SUFFOLK COUNTY
SAFE & BRIGHT FUTURES FOR CHILDREN INITIATIVE

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Identifying and Meeting the Needs of Children and Adolescents Exposed to Domestic Violence

FINAL REPORT
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Introduction

The Safe and Bright Futures Initiative was launched by the U.S. Department of Health and Human Services (DHHS) in 2003 to encourage communities to plan, develop, implement, and sustain a coordinated system of prevention, intervention, treatment, and follow-through services for children who have witnessed or been exposed to domestic violence.[1] In 2004, *The Child Witness to Violence Project* at Boston Medical Center and the *Children's Advocacy Center of Suffolk County* received a grant from the U.S. DHHS to create the Suffolk County Safe and Bright Futures for Children Project (this point forward "The SBF Project"), a two-year effort to design and implement a community needs assessment targeting the availability and delivery of services to children and adolescents exposed to domestic violence (CEDV).

The SBF Project sought to identify ways to improve the current response and coordination of care among the various systems serving CEDV. Designed and directed by a four-person Leadership Team, consisting of the directors of the two lead agencies, Betsy McAlister Groves and Susan Goldfarb; the full-time SBF Project Coordinator, Melissa Hagan; and an independent strategic planning consultant, Elizabeth O'Connor, the process was informed by continual feedback from more than 30 community stakeholders (see Appendix A for a complete list). The *quality* of services was not assessed during this Project; instead particular attention was paid to the service needs of CEDV and opportunities to increase and enhance the capacity of systems to meet those needs. All SBF Project activities were implemented by the SBF Project Coordinator and guided by the Leadership Team while an on-going dialogue with participating agencies was facilitated through direct contact, email correspondence and an SBF Project web site.

This report provides a detailed overview of the findings from the needs assessment, possible interpretations of these findings as well as recommendations on how these findings could be used to improve services to children and adolescents affected by domestic violence. All interpretations and recommendations, unless otherwise stated in the report, are from the perspective of the members of the Leadership Team. They are offered with the assumption that resources and programs are constantly changing, and that a continuing dialogue among stakeholders, service providers, and consumers is needed to meet the unique needs of this population.

Scope of the Problem

Domestic Violence and Child/Adolescent Exposure: National & Regional Prevalence

National surveys tell us that between 25-31% of women and between 7-22% of men experience some form of domestic violence (DV) during their lifetime, and approximately 1.3% of women and .9% of men experience physical

DV each year.[2,3,4] However, a recent study found that as many as 21% of dual-couple households experience DV annually.[5] According to the 2001 Massachusetts Behavioral Risk Factor Survey this rate is even higher in the Commonwealth. 2.3% of Massachusetts residents surveyed and 1.4% of those living in Suffolk County reported at least one incident of DV during the preceding year.[6] A disproportionate number of these individuals are foreign born: although immigrants and refugees make up only 13.7% of the state's population, 37% of all domestic violence homicide victims between 1993 and 2003 in Massachusetts were immigrants or children of immigrants.[7]

It is estimated that at least 93,600 individuals over the age of 18 living in Massachusetts and 7,580 adults in Suffolk County report experiencing DV in a 12-month period.

Unlike children who may be victims of child abuse or intentional injury and whose injuries are obvious, children who live with domestic violence are often hidden victims.[8] According to a study published earlier this year, approximately 15.5 million American children (ages 0-17) live in dual-parent families in which some form of intimate partner violence occurred at least once in the previous year; this estimate represents almost 30% of the total number of children in the United States living in married or cohabiting opposite-sex households.[5,9] Given that same-sex couples and single-parent families were excluded from this study, this number is likely to be an underestimate.

There is currently no direct way to identify the number of children and adolescents exposed to domestic violence in Suffolk County, so it is necessary to extrapolate from published studies and estimate by applying those findings to local demographics. Based on the results of the recent study which found that 1 out of 8 married/cohabitating couples experienced DV in the last year and had children living in the home (with each couple reporting 2 children on average), we can estimate that at least 25,000 children and adolescents in Suffolk County are living with married/cohabitating opposite-sex couples who have experienced DV in the previous 12 months. Research undertaken in a Boston hospital adds further evidence. A study conducted at Boston Medical Center's outpatient pediatrics clinic found that 28% of children age 6 and under had witnessed severe or moderate violence over a 12-month period; half of this violence occurred in the home.[10] Another study in the pediatrics clinic of this hospital found that 40% of a sample of 160 mothers visiting the clinic and living in high crime neighborhoods of Boston had sought a restraining order against an abusive partner.[11]

Effects of Domestic Violence Exposure on Children and Adolescents

There are many studies that have focused on the impact of domestic violence on children and adolescents.[12] These studies indicate that domestic violence may affect children's emotional, cognitive, and moral development as well as their ability to learn and function in school; it is associated with greater rates of antisocial behavior, substance abuse, mental illness, and adverse health outcomes in adulthood.[12,13,14,15,16] According to researchers from the National Child Traumatic Stress Network, teenagers who experience traumatic stress as a result of witnessing violence have an increased risk of becoming juvenile offenders.[17] Children who grow up with domestic violence may also learn powerful lessons about the use of intimidation and force in relationships. Exposure to domestic violence may affect children's social functioning and their ability to negotiate intimate relationships in adolescence and adulthood. In violent homes, children learn that aggression is an integral part of intimate

relationships, or that it is acceptable to relieve stress by yelling at or threatening another family member.[18] These lessons do not work well for children in other social contexts; they may misinterpret other children's behavior or behave in distrustful and aggressive ways.

Young children appear to be particularly vulnerable to the effects of domestic violence. Davidson and Connor (1999) found that if an adult and a child were exposed to the same traumatic event, a child under the age of 11 was three times more likely to develop symptoms associated with PTSD[19]. In a study of children under the age of four, Scheeringa and Zeanah (1995) found that the child's perceptions of the danger toward his/her caretaker was a strong risk factor for the development of PTSD.[20] Young children's perception of their own safety is closely linked to the perceived safety of their caregivers, and if that caregiver is not safe, the effects may be profoundly overwhelming. Perhaps the greatest distinguishing feature of domestic violence for young children is that it psychologically robs them of both parents. One parent is the terrifying aggressor; the other is the terrified victim. For young children who depend exclusively on their parents to protect them, there is no refuge. They cannot trust that their caretaking environment will reliably protect them and this increases their psychological vulnerability.[21,22,23]

A retrospective analysis of clinical information from 149 children under the age of seven seen in *The Child Witness to Violence Project* at Boston Medical Center gives an interesting profile of young children whose parents decide to seek help for exposure to domestic violence. The majority (73%) of referrals were boys. Nearly two-thirds of the children had been exposed to violence chronically since birth, according to parent report. The most common symptoms mentioned by parents were increased aggression, impulsivity, temper tantrums, sleep dysregulation, and separation anxiety. In addition, parents mentioned preoccupation with the violent event, as seen in play and verbalizations, avoidance, and withdrawal.[24]

The U.S. Advisory Board on Child Abuse suggests that domestic violence may be the single major precursor to child abuse across the country.[25] A number of studies have documented the overlap between witnessing domestic violence and being a direct victim of child abuse. One study shows a 40 percent median co-occurrence of domestic violence and child maltreatment in the same family.[26] As domestic violence becomes more chronic in families, the risk that a child will be directly abused grows accordingly. It is not uncommon for older children and adolescents to intervene directly, in an attempt to protect their mothers, thereby increasing the risk of direct injury. Infants and toddlers, who may be unable to anticipate danger or get out of harm's way, are also more vulnerable to injury.

Although research enumerates many adverse effects of domestic violence on children, there are several variables that may mediate the intensity and severity of a child's response.[27] These variables include the chronicity and severity of the domestic violence, the proximity of the child to the violence, and the existence of other risk factors in the child's and family's life: substance abuse, poverty, and mental illness, for example. In addition, exposure to family violence among

Among immigrant and refugee children and families, exposure to family violence can be compounded by additional risk factors: a history of persecution and trauma, loss of an extended family network, the stress of adapting to a new culture, isolation from the broader community due to language and other barriers, and lack of available resources can reduce the protective factors that help children and families cope.[28]

immigrant and refugee children and families can be compounded by additional risk factors (see insert on previous page).[28] Children are affected in different ways, and not all children are equally affected. Some children appear to withstand the stresses of domestic violence. Protective factors may include child temperament, parental attunement, access to safe spaces in the community (such as community centers and churches), and a child's relationship with other caring adults. The fact that children are affected in such a range of ways has implications both for practice and policy. Services for children and families affected by domestic violence should offer a range of supports that build on strengths and encourage growth.

Addressing the Impact of Domestic Violence on Children & Adolescents: Best Practices

According to professionals experienced in working with CEDV, children are best served by a continuum of prevention and intervention programs, beginning with naturally occurring supports within the family, and including community and school services that promote resilience and increase protective factors, trauma-informed mental health services; and interventions specifically designed for CEDV.[29]

Formal intervention services for CEDV typically strive to meet one or more of a variety of objectives, including:

- ✓ Helping children and adolescents to resolve trauma-related feelings and/or behavioral symptoms through play or group activities
- ✓ Increasing children's social or problem-solving skills
- ✓ Strengthening child-parent relationships with the non-offending parent
- ✓ Modeling & teaching non-violence
- ✓ Offering educational advocacy or academic support

Regardless of the specific objectives of the intervention, child development and trauma experts suggest several guiding principles to shape a program that is both comprehensive and effective. For example, children's needs vary according to their developmental stage and the characteristics of the exposure to violence; therefore, interventions targeting this population should be informed by an understanding of child development, the impact of trauma on children, and domestic violence issues.[30] Interventions should also include the active involvement of the non-offending caregiver and a component specifically designed to strengthen the parent-child relationship.[31] Finally, interventions that aim to reduce risk and promote resilience among children affected by the violence and that are tailored to meet cultural, economic, and other contextual needs are likely to be the most comprehensive.[30,32]

In domestic violence shelters, children often outnumber the adult residents. These children have likely been exposed to significant degrees of trauma and upheaval, related both to domestic violence and homelessness. According to Gerwitz and Menakem (2004), several state-level domestic violence coalitions have agreed upon minimal standards for domestic violence programs serving children. More specifically, these standards instruct that programs offer the following:[32]

- An intake process designed and delivered separately for children
- Orientation, specifically for children, to the shelter or program
- Opportunities for children to talk about their experiences if they wish

- Developmentally-appropriate groups for children

- Brief handouts for parents, including information on
  - Recognizing the typical behaviors seen in children under stress
  - Identifying age appropriate behaviors
  - Tips on when and where to get help for their child

"Agencies serving battered women and their children should have staff members who possess some expertise in child development and programming for children."[30]

Finally, experienced child mental health providers recommend that the training of shelter advocates include content on child development, assessing children's exposure to violence, abuse and neglect, engaging in supportive interactions with parents, procedures for reporting child maltreatment, and advocating for mothers and children within child protection systems.[32]

A Summary of the Findings from Statewide Needs Assessments of Children Exposed to Domestic Violence in Massachusetts (1992 – 2005)

Several state-level needs assessment reports written over the past 15 years offer important information on the history of the service needs of CEDV in Massachusetts. Although these assessments focused on the entire Commonwealth, the findings (summarized below) were a significant asset to the design and conduct of the county-level SBF Project.

In November 1992, the Massachusetts Coalition of Battered Women Service Groups (now Jane Doe, Inc.) published a report on ending violence against women and children. This report detailed the critical steps needed to improve services over the five years following its publication.[33] Some of the needs identified include:

- Training and policies to guide the work of health care and mental health professionals
- An increase in funding for shelters to provide services and advocacy to children
- An increase in the number of domestic violence advocates available to case workers and supervisors in the Department of Social Services (at the time of the report there were 5 advocates for the entire Commonwealth; this number increased to 14 over the following years but was recently cut back to 6).

In addition, it highlighted Jane Doe, Inc.'s responsibility to educate the legislature, public schools, and mental health agencies about the needs of children exposed to domestic violence. Finally, it recommended that Jane Doe, Inc. add a staff position dedicated to developing and monitoring policies and programs that benefit the children of battered mothers.

In 1996, the Governor's Commission on Domestic Violence published a report called "The Children of Domestic Violence."[34] This report described the impact of domestic violence on children, detailed the status of services to CEDV in Massachusetts and made extensive recommendations to improve services to this vulnerable population (see Appendix B for a description of the recommendations made by the Commission). Following its report, the

Commission contracted with an independent consultant who conducted a needs assessment focused on the service needs of children exposed to domestic violence. The result was an unpublished report titled "Meeting the Service Needs of Children Exposed to Domestic Violence."[35,36] Written approximately 5 years ago, it identified such service needs as:

- Increasing the number of programs to meet the needs of child witnesses of domestic violence
- Raising awareness in schools about the effects of domestic violence on children and the dilemmas faced by non-abusing parents
- Training of court staff and custody evaluators
- Increasing the number of clinicians and other social service providers with a sophisticated understanding of domestic violence and its effects on children
- Increasing community stakeholders' understanding of one another's roles, challenges and expertise.

Most recently, in preparation for the FY07 Domestic Violence Request for Responses that would procure domestic violence services across the Commonwealth, the Department of Social Services, in partnership with the Department of Public Health, the Massachusetts Office of Victim Assistance, the Executive Office of Public Safety and the Department of Transitional Assistance conducted a year-long Listening and Learning Tour to assess the current state of services to families experiencing domestic violence and to identify local community needs.[37] The need for children's services was one of the most prominent issues raised throughout the Tour and the resulting report. The following were identified as being the most critical needs for CEDV:

- Clinical and/or intensive trauma services
- Individual counseling treatment that addresses the violence experienced and/or witnessed
- Therapy groups for children
- Culturally-competent services
- Services for older boys, including services for teenagers who are violent.

The statewide needs assessments described above provided a valuable context for the planning and implementation of the SBF Project in Suffolk County. Building on the findings of these reports, we saw our role not only to provide an updated, county-focused needs assessment, but also to craft recommendations that could be met in the real world of limited resources.

