## 1.    INTRODUCTION AND OVERVIEW

In 1995, more than 200,000 acts of violence were reported to Chicago police, with thousands of additional incidents likely going unreported.  That same year, a survey of female clients at City health centers revealed that nearly half of those interviewed had been abused at least once in their lives.  And on the city's impoverished west side, health care providers were reporting that access to care for both teens and senior citizens was impeded by their fears of crossing gang lines to get to a neighborhood clinic.

While it was clear that something must be done, the appropriate role of a local health department in response to violence was not as readily apparent.  Thus, in an attempt to determine what the Chicago Department of Public Health's response should be, its traditional role as "gap filler" led to an exploration of what others in the city were doing in this area.  What was revealed was a city rich with agencies and individuals engaged in independent activities, and some in limited collaboration.  With few exceptions, however, most could not articulate how their initiatives fit into a larger prevention effort.  With this in mind, in May of 1996, Chicago's Commissioner of Health, Sheila Lyne, R.S.M., initiated a process which would, in the end, not only define what her agency should do, but also provide a blueprint for citywide violence prevention efforts.

### Purpose of the Plan

The Chicago Violence Prevention Strategic Plan is intended to serve as a framework for a comprehensive citywide approach to the development and implementation of violence prevention programs.  Specifically, the planning process and the Plan would:

! create a forum for the identification and discussion of violence-related issues which would allow the airing of alternative viewpoints and facilitate building consensus towards solutions;

! set a collective direction and focus public and private efforts in addressing violence;

! prepare the City, providers and communities to respond to unforeseen events and opportunities by creating a sound basis for decisionmaking;

! build consensus about funding allocations and action priorities; and

! identify how responsibilities should be divided among key sectors.

**Planning Principles and Assumptions**

The planning process was guided by the following set of principles and assumptions which served as a touchstone for ensuring that the process remained true to its original vision.

!      The planning process and resultant plan would reflect a public health approach, emphasizing the identification of policies and programs aimed at prevention and early intervention.

!      Recognizing that much work has already been done within the framework of well established approaches to violence, by ongoing public health efforts, and by communities themselves, the planning process would not attempt to reinvent the wheel but would be informed by and build upon previous efforts.

!      The plan would recognize that violence emerges more from a complex web of causality rather than solely from the intentions of the offender. Thus, the plan would focus more on the identification and modification of elements of situations that surround violent events as well as interpersonal dynamics and less on the punishment or rehabilitation of persons who commit violent acts.

!      The development of interventions must consider the social context in which violent behavior occurs. Interventions must acknowledge the socioeconomic, demographic and cultural realities of Chicago's diverse communities.

!      The plan would reflect a systems approach recognizing that a comprehensive response to violence requires an interdisciplinary effort aimed at linking various disciplines, organizations and communities.

!      The plan must be developed through the broad-based participation of organizations, communities and individuals whose involvement is necessary for its implementation.

!      Effective solutions require a common understanding. The violence prevention strategic planning process would provide an understanding of violence and potential interventions through the collection and analysis of the best available data and the informed judgment of key stakeholders from a variety of sectors involved in prevention.

!      The plan would focus not just on the roles of government agencies in general or public health agencies specifically, but on how the limited resources available to public health can be used to facilitate a community process which leverages resources from a variety of sectors.

!      While the plan would call for additional resources, recognizing that violence prevention resources are limited, the planning process would also emphasize leveraging and maximizing the use of existing resources.

**The Planning Process**

Recognizing that for a plan to be implementable it must be developed through the broad participation of key stakeholders committed to preventing violence, a planning structure was devised to ensure an inclusive but manageable process. A 14-member Project Oversight Committee was convened by the Health Commissioner and charged with policy and decisionmaking responsibilities and overseeing the process of developing the plan. A 40-member Violence Prevention Strategic Planning Council, consisting of stakeholders expected to implement the plan, provided input on the substance and content of the plan. Finally, the vast majority of the Planning Council's work was conducted by workgroups which were open to other stakeholders or non-members with an investment in the issue of violence prevention. In all, the process benefited from the input and participation of over 160 individuals and agencies.

The process through which the Plan was developed included four steps.

! The *Problem Analysis* allowed for a common understanding of both the scope and the nature of violence in Chicago. Workgroups first considered epidemiological data and literature reviews and then carried out an extensive contributing factor analysis.

! *Strategic Issue Identification* shifted attention from specific types of violence (e.g., child abuse) to common and pervasive issues which must be addressed in a comprehensive response to violence.

! *Systems Assessments* were conducted to consider the resources implicated in solving identified problems and how those resources might be organized most effectively.

! *Strategy Development* resulted in recommendations to correct the deficiencies and enhance the strengths identified in the systems assessments and to facilitate the development of a violence prevention system that integrates aspects of multiple systems.

**Organization of the Plan**

The Chicago Violence Prevention Strategic Plan is organized into three freestanding reports: this *Executive Summary*, the *Chicago Violence Prevention Strategic Plan*, and the *Appendices* which presents Data Sources for Understanding Violence and Literature Reviews. The remainder of this

Executive Summary consists of a brief review of the contents of the Chicago Violence Prevention Strategic Plan.

## 2.   PROBLEM ANALYSIS

As the Plan could not adequately address each and every type of violence in Chicago, participants chose to focus on those forms of violence where there is typically a relationship between the victim and offender: child abuse, youth violence, partner abuse, and elder abuse.  Efforts to understand violence were carried out by four respective workgroups which first considered the epidemiology of violence in the city and then conducted an extensive analysis of factors that contribute to these four forms of violence.  The results of those processes are summarized below, followed by an overview of the strategic issues that emerged from those efforts.

### A.   Epidemiology of Violence in Chicago

Unlike many public health conditions that are reportable by law, acts of violence often go undetected, unacknowledged, and in the absence of a fatality, unreported.  And while efforts to understand the magnitude of many public health problems such as tuberculosis or measles may require little more than contacting a local or state health authority, elucidating the true scope of violence requires piecing together numerous data bases, many of which are incomplete.  In the absence of a national or Chicago-specific violence surveillance system, a collaboration between the Chicago Police Department (CPD) and the Chicago Department of Public Health has led to the creation of the *violent crimes data set*.  While limited to only those crimes reported to the CPD, the dataset (which is the primary source of the data presented below) provides a vivid picture of violence in Chicago.

This section of the problem analysis provides a brief overview of some of the general characteristics of violence in Chicago and then summarizes the impact of violence on the four populations which are the Plan's focus: children, youth, intimate partners, and the elderly.

**Incidence and Characteristics of Violence in Chicago**

In 1996 over 200,000 victims experienced 83 types of violent crimes - a rate of 7,598 per 100,000 Chicago residents.  Simple battery, the most frequently committed crime, occurred more often than homicide, aggravated battery/assault, robbery and criminal sexual assault combined.  Homicide, the rarest form of violent crime, accounted for less than half of a percent of all violent crime victims.  In fact, for every person who was murdered in Chicago, there were 115 victims of simple battery, 44 victims of aggravated battery/assault, 31 victims of robbery and 3 victims of criminal sexual assault.

| Percent Change in Number of Violent Crimes Chicago occurrence, 1994-1996 | | | |
|---|---|---|---|
| Crime | 1994 | 1996 | % Change |
| **Index Violent Crimes** | 78,718 | 65,421 | -16.9 |
| Homicide* | 930 | 789 | -15.2 |
| Criminal Sexual Assault | 3,120 | 2,757 | -11.6 |
| Robbery | 33,888 | 24,343 | -28.2 |
| Aggravated Battery/Assault | 40,780 | 37,532 | -8.0 |
| **Non-Index Violent Crimes** | 140,501 | 146,096 | 4.0 |
| Simple Battery | 85,498 | 90,871 | 6.3 |
| Simple Assault | 20,061 | 22,847 | 13.9 |
| Sex Offenses | 2,536 | 2,564 | 1.1 |
| Telephone Threat/Harassment | 16,207 | 17,407 | 7.4 |
| Other Violent Crimes | 16,199 | 12,407 | -23.4 |
| **Total Violent Crimes** | 219,219 | 211,517 | -3.5 |

Source: CPD Crime System Files of all violence crimes reported to the police; processed and analyzed by CDPH; * Data on homicide obtained from the CPD detective divisions' 1996 *Murder Analysis.*

Although comparatively rare, the impact of homicide in Chicago is significant. The seventh leading cause of death overall in the city, from 1993 to 1995 homicide was the leading cause of death among Non-Hispanic Black, Mexican, and Puerto Rican males and females aged 15-24. Underscoring its impact is the fact that the eradication of homicide among males 15-24 would decrease the corresponding Non-Hispanic Black mortality rate by 71% and the Hispanic mortality rate by 56%.

