothers and other family members through home visits. Home visits were used to assist families with issues of child rearing, family relations, employment and community function. They provided non-judgmental family advocacy, oriented toward assisting families to become aware of and operate in the various systems in their environment. The children of the program were provided with four and a half continuous years of quality childcare at the Syracuse University Children's Center beginning with half daycare from 6 to 15 months, followed by full-day care until school age.

- ***Houston Parent Child Development Center***<sup>7, 14</sup>

The Houston (PCDC) was an intervention designed to promote social and intellectual competence in children from low-income Mexican American families. A parent-oriented program, the Houston PCDC sought to enhance school performance, reduce the incidence of behavioral problems in school-age children and promote the mental health of participating families. With the major focus being the mother-child relationship in the family setting, 550 hours of participation over a 2-year period was required. During the first year the program

mothers were visited by home visitors 25 times for 1 ½ hour sessions during which they exchanged information about child development, parenting skills, and use of the home as a learning environment. In order to include other family members weekend workshops were also conducted and concentrated on decision making in the home and family communication. During the second year, the mother and child came to the project center four mornings a week to participate with other families in classes on child management, child cognitive development, family communication skills and other topics related to family life.

### ***Analysis of Short and Long Term Program Outcomes***

The primary purpose of the SFSC Program is to decrease youth violence. The results from the programs reviewed showed various levels of effectiveness and sustainability. The Chicago CPC and the High/Scope Perry Preschool Program produced reduced rates of youth violence that have been shown to be sustainable into adulthood. The Yale Child Welfare Program, Syracuse FDRP, and the Houston PCDC generated varied short-term effects on youth violence. In the following section the results of programs with long-term and varying short-term effects will be analyzed separately. Study methods and design, participant characteristics, and primary outcomes will be explored in order to identify effective components that can be incorporated into the SFSC Program.

#### **▪ *Programs With Long-Term Success***

The Chicago CPC and the High/Scope Perry Preschool Program are regularly cited examples of effective early prevention programs that have achieved long-term success. The Chicago Longitudinal Study used the incidence of juvenile arrest ( $\geq 1$  arrest), the incidence of multiple arrests ( $\geq 2$  arrests), and the number of arrests as indicators of long-term youth

violence.<sup>10</sup> Data were collected through record searches at the Cook County Juvenile Court and 2 other locations. At 20 years of age the cohort of children who participated in the preschool portion of the Chicago CPC program had a significantly lower rate and number of juvenile arrests compared to children with no intervention.<sup>10</sup> Preschool participants had a lower adjusted rate of arrest (16.9% vs 25.1%, P = 0.003), multiple arrests (9.5% vs 12.8%, P=0.01), and violent arrests (9.0% vs 15.3%, P=0.002).<sup>10</sup> For those children only receiving school-age participation there was no association with lower arrest rates. Extended participation, with preschool and elementary school activities, was not associated with significant benefit in regards to decreased crime incidence when compared to those children with preschool intervention only. Authors concluded that participation in an established early childhood intervention that involved early child education and family support was associated with a long-term decreased incidence of youth violence.

Similar trends of decreased long - term violence by project participants were also seen in the High/Scope Perry Preschool Program. By age of 14 participants exhibited less self reported delinquent behaviors compared to controls, and at ages 19 and 27 participants had a significantly lower number and decreased severity of arrests.<sup>7</sup> Between ages of 28 and 40 the intervention group had significantly fewer arrests for violent felonies (2% vs. 12%) compared to the control group.<sup>12</sup> The most recent evaluation of participants at age 40 revealed that individuals who participated in the High/Scope Perry Preschool Program had significantly fewer lifetime arrests (36% vs. 55% arrested 5 or more times), arrests for violent misdemeanors (19% vs. 37%) and arrests for violent crimes (32% vs. 48% ever arrested).<sup>12</sup>

The Chicago Longitudinal and the High/Scope Perry Preschool studies had similar study populations; targeting preschool aged low-income minority children. They both had early child

education and family support components. In terms of early-childhood education both studies provided similar hours of instruction, with the Chicago study providing three hours and the Perry Program two and a half hours a day, five days a week. The curriculum for the Chicago study was structured and emphasized the acquisition of basic skills in language arts and math through diverse learning experiences. Conversely, the Perry Program used an open-framework approach, in which the teacher and child both planned and initiated activities working actively together. Both programs had small class sizes of 7 to 8 students per teacher. In regards to family support services, the Chicago study required one-half day per week of parent involvement in the center in the form of classroom volunteering and participation in school activities. Alternatively, the Perry program's family support services were offered in the form of weekly 90-minute home visits by the teacher. Unique features of the CPC program, compared to the Perry Program, were physical health and medical services, a coordinator exclusively for school-community outreach services and longer options for participation with kindergarten and elementary school components. The Perry Program offered parents small group meetings to share and learn from similar experiences.

▪ ***Programs with Varying Short Term Success***

The Yale Child Welfare, Syracuse FDRP, and the Houston PCDC displayed varying results of decreasing rates of youth violence. In the 10-year follow up of the Yale Child Welfare Program, only the boys of the intervention group had a statistically significant decrease in the rates of antisocial behavior as rated by their teachers compared to the comparison group.<sup>8</sup> They were also described as being more socially well adjusted.<sup>8</sup> No significant differences were seen in the girls.<sup>8</sup> Initially in the Syracuse FDRP study, the intervention group exhibited more aggressive behavior compared to the control group in grade one. Ten years post-program

however, the intervention group had a significantly smaller number and decreased severity of juvenile offenses.<sup>8</sup> The authors of the Syracuse FDRP study concluded that the program decreased the total number, severity and chronicity of later involvement with the juvenile justice system.<sup>8</sup> The Houston PCDC program resulted in a significant decrease in aggressive behavior at 1- and 8-years post program as rated by parents and teachers.<sup>7</sup> However follow up at 11 years post-program did not find significant effects on aggressive behavior.<sup>7</sup>

Compared to the Chicago CPC and High/Scope Perry Preschool programs, the Yale Child Welfare, Syracuse FDRP and Houston PCDC targeted slightly different groups. The Syracuse FDRP and Yale projects recruited low-income African American prenatal mothers and worked with children from 0-30 months and 0-5 years of age respectively. The Houston PCDC enrolled low-income Mexican American families with healthy one year olds. There were also differences in the program components when compared to the Chicago CPC and High/Scope Perry Preschool Programs. The Yale Child Welfare, Syracuse FDRP, nor the Houston PCDC had a formal early-childhood education component incorporated into the entirety of their programs. The Houston PCDC included a half-day educational school component, but only in the second year of the intervention. The Syracuse FDRP provided “quality childcare” through the Syracuse Children’s Center from ages zero through five, but there was no formal educational curriculum made explicit with in published program methods. The Yale Child Welfare program had no early education component. In terms of family support, all of the programs had home visit components that offered families education and training. The Yale Child Welfare Program is the only program that offered interventions through a clinical setting, including medical staff in prevention efforts.

- ***Additional Favorable Outcomes***

Though the main objective of SFSC is to decrease youth violence, through review of the highlighted programs it is evident that interventions that provide early education and family support have additional benefits to the child and the family. In several studies variable degrees of increased cognitive ability were shown in study participants. In the Perry Program those children in the intervention group out performed their counterparts in various intellectual and language tests from their preschool years up to age seven; on school achievement tests at ages nine, ten, and fourteen; and on literacy tests at ages nineteen and twenty seven.<sup>12</sup> The program participants also had a higher percentage of individuals graduate from a regular high school (65% vs. 45%).<sup>12</sup> Similarly, in the Chicago Longitudinal Study preschool participants had a significantly higher rate of high school completion at age 20 years (49% vs. 38.5%,  $p=.01$ ), a lower rate of dropout (46.7% vs. 55%,  $p=0.47$ ) and completed more years of education (10.6 vs. 10.2 years,  $p=0.03$ ) than the comparison group.<sup>10</sup>

Favorable family outcomes were also appreciated in various studies. With in the High/Scope Perry Program participants had more positive child rearing attitudes compared to the controls at ages 4 to 5.<sup>7</sup> Parents who participated in the Houston PCDC had higher Hollingsworth SES scores and reported higher job and educational aspirations for their children at follow up.<sup>8</sup> At the 10-year follow up of the Yale Child Welfare Project compared to the control group, the intervention group families had a smaller family size, a larger delay in time to next pregnancy, a smaller percentage of participants on federal assistance programs and a greater percentage of mothers with a high school diploma or GED.<sup>8</sup>

## **Conclusion**

The Chicago Longitudinal Study, Yale Child Welfare Program, Houston PCDC, Syracuse HDRP, and the High/Scope Perry Preschool Program all contribute important information that can be used to create an effective early-childhood youth violence prevention program. From this review of literature I identified three topics that warranted deliberate consideration before the development of a program plan for the reduction of youth violence. These topics included (a) who is the target group of my intervention, (b) what is the target age range for the children enrolled in the program, and (c) what are the essential components of a youth violence program.

The target populations for all of the programs reviewed were low-income minority families. As will be discussed in further detail in the following sections, children from low socio-economic status backgrounds have been found to have a higher incidence of behavior problems when compared to children in the general population.<sup>15</sup> Low income families will be targeted in the SFSC program because of the previous success in the reduction of youth violence illustrated in the literature with programs similar to SFSC and because the SFSC program will be providing a resource that is possibly much needed and not easily accessible in lower-income communities.