Supporting Children Exposed to Domestic Violence in Suffolk County: The SBF Project

Goals, Objectives, Guiding Principles, and Important Definitions

The goal of the SBF Project was to inform the design of a coordinated system of culturally competent, age-appropriate services for children and adolescents exposed to domestic violence. To meet this goal, we defined the following objectives:

- Describe the primary service needs of CEDV and their families.

- Examine the type and scope of services currently available to CEDV and their families, paying close attention to proximity, accessibility, cost/affordability, acceptability, and developmental and cultural appropriateness.
- Describe current protocols for screening and referring children and adolescents who may have been exposed to domestic violence.
- Identify the barriers and opportunities to enhancing the capacity to effectively identify and serve the needs of CEDV and to improving coordination among community stakeholders serving CEDV.

Participating stakeholders agreed that SBF Project activities would be undertaken within the context of the following guiding principles:

- Children and families are affected by domestic violence in a range of ways: not all children are equally affected and some children and families are more resilient than others.
- Some children exposed to domestic violence will need a variety of services, perhaps ranging from after-school and community-based activities to intensive therapy, while other children will need no services.
- It is a priority to ensure that services are accessible to families. Accessibility refers to services that are culturally and linguistically appropriate and linked to the communities in which families live.
- Children are best helped when the issues of safety for their non-abusing caregiver can also be addressed as a part of the intervention.
- In most cases, children are well served if the intervention can also support parenting and the parent-child relationship. This is especially true for young children, who depend by and large on their parent(s) for protection, care giving, and support.

Finally, important terms were defined at the beginning of the project period.

- Domestic violence is defined as a pattern of behaviors in partner relationships that incorporates a range of abuse tactics and behaviors which serve to establish coercive control of one partner over the other. For purposes of the SBF Project, we will use the broader definition that includes threats or intimidation, and/or psychological abuse.
- We defined witnessing domestic violence as including a child's seeing, hearing, or living with the aftermath of domestic violence, including becoming homeless, leaving home, going to shelter, or suffering the psychological effects of a parent's injury.[20,38,39,40]

Methods Used to Conduct the SBF Needs Assessment

Using a combination of quantitative and qualitative methods, we sought to better understand how CEDV are identified and supported in Suffolk County. The following instruments and methods were used to conduct the assessment: surveys of community-based and shelter-based domestic violence advocates (n=41); structured interviews with community health centers (n=24) and community-based mental health agencies (n=7); 2 focus groups (approximately 6 participants per group) with mothers who are survivors of domestic violence; 4 focus groups with providers working in various community-based settings; and key informant interviews conducted with 50 providers and administrators from a wide range of programs. In addition, we conducted a thorough review of the

relevant needs assessment activities conducted within the Commonwealth over the last 15 years (described in the previous section). The findings from these activities are presented below.

The Perceived Service Needs of Children Exposed to Domestic Violence: Findings from the SBF Project

Telephone-based surveys were conducted with domestic violence advocates working in shelters, community health centers, community-based domestic violence programs, district courts, local offices of various state agencies, and the Boston Police Department. During the survey, advocates were asked to choose the top three service needs of CEDV from a list of needs identified during the focus groups and within our review of past needs assessment activities. According to the 41 advocates surveyed, the top three primary service needs include:

- Therapeutic or psycho-educational groups for mothers and children (together or concurrently)
- Individual mental health therapy and assessment for the mother, and
- Individual mental health therapy and assessment for the child.

These particular services were also identified during many of the key informant interviews conducted with providers, administrators, and directors (see Appendix A for a list of agencies represented). 50 semi-structured interviews yielded divergent responses about service needs. Given this range of responses, we are unable to draw definitive conclusions. We include below a list of the service needs that were identified by at least two respondents (in no particular order):

- Affordable services designed specifically for adolescents
- Educational advocacy for families whose children are not getting their academic needs met in school
- Accessible and affordable child care options
- Culturally-informed services for CEDV and their parents ("culture" was defined in many ways including ethnicity, religion/spirituality, sexual orientation and other factors defining a particular family's experience and/or community)
- An increase in the number of clinicians who understand domestic violence and offer affordable, trauma-informed clinical services to children and adolescents
- Psycho-educational services for children and adolescents around interpersonal conflict, building social skills and conflict resolution skills
- Therapeutic or trauma-informed after school programs
- Services that consider the on-going relationship many children and adolescents have with the abusing parent
- Increase in supervised visitation services that are affordable, culturally and linguistically-appropriate

Finally, we conducted two focus groups with mothers who had experienced domestic violence: one with a group of English-speaking mothers attending a community-based support group and the other with a group of non-native English speakers who had immigrated from various countries. The most prominent themes of the two discussions included the needs for affordable and accessible child care; more flexible income level requirements for the services reserved for low-income families (child care vouchers, after school programs, housing assistance, etc.); general social support ("someone to listen"); and increased academic support for their children. Given the small

number of participants, the issues raised in these groups may not be representative of the majority of mothers who have been victims of domestic violence.

A Capacity Inventory: An Overview of Existing Services

CEDV in need of support are identified and served through one or more of a range of service delivery systems. We have organized this "capacity inventory" according to the service delivery categories listed below - from the very broad (community-based services through which children exposed to domestic violence may be identified or served in some capacity) to the very specific (specialized services targeting children exposed to domestic violence).

Service Delivery Settings

1. Hospitals & Community Health Centers
2. Early education and day care
3. Schools
4. Law Enforcement
5. Courts
6. Government-Administered Social Services
7. Specialized Services: Cross-Sector Programs, Domestic Violence Shelters and Community-Based Child Witness Programs

For each service setting, we describe the potential role providers might play in a system of care for children exposed to domestic violence, what is offered now in terms of responding to CEDV needs, the gaps in this response, and the opportunities available to improve services to this population.

1. Hospitals and Community Health Centers (including Mental Health services/departments)

Overview:

Health care institutions fulfill a variety of roles in responding to CEDV. Guidelines for screening and referring exist to assist health providers in responding to domestic violence (DV) in the pediatric health care setting.[41] Adult primary care physicians may be especially likely to see adults experiencing domestic violence as victims have been found to have more health problems and make more visits to the doctor than non-victims.[42] Also, according to some studies, victims feel more comfortable disclosing present or historic abuse to their physicians than in other settings.[43,44] Finally, a number of the children accessing counseling services in the behavioral and mental health departments of hospitals and health centers may have been exposed to domestic and/or community violence – identification of this exposure might assist clinicians in creating an informed treatment plan.

What We Offer Now:

The type and scope of services available for families experiencing domestic violence and the level of awareness of the needs of CEDV vary depending on the location and size of the healthcare facility in the County. There are 5 large hospitals operating in Suffolk County, and all but one host a formalized domestic violence program for adult victims. These domestic violence programs offer training to providers on screening and responding to DV, advocacy

and referrals to adult patients experiencing DV and in some cases support groups for DV victims and/or staff. These programs also advocate and assist in the development of hospital-wide domestic violence screening and referral protocols. While a few of these hospitals have specialized mental health services for CEDV on-site, most do not (see Figure #1). The specialized, hospital-based child witness programs will be discussed in detail later in this report.

Figure #1

Service Capacity	Hospitals (n=5)
Organized domestic violence program for adults	4
Mental health services for children	3
Specialized program for children exposed to violence	2

To find out more about the level of awareness, resources, and response available to CEDV in community health centers (CHCs), we conducted telephone surveys with 24 of the 29 CHCs located in Suffolk County (83% response rate). The CHCs interviewed represent almost all of the communities in Suffolk County including Chelsea, Revere and the Boston neighborhoods Allston, Boston Downtown, Back Bay, Chinatown, Dorchester, East Boston, Jamaica Plain, Mattapan, North End, Roxbury, South Boston, and the South End. Preliminary findings from focus groups with service providers and key informant interviews with a variety of professionals had indicated a need for more mental health service supports for children, especially trauma-informed services. Therefore, to find out more about the mental health services available for CEDV in the community, we limited the full survey to those CHCs offering counseling to children (20/24).

While most of these 20 CHCs serve children ages 4 – 18 years, 1 serves adolescents only and 5 also serve children under the age of 4 years old (see Figure #2). Not all CHCs will serve children who are not already patients at the facility: at least 4 of the 20 centers reported taking internal referrals only.

Eighteen of the CHC mental health departments reported that they screen specifically for domestic violence at intake. Nine of the 20 CHCs with mental health services for children also had a domestic violence advocate. Of the 11 CHCs without a domestic violence advocate, 3 mental health departments reported having a formal protocol to follow when families screen positive for domestic violence. Of the remaining CHCs without a formal protocol, 1 described referring the family to a social worker on staff who "has worked in the domestic violence field before" and 3 described their response to a positive screen for DV as "filing a 51A if the violence is 'active' or 'ongoing'".

When asked about the level of training that mental health clinicians and departmental staff receive on domestic violence, 3 of the 20 centers responded that they have mandatory training on a regular basis. 11 centers reported offering domestic violence training or awareness-raising events from "time to time" but only 4 of these centers actually require staff attendance when the trainings are held. 6 centers reported offering no domestic violence training to mental health staff at all.

Figure #2

Service Capacity of Health Center Mental Health Departments	Community Health Centers with Mental Health Services for Children (n=20)
Services for children <4 years old	5
Services for adolescents only	1
Screen for domestic violence during intake	18
Access to a domestic violence advocate on-site	9
Formal domestic violence protocol	12
Clinicians/staff mandated to receive DV training on regular basis or upon orientation	3

Gaps:

Examining the screening practices of pediatricians employed by hospitals and community health centers in Suffolk County was beyond the scope of this particular needs assessment. However, interviews conducted with domestic violence advocates in community health centers indicate that screening rates may be low among health center-based pediatric providers. For example, a focus group discussion with domestic violence advocates based in Boston community health centers revealed that screening in pediatric settings is either inconsistent or lacking. Further evidence for low screening rates in health centers has been documented in the literature: according to a 1995 study conducted at two health care centers in Boston, screening was 23 times more likely during adult medical visits and 10 times more likely during gynecologic visits than during pediatric visits.[45] Although we found no information on screening rates in the county's larger hospitals, the availability of formalized hospital-based domestic violence programs suggest that larger hospitals at least have the infrastructure to ensure dedicated screening practices.

Key informant interviews with advocates, surveys of providers, and focus groups with providers indicate that hospital-based domestic violence programs and center-based domestic violence advocates do not have the capacity to adequately assess or attend to the service needs of children. For example, domestic violence programs in most of the large hospitals focus on serving adult victims and generally do not typically screen for children's needs. Domestic violence advocates based in CHCs also primarily represent the adult victims and report a lower level of support for the children of those victims. It is important to note that this is largely due to the limited capacity of domestic violence programs and advocates and not because children are considered to be less important. For example, one hospital offers a comprehensive domestic violence advocacy and support program for adult victims but, according to the program director, because the overall institution does not offer mental health or behavioral health services to children, it has not been a routine practice among domestic violence advocates program to assess or address the service needs of CEDV who may have emotional/behavioral problems. With the exception of two programs in larger hospitals, there are no domestic violence resources in Suffolk County healthcare facilities dedicated to the children of parents experiencing intimate partner violence. Furthermore, the two child witness programs can serve no more than approximately 150 children annually. Finally, focus groups with advocates and

the telephone surveys conducted with center-based mental health providers highlighted the need for increased training of providers on domestic violence and how it impacts children and adolescents.

Opportunities:

The opportunities to improve the identification of CEDV and increase the capacity of healthcare institutions to respond to their needs include the following:

A) Provide training to hospital-based advocates to help them incorporate children into the advocacy currently offered to adult victims
B) Increase the availability of on-site domestic violence advocacy in community health centers
C) Require on-going training in domestic violence screening and response for mental health clinicians in community health centers
D) Offer information and resources for parents of CEDV on the hospital and health center web sites

During key informant interviews, directors of hospital-based domestic violence programs expressed interest in learning more about how to incorporate children in the advocacy currently offered to adult victims. This might include offering advocates more education on the impact of domestic violence on children, outlining questions to ask adult victims to help advocates identify possible needs of children in the family, creating resources for advocates on how to talk to families about children and domestic violence, and compiling a directory of local services and supports available to CEDV. Opportunities within community-based health centers include increasing the availability of on-site domestic violence advocacy, which could be done either through resource sharing with other facilities, hiring a dedicated domestic violence advocate, or adding domestic violence advocacy to an existing staff position's job description. In addition, mental health clinicians and staff serving children in CHCs could receive domestic violence training during orientation or at regularly scheduled times throughout the year to help ensure that mental health providers understand the unique factors presented when domestic violence is involved.

Finally, a cursory assessment of hospital and CHC web sites reveals that a few offer comprehensive information to adults on domestic violence, including domestic violence definitions, safety planning information, and community resources for victims. These web sites could also include information on the impact of domestic violence on children and adolescents living in the home, community-based services for CEDV, or how to talk to children about the violence.

2. Early Education, Day Care (ages 0 – 5) and Early Intervention (ages 0- 3)

Overview

Families experiencing domestic violence are often identified through traditional governmental support systems, such as law enforcement, welfare assistance, and child protection teams. However, many families do not come to the attention of these systems, or they have had negative experiences with them; therefore, it is important to consider the role of other supportive community services in addressing the impact of domestic violence on children and adolescents.[46,47] Strengthening the capacities of voluntary family support agencies, such as day care programs

and early intervention services, to recognize and intervene with children who are exposed to domestic violence may help improve the system of care serving this vulnerable population.