*Time Trends:* Consistent with national trends, Chicago experienced a 17% decrease in index violent crimes from 1994 to 1996. Robbery showed the largest decrease of approximately 28% and homicide decreased 15%. Decreases did not occur across all violent crimes, however; simple battery and simple assault, which accounted for more than half of all violent crimes, increased 6% and 14% respectively.

*Age:* Both nationally and in Chicago, data on homicide and nonfatal crimes consistently show that those at greatest risk are adolescents and young adults. In 1996, the risk of victimization in Chicago was highest for people aged 15-24 in five of six selected crimes. Yet unlike homicide where people aged 15-24 were at nearly three times greater risk than any other age group, the

victimization rates of any other nonlethal crime remain relatively high until age 45 when the rates begin to decrease.

*Gender:* Men represented more than 80% of the perpetrators of violent crimes in Chicago in 1996, a pattern similar to that of homicide and other index violent crimes nationally. However, gender differences in violent crime victimization rates varied considerably according to types of violence. For example, females were nearly ten times more likely to be victims of criminal sexual assault than

were males and twice as likely to be victims of simple battery. Males were five times more likely than females to be victims of homicide.

*Race/ethnicity:* People of color are at considerably higher risk of violent crime victimization. In 1996 in Chicago, 12% of Non-Hispanic Black people, 5% of Hispanic people and 4% of Non-Hispanic White people were victims of violent crimes. People at greatest risk of being offenders were basically the demographic mirror of their victims. For instance, in cases where the victim's race is known, 87% of crimes committed by Non-Hispanic Black people were against Non-Hispanic Blacks, 77% of crimes committed by Non-Hispanic White people were against Non-Hispanic Whites and 69% of crimes committed by Hispanic people were against Hispanics.

*Socioeconomic Status:* Chicago communities with the highest incidence of violence also tend to have the highest rates of unemployment and other measures of poverty. The suggestion of a causal relationship in the Chicago data is supported by findings from outside the city. For example, two studies found that a sixfold difference in Black and White intra-racial domestic homicide rates was entirely accounted for by differences in socioeconomic status between the respective Black and White populations.[1,2]

*Victim/Offender Relationship:* Of all nonfatal violent crimes committed in Chicago in 1996, 24% were among intimate partners, 7% involved other family members, 18% involved friends or acquaintances and 49% were between strangers. In contrast, victims of homicide were most often murdered by someone the victim knew. Close to half of all criminal sexual assault victims in Chicago were sexually assaulted by an intimate partner, a family member or a friend or acquaintance; the remaining by a stranger.


**Profile of Violence Among the Four Populations Considered by the Plan**

A significant proportion of the 211,517 reported victimizations in 1996 involved the four populations which are the focus of this Plan: children under 13 years of age; youth between 13 and 19 years old; intimate partners over age 18; and the elderly, defined as 60 years of age and older.


*Child Victimization:* Of the 8,367 violent crimes against children under the age of 13 reported to the Chicago police in 1996, the most frequent acts were: simple battery (48%), criminal sexual assault/other sex offenses (13%), and serious battery (12%). The risk of victimization increased substantially with age: among all children under the age of 13, those between 10 and 12 were at highest risk of victimization, and those between 0 and 3, at lowest risk. The most likely offender against children under 13 was someone close in age to the victim: 10-12 and 13-19 year olds had four times the offending rate of any other age group. Forty-four percent (44%) of the reported violent offenses against children were committed by someone known to the victim, usually a

| Total Crimes By Selected Populations - 1996 | | |
|---|---|---|
| | Total Crimes | Rate per 100,000 |
| Children | 8,367 | 1,547 |
| Youth | 33,784 | 12,241 |
| Intimate Partners (females) | 38,453 | 3,525 |
| Elderly | 7,011 | 1,593 |
| Source: CPD Crime System Files; processed and analyzed by CDPH; | | |

friend or acquaintance, but in 34% of cases, a parent or other relative. In the case of sexual assault, offenders were known to victims in 69% of the cases.

*Youth Violence:* Adolescents between the ages of 13-19 experienced 33,784 violent crimes in Chicago during 1996. In 48% of these cases the offender was someone known by the victim. Adolescents were more likely to experience physically harmful crimes such as simple/serious battery and homicide (67% of all violent crimes) compared to the general population (55% of all violent crimes).

Despite significant increases in homicides among persons aged 10-24 between 1988-1993, more recently, homicides in Chicago, as nationally, have been declining (15% from 1994-1996).

A recent report analyzing street gang-related crimes (that is, crimes that grew out of a street gang function) showed that from 1965-1994, 9% of all homicides in Chicago were gang-related ranging from 3% in 1965 to 26% in 1994.[3] Among adolescents ages 13-19, the percent of gang-related homicides is considerably higher. Comparing 1995 violent crimes with data from the Early Warning System[4] indicates that less than 10% of adolescent victims and offenders of nonlethal violent crimes were street gang-related. However, when violence turns deadly, the proportion of street gang-related incidents increases substantially. In 1995, for example, 59% of adolescent homicide victims were murdered as a result of a street gang-related violent crime incident and 52% of adolescent homicide offenders were part of a street gang-related incident.

*Partner Abuse:* The 38,453 female adult victims of domestic violence represented 90% of all adult domestic violence victims in 1996. During that same year, 26 women died at the hands of an intimate partner. Thus, for every female who died as a result of domestic violence, there were

1,479 female adult victims of violent crimes committed by an intimate partner. The three most frequent violent crimes were simple battery (74%), simple assault (9%) and aggravated battery (5%). Thus, 88% of domestic violence-related crimes were threats of or actions that led to bodily harm or serious injury to the victim. A dangerous weapon was used or present in 10% of all domestic violence-related crimes.

*Elder Victimization:* There were 7,011 victims aged 60 and over who experienced a violent crime in 1996. The most frequent violent crimes against the elderly were: simple battery (33%), robbery

(21%) and simple assault (16%). In nearly 43% of incidents the offender was someone known to the victim; of these cases, close to 60% were family members or intimate partners. The rate of victimization among the elderly decreased with age, with the highest rate among people aged 60-64 years, which at 2,106 per 100,000 was 56% greater than the rate for persons over 70.


## B.      Factors That Contribute to Violence

Following a review of the epidemiologic data, each workgroup engaged in a process of analysis to better understand the problem of violence, focusing on major risk and contributing factors and the dynamics and interrelationships of those factors. Workgroups began this exercise by identifying what they believed to be the major risk factors for the type of violence under their consideration; they then explored the chain of influences that contribute to each identified risk factor, as reflected in the partial example below.

| Risk Factor | Direct Contributing Factors | Indirect Contributing Factors |
|---|---|---|
| Alcohol Use | Lack of prevention education | Decreased public funding |
| | | Lack of school-based curricula |
| | Acceptance of alcohol use as norm | Family history of use |
| | | Use of alcohol by peers |
| | | Excessive and targeted billboard advertising |
| | Accessibility of alcohol | Inadequate enforcement of sales laws |
| | | Disproportionate liquor license distribution |
| | Family history of alcohol use | Inadequate social supports |
| | | Cultural norm of acceptance of alcohol use |

It should be noted that while the exercise yielded several factors that have been well established through research, members also elected to focus on less traditional risk factors which, while not necessarily meeting a scientific definition, were believed to be significant enough to warrant further exploration. The risk factors that were the primary focus of analysis for each of the four workgroups are identified below.

