

Vermont's Partnership Between Domestic Violence Programs and Child Protective Services

Publication # 7

A collaboration of the Vermont Network Against Domestic Violence and Sexual Assault, the Vermont Department for Children and Families, and the Vermont Center for Crime Victim Services.

Understanding the
Current Mental Health
Needs of Children
Experiencing Domestic
Violence in Vermont:
Recommendations
for Enhancing and
Improving Responses

Report to the
Rural Domestic Violence and
Child Abuse Project

By
Kathleen J. Moroz, DSW, LICSW

In consultation with:
Ellie Breitmaier, LICSW,
Coordinator Domestic Violence
Unit, Vermont Department for
Children and Families
and
Amy Torchia,
Children's Advocacy Coordinator,
Vermont Network Against
Domestic and Sexual Violence

August 26, 2005

For further information on this project, please contact:

Coordinator of the Domestic Violence Unit
Vermont Department for Children and Families (DCF)
103 South Main Street, Osgood 3, Waterbury, VT 05676; (802) 241-2131

Children's Advocacy Coordinator
Vermont Network Against Domestic and Sexual Violence
PO Box 405, Montpelier, VT 05601; (802) 223-1302

This project was supported by **Rural Grant # 96-WR-NX-007** awarded by the Violence Against Women Office, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Understanding the Current Mental Health Needs of Children Experiencing Domestic Violence in Vermont: Recommendations for Enhancing and Improving Responses

Report to the Rural Domestic Violence and Child Abuse Grant

Table of Contents

Overview of the Study

Rationale for this Report
Definition of Terms
The Scope of the Problem
The Effects of Exposure to Domestic Violence
Recognizing Signs of Trauma and Strengthening Safe Relationships
How Many Children Are Affected by Domestic Violence in Vermont?
**The Intersection of Domestic Violence and Trauma: Impact on Women and
Children**
Data Collection Methods in this Study
**Questionnaire for Child/Youth Advocates in Vermont Network Against Domestic
and Sexual Violence Programs**
Focus Group for Child/Youth Advocates
Questionnaire for Community Mental Health Center Children's Directors

Summary of Findings from Child/Youth Advocate Questionnaire and Focus Group

Services
Summary of Service Descriptions by Age Group
Parenting Support Services
Additional Services Advocates Would Like to Offer
Barriers that Keep Programs from Being Able to Provide Additional Services
**Concerns about Children's Social, Emotional and Psychological Development
and/or Mental Health**
Connecting to Mental Health Services
**Services Offered by Other Agencies in Community for Children Who Experience
Domestic Violence**
Gaps in Services for Children Who Experience Domestic Violence
**Child/Youth Advocates' Views of the Relationship Between Domestic Violence
Programs and Community Mental Health Centers**
Community Barriers That Limit Access to and Community Mental Health Services
Training Needs Identified by Child/Youth Advocates

Summary of Responses from Community Mental Health (CMHC) Children's Directors Questionnaire

Screening for the Presence of Psychological Trauma History
Screening for Domestic Violence
Use of a Specific Screening Tool or Instrument
Use of a Domestic Violence Treatment Protocol (*Guidelines for Best Practices*)
Estimate of the Percentage of Children/Youth Seen in CMHC's

**for Whom Domestic Violence Is a Contributing Factor
Formal or Informal Relationship with Nearest Domestic Violence Shelter/Program
Community Barriers That Limit Access to Mental Health Services
Specialized Domestic Violence Related Training Needs of CMHC Staff**

Findings and Recommendations

References

Appendices

Summary of Child/Youth Advocate Questionnaire Responses

Summary of Children's Mental Health Directors Responses

Understanding the Current Mental Health Needs of Children Experiencing Domestic Violence in Vermont: Recommendations for Enhancing and Improving Responses

Report to the Rural Domestic Violence and Child Abuse Project

Overview of This Study

Rationale for this Report

The Rural Domestic Violence and Child Abuse project, a partnership between The Vermont Network Against Domestic and Sexual Violence the Vermont Department for Children and Families and the Vermont Center For Crime Victim Services, hired the author, Dr. Kathleen Moroz to prepare a report on the status of the mental health needs for Vermont children who have been exposed to domestic violence. Under the terms of the contract, the author sought to discover the number of children/youth in Vermont exposed to domestic violence, the effects of this exposure on their social/emotional development and mental health, services provided by domestic violence network and mental health programs, perceived barriers to providing services, the training needs of service providers in Vermont and both strengths and gaps in the continuum of services for these children/youth.

Definition of Terms

Domestic violence typically refers to violence in intimate partner relationships. These relationships include marital partners, cohabiting partners, and former partners, as well as non-cohabiting dating couples, both heterosexual and same-gender (Salcido, Weithorn & Behrman, 1999, p. 15). Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual and psychological tactics as well as economic coercion that adults or adolescents use against their intimate partners. Domestic violence happens when one partner uses these tactics to gain and maintain power and control over the other partner (The Vermont Children's Upstream Services (CUPS) Handbook, (2004) p. 202). Most adult victims of domestic violence are female and most perpetrators are male. For this reason, this report may refer to victims as female and perpetrators as male, although these roles are sometimes reversed and may sometimes occur in same-gender couples.

It should also be noted that the terms *witnessing* domestic violence and *exposure to* domestic violence are often used interchangeably. However, researchers (Edleson, 1999; Wolak & Finkelhor, 1998) are beginning to make a distinction between the two terms using *witnessing* to describe being present in the room when the violence occurred and *exposure* to refer to the much broader range of sensory experiences a child may have in relation to domestic violence.

To avoid the repetitive use of the terms *domestic violence* and *community mental health center(s)*, the acronyms DV and CMHC will be used at times in this report.

The Scope of the Problem

In the United States, estimates of the number of children exposed to intimate partner violence vary from 3.3 million to 10 million children per year, depending on the specific definitions of witnessing violence, the source of the interview and the age of the child included in the survey (Edleson, 1999). While researchers agree that millions of children are exposed to domestic violence each year, there is no consensus about the number of children affected, and the above estimates are based on methodologically limited studies. As Carter, Weithorn & Behrman argue, “this absence of trustworthy statistics on the prevalence of child exposure to domestic violence affects the ability of policymakers, practitioners, and advocates to argue for and design effective interventions and policies for this population” (p.5).

In Vermont, the Vermont Network Against Domestic and Sexual Violence reported that 6,922 children/youth were identified (through the 14 domestic violence programs in the state) as experiencing or having experienced domestic violence between July 1, 2003 and June 30, 2004. This is a conservative estimate of the children/youth exposed to domestic violence in Vermont during that year since it only represents the number of children/youth reported in the home by those victims of domestic violence who came in contact with one of the 14 domestic violence programs. Many battered women do not utilize shelters (Carter, Weithorn & Behrman, 1999). As is true nationally (Carter, et al, 1999), domestic violence services (shelters as well as community and school prevention, education and outreach programs) do not reach all the children actually exposed to domestic violence in Vermont.

Over the past 15 years, domestic violence has been recognized not just as a significant social issue, but as a major health problem with devastating and costly effects on individuals, families and communities in the United States (Harris, Putnam & Fairbank, 2004). In 1998, the American Academy of Pediatrics issued a position statement declaring, “the abuse of women is a pediatric issue.” Children under 5 are disproportionately represented in households in which there is intimate partner violence. A sizeable number of these children are involved because they are calling for help, are identified as the cause of the dispute that led to violence, are caught in the cross fire, or are directly physically abused by the perpetrator (Fantuzzo, J., Boruch, R., Beriama, A., Atkins, M. & Marcus, S. 1997).

The Effects of Exposure to Domestic Violence

More than 100 studies have explored the effects of intimate partner violence on children. It should be noted that studies examining the effects of domestic

violence often do not differentiate between children exposed to domestic violence and those who are abused *as well as* exposed to domestic violence. In addition, other factors that exacerbate or ameliorate the effects of domestic violence, both risks and protective factors, need additional attention, if we are to understand fully the effects of domestic violence and give attention to those children who are at greatest developmental and long-term risk for social, emotional and behavioral difficulties.

With the above caveats in mind, studies of young children exposed to domestic violence have been found to have high levels of internalizing and externalizing problems that include affect dysregulation, difficulty establishing relationships, play reenactment of the traumatic experience, sleep disturbances, bouts of intense fear and uncontrolled crying, regression in developmental achievements, aggression, and noncompliance (Pynoos & Eth, 1985; Gaensbauer & Siegel 1995; Pynoos & Nader, 1988; Terr, 1981). Lieberman and Van Horn (1998) state that these child behaviors do not exist in a vacuum but reflect the impact of the trauma on the child as well as the stresses of the parent-child relationship in family environments marked by conflict and strife.

Children who witness domestic violence are more likely to exhibit behavioral and physical health problems including depression, anxiety, and violence towards peers (Jaffe & Sudermann (1995). They are also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution, and commit sexual assault crimes (Wolfe, Wekerle, Reitzel, & Gough, 1995). These child behaviors are likely to be early antecedents of adult responses to trauma, including avoidance, numbing, hyperarousal, and intrusive recollection of the trauma (Herman, 1992; van der Kolk, 1987; DSM-IV-R; Scheeringa & Gaensbauer, 2000). If children experience trauma, a critical link between the stress experienced as the result of the traumatic situation and the child's personality development is the formation of trauma-related expectations that shape the biology of the developing child (Perry, 1994,1997) and are expressed through perceptions, feelings, thoughts and behavior (Groves, 2002; Lieberman & Van Horn, 2005).

In addition, in families where domestic violence occurs, there is a 45-60% chance that children will also be the target of abuse. In homes where there is domestic violence, children are abused at a rate 15 times higher than the average. Young children and adolescents are more vulnerable to the abuse; very young children cannot get out of harm's way (neither are they immune to the effects of witnessing abuse), and adolescents more frequently intervene to stop the violence, thereby putting themselves at greater risk for injury.