The target age range of the children involved in the programs cited in this literature review varied, with some families being enrolled while the child was in utero and others beginning when the child reached preschool age. The Chicago CPC program and the High/Scope Perry Preschool program enrolled families of preschool aged children. The Yale and Syracuse FDRP programs targeted families of children in utero and the Houston PCDC at one year of age. Since the Chicago CPC and High/Scope Perry Preschool Program had greater long-



term success than the Yale, Syracuse FDRP or Houston PCDC I am comfortable setting the target enrollment age range for child participants at birth to two months old. In the literature reviewed there was no added benefit in starting the intervention program in utero.

From the review of the cited literature one of the distinct features that distinguished programs with long-term success from those with varying was the incorporation of a formal-early education component for child participants. Both the Chicago CPC and the High/Scope Perry Preschool programs had early education components, with the former having a structured and the latter a more open framework. Both programs had small class sizes and provided instruction for 2 ½ - 3 hours a day five days a week. The Chicago CPC program is still operational in Chicago and the entire program will be incorporated into the SFSC initiative.

A detailed description of the SFSC program will be given in the following section, the Strong Family Strong Community Program Plan, along with the specific program rationale, context, theory, goals and objectives and program implementation plan.

### **III. Strong Family Strong Community Program Plan**

#### **Introduction**

The following is the program plan for the Strong Family Strong Community Program (SFSC). For perspective the first section, program rationale, will discuss the current magnitude of youth violence in the United States and in Chicago, the risk factors associated with youth violence, and the setting in which SFSC will be held. The next section, program context, will highlight the current national and local policies and programs that address youth violence and identify potential stakeholders that will be invested in the SFSC program. This section will also consider program acceptability from participants and stakeholders, propose program infrastructure and funding sources, and contemplate possible challenges SFSC may face. The last sections of this program plan will elucidate the theories, goals and objectives, logic model and program implementation plan of the SFSC program.

#### **Program Rationale**

##### ***Magnitude of Youth Violence***

The search for solutions to decrease or prevent juvenile violence in the United States has become a matter of national urgency, as the incidence of serious offenses continue to rise.<sup>7</sup>

- ***National Perspective***

A significant number of youth admit to committing acts of violence.<sup>5</sup> According to a national study of students in grades in 9-12 conducted in 2003, 33% reported being in a physical fight during the preceding 12 months, 17.1% reported carrying a weapon on one or more of the 30 days preceding the survey and 8.9% reported being physically hurt on purpose by their

boyfriend or girlfriend in the 12 months prior.<sup>5</sup> Estimations of the cumulative prevalence of youth violence approximate that about 30 to 40 percent of male and 16 to 32 percent of female youth have committed a serious violent act by age seventeen.<sup>16</sup>

Law enforcement agencies estimate that in 2008 there were 2.11 million arrests of youth under the age of 18 in the United States.<sup>6</sup> Of the 2.11 million arrests, 1,280 were for murder and non-negligent manslaughter, 3,340 for forcible rape, 287,700 for aggravated assault and other assaults, 107,300 for vandalism and 40,000 for weapons possession.<sup>6</sup>

- ***Chicago Perspective***

Every year the Chicago Police Department releases data regarding juvenile arrests made in the Chicago area, defining a juvenile as persons five to sixteen years of age. In 2008, the majority of juvenile arrests (69.2% of 23,018 total juvenile arrests) in Chicago involved youth aged 15 and 16 years old.<sup>6</sup> Males comprised the majority of these arrests (83.5%).<sup>6</sup> If subdivided by race, Caucasians accounted for 3.5%, Hispanics 18% and African Americans 78.1% of youth arrests in the city of Chicago during 2008.<sup>6</sup> The four most common locations of juvenile arrests were on public, educational, residential and retail sales/services properties.<sup>6</sup> Gang activity contributes significantly to the trends of youth violence in Chicago. Of the 3,762 known gang motivated murder offenders in Chicago between 1991 and 2004, 47.7% were between 15-19 years old.<sup>17</sup>

### ***Risk Factors for Youth Violence***

The predictive power of risk factors associated with youth violence vary depending on when they occur in a child's development, in what social context and under what circumstances.<sup>16</sup> A risk factor is anything that increases the probability that a person will suffer

harm and in this context the probability that a young person will become violent.<sup>16</sup> Risk factors for youth violence are identified by tracking the development of children and adolescents over the first two decades of life and measuring how frequently particular personal characteristics and social conditions at a given age are linked to violence at later stages of the life course.<sup>16</sup> In addition to having an empirical relationship, risk factors for violence must also have a theoretical rationale and a demonstrated ability to predict violence.<sup>16</sup> There have been scant biological risk factors identified and youth violence is hypothesized to be predominately the end result of social learning or the combination of social learning and some unknown biological process.<sup>16</sup>

Children from low socio-economic status (LSES) backgrounds are found to have a higher incidence of behavior problems when compared to children in the general population.<sup>15</sup> The prevalence of behavior problems has been estimated to be between 3% and 6% in the general population with a higher incidence (30%) among low-income preschool children.<sup>15</sup> The probability of developing behavior problems is increased when in addition to LSES, preschoolers are also exposed to multiple risk factors including ineffective and unstable family units. Findings from a systematic review of studies conducted between 1991 and 2002 have been consistent in indicating that children from low-income backgrounds, who were identified as having more problem behaviors in their preschool years, tended to come from relatively more dysfunctional families.<sup>15</sup> The overall finding of the systematic review suggests that children from low-income backgrounds, identified as having more behavior problems in preschool years tended to have parents who are more stressed, more depressed and harsher in their use of child discipline.<sup>15</sup>

The risk factor for youth violence that the SFSC Program will concentrate on is the ineffective family unit. Several risk factors including poor parent-child relations,

harsh/lax/inconsistent discipline, separation from parents, abusive parents and neglect are all interrelated with in this concept. In Chicago, 20% of children live in crowded housing compared to only 10% statewide and 13% nationally.<sup>18-20</sup> The number of children living in single parent families is also higher in Chicago (48%), with 40% living in mother only households and 8% living in father only households.<sup>18-20</sup> There is a considerably greater number of children living in the care of their grandparents or with neither parent in Chicago compared to national estimates.<sup>18-20</sup> These factors seen in Chicago area families create conditions in which ineffective family units are more probable.

Though individually, these risk factors are considered to have small effect sizes in predicting youth violence, collectively their power increases.<sup>16</sup> For example, in one study it was found that a 10 year old exposed to 6 or more risk factors was 10 times more likely to be violent by age 18 than a 10 year old exposed to only a single factor.<sup>16</sup> Risk factors usually occur in clusters, not in isolation and the more risk factors a child is exposed to, the greater the likelihood that he or she will become violent.<sup>16</sup>

The SFSC Program takes place in a predominately lower socioeconomic community that has a large prevalence of multiple family risk factors that are associated with youth violence. The SFSC Program will provide community based family support and education to strengthen the family unit and decrease family risk factors associated with youth violence.

### ***Program Setting***

The SFSC Program will be based out of the pediatric department of Chicago Provident Hospital of Cook County. Provident Hospital has a rich tradition of delivering quality healthcare and resources to its surrounding community. Considered a community teaching hospital, more

than 900 babies are delivered annually, many of whom continue to receive care from the Southside Children's Health Center, Provident's out-patient pediatric clinic.<sup>21</sup>

Provident Hospital predominately serves its surrounding communities on the South Side of Chicago. Demographic data from the 2000 United States Census, using data from the surrounding area zip codes 60615, 60653, 60637, 60621, and 60609, illustrate a population that is predominately lower income with 17.6 – 41.3 % of families falling below the national poverty level compared to only 9.2 % of American families nationally.<sup>22-26</sup> Median household incomes ranged from \$14,205 to \$31,571 in the previously mentioned zip codes.<sup>22-26</sup> Black/African American individuals accounted for the majority (71.6 %) of the population, followed by White Americans at 17.4% and Hispanic/Latino Americans at 14.1%.<sup>22-26</sup> Children under the age of 18 accounted for 21.8% of this population.<sup>22-26</sup> It is of importance to note the pockets of affluent areas included in this data created by academic institutions such as the University of Chicago and the Illinois Institute of Technology. In addition this data also includes areas of urban gentrification such as parts of the Bronzeville neighborhood. If those areas were excluded, it could be hypothesized that the percent of families that fall below the federal poverty level would be even higher and the median income even lower.

### **Program Context**

The current political and social environment in Chicago provides an excellent opportunity to collaboratively develop a program aimed at decreasing youth violence with all the key stakeholders involved.

## ***National Priorities***

In response to the epidemic of youth violence in America, several national youth violence prevention plans and policies have been constructed in hopes of decreasing rates of violence. The Striving to Reduce Youth Violence Everywhere (STRYVE) Plan, Safe Schools Healthy Students Initiative (SS/HS) and Families and Schools Together (FAST) Project are all national plans that provide the SFSC Program with guidelines, grant opportunities and resources to develop successfully. The SFSC Program is also aligned with national policies created by Healthy People 2010, Healthy People 2020, the American Medical Association, the American Academy of Pediatrics and the American Public Health Association.