### Risk Factors for Child Abuse

- Lack of nonviolent childrearing skills
- Belief in violence as appropriate means of child discipline
- Poor caregiver/child attachment
- Early onset of verbal abuse
- Unusual hostility associated with child interaction
- Family discord
- Unsupported mental health issues
- Substance abuse
- Inadequate child protection systems response
- Lack of response to suspicious circumstances
- Family isolation

### Risk Factors for Youth Violence

- Societal disenfranchisement
- Limited economic opportunities
- Limited access to youth-focused community institutions
- Lack of positive role models
- Lack of caregiver presence
- School failure
- Gang involvement
- Violent peers
- Weapon possession
- Direct exposure to violence
- Personal substance use
- Excessive violence in the media
- Lack of future orientation
- Propensity to take risks

### Risk Factors for Partner Abuse

- Victim entrapment
- Leaving the relationship
- Insufficient abuser accountability
- Violence as a norm
- Alcohol and other drug use
- Inappropriate legal system response
- Inappropriate health and mental health systems responses
- Insufficient community accountability to confront the abuser
- Insufficient family support for victims leaving a violent relationship
- Convergence of disabilities with intimate violence
- The abuser's perceived powerlessness and simultaneous entitlement that leads to force

### Risk Factors for Elder Abuse

- Vulnerability of elder
- Financial dependency
- Poor caregiver practices
- Caregiver stress
- Caregiver hostility
- Mental health problems
- Substance abuse
- Limited utilization and availability of elder abuse services
- Elder remains in an abusive or potentially abusive situation

## C.      Strategic Issues

The problem analysis conducted by the four workgroups resulted in the identification of more than 2,000 factors that contribute to the 45 risk factors listed on the previous page. To further focus the process, a second level of analysis was conducted and yielded a set of 14 key strategic issues which represent predominant and cross-cutting forces. In general, three categories of issues emerged: (a) those which predominated within a single form of violence, such as the role of poor parenting skills in child abuse; (b) those which emerged as significant contributors to multiple forms of violence, such as substance abuse; and (c) factors, such as religion, which while not prominent in any single workgroup's analysis, emerged as underlying influences across all types of violence.

**Child Care - Fostering Access to Advancement and Service Opportunities:** Child care emerged as an issue critical to permitting access to economic and educational opportunities (both of which relate to violence) and to affording access to supportive services, including those for victims. The workgroups also noted the role that child care plays in relieving family stress by providing parents with respite from their daily caregiving duties.

**Parenting Skills - Key to Prevention:** Limited opportunities for parenting skills development was viewed as contributing to numerous precursors to violence including: a belief in violence as an appropriate means of discipline, early onset of verbal abuse, poor parent-child attachment, and feelings of hostility associated with the parent-child interaction. The principal parenting issues that emerged from the problem analysis were the need to help caregivers to have more realistic expectations of their children and of the parenting role, and to help them to develop appropriate child rearing skills.

**School Influences - Risks and Opportunities:** Outside of the family, schools are one of the few institutions with regular and sustained access to young people. Providing both instructional and constructive socialization opportunities for children and youth, schools represent a fundamental setting for violence prevention and early intervention activities. Key issues identified in the problem analysis included: challenges to academic success; inadequate life skills development, including conflict resolution; and threats posed to personal safety.

**A Role for Youth Development in Violence Prevention:** The concept of youth development has typically been explored within the context of preventing violence among youth. However, recognizing the potential impact of such opportunities in terms of positive individual growth and self esteem suggests an influence across all types of violence. Throughout the problem analysis issues were explored regarding (a) barriers to adult/youth interaction, (b) influences of peer interactions, and (c) accessibility to youth development opportunities.

**Religious Influences - Barriers and Supports:** While not emerging as one of the most prominent issues considered in the problem analysis, religious influences were identified both in terms of the barriers posed to victim helpseeking behaviors and the opportunities provided for preventing all forms of violence.

**Media Influences on Violence:** Issues related to the media emerged most prominently as factors contributing to youth violence and partner abuse, but were also considered in relation to violence against children and the elderly. Factors emerged in three general categories suggestive of potential points of intervention: excessive violence in the media, negative portrayals of selected populations, and inadequate and inappropriate attention to issues related to violence and violence prevention.

**A Role for Health Care - Opportunities Across the Continuum:** Unlike some systems which by definition have a primarily preventive focus (e.g. schools) and those with a mission of intervention (victim services), the health and public health care systems are uniquely situated to carry out primary, secondary and tertiary prevention activities. The problem analysis identified several factors that can impede an adequate response to violence by the health and public health care systems. These factors fall largely within the two broad categories of limited access to health care services and an inappropriate health care response to violence-related issues.

**Supports for the Elderly - Opportunities For Prevention:** While the provision of elder care services can present opportunities for violence prevention, there are also inherent challenges (both in formal and informal caregiving) that may contribute to the risk of abuse. By providing the elderly with services that enable them to maintain the highest possible quality of daily living and by relieving family members of the stresses often associated with caregiving, professional caregiving can serve as a means of primary abuse prevention. Key in the analysis of elder abuse were issues related to the accessibility and use of elder care services and the training provided to caregivers.

**Mental Health Supports - Mitigation and Response:** Throughout the problem analysis, workgroups identified mental health problems or service delivery issues as they pertained both to primary violence prevention and intervention. Specifically considered were issues related to service needs to mitigate stressors, personal barriers to accessing care, and impediments posed by the system itself.

**Substance Abuse - A Common Risk Factor:** The only risk factor explored by all four workgroups, substance abuse was considered both as a factor contributing to violence and as a response to victimization. Specifically, attention was paid to personal and family use of substances, social reinforcements for use, the availability and accessibility of drugs and alcohol, and deficiencies within prevention and treatment systems.

**Supports for Victims - A Critical Continuum:** Issues related to victim services, including support and prevention programs, were implicated in varying forms as contributing to many of the identified risk factors for partner abuse and elder abuse. The emerging factors, all related to service capacity limitations, were most prominent as they pertained to victim entrapment, public awareness, and the appropriateness of services delivered.

**Need for Effective Response Systems - Child Welfare and Legal:** Issues related to response systems emerged as critical in the analysis of factors that influence all forms of violence. The factors that emerged from the problem analysis can be organized into three broad categories: (a) barriers to reporting, (b) systemic impediments to an effective response, and (c) the impact of victim behaviors and beliefs on system responsiveness.

**Discrimination - Cause and Effects:** The influences of discrimination on violent behavior and violence prevention emerged to varying degrees throughout the problem analysis. Consideration was focused both on discrimination as a factor that contributes to violence and that impedes an effective response.

**Economic Opportunities - An Underlying Influence:** While debate persists as to whether the nature of the relationship between poverty and violence is in fact causal, the existence of some relationship is indisputable. As previously noted, Chicago communities with the highest unemployment rates also experience the highest rates of violent crimes. Issues related to and resulting from a lack of economic opportunities emerged prominently throughout the deliberations of each of the four workgroups. Factors identified pertain largely to: limited job opportunities, challenges to job preparation, and financial dependencies.

## 3.    KEY FINDINGS OF SYSTEMS ASSESSMENTS

The strategic issues suggested several systems that should play a role in Chicago's violence prevention efforts. Some of these systems are real, characterized by some degree of formality and structure. In other cases, formal systems are not in place, but are implied either through ongoing relationships between agencies or by the strategic issues which suggest how they should work. Presented below are selected findings of 13 system assessments conducted to understand the resources available to address violence and how those resources might be organized most effectively.

- Child Care Services
- Parenting Education and Support Services
- Schools
- Youth Development
- Religious Communities
- Media
- Health Care Services
- Elder Care Services
- Mental Health Services
- Substance Abuse Services
- Victim Services
- Child Welfare System
- Legal/Law Enforcement System

**Child Care Services**

! The current and serious shortage of child care in Chicago will be exacerbated by demands resulting from welfare reform. Only 11% of infant care and 30% of school-aged child care needs are currently being met in low-income communities; with 50% participation in welfare reform by 2002, the proportion of unmet need for these forms of care is expected to be as high as 93% and 80% respectively by year 2002.[5]

> *There are 109,042 infants, pre-school and school-aged children in Chicago in need of child care. Slots are available for less than half of them.[a]*

! Center-based child care, delivered by 43% of the city's 1,804 known child care providers, is insufficient to meet demand. However, while funds are available to pay for child care, none have been designated to develop new sites. Additional deterrents to the provision of center-based care include cumbersome licensing requirements and the high costs of meeting codes.

! Low wages contribute to high rates of staff turnover in the child care field. Such turnovers threaten the continuity of care a child experiences and consequently his or her ability to learn.

