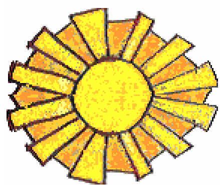

King County Safe and Bright Futures Project Final Report:

Developing a plan for Infants, Children, and Youth Exposed to Domestic Violence

December 2006

Public Health – Seattle & King County (PHSKC) and King County Community Partners

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Table of Contents

Section One: Executive Summary .... page 7

Section Two: Project Background, Purpose and Methods .... page 11

Section Three: Overview of Children and Domestic Violence .... page 14

Section Four: Evidenced Based Practices for Children Exposed to Domestic Violence .... page 20

Section Five: Theoretical Models, Project Goals, and Continuum of Services .... page 34

Section Six: Strategies for Individual Children and their Families .... page 38

Section Seven: Strategies for Professional Providers .... page 45

Section Eight: Strategies for King County Communities .... page 51

Section Nine: Discussion and Next Steps .... page 58

References .... page 62

Glossary of Terms

The following is a list of terms used in this document and their intended definitions.

"Child Maltreatment" is defined as physical abuse, sexual abuse or neglect of a child that constitutes a clear and present danger to a child's health, welfare or safety.

"Children" are defined as all infants, children and adolescents ages birth to eighteen years.

"Children Exposed to Domestic Violence" or "Exposed Children" is defined as children who are present when acts of domestic violence occurs with their caregivers and/or other intimate partners. This includes hearing or seeing domestic violence events or being in the same location where domestic violence events occur.

"Domestic Violence" is defined as "a pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners[1]".

"Domestic Violence Perpetrator" or "Domestic Violence Abuser" means a person who inflicts acts of domestic violence onto their intimate partners

"Domestic Violence Survivor" means a person who is being abused by their intimate partner.

"DV" means domestic violence

"Emerging Practices" means practices that have some available writing or practice protocols but lacks adequate research to determine its efficacy.

"Promising Practices" means practices that have some writings or practice protocol and one effectiveness study with the use of a control group.

"Supported Practices" means practices where there has been more than one controlled study that supports the efficacy of the practice.

"Therapeutic Services" refers to counseling, therapy, or mental health services

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[1] Washington State Gender and Justice Commission (2002). Domestic Violence Manual for Judges.

Section One: Executive Summary

Background and Project Purpose

President Bush created the *Safe and Bright Futures for Children's Initiative* in 2004 to support community strategic planning projects regarding responses and interventions for infants, children, and youth who are exposed to domestic violence (DV). Public Health – Seattle & King County, in full partnership with the King County Judicial Administration and King County community partners, completed a two year countywide needs assessment and formulated a King County strategic plan. The purpose of this report is to present information about the needs of children exposed to DV and the Safe and Bright Futures Project strategic plan.

Project Methods

The Safe and Bright Futures Project developed and implemented the following components in the two year project.

- ***Project Design Team:*** The King County Safe and Bright Futures project was implemented with the active participation and guidance of the project's community partners. The design team was comprised of a diverse group of community experts representing community domestic violence agencies and coalitions, mental health, community planning and policy agencies, and refugee/immigrant services.
- ***Project Management Group:*** The Safe and Bright Future Project Management Team was comprised of the project co-directors from King County Judicial Administration and Public Health – Seattle and King County, along with the project planner, the evaluation consultant, and the children and DV consultant.
- ***Advisory Group:*** To augment the skills, knowledge and expertise of the project management team and design team, an Advisory Group was instituted. This group included a broad panel of King County providers.
- ***Review of Relevant Research Findings and Practice Models:*** An extensive literature review was conducted on the needs of children exposed to DV, evidenced based therapeutic approaches, and successful community response models.
- ***Comprehensive King County Children and DV Assessment*** *(see project needs assessment report below).*
- ***Strategic Plan Development*** *(see last item in this section).*

Project Needs Assessment Report

From December 2004 through March 2006, the Safe and Bright Futures Project planned, developed and implemented an extensive community needs assessment process throughout King County

A second companion report was generated by this project and is entitled: *King County, Washington State, Safe and Bright Futures Project: Needs Assessment Report for Infants, Children, and Youth Exposed to Domestic Violence.* This report details the results of the

project's extensive King County needs assessment. It includes information about King County children and families from the following sources:

- Review of King County regional profiles.
- Relevant 2000 Census data for King County children.
- Estimates of the number of children exposed to DV.
- King County service data and local reports for children and DV.
- Focus groups and interviews with adults and teens who experienced DV as children or youth.
- Focus groups and interviews of mothers whose children were exposed to DV.
- Input from King County providers through stakeholder meetings, surveys, interviews, focus groups and the Safe and Bright Futures Project Advisory Group.

Safe and Bright Futures Project Strategic Plan

The project utilized two conceptual models as the framework for the strategic plan development. These were the Ecological Model and Loftquist's Model of Community Change. With these models three main domains or targets of change were identified for the Safe and Bright Futures Project. The domains were:

- ***Individual Children and their Families***
- ***Professional Providers***
- ***King County Communities.***

Three project workgroups were formulated for each domain. The workgroups were tasked with the following activities:

- Analyze the needs assessment findings
- Develop goals and desired outcomes to be achieved
- Develop strategies to achieve goals and outcomes
- Develop a plan of activities, supports or services.

The workgroups met from August 2005 to June 2006 and completed their strategic plans. The workgroup plans were reviewed and approved by the Design Team in July 2006. The following goals and strategies to achieve the goals were developed by the project workgroups. (Sections six, seven and eight of this report summarize the work and strategies developed by the project workgroups.)

- **For Individual Children and their Families**

Goal: The effects of DV exposures on infants, children and youth are mitigated, and they are able to develop and maintain positive and healthy relationships with supportive caregivers and other support systems.

Strategy: Develop and pilot a specialized Children and DV Response Team which integrates mental health services with community-based children's DV advocacy. This integrated team would provide a range of services and supports based on families' strengths, needs and priorities.

The Individual Children and their Families Workgroup full strategic plan is presented in Section Six of this report.

- ***For Professional Providers***

Goal: The goal is to improve the way mental health providers respond to children exposed to DV and their families.

Strategy One: Improve DV expertise of mental health providers through the development and implementation of a pilot DV training project.

Strategy Two: Identify and advocate for other policy changes that would make the provision of mental health services for children exposed to DV financially sustainable.

The Professional Providers Workgroup full strategic plan is presented in Section Seven of this report.

- ***For King County Communities***

Three goals were identified for working with King County communities.

Goal One: Communities throughout King County act collectively to foster attitudes and norms that DV is not acceptable in the lives of children and their families.

Goal Two: Communities take steps towards eliminating the incidence of DV with children and their families.

Goal Three: Communities engage members of ethnic populations, refugees and immigrants groups, faith communities, youth, men, seniors, the Gay/Lesbian/Bisexual/Transgender communities; business communities; and professional/agency providers serving children and families in DV prevention and intervention activities.

Three strategies were formulated for working with King County communities.

Strategy One: Implement a Children and DV Community Education Campaign.

Strategy Two: Expand and assist with the implementation of "Coaching Boys Into Men" Campaign.

Strategy Three: Encourage and assist community organizations to provide evidence-based DV education to children and youth.

The Communities Workgroup full strategic plan is presented in Section Eight of this report.

Safe and Bright Futures Next Steps

The initial Safe and Bright Futures Phase One grant award allowed for an extensive community assessment and development of a strategic plan. It was projected that competitive grant applications for Phase Two implementation projects would occur at the end of the two year planning grant period. Unfortunately, the Safe and Bright Futures recipients were notified that the Phase Two funding for implementation of project plans was not available. Despite this loss of funding, the project's community partners remained committed to the project and are exploring other funding opportunities and partnerships to realize the work of this project. Several factors need to be considered in implementing the strategic plan.

- ***Full support of DV survivor services:*** Service expansion to children cannot be provided in lieu of basic safety, advocacy and crisis services that are currently in place for adult survivors of DV.

- ***Pilot Projects:*** It is important that we expand our capacity to effectively serve children who are exposed and affected by DV. One way to begin to plan implementation is through the development of pilot projects.

- ***Community Champions:*** To facilitate broad social changes to end DV in the lives of children and their families, community leaders will need to be identified and recruited to champion the cause. This will need to occur throughout public and private sectors.

Section Two: Project Background, Purpose and Methods

Background: Providers among agencies across King County of Washington State have long recognized that children exposed to acts of domestic violence (DV) between their significant adults or caregivers can be profoundly affected in a multitude of ways. During the 1990's, efforts began with local government, public agencies and private providers to initiate dialogue, and to plan and develop strategies and programs. Although these community planning efforts had started, they were not sustained. Prior to this Safe and Bright Futures Project, there has not been a comprehensive assessment of the prevalence of the problem, the number of children served by existing services, and DV survivors' and professionals providers' concerns for children exposed to DV. These issues make it quite complex when communities are attempting to design a system of care for this population.

At the national level, specific legislative and program changes grew out of concern for the youngest victims of DV, children. President Bush created the *Safe and Bright Futures for Children's Initiative* in 2004 to support strategic planning for children exposed to DV in communities across the United States. This initiative was made available through the U.S. Office of Public Health and Science and Department of Health and Human Services. The purpose of the initiative was to develop community strategies targeted to diminishing the damaging effects of DV on children and youth and to stop the perpetuating cycle of abuse PHSKC in full partnership with King County Judicial Administration and the community partners submitted a grant application. In October 2004 King County was one of twenty two sites across the country to receive this award.

Project Purpose: The overall purposes for this two-year King County Safe and Bright Futures Project was to complete an extensive community needs assessment and develop a comprehensive, county-wide strategic plan for infants, children, and youth exposed to domestic violence (DV).

Project Methods:

- ***Design Team:*** The King County Safe and Bright Futures project was implemented with the active participation and guidance of the project's community partners, otherwise known as the project's design team. The design team was comprised of a diverse group of community experts representing community domestic violence agencies and coalitions, mental health providers, community planning and policy agencies, and refugee/immigrant services. The partnering agencies were Children's Response Center, City of Seattle Domestic and Sexual Violence Prevention Office, Domestic Abuse Women's Network, Eastside Domestic Violence Program, King County Coalition Against DV, King County Superior Court Family Court Operations, New Beginnings, Refugee Women's Alliance, Seattle Mental Health, South King County Community Network, and YWCA South County. The project design team and project management group met monthly throughout the project and participated in all the project's workgroups. A process evaluation was completed with the community partners midway through the project with the community partners to identify issues of concern with project activities. The process evaluation results were reviewed by the design and project

management team, and changes were made to strengthen communication and decision making.

- ***Project Management Team:*** The Safe and Bright Future Project Management Team was comprised of the project co-directors from King County Judicial Administration and Public Health – Seattle and King County, along with the project planner, the evaluation consultant, and the children and DV consultant. The project management team organized, coordinated, and directed all activities of the project and all the project workgroups.

- ***Advisory Group:*** To augment the skills, knowledge and expertise of the project management team and design team, a larger, more diverse Safe and Bright Futures Advisory Group panel was instituted. Advisory Group meetings were conducted on a quarterly basis during the project. This group included a broad panel of King County providers from childcare, children and family services, schools, human services and government of our suburban cities, researchers and academic professors with our local universities, juvenile court, prosecution, law enforcement, DV providers, mental health providers, and other service providers. The Advisory Group reviewed project activities and gave feedback and guidance to the project. Advisory Group members assisted with needs assessment, project workgroups, promising practices forum, analysis of needs assessment findings and review and feedback on the proposed strategic plan.

- ***King County Needs Assessment:*** From December 2004 through March 2006, the Safe and Bright Futures Project planned, developed and implemented an extensive community needs assessment process throughout King County. This entailed collection and review of existing information from the following sources:

  - Census data to develop a profile of children across the county
  - Estimates on children's exposure to DV
  - Existing available service data for this population
  - Review of available local reports on this issue.

  As available community data on children exposed to DV was limited, other qualitative needs assessment strategies were implemented to gather community input. This included:

  - Focus groups or interviews with adults and teens that had experienced DV during their childhood years
  - Focus groups or interviews with mothers whose children were exposed to DV
  - Community providers' input through stakeholder meetings, surveys, interviews, and focus groups.

  In addition to gathering community input, a promising practices forum was also conducted along with a review of research and literature on effective responses and interventions for children affected by DV. Analysis of local policy was conducted to identify potential problems and barriers that could impact the strategic plan development.

- ***Safe and Bright Futures Children and DV Community Response Plan:*** All project needs assessment data and community input was reviewed by the project management and design teams. In order to better organize and structure the information gathered in the assessment process, the Design Team elected to utilize two conceptual models: the Ecological Model and Loftquist's Model of Community Change. From these models three domains were identified to serve as the organizing framework for the needs assessment data and the development of the project plan. Three workgroups were developed for each domain. These workgroups were *individual children and their families' workgroup, professional provider workgroup and community workgroup*. The purposes of each workgroup were to:

  - Analyze the needs assessment findings
  - Develop goals and desired outcomes to be achieved
  - Develop strategies to achieve goals and outcomes
  - Develop a plan of activities, supports or services.