### ▪ ***National Plans***

- ***Striving to Reduce Youth Violence Everywhere (STRYVE):*<sup>27</sup>** Created by the U.S. Centers for Disease Control and Prevention, STRYVE is a guide for communities, states and the country to use in developing and implementing evidence-informed strategies, programs and policies. STRYVE articulates the need for a multidisciplinary, multi-component, and coordinated strategic plan of action to increase the potential effectiveness and efficacy of youth violence prevention programs.
- ***Safe Schools Healthy Students Initiative (SS/HS):*<sup>28</sup>** The SS/HS Initiative is a Federal grant-making program designed to prevent violence and substance abuse among our Nation's youth, schools, and communities.
- ***Families And Schools Together (FAST):*<sup>29</sup>** FAST systematically reaches out to entire families and organizes multi-family groups to increase parent involvement with at risk youth. Currently being implemented in more than 450 schools in 31 States and 5 countries, FAST helps families strengthen the parent-child relationship in specific,

focused ways and empowers the parents to be the primary prevention agents for their children. Program is for children ages 3-14.

▪ ***National Policies***

- ***Healthy People 2010 Objective 15-38 / Proposed Healthy People 2020 IVP HP2020-13***<sup>30</sup>
  - Reduce physical fighting among adolescents.
- ***Healthy People 2010 Objective 15-39/Proposed Healthy People 2020 IVP HP2020-14***<sup>31</sup>
  - Reduce weapon carrying by adolescents on school property.
- ***Proposed Healthy People 2020 Objective IVP HP2020-41***<sup>32</sup>
  - Reduce bullying among adolescents.
- ***American Academy of Pediatrics: Policy Statement Role of the Pediatrician In Youth Violence Prevention***<sup>33</sup>
  - There are 4 domains in which pediatricians should be expected to apply their skills and influence in the implementation of youth violence prevention strategies: clinical practice, advocacy, education, and research.
- ***American Medical Association Policy D-515.995 Time for Action on Youth Violence***<sup>34</sup>
  - Our AMA will advocate for a national task force of diverse organizations to address youth violence prevention (and not solely limited to school violence and community violence).
- ***American Medical Association Policy D-515.997 School Violence***<sup>35</sup>
  - Our AMA will collaborate with the US Surgeon General on the development of a comprehensive report on youth violence prevention, which should include such issues



as bullying, racial prejudice, discrimination based on sexual orientation or gender identity, and similar behavior and attitudes.

○ **American Public Health Association: Building Public Health Infrastructure for Youth Violence Prevention – Policy # 200914**<sup>36</sup>

- Urges the Congress and states to fund comprehensive, culturally based programs based on scientific evidence and using the following guidance from Youth Violence: A Report of the Surgeon General and other evidence.
- Urges support of CDC in the development and implementation of a National Public Health Prevention Strategy to Prevent Youth Violence that aims to create a national movement with the collaboration of partners and stakeholders (e.g., parents and educators), working together to reduce youth violence.
- Encourages local, state, and federal public health organizations to take a leadership role through coordination and collaboration with justice, education, business, and other partners to develop and implement plans to address youth violence and prevent it before it occurs.
- Urges Congress and states to enhance the capacity and infrastructure of the public health community at the federal, state, and local levels to address the ongoing public health crisis of violence.
- Urges Congress, state, and local public health departments in building infrastructure, capacity, and systems to develop adequate data and surveillance systems.
- Urges federal, state, and local governments to develop coordinated prevention planning, program implementation, and evaluation efforts in the most needed

locales, including incentives and opportunities to participate in citywide efforts. Efforts should adopt a comprehensive, culturally based approach, including equitable distribution of interventions and greater collaboration between cities.

- Urges training for state and local public health departments about the role of public health in preventing violence and effective, evidence-based programs for youth violence prevention. APHA also supports the integration of such training programs in all public health graduate school curricula.
- Calls for the support of additional research to understand the community and societal factors that can contribute to or prevent youth violence and how these factors can be modified to reduce risk or enhance protection. Research is needed in all communities, including ethnic minority communities.
- Calls for resources to support dissemination and implementation of evidence-based youth violence prevention programs, strategies, and policies and on-going evaluation to ensure that these efforts are being implemented appropriately and that they are having the intended effects on youth risk for violence.
- Urges federal, state, and local governments to improve data collection, including supporting nationwide expansion of CDC's National Violent Death Reporting System.

### ***State and Local Priorities***

The goals and objectives of the SFSC Program are similar to initiatives such as the Illinois School and Youth Prevention Plan, We Go Together in for Kids, Becoming A Man (BAM), CeaseFire, and Project Safe Neighborhoods already in establishment in Chicago.

▪ **Local Plans**

- **We Go Together For Kids:**<sup>37</sup> Mission is to mobilize all segments of the West Chicago Elementary School District 33 and community to cooperate in a coordinated and comprehensive approach that addresses the health, safety, and well being of students and families.
- **Becoming A Man (B.A.M.):**<sup>38</sup> Initiative to help steer Chicago's youth away from violence. Sports activities and group counseling will be offered in an effort to keep teenage boys away from gangs, crime and violence.
- **CeaseFire:**<sup>39</sup> The Chicago Project for Violence Prevention (CeaseFire) is an evidence-based public health approach to reduce shootings and killings in Chicago. Its mission is to work with community and government partners to reduce violence in all forms, and to help design interventions required to better define what should be included in a community or city anti-violence plan.
- **Project Safe Neighborhoods:**<sup>40</sup> Project Safe Neighborhoods is a comprehensive strategy designed to prevent youth from committing gun crime and reduce the incidence of gun violence in Chicago's most afflicted neighborhoods.

▪ **State Policy**

- **Illinois School and Youth Violence Prevention Plan**<sup>41</sup>
  - Assure all school aged children and teens access to after school, weekend and summer youth development programs to shut down the "Prime Time for Juvenile Crime"
  - Assure all babies and preschool children access to early childhood care and school readiness programs proven to cut crime.

- Help parents, early childhood caregivers, and schools identify and assist troubled and disruptive children at an early age, and provide children and their parents the counseling and training that can help equip kids with the social emotional skills needed for success.
- Prevent child abuse and neglect by: a) providing resources and well trained child protective services to safeguard endangered children; and b) Offering high-risk parents the in-home parent coaching programs proven to cut in half abuse, neglect, and subsequent teen delinquency.

### ***Program Stakeholders***

In order for the SFSC Program to be successful it will require a coordinated effort and support from all parties involved. One such party would be Provident Hospital and its pediatric department staff. Provident has a long history of community advocacy and involvement. Actively committed to prevention, a youth violence reduction initiative would complement the hospital's strong tradition working with community residents to promote good health and wellness. The SFSC Program will also require the support of community programs and the Child Parent Centers of the Chicago Public School System in order provide additional support to participant families. Most importantly, the SFSC Program will require the buy in and active participation of its participant families. In addition, SFSC's community stakeholders will include community programs, faith-based organizations, local political representatives, the local health department, local State Children's Health Insurance Program (SCHIP) representative, Safe Schools Healthy Students Initiative, A Brighter Future Youth Violence Prevention Grant administrators, Robert Wood Johnson Foundation, Medicaid and private insurance companies.

### ***Program Acceptability***

The SFSC Program aims to decrease youth violence by strengthening families using family centered anticipatory guidance orchestrated in a clinical pediatric setting. Anticipatory guidance is the cornerstone of pediatrics and as such is expected to be accepted by families. The major stakeholders of the community will be involved in the development, implementation and evaluation of the program in the form of an advisory board and focus groups. Program staff and participant constructive criticisms will be collected and discussed at various points in order to develop a program that is feasible for all parties involved.

### ***Program Infrastructure and Funding***

The SFSC Program will seek administrative office space at Provident Hospital. Well check visits and developmental assessments will take place in the Provident Southside Children's Health Center.

The SFSC Program will be partially funded by medical reimbursements from private insurance companies and Medicaid, using codes such as for new patients under 1 year, individual counseling (15 or 30 minutes), team medical conference (30 minutes), supervision of patient in home (15-29 minutes per month) or telephone call (simple/intermediate/complex). In addition funds will be sought from grants provided from the Safe Schools Healthy Students Initiative, A Brighter Future – Youth Violence Prevention Grant, Robert Wood Johnson Foundation Peaceful Pathways: Reducing Exposure to Violence, and the Robert Wood Johnson Foundation Local Funding Partnership.

## ***Challenges***

The SFSC Program compliments the national and local political environments and local, state, and national priorities. However, possible challenges foreseeable with a program that is based out of a pediatric clinic are sustainability, time constraints, participant interest and migration of participant families. In order to increase the likelihood of sustainability financially the SFSC Program will rely on reimbursements from insurance companies and Medicaid, in addition to grant sources. To increase sustainability within the infrastructure, the SFSC Program will hire a program manager whose job description will include troubleshooting, writing grant applications and keeping all parties of the project actively involved. In order to maintain participant interest, participants will be provided with travel vouchers, home visits will be scheduled during convenient times, and incentives (diapers/clothes/toys etc.) from community supporters will be provided. Migration of families does occur and individual cases will be addressed in order to try to retain participation.