! While the child care setting provides good opportunities to screen families for abuse or neglect, reporting of maltreatment by providers is impeded by fears of retribution, the potential loss of contact with the child, limited training on how to report suspected abuse, and a lack of confidence in the child welfare system.

! Child care training is not required for the majority of providers. Staff delivering center-based care are required to obtain 15 hours of training annually, while home-based

    providers are at most required to receive CPR and First Aid training. Additionally, many suggest that neither the standard formal education curricula nor continuing education by child care employers are comprehensive enough.

! Increases in unlicensed child care are expected due to changes in the child care subsidy system and the impact of welfare reform. This raises several concerns as unlicensed providers are not required to receive any training, are often isolated from social supports, and are less likely than licensed providers to use a formal child development/education curriculum.

! The cost of child care consumes increasingly significant portions of families' incomes. For example, recent changes in the State-operated system will increase payments for a low-income family of three from one dollar to $104 per month.[6]

! While the numbers of families served through subsidies is expected to increase with recent State changes, those who will no longer be eligible for care include parents who are in school or in training and temporarily poor families.

! Many former welfare recipients are being encouraged to look to the child care industry for employment. Such efforts fail to acknowledge the difficulty of making a living in this field and the impact of a new group of workers motivated less by a desire to work with children and more by the mere availability of a job.

**Parenting Education and Support Services**

! In Chicago, several different types of parenting programs are provided through a variety of arenas, including health care, schools, social services, the workplace, and the legal system. Parenting programs tend to be delivered in institutional settings, community-based centers and in the home of the parent.

! Populations in Chicago with particular needs for parenting education and support services include teen parents, accounting 20% of all births; first-time parents (39% of all births in 1996); the growing number of grandparents who are parenting; and foster parents.

! There are between 40 and 90 programs in Chicago with the primary goal of parenting education and well over 200 programs that incorporate parenting education as a component of a larger array of family services.

! The majority of parenting programs exist independently with few coordinating bodies or affiliations. This lack of structure, coupled with inconsistent funding mechanisms and a reliance upon voluntary staff, results in a lack of organized advocacy and limited coordination among existing providers.

! There are no nationally established or accepted training protocols for parenting educators. While a few states have set standards for workers in this field, Illinois is not one of them.

! A majority of parenting programs are designed to address problems after they have occurred, such as with court-mandated programs; fewer have a truly primary prevention orientation.

! There is a need for greater information about the quality and effectiveness of parenting education programs. Evaluation in this area has traditionally been poor due to limited resources and the amount of time necessary for long-term follow-up.

!      With welfare reform, parenting education programs will need to adapt to a working clientele, e.g., be offered at night and on weekends. Home visiting programs may be impacted to the greatest degree in having to adjust to making evening visits and thus face additional issues relating to staff safety.

**Schools**

!      A new chief school executive and "super board" of Trustees manage the Chicago Public Schools (CPS), and have taken dramatic action that has (a) stabilized the financial picture; (b) led to unprecedented levels and forms of collaboration with other institutions; and (c) created innovative efforts to solve long-term problems. Hope for effective action is high.

> *30% of girls surveyed reported having been struck on dates, and 35% felt a boy is less likely to date her when she makes it clear she doesn't like being hit. 28% of boys agreed that girls need be punched or slapped.[b]*

!      The achievement of significant administrative cuts, a long-term contract with teachers, and budget increases from the state legislature have resulted in monies available and allocated, for the first time in years, for innovative responses to school problems. This attention to fiscal stability is essential to accomplishing new violence prevention programming.

!      Decentralized violence prevention planning, development and implementation results in highly variable attention to violence issues in local schools. It is estimated that formal violence prevention programs exist in just 15% of public schools. Among those schools that offer violence prevention programming, there no uniform violence prevention curriculum. Additionally, staff time to develop violence prevention materials is limited.

!      There is no required teacher training regarding violence, including reactions to violent students, violence prevention in classrooms, mandated reporting, etc. School faculty and staff also need training on how to conceptualize, plan and implement comprehensive violence prevention programming.

!      Despite current record-high levels of community involvement, welfare reforms that require paid employment will likely deplete the ranks of currently available parent volunteers who do much for school management and safety now.

!      Within the Catholic schools, violence prevention is a relatively low priority. This is attributed to the schools' ability to remove disruptive students and a reluctance among some to address issues such as child abuse and domestic violence which threaten family sanctity.

**Youth Development**

! Youth development is a field that is in the process of re-defining itself. New emphases are being placed on developing partnerships with youth, providing healthy interactions and role modeling for youth, and developing professional standards and credentialing.

! Youth development activities in Chicago are delivered by government agencies, citywide and community-based agencies, and larger collaborative efforts between providers. Activities include: programming for non-school hours; mentoring; special counseling of at-risk youth; alternative and innovative programming; recreational and physical activities; youth job training and placement; and youth gang prevention and intervention activities.

> *Nearly $10 million in federal funding was available for Chicago's youth job training programs in 1993. By 1996, this figure had been reduced by 86% to $1.4 million.[c]*

! The largest funder of such programs is Chicago For Youth (operated out of the City's Department of Human Services), which administers over $12 million annually to 130 community-based agencies delivering programs at 350 sites.

! Many youth development service providers incorporate distinct violence prevention programs into their broader service scope, while other programs have been designed with violence prevention and intervention as the primary focus. However, the capacity of

Chicago's youth-serving agencies to address violence is limited by an absence of standardized protocols on how to screen for and respond to violence-exposed youth.

! There exist system-wide tensions between programming and resources for "good kids" versus for already-troubled or high-risk kids. For example, informants described some programming as providing an unfair "reward" for kids who misbehave - "If you want a job or job training, drop out of school."

! Some service providers see the youth development system as very fragmented, with little information sharing, unnecessary duplication of services, and insufficient partnering across agencies that could complement one another. In addition, there is insufficient coordination between youth development services and the business community. Programs are usually not informed by business needs and miss opportunities for collaboration with businesses in training and for funding assistance.

! Youth development programs lack sufficient focus on program evaluation as most funders do not hold service providers accountable for evaluating and documenting their program impacts.

Consequently, resource allocation is not driven by evidence of program effectiveness and limited funding may not be used most effectively.

## Religious Communities

! Organized religion plays a strong role in many aspects of civil life in Chicago. The Catholic Church is the dominant religious group in the city, but may no longer represent a majority of those with religious affiliation. The more than 3,000 places of worship in the city are estimated to reach 700,000 to over one million people in Chicago each week.

! Religious institutions have great potential for prevention and early intervention in partner abuse and youth violence. Some large and well-funded religious-based organizations in Chicago sponsor anti-violence efforts. Other large-scale collaborative religious efforts are based more on shared local (geographic) concerns than on shared theologies. Many individual congregations are centers of other innovative anti-violence and anti-poverty efforts. Many of Chicago's most compassionate, creative and effective anti-violence measures are coming from religious communities.

! The enlightened approaches of the leadership of some religious bodies do not always translate to the level of pastoral care, where religious leaders may turn a deaf ear to indirect and even direct pleas for help in cases of domestic violence and youth violence in the community.

! Religious communities may be underresourced and overwhelmed when it comes to violence prevention. There is a lack of training among the clergy, first, in recognizing the violence problem, and second, in knowing how to respond.

! The cumulative effect of violence upon a church family - that is, when violence affects a substantial number of people in a fairly small congregational and/or geographic group - can result in trauma that is literally immobilizing and devastating. Sometimes religious leaders and congregations will respond to shocking acts of violence, but all too often the response is not sustained or mobilized in a way that leads to change.

! There are increasing numbers of partnerships between the religious community and government. The Chicago Public Schools' Interfaith Community Partnership, perhaps the largest, has engaged 300 leaders of faith communities in efforts to enhance the education of Chicago's children.

! Even at their most effective, religious communities cannot address the problem of violence alone. They will be most effective when supported by and in partnership with secular civil institutions, businesses and government.