  Members of the project management team, design team, and advisory group members participated in the three workgroups. These workgroups met from August 2005 to June 2006. The workgroups shared their activities and products with both the project's Design Team and Advisory Group. The Safe and Bright Futures Project staff also made presentations to other community constituents on the results of the needs assessment and project plan. All community feedback was given to the project workgroups for further refinement of the plan. The Design Team gave their approval of the final Safe and Bright Futures project plan in July 2006. Sections six, seven and eight of this report summarize the work and strategies developed by the three project workgroups.

Section Three: Overview of Children and Domestic Violence

Many assume that a violent man's behavior toward his adult victim does not represent a risk to children in the home. Over 30 studies of the link between physical child abuse and domestic violence show a 41% median co-occurrence in families studied when a conservative definition of child abuse was used.[2] The majority of these studies found a co-occurrence between 30% and 60%.[3]

Co-Occurring Child Maltreatment and Adult Domestic Violence:

The data on co-occurring maltreatment come from a wide range of studies in the US and other countries. The National Family Violence Survey of 1985 also revealed that 50% of the fathers who beat their wives three or more times in the year of the study had also physically abused their children three or more times that year.[4] A range of other studies based on child protection records, hospital records, and interviews with battered mothers in shelters indicates similar levels of co-occurring violence in homes. In a study of at-risk mothers participating in a home-visiting program, McGuigan and Pratt found that child maltreatment was confirmed in 155 of the 2,544 families in the sample.[5] Of these 155 families, 38% (59 families) also had confirmed domestic violence. A closer analysis of the 59 families with both confirmed domestic violence and child maltreatment revealed that in 78% (46) of the families, domestic violence preceded child maltreatment. The wide variation in the degree of co-occurrence among all available studies is most likely the result of the samples used in each study, with some of the lowest co-occurrence rates found in studies drawing participants from the general community and the highest drawing their samples from social service agencies.

As Appel and Holden have also pointed out, co-occurring violence may develop in many different ways.[6] Often it is the perpetrating male who beats both the woman and child, but it may also be that the male beats the woman who abuses the child, or that both parents abuse the child.

English, Edleson and Herrick have estimated, based on a random sample of 2,000 Washington State CPS cases, that 47% of the referrals accepted for investigation and were rated as moderate, moderately high or high risk of CAN have some indication that adult domestic violence was also occurring in the referred child's home.[7] If this estimate of 47% of referrals with domestic violence indications is applied to the 2004 King County CPS data where 5,215 cases were accepted for investigation, 2,415 of these cases, involving approximately 3,687 children, had indications of domestic violence.

In the most lethal forms of domestic violence, children can witness a homicide in their home or may even be murdered themselves. For example, child fatality reviews in Oregon and Massachusetts found between 41% and 43% of the murdered children's mothers were also

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[2] Appel and Holden, 1998
[3] Edleson, 1999a
[4] Straus and Gelles, 1990
[5] McGuigan and Pratt, 2001
[6] Appel and Holden, 1998
[7] English, Edleson, and Herrick, 2005

victims of adult domestic violence.[8] The Washington State Coalition Against Domestic Violence reports that half of the women murdered by an intimate partner from January 1997 to June 2004 had children living with them. In 63% of these cases children were in the home when the murder occurred, and in 43% of these cases the children witnessed their mother's murder. Five percent (n=8) of these children were murdered along with their mothers.[9]

Children Exposed to Domestic Violence but are not Maltreated:

While somewhere close to half of children of domestic violence victims are likely to be physically abused, there is also growing concern for those children who are exposed to domestic violence but are not themselves the victims of physical or sexual abuse. Recent meta-analyses - statistical analyses that synthesize and average effects across studies - have shown children exposed to domestic violence to exhibit significantly more problems than children not so exposed.[10] Overall, existing studies reveal that on average children exposed to adult domestic violence exhibit more difficulties than those not so exposed. These difficulties can be grouped into the two major categories associated with recent exposure: (1) behavioral and emotional functioning, and (2) cognitive functioning and attitudes. For example, several studies have reported that children exposed to domestic violence exhibit more aggressive and antisocial behaviors ("externalized" behaviors) as well as fearful and inhibited behaviors ("internalized" behaviors) when compared to non-exposed children.[11] Exposed children also showed lower social competence than did other children,[12] and were found to show higher than average levels of anxiety, depression, trauma symptoms, and temperament problems than children who were not exposed to violence at home.[13]

A number of studies have measured the association between cognitive development problems and exposure to adult domestic violence. While academic abilities were not found to differ between children exposed to domestic violence and other children in one study[14], another study found exposed children in King County were more likely to be suspended from school[15] and increased violence exposure was associated with lower cognitive functioning.[16] Repeated exposure to multiple victimizations, including exposure to domestic violence, has been found to represent a cumulative risk to children's long-term mental health.[17]

The relationship of the child to the violent adult appears to influence how a child is affected. A study of 80 shelter resident mothers and 80 of their children revealed that an abusive male's relationship to a child directly affects the child's well-being, without being mediated by the

[8] Felix and McCarthy, 1994; Oregon Child Welfare Partnership, 1996
[9] WSCADV, 2004
[10] Kitzmann, Gaylord, Holt & Kenny, 2003; Wolfe, Crooks, Lee, McIntyre-Smith & Jaffe, 2003
[11] Fantuzzo et al., 1991; Hughes, 1988; Hughes, Parkinson, and Vargo, 1989
[12] Adamson and Thompson, 1998
[13] Hughes, 1988; Maker, Kemmelmeier, and Peterson, 1998; Sternberg et al., 1993
[14] Mathias, Mertin, and Murray, 1995
[15] Kernic, Holt, Wolfe, McKnight, Huebner, and Rivara, 2002
[16] Rossman, 1998
[17] Turner, Finkelhor and Ormrod, 2006

mother's level of mental health.[18] Violence perpetrated by a biological father or stepfather was found to have a greater impact on a child than the violence of non-father figures, such as partners or ex-partners who played a minimal role in the child's life. Children whose fathers or stepfathers were the abusers showed lower scores on self-competency measures when compared to the other children. (It is important to note that the self-competency of children in this sample were within the normal range for their age group.) The researchers concluded: "there may be something especially painful in the experience of witnessing one's own father abuse one's mother".[19]

Differing Presence of Risk Factors:

A number of additional factors seem to play a role in children's exposure and interact with each other creating unique outcomes for different children. This section summarizes some risk factors that can increase the severity of problems that children may experience with domestic violence exposures.

Many children exposed to domestic violence are also exposed to other adverse experiences. In a study of 17,421 patients within a large health maintenance organization, Felitti, Anda and their colleagues found that ***increasing exposure to adult domestic violence*** in a child's life was associated with increasing "adverse childhood experiences" such as exposure to substance abuse, mental illness, incarcerated family members, and forms of abuse or neglect.[20]

One such factor is whether or not the child has also been a ***direct victim of child abuse***.[21] Again, in a study of adverse childhood experiences, Felitti, Anda and their colleagues found that, among the 8,629 HMO patients studied, that men exposed to physical abuse, sexual abuse and adult domestic violence as children were 3.8 times more likely than other men to have perpetrated domestic violence as adults.[22]

Problems associated with exposure have also been found to vary based on the ***gender and age*** of a child but *not* based on his or her race or ethnicity.[23] Problems associated with exposure also vary by when DV exposures have occurred. The longer the ***period of time since exposure*** to a violent event appears to be associated with lessening of problems for children.[24]

Finally, ***parenting*** has also been identified as a key factor affecting how a child experiences exposure. More data are available on battered mothers and their caregiving behaviors than on perpetrators and their caregiving. Unfortunately, at times the over reliance on data collected from and about battered mothers may lead to partial or inaccurate conclusions. For example, it may be that the perpetrator's behavior is the key to predicting the emotional health of a child. By not collecting data about the perpetrators, we may incorrectly conclude it is the mothers' problems

[18] Sullivan et al., 2000a
[19] Sullivan et al., 2000a, p. 598
[20] Dube, Anda, Felitti, Edwards, and Williamson, 2002
[21] Hughes, Parkinson, and Vargo, 1989; McClosky, Figueredo, and Koss, 1995
[22] Whitfield, Anda, Dube, and Felitti, 2003
[23] Carlson, 1991; Hughes, 1988; O'Keefe, 1994; Spaccarelli et al., 1994; Stagg, Wills, and Howell, 1989)
[24] Wolfe, Zak, Wilson and Jaffe; 1986

and not the perpetrators' violent behavior that is creating negative outcomes for the children. Given this imbalance in the research, the available studies reveal that battered mothers appear to experience significantly greater levels of stress than non-battered mothers but this stress does not always translate into diminished parenting.[25] For example, Levendosky et al. found that among the 103 battered mothers they studied many were "compensating for the violence by becoming more effective parents".[26]

What little research there is on violent men shows that they directly impact the parenting of mothers. For example, Holden et al. (1998) found that battered mothers, when compared to other mothers, more often altered their parenting practices in the presence of the abusive male. Mothers reported that this change in parenting was made to minimize the men's irritability. A survey of 95 battered mothers living in the community indicated that their abusive partners undermined the mothers' authority with their children, making effective parenting more difficult.[27] In an earlier qualitative study of one child support and education group program, Peled and Edleson found that fathers often pressured their children not to attend counseling when mothers were seeking help for their children.[28] Finally, the relationship between the child and the adult perpetrator appears to influence how the child is affected by exposure. A recent study of 80 mothers residing in shelters, and 80 of their children revealed that an abusive male's relationship to a child directly affects the child's well-being, without being mediated by the mother's level of mental health.[29] As stated earlier, violence perpetrated by a biological father or stepfather was found to have a greater impact on a child than the violence of non-father figures.

Children's Resilience and Protective Factors:

Most would be convinced by the above studies that children exposed to adult domestic violence would all show evidence of greater problems than non-exposed children. In fact, the picture is not so clear. There is a growing research literature on children's resilience in the face of trauma.[30] The surprise in these research findings is that many children exposed to trauma show no greater problems than non-exposed peers, leading Masten to label such widespread resilience as "ordinary magic".[31]

How does one explain these great variations among exposed children? There are likely a number of protective and risk factors that affect the degree to which each child is influenced by violence exposures. One likely factor that leads to variation in children's experiences is the great ***variation in severity, frequency, and chronicity of violence.*** Research indicates the great variation of violence across families.[32] It is likely that every child will experience different levels

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[25] Holden and Ritchie, 1991; Holden et al., 1998; Levendosky and Graham-Bermann, 1998
[26] Levandosky et al., 2003, p. 275
[27] Levendosky, Lynch, and Graham-Bermann, 2000
[28] Peled and Edleson, 1995
[29] Sullivan et al., 2000a
[30] See, for example, Garmezy, 1974; Werner and Smith, 1992; Garmezy and Masten, 1994
[31] Masten, 2001
[32] Straus & Gelles, 1990

of exposure to violence over time. Even siblings in the same household may be exposed to differing degrees of violence depending on how much time they spend at home.

The studies of exposed children reviewed earlier compared groups of children who were either exposed or not exposed to adult domestic violence. The results reported were group trends and may or may not indicate an individual child's experience. Graham-Bermann points out that, consistent with the general trauma literature, many children exposed to domestic violence show no greater problems than children not so exposed.[33] Several studies support this claim. For example, a study of 58 children living in a shelter and recently exposed to domestic violence found great variability in problem symptoms.[34] Over 62% the children in the study were classified as either "doing well" (n=15) or "hanging in there" (n=21). Children "hanging in there" were found to exhibit average levels of problems and self-esteem and some mild anxiety symptoms. The remaining children (42%) in the study did show problems: nine showed "high behavior problems", another nine "high general distress" and four were labeled "depressed kids". In another study, Grych et al. found that of 228 shelter resident children in the study, 71 (31%) exhibited no problems, another 41 (18%) showed only mild distress symptoms, 47 (20%) exhibited externalized problems and 70 (31%) were classified as multi-problem.[35]

The resilience literature also suggests that as assets in a child's environment increase, the problems he or she experiences may actually decrease.[36] ***Protective adults*, **including the child's mother, relatives, neighbors and teachers, older siblings, and friends may all play protective roles in a child's life. The child's larger ***social environment*** may also play a protective role if extended family members or members of church, sports or social clubs with which the child is affiliated act to support or aid the child during stressful periods. Harm children experience may also be moderated by *how a* ***child interprets or copes*** with the violence.[37] Sternberg et al. suggest that "perhaps the experience of observing spouse abuse affects children by a less direct route than physical abuse, with cognitive mechanisms playing a greater role in shaping the effects of observing violence".[38]

Children's Diverse Experiences Require Diverse Responses:

The studies reviewed above have shown children exposed to domestic violence to exhibit significantly more problems than children not so exposed.[39] These studies also reveal that children who are exposed to domestic violence have greatly varying experiences and outcomes based on the level of protective and risk factors available in their lives.[40] Some children show significant negative impacts on their development as a result of domestic violence exposure

[33] Graham-Bermann, 2001
[34] Hughes & Luke, 1998
[35] Grych et al., 2000
[36] Masten & Reed, 2002
[37] Hughes, Graham-Bermann and Gruber, 2001
[38] Sternberg et al, 1993, p. 50
[39] Kitzmann, Gaylord, Holt and Kenny, 2003; Wolfe, Crooks, Lee, McIntyre-Smith and Jaffe, 2003
[40] Edleson, 2004

while others show more mild impacts and still others show few problems resulting from their exposure. These varied responses and outcomes with children's exposure to domestic violence will require that communities develop a range of responses to best meet their needs.