## **Program Theory**

Change theory will be used to guide the development of the SFSC Program and offer a systematic approach to understanding the dynamics of youth violence. In order to do this the ecological perspective will be used acknowledging that behavior both affects, and is affected by, multiple levels of influence and that individual behavior both shapes and is shaped by the social environment.<sup>42</sup> On the intrapersonal level it is useful to use the Health Belief Model for the development of the SFSC Program in order to acknowledge, educate and advocate change strategies focused on the perceived susceptibility, severity, benefits, and barriers related to reducing youth violence amongst participants.<sup>42</sup> Under the context that individuals exist with in

and are influenced by a social environment in which they also exert influence on, the interpersonal level of theories of health behavior will also be utilized with in the SFSC Program.<sup>42, 43</sup> Specifically, the Social Cognitive Theory will be used to develop strategies aimed at decreasing youth violence through community based support and education.

### ***Intrapersonal Level: The Health Belief Model***

In order for the SFSC Program to be successful, familial attitudes and beliefs about the importance of a healthy family unit and youth violence must be identified and addressed in order to change and sustain family behaviors and dynamics. Violence is commonplace in many inner-city communities.<sup>43</sup> Many inner-city children have experienced multiple losses to violence and are themselves exposed to violence, shootings and mayhem on a regular basis.<sup>43</sup> In a study in New Orleans, mothers of African American children became so accustomed to violent events occurring on a daily basis that they started to think of them as normal events.<sup>43</sup> Similar observations were seen in a study based out of Chicago, in which children were found to be less sensitized to violence because of the frequency to which they were exposed.<sup>43</sup> The nurse home visitor segment of the SFSC Program will help families develop an accurate perception of their own risk, specify the consequences of unhealthy or destructive behaviors and recommend action. In addition, nurse home visitors will offer reassurance and assistance while providing training and guidance in performing actions. The routine pediatric visit portion of the program will use progressive goal setting in order to change family behaviors. Through involvement with all of the components of the SFSC Program simultaneously families will receive repeated verbal reinforcement.

### ***Interpersonal Level: The Social Cognitive Theory***

In developing a program that reduces youth violence the Social Cognitive Theory provides the notion that “Behavior is not simply a product of the environment and the person, and environment is not simply a product of the person and behavior.”<sup>42 (p.20)</sup> If one was to replace behavior with youth violence this would mean that, youth violence is not simply a product of the environment and the child, and conversely the environment is not simply a product of the child and youth violence. Modeling the social cognitive theory, segments of the SFSC Program incorporate reciprocal determinism, behavior capability, expectations, self-efficacy, observational learning and reinforcements into their activities. The nurse home visitor offers a credible role model and a resource to families. The dialectic nature of the relationship formed between the nurse home visitor and the family will promote self-efficacy and behavior capability. All segments of the SFSC Program will encourage families to consider multiple ways to promote behavior change.



## **Strong Family Strong Community Goals and Objectives**

**Goal:** To decrease the incidence of youth violence in the Bronzeville area of Chicago.

### **Short - Term Objectives**

- With in 6 months, 25 first time mothers will be identified and enrolled into the SFSC Program by their pediatric physician.
- With in 9 months, 25 family/social service community organizations will be identified and partnered with by SFSC social worker.
- With in 2.5 years, 50 enrolled children will have completed their routine pediatric clinic visits at 4 days after birth, at months 1, 2, 4,6,9,12,15 and 18 and annually after the age of 2.
- With in 18 months, each nurse home visitor will provide 12 families with 18 forty-five minute home visits.

### **Medium - Term Objective**

- With in 3.5 years, 50 child participants will enroll in a Chicago Child Parent Center in their neighborhood.

### **Long - Term Objectives**

- With in 13 years, 50 child participants will have completed elementary school with decreased rates of school disciplinary actions compared to other classmates.
- With in 18 years, 50 child participants will have successfully completed high school with decreased rates of school disciplinary actions compared to other classmates.

## Strong Family Strong Community Logic Model

Resources/Inputs	Activities	Outputs	Short & Long Term Outcomes	Impact
<p><b><u>Organizational</u></b>            *Stakeholder buy-in            *Chicago Provident Hospital support            *Community support (organizations, churches, businesses)</p> <p><b><u>Family Team</u></b>            *Pediatrician            *Nurse Home Visitor            *Social Worker            *Project Manager            *Staff from CPS Child Parent Center</p> <p><b><u>Infrastructure</u></b>            * Chicago Provident Hospital Resources            *Electronic Medical Record System            *Community programs and organizations</p> <p><b><u>Funding</u></b>            * Possible grant sources            - Safe Schools Healthy Students Initiative            - A Brighter Future Youth Violence Prevention Grant            - RWJ Foundation Local Funding Partnerships            - RWJ Foundation Peaceful Pathways: Reducing Exposure to Violence Grant            * Reimbursement from Medicaid and Private Insurances</p>	<p>Identify and recruit families of first born children</p> <p>Work with families to develop individualized goals and objectives</p> <p>Complete routine pediatric well visits</p> <p>Complete home visits with families every three weeks</p> <p>Provide psychological and social support to families</p> <p>Create a Chicago Area Family Resource Guide</p> <p>Create community partnerships to develop support and referrals for program</p> <p>Enroll children at a local CPS childcare center at age of 3.</p> <p>Complete monthly multi-departmental family team progress meetings</p> <p>Complete electronic monthly progress forms</p>	<p># of routine pediatric clinic visits</p> <p># of home visits by home visitor</p> <p># of physicians aware of and using Chicago Family Resource Guide</p> <p># of community relationships developed</p> <p># of developmental assessment sessions</p> <p># of communications among family team</p> <p># of multi-departmental meetings</p> <p># of children enrolled in CPS Child Parent Centers</p>	<p><b><u>Short Term</u></b>            Pediatric staff more aware of community resources available for referral</p> <p>Increase knowledge by family of available resources.</p> <p>Parents function more effectively</p> <p>Increase family self efficacy and self awareness</p> <p>Improved parent-child interactions</p> <p>Increase rates of family planning</p> <p><b><u>Long Term</u></b>            Decrease rates of child neglect and abuse</p> <p>Decrease rates of school disciplinary actions for child.</p> <p>Increase rates of high school graduation by child</p> <p>Increase rates of higher education attainment by child</p>	<p>Decrease rates of youth delinquency and violence.</p> <p>Decrease rates of youth arrests and incarceration</p> <p>Decrease the number of youth involved in gangs.</p>

## **Program Implementation**

The implementation plan for the SFSC Program is subdivided into sections based on the role of each member of an individual family unit. The phrase *family unit* refers to the multidisciplinary team that is working with each individual family and is composed of the pediatrician, nurse-home visitor, social worker, project manager and staff at the CPS Child Parent Center. Each person within the family team has a distinctive role and carries out activities concurrently with other members.

### ***Pediatrician***

The pediatrician of a family unit will serve as the source of primary health care for the child. Working with the administrative staff of the pediatric department and project coordinator, the pediatrician will identify and recruit families of first-born children that are between 1- 4 weeks old. Each child and his or her family will have a specific pediatrician that they will work with for the duration of the program. The pediatrician is responsible for periodic well child examinations and the care of the child when he or she is sick from birth on. Working with administrative staff, the pediatrician will schedule routine visits monthly for the first year and thereafter at ages 15, 18, 21, 24, 27 and 30 months. Working together, the pediatrician and family will develop objectives and goals specific to the family's circumstances and values. The pediatrician will provide parents with anticipatory information and encourage parents to bring their questions and observations about their child to clinic visits. In doing this the physician will help parents increasingly feel confident of their ability to decide when they need to seek or talk with the doctor. After each visit, the pediatrician will complete electronic progress notes that will be accessible to the entire family team. The pediatrician will also be in attendance at monthly multi-departmental family team progress meetings.

### ***Nurse Home Visitor***

The nurse home visitor is considered the “parents’ person” of the team. He or she is the individual, more than any other member of the team, who identifies with the parental needs of the family. The nurse home visitor will complete home visits every three weeks for the first six months of life, every month until the age of two and once every three months thereafter or as warranted. The purpose of the home visits is to improve the health and development of the child by helping parents provide more competent caregiving. The nurse will be required to have a BSN degree and experience in community or maternal child health nursing.

The nurse home visitor will deliver a preset structured home visit curriculum and work with families to develop personal short term and long-term goals. He or she will also provide psychological/social supports and be the liaison between the family and the team when concerns arise. After each session the nurse home visitor will complete an electronic short report. The nurse home visitor will be in attendance at monthly multi-departmental family team progress meetings.

### ***Social Worker***

The social worker will serve as a link between the family team and community resources. He or she will be in charge of constructing a Chicago Area Family Resource Guide that will include children, parental, family, social, educational and economic resources. Once constructed, the social worker will disseminate the book to members of the family team and medical pediatric staff. He or she will also work with Provident Hospital administrators to create a web version for the general public. The social worker will develop a 15-minute presentation that will highlight key programs in the surrounding area. The presentation will be given during a

morning conference for the physicians and residents. The social worker will connect families with programs and resources when referred by any of the family team and will be present at monthly multi-departmental family team progress meetings.

### ***Project Manager***

The project manager will serve as the coordinator between the different members of the family team. He or she will be responsible for all of the administrative duties of the SFSC Project and track the progress of participants.