Children exposed to domestic violence are at increased risk for developing posttraumatic stress disorder (PTSD); girls are more vulnerable to PTSD than boys (Naparstek, 2004) and long term, the presence of PTSD represents a formidable risk factor to adult functioning, including potentially affecting the

capacity to parent. Batterers model the use of aggression, anger and violence as well as negating and undermining behaviors including coercion, control and isolation. Boys and girls see their mothers beaten through physical, emotional and physical abuse at the hands of the batterer who is often their father or a father figure.

Children learn most from what they see and experience; boys identify with their fathers and often model their behavior on his behavior. Girls often identify with their mothers and conform to gender specific role models imposed by the battering parent. Fathers who are violent are often unable to respond sensitively to challenging or out-of-control behaviors in their children; they are often authoritative and under-involved due to their self-centeredness and need to control all aspects of the family. Mothers who are victims of domestic violence often have to focus on how to keep themselves and their children safe. They may be overwhelmed by anxiety, depression and fear in anticipation of the next episode of violence by the batterer. Responsive and sensitive parenting is often a challenge under these circumstances.

The young child's sense of self evolves in the context of their relationships with their primary caregivers, and as van der Kolk has noted (1987), "the earliest and possibly most damaging psychological trauma for a child is the loss of a secure base" (p. 32). The attachment system is the main organizer of children's responses to danger and safety in the first five years of life (Bowlby, 1969/82; Ainsworth, 1969; Ainsworth, Blehar, Waters, & Wall, 1978). Mothers who live in fear for themselves and their children face many challenges in providing a secure base for their children.

Battered mothers struggle to provide a secure base for their children but often cannot do so when they are not safe themselves. Children who witness violence at home are caught in the biologically based "fight or flight" response to events that trigger fear and threaten their survival. They often blame themselves when there is violence in the home and feel torn between fear of the battering parent and a longing to be close to him. Their conflicts may be expressed in externalizing behaviors such as aggression, defiance and non-compliance, and in internalizing problems such as excessive fearfulness and withdrawal. Children look to their parents as role models for their identity development. Based on what they see and experience, children are likely to see themselves and others in the prescribed roles of victim or abuser depending on their gender. Both girls and boys may learn that relationships have to do with sex and power and that violence and abuse is an acceptable way to be in a relationship. They may also believe that anger equals aggression rather than see anger as an emotion and violence as a choice. Children learn early on that their world is nurturing, safe and predictable or harsh, dangerous and chaotic.

Children's risk levels and reactions to domestic violence exist on a continuum where some children demonstrate enormous resiliency while others show signs

of significant maladaptive adjustment (Carlson, 2000; Edleson, 1999; Hughes, Graham-Bermann & Gruber, 2001). *Protective factors*, such as a strong relationship with the non-offending parent and/or other adults, strong sibling and peer relationships, social and community support, capacity to cope, high self-esteem, and outgoing temperament, can help protect children from the adverse affects of exposure to domestic violence.

Professionals are cautioned against assuming that witnessing domestic violence constitutes child maltreatment or should automatically prompt a child protective services intervention (Aron & Olson, 1997; Beeman, Hagemester & Edleson, 1999; Findlater & Kelly, 1999). Many states, including Vermont provide a *differential response* to children exposed to domestic violence through specialized domestic violence units within child protection agencies and by formal collaborations with domestic violence advocacy programs and other community agencies. Understanding that each child experiences domestic violence in a different way, a *differential response* honors the uniqueness of each child's situation; responds based on a child's individual experiences, level of impact, and needs; considers the existence and strength of protective factors in each child's life; considers the impact that interventions will have on the safety of the family; and works toward a comprehensive coordinated community response to domestic violence.

Recognizing Signs of Trauma and Strengthening Safe Relationships

All children exposed to domestic violence can benefit from basic levels of support and advocacy. For others, mental health treatment might also be critical. Mental health difficulties identified in infants and young children need to be addressed in the context of the child's primary attachment relationships (Fraiberg, 1980; Lieberman, Silverman & Pawl, 2000; Lieberman & Zeanah, 1995). Lieberman and Van Horn (2005) have provided a treatment manual, highly congruent with the Vermont CUPS model of early childhood mental health intervention, that elaborates this promising approach to parent-child psychotherapy.

For children exposed to domestic violence where mental health treatment is indicated, intervention should be based on a comprehensive assessment that takes into consideration individual, family and environmental factors that provide protection or increase risk to the child and influence the impact of domestic violence. Protective factors, such as social competence, intelligence, high self-esteem, outgoing temperament, strong sibling and peer relationships and a supportive relationship with an adult can help protect children from the adverse effects of exposure to domestic violence (National Clearinghouse on Child Abuse and Neglect, 2003).

Additional assessment factors include the following:

- The quality of the child's attachment relationship(s);
Does the child have a secure attachment relationship that provides a buffer to the

- exposure to domestic violence?
- **The nature of the violence;**
How often is the child exposed to violence and how severe is it?
- **The child's coping strategies and skills;**
Coping strategies are related to the age of the child and the child's abilities and opportunities to express her or himself as well as to the availability of sensitive and responsive adults in the child's environment.
- **The age and gender of the child;**
Younger children respond to violence with heightened levels of psychological and emotional distress. Age and gender may also affect the child's sense of helplessness and loss of control.
- **The elapsed time since exposure;**
The closer to the event, the more acute the child's response will be.
- **The presence of child physical or sexual abuse;**
Children who witness domestic violence and who are physically abused are at greater risk for increased levels of emotional and psychological maladjustment than children who only witness violence and are not abused (Edleson, 1999; Hughes, et al, 2001).
- **The abuse of drugs and/or alcohol by one or both parents;**
Substance abuse is frequently a co-occurring factor in both domestic violence and child abuse. Risks increase for children who are exposed to alcohol and drug-related behavior on the part of the adults they rely on for safety and nurturing.
- **The occurrence of additional traumatic events in the child's life.**
Is the child coping with medical problems, surgeries, violence in the community as well as in the family, deaths and losses of important people, or other frightening events like car accidents, fires or floods?

In keeping with recommendations from the National Child Traumatic Stress Network, as well as the important work being done in programs like the Child Witness to Violence project at Boston Medical Center and the Child Trauma Research Project in San Francisco, treatment for child and youth victims of domestic violence should follow a phase-based approach that focuses on 1) safety in one's environment, including home, school and community, 2) skills development in emotional regulation and interpersonal functioning, 3) meaning-making about post traumatic events they have experienced so that youth can consider more positive adaptive views about themselves in the present and express hope about the future, and 4) enhancing resiliency, positive relationships and social networks. These activities can be accomplished in several different settings depending on the severity of the impact to the child and what works in the child's social and community context. While it is beyond the scope of this report, additional attention must be given to the specific needs of adolescent boys and girls whose identity formation, beliefs and views about relationships have been adversely affected by witnessing domestic violence.

How Many Children Are Affected by Domestic Violence in Vermont?

It is difficult to get an accurate estimate of the number of children affected by domestic violence in Vermont. Various data sources provide the following information (July 1, 2003 to June 30, 2004):

Vermont Data About Children	
Number of children in Vermont (Birth to age 18 – July 1, 2003)	148,135
Number of children/youth identified as having been exposed to domestic violence in their homes (by mothers who sought services from a Network Program)	6,922
Number of children sheltered in Network Program shelters or safe homes	219
Number of DCF intakes in which domestic violence was identified as a contributing family factor	1,533 (of 12,397)
Number of children linked to 1533 intakes ¹	2,861
Number of different cases on which the Domestic Violence Unit (within DCF) consulted ²	1,652
Number of children/youth reached through Network Program prevention/education programs throughout the state	23,507
Number of children who received community mental health services	8,713 (+/-40) Male [5,026] (+/-32) Female [3,697] (+/-24)
Number of Children identified by DCF as Abused/Neglected July 1, 2002- June 30, 2003	2,148 (+/- 11) Male [1,029] (+/- 7) Female [1,119] (+/- 8)
Number of children in DCF custody that received Community Mental Health services	515 of 2,148 (+/-1.1) OR 24%
<p>¹ This figure does not include cases that may have identified domestic violence further along in the assessment process.</p> <p>² The 119 additional cases (over and above the 1533 intakes) represent non- DCF case referrals or cases the DV unit became involved in post-intake.</p> <p>³ Pandiani, J. & Ghosh, K. (2004). Young trauma victims served in mental health programs. Vermont Menal Health Performance Indicator Project. Waterbury, Vermont: State of Vermont Agency of Human Services website, February 6, 2004.</p>	

Although 24% of children identified by DCF as abused and/or neglected *did* receive CMHC services during FY 03, 76% of them did not. This percentage represents **1633 children** who did not receive treatment through the CMH centers and whom we may conservatively estimate have experienced severe trauma, including trauma due to domestic violence. A portion of these children no doubt receive mental health services through private mental health professionals (paid for through Medicaid) or residential treatment programs. DCF does not track this information per se, although it might be possible to get this data from the Medicaid claims information at Economic Services Division.

According to Pandiani, Banks and Schacht (2004) children under seven years of age in Vermont are substantially *less* likely to receive community mental health

services than young people in the 7-12 or 13-17 age groups (14% vs. 19% and 28%). Girls were less likely to be served than boys in every age group. Young children are exposed to domestic violence at rates that are disproportionately **higher** than older children. Children under age 12 resided in 43% of the households where intimate partner violence occurred (compared to the 27% of households in the US that were home to children under the age of 12 (Rennison, C. & Welchans, S. 2000).

The Intersection of Domestic Violence and Trauma: Impact on Women and Children

95% of domestic violence perpetrators are male and their victims are female. Regardless of country, race or culture, women are consistently more vulnerable to PTSD than men. A greater percentage of women will develop post-traumatic stress over their lifetimes – roughly 10-12 percent of them, as compared with 5 percent of men. A Canadian survey of trauma exposure in Winnipeg showed that women were as much as six times as likely as men to develop PTSD, when exposed to comparable trauma. Another universal finding is that children are more vulnerable to PTSD than adults (Naparstek, 2004). The younger the child, the greater the likelihood of post-traumatic stress occurring, and the more severe the symptoms. Even with young children, the male-to-female differences hold up, compounding vulnerability for young girls and leaving two strikes against them: once for being a child and once again for being female (Naparstek, 2004).