Section Four: Evidenced-Based Practices for Children Exposed to Domestic Violence

A variety of responses to children exposed to domestic violence have been developed. These include individual trauma treatment with a child, child-parent trauma therapy and coordinated community responses that harness diverse agency and program responses to provide a unified approach for exposed children and their families. Some of these responses are promising practices with deep on-the-ground experience and others have, in addition to experience, evidence that supports their use. This and the next section will review these major approaches and the evidence to support them. For organizational purposes these responses will be divided into *individual and family* in this section and *co-located* or *coordinated response* categories in the next section.

Intervention with Individual Children and their Families

A major intervention strategy has been to work with battered mothers, their children and in some cases the children's fathers. Several approaches have been developed, documented and evaluated. Four are the focus of this section:

- Child-Parent Trauma Interventions
- Parent-Child Interaction Therapy
- Parallel support for child and advocacy for battered parents
- Small support groups for children

The table below lists these major interventions and their key components. All of these interventions are supported by positive results in randomized clinical trials.

Programs	***Ages***	***Key Concepts***
Child-parent trauma intervention	3-12*	• Intensive child and mother therapy focused on trauma relief * *Empirically supported with 3-5 years of age*
Parent-Child Interaction Therapy	4 - 12	• Behavioral management and communication skills training for parents in sessions with children
Parallel support for child/Advocacy for mother	4 - 9	• Home visits to provide support to child and advocacy for mothers
Small support groups	6 - 12	• Small education and support groups for up to 10 children • Concurrent parent groups sometimes offered

Table One: Programs for individuals and families, ages of intervention and key concepts

Child-Parent Trauma Interventions:

- ***Overview of Child Trauma***

When children and adolescents are exposed to traumatic events or traumatic situations (including domestic violence), and when this exposure overwhelms their ability to cope with what they have experienced, the result can be traumatic stress. Children respond to traumatic stress in different ways depending on their age and other environmental circumstances. Some children may show signs of intense distress when they experience reminders of their initial traumatic experience: disturbed sleep, difficulty paying attention and concentrating, anger and irritability, withdrawal, repeated and intrusive thoughts, and extreme distress. Some children may develop psychiatric conditions such as posttraumatic stress disorder, depression, anxiety, and a variety of behavioral disorders.

There are children who recover from adverse experiences without apparent lasting effects. For others, traumatic experiences can result in a significant disruption of child or adolescent development and have profound long-term consequences. Repeated exposure to traumatic events can affect the child's brain and nervous system and increase the risk of academic difficulties, engagement in high-risk behaviors, and difficulties in peer and family relationships. Other negative outcomes may include increased use of health and mental health services and increased involvement with the child welfare and juvenile justice systems. Adults who experienced trauma during childhood or adolescence may have difficulty establishing relationships, being successful in the workplace, or successfully adjusting to other adult responsibilities.

Children who grow up in homes where they are exposed to trauma, including domestic violence, over long periods of time may develop a range of responses including intense feelings of fear, loss of trust in others, decreased sense of personal safety, guilt, and shame. This type of exposure is referred to as ***chronic trauma***. Trauma, including domestic violence, that involves a more short lived event occurring at a particular time and place may reflect ***acute trauma*** as characterized by (1) experiencing a serious injury or witnessing a serious injury to or the death of someone else, (2) facing imminent threats of serious injury or death of oneself or others, or (3) experiencing a violation of personal physical integrity. This kind of childhood experience can involve overwhelming feelings of terror, horror, or helplessness. [41]

- ***Child Witness to Violence (CWV) projects:***

Several hospitals in the United States have developed specialized clinics that provide trauma therapy for child-parent dyads to work through the impact of domestic violence on the children. These programs, often called Child Witness to Violence (CWV) projects, work primarily with battered mothers and their children within an adult or child medical center. The best known are the Child Witness to Violence Project at the Boston Medical Center directed by Betsy McAlister Groves and the Child Trauma Research Project at San Francisco General Hospital directed by

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[41] References for child trauma overview section: AACAP (1998): Cohen, JA, Berliner, L & Mannarino, AP (2000); Cohen, JA, Berliner, L & March, JS (2000).

Drs. Alicia Lieberman and Patricia Van Horn. Each program conducts a slightly different version of child-parent work.

CWV projects focus their intervention on parent-child pairs, usually involving a battered mother with her child but sometimes working with father-child dyads. These interventions focus on helping the parent interact with his or her child regarding the violence experienced in their lives and to work through a healing process regarding the trauma. Extensive assessments are performed with both the child and parent. The therapy usually involves parent-child meetings where violence and safety in the family's life are openly discussed. This structure speaks to several key goals that Groves has outlined in her book entitled *Children Who See Too Much.*[42] These include: (1) the importance of supporting a safe and caring relationship between the child and an adult in his or her life; (2) giving children permission to talk about their experiences with violence; and (3) helping families find a safe environment. The work usually begins after the child's mother has had an opportunity to work through her own healing and stabilize her family's life in the aftermath of violence. In San Francisco, mothers and children meet weekly with a therapist for up to a year. Meetings take place at the clinic or in homes.

More recently these programs have begun to experiment with including, in selected cases, men who batter in work with their children. Men are included only when it is deemed advantageous to the child's progress and both mother and child agree. Boston's project is particularly well coordinated with local battered women's services.[43] While these projects are relatively new, there is some evidence to support their effectiveness.

- ***Trauma-Focused Cognitive-Behavioral Therapy (TR-CBT):***[44]

The therapeutic interventions used in these and other centers draw on extensive prior research into Trauma-Focused Cognitive-Behavioral Therapy (TR-CBT) with sexually abused children but not necessarily children exposed to violence.[45] More specifically, Lieberman, Van Horn and Ippen have recently published the results of their first clinical controlled trial in which 75 mothers with children ages 3 to 5 were randomly assigned to receive either their model of child-parent psychotherapy or a comparison intervention consisting of case management and referral to individual treatment.[46] They found those receiving child-parent psychotherapy significantly reduced total child problems, traumatic stress symptoms and clinical level diagnoses when compared to those receiving case management and referrals. Mothers in the child-parent condition also improved on a number of measures when compared to the other mothers, including on measures of post-traumatic symptoms and general distress.

In King County, the Harborview Center for Sexual Assault and Traumatic Stress (HCSATS) and the Children's Response Center both specialize in providing TF-CBT to children, adolescents and families impacted by traumatic events. Mental health centers in the county and some youth

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[42] Groves, 2002.
[43] Groves, Van Horn and Lieberman, 2007
[44] Cohen, JA, Mannarino, AP, Berliner, L, & Deblinger, E (2000).
[45] Cohen, Deblinger, Mannarino and Steer, 2004; Cohen, Mannarino and Knudsen, 2005; Deblinger, Steer, Lippman, 1999; Deblinger, Stauffer and Steer, 2001.
[46] Liberman, Van Horn & Ippen, 2005

and family service agencies also have trained personnel available to provide TR-CBT. The Substance Abuse and Mental Health Services Administration recognizes TF-CBT as a "Model Program" for the treatment of childhood trauma. It is an empirically supported treatment model to assist children, youth and their parents/caretakers in the aftermath of traumatic experiences. In particular, it has been shown to effectively address symptoms of PTSD, depression, anxiety and features associated with these conditions. Core values of the treatment approach include: components based, respectful of cultural values, adaptable and flexible, family focused, therapeutic relationship is central, self-efficacy is emphasized. TF-CBT is a skills and strength based treatment model that addresses: psycho-education and parenting skills; relaxation; affect modulation; cognitive coping and processing; trauma narrative; in vivo mastery of trauma reminders; conjoint child-parent sessions; enhancing future safety and development. Parental participation in parallel or conjoint treatment sessions may focus on child behavior management strategies, enhancing communication and creating opportunities for therapeutic discussion of the trauma.

Extensive resources are available on the web regarding traumatic stress and TF-CBT including: The National Child Traumatic Stress Network is an invaluable resource for both those impacted by trauma and those who respond to trauma (see: http://nctsnet.org). An excellent resource for clinicians is TF-CBT Web, an online web-based training course (see: http://tfcbt.musc.edu/).

- ***Parent-Child Interaction Therapy (PCIT):***

PCIT is a short-term form of parent training that focuses on teaching parents specific child management and communication skills so as to alter negative interactions between them and their children for the better. PCIT has been widely tested and is considered an empirically supported intervention[47]. Little research has been conducted specifically with children exposed to domestic violence and their parents.

PCIT is generally provided in clinical settings to individual parent-child dyads with young children, most often between two and six or seven years of age. Changes in parent-child interactions are expected to create change in child behavior. Chaffin and his colleagues have recently reported a study that provided PCIT with physically abusive parents and their children. According to Chaffin et al., PCIT is most often delivered in two phases; work on strengthening child directed interactions followed by strengthening parent directed interactions.[48] Each of the two phases starts with a didactic session followed by a five or six parent-child dyadic sessions in the presence of a therapist acting as a coach. In the child directed phase emphasis is on promoting positive child-parenting interactions. In the parent directed phase emphasis is on parent management of child conduct.

Chaffin et al. added several components to the standard PCIT model.[49] First, all parents attended a motivation enhancement module before beginning PCIT and participated in a third phase

[47] Eyberg, S.M. (2003); Herschell, A., Calzada, E., Eyberg, S.M., & McNeil, C.B. (2002); Querido, J.G., Bearss, K., & Eyberg, S.M. (2002).
[48] Chaffin et al., 2004.
[49] Chaffin et al., 2004.

consisting of a four-session group program that helped parents implement what they learned earlier in PCIT. Finally, some parents received enhanced individualized services (EPCIT) focused on parental substance abuse, depression and family problems including domestic violence. Enhanced individualized services included home visits.

In their study of 110 physically abusive parents of 4 to 12 year olds, Chaffin and his colleagues found that 19% of the parent-child dyads receiving PCIT had subsequent reports of physical abuse compared to 49% among a comparison group randomly assigned to receive standard services. Those randomly assigned to receive PCIT plus enhanced services showed no additional gains over the traditional PCIT approach.

In Washington State, The Department of Social and Health Services, Children's Administration (CA) is implementing Parent Child Interaction Therapy (PCIT) as a service to be available for their client families. The CA is committed to establishing and expanding the use of PCIT with children and families receiving services through the Division of Children and Family Services (DCFS) throughout the state. In September 2006, providers were identified throughout Washington in a competitive bidding process. King County has 70 PCIT slots available for families receiving DCFS services. Providers selected to deliver the services (both clinic based and in-home) represent a diverse group in order to respond to the diverse needs of the department. Providers with trained personnel include: Harborview Center for Sexual Assault and Traumatic Stress; Children's Response Center; Institute for Family Development; Children's Hospital Regional Medical Center (Odessa Brown Clinic); King County Sexual Assault Resource Center; Encompass, Auburn Youth Resources; Grayson and Associates: Service Alternatives.

In addition to these providers under contract with DCFS, there are other PCIT providers in the county collaborating with one another under the umbrella of the Washington State PCIT Leadership Group. These organizations include: Ruth Dykeman Children's Center; Seattle Mental Health; Consejo Counseling Services. A complete PCIT literature review is available on the web (see:http://www.pcit.org/).

- ***Providing Support for Children and Skills/Advocacy for Parents:***

This intervention draws on promising practices with children exposed to violence, advocacy for battered women and empirically supported strategies for both home visiting and parent training. It is a unique, multi-method approach that is strongly research based and focused on exposed children with conduct problems.

Jouriles and his colleagues have developed a theory-based intervention for battered mothers of children with specific conduct disorders. They have drawn of some of the early work with children exposed to violence, advocacy for battered women as well as the extensive work of Patterson and his colleagues at the Oregon Learning Center on the issue of child-management training for parents. They have completed several controlled studies of their intervention in

recent years.[50] Mother-child dyads were an intervention that included home-visits to provide support, education and child-management skill training for mothers as well as a mentoring intervention for children ages 4 to 9 that consisted of support and education. A two-member team, consisting of a therapist/advocate who worked primarily with the mother and an undergraduate trained to work with the children, visited the family home for one to one and a half hours a week for up to eight months after the mother and her child(ren) left a battered women's shelter. Mothers and children were compared to others who received existing services and, when contacted monthly by the research team, were encouraged to seek services. The combination of advocacy, parent child-management training and child support through home-visits resulted in more rapid decreases in conduct problems of children and greater improvement for mothers in parenting skills when compared to those in the comparison condition.

The South King County YWCA's Children's Domestic Violence Program is a local variation of the Jouriles model and is considered an emerging effort. It is a ten-week education and skill based curriculum for children, age 3 through 13, and their non-abusive caregivers. These services are delivered to families in their home after they have left the abusive environment and achieved housing stability. The curriculum is aimed at reducing the anxiety surrounding the domestic violence experience, as well as teaching children effective coping skills and positive conflict resolution skills. Children create and execute a developmentally appropriate safety plan, learn to identify unsafe situations based on their experience, and strategize with the caregiver and program staff on how to stay safe.

This program has completed a program level outcome evaluation. Those results appear to be encouraging. Initial outcomes have shown children often feel much relief to learn that the violence was not their fault. A recently revised and more complex evaluation survey is just beginning to yield more in-depth information on the changes in children's and non-offending parents. Especially impressive is a program completion rate of over 90%, a fact that is likely attributable to the program's design and home visiting component.