Early education and day care is offered throughout the County in the forms of family day care and center-based care, including programs targeting particular populations with unique needs or preferences such as Early Head Start and Head Start programs, programs serving homeless families, culturally-based care for families from various ethnic backgrounds, or services offered in a particular religious or spiritual context. Many children living in domestic violence shelters also have access to on-site childcare or day care offered through another program in partnership with the shelter. According to providers and families interviewed for this needs assessment, early education and day care that is affordable, flexible, accessible, and trauma-sensitive represents one of the greatest resources we can offer families experiencing DV. Early education providers may be in the position to recognize children affected by domestic violence and offer information and referrals to families. At minimum, early education and day care represents a direct service that helps both the non-abusing parent and the child.

Early Intervention (EI) serves families with children between ages 0 – 3 who are not reaching age-appropriate developmental milestones or who are experiencing developmental delay. EI providers are in the position to recognize children whose development is being affected by domestic violence and/or offer information to families on the impact of domestic violence on children and the local services available to help families.

What We Offer Now:

In 2004, Early Intervention (EI) services located in Suffolk County reported a total active caseload of more than 2,800 children. As of 2005, there were 8 certified EI programs serving eligible children in Suffolk County. [48] To be eligible, a child must have an established medical condition or a diagnosed developmental delay. A child may also be eligible if the child and/or family exhibit at least four of the characteristics defined by the EI program guidelines as risk factors. “Multiple trauma and/or losses” and “occurrence of domestic violence” are the factors included that most directly relate to intimate partner violence in the home. In addition to the four or more risk factors, the child must present with a developmental delay or questionable quality of developmental skills (as defined by the evaluating clinician).

There are currently 1,245 day care programs currently operating in the Metro Boston area (including Chelsea, Revere and Boston) that are licensed by the Department of Early Education and Care (DEEC). As of March 2004, these programs served over 20,500 children, or approximately 50% of the total number of children ages 0 – 5 living in the area. In addition to DEEC-licensed care, 8 of the 11 Suffolk County domestic violence shelters report offering regularly scheduled day care – a few of which offer it in partnership with the *Horizons for Homeless Children* playgroup program that operates in shelters across the state. *Horizons for Homeless Children* reports serving 100 of the 300 children living in shelters in Suffolk County at any given time.

A family’s access to day care currently depends on space available, cost, eligibility for, and availability of vouchers/subsidies (if cost is unaffordable). The average annual cost of full-time care ranges from $9,964 for

preschoolers to $13,369 for infants. The Department of Early Education and Care offers vouchers and/or subsidized fees for care to families based on income requirements, work requirements, and service need. There are a total of approximately 50,000 – 68,000 state-wide vouchers through various funding and/or administrative mechanisms. In FY06 DEEC added 3,600 new vouchers to take children off waiting list for financial assistance with eligibility based on income and service need in addition to a work or related activity requirement. Finally, as of 2005, there were 50 spots (the cap at 50 was budget driven) across state for homeless families who need immediate help through DTA; families must meet a self-sufficiency requirement.

Gaps:

There is no estimate of the number of children accessing EI services who may have been exposed to domestic violence. According to data collected by the Department of Public Health (DPH), children in Suffolk County (regardless of exposure to domestic violence) are 20% less likely to be referred for Early Intervention services compared to children in other Massachusetts counties.[49] DPH has not yet investigated why this might be; however, a key informant from the Department interviewed as part of the SBF Project indicated that DPH is currently looking into the low referral rates among children of foreign-born parents.

Of the 90,631 children born in Massachusetts between 1998 and 2003 who had one or more Early Intervention evaluations, 4,342 (4.79%) had the domestic violence risk factor checked off at one or more points in time. 8,948 (9.87% of kids evaluated in EI) had multiple trauma checked off at one or more points in time. 1,995 (2.2%) had both (either both at same evaluation or at different evaluations).

The SBF Project did not include a survey of day care programs and their level of awareness of domestic violence as an issue affecting children, nor did it include a standardized survey of day care providers' level of familiarity with local resources and service options available to families experiencing domestic violence. However, individual interviews and group discussions with providers revealed that childcare staff need and want training on how to recognize and talk to families about domestic violence and what services are available to help families. For example, a focus group with faith-based, minority day care and after school providers serving approximately 500 children in Boston revealed that while staff may suspect that a parent is the victim of domestic violence, they aren't aware of options for intervention other than filing a 51A with the Department of Social Services. Moreover, staff are often reluctant to file.

Families experiencing domestic violence are not always given special consideration when they apply for assistance with obtaining childcare. As of FY2006, families who are experiencing domestic violence but are not DSS-involved, are not uniformly granted exceptions to the income and/or activity requirements and are not considered priority cases by the Department of Early Education and Care (DEEC). According to our interviews with DEEC administrators, "current policy across all [early care and education] programs [licensed by the DEEC] is not uniform and programs/divisions have varying ways of considering at-risk factors [such as domestic violence] and serving the needs of these populations". Furthermore, DEEC-licensed providers are not required as part of licensure to screen for domestic violence. While childcare providers are required to participate in training on recognizing and reporting suspected cases of child abuse and/or neglect, there is no formal guidance on how to recognize or help families

experiencing domestic violence. In fact, DEEC-licensed childcare programs are not currently mandated to receive DV training as part of the licensing process.

Opportunities:

The opportunities to better serve CEDV through coordination and leverage of the state-funded child care system include the following:

A) Increase opportunities for EI to work with underserved populations in Suffolk County
B) Increase financial support for parents of CEDV in need of day care
C) Mandate training in CEDV screening and response as part of day care licensing
D) Update the domestic violence training curriculum developed in 2000 for day care providers

According to a statewide EI administrator, "the future growth of our system will involve moving into more targeted outreach with subsets of populations," and eventually Massachusetts will be varying services according to the unique needs of these population subsets. EI programs are moving toward conducting more targeted outreach to families with specific risk factors such as immigrant/refugee families, teen mothers and children exposed to domestic violence. These risk factors and other gaps in outreach and services have been identified during the Pregnancy and Early Life Longitudinal Study (PELL).[50,51]

According to advocates working in domestic violence shelters throughout the County, affordable day care is one of the three most needed services for children exposed to domestic violence. Although 3 out of 11 shelters reported not offering regularly scheduled day care, this gap is likely to close if those 3 shelters receive funding in the current round of domestic violence bidding with the Department of Social Services (DSS). Access to childcare is now a requirement for programs applying for domestic violence funds through DSS.[52]

With the recent reorganization of the Office of Child Care Services and the Early Learning Services Division at the Department of Education into one independently governed agency, the DEEC is reviewing all of its policies and regulations, including examining the way the agency prioritizes assistance to families with different risk factors. According to a recent presentation made to the DEEC Board of Directors, a DEEC working group focused on access and coordination has examined current policy and recommended the addition of "domestic violence" or "trauma" to the list of exception categories, making it easier for these families to qualify for exemptions from requirements or to be considered a priority for access to care and moved up on the waiting list.[53] The proposed "verification process" will require that the Department of Transitional Assistance verify and approve a family's eligibility for priority status.

In 2000, the Executive Office of Health and Human Services, the Governor's Commission on Domestic Violence and the Office of Child Care Services partnered with the Child Witness to Violence Project at Boston Medical Center to develop the training curriculum "The Trauma of Domestic Violence: Creating Safe and Supportive Environments for Children in Child Care Programs." Revising and/or updating this curriculum and offering the training on a regular basis could be an important first step to raising awareness among early care providers. If

DEEC were to mandate that providers attend the training, such a requirement could ensure that all early care providers have the same knowledge. Key informants from DEEC interviewed for this project indicated that since the department is currently revising licensing standards there may be an opportunity to include DV training as part of the licensing requirements.

3. Public School Systems (ages 5 – 18)

Overview:

Children and adolescents affected by domestic violence at home carry the effects with them into school each day. Exposure to family violence can negatively impact learning and academic functioning. When home is not a "safe haven" for a child, an adult caregiver who plays a significant role in a child's life outside of the home, such as a teacher, school nurse, school psychologist, or other school staff member, might be an important source of stability, nurturance, and safety for children exposed to domestic violence. As an institution that touches the lives of *all* children and adolescents, the school system is a place where CEDV in need of help might first be identified and supported. This requires training school personnel on how to recognize the effects of domestic violence, to understand its impact on children, and to identify services available to families experiencing domestic violence. At minimum, educating school personnel on the impact of trauma on children's ability to learn and function effectively in a school environment, and offering local directories of services to schools in all districts so that families who do disclose domestic violence to school personnel will be connected with the proper supports could enhance the school's capacity to respond to CEDV. Finally, the school system infrastructure provides opportunities to universally educate children and adolescents on what it means to be in healthy, respectful relationships and to prevent children from seeing violent behavior in intimate relationships as normative.

What We Offer Now:

There are currently 70,735 children attending public school in Suffolk County (see Figure #3). While there are no school-based direct services designed specifically for children and adolescents experiencing domestic violence at home, CEDV have access to resources that are available to all children in need of extra support including school nurses, social workers, behavioral specialists and other student support staff.

Parents experiencing domestic violence who are concerned about their child's academic performance and who require assistance in meeting their child's academic needs may also contact educational advocacy programs for advice, guidance and/or assistance in acquiring the necessary academic support. For example, advocates from the Federation for Children with Special Needs (FCSN) help children access supportive services that schools are required to provide under special education law/regulations. According to a FCSN staff member interviewed for this report, "this does not mean the child has to already have a documented disability. It may be worth it to get a child evaluated by the school in order to get supportive services that the child may need." A focus group conducted with mothers attending a domestic violence program revealed that getting their child appropriate academic support is a primary concern. Many of the focus group participants expressed frustration around meeting their child's academic needs without adequate support from the school system.

Although most students in Suffolk County public schools do not receive specific information on domestic violence at school, they are taught some kind of violence prevention curriculum at different points in their education. For example, every elementary and middle school in Chelsea and Winthrop and many of the elementary and middle school grades in Revere and Boston utilize the *Second Step* curriculum. According to the Substance Abuse and Mental Health Services Administration, *Second Step* is a "model program" that "teaches, models, practices and reinforces skills in empathy, impulse control, problem solving, and anger management" and uses "developmentally and age appropriate" methods.[54] Although the curriculum does not address domestic violence directly, it does, according to one local director of health and guidance services "open the door for kids to talk about things they've seen at home."

Boston utilizes "Teenage Health Teaching Modules" in its high schools: modules that are designed to prevent substance use and violence between peers. These modules do not address teen dating violence or domestic violence. Although there is a BPS Violence Prevention Specialist dedicated to bringing in evidence-based programs aimed at preventing and addressing teen dating violence and domestic violence, the implementation of such programs appears to vary across the different schools. Select BPS schools conduct a Teen Dating Violence Intervention Program with the domestic violence organization Transition House and others work with the Asian Task Force Against Domestic Violence. School-based health centers in Revere high schools are affiliated with Haven, the domestic violence program of Massachusetts General Hospital. This affiliation gives students and teachers the opportunity to interact with a Haven domestic violence advocate. In addition, the alternative high school in Revere offers a teen dating violence intervention program for students. According to a Chelsea public school administrator, teen dating violence is generally addressed "one-on-one" at the Chelsea high school.

Figure #3

District	*Total # Schools*	*Total # Students*	*% of Children in District*
Boston	139	57,349	83%
Chelsea	9	5,495	93%
Revere	10	5,839	93%
Winthrop	4	2,052	91%
COUNTY TOTAL	162	70,735	

Gaps:

According to the coordinator of a district wide violence & drug abuse prevention curriculum for elementary and middle schools, domestic violence is "just not talked about in the classroom." It also not directly addressed in health classes or violence prevention efforts in elementary and middle schools. The coordinator suggests that this may be due, in part, to the discomfort students feel talking about difficult subjects with teachers.

School personnel from 3 of the 4 Suffolk County school districts report that families disclose domestic violence and that schools have different methods of addressing it. While some staff members interviewed focused on describing their referral practices (i.e. connecting mothers to the local domestic violence program), other staff members report that it is not uncommon for them to file a 51A when it is discovered that a student's caregiver is a victim of domestic violence and the domestic violence is "bad enough,"

School-based resources for children affected by domestic violence vary by location and each district's ability to raise government and private funds to support activities not considered part of the core academic curriculum. While a larger district like Boston Public Schools has social workers, behavioral specialists, violence prevention specialists, and psychologists available to support students, a smaller district like Winthrop must depend on resources located outside of the town (for example, there is no longer a community health center in Winthrop). Furthermore, regardless of the district, school personnel may not receive training on domestic violence and/or effects of trauma on academic performance. The BPS Violence Prevention Specialist responsible for identifying services addressing intimate partner violence has brought in groups to present to school nurses and school psychologists on domestic violence and the legal response; however, these trainings are not mandatory or offered regularly. Although this needs assessment did not collect standard information on DV training of school staff, interviews with health services and guidance directors and school staff revealed a lack of knowledge regarding the domestic violence support resources available in their community.

Opportunities

School-based opportunities to address the impact of domestic violence on children and adolescents include:

A) Incorporating the approaches identified in "Helping Traumatized Children Learn" into standard school policy and practice
B) Integrating discussions about domestic violence into existing curricula focused on violence and healthy relationships

Massachusetts Advocates for Children's *Trauma and Learning Policy Initiative*, in collaboration with the Hale and Dorr Legal Services Center of Harvard Law School and the Task Force on Children Affected by Domestic Violence, has published an education and policy agenda that seeks to create school environments where the negative effects of trauma on learning and behavior can be ameliorated. While "Helping Traumatized Children Learn" provides a *Flexible Framework* that can be adapted by any school to create a climate in which children traumatized by family violence can learn most effectively, the focus of the publication is on developing opportunities to educate teachers about how trauma, including trauma caused by domestic violence exposure, affects learning; helping teachers learn skills to manage the behavioral impacts of trauma; training teachers to engage in teaching methods that are effective in helping traumatized children learn; and creating school policies and procedures that support vulnerable, traumatized students rather than punish them for exhibiting trauma symptoms. Training on the *Framework* has been funded in several schools throughout Massachusetts through grants provided by the Massachusetts Department of Education and has been one of the topics explored by the Boston Public Schools' Full-Service

Schools Roundtable – a coalition that seeks to increases Boston's capacity to provide comprehensive school-based supports for children, youth and families through integrated school-community partnerships.

