




center for
CHILD & FAMILY HEALTH



the
needs of
children



in domestic
violence shelters




A Toolkit to Assist North Carolina
Domestic Violence Agencies and
Other Service Providers to Identify
and Respond to Children Exposed
to Domestic Violence





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THERE ARE NUMEROUS individuals and organizations that have contributed to the development of this toolkit through research, practice, funding, and feedback. This groundbreaking project dedicated to improving services for children in domestic violence shelters would not have been possible without the generosity and commitment of the following:

Pilot Sites

The enthusiasm and participation of the directors and staff at the pilot sites helped to make this project a success and beneficial to other shelters in North Carolina. Their vision and commitment to helping families and children is commendable and greatly appreciated. We extend special thanks to: Area Christians Together in Service (ACTS) in Vance County; Family Services of the Piedmont in Guilford County; Hannah's Place in Halifax County; Shelter Home of Caldwell County; Southeastern Family Violence Center in Robeson County; and Wesley Shelter in Wilson County. Also, we are very grateful to Margaret Samuels, MSW, and Yvonne Wasilewski, PhD, for their leadership and contribution to the original pilot project and the early development of the toolkit.

The Families Served

Thank you to the mothers, caregivers, and children served for their feedback during the pilot project assessments and parenting skills training, and for demonstrating courageous and sincere effort on behalf of their children and families.

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We express our appreciation to The Duke Endowment and Z. Smith Reynolds Foundation for their support and commitment to building a comprehensive, trauma-informed system of response for children and their caregivers in shelter.

The Reviewers

Many thanks to those who have taken the time and shared their expertise in reviewing this toolkit. Their generous and useful suggestions have been invaluable.





APPROXIMATELY SIX TO EIGHT THOUSAND CHILDREN reside in North Carolina's domestic violence shelters for some time during each year, with many more coming into contact with community domestic violence agencies. Their stays typically are short-term, brought on by an acute crisis or violent incident, unexpected by the child, and one more step in a cascade of family and social disruptions. Despite the need to help these children achieve safety and emotional well-being, and stop the cycle of domestic violence facing them, only a small handful of North Carolina's more than 90 domestic violence shelters are able to provide comprehensive child-focused services, and state funds do not require programs nor fund them specifically to design and deliver services around children's needs. Even if full funding and state support for children's services in shelters were available, existing domestic violence programs vary widely across the state in terms of capacity, as does the availability of child and adolescent community resources.

In order to take steps to alleviate these barriers, the Domestic Violence Shelter Screening Project sought to inform domestic violence shelter service providers on how to identify the mental health and community service needs of resident children, and improve their capacity to educate and support battered parents and caregivers. In 2006, The Duke Endowment and Z. Smith Reynolds Foundation jointly funded an endeavor of the Center for Child and Family Health (a collaboration of Duke University, the University of North Carolina Chapel Hill, North Carolina Central University, and Child and Parent Support Services), Duke University's Center for Child and Family Policy, and six domestic violence shelters to test various strategies for improving the identification and response to children.

The project's goals included: determining whether it was feasible to train shelter staff to provide routine screening for traumatic stress and other behavioral and developmental concerns in children entering domestic violence shelters; enhancing the care and support for children while living in shelter through the delivery of training on developmentally appropriate parenting strategies; and establishing a system for referrals within the community for children experiencing symptoms of distress or developmental delays, including how to address legal considerations for both children and parents.

The six pilot sites across North Carolina were selected for their variety of community and program strengths and challenges, including: Area Christians Together in Services (ACTS) in Vance County; Family Services of the Piedmont in Guilford County; Hannah's Place in Halifax County; Shelter Home of Caldwell County; Southeastern Family Violence Center in Robeson County; and Wesley Shelter in Wilson County.

The comprehensive training and consultation at the pilot sites was provided by mental health and legal staff from the Center for Child and Family Health, while the Center for Child and Family Policy conducted research and evaluation regarding quality of assessment, training, and community referral.

The project provided the basis for what is included in this toolkit. A full report on the Domestic Violence Shelter Screening Project can be downloaded at http://www.childandfamilypolicy.duke.edu/evalsvcs/files/Final_Report_DVS_071608.pdf

about the center for child and family health

THE CENTER FOR CHILD & FAMILY HEALTH (CCFH) was founded in 1996 and continues to function as a non-profit consortium of faculty and staff from Duke University, the University of North Carolina at Chapel Hill, North Carolina Central University, and Child and Parent Support Services, Inc. CCFH uniquely combines direct clinical practice with academic resources as a multidisciplinary endeavor, so that all of its services benefit children and families from both a holistic approach and use and development of evidence-based, best practices.