### ***CPS Child Parent Center***

Children will be referred to their local CPS Child Parent Center once the child is 3 years of age. All ready well established within the Chicago Public School System, the Child Parent Centers will provide comprehensive services, requiring parent participation and implement child-centered approaches to social and cognitive development for children.

### ***Family Group Sessions***

Monthly family group sessions will be held in a community facility in order to provide participants the opportunity to learn from each other's experiences, share triumphs and obstacles and develop a sense of community. Meetings will be participant controlled giving the group autonomy and power. Attendance will be optional and there will be funds provided for food.

## **IV. Strong Family Strong Community Evaluation Plan**

### **Rationale & Approach to Evaluation**

#### ***Rationale for Evaluation***

An evaluation of the Strong Family Strong Community (SFSC) Program will be conducted in order to systematically track the progress of the program, to identify any logistical complications in the implementation of the program, to make modifications as needed and to support further funding from financial backers. Program evaluation also creates the opportunity to incorporate the different perspectives of the key stakeholders involved.

#### ***Role of the Evaluator***

My role in the evaluation of this program will be that of an internal member of the evaluation team. The evaluation team of SFSC will include both internal and external evaluators, with one individual from the internal program staff serving as the lead coordinator. I think it is important to have an internal evaluator as part of the evaluation team because of his or her vantage point of activities and his or her familiarity with the program operations and components. An external evaluator is important because he or she brings impartiality to the evaluation process and can also provide high levels of evaluation expertise that other members may not have.<sup>44</sup> Key skills and/or characteristics an evaluator should have include: (a) having experience in the type of evaluation needed, (b) being able to work with a wide variety of stakeholders, (c) having the ability to develop innovative approaches to evaluation while considering the realities affecting the program, (d) having the ability to incorporate evaluation into all program activity, (e) being able to understand both the potential benefits and risks of

evaluation and (f) exhibiting cultural competence.<sup>44</sup> All of these characteristics may not be found in a single individual, but should be embodied within the evaluation team.

### ***Stakeholder Involvement***

In order to increase the sustainability of SFSC it will be important that the evaluation of this program not only address logistical and program specific questions, but in addition take into account the specific concerns of SFSC stakeholders. In order to accomplish this some stakeholders will serve as members of the evaluation team, and all will be included in the evaluation process through pre- and post written surveys, pre- and post phone surveys, focus groups and individual interviews. SFSC stakeholders include participant families, community programs, faith-based organizations, local political representatives, the local health department, local State Children's Health Insurance Program (SCHIP) representative, Safe Schools Healthy Students Initiative, A Brighter Future Youth Violence Prevention Grant administrators, Robert Wood Johnson Foundation, Medicaid and private insurance companies. Salient questions for stakeholders include but are not limited to the following:

- **Parents:** Does the value or benefit of achieving the program's goals and objectives exceed the personal cost, time and imposition to families? Am I seeing results from the program that reflect ultimate goals?
- **Community Programs/Faith-based Organizations/Local Political Representatives:** Is the program achieving the goals and objectives it intended to accomplish? Who are the people who are benefiting from this program?
- **Local Health Department/Local SCHIP Representative:** What services overlap with services already being provided? What proportion of participants also participate in state or federal programs? Is the program moving toward the ultimate goal?

- **Funding Sources:** Are the program's activities being produced with appropriate use of financial resources? Is the program achieving the goals and objectives it intended to accomplish? Does the value or benefit of achieving the program's goals and objectives exceed the cost of producing them?

### ***Potential Challenges***

Potential challenges that the evaluation process may incur include developing an evaluation that will gather information that will address the concerns of stakeholders while still being feasible to conduct. Another potential challenge will be making all key stakeholders active participants in the evaluation process. Additionally, the ultimate goals of the program are long term, and family migration is a possibility in this setting, which may affect the accuracy and validity of results.

## **Evaluation Design and Methods**

### ***Evaluation Design***

SFSC is a pilot program, and as such it is important to develop an evaluation process that examines the program's implementation, outcomes, efficacy and effectiveness. The entire program will not be evaluated at any one point of time, but rather at multiple points during the planning, implementation, and evaluation stages. Evaluation will be used to identify areas for improvement, improve the content of program materials, and document the level of success of SFSC in achieving set objectives.

Understanding that an ideal evaluation design for SFSC is one that creates minimal bias, a quasi-experimental design will be used. Prospective in orientation, a quasi-experimental



design makes comparisons between nonequivalent groups and does not involve random assignment to intervention and control groups.<sup>44</sup> More specifically, a two-group, pre-test/post-test design will be utilized that will collect outcome variable data on or from program participants and non-participants both before the program begins and after the program completes. The intervention group will consist of families of first-born children who use the Provident Hospital Pediatric Clinic as their primary source of health care and wish to be involved in the SFSC program. The comparison group will consist of families of first-born children who use a neighboring hospital, Mercy Hospital and Medical Center, as their primary source of health care. Mercy Hospital and Medical Center is within 5 miles of Provident Hospital and the surrounding community that it serves is similar to that of Provident Hospital.

Observational and descriptive design methods will also be used in the evaluation of SFSC in order to provide a greater depth of understanding of program processes and short-term outcomes. Observational methods that will be used in the evaluation include focus groups, phone and written surveys with open-ended questions, and individual in depth interviews.

### ***Evaluation Methods***

In order to conduct a comprehensive analysis of SFSC's implementation, outcomes and effectiveness, multiple methods will be used to evaluate the program. Quantitative and qualitative methods will be utilized to help increase the accuracy and certainty of conclusions. Methods were chosen based on their utility, feasibility, propriety and accuracy and will be used concurrently pre- and post-intervention.

Primary data collection methods will be used to acquire both quantitative and qualitative data. Quantitative methods will include the review of electronic medical records, review of program logs (meeting notes, memos, schedule logs, etc.), written closed-ended surveys, and

phone close-ended surveys. Qualitative methods will include use of in-depth individual interviews, focus groups, written open-ended surveys, phone open-ended surveys and focus groups.

The diversity of evaluation methods will provide results that are multi-dimensional and provide insights into the needs, problems, barriers, and issues faced by the target population. The closed and open telephone surveys are rapid, inexpensive, have the potential to control the quality of the interview and are particularly appropriate in populations where literacy may be low. Conversely, they can introduce selection bias by omitting families without phones and provide less anonymity for respondents. The focus group method takes advantage of the group dynamics, which can lead to discussions and revelations of new information in a less intimidating manner for participants compared to individual methods. Qualitative methods are able to consider perspectives in content analysis, critical analysis, ethnography, grounded theory, and phenomenology that may be missed if conclusions were solely based on quantitative methods.<sup>45</sup> Using these methods in conjunction with each other creates the opportunity to control for disadvantages of individual methods.

## Evaluation Planning Tables

### Short Term Objective 1

Within 6 months, 25 first time mothers will be identified and enrolled into the SFSC Program by their pediatric physician.

<b>Evaluation Question</b>	<b>Participant</b>	<b>Evaluation Method</b>
How many first time mothers were identified and enrolled into the program by their pediatric physician by 6 months?	Pediatrician Program Manager Parent Participant(s)	Review of program logs Review of medical records
If pediatricians did not identify participants, how else were they identified?	Program Manager Parent Participant(s)	Review of program logs Post closed-ended survey Post open-ended survey
What percentage of 1st time mothers who use the outpatient pediatric facilities at Provident Hospital enrolled into the program?	Program Manager	Review of program logs
To what extent were the enrollment activities carried out as planned?	Pediatricians Program Manager	Review of program logs Post closed ended surveys (Written/Phone) In-depth individual interviews Post open-ended surveys (Written/Phone) Focus groups
What aspects of the enrollment process worked especially well and why?	Pediatrician Program Manager Parent Participant(s)	Review of program logs Post closed ended surveys (Written/Phone) In-depth individual interviews Post open-ended surveys (Written/Phone) Focus groups
Were there any unanticipated burdens experienced because of enrollment methods? What?	Pediatrician Program Manager Parent Participant(s)	Review of program logs Post closed ended surveys (Written/Phone) In-depth individual interviews Post open-ended surveys (Written/Phone) Focus groups
What are three things you would suggest to improve the enrollment process of SFSC?	Pediatrician Program Manager Parent Participant(s)	In-depth individual interviews Post open-ended surveys (Written/Phone) Focus groups

## Short Term Objective 2

Within 9 months, 25 family/social service community organizations will be identified and partnered with by the SFSC social worker.

<b>Evaluation Question</b>	<b>Participant</b>	<b>Evaluation Method</b>
How many family/social service community organizations were identified and partnered with by the SFSC social worker by 9 months?	Social Worker Program Manager	Review of program logs Post closed-ended survey Post open-ended survey
If social workers did not refer families to family/social service community organizations, how did families find out about resources?	Social Worker Parent Participant(s) Community Organization	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
What percentage of participants was referred to family/social service community organizations?	Social Worker Program Manager Parent Participant(s)	Review of program logs Post closed-ended survey Post open-ended survey
Of those participants referred to family/social service organizations what percentage of participants actually followed through and utilized services?	Social Worker Program Manager Parent Participant Community Organization	Review of program logs Post closed-ended survey Post open-ended survey
What were some barriers encountered by participants in utilizing community resources?	Social Worker Parent Participant(s) Community Organization	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
What were some of the barriers of community organizations enrolling participants?	Social Worker Parent Participants Community Organization	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
To what extent was the referral activities carried out as planned?	Social Worker Program Manager Community Organization	Review of program logs Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups

### Short Term Objective 3

Within 2.5 years, 50 enrolled children will have completed their routine pediatric clinic visits at 4 days after birth, at months 1, 2, 4, 6, 9, 12, 15 and 18 and annually after the age of 2.