Children witness 68-80% of domestic assault (and a greater percentage experience some aspect of the domestic abuse, even though they may not actually see it). Children who witness woman abuse exhibit symptoms similar to children who have been physically, sexually or emotionally abused (CUPS Handbook, p.202). Children from homes where domestic violence occurs are physically or sexually abused and/or seriously neglected at a rate 15 times the national average (McKay, 1994). Approximately, 45% to 70% of battered women in shelters have reported the presence of child abuse in their home (Meichenbaum, 1994). About two-thirds of abused children are being parented by battered women (McKay, 1994). Of the abused children, they are three times more likely to have been abused by their fathers.

The brain and central nervous systems of infants and young children are still developing and being shaped by their experiences. Trauma that occurs in infancy and early childhood is especially concerning because it can adversely affect brain development. These are children whose development is compromised by high stress and limited capacities to cope with threats to their own or to their mother's survival. Under such circumstances, a child's sense of self and view of the world are permeated with loss of control, helplessness, fear and lack of safety. Children may react by freezing and dissociating (flight) or hyperactivity and aggression (fight). Later, they may cope with fear and feelings

of helplessness, agitation or numbness in a variety of ways that may include self-medicating with food, alcohol, drugs, sex, or other self –destructive behaviors.

Data Collection Methods in this Study

The Questionnaire for Child/Youth Advocates in Domestic Violence Programs was developed and mailed to 14 Child/Youth Advocates in The Vermont Network's 14 Domestic Violence programs in May, 2004. The questionnaire was developed in collaboration with Amy Torchia, Children's Advocacy Coordinator of the Vermont Network Against Domestic and Sexual Violence and Ellie Breitmaier, Coordinator of the Vermont Department for Children and Families Domestic Violence Unit. 13 questionnaires were returned.

The questionnaire included two main parts: the completion of a chart which summarized the direct services each program offers to children/youth experiencing domestic violence, and responses to questions elaborating the kinds of services offered to each of the following age groups:

- A. Infants/Young Children (Birth to Age 5),
- B. School-Aged Children (Age 6-11),
- C: Teen Boys (Age 12-18), and
- D. Teen Girls (Age 12-18)

In addition, advocates were asked to describe their concerns about children and youth who are exposed to domestic violence regarding their social, emotional and psychological development and/or mental health, the relationship of their domestic violence program to the community mental health center nearest them, barriers to services, and service and training needs.

Focus Group for Child/Youth Advocates

As a follow-up to the questionnaire, a focus group was convened on July 16, 2004. Nine of the 13 child/youth advocates took part in the focus group, all of whom completed the questionnaire. Examples and comments from focus group participants appear in relevant sections of the report below.

Questionnaire for CMHC Children's Directors

A questionnaire was designed for Community Mental Health Center (CCMH) children's directors in collaboration with Ellie Breitmaier, Coordinator of the Vermont Department for Children and Families Domestic Violence Unit and Amy Torchia, Children's Advocacy Coordinator of the Vermont Network Against Domestic and Sexual Violence as well as Division of Mental Health staff members John Pierce, Alice Maynard, Cecile Sherburn and Brenda Bean (now with the Department for Children and Families). The questionnaire was mailed to children's directors with a cover letter from Charlie Biss, Department of Health,

Division of Mental Health, Director of Child, Adolescent and Family Unit on February 7, 2005. All 13 children's directors returned completed questionnaires.

Summary of Findings from Child/Youth Advocate Questionnaire and Focus Group

Services

The 13 respondents indicated that their DV programs provide a range of services to children, youth and their mothers. The majority of programs have one or two staff members who provide multiple services and whose attention is split between prevention/education work in schools and communities and offering support (individually and/or in groups) to mothers and children in shelter. Services provided by domestic violence programs in Vermont are described in the Vermont Network Against Domestic and Sexual Violence, Children and Youth Advocacy Directory and Annual Report available from the Vermont Network Against Domestic and Sexual Violence (statewide office), P. O. Box 405, Montpelier, Vermont 05601 (PHONE: 802-223-1302; FAX: 802-223-6943; TTY: 223-1115; EMAIL: vtnetwork@vtnetwork.org).

A list of services and the number of programs offering them follows:

Types of Direct Service	# of Network Programs Offering Services
Emergency Shelter	13 (one refers)
Court Advocacy for or on Behalf of Children/Youth	12
Child Care Provided by Program's Staff or Volunteers	9
Individual Parenting Support for Mothers	10
Support of Mother/Child Interactions	11
Parenting Support Groups for Mothers	5
Support Groups for Mothers and Children/Youth Together	2
Child Care/Play Groups for Children Concurrent with Mother's Group	8
Support Groups for Children/Youth	8
Hotline Support (available to Children/Youth)	12
Individual Support for Children/Youth	11
Individual Counseling	1
Referral to Mental Health Services for Children/Youth	13

Summary of Service Descriptions by Age Group

Infants/Young Children (Birth to Age 5)

Shelter programs provide for basic needs including diapers and toiletries as well as some on-site childcare (during intake and during mothers support groups) and referrals to childcare. Almost all programs reported offering legal advocacy for and child protection team participation for or on behalf of children/youth. Advocates model parenting skills and offer direct support for mother/child “bonding” and interactions through one-on-one work with parents and children. Several programs reported offering groups for pre-school children. One program reported offering a creative 8-week play group for children (*Nobody Like Me*), and other programs offer a conflict resolution program (*Hands are Not for Hitting*) and personal safety programs for pre-school and kindergarten children as well resources and training for Head Start and other educators. Programs offer information to parents on child development and the effects of domestic violence on children.

From the Focus Group

When a new client comes in, and maybe there's a 4 or 5 year old child, one of us will just spend time talking with the child, playing or looking at different things we have in our library, just hanging' out with them.

One little boy was afraid to go to bed in his room at night, afraid there were things in the closet and afraid to go downstairs to brush his teeth by himself. So, we asked him if it would help if mom looked in the closet to make sure he was safe and if mom would go downstairs with him when he brushed his teeth. These were really simple specific things (not rocket science or anything, just very concrete and logical) that her child identified that would help him and that made a big difference to him.

School-Aged Children (Age 6-11)

Shelter programs typically offer child care/play groups, parenting support for mothers, staff who work specifically with mothers and children together and with children to address their concerns. Shelter programs provide basic and material needs to mothers and children. In addition to the services offered to younger children, some programs offer groups about healthy relationships for children (*My Choice* – for children aged 9-11) and violence prevention education programs (related to teasing, bullying, confliction resolution, self-esteem and personal safety) in the schools and community.

From the Focus Group

When families are in shelter child advocates often just hang out with the kids and play because lots of times moms don't have time to do that, when they are in crisis and transition.

Sometimes we offer kids support while they are in shelter and then we follow up with the kids after they leave. We offered support and activities and a safe, grown-up who would listen just to

her. We do that kind of thing lots of times with kids who may be in a group and then we ask their mom if we can check in with her and her child after the group. Just by going out for an activity, something fun, we keep in touch and we offer whatever the individual kid needs. Sometimes these children are a little bit depressed. A lot of times it may mean just doing something with the children by themselves, so that they can get out and do some activities without having to worry about their mom.

One 6-year-old boy was sort of the mother and the father in the apartment, and his mom sometimes saw her batterer in her son. This was a real difficulty for the child because mom's anger rose more towards this one child than the other children. She could sometimes acknowledge it... "Oh, he's just like his father," but being reacted to that way is a real problem for the child.

It's really common to see children concerned about their Moms, and Mom sometimes doesn't really recognize how preoccupied and concerned the children are about her.

Kids have so many questions, and they invent stuff, like the worst scenarios, when they don't know what is going on. But too many details can also make a kid really upset, and just because a child was there, they don't really want to hear about what happened over and over again. It's almost like it's happening again and again with all the repeating of the story (re-traumatizing each time for the child).

The child has a hard time perceiving the situation the same way the Mom does because if the family breaks up, chances are there's going to be a lot of turmoil in the child's life. They may have to move to a different town or a different house, or move from a house to an apartment, where now they have to get rid of their pets, or they need to go to a new school, so they're not having their same friends. Sometimes, their perspective may be "Why are you doing this to me, Mom?" And not that Dad is doing this to me, but seeing Mom as the person responsible for all the changes that they don't want. And sometimes, there are family changes that have taken place, Mom maybe was working part-time before and now she has to work full-time, and so they don't get to see her a lot either. Sometimes they don't get to do things that other kids may be able to do, and this is really sad. Mom takes on all of these responsibilities by herself; all this stuff is heaped on her, working, taking care of the kids, everything, and she is overwhelmed.

Another challenge every one of us faces is helping a child navigate the relationship with their dad – when children want to see their fathers and mom doesn't think it's a safe situation for them to see their father.

Kids are so black and white. One minute they're on their dad's side and the next minute they can see their mom's perspective, but they can't seem to see both perspectives at the same time – so they pick one side, then the other.

Teen Boys and Girls

Many programs offer school-based educational programs in classes for teen boys and girls together. Many programs offer outreach, advocacy, educational programs and one-on-one support and follow-up to teens. Hotline services are available to teens although it is not clear that they are utilized by them.

Some programs offer gender specific and mixed gender groups and education workshops in schools that focus on bullying, sexual harassment, gender stereotypes, dating domestic violence, sexual violence and bystander intervention in co-ed settings.

From the Focus Group

Most of my connection is through educational programs with students in the schools, and I had a teenaged boy who said something to me a couple of months ago. I'd been doing this healthy relationships piece, saying something about the fact that the abuser could be anyone and that the survivor could be anyone. It could be someone who's an alcoholic; it could be not. It could be someone who does community service, a professional person in the community... and I could see this boy, he was probably 16 or 17, as I was saying these things, he started to nod his head in agreement. Afterwards, he came up to me and said, "You know you were describing my dad. And people keep saying to me "Your dad is such a great guy! And I want to say to them "NO, he's not."

Teen Girls

In addition to the above services offered to teen boys and girls, some programs offer one-on-one support for girls who are in an abusive relationship and a healthy relationship group for pregnant or parenting teens.