There are many opportunities to integrate discussions around intimate partner violence into existing curricula focused on healthy relationships, bullying and violence. At minimum, high schools can continue to explore low-cost, resource-efficient ways to address teen dating violence, such as partnering with local shelters and/or health centers/hospitals to offer teen dating intervention supports to students.

4. Law Enforcement

Overview:

Police officers are in a unique position to identify and refer children exposed to domestic violence when they respond to domestic violence incident calls. In addition, the police department could collect meaningful data on possible child exposure by routinely documenting the presence and/or existence of children when officers are called to the scene of a domestic violence incident. Finally, through partnerships with community-based agencies, law enforcement personnel may be able to connect children and families to supportive services. Given that resources and support for children exposed to domestic violence vary widely by city/town, we report resources by city/town below, followed by gaps and opportunities that exist throughout the county.

Specialized Domestic Violence Services in BOSTON

The Boston Police Department's Family Justice Unit (formerly the Domestic Violence Unit), which was recently centralized and re-located at the *Family Justice Center* in Brighton, includes domestic violence detectives assigned to each of the 11 districts as well as approximately 8 civilian domestic violence advocates who work in district stations conducting follow-up threat assessments, assisting in safety planning with victims, and referring victims to various services available in the community.

To identify the availability of and barriers to services for victims reporting domestic violence incidents to the police, we conducted standardized telephone surveys with all of the Boston Police Department (BPD) domestic violence advocates (for complete data, see Appendix C). The BPD domestic violence advocates are diverse, well trained and have a long history of working in the domestic violence field. Although the majority of advocates report "seldom" or "never" meeting the children of adult victims, they do estimate that 80% of adult victims contacted have children. All but one of the advocates report that they have a formal protocol which offers guidance on how to assess for the service needs of children living in homes with domestic violence. Furthermore, all advocates report receiving some kind of formal training on the impact of domestic violence on children, and all but one advocate report having educational materials available for adults who want to know more about the impact of domestic violence on children.

Specialized Domestic Violence Services in CHELSEA

Domestic violence represents the largest proportion of violent crimes in Chelsea. The Domestic Violence Unit at the Chelsea Police Department (CPD) employs one DV detective and all officers are trained on how to respond to domestic violence calls. Through a partnership with MGH-Chelsea Healthcare Center, CPD also offers a clinical response to children affected by domestic violence. Called the Police Action Counseling Team (PACT), the partnership enables MGH mental health professionals to accompany officers in police cruisers during one shift per week and offer crisis intervention and assessment to children present during domestic violence calls. Clinicians are also available by beeper 24 hours per day for on scene response to 911 calls where children are present (the victim caller must give permission prior to sending a clinician to the scene). According to one detective, although the initiative began as an activity added to selected officers' existing job descriptions, it is now an integral part of every officer's work, and every officer is mandated to participate once per year in an extra day of training on domestic violence.

Specialized Domestic Violence Services in REVERE

Revere reports a significantly lower number of domestic violence calls compared to Chelsea and Boston; the Revere Police Department (RPD) employs one full-time domestic violence advocate who accompanies officers on domestic violence calls and offers support to victims and children.

Gaps

Police officers responding to domestic violence calls in Suffolk County cities/towns are not required to routinely document the presence or existence of children unless the child is "part of the crime." For example, according to a Boston detective interviewed for this assessment, children are considered "secondary victims," and because the police officers responding to domestic violence calls must focus primarily on the actual crime, they aren't able to consistently identify and document the presence or existence of victims' children. In addition, capacity to offer on-site assistance and referrals for children possibly exposed to domestic violence varies by department, as do resources and partnerships with community-based agencies.

Key informants in Winthrop and Revere stated that there are fewer services for families in these communities, and articulated the need for more resources for families affected by domestic violence. Although one key informant interviewed in Revere recognized a lower level of domestic violence incident reports, the informant also described a lower level of awareness and acceptance of domestic violence as a problem worthy of a response. One informant also mentioned the need for a YMCA and expressed a desire for increased collaboration with Massachusetts General Hospital.

Opportunities

Opportunities within law enforcement to enhance a system-wide response to CEDV include:

A) Routinely documenting the presence and/or existence of CEDV
B) Increasing or enhancing training on CEDV for domestic violence advocates and police officers
C) Increasing or enhancing collaborations between police departments and other community-based organizations

One opportunity within the law enforcement system is the collection of meaningful data on the presence and/or existence of children in homes reporting domestic violence incidents. Officers could routinely ask standardized questions regarding the presence or existence of children. In addition, domestic violence advocates could engage in data collection that improves our knowledge of the prevalence and extent of exposure. This, in turn, could allow the department to collect standardized, consistent data on the presence and service needs of children.

Key informant interviews with law enforcement personnel revealed an opportunity for more training on domestic violence and child exposure issues as well as the potential for more partnerships between police departments and community-based agencies in some locations. For example, although all BPD officers are exposed to some information on domestic violence and children during the police academy training, BPD leadership could help ensure that this training is internalized and applied consistently throughout each officer's work. In addition, BPD domestic violence advocates indicated a desire for more training on the impact of domestic violence on children. Finally, in regard to partnerships, it would be beneficial for all police departments to increase or enhance collaborative relationships with health centers or other community programs.

5. Courts

Overview:

Victim Witness Advocates (VWAs) assisting domestic violence victims offer mandated services as authorized by the Victims' Bill of Rights (MGL 258 ch. B). These services include (but are not limited to) the provision of information, crisis intervention, planning and assistance for safety and protection, orientation and support throughout court processes and referrals to other supportive services crime victims, witnesses, and family members might need. As part of these services, VWAs are in a position to help connect parents and their children to services when parents disclose a child's exposure to domestic violence. To find out more about services offered to children of victims of domestic violence and their perceptions of the service needs of this population we interviewed key informants based in the District Attorney's Victim Witness Assistance Program, the Massachusetts Office of Victim Assistance, and the Family Justice Center and conducted telephone surveys with 8 of the 14 victim witness advocates working in Suffolk County District Courts

The need for court-based child care was a reoccurring theme through key informant interviews and focus group discussions.

What We Offer Now:

VWAs serve a broad range of victims of violent crime in the district courts. While each court serves large numbers of domestic violence victims, it is an area of specialization only in the Dorchester Domestic Violence Court and the Family Protection and Sexual Assault Unit of the Suffolk County District Attorney's Office. VWAs primarily advocate on behalf of the adult victim. However, according to one key informant, victim advocacy also includes a

consideration of the safety needs of the child. VWAs are instructed to file a report of suspected child abuse with the Department of Social Services (51A) on behalf of the child in cases where a child's needs are not being met.

Gaps:

VICTIM WITNESS ASSISTANCE: During key informant interviews, a few VWA's reported that their role as employees of the court and mandated reporters can present challenges to effectively communicating with parents about their child's exposure to domestic violence. One VWA suggested that this challenge may be associated with the "fear mothers might have about getting their children taken away." This same advocate noted that mothers seemed receptive to talking about child exposure and service needs with on-site clinicians when they were available (these clinicians were based at certain courts as part of a grant program that no longer exists). According to our telephone surveys with advocates, VWAs generally made fewer referrals for children's services with families compared to other advocates (those based in hospitals, domestic violence agencies and police departments) and were more likely to report being hesitant to discuss parenting with clients for fear of offending them. However, the response rate among VWAs was low (we were only able to interview about ½ of all advocates) and the results may not be representative of all VWAs.

COURT-BASED CHILD CARE: Court-based child care, which offers respite care to child witnesses to domestic violence while adult victims attend to court business, is one basic support that is currently lacking. According to our interviews with providers and community members, many courts in Suffolk County offered court-based child care in appropriately designed child care facilities on-site. However, these services lost their funding in 2001. The absence of court-based child care prevents many parents from getting the legal assistance they need to ensure their own safety. Furthermore, without child care on-site, parents who must bring their children to court risk exposing their children to upsetting interviews and/or court testimony related to domestic violence.

Opportunities:

Opportunities in the court system to enhance and improve the system's response to CEDV include:

A) Increasing collaboration between state agencies and community-based organizations
B) Training of victim witness advocates on speaking with parents about the needs of CEDV
C) Making on-site child care available to parents utilizing court services

VICTIM WITNESS ASSISTANCE: According to key informants from the Suffolk County District Attorney's Office, the Victim Witness Assistance Program has "come a long way" in regard to its relationship with the Department of Social Services. For example, one key informant noted that the VWA program no longer files against the mother; instead, they file on behalf of the child against the batterer. Key informants also noted that coordination and collaboration between different state agencies improves when mandated by a funding agency and there may be opportunities to institutionalize these activities so that they occur regardless of a grant's status.

The VWA program currently collects paper-based data. Organizing and electronically entering this data would likely yield important information. In addition, the Suffolk County District Attorney's Office web site offers great information

on safety planning for victim's of domestic violence, including information on children's emotional, social or behavioral needs in the context of domestic violence could be an important resource for victims who are parents.

COURT-BASED CHILD CARE: If a court is moved into a new building or experiences renovations, the state requires the court to construct a physical space within the building that is designated for child care. However, the state does not require that funds be designated to pay for the staffing of these facilities. If the state were to require or earmark funds to staff these physical spaces, the courts could offer child care services. Some proponents of court-based child care continue to raise the issue by advocating for state funding to be re-instated or by exploring other avenues for funding. Due to competing needs for state funding within the court system, it is unclear whether the situation will change in the near future.

6. Government-Administered Social Services

Overview:

Government agencies serving some of the most vulnerable families in Suffolk County are also in a unique position to facilitate the identification or referral of families experiencing domestic violence. Screening practices, direct services, domestic violence resources and referral protocols vary across agencies as well as across the various programs within each agency. While some agencies are in a position to offer resources for prevention, such as the Department of Public Health, other agencies may be in a better position to screen for domestic violence, identify service needs and/or make referrals, such as the Department of Mental Health, the Department of Transitional Assistance and the Department of Youth Services. This subsection is organized by agency:

a. Department of Social Services
b. Department of Public Health
c. Department of Transitional Assistance
d. Department of Mental Health
e. Department of Youth Services
f. Cross-sector Programs/Agencies

a. DEPARTMENT OF SOCIAL SERVICES

Overview:

Through its Domestic Violence Unit, the Department of Social Services (DSS) fulfills two roles in meeting the needs of children exposed to domestic violence: (1) the strategic integration of domestic violence knowledge into case practice and (2) the administration of state and federal funds for domestic violence intervention services. DSS also has the potential to fulfill a third role by routinely collecting information on domestic violence exposure during the screening and/or investigation of cases.

(1) Domestic Violence Unit Specialists

What We Offer Now

The Domestic Violence Unit of DSS includes 7 domestic violence specialists and 2 coordinators whose role is to advise, support and train DSS caseworkers on the special needs of CEDV. Except for the Metro West region for which there are 2 specialists, one specialist is dedicated to each of the regions. The specialists work with regional staff and administrators on the integration of domestic violence knowledge into child protection case practices. In certain acute cases these specialists also provide consultation directly to caseworkers.

Gaps:

Key informants from DSS report that, given the Domestic Violence Unit's goal of advancing systemic change around case practices involving domestic violence, the Unit requires a minimum of 2 specialists per region to meet its objectives.

Key informants also indicated a need for standardized guidelines for collecting information on domestic violence occurrence.

Opportunities:

In addition to increasing the capacity of the Domestic Violence Unit, DSS has the opportunity to gather more in-depth information about the prevalence and service needs of children exposed to domestic violence who come in contact with DSS. DSS caseworkers are trained to document screening and/or investigation procedures, including screening for domestic violence. They could also be required to consistently and specifically record the presence or history of domestic violence onto the electronic data collection form that is used to document the procedures. DSS estimates that approximately 60% of its active cases also involve domestic violence exposure. Consistently and specifically documenting the existence of domestic violence would allow DSS to identify the prevalence of exposure (which may be higher than indicated in the previous count) and the service needs associated with this exposure.

(2) Administration of State/Federal Funds

What We Offer Now:

Since 1978, DSS has contracted with agencies to provide services to domestic violence victims and their children. In April 2006, the Domestic Violence Unit (DV Unit) of DSS released a request for applications for funds to support these services; this represents the third time domestic violence services have been competitively bid. For the area that includes Suffolk County (the Boston Region), approximately $5.7 million has been awarded to community-based domestic violence services and residential domestic violence programs over two years ($3.3 million was awarded to agencies serving the Boston Region for FY2008 and $2.5 million for FY2007 – see Appendix G for a list of the agencies who received awards). Given the prominence of children's service needs throughout the DSS Listening and Learning Tour (see page 6 of this report for more information), DSS focused many of its application requirements on addressing service needs unique to children. For example, programs applying for domestic violence funds must demonstrate their ability to:

- Conduct service needs assessments with parents on behalf of children
- Offer children's services such as groups and activities (education groups for child witnesses are required)
- Provide parenting support and/or education
- Provide developmentally appropriate childcare
- Mandate that staff engage in pre-service training, including education on serving child witnesses

Gaps:

The approximately $3.5 million allotted to support domestic violence services in the Boston Region represents no increase in funds from the previous fiscal year. It has been distributed to both existing and new programs. These funds are the primary source of support for many organizations serving domestic violence victims and their children and include services such as housing stabilization, emergency shelter, substance abuse and mental health services, supervised visitation services and community-based victim and child witness services. The question of gaps in children's services funded through this DSS domestic violence RFR will not be answerable until all programs in the new funding cycle are up and running.