<b>Evaluation Question (s)</b>	<b>Participant</b>	<b>Evaluation Method</b>
How many enrolled children completed their routine pediatric visits at 4 days after birth, at months 1, 2, 4, 6, 9, 12, 15, 18 and annually after the age of 2?	Pediatrician Project Manager Parent Participant(s)	Review of medical records Review of program logs
To what extent were the pediatric clinic visits carried out as planned?	Pediatrician Parent Participant(s)	Review of medical records Review of program logs
To what extent did pediatric clinic visits increase the ability of families to be more knowledgeable about their child's growth, development and health?	Pediatrician Parent Participant(s)	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
To what extent did pediatric clinic visits increase family self-efficacy and self-awareness?	Pediatrician Parent Participant(s)	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
To what extent did pediatric clinic visits increase family knowledge of and access to available community resources?	Pediatrician Parent Participant(s) Community Organizations	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
To what extent did pediatric clinic visits improve the parent-child interactions and decrease rates of child neglect and abuse?	Pediatrician Parent Participant(s)	Review of Medical Records Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups

<b>Evaluation Question (s)</b>	<b>Participant</b>	<b>Evaluation Method</b>
<p>What aspects of the pediatric visits worked especially well and why?</p>	<p>Pediatrician Project Manager Parent Participant(s)</p>	<p>Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups</p>
<p>Were there any unanticipated burdens experienced because of pediatric visits? What?</p>	<p>Pediatrician Project Manager Parent Participant(s)</p>	<p>Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups</p>

### Short Term Objective 4

Within 18 months, each nurse home visitor will provide 12 families with 18 forty five-minute home visits.

Evaluation Question (s)	Participant	Evaluation Method
How many home visits did each family receive by the home visitor within 18 months?	Program Manager Parent Participant(s) Home Visitor	Review of program logs
To what extent did home visits increase the ability of families to be more knowledgeable about their child's growth, development and health?	Parent Participant(s) Home Visitor	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
To what extent did home visits increase family self-efficacy and self-awareness?	Parent Participant(s) Home Visitor	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
To what extent did home visits increase family knowledge of and access to available community resources?	Parent Participant(s) Home Visitor	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
To what extent did home visits improve the parent-child interactions and decrease rates of child neglect and abuse?	Parent Participant(s) Home Visitor	Review Medical Chart Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
Were there any changes in family behavior or dynamics as a result of home visits that were unanticipated?	Parent Participant(s) Home Visitor	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups

<b>Evaluation Question (s)</b>	<b>Participant</b>	<b>Evaluation Method</b>
What aspects of the home visits worked especially well and why? Were especially burdensome and why?	Parent Participant(s) Home Visitor	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
What are three things you would suggest to improve the home visit component of SFSC?	Home Visitor Parent Participant (s)	In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
Does the value or benefit of achieving goals and objectives of the home visit exceed the personal cost, time and imposition to families?	Parent Participant (s)	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups



## Medium Term Objective 2

Within 3.5 years, 25 child participants will enroll in a Chicago Child Parent Center (CPC) in their neighborhood.

<b>Evaluation Question (s)</b>	<b>Participant</b>	<b>Evaluation Method</b>
How many child participants are enrolled in a CPC in their neighborhood?	Program Manager Parent Participant(s) CPC Center Administrator	Review of program logs Post closed-ended surveys
Were there any unforeseen barriers to enrolling into CPCs?	Parent Participant(s) Program Manager CPC Center Administrator	Post closed-ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
What aspects of the CPC worked especially well and why? Were especially burdensome and why?	Parent Participant(s) CPC Center Administrator	Review of program logs Post closed-ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
To what extent did the CPC increase family knowledge of and access to available community resources?	Parent Participant(s) CPC Center Administrator	Post closed-ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
To what extent did the CPC help decrease familial risk factors associated with youth violence?	Parent Participant(s) CPC Center Administrator)	Post closed-ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
To what extent did the CPC improve the parent-child interactions and decrease rates of child neglect and abuse?	Parent Participant(s) CPC Center Administrator Social Worker Pediatrician	Post closed-ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups

## Long Term Objective 1

Within 13 years, 25 child participants will have completed elementary school with decreased rates of school disciplinary actions compared to other classmates.

<b>Evaluation Question (s)</b>	<b>Participant</b>	<b>Evaluation Method</b>
How many child participants completed elementary school with decreased rates of school disciplinary actions compared to their classmates by 13 years old?	Program Manager Parent Participant(s) Child Participant School Administration Teacher(s)	Review of medical records Review of program logs Closed ended surveys (Written/Phone) Open ended Surveys (Written Phone)
Were parents satisfied with the SFSC program? Were child participants?	Parent Participant(s) Child Participant	Closed ended surveys (Written/Phone) In-depth individual interviews Open-ended surveys (Written/Phone) Focus Groups
What aspects of the program were felt to work particularly well and why?	Parent Participant(s) Child Participant	Closed ended surveys (Written/Phone) In-depth individual interviews Open-ended surveys (Written/Phone) Focus groups
What impacts did the child participant appreciate at age 13 because of the program?	Parent Participant(s) Child Participant	Closed ended surveys (Written/Phone) In-depth individual interviews Open-ended surveys (Written/Phone) Focus groups
Did the program contribute to decreased rates of youth violence by participants?	Parent Participant(s) Child Participant School Administrators Teachers	Closed ended surveys (Written/Phone) In-depth individual interviews Open-ended surveys (Written/Phone) Focus groups
Where the participants involved in any other programs that targeted the stability of the family unit or youth violence?	Parent Participant(s) Child Participant	Closed ended surveys (Written/Phone) In-depth individual interviews Open-ended surveys (Written/Phone) Focus groups

<b>Evaluation Question (s)</b>	<b>Participant</b>	<b>Evaluation Method</b>
Who all benefited from the SFSC Program?	Parent Participant(s) Child Participant Teachers Community Stakeholders	Closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Open-ended surveys <i>(Written/Phone)</i> Focus groups
Did the program achieve the goals and objectives that it intended to accomplish?	Pediatrician Program Manager Nurse Home Visitor Parent Participant(s) Child Participant Community Stakeholders	Closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Open-ended surveys <i>(Written/Phone)</i> Focus groups

**Long Term Objective 2**

Within 18 years, 25 child participants will have decreased rates of school disciplinary actions and/or rates of arrests compared to other classmates.

Evaluation Question (s)	Participant	Evaluation Method
How many child participants had decreased rates of school disciplinary actions and/or rates of arrests compared to other classmates?	Program Manager Parent Participant(s) Child Participant School Administration	Post closed-ended surveys (Written/Phone) Post open ended surveys (Written/Phone) Review of program logs
Were parents satisfied with the SFSC program? Were child participants?	Parent Participant(s) Child Participant	Post closed-ended surveys (Written/Phone) In-depth individual interviews Post open-ended surveys (Written/Phone) Focus groups
What long lasting effects from the SFSC Program did participants appreciate at age 18? By parents?	Parent Participant(s) Child Participant	Post closed-ended surveys (Written/Phone) In-depth individual interviews Post open-ended surveys (Written/Phone) Focus groups
Did the program contribute to decreased rates of youth violence by participants?	Parent Participant(s) Child Participant Teachers School Administration	Post closed-ended surveys (Written/Phone) In-depth individual interviews Post open-ended surveys (Written/Phone) Focus groups
Were there decreased rates of youth arrests and incarceration appreciated by program participants compared to non-participants?	Parent Participant(s) Child Participant Community Organization	Post closed-ended surveys (Written/Phone) In-depth individual interviews Post open-ended surveys (Written/Phone) Focus groups
Where the participants involved in any other programs of any kind that targeted the stability of the family unit or youth violence?	Parent Participant(s) Child Participant	Post closed-ended surveys (Written/Phone) In-depth individual interviews Post open-ended surveys (Written/Phone) Focus groups

Evaluation Question (s)	Participant	Evaluation Method
Who all benefited from the SFSC Program?	Parent Participant(s) Child Participant School Administration Community Organization	Post closed ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
Did the SFSC program achieve the goals and objectives that it intended to accomplish?	Pediatrician Program Manager Parent Participant(s) Child Participant Community	Post closed-ended surveys <i>(Written/Phone)</i> In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups
What are three things you would suggest to improve the SFSC program?	Pediatrician Program Manager Parent Participant(s) Child Participant Community	In-depth individual interviews Post open-ended surveys <i>(Written/Phone)</i> Focus groups

## **Dissemination Plan**

Recognizing that the dissemination process of a program evaluation is an opportunity to communicate evaluation procedures and lessons learned to relevant parties in a timely, unbiased and consistent manner, the SFSC Program will use multiple methods to share appropriate information with stakeholders and the general public. Dissemination of the evaluation results will be used to (a) provide direction for program staff, (b) identify training and technical assistance needs, (c) aid in forming budgets and justifying the allocation of resources, (d) support annual and long-range planning, (e) enhance the image of SFSC and Provident Hospital, (f) focus attention on the issue of youth violence in Chicago, and (g) demonstrate to legislators and other stakeholders that resources are being well spent and that the program is effective.