From the Focus Group

Something I've noticed with a girl I'm working with is that she tends to blame her mom for lots of different things, but I don't think Mom realizes that at all.

It is really hard for mom to understand when children who witnessed abuse or were abused by their fathers later decide as teen-agers that they want to go live with their dads.

Parenting Support Services

Specific parenting support, in addition to the services already mentioned, includes discussing ways of disciplining, addressing specific child development/parenting concerns and safety planning. In addition, programs offer groups for survivors and their children [including information about domestic violence and how domestic violence may affect children], parenting workshops and in one program, a parenting consultant who comes to the shelter as needed to work with individual parents. One advocate reported offering a support group for victims of domestic violence with a specific focus on parenting. Shelter programs provide emergency/crisis services and advocacy as well as longer-term support and follow-up for parents and children/youth after they leave shelter. Many programs reported working closely with Parent-Child Centers.

From the Focus Group

Lots of times, the mother needs help and she knows she needs help but she doesn't know exactly what to do. If we had more opportunities to observe, then we could reflect with mom about how things are going and maybe she acknowledges that things are not going so well, and we could suggest she try something different the next time. Then, we might go up at that time and try something else and sort of model it – then check in with Mom afterward and ask her how she feels about how things went.

It's hard because moms don't always pick up on new ways of parenting...since they are doing

lots of stuff all at once in the shelter. Afterwards, they tell us that what we told them and showed them was really helpful. It's just that they have too much going on all at once while they are in shelter and it's really stressful and hard to focus on everything all at once.

Some shelters don't have 24-hour coverage, so there are guidelines for parents, but it's not like staff are there to monitor or help out all the time. A lot of parents who definitely do want help with their kids are open and receptive to new ideas. And sometimes it's difficult to know how to approach parents; they can be a little defensive. No matter how non-threatening you try to be, there's just that wall, especially when they're in crisis. One of the only things they have to hold onto is their kids and being a mom...so saying anything about their parenting is pretty threatening. Telling them they are a bad parent is a strategy often used by batterers as well, so it can feel really threatening to bring up parenting concerns.

One child advocate described her creation of an activity board with ideas about fun things moms can do with your kids. Sometimes mothers don't have a clue about what they can do, and they're always wondering things like "what does my baby need? What does she want? How do I know if he's thirsty, etc.?"

Additional Services Advocates Would Like to Offer

The following desirable additional or expanded services were identified:

- Specific advocacy for more types of court cases including child custody and criminal cases.
- More mental health services for youth and adults; practitioners who are knowledgeable about the effects of domestic violence.
- Visitation that is safe.

- Gender-specific support groups for teen boys and girls.
- Teen sexual assault peer support groups.
- Additional prevention efforts for teen boys.
- More support groups in the schools for children who have witnessed violence.
- More groups for mothers with a specific focus on parenting.
- More intervention with elementary-age kids, including play groups.

From the Focus Group

I'm doing a group in the fall for new moms and infants and we also use infant massage. You don't even have to say 'domestic violence', you just say 'encouraging attachment'. At first, people didn't understand why it would make sense to offer a group for moms and their infants. I used to work in another agency and I saw a lot of moms who had been assaulted. Bonding starts when you're pregnant, and these mothers were not bonding with their children.

It would be really good to do some kind of educational classes on parenting for moms, but I wouldn't want to call it parent education or parenting class because you know they would see that title and think - I don't need a parenting class. We can't start any new programs. There are funding issues, so (we can't start) any new program in case my hours get cut, then the program would not be able to continue. So, for various reasons, (I can't) to do this kind of group.

I do think that more groups for moms with young kids together would be good. (Program) is a group for moms and kids together, and some other programs offer a group for parents and a

group for kids concurrently, but the parents and kids are in separate rooms. They meet separately because moms talk about things they don't want their kids hearing.

Barriers that Keep Programs from Being Able to Provide Additional Services

The following barriers were listed, from most to least often checked:

- Not enough funding for programs/services;
- Too few staff ;
- Lack of public transportation for mothers and children;
- Too few staff with needed knowledge and skills;
- Not enough training for staff;
- Not enough physical space;
- Challenges related to rural areas (few good roads, no centralized location for services, not enough therapists in the area, no other parenting or childcare options in the community, lack of volunteers).

From the Focus Group

Historically and philosophically within domestic violence programs, there have always been issues and challenges related to dealing with parenting in an empowering way. In other words, that's not the first thing on some lists for us to be doing.

Concerns about Children's Social, Emotional and Psychological Development and/or Mental Health

Infants and Young Children

- Mothers need more awareness of how domestic violence is affecting their children.
- Concerns about attachment and bonding, poor relationship skills, attachment disorder, high levels of stress, aggression and anxiety in children.
- Concerns about ongoing violence that continues at home even though child may be receiving therapy.
- Low birth weight, Failure to Thrive, Neglect, Developmental Delays, Attachment Disorder, PTSD, Developmental Delays, Aggressive Behavior, Violent Behavior, *Parentified* Behavior.
- Treating children with medication for ADD when the real problem is traumatic stress due to domestic.

From the Focus Group

Even though it is recognized there is a high abuse rate of women during pregnancy and people know that the problems kids have don't just appear out of nowhere at age 5, it is still hard to get support for primary prevention or early intervention. Infants living with abuse at home exhibit symptoms like failure to thrive and post traumatic stress disorder just like kids living in a war-torn country.

We worked with an infant who was neglected, lots of propping bottles and not enough attention, and the 5-year-old daughter was doing a lot of taking care of her mother and the baby. This is a pretty typical example. The five-year-old child just wanted and needed to be a five year old, to go out and have fun, so we took her on some outings by herself.

A mom who didn't really understand child development or her child's stage of development (a 5-month-old infant), for example, didn't know that when she left the room her baby didn't know she was coming right back. She also wasn't feeding him nearly enough and he was really small for his age. Thankfully, (after they left) we did some follow up and we ended up hooking her up with the (Parent Child Center), and her roommate also happened to be really good at helping with the baby.

School-Aged Children (Age 6-11)

- Habitual anger responses (children who have an incredibly “short fuse” and who go into harmful rages often). PTSD symptoms (fear, inability to focus, worrying about mom).
- Children in violent homes identifying with the victim or the aggressor and abusing or being abused by siblings.
- Lack of boundaries; unawareness of other's personal space. Poor self-esteem. Acting-out power and control over others.

- Discomfort expressed by teachers with domestic and sexual violence; concerns about the ability of teachers/school personnel to serve as mandated reporters. Meeting resistance in the schools to training regarding domestic and sexual violence.
- Developmental delays, behavior problems, extreme levels of internalized fear, misinformation and misperceptions, guilt.
- Inconsistent parenting (including under involvement or neglect). Concerns about self-esteem, self-blame, depression, anxiety, PTSD symptoms, attachment disorder, high-risk behaviors.
- Concerns about children who blame the victim (mom) for the abuse.
- Children whose ability to grow up feeling whole, worthy and confident is compromised due to fear and violence at home.

From the Focus Group

Many times we have concerns about the safety of moms and kids. For example, the same man had assaulted both a mother and her daughter. Mom worried that the man who battered her would harm her daughter. The children's advocate taught the daughter about street safety and ongoing safety skills.

When the mom and child have different perceptions...sometimes the child will mention more than the mom does. It may be difficult for mom to realize that the child was there when she was being strangled or when the cops came and in fact the child did see the whole thing.

Teen Boys (age 12-18)

- Several boys in one county have attacked their mother's abusers and are

- now in the juvenile justice system.
- Violent behavior toward mom and partners. Small range of emotional expression. Being abusive or being abused by friends and partners. Lack of support around sexuality, sexual orientation.
- Lack of available mental health services and support, lack of GLBQT groups and support.
- In addition to those concerns expressed for younger children, concerns about teen boys learning abusive behavior and using it in relationships, becoming violence and abusive themselves, risk-taking behaviors, self-medication and low self-esteem and eating disorders.
- Lack of positive male role models. School problems (truancy etc.). High-risk behavior. Becoming abusive. Suicide. Depression. Anxiety. PTSD. Poor Choices. Lack of tools to problem solve nonviolently.
- I get concerned when I observe them acting superior to girls and/or toward “weaker” boys.
- In this community, sexual activity begins early; boredom and lack of healthy images of what it is to be a man are an issue.

From the Focus Group

Boys are into POWER, power, power. “I rule people and I tell them what to do, cha-ching baby!” Ruling Others. Inflated Egos. Acting more like perpetrators than victims, and some kids who are just dissociated all the time.

Teen Girls (Age 12-18)

- Being victimized
- Many involved in sexual behaviors early (6, 7, 8th grade). They lack engagement in school and a sense of self worth.
- Poor self-image, eating disorders, misinformation, influenced by media images of sex and violence, the degree to which they are vulnerable to dating violence.
- Poor body image, low self-esteem, and no knowledge of healthy relationships.
- School problems. Sexual activity and acting out. Poor social relationships. Teen pregnancy. Suicide. Anxiety. Depression. Confusion about gender roles. Violence becomes “normal”.

Connecting to Mental Health Services

All respondents reported they had helped a mother connect to mental health services for her child or children and cited examples of when they had done so. Child/Youth advocates are careful not to tell mothers what they “should” do, but to offer assistance making a referral only at the request of the women they serve.

The reasons cited for helping a mother connect to mental health services for her

child/youth were as follows:

- Safety of mother or siblings, fear of child's self-harm.
- Mother felt out of control and needed more help.
- To access counseling for a child experiencing PTSD symptoms; to access respite funds to help mother cope.
- Mom expressed concern. Child displayed violent behaviors.
- Child depressed.
- Child unable to focus attention; hyper-vigilant, hyperactive
- A 2½-year-old male was extremely aggressive to other children and adults in shelter, pushing, kicking and biting others repeatedly.
- Child's behavior extreme (out of control, uncontrollable). Mother's concern about child's behavior; child needed objective third party and a safe place to talk.
- Alcohol/drug abuse and early sexual activity.
- Violent behaviors. Depression, acting out, regression, PTSD, anxiety.
- Mother concerned about mental health of 3-year-old daughter who had witnessed her mother being beaten by father.