- ***Small Group Work with Children:***

The predominant intervention with exposed children is small, psycho-educational groups. From the earliest days of the battered women's shelter movement in the 1970s children have been present with their mothers. Shelters, and later mental health agencies, have long sought to provide support and education to children living in battered women's shelters. There are a number of published and unpublished curricula for children's groups that all focus on providing some type of support and education to these children. There are a growing number of formats and locations at which such services are provided.

Four to ten children meet once or twice a week with one or two adult facilitators; the adults often being an advocate or counselor who is also working with their mother. The groups typically meet weekly for one to two hour sessions over eight to twelve weeks. The curricula for these programs focus on defining the violence, developing safety plans and learning to express a range of feelings in a non-abusive manner. This approach has been developed by Honore Hughes at St. Louis University, Sandra Graham-Bermann at the University of Michigan, Cris Sullivan at

[50] Jouriles et al., 1998, 2001.

Michigan State University and detailed extensively by Einat Peled and Diane Davis[51] in a book about the program at the Domestic Abuse Project in Minneapolis. These groups are often offered concurrently with a parenting group program attended by mothers and sometimes the parent and child groups are merged for all or part of some sessions, to involve mothers in their children's programming.

Studies of this approach are promising. For example, Sullivan, Bybee and Allen reported a study of 80 mothers and their 7 to 11 year old children. In their study, the mother-child dyads were randomly assigned to receive either (1) an experimental intervention that consisted of advocacy services for mothers and children plus a 10-week child support and education group or (2) a no-treatment control group.[52] Mothers and children receiving the advocacy and small group intervention improved more than others on several measures and these improvements persisted over a four-month follow-up. In another study, Graham-Bermann randomly assigned 6-12 year old children and their mothers to one of three conditions: (1) child small group intervention only; (2) child plus parent intervention and (3) a control condition of services "as usual." She found that intervention produced lasting reductions in child problems both after intervention and at an eight-month follow-up.[53] The impact of intervention was the greatest when mothers were involved in intervention with the child.

In 2005 the Domestic Abuse Women's Network and Jewish Family Service began to provide the Kids* Club Program in King County. These groups were implemented as developed by Dr. Graham-Bermann and incorporating the recommendations to include the supportive parent in support group sessions. The program was well received by the community and referrals to these support groups far exceeded expectations. Therefore, in 2006 Kids* Club groups were expanded and offered through New Beginnings and Eastside Domestic Violence Program The Kids* Club program is now available county wide.

Successful Community Co-location Models

Another level of intervention is coordination of direct and indirect community responses to exposed children and their families. Strategies commonly used across the country include *co-location* of multiple agency staff in one location to enhance access by clients and coordination among agencies and formal *collaborations* that involve multiple agencies but may not include co-location of staff. The table below summarizes each effort reviewed. These efforts are listed as "supported" with more than one controlled studies of their efficacy, "promising" when there is at least one controlled efficacy study and "emerging" when there is some data to support its use but no controlled studies.

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[51] Peled and Davis, 1995.
[52] Sullivan, Bybee and Allen, 2002.
[53] Graham-Bermann, 2002.

Co-Location Efforts	***Key Concepts***	***Evidence***
Domestic Violence Enhanced Response Team	• Co-location of multiple services within the context of a law enforcement response to domestic assaults	Promising
Child Development-Community Policing Teams	• Creation of child development and community law enforcement teams to respond to children exposed to violence	Emerging
Dependency Court Intervention Program for Family Violence	• Screening of dependency court cases for adult domestic violence • Referral to co-located battered women's advocates in the court setting	Emerging
Joint Prosecution Units	• Coordinated prosecution and co-location of victim/witness advocates in domestic violence cases with children in the homes	Promising
Family Justice Centers	• Co-location of multiple service providers within the context of domestic assault prosecution	Emerging
Supports for Resilience	• Multiple forms of supports provided based on empirically identified protective factors	Promising

Table Two: Co-location efforts, key concepts and level of evidence

- ***Domestic Violence Enhanced Response Team (DVERT):***

Police were often frustrated that after they have intervened at a home where domestic violence has occurred that other parts of the criminal justice and social service system seldom followed through. In 1987, the City of Colorado Springs was one of several communities around the country selected by the National Institute of Justice to replicate an earlier experiment in Minneapolis where police responded to domestic violence incidents with one of several alterative actions, one being the then novel idea of arresting the perpetrator. Out of this early start grew a series of community initiatives that have drawn in an ever widening group of collaborative agencies.

The DVERT Team is an interdisciplinary group of professionals from 11 agencies who are co-located in a common space and coordinate their agencies' response to cases of domestic violence. Agencies contributing staff include probation, a battered women's program, two police and one sheriff's departments, the Humane Society, and legal services. The Team has been

expanded to include professionals working with children exposed to violence, including local child protective services and the CASA program.

The Team maintains several levels of intervention. Referrals are received from a variety of sources and the first level of intervention involves a confidential intake conducted by a victim advocate who is assigned to work with the victim from beginning to end. Cases moving beyond intake are also assigned a law enforcement detective who works with the victim and the advocate to ensure safety over time. Another level of intervention involves Problem Oriented Policing in which officers visit the victim's home to provide additional information and support in the community. Finally, the DVERT Team coordinates a variety of community resources in support of the adult and child victims' safety.

A series of evaluations published on the project's website (http://www.dvert.org) indicate that victims perceive the DVERT services to have enhanced their safety resources, and in some cases, to have saved their lives.[54]

- ***Child Development-Community Policing* (CDCP)*:***

The City of New Haven and the Yale Child Study Center developed a partnership to intervene with children exposed to any form of violence. The initial success of the Yale/New Haven program, commonly called "Child Development-Community Policing" (CDCP), led the federal government to fund the development of similar "Safe from the Start" initiatives in numerous cities around the county. Five years of funding for this first wave has now ended. Spokane, Washington, was one of the first sites. A new wave of 14 communities has just received funding to initiate five-year projects of their own.

CDCP sites have several basic features. First, policing in the community includes what is often referred to as "community policing" in which individual officers are assigned a geographic area and are to become deeply familiar with the families in this area. These community-based police officers work closely with local child development specialists to develop an emergency response to children who have been exposed to violence. The child development specialists often join police officers immediately on the scene and work with the children during the crisis, freeing the officers to focus on law enforcement activities. Consultations between the police and child specialists occur during the crisis and continue in the aftermath regarding a plan of interventions for police and child development specialists to assure on-going safety. Specialists are available for additional trauma treatment as well as helping the family make use of other mental health, legal and social services. Another innovative aspect of this project is that police are offered short fellowships at the Yale Child Study Center to learn more about child development and the impact of violence on children and, in the reverse, child development specialists are offered fellowships to work with police on their daily patrols so as to gain an important insight in the work of law enforcement.

The Department of Justice has funded a multi-site evaluation for Safe from the Start replication sites but no data is currently available about their effectiveness.

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[54] Uchida et al.,2001.

- ***Miami-Dade County Dependency Court Intervention Project for Family Violence (DCIPFV):***

The DCIPFV was developed under the leadership of Judge Cindy Lederman. Federal funding was allocated for domestic violence assessments of families coming before the court for dependency hearings. When domestic violence was identified, referrals were made to on-site, co-located confidential advocacy for battered mothers before further dependency court proceedings. Advocacy services were offered and in most cases accepted by mothers.[55]

An examination of families in the dependency court project found that in approximately 95% of the cases, mothers who screened positive for current or past domestic violence and were referred to DCIPFV advocacy services accepted such services. The study also found that children whose mothers were screened for domestic violence and referred to services were more than three times more likely (20.9% vs. 6.7%) to remain in their mothers' custody compared to those children whose mothers were not screened or referred to services.[56]

- ***Joint Prosecution Units (JPU):***

Ramsey County and the City of St. Paul, Minnesota, developed a Joint Domestic Abuse Prosecution Unity between the county and city attorneys' offices to coordinate prosecution with families involved in adult domestic assaults where children were present. [57] Victim/witness advocates are co-located within the unit to work with mothers and their children.

A study by Gewirtz, Weidner, Miller & Zehm compared 446 cases prosecuted by the JPU with an equal number prosecuted before the founding of the unit.[58] The authors found that co-location of county and city attorneys resulted in fewer cases being declined or dismissed and those prosecuted were at a significantly more stringent level. Statistical analyses indicated that factors associated with the child and weapons increased the seriousness of the charges for cases before the JPU.

- ***Family Justice Centers (FJC):***

The first Family Justice Center was started in San Diego and has been replicated in a wide number of locations across the country. FJC are one-stop locations where domestic violence survivors may receive multiple services instead of having to move to many locations to receive these services. In San Diego, the FJC has grown to a multi-service center with a long list of over 20 services supported by 100 professionals available to domestic violence survivors and their children. The GW Bush Administration allocated $20 million in 2003 to create family justice centers in 15 new communities across the United States. Despite great promise and many replications there is little empirical support for the FJC model.

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[55] For more information see http://www.miamidcip.org
[56] Rivers and Klein, 2005.
[57] For more information see http://www.co.ramsey.mn.us/attorney/SPdomesticabuse.asp
[58] Gewirtz, Weidner, Miller and Zehm 2006

- ***Strengthening Resiliency in Children:***

While the above interventions are specific models, this section raises the general issue of developing supports for children exposed to violence as outlined by Gewirtz and Edleson.[59] In the face of significant adversity and cumulative risk, some children develop successfully, performing at least as well as their low risk peers across a variety of domains.[60] These children have been labeled competent, resilient, and even invulnerable.[61] Studies have elicited several core characteristics of resilient children and their environments, among them competent parenting, intellectual resources, social competence, and easy temperament.[62]

Resilience is increasingly described as a pattern[63], a dynamic developmental process[64] or a developmental progression in which new strengths and vulnerabilities emerge over time and under changing circumstances.[65] Drawing from longitudinal data on high-risk children, Masten and colleagues have demonstrated a positive relationship between the level of adversity to which children are exposed, and the likelihood of negative outcomes.[66] In the reverse, Masten & Reed have proposed that as assets in a child's environment increase, the problems she experiences may decrease.[67] For example, Diener, Nievar and Wright found that greater cumulative assets were related to more secure attachment relationships in a sample of mother-young child dyads.[68] This supports the notion that minimizing the number of risk factors to which children are exposed, while simultaneously encouraging protective processes can be highly effective in reducing negative outcomes.

Programs aimed at strengthening supports in children's lives are many and varied. Perry has outlined six core strengths that he calls "*a vaccine against violence*".[69] These core strengths include: attachment, affiliation, self-regulation, attunement, tolerance and respect. Children and families can best be helped to achieve these strengths through a continuum of supports, from naturally-occurring supports within the family and the community to more intensive interventions offered by domestic violence advocates, social service and mental health agencies. From a resilience framework, efforts that target the major developmental tasks of early childhood, as well as efforts that directly reduce the impact of the stressors faced by children exposed to intimate partner violence, such as, homelessness, poverty, loss or separation from caregivers, and violence exposures, should be effective in helping young children negotiate developmental challenges. Intervening to support children exposed to intimate partner violence requires a consideration of the larger context within which the child resides. Hence, efforts that directly target the impact of exposure to intimate partner violence will be most helpful if they occur in conjunction with those that help promote children's competence in a variety of domains

[59] Gewirtz & Edleson, in press.
[60] Garmezy, 1974; Werner and Smith, 1992; Garmezy and Masten, 1994.
[61] Anthony and Kohler, 1987.
[62] Anthony and Kohler, 1987.
[63] Masten, 2001.
[64] Egeland et al., 1993.
[65] Luthar, Cicchetti, and Becker, 2000.
[66] Masten and Sesma,1999; Masten and Reed, 2002.
[67] Masten and Reed, 2002.
[68] Diener, Nievar and Wright 2003.
[69] Perry, 2004.

within the family, community and cultural contexts.[70] Linking a family with supportive resources that have proven effective with vulnerable children may provide additional protection and lessen risk factors. Supportive interventions are likely to be most effective when mothers and children voluntarily participate in services rather than being mandated to participate in them (which could result in their seeing service providers as part of the 'system' and threatens their parental rights).

Successful Community Collaboration Efforts

Listed below are a number of collaborative efforts, their key concepts and evidence supporting these efforts. Each is described in greater detail following the table. These efforts are listed as "supported" with more than one controlled studies of their efficacy, "promising" when there is at least one controlled efficacy study and "emerging" when there is some data to support its use but no controlled studies.

Collaborative Efforts	*Key Concepts*	*Evidence*
Children Who Witness Violence Project	• A unique collaborative funded by Cuyahoga County with grants for an assessment center and separate grants for services to exposed children and their families	Emerging
Child Protection and Domestic Violence Collaborations	• A set of collaborative projects throughout the US that focus on improving the coordination and types of services available to battered mothers and their children	Promising

Table Three: Community collaboration efforts, key concepts and levels of evidence

- ***Cuyahoga County Children Who Witness Violence Project (CWWVP):***

The CWWVP is funded through subcontracts from the county to a number of community-based non-profit agencies. One is a mental health agency that has set up an assessment team to received referrals from police, county child protection workers and others for children exposed to domestic violence. Upon referral the child and his or her family needs are assessed and then a service plan developed involving the services of a number of other agencies that also receive subcontracts from the county, including domestic violence, child abuse prevention and other services.