Keeping these goals in mind, the project staff (physicians, social workers, home visitors, CPC staff, and project manager) will receive quarterly updates and evaluation results in order to guide quality improvement efforts. At the conclusion of the evaluation process a formal evaluation report will be composed and distributed to the administrators of Provident Hospital, the Chicago Public School System, the Chicago Child Parent Centers, Cook County Health Department, funding partners (Safe Schools Healthy Students Initiative, A Brighter Future Youth Violence Prevention, Robert Wood Johnson Foundation, Public/Private Insurance Companies), and to community organizations, faith-based organizations and leaders. Included in the formal report will be an executive summary that will offer a one- or two-page synopsis of the SFSC program, its evaluation and key recommendations. Presentations will be given at pediatric grand rounds at Provident Hospital, and community organizations when opportunities arise. A press release will be forwarded to local media highlighting the program and evaluation findings. The

executive summary will be available on the SFSC and Hospital website giving access to the general public.

Remembering the importance of sharing results with participant families, a community dinner will be held for families, program staff and other key stakeholders. At the dinner a brief presentation will be given highlighting an overview of the program, results of evaluation, positive and negative lessons learned, and future recommendations. Lastly to contribute to the literature of programs targeting youth violence, SFSC will submit and publish an article to a peer-reviewed journal for dissemination.

## **V. Discussion**

The World Health Organization made the case in 2002, that youth violence is preventable.<sup>5</sup> The American Medical Association and the American Academy of Pediatrics both consider youth violence prevention initiatives a major priority for physicians and the medical community. Based upon the repetitive and confidential nature of the pediatrician/child/family relationship, it is thought that pediatricians can be pivotal participants in an interdisciplinary effort to reduce youth violence.<sup>46</sup> They have multiple opportunities to address violence through teaching parents about discipline, media exposure, and firearm exposure.<sup>46</sup> The American Public Health Association has an extensive list of recommendations and policies regarding youth violence and there are many examples of successful public health initiatives targeting youth violence.

The Strong Family Strong Community Program combines the strengths and perspectives of clinical medicine and public health to create a multi-disciplinary initiative that targets youth violence in the Bronzeville area of Chicago by strengthening the family unit. Incorporated into SFSC's implementation plan are nurse home visitation sessions and enrollment into the Chicago Child Parent Centers. Longitudinal research has established the effectiveness of both approaches in preventing youth violence over the lifespan of a child's development.

Programs and policies that increase a child's exposure to safe, stable, and nurturing relationships and environments can improve their health over a life time and reduce criminal behavior.<sup>47</sup> Some researchers believe that safe, stable, and nurturing relationships and environments for children counter the adverse exposures that occur during childhood.<sup>47</sup> In the literature, evidence regarding protective factors against violence has not met the standards held



for risk factors because (a) not all studies define protective factors as buffering the effects of risk; (b) most studies have looked for an effect on antisocial behavior in general, not on violence specifically; and (c) those that have found buffering effects on violence have not been adequately replicated.<sup>16</sup> The SFSC program and evaluation results have the opportunity to add to the scant literature currently available about protective factors for youth violence.

Strong Family Strong Community is an ideal program developed to deal with the real problem of youth violence in Chicago. Through the different stages of developing this program and evaluation plan I have learned various theories, methods, and strategies that I am sure to use in the future. I believe there is great potential in programs that combine medical and public health efforts to tackle daunting issues such as youth violence.

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## References

1. Banchemo S, Mack K. 16-year-old boy beaten to death in roseland. *Chicago Tribune*. September 26, 2009 2009;News. Available from: [http://archives.chicagotribune.com/2009/sep/26/news/chi-teen\\_killed\\_roselandsep26](http://archives.chicagotribune.com/2009/sep/26/news/chi-teen_killed_roselandsep26).
2. Mack K, Banchemo S, Sweeney A. Fenger high school: Fear, frustration come to campus. *Chicago Tribune*. September 29, 2009 2009.
3. Saulny S. Attorney general, in chicago, pledges youth violence effort. *The New York Times*. October 8, 2009 2009.
4. Youth violence prevention, definitions Available at: <http://www.cdc.gov/NCIPC/dvp/YVP/YVP-def.htm>. Accessed 1/27/2010, 2010.
5. Notarianni MA, Tillman HJ. Caring for the future: Strategies for promoting violence prevention in pediatric primary care. .
6. Juvenile reports: Juvenile arrest trends 2003-2008. Available at: <https://portal.chicagopolice.org/portal/page/portal/ClearPath/News/Statistical%20Reports/Juvenile%20Reports>. Accessed 5/23/2010, 2010.
7. Yoshikawa H. Long-term effects of early childhood programs on social outcomes and delinquency. *The Future of Children LONG-TERM OUTCOMES OF EARLY CHILDHOOD PROGRAMS*. 1995;5:51-75.
8. Zigler E, Taussig C, Black K. Early childhood intervention: A promising preventative for juvenile delinquency. *Am Psychol*. 1992;47(8):997-1006.
9. Rescorla LA. The yale child welfare research program: Description and results. . 1979.

10. Reynolds AJ, Temple JA, Robertson DL, Mann EA. Long-term effects of an early childhood intervention on educational achievement and juvenile arrest: A 15-year follow-up of low-income children in public schools. *JAMA*. 2001;285(18):2339.
11. Schweinhart LJ, Barnes HV, Weikart DP. Significant benefits: The High/Scope perry preschool study through age 27. *Child Welfare: Issues in child welfare*. 2005:9.
12. Schweinhart LJ, Montie J, Xiang Z, Barnett WS, Belfield CR, Nores M. Lifetime effects: The High/Scope perry preschool study through age 40. *William S Barnett*. 2005:3.
13. Lally JR, Mangione PL, Honig AS. The syracuse university family development research program: Long-range impact of an early intervention with low-income children and their families. *Parent education as early childhood intervention: Emerging directions in theory, research, and practice*. 1988:79-104.
14. Johnson DL, Walker T. A follow-up evaluation of the houston parent-child development center: School performance. *Journal of Early Intervention*. 1991;15(3):226.
15. Qi H. Behavior problems of preschool children from low-income families: Review of the literature. *Topics for Early Childhood Special Education*. 2003;23(4):188.
16. United States Surgeon General. Youth violence: A report of the surgeon general. *Washington DC: US Department of Health and Human Services*. 2001.
17. Gang motivate murders 1991 - 2004. Available at:  
<https://portal.chicagopolice.org/portal/page/portal/ClearPath/News/Statistical%20Reports/Juvenile%20Reports>. Accessed 3/19/2010, 2010.
18. Profile for chicago (city) - illinois - KIDS COUNT data center Available at:  
<http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=IL&group=Custom&loc=103>

[&ind=4410,65,123,67,71,43,45,46,47,48,53,105,106,108,110,111,4158&dt=1,3,2,4](#). Accessed 3/23/2010, 2010.

19. Profile for illinois (state) - illinois - KIDS COUNT data center Available at:

<http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=IL&group=Custom&loc=15&ind=4410,4845,4857,4865,4900,65,66,4409,67,71,124,4194,4493,53,54,4856,105,106,108,110,111,4393,4854,19,4100,4158,4174,112,113,114,137&dt=1,3,2,4>. Accessed 3/23/2010, 2010.

20. National profile - data across states - KIDS COUNT data center Available at:

<http://datacenter.kidscount.org/data/acrossstates/NationalProfile.aspx?group=Custom&loc=1&ind=56,5043,58,5046,63,5053,61,5056,62,5057,65,66,67,4755,43,105,106,108,110,111,19,112,113,114&dt=1,3,2,4>. Accessed 3/23/2010, 2010.

21. Provident hospital of cook county | john stroger hospital of cook county Available at:

<http://medicine.johnstrogerhospital.org/dom/provident.html>. Accessed 2/28/2010, 2010.

22. 60615 - fact sheet - american FactFinder Available at:

[http://factfinder.census.gov/servlet/SAFFFacts?\\_event=Search&geo\\_id=&\\_geoContext=&\\_street=&\\_county=60615&\\_cityTown=60615&\\_state=&\\_zip=60615&\\_lang=en&\\_sse=on&pctxt=fph&pgsl=010&show\\_2003\\_tab=&redirect=Y](http://factfinder.census.gov/servlet/SAFFFacts?_event=Search&geo_id=&_geoContext=&_street=&_county=60615&_cityTown=60615&_state=&_zip=60615&_lang=en&_sse=on&pctxt=fph&pgsl=010&show_2003_tab=&redirect=Y). Accessed 2/28/2010, 2010.