**Media**

! Chicago is the nation's third largest media market and is home to 14 television stations, 100 cable stations; 100 radio stations; 10 daily newspapers; 60 ethnic newspapers; and 50 neighborhood papers.[7]

! There is a growing body of evidence of a causal relationship between exposure to TV and subsequent anti-social behavior. One recent study found that a majority (57%) of television programs contain violence, over 70% of the time perpetrators are not punished, and nearly half of the violence occurs in children's cartoons.[8]

> *By the time the average child completes elementary school, he or she has typically been exposed to 100,000 acts of violence, including 8,000 murders on television. These figures double by age 18.[d]*

! The Chicago media has a particularly poor reputation with regard to excessive violence in the news media according to several national and local studies. One Chicago station ranked 7th (out of 100) in a national ranking of highest percentages of newstime given to stories about crime, disaster and war.[9]

! The media's negative and differential portrayals of selected populations serve to perpetuate racial stereotypes and racist attitudes and reinforce feelings of powerlessness, all factors which contribute to violent behavior. Disproportionate coverage includes shorter stories on non-white victims; non-white alleged perpetrators more likely to be shown in handcuffs; and youth often depicted as cold and unfeeling.[10,11]

! The media could be a critical means of public education regarding violence prevention. However, few media outlets highlight violence prevention efforts and only 32% of Chicago media outlets air public service announcements of any type.[12]

! The few efforts in Chicago to address issues concerning the media and violence are community-based, generally stemming from community organizations or professional groups.

! Unlike other systems, positive change in the coverage of violence by the media is not likely to come from industry representatives on any large scale and will likely fall to parental actions (both in controlling what their kids watch and as advocates for industry change) and the community as a whole. In order to be advocates for change, parents and community members, however, must be educated regarding the negative effects of the media and be given tools for addressing this issue.

**Health Care Services**

!       Chicago's health care system consists of a combination of primary and specialty care providers delivering care under several different operating structures and in a variety of settings. Over 60 comprehensive and specialty health centers are operated by community-based non-profit organizations in Chicago. There are 42 hospitals with varying sizes, service arrays and levels of care.

!       While not universal, screening patients for victimization has become an increasingly common practice in health care settings. However, screening is often not conducted consistently and some populations may be overlooked. For example, while screening is most common for women and children, providers may not adequately screen individuals with disabilities, those with severe mental illness, or adolescents.

!       While training generally occurs regarding the use of screening tools for possible victims of family violence, provider trainings are still not comprehensive enough, do not reach enough staff and lack continual reinforcement. Adequate resources and time must be

allocated to training. Further, there is little formal education about violence in medical and other health professional schools.

!       While many providers are engaged in innovative violence prevention activities, violence prevention efforts in Chicago's health care system are generally fragmented. Providers note a need for strengthened collaboration around issues of violence prevention, both across the health care system and with larger social services and supports.

!       With a principal focus on treating injuries and symptoms, there is too little primary prevention occurring within the health care system. Providers believe that many efforts designed as primary prevention may actually be reaching individuals who have already had some exposure to violence.

!       Insufficient resources (both human and financial) impedes violence prevention efforts within the health care system. Staff of specific violence prevention efforts are generally poorly paid and more staff is always needed.

!       While there is consensus that managed care could become a leader in the system's response to violence if prevention were perceived as cost effective, the increasing trend to pay doctors per patient creates concerns of shortened visits and an inability to address complex social concerns such as violence.

**Elder Care Services**

!   The field of elder care services has shifted from a model that stresses a continuum of care and services for those ranging from very independent to completely dependent to a model of care as a constellation that offers a variety of services for impaired persons, depending on the nature of the impairment, medical needs and client preference. Elder care services typically fall into four categories: community and home-based care; supportive and assisted living programs; nursing home care; and elders' rights programs.

!   Driven by frozen Medicaid rates, inequities in service eligibility, and poor insurance coverage, resources are inadequate for optimal elder care services. While there is an abundance of services for those who can pay, resources for publicly funded services are insufficient.

*Illinois is among the top 10 states for nursing home deficiencies in areas such as accident prevention, dignity of care, and food sanitation.[e]*

!   The shortage of publicly supported home- and community-based elder care services (including assisted living options) results, for some, in premature and more costly nursing home placements and undue hardship on older individuals and their families.

!   Elder care staff are typically poorly compensated. Additionally, few providers are able to offer benefits to low-skilled workers, particularly those providing in-home care, as work may be intermittent depending upon clients' needs and insurance reimbursement eligibility. The result is negative impacts on the quality of available workers and high staff turnover.

!   The limited resources to support training for staff, addressing standards of quality care and specialized care, adversely affect the care that older persons receive. Training opportunities for informal (non-professional) caregivers about issues related to caring for the elderly are even more limited. The resulting lack of knowledge and skills can contribute to the frustration and resentment that are among the precursors to elder abuse.

!   As a result of adult children (who may be serving as informal caregivers) being forced back into the labor force by welfare reforms, some older persons may lose their primary source of daily care and be forced to either purchase services from community providers, enter nursing homes, or forego care altogether.

**Mental Health Services**

! Outpatient mental health services in Chicago are generally available through three types of programming: (a) community-based mental health centers and programs; (b) emotional support services included as components of other programs, such as youth development, parenting programs, and pastoral care; and (c) independent providers (e.g., psychologists, psychiatrists, social workers).

! Services are generally more available and better coordinated for seriously or persistently mentally ill persons than for others in need of services. All State mental health funding is dedicated to serve this population, however, services for the seriously mentally ill are still insufficient.

! For others who require emotional and psychosocial support either on a crisis basis or long term, there is no coordinated mechanism of assessment and referral. They must rely on insurance coverage (if their provider covers mental health services) or self-pay. Even with sliding fee scales and flexible patient options, care can be prohibitively expensive.

! Due to a lack of outreach and public education, individuals may resist seeking supportive services and may be unaware of how to access services if they do decide to seek help.

! Issues of violence emerge frequently during mental health practice and there are some existing efforts to train practitioners to appropriately screen, treat and refer victims (and, in fewer cases, perpetrators) of family violence. However, providers report that in many cases the awareness and skills to address and prevent violence are not comprehensively integrated into mental health service delivery.

! While State-funded providers are required to handle instances of abuse and neglect "in accordance with regulations and laws," for other providers, processes and standards for addressing violence are largely dependent upon the education and inclinations of individual providers. Local provider organizations report that there are no overarching mandates or recommendations locally to encourage the implementation of training and practice guidelines.[13]

**Substance Abuse Services**

! There is a direct relationship between the average income of a neighborhood and the availability of alcohol in Chicago. Per capita density of liquor stores in lower income areas is almost twice the density in higher income areas.[14]

! There are 110 State-licensed treatment providers in Chicago.[15] The limited collaboration across these programs is attributed to the fact that all incentives in the system are to maximize the number of clients served by one's own program, since reimbursement is on a per-client

basis. The State's Office of Alcohol and Substance Abuse (OASA) estimates that the unmet need for treatment statewide is about 90 percent.

! Many substance abuse treatment clients are also clients in other systems, and there is increasing evidence of collaboration across these systems of response, some of which specifically address the substance abuse-violence relationship. For example, OASA currently has active partnerships to ensure treatment for persons within the child welfare and criminal justice systems and for participants in welfare reform.

> *Half of the Cook County mothers involved in the child welfare system said that drugs were the main reason for their involvement with the system.[f] Over 80% of arrestees in Chicago test positive for two or more drugs.[g]*

! Barriers to treatment posed by the system itself include limited community outreach that provides information about and access to services limits treatment participation, referral processes that are not quickly and fully responsive to low-income drug abusers, long intervals between locating and being admitted to a program, transportation obstacles, and limited child care.

! OASA has provided scores of trainings to Chicago-based substance abuse providers on domestic violence issues and dynamics. However, while mandated screening and intake protocols ask about experiences with domestic violence, there is no consequent State protocol for treating those with this dual diagnosis.

! The State provides substance abuse prevention funds to 33 Chicago agencies and organizations.[16] Most of these prevention programs are tied into other community-based efforts geared to youth, reflecting the belief that many of the factors that contribute to substance abuse also contribute to a wide range of adolescent behavior problems, including truancy, premature sexual activity, and aggressiveness and violence. Thus, many interventions deal with these factors as a syndrome rather than as isolated behaviors.