Drotar et al. have described this program in detail and found that children referred to CWWVP had not received other services in the past.[71] They also found that mental health services were

[70] Masten and Gewirtz, in press.
[71] Drotar et al., 2003.

delivered in accord with the intended comprehensive crisis intervention model, and the great majority of families utilized the voluntary services to which they were referred after assessment.

- ***Child Protection, Courts, and Domestic Violence Collaborations:***

Decades of mounting tension between battered women's advocates and child protection workers resulted in a new effort in the early 1990s to find common ground between them. Funded by the Ford Foundation, Susan Schechter convened a select group of women's advocacy, child protection and family preservation experts at a meeting in June 1994. Soon thereafter the National Council of Juvenile and Family Court Judges, with funding from the David & Lucile Packard Foundation, convened a larger national working group of juvenile and family court, child welfare and battered women's advocacy leaders for meetings over two years that resulted in Effective Intervention in Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice.[72] The guidelines' green cover generated its nickname, the *"Greenbook"*. Published in 1999, the Greenbook's extensive reform recommendations have been widely applied and the subject of six federal demonstration projects as well as a national evaluation.

The Greenbook calls for collaborative leadership by judges, CPS administrators and battered women's advocates to improve the safety, stability and well-being of all victims of family violence and to hold batterers accountable. The book is divided into five chapters, the first two devoted to a guiding framework and common principles and then one chapter on suggested reforms for each of the three target systems (CPS, DV agencies, and the courts). The expectation is that child maltreatment, child exposure and adult domestic violence will be consistently assessed and, once identified, changes in response to families where these co-occur will be made within all three systems. The 67 recommendations suggest that children remain with non-abusive parents and that each system take steps to maximize safety resources for both adult and child victims. This implies that child protection and the juvenile courts will be concerned not only with the best interests of the child but also the safety concerns of adult victims in the same families. Also implied is that domestic violence service organizations make changes to recognize and intervene with abused children in their client populations. Many recommendations refer to cross-training, safety in sharing of information, supervision as well as direct practices.

A national evaluation of six federally funded Greenbook demonstration sites is currently being completed with final reports to be published in 2007. It appears that the sites have increased their ability to identify co-occurring cases, to utilize each other's services and to change some practices in accordance with the national best practices recommendations.

A team from the State of Washington took part in a regional "Greenbook Summit" and subsequently initiated the *Washington State Coordinated Response Protocol Project*. This statewide project published in 2005 a template for *Coordinated Response to Child Maltreatment and Domestic Violence*. This template sets out the mission, goals and elements of a desired local response to co-occurring domestic violence and child maltreatment. Each region in the state has been tasked with developing its own coordinated response guideline. In Region Four this effort is being led by King County Superior Court and Children's Administration, Division of Children

[72] NCJFCJ, 1999.

and Family Services. The coordinated response document in the process of being completed and will be implemented in 2007.

In summary, there are a number of well-supported individual and family level interventions as well as supported, promising and emerging strategies at the community level that provide a solid basis on which to build King County's response to exposed children and their families.

Section Five: Theoretical Models, Project Goals and Continuum of Services

In order to better organize and structure the information gathered in the Safe and Bright Futures Project two conceptual models were utilized: the Ecological Model and Loftquist's Model of Community Change Both of these models each had common elements of effecting change across differing levels or domains in a community from the micro or individual level and up to the macro or community level. Lofquist's model addresses not only identifying the domain in which to act, but also designates arenas of action, which are activities and strategies that would be initiated for development and problem solving.

By combining key elements of both models, the Safe and Bright Futures Project was able to create a conceptual model that provided a strong framework to organize the needs assessment data and strategic planning work. Figure One below is a depiction which blends these two conceptual models.

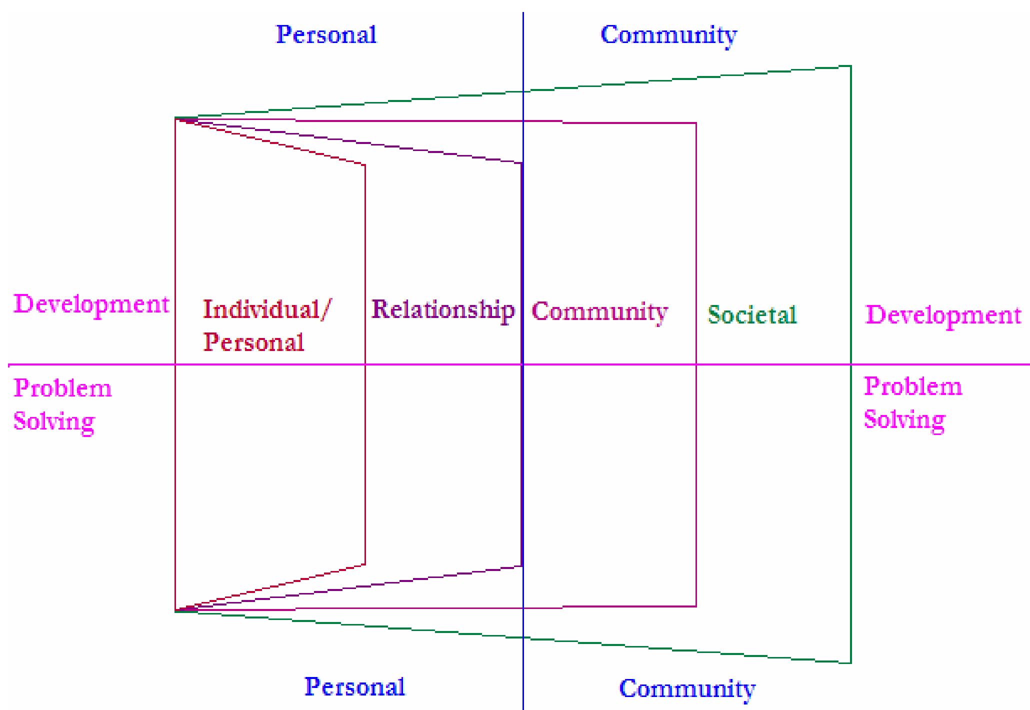

Figure One: Safe and Bright Futures Conceptual Model: Ecological Model and Lofquist's Community Change Model

Utilizing the above conceptual model, the project identified three main domains or areas to target strategies for change. The domains were: a) ***individual children and their families***,

b) relationships with ***professional providers,*** and c) ***communities*** at large. These domains served as the organizing framework for the development of the project's needs assessment and strategic plan. Three project workgroups were developed for each of these domains. The workgroups then formulated the following goals to be achieved for each domain.

Domain One: Individual Children and their Families

Individual Children and their Families Goal:

The effects of DV exposures on infants, children and youth are mitigated, and they are able to develop and maintain positive and healthy relationships with supportive caregivers and other support systems.

Domain Two: Professional Providers

Professional Providers Goal:

Service providers who come into contact with children exposed to DV have the ability to identify and effectively respond to their needs.

Domain Three: Communities

Communities Goals:

- Communities throughout King County act collectively to foster attitudes and norms that DV is not acceptable in the lives of children and their families.
- Communities take steps towards eliminating the incidence of DV with children and their families.
- Communities engage members of ethnic populations, refugees and immigrants groups, faith communities, youth, men, seniors, the Gay/Lesbian/Bisexual/Transgender communities; business communities; and professional/agency providers serving children and families in DV prevention and intervention activities.

To achieve these aforementioned goals and outcomes for each domain, the Safe and Bright Futures Project conceptualized that a broad continuum of intersecting supports and services be developed in King County. This continuum would encompass an array of strategies including community mobilization & prevention activities, early identification and referral of children exposed to DV, clinical assessment of exposed children, intensive case management, and other community supports. Figure Two depicts The Safe and Bright Futures Project's vision for a comprehensive continuum of services for children in King County.

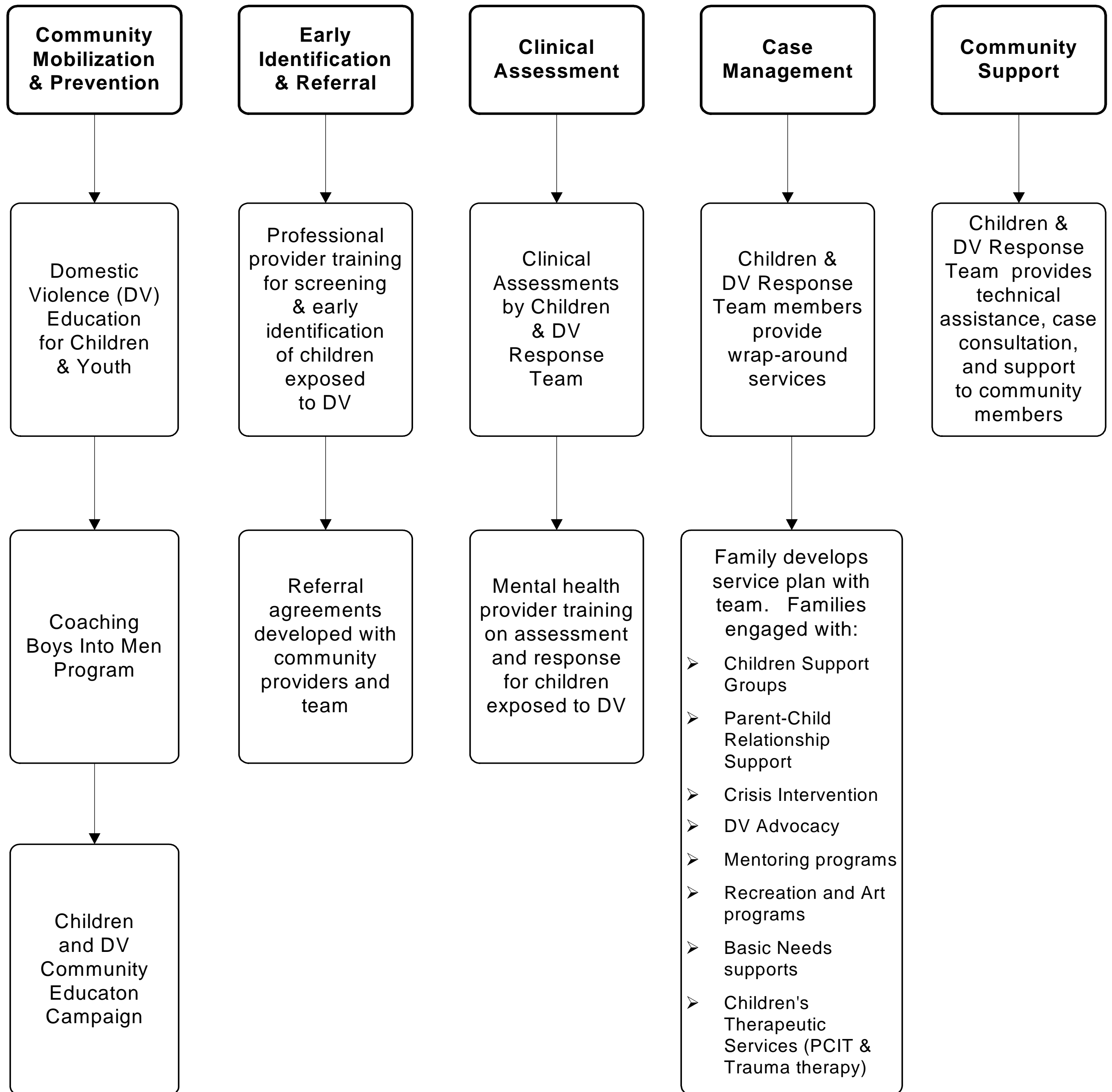

Figure Two: Safe and Bright Futures Project Continuum of Services for Children

Each of the elements outlined in the Safe and Bright Futures Continuum of Services is viewed as essential and necessary to address DV in the lives of children and their families and King County communities. The continuum also increases the competency, expertise, and capacity of community members and professional providers to recognize effects of DV on children, and to safely respond and take action. The continuum also outlines DV prevention strategies to decrease the perpetuation of DV in King County communities. The subsequent sections detail the strategic plans developed by the three project workgroups for individual children and their families, professional providers and communities.

Section Six: Strategies for Individual Children and their Families

The individual children and their families workgroup was staffed by members of the project management team, design team and advisory group. Workgroup members represented expertise in child trauma, mental health, children's DV advocacy, community DV advocacy, community health and safety network, judicial administration, and public health. The workgroup formulated goals and outcomes as well as key strategies to achieve the goals and outcomes for work with individual children and their families.

Goals for Individual Children and their Families:

The effects of DV exposures on infants, children and youth are mitigated, and they are able to develop and maintain positive and healthy relationships with supportive caregivers and other support systems.

Key Points from Literature Review:

- The literature reviewed earlier in this report also indicates that children exposed to DV experience a range of effects. Some children experience relatively minor effects while others experience severe behavioral problems, including externalizing or aggressive behaviors, mental health problems such as depression, trauma, anxiety, lower social competence, and/or impaired learning.
- Some children may have continued mental health problems and lower social competence skills that persist into adulthood.
- Although children may have problems from DV exposures not all children would benefit from therapeutic interventions such as trauma therapy.
- Exposed children may have protective factors or resiliency factors that can help mitigate the effects of domestic violence exposures. For some children, other services or supports are needed to strengthen their protective factors.