From the Focus Group

There are a lot of parallel mental health issues for moms and kids. These include issues about safety, stress, self-development, self-esteem, setting and keeping limits/boundaries, repeated patterns of behavior (like how someone deals with anger or sadness or numbing out); getting needs met, dealing with power and control.

There's a stigma against asking for services, especially mental health services. Mothers don't feel they can ask for mental health services for themselves or their children because it will be seen as a reflection of their inadequate or bad parenting. "It's your fault the kids are screwed up, you're crazy, and you're a bad mom." Dad may also report this to DCF and/or to his attorney. The law is heavily weighted toward parents' rights, not kids' rights, so if the court orders visitation, kids don't have a choice, they have to go. And if mom doesn't make sure they go, then she's in violation of the order. The batterer has more rights than the kids do, and that's really frustrating.

A lot of women want to believe that the abuse is not affecting their kids: "The kids were sleeping. They didn't hear what happened. They were too young to remember." And if moms recognize that it is affecting the kids, they take on all the responsibility for protecting them and all the blame for not having provided enough protection when they can see that their kids are hurt.

And let's face it, she's 'supposed' to be home and available to her children. Traumatized kids are not easy to be around. She may be home with 3 or 4 young kids who are bouncing off the walls and irritating each other. Then, she sends them to their father. She knows she has got to have a break, and the only place she can send the kids is to their father.

Services Offered by Other Agencies in Community for Children Who Experience Domestic Violence

- There are a lot of supports for children, but nothing for kids who experience domestic violence, except what the DV programs offer.

- One-on-one education aide may be possible in childcare or school and respite may also become available, based on the child's educational or mental health needs.
- Community mental health centers, CUPS programs, Parent/Child Centers and Child Advocacy Centers (re: sexual violence), private therapists who accept Medicaid, programs for runaways and youth, Community Action programs, Women, Infants and Children (WIC), Head Start, Success by Six and childcare resources, referrals and subsidies.

Gaps in Services for Children Who Experience Domestic Violence

- Not enough mental health services for children – waiting lists for CMHC services with waiting periods exceeding 6 months. Very few or no therapists available.
- Very few male mental health providers, educators or mentors for boys.
- Not enough therapists who use play therapy with young children. We need them closer to town; transportation is a huge problem.
- Not enough group therapy for children especially groups for children 8 years old and up who have witnessed domestic violence.
- Not enough developmental services for 3-6 year olds.
- Not enough funding for a school health curriculum and additional school-based programs.
- No groups and not enough counselors for youth aged 12-18.
- We need services that promote the safety of women *and* children while simultaneously reinforcing accountability for those who batter. These services should also promote a climate of zero tolerance towards domestic violence in communities.

From the Focus Group

We are always fighting for dollars within agencies. Emergencies always take priority. We would like to see solid support for children's programs and not see children's needs get preempted.

We would like to see acknowledgement of kids as a top priority and enough funding for children's programs.

(Some) People don't see the importance of what we are doing – that we're doing the education and prevention work with kids so there won't be so many women who are later abused. Also, there are a lot of people who don't really know what we do – I mean they know we do classroom presentations, but they say stuff like "What are you guys doing out there? You're just playing with the kids".

Our Board has said that they value the prevention/education piece as much as they value crisis intervention.

Child/Youth Advocates' Views of the Relationship Between the Domestic Violence Program and Community Mental Health Centers	
Programs Reporting An Informal Relationship	12
Programs Reporting A Formal Relationship (e.g., a memorandum of understanding)	2

Comments that reflected a positive working relationship were as follows:

- *We have a positive relationship formalized by a memorandum of understanding (1 program).*
- *We have a good relationship that builds upon our complimentary services.*
- *We have co-facilitated support groups for women and groups for school-aged kids.*
- *We receive preferential treatment – we can get an appointment quickly for someone in shelter.*
- *We sit on the area child protection teams with staff from the CMHC.*
- *A few specific clients have brought us together to help with a specific situation. Otherwise, we have nothing systematic or program-related.*
- *We refer clients to them and vice versa. We have done presentations for them about the impact of DV on children.*

Comments reflecting less positive experiences were as follows:

- *We have a memorandum of understanding but the relationship is negative.*
- *We really do not refer clients to them. We start to, but many clients have already had negative experiences there and they do not want to go back. We explain that they can ask to see a different person at the center but clients sometimes won't pursue the option of a different counselor.*
- *The CMHC has a 6-month waiting list. They seldom make referrals to us and often take on DV cases only to make a mess that we need to clean up.*
- *We use them very seldom. We use other therapists.*

Community Barriers That Limit Access to Mental Health Services

The most frequently checked barriers were the following:

- Waiting lists for mental health services.
- Too few mental health practitioners who know about the effects of domestic violence on mothers and children/youth.
- Lack of public transportation.
- Service eligibility restrictions.
- Mental health services available for one age group/gender but not for another
- Other:
 - *Practitioners overstepping their areas of expertise.*
 - *Too few mental health practitioners in general, too few working with children, too few who accept Medicaid.*
 - *Inadequate crisis response.*

From the Focus Group

Counselors are often miles away and that is a big problem. Transportation is a huge problem. Even if there is a service available, trying to get to it is difficult or impossible. Moms have to get to work, make sure the kids get to daycare and school, and to doctor's appointments and so forth. Just to function with all the daily needs is an enormous task.

Even when a mom has respite hours, there are no respite providers. You can be eligible for lots of respite hours, but you can't find a respite provider to save your life. Mentors for kids/youth are in short supply as well. And sometimes one child who is acting out especially may have a mentor and the other kids get jealous and act out even more.

Training Needs Identified by Child/Youth Advocates

For Staff in DV Programs

Child/Youth Advocates identified the following training needs for staff within domestic violence programs:

- How to provide better help to moms with mental health issues – indirectly this helps their kids.
- Cross-training between domestic violence programs and mental health providers.
- Additional training on:
 - *The effects of witnessing violence on children/youth.*
 - *Children's development and parenting styles.*
 - *Practical tools for working with parents and children together.*
 - *Specific knowledge about successful intervention strategies for working with moms and kids together.*
 - *Practical tools for teaching/interacting with teens.*
 - *Understanding the influence of the media and gender roles (music, television, movies, music videos, advertisements, etc.).*

Community Training Needs

Child and Youth Advocates identified the following community training needs:

“We could work more closely with mental health programs; we could help them and they could help us. There should be a domestic violence specialist in every community mental health center.”

- Cross-agency training on the effects of domestic violence on children and youth.
- Training for mental health providers on recognizing domestic violence and providing effective treatment for children and youth.
- Training for all staff who work with children/youth on basic knowledge about domestic violence and its prevalence in our society, the effects of violence on children, recognizing and understanding the dynamics of

- domestic violence in families and understanding the impact of sexual violence in domestic violence, especially related to children and youth.
- Training that challenges the myths and predisposed beliefs about domestic violence to increase awareness and safety for women and children in our communities.

From the Focus Group

There is a big need for cross training; it can't just be domestic violence workers out there doing this work! Domestic violence (doesn't seem like) a priority, even though probably 80% of kids in treatment have experienced domestic violence. We could work more closely with mental health programs; we could help them and they could help us. There should be a domestic violence specialist in every community mental health center.

Get judges trained on domestic violence; they need more general knowledge about domestic violence and especially how it affects children and youth. We've been trying to get on the Judge's training agenda, but apparently they don't think they need us.

Summary of Responses from Community Mental Health (CMHC) Children's Directors Questionnaire

Responses to the Mental Health Services for Children and Youth Affected by Domestic Violence questionnaire are reported below. The questionnaire was completed by **eleven** children's directors – **ten** CMHC children's directors and **one** director of a private/not-for-profit mental health agency.

Screening for the Presence of Psychological Trauma History

All **eleven** respondents reported that their CMHC routinely screens for the presence of psychological trauma history in children/youth referred for services. This question might have been improved if the term *screen* had been defined. An examination of the forms used statewide and required at intake do not direct the intake interviewer to seek information about trauma or explore the possibility of various trauma-related symptoms or to view presenting problems as a reflection of trauma. As already mentioned the possible problems that may be checked off on the required Intake form do not include trauma or domestic violence as possible contributing factors to a child's difficulties, and the indicators that one may choose from all appear to have been developed with adults in mind.

Screening for Domestic Violence

Ten children's directors reported that their CMHC routinely screens for domestic violence as a possible contributing factor to a child's mental health difficulties. Again, the meaning of this response would be clearer if the term *screen* had been defined in the question. The Intake form, a Narrative Diagnosis and Evaluation form and a Treatment Planning form are all required forms for Medicaid reimbursement, but only data from the Intake form is entered into the

statewide data base (and this form does not identify trauma or domestic violence per se). This means that handwritten information on the D & E form and the Treatment Planning form (that may or may not identify treatment concerns or goals related to domestic violence or other trauma) remain embedded in these narratives and do not find their way into any data base. Nor has much attention been given to training intake workers on the use of these forms, training on how to screen for domestic violence or other forms of trauma in children/youth or on measuring change in client functioning (progress toward or accomplishment of treatment goals) over time.

Use of Specific Screening Tool or Instrument

Only **two** centers reported using a specific tool or instrument to screen for trauma in children/youth; specifically identified were 1) a developmental and family assessment/family matrix chart and 2) the Child & Adolescent Functional Assessment Scale (CAFAS) and the Achenbach Children's Behavior Checklist in addition to the center's own initial assessment package.

The Achenbach Children's Behavior Checklist (CBC) is a well-known and well-researched instrument designed to gather information about children's behaviors and competencies. There are two versions of the instrument, one for children ages 1½ - 5 years, the other for children ages 6-18. The instrument can be filled out by parents, teachers or staff, and there is a self-report form for use by children 6-18. The Achenbach CBC can be used to measure changes in behavior over time or in response to treatment. This checklist measures aggression, hyperactivity, bullying, conduct problems, defiance and violence. The respondent did not specify whether the version for children aged 1½ -5 years as well as the version for children/youth aged 6-18 are both in use or not.