23. 60653 - fact sheet - american FactFinder Available at:

[http://factfinder.census.gov/servlet/SAFFFacts?\\_event=Search&geo\\_id=86000US60615&\\_geoContext=01000US|86000US60615&\\_street=&\\_county=&\\_cityTown=&\\_state=&\\_zip=60653&\\_lang=en&\\_sse=on&ActiveGeoDiv=geoSelect&\\_useEV=&pctxt=fph&pgsl=860&\\_submenuId=factsheet\\_1&ds\\_name=DEC\\_2000\\_SAFF&ci\\_nbr=null&qtr\\_name=null&reg=null:null&keyword=&\\_industry=](http://factfinder.census.gov/servlet/SAFFFacts?_event=Search&geo_id=86000US60615&_geoContext=01000US|86000US60615&_street=&_county=&_cityTown=&_state=&_zip=60653&_lang=en&_sse=on&ActiveGeoDiv=geoSelect&_useEV=&pctxt=fph&pgsl=860&_submenuId=factsheet_1&ds_name=DEC_2000_SAFF&ci_nbr=null&qtr_name=null&reg=null:null&keyword=&_industry=). Accessed 2/28/2010, 2010.

24. 60637 - fact sheet - american FactFinder Available at:

[http://factfinder.census.gov/servlet/SAFFFacts?\\_event=Search&geo\\_id=86000US60615&\\_geoContext=01000US|86000US60615&\\_street=&\\_county=&\\_cityTown=&\\_state=&\\_zip=60637&\\_lang=en&\\_sse=on&ActiveGeoDiv=geoSelect&\\_useEV=&pctxt=fph&pgsl=860&\\_submenuId=factsheet\\_1&ds\\_name=DEC\\_2000\\_SAFF&\\_ci\\_nbr=null&qr\\_name=null&reg=null:null&\\_keyword=&\\_industry=](http://factfinder.census.gov/servlet/SAFFFacts?_event=Search&geo_id=86000US60615&_geoContext=01000US|86000US60615&_street=&_county=&_cityTown=&_state=&_zip=60637&_lang=en&_sse=on&ActiveGeoDiv=geoSelect&_useEV=&pctxt=fph&pgsl=860&_submenuId=factsheet_1&ds_name=DEC_2000_SAFF&_ci_nbr=null&qr_name=null&reg=null:null&_keyword=&_industry=). Accessed 2/28/2010, 2010.

25. 60621 - fact sheet - american FactFinder Available at:

[http://factfinder.census.gov/servlet/SAFFFacts?\\_event=Search&geo\\_id=86000US60637&\\_geoContext=01000US|86000US60637&\\_street=&\\_county=&\\_cityTown=&\\_state=&\\_zip=60621&\\_lang=en&\\_sse=on&ActiveGeoDiv=geoSelect&\\_useEV=&pctxt=fph&pgsl=860&\\_submenuId=factsheet\\_1&ds\\_name=DEC\\_2000\\_SAFF&\\_ci\\_nbr=null&qr\\_name=null&reg=null:null&\\_keyword=&\\_industry=](http://factfinder.census.gov/servlet/SAFFFacts?_event=Search&geo_id=86000US60637&_geoContext=01000US|86000US60637&_street=&_county=&_cityTown=&_state=&_zip=60621&_lang=en&_sse=on&ActiveGeoDiv=geoSelect&_useEV=&pctxt=fph&pgsl=860&_submenuId=factsheet_1&ds_name=DEC_2000_SAFF&_ci_nbr=null&qr_name=null&reg=null:null&_keyword=&_industry=). Accessed 2/28/2010, 2010.

26. 60609 - fact sheet - american FactFinder Available at:

[http://factfinder.census.gov/servlet/SAFFFacts?\\_event=Search&geo\\_id=86000US60621&\\_geoContext=01000US|86000US60621&\\_street=&\\_county=&\\_cityTown=&\\_state=&\\_zip=60609&\\_lang=en&\\_sse=on&ActiveGeoDiv=geoSelect&\\_useEV=&pctxt=fph&pgsl=860&\\_submenuId=factsheet\\_1&ds\\_name=DEC\\_2000\\_SAFF&\\_ci\\_nbr=null&qr\\_name=null&reg=null:null&\\_keyword=&\\_industry=](http://factfinder.census.gov/servlet/SAFFFacts?_event=Search&geo_id=86000US60621&_geoContext=01000US|86000US60621&_street=&_county=&_cityTown=&_state=&_zip=60609&_lang=en&_sse=on&ActiveGeoDiv=geoSelect&_useEV=&pctxt=fph&pgsl=860&_submenuId=factsheet_1&ds_name=DEC_2000_SAFF&_ci_nbr=null&qr_name=null&reg=null:null&_keyword=&_industry=). Accessed 2/28/2010, 2010.

27. CDC - injury - violence prevention - STRYVE Available at:

<http://www.cdc.gov/violenceprevention/STRYVE/index.html>. Accessed 3/19/2010, 2010.

28. Education, school violence: Federal grants at safe schools healthy students Available at: <http://www.sshs.samhsa.gov/initiative/about.aspx>. Accessed 3/19/2010, 2010.

29. McDonald L, Frey HE. Families and schools together: Building relationships. *OJJDP Bulletin*. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. 1999.

30. Healthy people 2010 objective 15-38. Available at:  
<http://www.healthypeople.gov/hp2020/Objectives/ViewObjective.aspx?Id=54&TopicArea=Injury+and+Violence+Prevention&Objective=IVP+HP2020-13&TopicAreaId=31>. Accessed 3/20/2010, 2010.

31. Healthy people 2010 15-39. Available at:  
<http://www.healthypeople.gov/hp2020/Objectives/ViewObjective.aspx?Id=55&TopicArea=Injury+and+Violence+Prevention&Objective=IVP+HP2020-14&TopicAreaId=31>. Accessed 3/20/2010, 2010.

32. Healthy people 2020 VP HP2020-41. Available at:  
<http://www.healthypeople.gov/hp2020/Objectives/ViewObjective.aspx?Id=82&TopicArea=Injury+and+Violence+Prevention&Objective=IVP+HP2020-41&TopicAreaId=31>. Accessed 3/20/2010, 2010.

33. American academy of pediatrics: Role of pediatrician in youth violence prevention. Available at: <http://pediatrics.aappublications.org/cgi/reprint/peds.2009-0943v1>. Accessed 3/20/2010, 2010.

34. American medical association policy D-515.995 time for action on youth violence. Available at: <https://ssl3.ama-assn.org/apps/ecommm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/DIR/D-515.995.HTM>. Accessed 3/20/2010, 2010.

35. America medical association policy D-515.997 school violence. Available at:  
<https://ssl3.ama-assn.org/apps/ecommm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/DIR/D-515.997.HTM>. Accessed 3/20/2010, 2010.

36. APHA policy statement database: Building public health infrastructure for youth violence prevention. Available at:  
<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1392>. Accessed 5/23/2010, 2010.

37. We go together for kids. Available at:  
[http://www2.eboard.com/eboard/servlet/BoardServlet?ACTION=BOARD\\_SHOW&SITE\\_NAME=wegoed33&BOARD\\_NAME=WGTK&SESSION\\_ID=mtzb22268k9v9fm9741](http://www2.eboard.com/eboard/servlet/BoardServlet?ACTION=BOARD_SHOW&SITE_NAME=wegoed33&BOARD_NAME=WGTK&SESSION_ID=mtzb22268k9v9fm9741). Accessed 3/26/2010, 2010.

38. Chicago youth gun violence initiative. Available at:  
[http://crimelab.uchicago.edu/gun\\_violence/](http://crimelab.uchicago.edu/gun_violence/). Accessed 3/19/2010, 2010.

39. CeaseFire - the campaign to STOP the shooting Available at:  
<http://www.ceasefirechicago.org/>. Accessed 3/19/2010, 2010.

40. Project safe neighborhoods Available at: <http://www.psnchicago.org/>. Accessed 3/19/2010, 2010.

41. From illinois' front line against crime: A school and youth violence prevention plan. Available at:  
[http://www.eric.ed.gov/ERICWebPortal/custom/portlets/recordDetails/detailmini.jsp?\\_nfpb=true&&ERICExtSearch\\_SearchValue\\_0=ED476951&ERICExtSearch\\_SearchType\\_0=no&accno=ED476951](http://www.eric.ed.gov/ERICWebPortal/custom/portlets/recordDetails/detailmini.jsp?_nfpb=true&&ERICExtSearch_SearchValue_0=ED476951&ERICExtSearch_SearchType_0=no&accno=ED476951). Accessed 3/26/2010, 2010.

42. Glanz K, Rimer BK. *Theory at a Glance: A Guide for Health Promotion Practice*. US Dept. of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute; 1997.

43. Farrell AD, Bruce SE. Impact of exposure to community violence on violent behavior and emotional distress among urban adolescents. *J Clin Child Psychol*. 1997;26(1):2-14.

44. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Office of the Director, Office of Strategy and Innovation. Introduction to program evaluation for public health programs: A self study guide. Atlanta, GA: Centers for Disease Control and Prevention; 2005. Available from: <http://www.cdc.gov/eval/evalguide.pdf>.

45. Issel LM. *Health Program Planning and Evaluation: A Practical, Systematic Approach for Community Health*. 2nd ed. Jones and Bartlett Publishers; 2009.

46. Johnson CD, Fein JA, Campbell C, Ginsburg KR. Violence prevention in the primary care setting: A program for pediatric residents. *Archives of Pediatrics and Adolescent Medicine*. 1999;153(5):531.

47. Mercy JA, Saul J. Creating a healthier future through early interventions for children. *JAMA*. 2009;301(21):2262.