Key Findings from Project Needs Assessment:

- A significant number of children residing in King County are exposed to domestic violence. Based on national estimates of children's exposure to adult domestic violence and 2000 US Census data, approximately 39,064 to 78,129 of children and youth living in King County each year are exposed to domestic violence. An estimated 128, 913 King County children and youth have been exposed to domestic violence sometime during their childhoods.[73]
- Children are being identified as having domestic violence exposures by systems-based providers including law enforcement, child protective services, family court services, and protection order programs. Yet there are few King County providers that have developed

[73] (estimates based on Carlson, 2000).

the expertise to effectively assess and intervene with children who have had domestic violence exposures.

- Those DV survivors who participated in the needs assessment project reported that they are often isolated from other family members and friends as well as to supports and services outside the family. Mothers reported that it can be difficult to address DV, especially when the abusive partner still resides with the family. For those who did access outside supports, there were problems in how systems and providers responded to their concerns and with the information they received.
- Children's isolation can prevent them from understanding and normalizing their experiences. Peer support groups with other exposed children, individual therapeutic approaches, mentoring programs and providing information/discussion in school settings are ways for children to process their experiences.
- Providers and parents reported that children need information and support to develop safety plans even when the abusive parent is no longer living with the family.
- Since children have a range of DV experiences, a range of problems from DV exposures, and differing protective or resiliency factors, a range of services and supports need to be developed and provided to best meet the needs of these children and their families. Specialized services are needed for this population including effective DV screening and assessment of the children and their families, therapeutic interventions, children and adult survivors' advocacy, case management, and linkages to community supports and services.
- Providers and parents both reported that there are little available services for young children birth through five years and early elementary ages. By reaching children earlier, supportive parents could be engaged in identifying their children's responses and needs, and strategies could be employed to strengthen the parent-child relationships. Young children's misconceptions and misunderstandings about their experiences could be modified, thus leading to improvements in their well being, coping, and relationship development. When children's DV experiences are adequately assessed, evaluated, and supported, it can alleviate social and behavioral problems and school difficulties.

Key Outcomes to Achieve:

The outcomes to achieve with individual children and their families are as follows:

- Decrease trauma symptoms exhibited by children as a result of intervention.
- Increase protective/resiliency factors available to children and their non-abusive parents.
- Reduce children's belief that domestic violence is their fault and help children correctly assign responsibility for violent behaviors.
- Improve social and relationship skills so that children may access needed social supports in the future.
- Reduce children's violent behaviors and other behavioral problems as observed in school, community, and family settings.
- Increase awareness of supportive adults in the children's natural environment so that they may provide needed social supports when necessary.

Strategy: Provide a specialized Children and Domestic Violence Response Team which integrates mental health services with community-based children's DV advocacy services. This integrated team would provide a range of services and supports based on families' strengths, needs and priorities.

Rationale for Children and Domestic Violence Response Team Model:

As previously mentioned in the literature review of this paper, community response programs designed to assist this population are still undergoing research and evaluation. There are, however, strategies that have had some evaluation of their effectiveness and are being utilized across the country. This model blends these effective practices into a co-located specialized Children and DV Response Team that provides advocacy, engages networks of support, and strengthens relationships with DV survivors and their children

The purpose of The Children and DV Response Team is to:

- Engage supportive parents in identifying the needs of their children and families
- Provide effective services and supports
- Ensure that culturally competent approaches are employed to mitigate the risks of DV exposures with children.

With this model team members would continually assess and address the safety concerns of the supportive parent and their children in all service plans and activities provided by the team. The team will utilize promising and emerging therapeutic practices for children exposed to DV including Trauma-Focused Cognitive-Behavioral Therapy (TR-CBT*)*, Parent Child Interaction Therapy (PCIT), and Kids Club* DV support groups for children.

This proposed model would meet current service gaps by providing a unique and specialized assessment of children's and families' needs and strengths. It would also seek to engage the protective parent in recognizing and supporting their children's needs, facilitating better communications between the parent and child, and thereby strengthening the supportive parent and child's relationship. The model would also provide for longer-term ongoing support of families, and facilitate better linkages and utilization of community services and resources. It would expand community capacity and responses by providing better collaboration and coordination with existing services, documenting systems gaps for local government and service agencies, and leading the development and expansion of service capacity in the community.

Children and Domestic Violence Response Team Pilot Project Overview:

It is recommended that a specialized Response Team be developed through a pilot project. It is proposed that the initial pilot project be co-located with the King County Prosecuting Attorney's Office Protection Order Advocacy Program, located at the Regional Justice Center in Kent. The integrated response team would blend the expertise of the DV advocacy and mental health fields into a coordinated system of care. The team would be comprised of community-based children's

DV advocates and mental health clinicians. The team members would provide direct wrap-around services to families. They would also enhance linkages and improve access to their agencies' services and other community services for the families served by the response team.

The design of this model should readily facilitate the participation of parents and children by:

- Engaging families who already have identified DV as an issue as they are applying for protection orders. These families are already seeking assistance for the DV and are able to talk about their concerns.
- Providing services that are voluntary.
- Empowering parents to participate in an assessment and planning process. Parents would be encouraged to lead in planning what services or activities would best support their children and family's needs.
- Utilizing community-based team members who are outside of the court system to maintain confidentiality of information shared by the DV survivor.
- Connecting families with co-located specialized service providers is an empirically proven way to provide support and interventions.

There are several factors that support the rationale for locating the first phase of this project in the Regional Justice Center. These are as follows:

- The Safe and Bright Futures Project needs assessment findings indicate that the residents of South and East King County have the largest number of children in need. The Regional Justice Center serves these areas.
- The Protection Order Advocacy program in Kent serves approximately 650 parents and 1,200 children a year. The program serves and ethnically diverse population of children ages birth to eighteen years.
- The families accessing the Protection Order Advocacy Program are already identified as having children with domestic violence exposures.
- Domestic Violence survivors voluntarily seek services from the Protection Order Advocates. They are able to talk about their experiences and are asking for help and support. Most survivors are not engaged in other advocacy or assessment services for their families at the time they are seeking protection orders.
- The Regional Justice Center location affords a safe and secure location to approach DV survivors. This location also has accessible childcare.

It is recommended that the Response Team be managed and coordinated by a community-based agency that has the following demonstrated expertise and organizational infrastructure:

- Proficiency in the mental health field
- Proficiency in serving children and families affected by DV
- A proven history of cultural competency
- A proven history of working collaboratively with other community-based services
- Supports an infrastructure that can provide project management, clinical supervision, staff hiring and management, data collection and evaluation, and grant and report writing.

Pilot Project Phase One:

The first phase of the Children and DV Response Team would be implemented over a three year period. In the first year of the project, the community-based agency will designate a project coordinator who will recruit, hire a part time children's DV advocate and a part time mental health clinician. The team would provide on-site services at the Regional Justice Center in Kent, and referrals would be generated from the Protection Order Advocacy Program. During project start up time all protocols, procedures, service criteria, screening and assessment tools, service planning tools and community referral agreements would be developed.

To document the pilot project's effectiveness, a project evaluation consultant will be secured to assist the project coordinator in developing data collection instruments and data collection procedures. Data will capture children's needs, parents needs, family strengths, services provided, family outcomes, consumer satisfaction with services, and service gaps in the community. The data will provide critical information back to King County communities on existing services that need further increased capacity or development.

As procedures and operations are piloted and funding is secured, the service team would be expanded to two full time advocates and one full time mental health clinician. At this capacity referrals could be expanded for response team services from other community providers such as schools, childcare and other systems-based providers.

Children and DV Response Team Members Roles and Functions:

All team members will work in close collaboration for the families served by the project. Although their roles are different, each team member's role and perspective would be vital and complementary. There would be an equitable balance of power and shared decision making among team members in all project activities.

The mental health clinician's roles:

- Provide comprehensive clinical assessment of children and their families. The assessment would include the following information:

    - Families' DV histories
    - Existing DV safety issues or lethality risks
    - Safety planning needs
    - Children, parents and families' strengths and protective factors
    - Available support networks
    - Assessment of the children's mental, social, emotional, developmental and functional patterns
    - Assessment of parent-child relationships
    - Assessment of service utilization and/or or access barriers with available community resources and supports
    - Assessment of families' priorities and willingness to engage in services.

- Develop service plans with the children's DV advocate for families needing intensive support.
- Identify which children would benefit from therapeutic interventions. The clinician would provide direct therapeutic services for those without resources or would link families to providers who could deliver services.
- Assist and support the children's DV advocate with the service plan implementation through regular case staffing, review of the family's progress, and problem solving any identified issues.

The children's DV advocate roles:

- Provide outreach to families. This includes providing information about the project, screening families for their eligibility and willingness to engage in project services, assessing family safety concerns, and facilitating appointment scheduling with the mental health clinician for full assessments.
- Provide coordination and problem solving with all team members, and assisting with the development/implementation of service plans.
- Provide case management services and facilitate the ongoing development of safety plans with DV survivors and their children.
- Provide ongoing support for non-offending parents and facilitate linkages to DV advocacy, support, education, parent support groups, basic needs community resources and other community support services. Other linkages would be made for support services such as mentoring programs like Big Brothers/Big Sisters, tutoring, after school programs, camps and recreation programs.
- Employ strategies that reduce access barriers and facilitate linkages to children's services such as early childhood developmental services or childcare or education programs.

Children and Domestic Violence Response Team Service Flow:

The Response Team would provide services to families served by the Protection Order Advocacy Program. The following section describes how families are contacted and connected to the response team, screening and assessment procedures, and the provision of services and supports.

- ***Protection Order Advocate provides initial contact***. Protection Order Advocate briefly offers information, informs parent of the response team, and offers referral to advocate.
- ***Family accepting referral is connected with on-site Children and DV Response Team's advocate.*** Families accept or decline. Those declining are offered information with resources for future use.
- ***Children and DV Response Team advocate provides initial screening of family needs and informs parent of program.*** Families meeting service criteria are scheduled for comprehensive assessment with mental health clinician. Families not willing or not in need of service are provided community referrals.

- ***Mental health clinician meets with family and conducts a comprehensive strengths-based family assessment.*** Assessments will be scheduled at a safe and accessible location that best meets the family's needs.
- ***Service plan is developed.*** The children and DV response team members will evaluate the assessment data and develop the service plan for families requiring and wanting intensive support.
- ***Clinician provides therapeutic interventions or links family to other providers.*** Services are to be flexible and to be provided in a location that best meets the family's needs.
- ***On-going case management is provided by the Children and DV Response Team advocate***. Case management is to be accessible and flexible to meet family needs. The mental health clinician provides consultation and support to the case manager. The advocate facilitates linkages to community resources for the children and their parents.

Projected Cost of Phase One Pilot Team:

Developing a full team at the RJC during the first three-year period would cost approximately $260,000 per year. The project is proposed to be phased in over three years in the following order:

- Partial Team 1: Cost of 1.0 FTE advocate and .5 FTE clinician ($130K/yr)
- Partial Team 2: Cost of 1.5 FTE advocate and .75 FTE clinician ($195K/yr)
- Full Team: Cost of 2.0 FTE advocate and 1.0 FTE clinician ($260K/yr)

Proposed Phase Two Pilot Project:

Contingent upon data collection and analysis with the pilot project, it is proposed that a second response team be co-located at the King County Superior Court Courthouse in Seattle in order to provide geographic coverage throughout King County. After the team is established, referrals could be accepted from other community providers.

In addition to providing direct services to families, the project team members would also serve as community experts and consultants to other providers. The team members would be a resource for training in order to increase the expertise and capacity of other providers to provide effective screening and assessment of children, effective interventions, and community supports.

Section Seven: Strategies for Professional Providers

The professional providers' workgroup was staffed by the project's Design Team members, Project Management Team, and Advisory Group. This workgroup consisted of expertise from mental health, DV coalition, family court, juvenile court, DV program management, and public health's childcare program.

Goal for Professional Providers:

The goal is to improve the mental health system's response to children exposed to DV and their families.

Rationale for Targeting Mental Health Providers:

The Safe and Bright Futures Project recommends that strategies be implemented with providers in the mental health system for the following reasons.

- The mental health system is a primary source of help and support for children who are exposed to DV.
- The mental health system would provide direct therapeutic services and supports for children referred by the Safe and Bright Futures Project, Children's Domestic Violence Response Team (see Section Six).
- As mentioned in Section Four, the King County DV and Child Maltreatment Coordinated Response Project is currently developing a guideline for systems based providers who respond to families with DV and child maltreatment concerns. Extensive training and support is being planned for systems based providers including Child Protective Services, courts, and law enforcement; thus, these providers were not prioritized for this project.
- The Safe and Bright Futures Project recognizes that responses for children exposed to DV should be improved in other community settings, such as schools and childcare. It is recommended that professional training for DV screening, responses, and referral should be expanded to include staff in schools and daycare settings.

Key Outcome to Achieve:

The following key outcomes to be achieved are as follows:

- Increase the expertise of mental health providers to identify, assess, and help children exposed to DV.
- Increase the capacity of the mental health system to serve children affected by DV.