The CAFAS is designed to measure aggression and conduct problems with subtests that measure school, home, community (delinquent-like behavior), behavior toward others, mood/emotions, self-harmful behavior, substance use, thinking problems, material needs and family/social support.

Neither the Achenbach nor the CAFAS is a screening instrument for trauma per se, although both instruments call for the observation and rating of a child/youth's behaviors and competencies that may have been affected by traumatic experiences, including domestic violence.

The use of a specific screening tool within all the community mental health centers would provide a more accurate count of the numbers of children/youth affected by domestic violence or other forms of trauma. In addition, the use of a specific tool statewide would provide information about how children and youth have been affected by these experiences and point more directly toward the specific interventions that would increase safety, alleviate trauma symptoms and

promote emotional regulation and improvements in functioning across home, childcare, school and community domains.

Use of a Domestic Violence Treatment Protocol (Guidelines for Best Practices)

Only **three** children's directors (**of eleven**) reported that their CMHC *does* have a domestic violence treatment protocol. **One** children's director reported that their CMHC *does not* have such a protocol, but the community does. Another children's director reported this is a weak area and that such a protocol probably does not exist across all the different programs within their CMHC.

Of the three CMHC's with a specific domestic violence treatment protocol, **three** reported that the protocol includes the following:

- Information about services available through local domestic and sexual violence programs and referral procedures to these services.
- Referral of male batterers to batterers' intervention programs.

Two of the 3 protocols include the following:

- Guidelines to protect the safety of adult and child victims.
- Provisions for ongoing training on domestic violence for CMHC staff.
- Provisions to address intra-agency and inter-agency barriers that limit access to coordinated domestic violence/mental health services for children and adults.

While it is commendable that three of the eleven children's directors report that a domestic violence treatment protocol does exist, eight of the CMHC's do not have such a protocol. This is an area to be strengthened in most CMHC's. It is also an opportunity for collaborative work between domestic violence programs and community mental health centers to address safety issues and training priorities as well as program needs and barriers that limit access or fragment the community's response to domestic violence and to the needs of children/youth exposed to domestic violence.

Estimated Percentage of Children/Youth Seen in CMHC's for whom Domestic Violence is a Contributing Factor

Four children's directors estimated that domestic violence is a contributing factor for **26-50%** of the children/youth seen at the CMHC; **Seven** children's directors placed this estimate at **51-75%** of the children/youth seen at the CMHC.

Seven Children's
Directors estimated
that domestic
violence is a
contributing factor for
51-75% of the
children/youth seen at
their CMHC.

From these estimates, it appears that domestic violence is a major contributing factor statewide to the mental health difficulties of children/youth seen for treatment in the community mental health centers.

Formal or Informal Relationship With Domestic Violence Shelter or Program

None of the children's directors reported that a formal relationship (e.g., a memorandum of understanding that spells out the responsibilities of each agency, terms of confidentiality, referral procedures or inter-agency training agreements) exists between their CMHC and the nearest domestic violence program. **Nine** children's directors reported that an informal relationship does exist, which was described as follows:

How CHMC Children's Directors Describe Informal Relationships with DV Programs:

- Referrals and DV Staff come to our staff meetings to describe DV services;
- Consultation and participation on treatment teams, referrals;
- We regularly refer and accept referrals from the DV program in our community;
- Staff knowledgeable about local domestic violence agency and refer when necessary;
- Co-facilitate groups;
- The CMHC works with two DV programs in our area. Each DCF office has DV consultant. Trainings have been provided. DV specialist sits on Child Protection Team. Our ACCESS Case Manager is on the DV Task Force;
- Sharing of trainings and resources;
- Referring parents to hotline and support groups.

Community Barriers that Limit Access to Mental Health Services

Children's directors identified a number of similar barriers to those identified by child/youth advocates in domestic violence programs. Barriers such as lack of public (or any) transportation, waiting lists for mental health services, too few mental health providers with expertise in treating children/youth exposed to DV and lack of financial resources to develop or maintain treatment programs were identified repeatedly among children's directors and child/youth advocates.

Barriers to Accessing MH Services Identified by CMHC Children's Directors	
Number of Directors Who Identified	Barriers to Accessing Services
8	Lack of public transportation
7	Waiting lists for mental health services
6	Too few mental health providers with expertise in treating children/youth exposed to DV
6	Lack of financial resources to develop/maintain treatment programs
4	Mental health services available for one age group/gender but not for another
4	High mental health staff turnover
3	Service eligibility restrictions
3	Limited domestic violence services/programs in area
3	Lack of coordination between domestic violence program and CMHC
3	Lack of a comprehensive community response to domestic violence
2	Too few mental health providers
4	<p>Other: Please describe:</p> <ul style="list-style-type: none"> • Sometimes [waiting lists exist] for a long term treatment provider, but immediate access is guaranteed. • [lack of] ANY transportation [not just public]. • Coordination between DV program and CMHC could be stronger. • Consumers' willingness to access - our ability to make services accessible - appeal? • Service coordination between agencies. • No services for adults. • Social acceptance to seek services, etc.

Specialized Domestic Violence Related Training Needs of CMHC Staff

Children's Directors expressed the need for additional training in a number of areas related to domestic violence and its effects on children/youth. There are many fertile areas for cross training between domestic violence programs and community mental health practitioners. In addition, offering continuing education credits (CEU's) will likely increase participation by licensed mental health professionals in the state who are working with children and youth affected by domestic violence.

Specialized Training Needs of CMHC Staff Related to Domestic Violence		
Have	Need	Topic
4	8	Understanding the Social and Interpersonal Context of Domestic Violence
4	8	Screening for Domestic Violence in Children/Youth
5	7	Assessing the Effects of Domestic Violence on Children/Youth
3	6	Ensuring Safety for Children & Battered Women during screening, assessment & treatment
5	7	Understanding the Effects of Domestic Violence on Parent Functioning (Batterer and Victim)
3	7	Accessing Local and Statewide Domestic Violence Resources
Effective Intervention Approaches for:		
Have	Need	Topic
2	7	Infants/Young Children Affected by Domestic Violence
3	7	School-Aged Children Affected by Domestic Violence
4	8	Teen Boys Affected by Domestic Violence
4	8	Teen Girls Affected by Domestic Violence
2	8	Complex and Multiple Issues (intergenerational trauma, substance abuse, child abuse, mental health and/or developmental disabilities)
	5	Other: <ul style="list-style-type: none"> • My staff is huge - some have it and some need. We always have a group in need of more. • Individuals have knowledge in most of these areas, however collectively there is need for more training. • We would appreciate specialized training in the above [all categories?]. Our training is more general. • While some staff have skills and training re: DV, all staff could benefit from more training. • We have varying levels of knowledge across programs.

Findings and Recommendations

While major efforts have been made in Vermont to recognize and respond to the needs of children and youth exposed to domestic violence, this report identifies a number of areas for improvement in the state system of care for children, youth and their families.

1) Early Identification and Intervention

Early identification both in terms of the child's age and the amount of exposure to domestic violence as well as other sources of trauma should be a priority so that early intervention services can be offered to young children whose development is being undermined and shaped by violence and fear. Young children are at greater risk for physical and psychological trauma from exposure to domestic violence. They are more likely to be present in the home when domestic violence occurs; they are at increased risk for experiencing abuse themselves in the midst of the violence occurring in the family, and more at risk for developing post-traumatic stress disorder as a result.

Screening for domestic violence (and other forms of trauma) as a possible contributing factor to a child's health and/or mental health difficulties by pediatricians, other health care providers and early childhood mental health practitioners is needed.

From DCF Domestic Violence Unit Data (July 1, 2003-June 30, 2004), we know that in 1,533 of 12,397 intakes, domestic violence was identified as a contributing factor and that 2,861 children were linked to these intakes. We do not have data about how many of these children received CMHC services or whether those services involved mental health treatment related to DV. We also do not know how many of these children received mental health treatment related to DV through a private practitioner. In addition, from national data, we know that a significant number of children identified as abused and neglected

are also exposed to domestic violence. These children are at greater risk of mental health difficulties due to their greater exposure to trauma. Young children, children in the child protection system and girls in general are at higher risk for developing PTSD than boys. At the same time children under age 7 and girls are underrepresented in the VT community mental health system. Young children whose development is most malleable and fragile are more likely to be at home when domestic violence occurs, their safety and security is undermined when their mother's safety is threatened, and the consequences of their exposure to domestic violence are potentially the most severe and long lasting.

Screening for domestic violence (and other forms of trauma) as a possible contributing factor to a child's health and/or mental health difficulties by pediatricians, other health care providers and early childhood mental health practitioners is needed. Efforts by the Vermont Health Care and Domestic Violence Leadership Team to establish the use of screening for domestic violence by health care providers should be continued and expanded to include risk assessment of infants and young children in families where violence has or is occurring. Creating tools that would assist advocates and parents in determining when children should be referred for mental health services would be beneficial in assuring early identification and intervention.

2) Improve Data Collection

It is difficult to get an accurate picture of how many children and youth are affected by exposure to domestic violence and in what ways their development and functioning is affected. A priority should be to strengthen and link existing databases to facilitate the identification of children and youth who have or are experiencing domestic violence (and other forms of trauma). At present, the CHMC database does not include a specific category for exposure to domestic violence so that the number of children for whom domestic violence is a contributing factor is not identified and cannot be counted.

A priority should be to strengthen and link existing databases to facilitate the identification of children and youth who have or are experiencing domestic violence (and other forms of trauma).

Child protection workers on the DCF intake forms do indicate whether or not domestic violence is a contributing factor or an immediate concern to a child's current situation, and these cases are automatically referred to the Domestic Violence Unit for consultation. However, data regarding mental health treatment for these children is not readily accessible (although it might be gleaned from DCF records). Both CMHC and DCF services could improve the identification and ongoing tracking of mental health treatment these children and families receive. In addition, youth identified as unmanageable or delinquent need to be screened for exposure to DV or other traumatic experiences and/or perpetrating violence in relationships including dating violence. Child and youth advocates in the 14 Vermont Network programs count the numbers of children whose parents (typically mothers) receive services through their programs. Not all of these children receive direct services from child/youth advocates and the majority of programs do not currently track the number of children referred to or currently receiving mental health services.