! There is no formal coordination of substance abuse prevention services in Chicago. Due to the wide range of prevention services offered by different agencies in different communities, failure to coordinate limits their ability to leverage these efforts into a more comprehensive whole. Additionally, few programs in Chicago have as their mission the provision of violence prevention programming in conjunction with substance abuse prevention activities.

! By targeting 12-17 year olds, most substance abuse prevention programming in Chicago comes too late for many who are well into their substance-abusing years by this time.

! Efforts to increase outcome accountability among prevention programs is growing under State leadership. However, there is little outcome accountability among treatment providers, who

are not required to maintain outcome indicator data that would suggest the failure or success of drug treatment. For some treatment system clients, welfare reform employment requirements and state agency information sharing under the newly created Illinois Department of Human Services will create new indicators of client functioning and job participation.

## Victim Services

! The victim services system in Chicago includes services to adolescents, adults and elderly victims of abuse and their families (services to child victims are handled by the child welfare system). Components of the system include: case management and advocacy, counseling, legal advocacy, legal services, shelters, primary prevention, visitation services, and linkages to child protection services for child victims and witnesses.

! Elder abuse services in Chicago are delivered by three State-designated agencies. Elder abuse services are highly coordinated, enhanced both by the centralized funding and coordinating role of the Illinois Department on Aging and the small number of designated service providers.

*There are an estimated 61,300 victims of elder and partner abuse in Chicago each year. Only 14,913 (24%) received services in 1996.*

! Partner abuse services are provided by a diverse array of approximately 44 independent community-based organizations and agencies.[17] Partner abuse victim services are coordinated both on the state and local levels by various funding entities and specific efforts designed to establish a coordinated response to violence. Coordination between elder abuse and partner abuse services is limited, however, despite the overlapping populations served.

! There are six shelters in Chicago providing 211 beds dedicated to serving women and child victims of domestic violence.[18] Shelter beds are limited, especially for women with adolescent children, those with substance abuse or mental health problems, the elderly and disabled, and male victims, particularly gay or bisexual male victims who may experience hostility in male homeless shelters.

! Insufficient public awareness regarding elder and partner abuse leads to limited reporting of suspected abuse, lack of punishment of perpetrators and an inability of relatives and friends of victims to respond appropriately.

! The estimated unmet need for elder abuse assistance is approximately 47%; for partner and sexual assault, 77% and 70% respectively. Increasing numbers of cases identified, a result of enhanced screening efforts, are further stressing an already strained system. And while there is an overall shortage of services, particular challenges to care exist for persons with disabilities, adolescents, immigrants, and gays and lesbians.

! Resources are inadequate to support the number and range of services necessary for victims and thus quality of services may be comprised. The separation created by categorical funding impedes the integration of services as victims may require services that can address multiple types of violence.

! Victim service providers have a limited capacity to respond to persons presenting with multiple problems. Few victim services staff are trained to provide services to clients with untreated mental health problems and providers are also currently examining issues of staff competency to address substance abuse.

**Child Welfare Services**

! The Illinois Department of Children and Family Services (DCFS) accounts for the vast majority of child welfare services in Chicago. DCFS employs nearly 4,500 people throughout the state. Recent staffing efforts include reductions in administrative staff in order to increase direct service staff, increased hiring standards, reduced caseloads and staff retraining.

! DCFS increasingly relies on contract agencies to provide investigation and protection services (70% of services to families are now contracted out).[19] While this more community-based approach is desirable, some child welfare advocates are concerned that the small size, relative inexperience and financial needs of some contracted agencies may result in a lower quality of care for families.

> *About 80% of child maltreatment reports do not meet the State's criteria for abuse and neglect and thus are never investigated.[h]*

! Reports of suspected child maltreatment are made to the DCFS hotline by mandated and other reporters. However, only 20% of the reports placed meet DCFS criteria, while the remaining calls are rejected.[20] One possible contributor to the high rejection rate may be the limited training available for the large number of mandated reporters.

! The consequences of welfare reform which will impact the child welfare system include the challenge of balancing the demands placed on families by DCFS (e.g., mandated substance abuse treatment and parenting classes) with the demands related to the welfare-to-work transition, such as job training.

! Families that experience child maltreatment often experience multiple other problems such as substance abuse, mental health problems or other types of family violence. DCFS workers are challenged in having to attend to the child protection needs of the families while identifying and

responding to multiple other problems with limited resources to do so. There appears to be a mismatch between clients' needs and the services DCFS can and is mandated to deliver.

**!** Challenges exist in addressing the co-occurrence of partner abuse and child abuse in families. Aspects of the challenge include conflicting beliefs and practices of domestic violence advocates and child abuse advocates. Further, while mothers within the DCFS system are often referred for domestic violence services, the already stressed victim services system lacks the resources to respond to these additional demands.

**!** Despite current efforts, training for DCFS (and contract agency) staff is occurring slowly. Specialized training is still largely inadequate and domestic violence providers are not participating in trainings regarding the co-occurrence of partner and child abuse. Resources to support training are strained.

## Legal/Law Enforcement Systems

**!** Key to effective legal and law enforcement systems functioning is collaboration and coordinated planning between institutions. For example, collaborations between law enforcement and legal systems and the domestic violence services community in Chicago over the last 10-15 years have led to major positive changes in the understanding and approaches of legal system representatives.

**!** The Chicago Police Department's (CPD) commitment to its Community Alternative Policing Strategy (CAPS) is responsible for a major positive change in policing orientation and responsiveness to community concerns. While evaluations suggest CAPS has yet to achieve its full potential, it should, however, serve as a model to all agencies of how to implement and evaluate change at the same time.

**!** The physical settings of some courts threaten victim safety and may otherwise deter victims from following through on their cases. The domestic violence court building at 13th Street and Michigan, for example, is so severely overcrowded that victim and witness safety from attack is a serious issue. Additional challenges are faced by elderly and disabled victims of violence who must contend with facilities with limited wheelchair access, insufficient seating, and non-working TDD systems.

**!** Providers of services to abused elders must go through cumbersome steps to obtain the authority to investigate and intervene in abuse cases. Some providers to the abused elderly note that gaps occur while moving through the legal system.

! Despite substantial improvements in recent years, attitudinal barriers are not infrequent among judges and attorneys, and there is misinformation and misunderstanding among lawyers concerning domestic violence. Additionally, service providers report that attorneys, judges and victims are sometimes lacking in their knowledge of elder rights.

! Three abuser services programs that follow State-established protocols serve Chicago. The largest of these is within the Cook County Circuit Court, which most convicted batterers (about 1,000 annually) are mandated to attend. The need for batterer intervention programs far outstrips available services, and greater linkages between abuser and victim services are needed.

! Recent years have seen a punitive legislative trend toward juvenile offenders, including more automatic transfers to adult court and more conditions triggering discretionary consideration of such transfers.

! There is a need for changes to build respect and trust between police and youth. The Chicago Police Department has begun work in this area and is involved in a great number of collaborations with other agencies to build positive relations between youth and police, and to support youth development and education activities.

! There have been dramatic improvements in the past few years in the quality and concern for children in the Juvenile Court. Yet crushing court caseloads continue to threaten to overwhelm any improvements in personnel and advances in practices. And while Juvenile Code legislation seeks to promote "immediate and appropriate community-based responses" to juvenile offenders, there are few community-based options in place to meet this goal.

! The Cook County Juvenile Temporary Detention Center, responsible for holding youth who are awaiting a hearing and for holding some youth after delinquency adjudication, has made great strides in improving conditions and services in recent years. But severe overcrowding (40% above capacity) impedes the Center's ability to deliver prevention programming. Further challenges include limited family participation, participation considered essential to preventing subsequent delinquency.

## 4. STRATEGIC RECOMMENDATIONS

Members of the Project Oversight Committee, the Chicago Violence Prevention Strategic Planning Council, its four workgroups, and other key system representatives convened in a two-day strategy development conference. In a series of meetings, the findings and implications of each system

assessment were considered and participants generated strategies for addressing system weaknesses and building on existing strengths.  The more than 170 strategies developed at the conference tended to fall into one (and at times more) of seven action areas.  Key strategies follow:

*Working in Partnership - Collaboration and Coordination:* Achieving change requires the establishment of specific cross-system and multidisciplinary partnerships.