Key findings from project need's assessment:

In the project needs assessment's focus groups, interviews, and stakeholder meetings, it was identified that mental health providers have received little training about the dynamics of DV in families, or specific therapeutic approaches for assisting children exposed to DV. Mental health providers would benefit from comprehensive DV training to include:

- Standardized DV screening to minimize misdiagnosis and ineffective responses.
- Domestic Violence Children and Family Assessments that screen for:
  - Frequency and types of DV exposures
  - Effects of DV exposure on the children's cognition, emotions, behaviors, and coping
  - Children's strengths and protective factors
  - Relationship concerns with DV survivors and their exposed children
  - Family safety concerns.
- Development of DV safety plans with families.
- Targeted interventions which address the emotional, behavioral, and developmental needs of children birth through five years who are exposed to DV.

The needs assessment project also identified that children exposed to DV often have limited access to mental health services for these reasons:

- *One,* families have insufficient resources or medical insurance benefits for mental health services.
- *Two,* exposure to DV alone does not meet diagnostic criteria for mental health services. In order to meet diagnostic criteria children must have significant emotional or behavioral symptoms to qualify for services. Not all children affected by DV show clinical symptoms but do need support and follow up care.

Strategy One: Improve DV expertise of mental health providers through the development and implementation of a pilot DV training project.

The expertise of mental health providers could be supported through training, technical assistance, and case consultation services. It is proposed that a pilot comprehensive DV training project be developed for King County mental health providers. It is recommended that an agency with extensive knowledge of DV and King County mental health providers be the designated lead for this project. It was identified that the King County Coalition Against Domestic Violence (KCCADV) be the designated leader for the strategies in this section. A project coordinator would be hired to direct the project and provide technical assistance to project participants.

Overview of Proposed DV Training Project

The project coordinator will work with a community advisory group and with area mental health and community based DV agencies to develop the training project. The community advisory group will also advise and support the development of a case consultation model for providers participating in the pilot projects. The following activities are to be achieved in the project:

- ***Develop Needs Assessment.*** A project needs assessment tool(s) would be developed which identifies strengths and gaps with current agency practices. The needs assessment tool will gather information in the following areas:
    - Client intake procedures
    - DV screening procedures and practices
    - Assessment tools that evaluate how DV affects children and families' physical, emotional, cognitive and social functioning, and identifies what therapeutic practices and services are needed.
    - Service plans and documentation procedures
    - Level of staff training, knowledge, and experience in therapeutic interventions for children's DV exposures
    - Providers' knowledge of DV in families
    - Providers' knowledge of the effects of DV exposures on children
    - Knowledge and experience in DV safety planning
    - Case consultation practices.
- ***Recruit pilot agencies*** to participate in the training project.
- ***Conduct needs assessment*** with pilot agencies.
- ***Develop or revise agency policies and procedures.*** In conjunction with pilot mental health agency staff, the project coordinator would recommend changes to agency policies and procedures (such as revising intake forms, screening criteria, and assessment tools). The project coordinator would work within agency hierarchy to have changes adopted.
- ***Develop evaluation criteria*** to assess effectiveness of newly adopted policies and procedures.
- ***Develop agency DV training plan*** in conjunction with pilot mental health agency staff. This is to include training on new policies, procedures, and screening/assessment tools, as well as case management and clinical interventions with children and families.
- ***Obtain DV training curricula.*** Identify and obtain DV education curricula targeted for mental health providers.[74]
- ***Develop and adopt training curricula and materials*** with pilot project agencies.
- ***Develop pretest and posttest evaluation measures*** to evaluate changes in knowledge and skills of mental health providers attending DV training.
- ***Implement DV training*** in pilot sites.

[74] Curriculum example: *Shelter from the Storm: Clinical Intervention with Children Affected by Domestic Violence: A Curriculum for Mental Health Clinicians,* www.childwitnesstoviolence.org

- ***Collect data and analyze effectiveness of DV training.***
- ***Conduct data and analyze provider practices*** based on new policies, procedures and training.
- ***Modify policies and DV training procedures.*** In conjunction with pilot agency staff, make changes to policies, procedures and training as indicated by evaluation results
- ***Disseminate training.*** Use pilot project results to support expansion of comprehensive mental health provider training throughout King County.

Strategy Two: Identify and advocate for other policy changes that would make the provision of mental health services for children exposed to DV financially sustainable.

A critical component of assisting children exposed to DV involves ensuring that mental health assistance is available and that mental health services are adequately reimbursed. This is vital so that services are financially sustainable and mental health agencies can provide them. Three important areas need to be considered in achieving financial sustainability:

- *One,* changes need to occur in how Medicaid and commercial private insurance funds mental health services for children exposed to DV.
- *Two, m*any children do not qualify for Medicaid because their parent's income is too high (these families are often described as the "working poor"). Although they are employed, many lack health insurance coverage and cannot afford to pay for mental health services. Identifying alternative funding sources for these families is critical.
- *Three,* local funders of mental health agencies could consider adopting a mix of contract incentives and requirements so that publicly funded mental health agencies would improve their ability to respond to children and families exposed to DV.

Recommendations for Medicaid and Private Insurers

Currently, in order for mental health services to be supported by Medicaid, the "client" must meet a threshold of emotional and behavioral symptoms that constitute medical necessity. For clients who do have Medicaid, therapy for DV exposure needs to be better integrated into the Medicaid Medical Necessity Model. In 2004, the Center for Medicaid and Medicare Services (CMS) amended the Access to Care Criteria, thus narrowing the availability of mental health services for those without significant mental health problems. Often exposure to DV alone does not meet diagnostic criteria for mental health services. Not all children affected by DV show clinical symptoms but do need support and follow up care. As a result, unless a child exposed to domestic violence is exhibiting significant problems they no longer qualify for mental health care. The CMS created specific Access to Care Criteria (Criteria B) that would enable access to mental health services if the potential client meets one or more of the criteria. Advocating for policy change at the CMS level to include "exposure to domestic violence" as one of these criteria would guarantee access to mental health services for Medicaid eligible children affected by DV.

It will also be important to be able to integrate DV therapy into private insurance coverage. Again, the issue of medical necessity often excludes all but the most severely affected children. The child is evaluated in the light of his or her behavioral and emotional problems, and a diagnosis is given. For these children the focus is often on ameliorating the children's behaviors or symptoms and not on addressing the experience of violence in the home. Domestic violence has been repeatedly identified in the research as a predictor of future behavioral and mental health problems. It stands to reason, that early intervention is necessary if we are to prevent the worsening of symptoms resulting from exposure to domestic violence, as well as address the increased costs of treating these children affected by domestic violence. The insurance companies must be encouraged to modify their authorization criteria to include exposure to domestic violence as a justification of the need for mental health services.

Possible actions:

- Review funding policies for Medicaid and commercial insurance that affects payment for mental health services to children and their families who are experiencing DV.
- Analyze issues and strategies which can be addressed at local and statewide levels.
- Develop proposals for policy change that will improve funding and payment for these mental health services.
- Identify advocacy groups and key partners who can collaborate and mobilize efforts to get improved policies adopted.

Alternative Funding

The King County region has a relatively healthy mix of private and public funders of health and human services, including mental health services. A number of local initiatives have the potential to result in increased levels of funding for such services. In order to ensure that the kind of services envisioned in this plan will be eligible for any new sources of funding, advocacy will be required.

Possible Actions:

- Identify regional and state-wide groups that are involved in advocating for funding for health and human services (for example, the KCCADV, King County Alliance for Human Services, and the Children's Alliance).
- Monitor and participate in efforts to secure new funding for community health and human services.
- Communicate with policy makers about the needs of children affected by domestic violence and the plan for improved services.
- Identify opportunities to influence funding eligibility criteria for any new funding sources.

Contract Requirements and Incentives

It is recommended that local funders consider a mix of contract incentives and requirements to motivate publicly funded mental health agencies to improve their ability to respond to children and families exposed to domestic violence. It will be important to recognize that agencies already face a host of pressures and mandates that they struggle to meet, and often with inadequate resources.

Possible Actions:

- Amend the list indicators that King County and other local funders require mental health providers to report on so that it includes children's exposure to DV as an indicator.
- Build contract incentives and/or requirements for *publicly funded* mental health agencies to support the delivery of evidence-based mental health interventions and services for children affected by DV.
- Develop financial incentives for *private providers* to provide evidence-based mental health services for children affected by DV.

Section Eight: Strategies for King County Communities

The community workgroup was staffed by members of the project management team, design team and advisory group. Workgroup members represented expertise of community DV advocacy, city DV prevention offices, community health and safety network, community agency providers, Men's Network Against DV, and public health. The workgroup formulated goals and outcomes as well as key strategies to achieve the goals and outcomes for work with the community.

Goals for Community:

Two primary goals were identified for working with community members.

- Communities throughout King County act collectively to foster attitudes and norms that DV is not acceptable in the lives of children and their families.
- Communities take steps towards eliminating the incidence of DV with children and their families.

Three main strategies were formulated by the community workgroup to achieve the above goals. The remainder of this section outlines the recommended strategies to implement in King County communities.

Strategy One: Implement a Children and DV Community Education Campaign.

Key findings from project's needs assessment:

A dominant theme from the needs assessment was the necessity of developing community education campaigns regarding children affected by DV. Both community providers as well as DV survivors identified that there is not enough information available in communities. There are a few public service announcements on this issue on television and radio. Nor are there many billboards campaigns, posters, or other signs available about DV and children. More information and materials are needed to reach out to all community members.

Key outcomes:

The key outcomes to be achieved with the Children and DV Community Education Campaign are as follows.

- Help community residents gain knowledge, understanding and recognition of the impact of DV on infants, children and youth.
- Help community residents learn to recognize and support children exposed to DV, and how to safely take action.

To prepare for the development of the campaign it was recommended that a community education planning and oversight committee first be established. Members on this committee would be comprised of local experts on social marketing, public health education, mental health, and domestic violence. This committee would be responsible for the development and evaluation of the education campaign. The work of this committee would be implemented over a three year project period.

Community Education Project Year One:

In the first year of the education campaign project, the following action items would be implemented:

- The community education committee would identify and recruit key partners across King County, such as public health, grassroots organizations, and the media, to act as advisors and assist with the work of the project.
- The community education committee and its partners would convene a "Great Minds Symposium." Panel participants would include local experts in social marketing who have knowledge and experience in developing and implementing successful King County community education campaigns. Panel participant would be asked to bring their insight and experiences from social marketing campaigns and tools or program materials from other educational efforts or from other national children and DV campaigns. This symposium would help identify key resources, strategies and campaign evaluation considerations for the development of the community education campaign.
- The community education committee would then evaluate the materials and recommendations made by the symposium participants. The key campaign elements and methods would be formulated and a scope of work would be developed for the hiring of the project coordinator. The project coordinator would then coordinate and implement the project activities.

The project coordinator in collaboration with the community education committee would develop the children and DV campaign. All community education messages and materials would be developed for implementation in year two of the project. The work of this project would include:

- Developing key messages for communities at large.
- Identifying key subpopulations to target for community education campaign.
- Developing messages that are culturally and language specific for key subpopulations.
- Conducting focus groups with adult DV survivors for messages development.
- Determining the primary methods to be employed in the delivery of the messages.
- Recruiting pilot sites to deliver messages and participate in project evaluation.
- Secure an evaluation consultant and develop the evaluation plan.

Community Education Project Year Two:

In the second year of the project, community baseline information about community awareness would be collected for project evaluation. The campaign would then be implemented in pilot

sites for the community at large and each identified subpopulation. Evaluation data would be collected through this campaign implementation phase and compared to the baseline data. Additionally, long term project implementation resources would be identified and secured.

Community Education Project Year Three:

In the third year of the project, all evaluation data would be analyzed to assess program effectiveness. Focus groups with adult DV survivors and community providers also would be conducted to assess project effectiveness of materials developed and methods employed for message dissemination. All messages and materials would be adjusted and revised per information obtained through the evaluation process. Revised materials would be made available throughout King County. The project coordinator and community education campaign planning committee would develop a plan for the ongoing dissemination of project materials. This plan would also include provisions for further review, analysis, and revision of project materials.

Strategy Two: Expand and assist with the implementation of "*Coaching Boys Into Men*" Campaign.

Key findings from project's needs assessment:

A key theme identified in the needs assessment was that communities should implement strategies to change social norms and values that reinforce or perpetuate DV. It was also identified that communities should engage males as mentors and role models to effect change with boys and young men.

Key Outcomes:

The outcomes to be achieved with the Coaching Boys Into Men Campaign Project would be to:

- Increase knowledge, understanding and recognition of the effect of DV on children and youth with coaches, male leaders, and adult male role models in specific ethnic communities.
- Increase understanding, recognition and skills of boys/youth to develop healthy intimate partner relationships.
- Increase the willingness of men to safely take action and address DV among family members, friends, and the young men with whom they interact.

The Coaching Boys Into Men project is a primary prevention campaign that was developed by the Family Violence Prevention Fund (see: http://www.endabuse.org/cbim/). This campaign has been evaluated and has shown to increase anti-violence attitudes and norms, and be an effective way to engage adult men with the mentoring of boys/youth. This campaign was designed to give coaches the skills to encourage healthy relationship development for boys and young men.

Coaches are trained to address unhealthy behaviors and encourage and reinforce healthy behaviors by implementing a value system within the team environment. Coaches are provided a "playbook" tool that gives information on the problem of violent attitudes and behaviors in boys/youth, their important roles with boys and ability to facilitate change, and how to respond to unhealthy attitudes and behaviors. Likewise, the program has made informational pamphlets for fathers, including one adapted specifically for African American fathers. Additionally, the program has also developed public service announcements and posters for community campaigns.