3) Trauma Assessment and Access to Mental Health Treatment by Knowledgeable and Skilled Mental Health Practitioners

Considerable attention should be devoted to ensuring that Vermont's most vulnerable children receive a comprehensive mental health assessment that evaluates the level of trauma each child has experienced and mental health treatment services that address the child's trauma. Any trauma screening should include screening for domestic violence and must address the immediate safety needs of children, youth and adults living in violent homes.

At present, there is no standardized assessment of each child's functioning or measurement of level of trauma (contributing factors, symptoms, etc.) for those children substantiated by DCF as abused or neglected or for youth identified as unmanageable or delinquent, no systematic record of treatment (who receives therapy from whom for how long with what outcomes), no measurement of

change in the child's level of well-being over the course of treatment and no measurement of treatment effectiveness. The Division of Family Services at DCF has implemented standardized assessment tools to be used statewide for all new children and youth who come into custody. These assessment tools will help standardize the evaluation of children and youth in custody in Vermont, however, this effort will not address the need to have standardized measures for the much larger number of children and youth not in the custody of the state but who need the services of mental health.

The most frequently identified barriers to accessing mental health services include lack of transportation, waiting lists for mental health services, too few mental health providers with expertise in treating children/youth exposed to domestic violence, too few Medicaid providers, and lack of financial resources to develop/maintain treatment programs.

Children of battered women also need access to comprehensive assessment and mental health treatment. Child and Youth Advocates within the Vermont Network Against Domestic and Sexual Violence Programs provide a range of services depending upon priorities in each program and the levels of knowledge and expertise of the workers and the stage of development of children's services within the program. One DV program employs 2 child therapists whose role is to provide clinical services to children/youth exposed to domestic violence. Other programs provide individual and group

education/support for children/youth who have or are experiencing domestic violence. Many programs provide outreach and prevention/education programs in schools and communities. While child and youth advocates acknowledge a therapeutic *role* with the children and youth they see, they do not describe themselves as therapists and the majority are not clinically trained or licensed to conduct mental health assessments or to provide mental health treatment. Understanding the varying levels of services required by different children and youth, advocates also acknowledge the need for more intensive therapeutic intervention to be available.

The most frequently identified community barriers that make it difficult for children/youth and parents who experience domestic violence to get the mental health services they need include lack of transportation, waiting lists for mental health services, too few mental health providers with expertise in treating children/youth exposed to domestic violence, too few Medicaid providers, and lack of financial resources to develop/maintain treatment programs. In addition, services are not always available to meet specific age and gender needs, and in some areas a high turnover in mental health staff, service eligibility restrictions, limited domestic violence services and lack of coordination between domestic violence programs and community mental health centers were identified as issues. Child and youth advocates reported that services and mentors for

adolescent boys in particular are lacking and that respite providers are in short supply.

4) Formalized Working Agreements and Domestic Violence Treatment Protocols

Strengthen collaborative working relationships between Domestic Violence Programs and Community Mental Health Centers through the development of formalized working agreements and domestic violence treatment protocols in all Community Mental Health Centers. According to all of the CMHC children's directors in Vermont, none of the CMHC's has a formal working agreement with a domestic violence program and only two directors indicated that a domestic violence treatment protocol is used in their agency. These are obvious areas for future development and collaboration between community mental health centers and domestic violence programs. These efforts could evolve from mutual training endeavors to create an integrated community response to meet the needs of battered women and children/youth exposed to domestic violence.

Strengthen collaborative working relationships between Domestic Violence Programs and Community Mental Health Centers through the development of formalized working agreements and domestic violence treatment protocols in all CMHCs.

There have been some formal attempts at collaboration between county domestic violence programs, community mental health centers and the Department for Children and Families to address the mental health needs of children exposed to domestic violence. Washington County recently collaborated on a federal grant application (Safe Start) that would set up specialized mental health services for children exposed to violence. The application included funding for one full time and one half-time clinician as well as funding for a full-time domestic violence advocate located on-site at the mental health center.

Both the Domestic Violence and the Mental Health Communities have identified training for mental health providers related to domestic violence as a major priority.

5) Training

The Child/Youth Advocate questionnaire, the CHMC children's director questionnaire and a previous training needs assessment (the Early Childhood and Family Mental Health training priorities survey, Division of Mental Health, 2004) have all identified training for mental health providers related to domestic violence as a major priority.

Children's directors indicated that more training for their staff members is needed in the following areas:

- Understanding the Social and Interpersonal Context of Domestic Violence;
- Screening for Domestic Violence in Children/Youth;
- Assessing the Effects of Domestic Violence on Children/Youth;
- Ensuring Safety for Children & Battered Women during Screening, Assessment and Treatment;
- Understanding the Effects of Domestic Violence on Parent Functioning (Batterer and Victim); and
- Accessing Local and Statewide Domestic Violence Resources.

In addition, more training is needed on Effective Intervention Approaches to meet the needs of specific age and gender groups, including Infants/Young Children, School-Aged Children, Teen Boys, Teen Girls and complex and multiple treatment issues involving intergenerational trauma, substance abuse, child abuse, mental health and/or developmental disabilities.

Children and Youth Advocates indicated the need for more DV/Mental Health cross trainings and DV staff trainings on child development, techniques for dealing with the effects of witnessing abuse, and working with moms and children together.

Although this study did not survey private mental health practitioners, they were identified by child/youth advocates as important providers of mental health services to children/youth exposed to domestic violence in the state. These are licensed mental health providers who are required to complete continuing education courses each year. Courses and training on best practices for working with families experiencing domestic violence should be offered by institutions of higher learning in Vermont as well as professional organizations such as VT-NASW. Training regarding domestic violence should be a priority for this group as well.

Domestic violence program advocates identified additional training needs for staff in their programs in the areas of:

- DV/Mental Health cross trainings;
- Overall training on specific mental health issues;
- Child/MH related Information and resources;
- Effects of witnessing abuse on children and youth;
- Techniques for dealing with the effects of witnessing abuse;
- Ways to support moms and kids together;
- Children's developmental stages;
- Supporting child sexual abuse victims; and
- Supporting moms with mental health issues.

Efforts to reach attorneys and judges who play critical roles in custody and visitation decisions should be increased, since visitation with a battering parent has the potential to heighten anxiety, stress and other effects on children due to witnessing domestic violence. The creation and maintenance of safety for children and battered mothers requires community-wide recognition and commitment. Community and cross-agency training can serve to strengthen our ability to provide safe families and communities for children and youth.

6) Evidence-Based and Promising Treatment Approaches

We are a long way from even describing the intervention approaches currently used with children/youth who experience domestic violence in Vermont, or examining the rationale for using one approach rather than another, measuring treatment effectiveness, or specific social, emotional or behavior outcomes for children, youth or families. First and foremost, we need clear information about how many children/youth are affected in what ways by domestic violence; information about factors in children's lives that offer them protection against the most deleterious effects of domestic violence or conversely exacerbate these adverse effects, and a clear picture of who at present is receiving what kind of mental health service from whom.

Promising models of intervention exist and are entirely congruent with the values and practices that have shaped Vermont's health/mental health system of care for children and families. The Vermont Network Against Domestic and Sexual Violence, the Division of Mental Health and the Department for Children and Families have collaborated in the past to bring training to Vermont from the Child Witness to Violence Project at Boston Medical Center. Many CUPS trainings expanded awareness, knowledge and skills of early childhood mental health providers and early childhood educators and care providers regarding the importance of relationships, security and safety for young children and parents. Additional training in Vermont by experts from programs like the Child Trauma Research Project in San Francisco and the Child Witness to Violence Project in Boston are needed.

References

- Ainsworth, M. D. S. (1969). Object Relations, Dependency and Attachment: a Theoretical Review of the Infant-mother Relationship. *Child Development*, 40: 969-1025.
- Ainsworth, M. D., Blehar, M., Waters, E., & Wall, S. (1978). Patterns of Attachment: A Psychological Study of the Strange Situation. Hillsdale, NJ: Erlbaum.
- American Medical Association (2001). Diagnostic and Treatment Guidelines on Mental Health Effects of Family Violence. IPPF/WHR
- American Psychiatric Association (2000). Diagnostic & Statistical Manual of Mental Disorders_(Ed.). Washington, DC: *American Psychiatric Press*.
- Aron, L.Y., & Olson, K. K. (1997). Efforts by Child Welfare Agencies to Address Domestic Violence. *Public Welfare* 55(3): 4-13.
- Baker, L.L., Jaffe, P.G., Ashbourne, L., M. & Carter, J. (2002). *Children Exposed to Domestic Violence: A Teacher's Handbook to Increase Understanding and Improve Community Responses*. London, ON: Centre for Children & Families in the Justice System.
- Baker, L.L., Jaffe, P.G., Ashbourne, L., M. & Carter, J. (2002). *Children Exposed to Domestic Violence: An Early Childhood Educator's Handbook to Increase Understanding and Improve Community Responses*. London, ON: Centre for Children & Families in the Justice System.
- Bancroft, L. (2002). *Why Does He Do That? Inside the Minds of Violent and Controlling Men*. Putnam.
- Bancroft, L. & Silverman, J. (2002). *The Batterer as Parent. Addressing the Impact of Domestic Violence on Family Dynamics*. Sage
- Beeman, S. K., Hagemester, A. K., & Edleson. J. L. (1999). Child Protection and Battered Women Services: From Conflict to Collaboration. *Child Maltreatment*, 4(2): 116-126.
- Bowlby, J. (1969/1980). *Attachment & Loss. Vol.1: Attachment*. New York: Basic Books.
- Carlson, B. E. (2000). Children Exposed to Intimate Partner Violence: Research Findings and Implications for Intervention. *Trauma, Violence, and Abuse*, 1(4): 321-340.

Carter, L. Weithorn, L. & Behrman, R. (1999). Domestic Violence and Children: Analysis and Recommendations. *The Future of Children*. 9: 4-20

Edleson, J.L. (1999). Children's Witnessing of Adult Domestic Violence. *Journal of Interpersonal Violence*. 14 (8): 839-870.