(1)     The Chicago Departments of Public Health and Human Services, other invested City agencies, and the Illinois Violence Prevention Authority should convene advocacy groups as the Chicago Child Care Task Force with the goal of creating a coordinated, citywide voice regarding child care issues.

(2)     Recognizing that all programs can't meet all needs, linkages between specific youth development programs and youth with specific needs should be enhanced, with additional linkages to other service systems.  The developing Chicago for Youth/Chicago Youth Agency Partnership data based should be used to foster these linkages.

(3)     The Chicago Department of Public Health should identify representatives from existing formal and informal religious coalitions and secure their support and advocacy for participating in violence prevention efforts - making certain to include women, religious and lay coalitions, and youth and elder religious groups.

(4)     The Illinois Coalition Against Domestic Violence and the Illinois Department on Aging should increase coordination between domestic violence and elder abuse services to ensure the availability of services to older victims of domestic violence.

(5)     A planning group should be convened by the Chicago Department of Public Health and Cook County Hospital's Crisis Intervention Project for the purpose of engaging the domestic violence, mental health, and substance abuse communities to resolve philosophical and training issues which impede service delivery.

(6)     The Chicago Department of Public Health and the Mayor's Office of Substance Abuse Policy should promote the development of a citywide network of substance abuse prevention and intervention programs to ensure better coordination among and between prevention and

treatment programs, provide for ongoing networking and idea/skills-sharing, and create a grassroots base for policy and resource advocacy.

(7)     The Illinois Department on Aging, the Chicago Department of Human Services, the Mayor's Office on Domestic Violence, the Chicago Department on Aging, and Chicago area victim service providers should work together to create more cost-effective alternative forms of shelter (e.g., safe homes, second stage, transitional, affordable).

(8)     The Chicago Police Department should encourage District Advisory Committees to establish youth subcommittees which should: (a) include on their agenda the issue of improving relations between youth and police; (b) function in a way that permits youth participants to see the tangible results of their commitment and efforts, and (c) include representation from youth with histories of police contact.

*Prevention Through Public Awareness:* Public education is required to increase awareness of violence as a family and community problem, methods for preventing violence, and mechanisms for victim support and assistance.

(1)     The Chicago Department of Public Health's Office of Violence Prevention, the Mayor's Office on Domestic Violence and the Illinois Violence Prevention Authority should develop a public awareness campaign regarding all types of violence. The campaign should target television and print media, including the women's, feature and op-ed sections, and utilize CTA bus and El placards.

(2)     The Chicago Department on Aging should work to increase employers' awareness of employees' needs for support and information around elder care.

(3)     The Chicago Department of Public Health should develop a public education strategy for violence and substance abuse prevention aimed at both the general public and specific groups to include, but not be limited to, policymakers - to avoid racial and class stereotypes, and parents - to increase their involvement with their children and within their communities.

(4)     The Illinois Department on Aging, in collaboration with Metropolitan Family Services, Lutheran Social Services, and Catholic Charities should, in an effort to increase reporting of abuse, conduct public education, a media campaign and training regarding the issue of elder abuse and how to identify and report it.

(5)     The Illinois Department of Public Health and the Illinois Violence Prevention Authority should implement a public awareness campaign regarding issues and risk factors for child abuse and appropriate sources of response.

*Enhancing the Service Delivery System:* Improvements in systems operations and effectiveness necessitates changes both within and, at times, across systems.

(1)     To reduce State-level licensing waiting lists for in-home child care providers: (a) the Illinois Department of Human Services should shorten its in-home child care provider licensing process from 6 months to 90 days, and (b) the Illinois Department of Children and Family Services should redesign its lengthy licensing process without jeopardizing standards.

(2)     The Chicago Park District should more formally incorporate parenting education and parent-child interaction programs into its existing programs and expand programs that educate and support parents and children.

(3)     To foster academic success, Chicago Public Schools and the Chicago Department of Public Health should ensure the delivery of basic health services to all students.

(4)     The Chicago Departments of Public Health and Human Services, the Parent-Teacher Association, the Illinois Department of Children and Family Services, and the Chicago Public Schools should contractually mandate that the core curricula of all funded parenting programs include a media literacy component.

(5)     The Chicago Department of Public Health should incorporate requirements for family violence screening and referral into all of its delegate agency contracts and partnership agreements. The Department should provide a screening tool, training and list of referral resources to these agencies.

(6)     The Chicago Department of Public Health and the Illinois Department of Human Services' Office of Mental Health and Developmental Disabilities (IDHS-OMHDD) should include violence prevention and detection services in existing mental health service systems for seriously mentally ill individuals.

(7)     The Chicago Departments of Public Health and Human Services and the Illinois Department of Human Services should work with domestic violence programs to expand the capacity of domestic violence shelters to address substance abusing and mental health clients who are victims of domestic violence by funding model programs, tapping existing funding sources, using set-asides in housing programs, etc.

(8)     Local, state and federal funding agencies of substance abuse services should revise funding and payment policies to better tie funding to performance using an incentive payment system that drives services to better match needs, increases the availability and appropriateness of treatment services, and documents service effectiveness.

(9)     The Illinois Department of Human Services should increase victim shelter capacity in Chicago with an emphasis on beds for the elderly, women with adolescent children, the disabled, men and gays.

(10)    The creation of a citywide centralized access toll-free helpline by the Mayor's Chicago Domestic Violence Advocacy Coordinating Council and the Metropolitan Battered Women's Network should be supported.

(11)    To increase responsiveness to case reports rejected as not meeting Illinois Department of Children and Family Services' criteria (but which might still benefit from other services), the Illinois Department of Human Services should create a 24-hour computerized referral and linkage system (tied to LANS) to which such calls can be directly routed.

(12)    The Cook County Board, in conjunction with the Circuit Court of Cook County, should improve the accessibility of courts by ensuring sufficient seating, safe and adequate waiting areas, child care, access to food service, and through compliance with the Americans with Disabilities Act.

(13)    The Chief Judge of the Cook County Circuit Court should create a strong case-coordination mechanism to ensure that each child receives planned, consistent, coordinated responses at all stages of contact within the Juvenile Court and related systems.

(14)    To enhance long-term outcomes for youth in the juvenile justice system, improve family involvement in the youth detention experience through support and expansion of the Juvenile Temporary Detention Center's existing Parenting Network.

*Strengthening Workforce Capacity:* Designed to enhance service delivery by improving the violence prevention and related skills of individuals working within given systems.

(1)     Community-based efforts should be developed to support and train mandated reporters and in-home child care providers about identifying and reporting child abuse.  Philanthropy should be encouraged to fund community organizations to provide community-based workshops.

(2)     The Chicago Public Schools should support and provide training for teachers and parents to understand and develop their own attitudes toward violence, and to modify their behaviors, in order to serve as models for the children and to reinforce the school curriculum.

(3)     The Chicago Department on Aging should promote the training of potential and actual informal caregivers and make them aware of available elder care services through cable access

television, Spanish language television and other ethnic media outlets, local community newspapers, church groups, etc.

(4)     The Chicago Department of Public Health and Cook County Hospital's Crisis Intervention Project should promulgate training for mental health providers to identify and understand the relationship between family violence and other mental health issues and/or substance abuse.

(5)     The Metropolitan Battered Women's Network, in collaboration with other interested entities, should ensure quality services by offering avenues for any interested providers to receive core 40-hour training and advanced training.

(6)     To better serve special populations, the Illinois Department of Human Services, in conjunction with other experts, should ensure cross training is delivered to providers of services for substance abuse, gay and lesbian populations, the disabled, immigrants, the elderly, adolescents, and victims service providers.

(7)     The Chief Judge and victims advocacy community should ensure training for attorney's and judges about elder abuse and domestic violence issues and the Victims Rights Amendment.

(8)     In an effort to address heavy caseloads in the Juvenile Court, the State's Attorney should re-examine the criteria for filing a case and the Chief Judge should move to expand the capacity of the system to hear abuse and neglect and delinquency cases.

(9)     The Chicago Police Department should ensure police officer training in (a) adolescent development and juvenile system goals for respecting youth, and (b) violence prevention.

*Changing the Rules: Policy and Advocacy:* Legislative, regulatory and advocacy actions are required to enhance the capacity of systems to respond to issues of violence or violence prevention.