Opportunities:

The re-bidding of domestic violence service contracts represents an opportunity to advance the integration of children's services into programs serving families experiencing domestic violence. The vision outlined in the RFR supports the enhancement of a continuum of services available to children exposed to domestic violence. In addition, it encourages collaboration among multi-disciplinary providers and the opportunity (within its data management requirement) for the collection of meaningful, standardized information regarding the prevalence and needs of children affected by domestic violence.

b. DEPARTMENT OF PUBLIC HEALTH

Overview:

The Massachusetts Department of Public Health (DPH) plays a role in the prevention of domestic violence by providing technical assistance to domestic violence programs; acting as a conduit of financial support for the coordination of domestic violence services (all funding is geared toward prevention); certifying, training and managing data collected by batterer intervention program services; and organizing and requiring, through grants and contracts, the training of health providers. DPH has recently engaged in a number of initiatives aimed at the prevention of domestic violence and improving services to families experiencing domestic violence. Although none of these efforts have focused specifically on children affected by domestic violence, many of the initiatives have targeted domestic violence program and batterer intervention program practices and staff training – all of which will improve responses to families affected by domestic violence including children.

What We Offer Now:

The Domestic Violence Screening, Referral and Information Program (DV SCRIP) was initiated in FY02 to improve the quality of care provided to women and children served by Maternal and Child Health programs funded through DPH including, but not limited to, WIC providers, Early Intervention programs and family planning providers. DPH completed a comprehensive guide, specifically for use with Maternal and Child Health providers, on offering education and training regarding screening, care and referral for violence against women and children – including specific information on CEDV and how to conduct screening in the presence of a child.

As a result:

- DPH identified the training needs of WIC programs and one DV SCRIP training session was provided to all WIC providers (DPH is currently exploring ways to conduct ongoing training)
- Home visitors and telephone responders in the following programs are now encouraged to screen for violence against women and children and make appropriate referrals:
  - FIRSTLink, a system in Massachusetts that provides an electronic screen of individual birth certificate information and a direct family contact at the community level, with referrals to appropriate child and family resources
  - Early Intervention Partnerships Program, a home visiting program that provides services in communities with some of the state's highest rates of infant mortality and morbidity
    - All Early Intervention Partnerships Program home visitors participated in DV SCRIP Training
  - F.O.R Families, a home visiting program whose primary goal is to help homeless families while they are temporarily sheltered in motels awaiting shelter placement and/or permanent housing.

DPH has also supported a number of initiatives to address the dearth of culturally and linguistically appropriate services for children and families affected by domestic violence in Suffolk County. These efforts have focused on increasing cultural competency and collaboration between agencies serving ethnically diverse communities. The CARE (Collaborative for Abuse Prevention in Racial and Ethnic Minority Communities) Networks is one example. CARE, a six-year CDC-funded initiative which was completed in 2006, enabled existing programs to form networks to develop protocols and outreach materials for particular ethnic communities specifically around domestic violence issues. Each network included a domestic violence program, a child witness program, a batterer intervention program, an immigrant/refugee organization and a rape crisis center. Two of the 4 Massachusetts CARE networks were in Suffolk County – the Boston network served the African-American communities and the Chelsea network served the Latino community (see Appendix D for more information on the organizations that participated in this initiative).

Finally, DPH is charged with certifying and monitoring batterer intervention program services throughout the Commonwealth according to the “Massachusetts Guidelines and Standards for the Certification of Batterer Intervention Programs” (hereafter, the Guidelines); conducting training on battering intervention services; and, collecting and analyzing data on batterers who attend certified batterer intervention programs (BIP) within

Massachusetts.[55] According to the DPH web site, there are currently 4 organizations offering 5 BIP groups in Suffolk County (4 in Boston and 1 in Chelsea). BIPs "primarily consist of group sessions whose purpose is to educate the perpetrator." Goals of BIPs include "cessation of coercive, dominating and violence behavior, and the safety of victim(s), current partner(s), and the children."

According to one key informant, children are integrated throughout BIP curricula, and groups are required to cover:

- Identification and discussion of the effects of violence and abuse on children
- The enumeration of the short and long term effects of violence on children.
- Evaluation and documentation (during intake) of the perpetrator's problems in parenting
- The teaching of non-abusive and responsible ways of treating their partner and children

Gaps:

Currently there are no DPH domestic violence prevention services that target children or adolescents exposed to domestic violence. Also, although the CARE initiative might have increased the number of referrals made to child witness programs, the capacity to meet this increase with culturally appropriate services is not adequate. According to the Director of Violence Prevention at DPH, one of the most important problems right now is the lack of intervention and treatment services available to meet the needs of children and adolescents exposed to domestic violence, and without appropriate care available, people are hesitant to explore whether domestic violence exposure has impacted a young person.[56] Finally, according to one DPH key informant, BIP services have historically considered children secondary to the adults involved and have not explicitly addressed the safety of children.

Opportunities:

Opportunities for DPH to improve the identification of and response to CEDV include:

A) Continuing and expanding DV SCRIP efforts
B) Facilitating and supporting culturally-competent responses to CEDV needs
C) Encouraging the integration of parent/child-specific issues across all communities offering BIPs

The DV SCRIP initiative is an opportunity to improve the identification and referral skills of the providers who are most likely to see parents and children (health care and women's health providers). It is also an opportunity to ensure that all providers are in compliance with screening guidelines. According to the Director of Violence Prevention, any provider that has a contract with DPH will be trained in regard to screening, referring and offering information on domestic violence and its impact on children.

The recently re-funded Refugee and Immigrant Safety and Empowerment (RISE) Program represents another opportunity. In January 2006, DPH funded 19 agencies statewide (including 9 in Suffolk County) to promote and enhance effective and accessible services for immigrant and refugee survivors of sexual and domestic violence; change social norms that foster sexual and domestic violence in refugee and immigrant communities; and develop culturally appropriate family and community based approaches to addressing sexual and domestic violence.[57]

According to many of the SBF key informant interview and survey responses, limited language capacity and a lack of cultural competency on the part of service providers represent significant barriers to meeting the needs of foreign-born and/or non-English speaking children. For the RISE initiative, DPH prioritized funding for programs that could offer bilingual, bicultural services (advocacy, enhanced referral, outreach, etc, community organizing around domestic violence and sexual assault, or immigration counsel and legal representation for immigrant victims and survivors of domestic violence and sexual assault. In addition to providing immediate relief in the form of direct services, RISE has the potential to develop models that can be adopted by existing programs and future initiatives.

Finally, the opportunity exists for DPH batterer intervention programs to ensure that the effects of domestic violence on children are discussed among batterers attending BIPs. Although not historically addressed, a few BIP groups in Suffolk County and surrounding areas are actively integrating more explicit content on child safety into their services. DPH is in the position to encourage this effort across all communities.

c. DEPARTMENT OF TRANSITIONAL ASSISTANCE

Overview:

The Department of Transitional Assistance (formerly the Department of Public Welfare) provides financial assistance, emergency shelter and other supports to citizens of the Commonwealth – many of whom have been victims of domestic violence. According to a 1997 study conducted by the McCormack Institute at the University of Massachusetts Boston, almost 65% (or 2/3) of Massachusetts TAFDC (Transitional Aid to Families with Dependent Children) clients reported experiencing domestic violence in their lifetime, and 20% of all clients reported experiencing intimate partner violence within the previous year.[58] Given the high rate of domestic violence among clients of the Department of Transitional Assistance (DTA), the agency can play a role in ensuring that domestic violence situations do not impede a family's access to services and supports offered through the agency.

According to the DTA 2005 annual report, a monthly average of 47,563 families received TAFDC benefits in 2005 (94% of participants are women) and an average of 1,246 families were housed by DTA in shelters monthly.[55]

What We Offer Now:

The Domestic Violence Unit at DTA provides services to over 3,900 women and children annually. [59] According to the 2005 DTA annual report, the Unit is a resource to DTA caseworkers with identified recipients who are victims of domestic violence. In Suffolk County, Domestic Violence Specialists are assigned to each of the 5 area offices. These Specialists assist clients with safety planning risk and need assessment; link families to services; help victims overcome barriers to working; and assist victims with applying for "waivers" of certain program requirements (such as work hour requirements, caps on family income, time limits on assistance and teen attendance requirements) when obtaining emergency, transitional and permanent housing. The Unit also supports families in reaching economic self-sufficiency by helping clients to obtain housing, developing and supporting economic self-sufficiency plans that increase job placement and retention and identifying ways to safely pursue child support.[59] The Unit receives referrals from community providers, DTA caseworkers and the victims themselves.

In addition to the casework provided to clients, the Domestic Violence Unit of the DTA works with several organizations to address the unique needs of children including, but not limited to, the Suffolk County Children's Advocacy Center, the Child Witness to Violence Project, and the Domestic Violence Unit of the Department of Social Services. The DTA Domestic Violence Unit also works with Horizons for Homeless Children to provide direct service to young children by implementing play groups in DTA shelters housing pre-school aged children.[60]

Gaps:

Although the DTA Domestic Violence Unit serves almost 4,000 women and children annually, it is estimated that as many as 9,000 TAFDC clients have experienced domestic violence within the previous year. According to a key informant, identification of domestic violence is a challenge because many women do not disclose. Under DTA policy, all caseworkers are instructed to provide a domestic violence brochure to every new client applying for assistance and to ask about domestic violence when someone applies for emergency. Caseworkers are also instructed to refer cases involving domestic violence to the Domestic Violence Unit. Given that many of the DV victims identified by DTA caseworkers had neither disclosed domestic violence to anyone nor accessed services until their interactions with Department caseworkers, the presence of Domestic Violence Unit Specialists on-site helps to ensure that these families receive appropriate supports and services. There are currently 12 Domestic Violence Unit specialists covering all of the offices in Massachusetts. If families exposed to domestic violence are not identified and/or referred to the Domestic Violence Unit, they may not be made aware of the family violence exemptions (waivers of particular program requirements, such as minimum work participation rates, when applying for aid and/or housing) for which they might qualify.

Opportunities:

An increase in the Domestic Violence Unit's capacity could ensure greater support to clients who report domestic violence and help to maintain a coordinated systemic response as victims of violence and their children become safely economically self-sufficient.

d. DEPARTMENT OF MENTAL HEALTH

e. DEPARTMENT OF YOUTH SERVICES

Overview:

The Department of Mental Health and the Department of Youth Services are two examples of other government agencies that may play a role in addressing and/or identifying CEDV. Although these agencies do not currently focus on CEDV and do not have funds or staff dedicated to identifying or addressing this issue, they provide case management, direct service and/or coordination of service to vulnerable children and adolescents – many of whom have likely been exposed to domestic violence.

What We Offer Now, Gaps & Opportunities

The Massachusetts Department of Mental Health (DMH) contracts with agencies to serve children and adolescents who have serious mental illness or serious emotional disturbance.[61] Although DMH administration expects contracted agencies to collect information on trauma exposure, these contracted agencies are not required to screen for domestic violence; therefore, it is not possible to identify how many children have been exposed specifically to domestic violence.[62] However, the DMH Director of Child and Adolescent Services in the Boston Metro area estimates that 75% of DMH child clients have experienced and/or witnessed some form of trauma. Over the past ten years, DMH has made an effort to encourage the prevention of trauma-associated mental illness by training community and family members to respond appropriately to children who experience traumatic events. In addition, the agency is committed to coordinating *trauma-informed* services for DMH.[62]

The Department of Youth Services (DYS) has a dual mission of protecting the public from juvenile crime and preventing further juvenile crime by promoting positive change in the lives of youth committed to DYS custody.[63] DYS serves approximately 900 youth in the Metro region at any given time.[64] Youth can be involved with DYS for a number of days, weeks, months or years. These young people are served in different ways depending on the nature of their involvement with the agency. For example, youth who are held in DYS custody temporarily while awaiting court proceedings will have different needs than those youth who are committed to DYS custody for a period of months or years.

If youth coming into contact with the juvenile justice system in Massachusetts have been exposed to domestic violence, there is an opportunity for DYS to identify and address this exposure (as well as other traumatic experiences) while they are in the agency's care. DYS does not screen for exposure to domestic violence; however, the agency's administration is introducing a philosophy of trauma-informed care into DYS practices.

7. Specialized Services: Cross-Sector Programs, Domestic Violence Shelters and Community-Based Child Witness Programs

    a. Cross-Sector Programs

The Family Justice Center of Boston (FJCB) is one example of a cross-sector program designed to serve victims and children exposed to domestic violence. Established in June 2006, the FJCB is a collaborative venture in which public and private partners are co-located in one building to meet the needs of victims of domestic violence and sexual assault, children of victims and children who have been abused or neglected. Services provided include advocacy, crisis intervention, trauma evaluation and counseling, forensic interviews and specialized medical exams for children, civil legal assistance (including support with restraining orders, family law issues, housing education, privacy, employment, welfare advice, and immigration issues), assistance accessing DTA services, and on-site drop-in childcare (see Appendix G for a list of on-site partners).

Based at the FJCB, the Children's Advocacy Center of Suffolk County (CAC) is an example of a public/private partnership to support children and families when questions of child physical and sexual abuse arise. By law,

several agencies are required to investigate reports of child abuse; the CAC was created to coordinate investigations and assessments with clinical and legal competence to ensure that children and families receive a comprehensive and unduplicated set of services including multi-disciplinary investigative teams, forensic interviews, case reviews, medical and mental health services, and domestic violence services. Given the overlap between child abuse and domestic violence exposure, the CAC offers risk assessment, safety planning, supportive services and referrals to support families who are experiencing domestic violence.

b. Domestic Violence Shelters

What We Offer Now:

As of January 2006, there were 7 organizations sponsoring at least 12 shelter programs in Suffolk County offering emergency and/or transitional housing specifically for battered women and their children. They include F.I.N.E.X House, Casa Myrna Vasquez, Elizabeth Stone House, Renewal House, HarborCov, Asian Task Force Against Domestic Violence and The Women's Union (as of July 1, 2006 they are known as the Crittenton Women's Union). All but one of the organizations reported employing at least one advocate dedicated to meeting the needs of child residents. Not including the Women's Union (which was not funded by DSS at the time the following statistics were collected), these programs sheltered a total of 1,905 children in 2005; this represents 27% of all children served by DSS-funded domestic violence shelters in Massachusetts in 2005.[65] There are approximately 12 full-time equivalent child advocates (a few organizations have children's services directors in addition to advocates and/or have multiple part-time child advocates) employed by the shelter programs in Suffolk County.