Family Violence Prevention Fund. The Facts on Children and Domestic Violence. www.endabuse.org

Fantuzzo, J., Boruch, R., Beriama, A., Atkins, M. & Marcus, S. (1997). Domestic Violence and Children: Prevalence and Risk in Five Major U.S. Cities. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36 (1): 116-122.

Fantuzzo, J. & Mohr, W. (1999). Prevalence and Effects of Child Exposure to Domestic Violence. *The Future of Children*. 9: 21-32.

Findlater, J. & Kelly, S. (1999). Michigan's Domestic Violence and Child Welfare Collaboration in J. L. Edleson & S. Schechter (Eds.), *In The Best Interests of Women and Children: Child Welfare and Domestic Violence Services Working Together* (pp. 167-174). Thousand Oaks, CA.

Fraiberg, S., Adelson, E., & Shapiro, E. (1975). Ghosts in the Nursery. *Journal of the American Academy of Child Psychiatry*. 14(3): 387-422.

Fraiberg, S. *Clinical Studies in Infant Mental Health*. New York: Basic Books.

Gaensbauer, T.J. & Siegel, C. H. (1995). Therapeutic Approaches to Traumatic Stress Disorder in Infants and Toddlers. *Infant Mental Health Journal*. 16(4): 292-305.

Graham-Bermann, S. & Edleson, J.L. (Eds.). (2001). Domestic Violence in the Lives of Children: the Future of Research, Intervention, and Social Policy. Washington, DC: *American Psychological Association*.

Groves, B. M. (2002). *Children Who See Too Much*. Boston: Beacon Press.

Groves, B. M. (2003). Shelter from the storm: Clinical Interventions with Children Affected by Domestic Violence. Boston: Boston Medical Center handout.

Groves, B. M. (1999). Mental Health Services for Children Who Witness Domestic Violence. *The Future of Children. Domestic Violence and Children*. 9 (3), Winter: 122-132.

Groves, B. M., Augustyn, M. Lee, D. & Sawires, P. (2004). Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health. Family Violence Prevention Fund.

Harris, W. W., Putnam, F. W. & Fairbank, J. A. (2004). Mobilizing Trauma Resources for Children. Paper presented in part at the meeting of the Johnson and Johnson Pediatric Institute: Shaping the Future of Children's Health. San Juan, Puerto Rico, February 12-16, 2004.

Herman, J. (1992). Trauma and Recovery. New York: Basic Books.

Hughes, H. M., Graham-Bermann, S. A., & Gruber, G. (2001). Resilience in Children Exposed to Domestic Violence. In S. A. Graham-Bermann & J. L. Edleson (Eds.), *Domestic Violence in the Lives of Children: The Future of Research, Intervention and Social Policy* (pp. 67-90). Washington, DC: American Psychological Association.

Jaffe, P, & M. Sudermann (1995). Child Witness of Women Abuse: Research and Community Responses, in Stith, S. and Straus, M. Understanding Partner Violence: prevalence, Causes, Consequences, and Solutions. *Families in Focus Services, Vol.II* Minneapolis, MN: National Council on Family Relations.

Jaffe, P.G., Baker, L.L., & Cunningham, A. J. (2004). *Protecting Children from Domestic Violence: Strategies for Community Intervention*. New York: Guilford Press.

Kendall-Tackett, K. A. (Ed.) (2004). *Health Consequences of Abuse in the Family: A Clinical Guide for Evidence-based Practice*. Washington, DC, US xiii: 289.

Koenig, L. L., Doll, L. S., O'Leary, A. & Pequegnat, W. (Eds.) (2004). *From Child Sexual Abuse to Adult Sexual Risk: Trauma, Revictimization, and Intervention*. Washington, DC, US: American Psychological Association., xv: 346.

Lieberman, A. F. & Van Horn, P. (1998). *A Treatment Manual for Children Traumatized by Family Violence*. Washington, DC: Zero to Three.

Lieberman, A. F., Silverman, R. & Pawl, J. H., (2000). Infant-parent Psychotherapy. In Zeanah, C. H., Jr. (2000, 2nd ed). (Ed.), *Handbook of Infant Mental Health*. New York: Guilford Press.

Lieberman, A. F., & Zeanah, C. H., Jr., (1995). Disorders of Attachment in Infancy. *Infant Psychiatry Child and Adolescent Psychiatric Clinics of America*. 4(3): 579-588.

Lieberman, A. F., & Van Horn, P., (2005). *Don't Hit My Mommy! A Manual for Child parent Psychotherapy with Young Witnesses of Family Violence*. Washington, DC: Zero to Three.

Naparstek, B. (2004). *Invisible Heroes*. New York: Bantam Dell.

Osofsky, J. D. and E. Fenichel (Eds.) (1994). *Caring for Infants and Toddlers in Violent Environments: Hurt, Healing and Hope*. Arlington, Virginia: *Zero To Three*. (December 1993/January 1994)

Osofsky, J. D. (Ed.). (1997). *Children in a Violent Society*. New York: Guilford Press.

Osofsky, J. D. (1999). The Impact of Violence on Children. *The Future of Children*. 9:33-49.

McKay, M. (1994). The Link Between Domestic Violence and Child Abuse: Assessment and Treatment Considerations. *Child Welfare League of America*, 73: 29-39.

Meichenbaum, D. (1994). *A Clinical Handbook/practical Therapist Manual for Assessing and Treating Adults with Post-traumatic Stress Disorder*. Ontario, Canada: Institute Press.

Pandiani, J. & Ghosh, K. (2004). Young trauma victims served in mental health programs. Vermont Menal Health Performance Indicator Project. Waterbury, Vermont: State of Vermont Agency of Human Services website, February 6, 2004.

Pandiani, J. A., Banks, S. M. & Schacht, L. M. (2004). A Multi-state Study of CMHC Utilization by Individuals With a History of Trauma. (A paper presented at the Fourteenth Annual Conference on State Mental Health Agency Services Research, Program Evaluation and Policy, NASMPD Research Institute. Arlington, VA, February 9, 2004).

Perry, B. D. (1997). Incubated in Terror: Neurodevelopmental Factors in the "Cycle of Violence". In Osofsky, J. (Ed.)(1997). *Children in a Violent Society*. New York: Guilford Press.

Perry, B. D. (1994). Neurobiological Sequelae of Childhood Trauma: PTSD in Children. In Mumberg (Ed.) *Catecholamine Function in Post-traumatic Stress Disorder: Emerging Concepts*. Washington, DC: American Psychiatric Press, 233-255.

Perry, B.D., Pollard, R. A., Blakley, T. L., Baker, L., Vigilante, D., (1995). *Childhood Trauma, the Neurobiology of Adaptation and Use-dependent*

Development of the Brain: How States Become Traits. *Infant Mental Health Journal* 16: 27-291.

Pynoos, R. & Eth, S. (1985). *Children Traumatized by Witnessing Acts of Personal Violence: Homicide, Rape, or Suicide Behavior*. In *Post-Traumatic Stress Disorder in Children*. Washington DC: American Psychiatric Press, 19-43.

Pynoos, R. & Nader, K (1988). Children Who Witness the Sexual Assaults of Their Mothers. *Journal of the Academy of Child and Adolescent Psychiatry*, 27: 567-572.

Pynoos, R.S., Steinberg, A. M., & Wraith, R. (1995). A Developmental Model of Childhood Traumatic Stress. In D. Cichetti & D. J. Cohen (Eds.) *Manual of Developmental Psychopathology*. (pp.72-95). New York: Wiley

Scheeringa, M. S., & Gaensbauer, T.J. (2000). Posttraumatic Stress Disorder. In Zeanah, C. H., Jr., (2000). *Handbook of Infant Mental Health*. (pp. 369-381). New York: Basic Books.

Scheeringa, M. Zeanah, C., Myers, L., & Putnam, F. (2003). New Findings on Alternative Criteria for PTSD in Pre-school Children. *Journal of the American Academy of child and Adolescent Psychiatry*. 42:561-570.

Silva, R. R. (Ed.) (2004). *Posttraumatic Stress Disorders in Children and Adolescents: Handbook*. New York/London: W. W. Norton & Co.

Stoesen, L. (2005). Children Not Accessing Available State Services. Washington, DC: *NASW News*, Vo. 50, No. 3, March, 2005: 11.

Terr, L. (1981). Psychic Trauma in Children: Observations following the Chowchilla School-Bus Kidnapping. *American Journal of Psychiatry*, 138, No. 1: 14-19.

Terr, L. (1990). *Too Scared To Cry*. New York: Harper and Row.

Vermont Medical Society website – Domestic Violence Home. Vermont Health Care and Domestic Violence Leadership Team Statewide Action Plan. Vermont Health Care and Domestic Violence Leadership Team Advisory Group. 2004. <http://www.vtmd.org/Domestic%20Violence/DVHome.html>

Van der Kolk, B. A. (1994). The Body Keeps the Score: Memory and the Evolving Psychobiology of PTSD. *Harvard Review of Psychiatry*, 1, 253-265.

Van der Kolk, B. A. (1987). *Psychological Trauma*. Washington, DC: American Psychiatric Press.

Warshaw, C. & Barnes, M. A., (2003). Domestic Violence, Mental health, and Trauma: Research Highlights References (PDF).

Warshaw, C. & Moroney, G. (2002). Mental Health and Domestic Violence: Collaborative Initiatives, Service Models, and Curricula. (PDF) Working Paper, September, 2002.

Wolak, J. & Finkelhor, D. (1998). Children Exposed to Partner Violence. In J. L. Jasinski & L. M. Williams (Eds.). *Partner Violence: A Comprehensive Review of 10 years of Research*. In Thousand Oaks, CA: Sage Publications.

Wolfe, D. A., Wekerle, C., Reitzel, D. Gough, R. (1995). Strategies to Address Violence in the Lives of High Risk Youth. In Peled, E., Jaffe, P. G. & Edleson, J. L. (Eds.) (1995). *Ending the Cycle of Violence: Community Responses to Children of Battered Women*. New York: Sage Publications.