(1)     The Illinois Department of Human Services should change child care subsidy eligibility criteria to ensure that parents in educational and training programs have access to child care subsidies for the time period that clients remain on cash assistance.

(2)     The Chicago Department of Public Health should consider legislation for universal parenting education for women who deliver at hospitals.

(3)     The leadership of the Chicago Public Schools, the Chicago Department of Public Health, the Illinois Department of Chicago and Family Services, the Juvenile Court, and others should jointly advocate (to the legislature and public) for increases in the amount and equity of school funding.

(4)     The Chicago and Illinois Departments of Public Health should promulgate hospital regulations to require available translation services for victims of violence, private space for screening, and education materials for the hearing and vision impaired as well as those with language barriers.

(5)     The Illinois Department of Public Health and the Illinois Department on Aging should promulgate regulations for assisted-living facilities to increase access and availability and to ensure standards of care.

(6)     Convene "Governor's Mansion" Conference on Aging, modeled after the White House Conference on Aging, for state-level strategic planning to identify funding priorities and provide information on how Illinois compares with other states on financing of elder care services.

(7)     The Chicago Department of Public Health's Office of Managed Care should assess managed care policies regarding mental health and violence in order to: (a) monitor the impact of policies on access to services, (b) promote adoption of standards of care, and (c) promulgate legislative and/or regulatory changes as warranted by the assessment.

(8)     The Chicago Department of Public Health should develop a legislative/policy agenda that: (a) addresses a more flexible use of asset forfeiture funds, (b) addresses a more flexible use of categorical funding streams, (c) increases funding for new treatment and prevention programs, and (d) increases neighborhood control over local liquor sales outlets.

(9)     The Chicago Department of Public Health and the Mayor's Office of Substance Abuse Policy should develop an approach to alter the marketing strategies of alcohol manufacturers and distributors (now aimed at minors and minority communities) and hold them accountable for the consequential morbidity from alcohol abuse.

*Resource Development:* Strategies related to the identification, procurement, and allocation of resources required to fill identified gaps in service.

(1)     New state-level funds should be allocated for child care facility development. The Illinois Department of Human Services should develop the capacity to ensure ongoing facility development.

(2)     A resource strategy should be developed that can ensure a sustained flow of funding for youth job training, e.g., employer head tax (per employee) and tax-reduction incentives for placing youth in jobs.

(3)     Private and public funders of youth development programs should allocate resources to geographic areas of greatest need.  Where providers don't exist, service capacity should be developed.

(4)     The Illinois Department of Public Aid and Illinois Department on Aging should reallocate a portion of Medicaid home/community-based waiver dollars to fund assisted living facilities.

(5)     The Chicago Department of Public Health should facilitate, with the Mental Health Association in Illinois and IDHS-OMHDD, a process to increase funding for mental health services for non-seriously mentally ill populations.

(6)     The Mayor's Domestic Violence Advocacy Coordinating Council should meet with individual State funders in an effort to develop a strategy for increased victim services funding. Victim service providers should advocate with Illinois Coalition Against Domestic Violence for greater funding to Chicago.

(7)     Increase available resources for court-mandated abuser services that meet the State protocol. To avoid direct competition for funds from victim assistance programs, a designated funding stream for batterers' programs should be identified.

*Assessment and Evaluation: Strengthening Program Effectiveness:* Determining the impact of violence prevention efforts requires assessments of existing system practices and policies as well as more rigorous program evaluation.

(1)     The Chicago Department of Human Services' Chicago For Youth (as the primary funder and convener of area youth service providers) should create a functional unit to provide information, ongoing technical assistance, evaluation support, and training to youth development staff and program participants.

(2)     To enhance the capacity of programs to respond to the changing composition of the elderly population, the Chicago Department on Aging should conduct gerontological needs assessments on different sectors of elderly as the population ages.

(3)     To increase the appropriateness and effectiveness of the law enforcement response to substance abuse, the State's Attorney's Office should convene a task force with citizen representatives that assesses: (a) the nature and effectiveness of current law enforcement policies and efforts, (b) the use of incarceration instead of treatment for minor drug offenses, and (c) the local impact of federal drug law enforcement policies.

(4)     The Illinois Department of Human Services' Office of Alcohol and Substance Abuse and the federal Substance Abuse and Mental Health Services Administration should support the evaluation of current and new treatment models that integrate violence prevention and intervention.

(5)     To increase hotline effectiveness, the Illinois Department of Children and Family Services should engage an independent evaluator. Evaluation should include assessment of current screening criteria, analysis of rejected calls, and relationships to mandated reporters and communities.

(6)     Recognizing the limited effectiveness of the current "one-size-fits-all" approach to batterer intervention programs, research should be supported that would identify the most appropriate program modality for different types of abusers. In addition, evaluation designs should be developed, funded and implemented for each program.


**5.     MOVING TOWARDS IMPLEMENTATION: THE ROLE OF THE PUBLIC HEALTH DEPARTMENT**

Just as the development of the Chicago Violence Prevention Strategic Plan required the active commitment of myriad agencies and organizations throughout Chicago, so too will its implementation. In some of the recommendations contained in the Plan, agencies have already been identified and directly named as implementors. This is most commonly the case with local and state governmental agencies which play critical funding and/or regulatory roles and with larger membership organizations and coordinating bodies with a violence prevention or intervention mission. In other instances, however, the range of implementors is broader and may include any number of agencies operating within a given service system or arena; these might include, for example, youth service agencies or child care providers. To support citywide efforts towards implementation, the Chicago Department of Public Health will assume the three roles identified below.

*CDPH as Implementor:* First, like numerous other entities across the city, CDPH will implement those strategies which pertain directly to its own operations and its role both as a service provider and the local public health authority. Such strategies range from changes in the delivery of mental health and health care services to convening and/or participating in issue-specific committees. In addition to its role as a direct implementor, CDPH will also work to promote the implementation of selected strategies charged to other entities.

*CDPH as Convener:* As convener of the planning process, CDPH will provide a structure and staff to facilitate overall coordination and implementation of all of the strategies contained in the Plan. This will be achieved through the reconstitution of the Project Oversight Committee which will shift its attention from providing the policy and other direction required for the Plan's development to ensuring

that an effective system to support implementation is established and remains in place. The Chicago Violence Prevention Planning Council, with a focus on implementing the Plan's strategies, will be expanded to formally include all of the members of the project's workgroups as well as other entities that wish to play a role in implementation.

*CDPH as Policy Leader:* Throughout the Plan, there are numerous recommendations about policy level changes regarding both how systems operate and how resources are provided. In many of these strategies, CDPH is called upon directly to develop legislation or otherwise advocate for change. Towards this end, CDPH will draw from this Plan to create a violence prevention legislative agenda that will be included in the City of Chicago's annual federal and state legislative agendas.

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4.      The *Early Warning System Data set* is produced by the Chicago Police Department in collaboration with the Illinois Criminal Justice Information Authority.  The *Data set* contains information on all street gang motivated incidents that occurred in Chicago and were recorded by the police from 1987 through 1994. Based on police investigation, a preponderance of evidence must indicate that the incident grew out of a street gang function in order to be identified as a street gang-related offense. Gang membership of either party is not enough to determine gang-relatedness.

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18.     Mayor's Office on Domestic Violence, 1997.

19.     Parsons C. Audit says DCFS is on right track. *Chicago Tribune,* November 3, 1997.

20.     Personal communication with Linda Williams, Illinois Department of Children and Family Services, November 19, 1997.

a.      GAO/HESS - 97 - 95

b.      Sound off: Boys, girls say hitting girls is a big part of dating. *The East Garfield (H.S.) Connection*, July 1997.

c.      Mayor's Office of Employment and Training, *Meeting the Challenges of Welfare Reform*, June 1997.

d.      Center for Media and Public Affairs, 1992.

e.      *Nursing Home Monitors*, 1996.

f.      Illinois Department of Alcohol and Substance Abuse (DASA), *Alcohol, Tobacco and Other Drugs Use by Women in Illinois Child Welfare System.* DASA Needs Assessment Series, Report 96-005, 1996.

g.      Wiebel, W. and Thorpe, L. Patterns and trends of drug abuse in Chicago, *Community Epidemiology Workgroup Report*, June 1997.

h.      Personal communication with Linda Williams, Illinois Department of Children and Family Services, November 19, 1997.