We conducted key informant interviews with the directors and staff of these organizations and administered a standardized survey by telephone to one advocate in each of 12 shelters programs (one advocate served two shelters) sponsored by these organizations. With the exception of the one organization who does not employ a "child advocate," all advocates interviewed were considered either the "child advocate" or the "family advocate." None of the programs reported having more than one full-time child advocate per shelter. These advocates have been in their positions for an average of 5 years and all have received some form of training/education focused on domestic violence and children, with 8/11 having attended a formal training program or course dedicated to the subject. In addition, 5/11 advocates speak at least one other language in addition to English.

According to advocates, between 80-100% of the adult residents have children, and the majority of advocates (9/11) "always" meet the children. All but one of the advocates reported that they coordinate mental health, educational advocacy, and other social services for every child as needed. Out of the 11 advocates, 8 reported that their shelter program offers regularly scheduled day care for clients' children, and 9 reported offering organized activity/psycho-educational groups for child residents and support/psycho-educational groups for mothers. Eight of the 11 advocates reported "always" asking parents about a child's exposure to domestic violence or behavioral/emotional problems. Eight of the 11 shelters have educational materials on the impact of domestic violence on children available to give to parents. Six shelters reported a formal relationship with a mental health center or program, and eight advocates reported having access to a resource list/directory with services for

children. In contrast to community-based domestic violence advocates, 0 of the 11 shelter-based advocates reported feeling hesitant to discuss parenting issues with adult clients for fear of insulting or offending them.

Gaps:

Results from the advocate surveys, key informant interviews, and needs assessment projects conducted by other agencies (such as the DSS Listening and Learning Tour) indicate that developmentally-appropriate services for children vary by shelter and location (there is currently no emergency shelter in Revere or Winthrop) and may depend on the size of the budget, the level of volunteer support and the ratio of staff to clients. According to our survey results, many child advocates spend a relatively small proportion of their time with children.. Shelter-based advocates who responded to our telephone survey reported that the time spent with children ranges from 10% of their time to 100% with an average of only 50% of their time being spent with the children. It is not clear from our survey whether the remaining staff time is spent completing paperwork, working with adults or engaging in other activities. The survey results also indicate that not all shelters have educational materials for parents/caregivers on the impact of domestic violence on children. Out of the 8 advocates who reported having educational materials available, only 3 reported “always” giving these materials to parents.

Opportunities:

It may be valuable to increase staff and/or volunteer time with children. Increasing the availability and dissemination of educational materials for parents represents another opportunity for shelters. Finally, the opportunity exists to provide more training to advocates currently working in Suffolk County domestic violence shelters. In fact, all 11 advocates responding to our survey requested more training on the effects of domestic violence on children and child development.

c. Community-based Child Witness Programs

What We Offer Now:

Two community-based intervention programs for children exposed to domestic violence exist in Suffolk County: the Chelsea Children’s Advocacy Team at Massachusetts General Hospital Chelsea HealthCare Center (MGH/Chelsea) and the Child Witness to Violence Project at Boston Medical Center. These programs differ in target population, services and organizational structure; however, both offer therapeutic interventions to children exposed to domestic violence.

The Chelsea Children’s Advocacy Team (CHAT), a partnership between MGH/Chelsea and Harbor Communities Overcoming Violence (HarborCov), is a multidisciplinary team of providers that provide comprehensive mental health assessments, clinical follow-up services and case management to children, ages 0 –18, who have been affected by domestic violence. The team includes a child advocate from HarborCov, advocates from the MGH Haven domestic violence program, and an interdisciplinary group of clinicians from MGH/Chelsea. More specifically, CHAT clinicians provide individual and parent-child therapy, advocacy, case management, and groups for mothers and children. Funded by the Department of Social Services and the MGH Community Benefit Fund, the project does not include any full-time staff dedicated solely to the Team, instead providers dedicate a number of

hours each week to offering CHAT services to clients and meeting with fellow CHAT members. In 2005, CHAT received 69 new child referrals and provided ongoing services to an average of 22 children per month. CHAT accepts most forms of insurance and provides services free of charge on an as-needed basis.

The Child Witness to Violence Project (CWVP) at Boston Medical Center (BMC) is a therapeutic intervention program for children, ages 0 – 8, who have witnessed community and domestic violence. Approximately 80% of the 100 children served annually have been exposed to domestic violence. The program is staff by a multidisciplinary team of clinicians who provide individual therapy (play therapy), parent-child therapy, advocacy and case management in English and Spanish. The program is based at BMC but exists separately from the hospital in that clients of the CWVP do not have to be patients at BMC and BMC medical records are separate from the records and documentation kept by the CWVP. The CWVP staff consists of 6 full-time clinicians offering services during daytime and evening hours, including a clinician offering services part time at the Family Justice Center of Boston/Children's Advocacy Center of Suffolk County. The CWVP is grant-funded which means that all services can be provided free of charge.

Recommendations from the Safe and Bright Futures Needs Assessment

Four prominent "system-wide" themes emerged during the SBF data-gathering process. They are listed in no particular order:

- The need to increase specialized, trauma-informed services for children and adolescents exposed to domestic violence
- The need to improve data collection efforts with the goal of enhancing our understanding of the prevalence of domestic violence exposure and the service needs associated with exposure
- The need for training for child-serving providers on the impact of domestic violence on children and adolescents and talking with parents about child needs
- The need to disseminate accurate and up-to-date information on services currently available and how to access these services for CEDV and their families

Using the information gathered from past needs assessment activities, the results from the SBF interviews and data collection, and extensive input from community stakeholders, the SBF Leadership Team has developed a list of specific recommendations addressing these themes. The recommendations are organized according to the target audience (e.g. the service sector within which the recommended activities are proposed to take place) and are assigned to one of the following three categories:

1. no/low cost & high readiness to implement (infrastructure exists, use of existing staff)
2. moderate cost & moderate readiness (some capacity building required)
3. high cost & low readiness (substantial capacity building required)

Although the recommendations are based on significant input from community members, providers and administrators, they do not necessarily reflect consensus among the many stakeholders who participated in the

SBF needs assessment process. In addition, the level of readiness of each sector to implement a recommendation (or work with partners to do so) depends on many interrelated factors. We suggest a level of readiness for each recommendation based on the information gathered. It is likely that the suggested readiness levels will have to be re-categorized as new information is introduced.

Conclusion

The process of collecting data for this report has been extensive and thorough, taking place over an 18-month period, and involving reviews of state-level statistics, local data, and past reports on the subject, hundreds of key informant interviews, focus groups with several community members and providers, and dozens of paper-based surveys. The result is a detailed description of the services available to CEDV and their families in Suffolk County and the service gaps that prevent children from getting what they need following this kind of trauma..

This report reminds us that there are thousands of children in Suffolk County who live in homes where there has been at least one incident of domestic violence in the past year. There are hundreds of studies attesting to the short- and long-term consequences for children of growing up with domestic violence. This risk of harm is both physical and psychological. Even after 15 years of sporadic efforts to highlight this group of vulnerable children, they are still largely hidden victims. While there are excellent services and dedicated, skilled providers in all service sectors, what becomes clear in this report is the variance in program/agency focus and depth of expertise on serving children and adolescents affected by domestic violence. There are major service sectors in Suffolk County that lack the tools to suitably address child and adolescent exposure to domestic violence. Virtually all programs could improve their response to this under-served population.

In talking with the many dedicated professionals who work in this field, we came to realize that no single prevention, intervention, or treatment initiative will be successful in addressing child exposure to domestic violence. Rather, to effectively meet the needs of CEDV, community stakeholders, including service providers, policy makers, administrators, academic researchers, community members, and others must work together to implement a multi-faceted approach that involves both small- and large-scale change. Some of the changes require financial investment; others may require a realignment of resources or changes in operational policies.

Together, we can make these changes. If we are to break the cycle of violence in families, it is essential to begin with children. Early identification and intervention are perhaps the best forms of prevention. Our children and society deserve no less.

Service Sector	*Recommendation*	*Ideas for Action*	*1*	*2*	*3*
Health Centers and Hospitals	Routinely offer training for child-serving mental health clinicians on the impact of domestic violence on child development and mental health.		✓		
	Increase access to domestic violence (DV) & child advocacy services for staff and clients of health centers and hospitals.	Explore possibility of resource-sharing between health centers that employ DV advocates and those that do not.	✓		
	Increase training and information for health center and hospital-based DV advocates on how to incorporate child needs into their advocacy efforts.	Offer advocates education on the impact of DV on children, how to appropriately identify their needs, and how to advocate on behalf of the child and non-abusing parent.	✓		
	Develop educational materials on DV and its impact on children and increase access to these materials for parents.	Add educational information on domestic violence and children to health institution web sites.	✓		
Early Education, Day Care and Early Intervention	Raise awareness among day care, child care, early education and early intervention providers of domestic violence as an issue affecting children and/or of the service options available to families who disclose domestic violence.	Develop a survey for providers to gauge awareness level of DV, comfort in talking to families who disclose DV, and familiarity with local service options. Create and distribute educational materials and resource lists that directly address gaps in knowledge indicated by the survey results.		✓ ✓	
	Require training on domestic violence as an issue affecting children and families for providers licensed by the Department of Early Education and Care.	Update the child care training curriculum created by the Executive Office of Health and Human Services, the Governor's Commission on Domestic Violence, the Office of Child Care Services, and the Child Witness to Violence Project in 2000 and implement as part of the required training for child care/early education licensure.		✓	
Public School System	Incorporate domestic violence prevention efforts into already existing violence prevention initiatives, such as bullying, teen-dating interventions and conflict resolution skill building	Utilize the curriculum developed by the Boston Public Health Commission, "Choose Not To Abuse".		✓	

Service Sector	*Recommendation*	*Ideas for Action*	*1*	*2*	*3*
	Enable schools to become supportive environments in which children exposed to domestic violence can better focus, behave appropriately and learn.	Implement the "Flexible Framework" created by the Massachusetts Advocates of Children's Trauma and Learning Policy Initiative and published in the report "Helping Traumatized Children Learn".			✓
Law Enforcement	Establish a policy that requires officers to routinely document the presence or existence of children when responding to a domestic violence call.	Brief 5-10 minute trainings on how to document important information regarding children on forms used for domestic violence calls (including names, ages, and physical custody). Make appropriate changes in reporting forms to ensure information is collected and documented properly and routinely.		✓	✓
Court System	Increase connections between the Victim Witness Assistance program and outside agencies serving CEDV.		✓		
	Ensure that all courts offer resource list of therapeutic and supportive services for CEDV and educational materials on the impact of DV on children for DV victims and their families.			✓	
	Increase referrals made by Victim Witness Advocates based in district courts on behalf of CEDV		✓		
	Make childcare available at or in the immediate vicinity of court facilities	Partner with existing volunteer and/or community-based programs to set up and staff child care in community centers, schools or other facilities in walking distance to court			✓
	Develop protocol for collecting and documenting existence of children when restraining orders are filed to ensure feasibility of reporting aggregate data on numbers of children possibly affected				✓

Service Sector	*Recommendation*	*Ideas for Action*	*1*	*2*	*3*
Government-Administered Social Services	Increase capacity of Domestic Violence Unit of the Department of Social Services to include 2 specialists per region				✓
	Monitor the impact of domestic violence contracts awarded by DSS in 2006 on services for CEDV				✓
	Ensure data collected by DSS-funded domestic violence programs includes standardized information regarding the demographics and service needs of CEDV	Existing DV/Child advocacy trainers/staff and data experts at local universities could work with DSS to develop appropriate data collection protocols that include needed information on children		✓	
	Monitor the impact of the Refugee and Immigrant Safety and Empowerment Program (recently re-funded by DPH) on improving and increasing culturally competent services to CEDV			✓	
	Increase capacity of DTA DV-Unit to improve support to DTA clients disclosing domestic violence				✓
Domestic Violence Shelters	Create and disseminate culturally-relevant, linguistically-appropriate and easy to read information on the impact of domestic violence on child development			✓	
Specialized Community-Based Child Witness Services	Increase capacity of community-based programs targeting children exposed to domestic violence				✓
	Increase availability of programs and services targeting adolescents who have been exposed to domestic violence including group services, psycho-educational services, mentoring services and therapeutic interventions developmentally appropriate for pre-adolescents and adolescents.				✓
Cross-Sector[♣] Issues	Increase availability of affordable, culturally competent and trauma-informed supervised visitation services				✓

[♣] Recommendations included in this final category may be implemented in one or more of a variety of service settings.