In 2006 the King County, the Men's Network Against DV (MNADV) began to implement the Coaching Boys Into Men campaign. MNADV has begun to secure funding and develop staff capacity to implement this program. MNADV received training in this program and started recruiting and training coaches of sports teams to implement this program. However, their efforts are just beginning so the current program is very limited in its capacity to serve children. MNADV is seeking to increase community partnerships to effectively provide this program throughout the county.

The King County Safe and Bright Futures Project has identified that the Coaching Boys Into Men campaign would be an effective way to increase the involvement of men, increase education and support to boys/youth, and facilitate social norm and attitude changes. It is recommended that we partner with the MNADV to increase financial resources and staff support in order to expand their capacity to provide this campaign. MNADV would continue to direct and coordination the Coaching Boys Into Men campaign.

Through the Safe and Bright Future project's needs assessment it was identified that many at risk youth have barriers that prohibit their participation in organized sports and thus would not benefit from the campaign as it is currently designed. Also, the campaign has not been adapted to cultural norms, attitudes and practices which could impact its effectiveness in ethnically diverse communities. Therefore, in expanding the current effort the following is also recommended.

- *One,* it is recommended that the Coaching Boys into Men playbook be adapted for use outside sports teams. The principles, methods and responses outlined in the playbook could be utilized with other supportive adult males who work with boys/youth. Male leaders could be recruited and trained to implement the campaign in other settings such as schools, youth and family organizations, after school programs and faith based programs.

- *Two,* it is recommended that male leaders in ethnically diverse communities would be recruited to implement this campaign. These male leaders would help to identify cultural norms, attitudes and behaviors that would need to be incorporated into the campaign and adapt materials as needed. These male leaders would also identify opportunities to engage and work with the boys/youth in their communities.

- *Three,* it is recommended that community leaders from the ethnic communities that have implemented the campaign participate in program evaluation activities to evaluate the

campaign's effectiveness. It is recommended that a minimum of three years is needed to implement and evaluate the campaign.

Strategy Three: Encourage and assist community organizations to provide evidence-based DV education to children and youth.

Key findings from project need's assessment:

Two major themes were identified in the project's needs assessment:

- The need to increase opportunities for children to learn and talk about DV. It was strongly recommended to provide education across children's lifespan and developmental stages.
- The need to foster the development of non-violent, non-abusive relationship skills for all children in King County. It was also suggested that in order to have the broadest engagement of children, programs should be developed and implemented in education or school settings as well as other programs in community settings.

The needs assessment identified that there have been efforts in some King County middle and high school settings to provide DV education, particularly for the prevention of teen dating violence. The recommendation is to expand the availability of effective violence prevention education curricula for all children. Education curricula should be provided to preschools and early elementary school children as well as middle and high school children and youth.

An example of a standardized and evaluated DV education program aimed at promoting healthy behavior and reducing risky ones among adolescents is "*The Fourth R*", which is a comprehensive school-based program developed in Ontario, Canada.[75] The program is being evaluated in a randomized trial among 20 schools in Ontario and preliminary results indicate greater changes among boys and girls in demonstration schools when compared to other students in their knowledge and awareness of relationship violence, sexual health and substance use or abuse and that boys in demonstration sites showed a significant decrease in use of relationship violence when compared to those in control sites.[76] Other DV education curricula and programs have promising results and will also be considered.

Key Outcomes:

The key outcomes to be achieved with the provision of evidence based DV education to children/youth are to:

- Children and youth increase their understanding and recognition of abusive behaviors and develop healthy relationship skills.
- The long term outcome would be that children and youth would have healthy relationships with future intimate partners.

[75] See: http://www.thefourthr.ca
[76] Wolfe et al 2005

To achieve this strategy several phases would need to be implemented over a minimum of two to three years. It has been recommended that the King County Coalition Against DV or other community-based organization serve as the lead agency to implement this strategy. The long term goal is to increase the expertise and capacity of community providers in King County to provide DV education to children.

Proposed Project Phase One:

A project coordinator would be recruited and hired for the project. The project coordinator would serve as the project lead and would organize, implement and coordinate the work of the project. The coordinator also becomes the technical expert to the community.

The coordinator would convene a children/youth DV education committee with countywide representation. Committee members would be recruited from preschool and child care settings, early elementary, middle and high schools, after school programs, parks and recreation programs, and youth & family programs. In addition, community based DV advocates, including specialized DV providers serving specific populations, and health educators would be recruited. This committee would work in collaboration with the project coordinator and assist in the project development. The committee would help to identify what training curricula are currently being implemented in the county, what schools are participating and what have been the experiences of those using the curricula.

The project coordinator, with the assistance of the education committee, would research available education curricula and make recommendations on what materials to obtain. The project coordinator would obtain recommended curricula and receiving training/certification on curricula. The project coordinator would develop a clearing house of training materials across children's developmental stages as a resource for King County providers. Evaluation tools would be collected and evaluation plan will be developed to assess curricula effectiveness. It is anticipated that phase one of this project would require additional dedicated financial resources to obtain evidence based training curricula and required training/certification to utilize the curricula.

Proposed Project Phase Two:

The project coordinator would provide technical assistance and training to other community partners. The project coordinator and community partners would design and implement a "train the trainer" and/or certification process for community providers to implement the curricula. A registry would be developed for providers and agencies that have been certified to implement DV education curricula. Pilot sites serving children ages preschool through high school would be selected. Pilot sites would include urban and rural settings and culturally diverse groups. Curricula will be implemented by the trained community providers, with technical assistance and support of the project coordinator. Evaluation data would be collected by all pilot sites.

Proposed Project Phase Three:

The project coordinator and the training committee would analyze the evaluation data. Evaluation is to include assessment of training content and materials, student responses, observations and discussions teachers or community providers have had with the students post training, and observations of the trainers. Effective training curricula would be identified through the review of the evaluation data. Policy recommendations would be developed for the provision of DV education curricula to children/youth. The project findings and policy recommendations would be disseminated to city and county governments, preschool programs, school districts and other community programs.

Section Nine: Discussion and Next Steps

To effectively respond to the needs of children exposed to DV in King County and diminish the incidence of DV exposures multiple strategies will need to be employed. The King County Safe and Bright Futures Project identified three key domains or areas for intervention, which are individual children and their families, professional providers and King County communities. Strategies were then developed for each domain and are as follows:

For individual children and their families the key proposed strategy is:

- Develop and pilot a specialized children and DV response team which integrates mental health services with community-based children's DV advocacy. This integrated team would provide a range of services and supports based on families' strengths, needs and priorities.

For professional providers two key strategies are proposed:

- Improve DV expertise of mental health providers through the development and implementation of a pilot DV training project.
- Identify and advocate for other policy changes that would make the provision of mental health services for children exposed to DV financially sustainable

For King County communities three key strategies are proposed:

- Implement a Children and DV Community Education Campaign.
- Expand and assist with the implementation of "Coaching Boys Into Men" Campaign.
- Encourage and assist community organizations to provide evidence-based DV education to children and youth.

Federal Funding of Safe and Bright Futures Project Strategic Plans

The Safe and Bright Futures for Children Initiative project provided an important opportunity to engage community providers and residents of King County in planning for the needs of children exposed to DV. The initial Safe and Bright Futures Phase One grant award allowed for an extensive community assessment and development of a strategic plan. It was projected that competitive grant applications for Phase Two implementation projects would occur at the end of the two year planning grant period. Unfortunately, the Safe and Bright Futures recipients were notified in March 2006 that the Phase Two funding was not available. Despite this loss of funding, the project's design team community partners remained committed to the project and successfully completed their comprehensive plan. At this time there have not been other federal agencies that have been able to commit funding for community pilot projects. Other strategies for funding by local/state, and public/private partners will be needed to realize the work of this Safe and Bright Futures Project.

Implementation of Safe and Bright Futures Plan

Several factors need to be considered in implementing the strategic plan. These include supporting DV survivor services, identifying community champions and staging of strategies implementation through pilot projects.

- ***Full support of DV survivor services:*** Service expansion to children cannot be provided in lieu of basic safety, advocacy and crisis services that are currently in place for adult survivors of DV. As funding resources continue to erode for community DV agencies, it is has been quite difficult just to maintain current service capacity. The funding challenge for this Safe and Bright Futures plan will be to fully support these crucial adult DV survivor services while improving our ability to serve children. In order to do this, new funding partners need to be secured that have not been involved in addressing DV in the lives of children and their families. This can include other non-profits, private foundations, faith based communities, and business organizations.

- ***Community champions:*** To facilitate broad social changes to end DV in the lives of children and their families, community leaders will need to be identified and recruited to champion the cause. This will need to occur throughout public and private sectors. Community champions are crucial to ensure that attention remains focused on this issue and that community members are mobilized to support efforts in better serving children and their families. Community champions can also be instrumental in recruiting funding partners and mobilizing fund raising events.

- ***Pilot projects:*** With the work of this Safe and Bright Futures Project, community members have increasingly begun to dialogue and contemplate what is needed for children and families exposed to DV. There has been great interest and desire expressed with the project's community partners and community constituents to find ways to provide better supports to these children. As the momentum has been building over the last decade to make changes in how we currently provide services to children, it is important that targeted services are developed and implemented. It is important that we expand our capacity to effectively serve children who are exposed and affected by DV. One way to begin to plan implementation is through the development of pilot projects. Therefore it is recommended that a pilot specialized DV and children response team be initiated. The pilot project could document trends and needs of children exposed to DV, what supports are helpful to families and document the effectiveness of case management and therapeutic interventions.

Considerations for Coordination with Other Existing Efforts

There are some potential opportunities for the development of partnerships in order to implement the plan developed through the Safe and Bright Futures Project. The following section presents some possibilities for partnerships.

- ***Early Intervention Services:*** It was identified in the needs assessment that few intervention services are available for infants and toddlers exposed to DV. One potential resource for these children is through the Individuals with Disabilities Education Act (IDEA). IDEA provides Part C funding for early intervention supports and services to families with infants and toddlers who are at risk of developmental and behavioral problems, including traumatic distress and regulatory disorders. Part C funding and programs could be an effective resource to families with infants and toddlers exposed to DV and provide early intervention services by a skilled infant mental health therapist. Partnerships with the early intervention birth to three centers and Division of Developmental Disabilities could be developed for screening and assessment of infants and toddlers exposed to DV.

- ***School Readiness Programs:*** As previously presented in this report, children exposed to DV can suffer adverse risks to their overall development and ability to learn. Efforts could be initiated to provide effective assessment and supports to children exposed to DV in early childhood settings. One potential partnership is with the organizations that are developing school readiness efforts for young children. Washington State developed the Department of Early Learning in 2006. This department coordinates efforts across the state to better prepare infants and preschool children to be socially, emotionally and cognitively prepared to succeed in academic settings. The Department of Early Learning is also working in collaboration with other partnerships including the "Thrive by Five" projects in Washington State. The Thrive by Five projects are private-public partnership non-profit organizations dedicated to increasing school readiness for children birth through five. This could be an excellent opportunity to develop effective screening of families with young children for DV exposures and engaging families in comprehensive assessments and services.

- ***Mental Health Partnerships:*** It was identified in the needs assessment that there needs to be an expansion of mental health services to children exposed to DV and their families. With the current system of care it is difficult for families to engage in and access mental health services. Washington State has received a five-year Transformation Project, entitled "Partnerships for Recovery" from The Substance Abuse and Mental Health Services Administration. This provides an opportunity to plan significant system reform, and facilitate changes through the various publicly funded systems providing mental health care. The goal of Partnerships for Recovery is to build an infrastructure that supports an array of effective and accessible mental health services. This is an opportunity to collaborate with publicly funded mental health partners on how to better screen, assess and provide accessible services to children exposed to DV.

- ***Homelessness Services Partnerships:*** DV is a leading cause of homelessness for families. In King County, DV shelters and transitional housing programs cannot meet the demand for services. Lack of longer term affordable housing also increases risk for homelessness with families experiencing DV. Increasing the capacity of long term

housing options could enhance survivor's abilities to maintain their independence from abusive partners and provide for safe and stable family environments so that children can recover from DV exposures. Better partnerships should be developed among those who serve homeless families to effectively assess and plan for the needs of children and their families experiencing DV.

- ***Criminal Justice System Partnerships:*** Criminal Justice Systems across the county have been strong leaders and social change agents in addressing DV. As discussed earlier in this paper, The National Council of Juvenile and Family Court Judges spearheaded the Greenbook Initiative Projects for "Effective Intervention in Domestic Violence & Child Maltreatment Cases".[77] The criminal justice system in San Diego also began the creation of Family Justice Centers as a way to provide better engagement in court/legal services with adult DV survivors. It is important to ensure that families involved in the criminal justice system and Child Protection Services/Child Welfare Services receive adequate DV screening and assessments so that the children and their families receive adequate interventions and support for their DV exposures. Strong partnerships should be developed with these systems, as they often see children who are at the greatest of risk for problems from their DV exposures.

- ***Violence Against Women Act (VAWA):*** In 2005 the U.S. government reauthorized VAWA. With the reauthorization new provisions were added to include intervention services and prevention programs for children and teens exposed to DV. This important legislation was the first to establish the need to provide effective services for children. Currently, there has not been funding allocated to support the development of these programs. Federal funding through VAWA could be an important long-term support for the development of community based projects for children and families.

[77] NCJFCJ, 1999.

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