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APPENDIX A

Participating Stakeholders

State Government Agencies

Governor's Commission on Sexual and Domestic Violence
Massachusetts Department of Early Education and Care
Department of Mental Health
- Child and Adolescent Services

Massachusetts Department of Public Health
- Batterer's Intervention Program
- Early Intervention Program
- Violence Prevention and Intervention Services

Massachusetts Department of Social Services
- Domestic Violence Unit

Massachusetts Department of Transitional Assistance
- Domestic Violence Unit

Massachusetts Department of Youth Services
Massachusetts Office of Victim Assistance

County and City Government Agencies

Suffolk County District Attorney's Office
- Children's Advocacy Center
- The Victim Witness Program
- District and Probate Courts

Suffolk County Family Justice Center
Boston Police Department
- Family Justice Unit

Boston Public Health Commission
Boston Public Schools
Chelsea Department of Health and Human Services
Chelsea Police Department
- Domestic Violence Unit
- Police Action Counseling Team

Chelsea Public Schools
Revere Police Department
- Domestic Violence Unit

Revere Public Schools
Winthrop Police Department
Winthrop Public Schools

Domestic Violence Shelters and Community-based Domestic Violence Programs

Asian Domestic Violence Task Force
Casa Myrna Vasquez
Close to Home
Crittendon House
Elizabeth Stone House

Jewish Family and Children's Services/Kol Isha
Family Violence Prevention Fund
FINEX House
Harbor Communities Overcoming Domestic Violence
Jane Doe, Inc.
Network for Battered Lesbians/La Red
Renewal House
Safe Havens Interfaith
Women's Educational and Industrial Union: Horizons Housing

Community Health Centers, Hospitals, and Mental Health Programs

Beth Israel Deaconness Hospital/Center for Violence Prevention and Recovery
Boston Medical Center/The Child Witness to Violence Project
Bowdoin Street Community Health Center
Brigham and Women's Hospital/Passageways
Broadway Medical Associates
Brookside Community Health Center
Children's Hospital/AWAKE
Codman Square Health Center
Community Advocacy Program at CCHERs
Dimock Community Health Center
Dorchester House
East Boston Neighborhood Health Center
Family Services of Greater Boston
Fenway Community Health Center
Harbour Family Health Center
Harvard Street Neighborhood Health Center
Home for Little Wanderers
Joseph Smith Community Health Center
Justice Resource Institute, Inc./The Trauma Center
Martha Eliot Health Center
Massachusetts General Hospital, Back Bay
Massachusetts General Hospital, Chelsea/Chelsea Children's Advocacy Team
Massachusetts General Hospital, Charlestown
Massachusetts General Hospital/Havens
Massachusetts General Hospital, Revere
Massachusetts Society for the Prevention of Cruelty to Children
Mattapan Community Health Center
North End Community Health Center
North Suffolk Mental Health Association
Sidney Borum Jr. Health Center
South Boston Community Health Center
South Cove Community Health
South End Community Health Center
Southern Jamaica Plain Community Health Center
Trauma Recovery Foundation
Tufts New England Medical Center

Uphams Corner Health Center

Other Non-Governmental Organizations
Boston University School of Public Health
CAPIC, Inc.
Greater Boston Legal Services
Grove Hall Youth Workers Alliance
Federation for Children with Special Needs
Horizons for Homeless Children
Massachusetts Advocates for Children
Northnode, Inc.
Strategy Matters, Inc.
Victory Generation/Black Ministerial Alliance

APPENDIX B

SAFE AND BRIGHT FUTURES FOR CHILDREN
SURVEY OF DOMESTIC VIOLENCE ADVOCATES

DO NOT READ ITALICIZED NOTES OUTLOUD

Note: All questions should be answered in context of services to children exposed to domestic violence.

1. **Respondent Profile:**

First, I would like to collect some demographic information from you.

a. Age:_____ (Years) **b. Gender:** ☐$_1$ Female ☐$_2$ Male ☐$_3$ Transgendered

c. Ethnicity: ☐$_1$ Hispanic/Latino ☐$_2$ Caucasian ☐$_3$ African-American ☐$_4$ Asian-American
☐$_4$ Other: Please Specify_____

d. Languages Spoken Other Than English:

g. Hire date for current position (*month/year)*:

h. Number of hours work per week in this position:

i. What percent of your time is spent working directly with children? _____%

j. Number of years working in the domestic violence field: _____ (Years)

k. How much previous training in regard to child/adolescent exposure to domestic violence have you had? (Check all that apply)

☐None
☐Read articles/materials related to child exposure to domestic violence
☐Watched a video
☐Training provided by Child Witness to Violence Project
☐A brief (1-2 hour) training (not with Child Witness to Violence Project staff)\
☐Several brief (1-2 hour) trainings, grand-rounds or in-service courses
☐A semester course or equivalent
☐Other (Please specify): _____

2. What percentage of your clients have children? _____%

3. How often do you meet the children of the mothers that you serve?
   ☐$_1$ Never
   ☐$_2$ Seldom
   ☐$_4$ About half the time
   ☐$_3$ Always

4. Are there education or resource materials (posters, brochures, etc.) on the **impact of domestic violence on children and adolescents** available for you to give to clients?

    ❑ yes ❑ no ❑ unsure Comments:

If answered no, skip to question #6.

5. If yes, how often do you give out these materials to clients?

    ☐$_1$ Never
    ☐$_2$ Sometimes
    ☐$_3$ Always
    ☐$_6$ I do not hand them out, but they are on display for clients to take

6. If you do not have materials on the impact of domestic violence on children, do you think having these to give to clients would be helpful to them?
    ☐$_1$ Yes
    ☐$_0$ No
    ☐$_9$ N/A (we have materials to offer clients)

<u>Services You Offer to Children and Parents</u>

7. Do you offer case management to children – that is, do you coordinate mental health, educational, advocacy, recreational services, and other social services for every child as needed?

    ❑ yes ❑ no ❑ unsure Comments:

8. Does your agency offer regularly scheduled day care for the children of clients?

    ❑ yes ❑ no ❑ unsure Comments:

9. Does your agency offer regular, organized groups for children (such as therapeutic, psychoeducational, peer groups)?

    ❑ yes ❑ no ❑ unsure Comments:

10. Does your agency offer regular, organized groups for mothers that include support and assistance with parenting in the context of domestic violence?

    ❑ yes ❑ no ❑ unsure Comments:

The Clients You Serve

11. Think about the clients you have seen over the last six months – specifically those clients who have children. Parents may offer you information without you having to ask. We're interested in the questions you ask if a parent doesn't bring it up on her own.

    For the next few questions, I'd like you to answer by picking one of the following choices: *(You may want to read this list twice)*

    ☐$_1$ Never
    ☐$_2$ Seldom (less than 25% of the time)
    ☐$_3$ Sometimes (25-50% of the time)
    ☐$_4$ Nearly Always (about 75% of the time)
    ☐$_5$ Always (100% of the time)

    b. Over the last 6 months, how often have you asked a parent about a child's exposure to domestic violence (i.e. whether child heard, saw, intervened, etc.)

    ☐$_1$ *Never*
    ☐$_2$ *Seldom*
    ☐$_3$ *Sometimes*
    ☐$_4$ *Nearly Always*
    ☐$_5$ *Always*

    c. Over the last 6 months, how often have you asked parent whether child was exhibiting behavioral or emotional problems

    ☐$_1$ *Never*
    ☐$_2$ *Seldom*
    ☐$_3$ *Sometimes*
    ☐$_4$ *Nearly Always*
    ☐$_5$ *Always*

    d. Over the last 6 months, how often have you asked parent or child whether child is in need of or receiving support in school for academic or behavioral difficulties

    ☐$_1$ *Never*
    ☐$_2$ *Seldom*
    ☐$_3$ *Sometimes*
    ☐$_4$ *Nearly Always*
    ☐$_5$ *Always*

e. Over the last 6 months, how often have you asked parent about child's physical health/medical needs

☐1 *Never*
☐2 *Seldom*
☐3 *Sometimes*
☐4 *Nearly Always*
☐5 *Always*

e. Over the last 6 months, how often have you offered individual parenting support for mothers having difficulty with their children

☐1 *Never*
☐2 *Seldom*
☐3 *Sometimes*
☐4 *Nearly Always*
☐5 *Always*

12. Approximately how many parents report that their children are unaware of the domestic violence if the subject comes up?

☐1 Almost all parents report children are unaware
☐2 About half of parents report children are unaware
☐3 Very few parents report children unaware
☐4 The subject of their child's awareness of the domestic violence rarely comes up
☐5 *Other PLEASE SPECIFY*_____

Referrals to Services Outside Your Agency

13. Do you have **access to a resource list or directory** at your agency that contains **services for which you can refer children and adolescents** who need support?
    ❑ yes ❑ no ❑ unsure Comments:

14. Do you feel you have **adequate knowledge** of referral resources in the community for children and adolescents exposed to domestic violence?

❑ yes ❑ no ❑ unsure Comments:

15. Does your agency have a formal/informal relationship with a mental health center or community health center which enhances your ability to get children and adolescents mental health services?

If yes, is it Formal or Informal? ❑ Yes ❑ no ❑ unsure

16. During the last 6 months, did you provide any of the following referrals or advocacy on behalf of a client's child/adolescent?

a. Referral to a self-identified child witness program
☐Yes ☐No

b. Referral to mental health services for assessment/therapy (not including EI)
☐Yes ☐No

c. Consulted with the child's teacher or school counselor
☐Yes ☐No

d. Referral to parenting program to assist parent with child's behavior
☐Yes ☐No

e. Referral to an after-school program
☐Yes ☐No

f. Referral to legal services to assistant client wirh issue of custody of children
☐Yes ☐No

g. Referral to Early Intervention services
☐Yes ☐No

h. Other (please describe):_____

(Skip to question #14 if you checked "yes" for any of the above)

i. I did not provide any referrals or advocacy on behalf of children in the past 6 months. ☐Yes ☐N/A

(Skip to question #15 if you checked "N/A")

17. What percent (approximately) of your clients do you think generally **attempt to follow up** on the **referrals you make on behalf of the child**?_____%

Services to Children Affected by Domestic Violence

18. I'm going to read you a list of SEVEN services which have been identified as being needed by families in Suffolk County experiencing domestic violence. I'd like you to identify the **THREE services** that are, in your opinion, most needed in the community you serve for children affected by domestic violence and their families.

a. Mental Health Assessment & Therapy for Mother _____
b. Child Care or After-School Program for Children _____
c. Mental Health Assessment & Therapy for Child _____
d. Groups for Young Children _____
e. Groups for mothers and children (together or concurrently) _____
f. Medical Care (Physical Health) _____
g. Academic support for school aged children _____

19. Which one of these three needs is the most urgent?
#1 Most Needed _____

20. If you identified a child and/or mother in need of services due to a child's exposure to domestic violence, how easy would it be for you to connect the family with the community-based (i.e. assume your agency does not offer this services) services below? ***Very Available means that there are several places in the community to which you can refer a client. Accessible means that there are few if any barriers (eligibility requirements, cost, transportation, etc.) to getting the services.***

a. **Mental Health Assessment/Counseling for Mother**
- ☐1 Very available, and easily accessible for most families
- ☐2 Available, but there are barriers (Please list barriers)
- ☐3 Not available
- ☐5 Don't know/not sure

Barriers:

b. **Individual Therapeutic Counseling for Child/Adolescent**
- ☐1 Very available, and easily accessible for most families
- ☐2 Available, but there are barriers (Please list barriers)
- ☐3 Not available
- ☐5 Don't know/not sure

Barriers:

c. **Therapeutic Group for Child/Adolescent (i.e. run by licensed clinicians)**
- ☐1 Very available, and easily accessible for most families
- ☐2 Available, but there are barriers (Please list barriers)
- ☐3 Not available

☐5 Don't know/not sure

Barriers:

d. **Skill Development/Psychoeducation for Children (i.e. perhaps modeling non-violent behaviors, teaching ways to deal with emotions)**

☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)
☐3 Not available
☐5 Don't know/not sure

Barriers:

e. **Physical Health Care**

☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)
☐3 Not available
☐5 Don't know/not sure

Barriers:

f. **Respite Care for Mother** (Do you know what I mean by respite care? *If respondent says "no" read the following definition:* Trained parents or counselors take care of the child for a brief period of time to give families relief from the strain of caring for the child. This type of care can be provided in the home or in another location. Some parents may need this help every week.)

☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)
☐3 Not available
☐5 Don't know/not sure

Barriers:

g. **Child Care**

☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)
☐3 Not available
☐5 Don't know/not sure

Barriers:

h. **After-School Programs for Children**

☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)

☐3 Not available
☐5 Don't know/not sure

Barriers:

i. **Substance Abuse Intervention/Treatment for Non-Abusing Parent**
☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)
☐3 Not available
☐5 Don't know/not sure

Barriers:

j. **Criminal Justice/Law Enforcement Assistance**
☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)
☐3 Not available
☐5 Don't know/not sure

Barriers:

k. **Proper legal representation for parents**
☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)
☐3 Not available
☐5 Don't know/not sure

Barriers:

l. **Educational Advocacy for Child**
☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)
☐3 Not available
☐5 Don't know/not sure

Barriers:

21. What is the **most frequent barrier** that you encounter when trying to connect children and families with mental health services?

☐1 Waiting list
☐2 Eligibility restrictions
☐3 Lack of Insurance or Money to Pay for Services
☐4 Undocumented status
☐5 Services not offered in appropriate language and other cultural barriers
☐6 Transportation barriers

☐$_7$ Other (please specify)

For this final section of the survey, I'm going to read you a series of statements. For each statement, I want you to tell me whether you strongly disagree, disagree, agree, strongly agree or are neutral.

Statements		**Strongly Disagree**	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
1.	I don't have time to carefully assess the service needs of children exposed to domestic violence.	1	2	3	4	5
2.	I would like more training on the effects of domestic violence on child development.	1	2	3	4	5
3.	Mental health services are easily accessible should my client's children need referrals.	1	2	3	4	5
4.	My workplace does not adequately support me in adequately attending to the needs of client's children	1	2	3	4	5
5.	Competing needs and demands of working with mother makes it difficult to thoroughly assess the service needs of their children.	1	2	3	4	5
6.	I consult with the teachers or school counselor when a client's child is in school (or should be in school).	1	2	3	4	5
7.	I am hesitant to discuss parenting with a client for fear of insulting or offending them.	1	2	3	4	5
8.	Of the families I see, most children require mentoring and role modeling, not clinical intervention such as therapy	1	2	3	4	5

Statements		Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
9.	There are not enough services and supports available for older children affected by domestic violence (age 12 and up)	1	2	3	4	5
10.	I don't have the necessary skills to explain to parents the symptoms they might see in children and adolescents exposed to domestic violence.	1	2	3	4	5
11.	Clients often don't discuss the needs of the children for fear that they will be taken away by DSS.	1	2	3	4	5

APPENDIX C

SAFE AND BRIGHT FUTURES FOR CHILDREN
SURVEY OF DOMESTIC VIOLENCE ADVOCATES

DO NOT READ ITALICIZED NOTES OUTLOUD

Note: All questions should be answered in context of services to children exposed to domestic violence.

1. **Respondent Profile:**

First, I would like to collect some demographic information from you.

a. Age:_____ (Years) **b. Gender:** ☐$_1$ Female ☐$_2$ Male

c. Ethnicity: ☐$_1$ Hispanic/Latino ☐$_2$ Caucasian ☐$_3$ African-American ☐$_4$ Asian-American
☐$_4$ Other: Please Specify_____

d. Languages Spoken Other Than English:

e. Position:
☐$_1$ DTA
☐$_2$ Police Department
☐$_3$ Courts
☐$_4$ DSS
☐$_5$ Non-shelter based DV organization
☐$_6$ DV Shelter/SafeHome/Transitional Living Program
☐$_7$ Community Health Center
☐$_8$ Hospital
☐$_9$ Other_____

f. Geographic area within Suffolk County that you primarily serve:
☐$_1$ Chelsea ☐$_2$ Winthrop ☐$_3$ Revere ☐$_4$ Boston ☐$_5$ All of the Above ☐$_6$ Other_____

g. Hire date for current position (*month/year)*:

h. Number of hours work per week in this position:

i. What percent of your time is spent working directly with children? _____%

j. Number of years working in the domestic violence field: _____ (Years)

k. How much previous training in regard to child/adolescent exposure to domestic violence have you had? (Check all that apply)
☐None
☐Read articles/materials related to child exposure to domestic violence
☐Watched a video
☐Training provided by Child Witness to Violence Project

Question Continues on Next Page

☐A brief (1-2 hour) training (not with Child Witness to Violence Project staff)\
☐Several brief (1-2 hour) trainings, grand-rounds or in-service courses
☐A semester course or equivalent
☐Other (Please specify): _____

2. Many domestic violence organizations have a "formal" protocol (such as written guidelines, manual or handbook) that guides how their staff interact with their adult clients. At your agency, is there a "formal" protocol or a section of the protocol specific to the **assessment of the needs of a client's children who may have been exposed to domestic violence?**

   ❑ yes ❑ no ❑ unsure Comments:

If answered "no" or "unsure," skip to question #4.

3. How many times in the last 6 Months have you looked at this protocol**?**
   ☐ 0 times
   ☐ 1 or 2 times
   ☐ 3 or more times

4. Are there education or resource materials (posters, brochures, etc.) on the **impact of domestic violence on children and adolescents** available for you to give to clients?

   ❑ yes ❑ no ❑ unsure Comments:

If answered no, skip to question #6.

5. If you do not have materials on the impact of domestic violence on children, do you think having these to give to clients would be helpful to them?
   ☐$_1$ Yes
   ☐$_0$ No
   ☐$_9$ N/A (we have materials to offer clients)

6. If yes, how often do you give out these materials to clients?

   ☐$_1$ Never
   ☐$_2$ Sometimes
   ☐$_3$ Always
   ☐$_6$ I do not hand them out, but they are on display for clients to take

<u>The Clients You Serve</u>

7. What percentage of your clients have children? _____%

8. How often do you meet the children of the mothers that you serve?
   - ☐1 Never
   - ☐2 Seldom
   - ☐3 Always
   - ☐4 Children are my primary clients
   - ☐5 I don't meet any of my clients; all communication is done by phone

9. Think about the clients you have seen over the last six months – specifically those clients who have children. Parents may offer you information without you having to ask. We're interested in the questions you ask if a parent doesn't bring it up on her own.

   For the next few questions, I'd like you to answer by picking one of the following choices: *(You may want to read this list twice)*

   - ☐1 Never
   - ☐2 Seldom (less than 25% of the time)
   - ☐3 Sometimes (25-50% of the time)
   - ☐4 Nearly Always (about 75% of the time)
   - ☐5 Always (100% of the time)

   b. Over the last 6 months, how often have you asked a parent about a child's exposure to domestic violence (i.e. whether child heard, saw, intervened, etc.)

   - ☐1 *Never*
   - ☐2 *Seldom*
   - ☐3 *Sometimes*
   - ☐4 *Nearly Always*
   - ☐5 *Always*

   c. Over the last 6 months, how often have you asked parent whether child was exhibiting behavioral or emotional problems

   - ☐1 *Never*
   - ☐2 *Seldom*
   - ☐3 *Sometimes*
   - ☐4 *Nearly Always*
   - ☐5 *Always*

   d. Over the last 6 months, how often have you asked parent or child whether child in need of or receiving support in school for academic or behavioral difficulties

   - ☐1 *Never*

☐$_2$ *Seldom*
☐$_3$ *Sometimes*
☐$_4$ *Nearly Always*
☐$_5$ *Always*

e. Over the last 6 months, how often have you asked parent about child's physical health/medical needs

☐$_1$ *Never*
☐$_2$ *Seldom*
☐$_3$ *Sometimes*
☐$_4$ *Nearly Always*
☐$_5$ *Always*

10. Approximately how many parents report that their children are unaware of the domestic violence if the subject comes up?

☐$_1$ Almost all parents report children are unaware
☐$_2$ About half of parents report children are unaware
☐$_3$ Very few parents report children unaware
☐$_4$ The subject of their child's awareness of the domestic violence rarely comes up
☐$_5$ *Other PLEASE SPECIFY*_____

Referrals to Support Outside Your Agency

11. Do you have **access to a resource list or directory** that contains **places and services for which you can refer children and adolescents** exposed to domestic violence at your agency?
    ❑ yes ❑ no ❑ unsure Comments:

12. Do you feel you have **adequate knowledge** of referral resources in the community for children and adolescents exposed to domestic violence?

    ❑ yes ❑ no ❑ unsure Comments:

13. During the last 6 months, did you provide any of the following referrals or advocacy on behalf of a client's child/adolescent?

    a. Referral to a self-identified child witness program
    ☐$_{Yes}$ ☐$_{No}$

    b. Referral to mental health services for assessment/therapy (not including EI)
    ☐$_{Yes}$ ☐$_{No}$

c. Consulted with the child's teacher or school counselor

☐Yes ☐No

d. Referral to parenting program to assist parent with child's behavior

☐Yes ☐No

e. Referral to an after-school program

☐Yes ☐No

f. Referral to legal services to assistant client wirh issue of custody of children

☐Yes ☐No

g. Referral to Early Intervention services

☐Yes ☐No

h. Other (please describe):_____

(Skip to question #14 if you checked "yes" for any of the above)

i. I did not provide any referrals or advocacy on behalf of children in the past 6 months. ☐Yes ☐N/A

(Skip to question #15 if you checked "N/A")

14. What percent (approximately) of your clients do you think generally **attempt to follow up** on the **referrals you make on behalf of the child**?_____%

Services to Children Affected by Domestic Violence

15. I'm going to read you a list of SEVEN services which have been identified as being needed by families in Suffolk County experiencing domestic violence. I'd like you to identify the **THREE services** that are, in your opinion, most needed in the community you serve for children affected by domestic violence and their families.

a. Mental Health Assessment & Therapy for Mother _____
b. Child Care or After-School Program for Children _____
c. Mental Health Assessment & Therapy for Child _____
d. Groups for Young Children _____
e. Groups for mothers and children (together or concurrently) _____
f. Medical Care (Physical Health) _____
g. Educational Advocacy for Child _____

16. Which one of these three needs is the most urgent?

#1 Most Needed _____

17. If you identified a child and/or mother in need of services due to a child's exposure to domestic violence, how easy would it be for you to connect the family with the community-based (i.e. assume your agency does not offer this services) services below? ***Very Available means that there are several places in the community to which you can refer a client. Accessible means that there are few if any barriers (eligibility requirements, cost, transportation, etc.) to getting the services.***

a. **Mental Health Assessment/Counseling for Mother**

- ☐$_1$ Very available, and easily accessible for most families
- ☐$_2$ Available, but there are barriers (Please list barriers)
- ☐$_3$ Not available
- ☐$_5$ Don't know/not sure

Barriers:

b. **Individual Therapeutic Counseling for Child/Adolescent**

- ☐$_1$ Very available, and easily accessible for most families
- ☐$_2$ Available, but there are barriers (Please list barriers)
- ☐$_3$ Not available
- ☐$_5$ Don't know/not sure

Barriers:

c. **Therapeutic Group for Child/Adolescent (i.e. run by licensed clinicians)**

- ☐$_1$ Very available, and easily accessible for most families
- ☐$_2$ Available, but there are barriers (Please list barriers)
- ☐$_3$ Not available
- ☐$_5$ Don't know/not sure

Barriers:

d. **Skill Development/Psychoeducation for Children (i.e. perhaps modeling non-violent behaviors, teaching ways to deal with emotions)**

- ☐$_1$ Very available, and easily accessible for most families
- ☐$_2$ Available, but there are barriers (Please list barriers)
- ☐$_3$ Not available
- ☐$_5$ Don't know/not sure

Barriers:

e. **Physical Health Care**

- ☐$_1$ Very available, and easily accessible for most families
- ☐$_2$ Available, but there are barriers (Please list barriers)

☐$_3$ Not available
☐$_5$ Don't know/not sure

Barriers:

f. **Respite Care for Mother** (Do you know what I mean by respite care? *If respondent says "no" read the following definition:* Trained parents or counselors take care of the child for a brief period of time to give families relief from the strain of caring for the child. This type of care can be provided in the home or in another location. Some parents may need this help every week.)

☐$_1$ Very available, and easily accessible for most families
☐$_2$ Available, but there are barriers (Please list barriers)
☐$_3$ Not available
☐$_5$ Don't know/not sure

Barriers:

g. **Child Care**
☐$_1$ Very available, and easily accessible for most families
☐$_2$ Available, but there are barriers (Please list barriers)
☐$_3$ Not available
☐$_5$ Don't know/not sure

Barriers:

h. **After-School Programs for Children**
☐$_1$ Very available, and easily accessible for most families
☐$_2$ Available, but there are barriers (Please list barriers)
☐$_3$ Not available
☐$_5$ Don't know/not sure

Barriers:

i. **Substance Abuse Intervention/Treatment for Non-Abusing Parent**
☐$_1$ Very available, and easily accessible for most families
☐$_2$ Available, but there are barriers (Please list barriers)
☐$_3$ Not available
☐$_5$ Don't know/not sure

Barriers:

j. **Criminal Justice/Law Enforcement Assistance**
☐$_1$ Very available, and easily accessible for most families
☐$_2$ Available, but there are barriers (Please list barriers)
☐$_3$ Not available

☐5 Don't know/not sure

Barriers:

k. **Proper legal representation for parents**

☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)
☐3 Not available
☐5 Don't know/not sure

Barriers:

l. **Educational Advocacy for Child**

☐1 Very available, and easily accessible for most families
☐2 Available, but there are barriers (Please list barriers)
☐3 Not available
☐5 Don't know/not sure

Barriers:

18. What is the **most frequent barrier** that you encounter when trying to connect children and families with mental health services?

☐1 Waiting list
☐2 Eligibility restrictions
☐3 Lack of Insurance or Money to Pay for Services
☐4 Undocumented status
☐5 Services not offered in appropriate language and other cultural barriers
☐6 Transportation barriers
☐7 Other (please specify)

For this final section of the survey, I'm going to read you a series of statements. For each statement, I want you to tell me whether you strongly disagree, disagree, agree, strongly agree or are neutral.

Statements	**Strongly Disagree**	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
1. I don't have time to carefully assess the service needs of children exposed to domestic violence.	1	2	3	4	5

Statements		Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
2.	I would like more training on the effects of domestic violence on child development.	1	2	3	4	5
3.	Mental health services are easily accessible should my client's children need referrals.	1	2	3	4	5
4.	My workplace does not adequately support me in adequately attending to the needs of client's children	1	2	3	4	5
5.	Competing needs and demands of working with mother makes it difficult to thoroughly assess the service needs of their children.	1	2	3	4	5
6.	I consult with the teachers or school counselor when a client's child is in school (or should be in school).	1	2	3	4	5
7.	I am hesitant to discuss parenting with a client for fear of insulting or offending them.	1	2	3	4	5
8.	Of the families I see, most children require mentoring and role modeling, not clinical intervention such as therapy	1	2	3	4	5
9.	There are not enough services and supports available for older children affected by domestic violence (age 12 and up)	1	2	3	4	5
10.	I don't have the necessary skills to explain to parents the symptoms they might see in children and adolescents exposed to domestic violence.	1	2	3	4	5
11.	Clients often don't discuss the needs of the children for fear that they will be taken away by DSS.	1	2	3	4	5

Concluding Questions

Is there anything that we didn't cover in this survey that you thought should have been included?

What do you think should be done to improve service/support to children exposed to domestic violence and their families?

APPENDIX D

Mental Health Directors Questions

1. What age range of children do you see for mental health problems?

2. What forms are routinely filled out when a child is referred to your agency for services (e.g. Intake, Evaluation, Assessment, Narrative, Tx Planning, etc)?

3. At intake, does the interviewer routinely seek information about trauma or explore the possibility that presenting problems may be a reflection of trauma?
    a. Is this done routinely at any other time besides intake?

4. Do you screen for domestic violence as a possible contributing factor to a child's mental health problems?
    a. In your client base, what % of families and/or children experience abuse, neglect or domestic violence?

5. Does your agency have a domestic violence treatment protocol?

6. What percentage of children/youth seen at your agency do you estimate have domestic violence as a contributing factor to their problems?

7. Do you have a formal relationship between your agency and a domestic violence program (e.g., a memorandum of understanding that spells out responsibilities of each agency, terms of confidentiality, referral procedures or inter-agency training agreements?

8. If not, do you have an informal relationship? Can you describe it for me?

9. Are staff required to have domestic violence training?
    a. What does this training include?
        i. Understanding domestic violence
        ii. Screening for domestic violence
        iii. Effects of domestic violence on children/family
        iv. Ensuring safety for children and women
        v. Accessing domestic violence services