CCFH began with a small staff of medical, legal, and mental health providers and a board comprised of concerned community and university leaders. It has evolved into a staff of approximately 60 members, including several academic faculty, community oriented staff members, and interns and residents from multiple fields. The Center now has a governing and volunteer core of a 17 member board of directors and a 25 member Leadership Council. In 1999, Child & Parent Support Services, a longstanding Durham area non-profit focused on in-home abuse prevention services, became a consortium member.

From the time of its founding until 2003, most of the work at CCFH was comprised of prevention, assessment and direct services to local children and families by medical, mental health and legal service providers. Since then, CCFH has developed a wider influence and expertise in the field of children's services. In 2003, CCFH joined the National Child Traumatic Stress Network, a national network dedicated to improving mental health standards of care related to child traumatic stress, fostering increased CCFH provision of research and training statewide, nationally, and internationally. In 2006, the CCFH Legal Program expanded its work to include

teaching law school coursework, widening community legal referral, and increasing its statewide and national presence. CCFH has now expanded in breadth and depth into an organization that not only provides direct care, but also informs the body of knowledge around the best practices for the prevention and treatment of childhood trauma through training, dissemination, and research, as well as multidisciplinary services for traumatized children across the state, the nation and internationally.

The authors of this toolkit include the following staff at the Center for Child and Family Health: Ernestine Briggs-King, PhD (Director of Research), Jennifer Brobst, JD, LLM (Legal Director), Robert Murphy, PhD (Executive Director), Donna Potter, LCSW (Training Coordinator), Ebony Sneed, MPA (Research Coordinator), and the invaluable contractual services and expertise of Leslie Starsonneck, MSW.



What is the Toolkit for?


This toolkit is designed for use by shelter-based and other domestic violence direct service providers in North Carolina. Volunteers, program managers, and other collateral child-serving agencies across the State may also find the information and resources in the toolkit helpful when responding to the diverse needs of children and families exposed to domestic violence. Whether service providers are new to the work or have years of experience, whether they are licensed clinicians or dedicated survivors and volunteers, this toolkit will serve as a teaching tool and guide to understanding how trauma from domestic violence impacts children and how best to serve these children's needs.

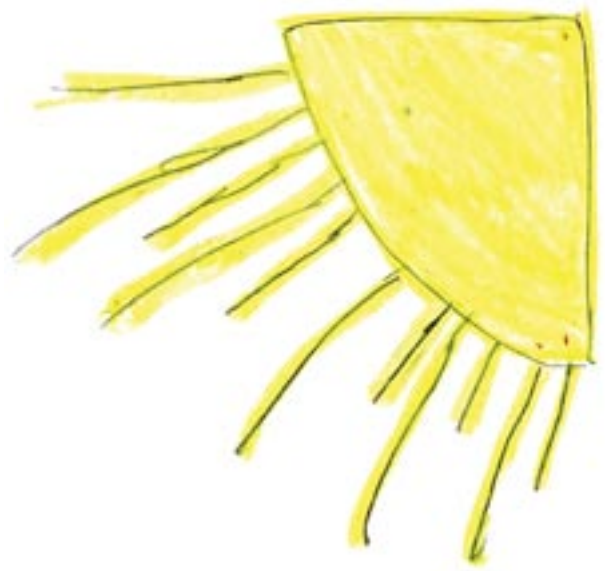
What is Covered in the Toolkit?

In Chapter I, service providers in shelters and other domestic violence agencies working with children will learn about the mental health and behavioral impact of domestic violence on children, with some guidance on how to approach children and their caregivers about the children's mental health needs. Chapter II provides specific assessment tools to help providers make appropriate identifications of mental health service needs. Chapter III describes ways to teach positive parenting skills to adult and teen parent residents in shelter. Chapter IV addresses the potential mental health needs of parents and the impact of domestic violence on parenting. Chapter V provides information on a number of additional community resources for children, including child care services, and children's health insurance. Chapter VI addresses legal concerns and referral sources for service providers working with children in families experiencing domestic violence. Finally, the Appendices include additional resources, research references relied upon in this toolkit, and a useful Self-Assessment Checklist for Community Referrals.

How to use this toolkit

Although each chapter of the toolkit builds on previous chapters, each can be read and referred to independently.

- For those using the toolkit for the first time, look closely at the key points (see key symbol to the right), and take advantage of the practice skills and scripts, role-playing and practicing the respective parts with your co-workers until you feel comfortable with the techniques and assessments. Reading the toolkit from beginning to end should give you a solid understanding of the basic symptoms of traumatic stress in children at different developmental stages caused by domestic violence, and how to improve your skills in meeting their needs. 
- For those who already have substantial training in understanding the mental health needs of traumatized children, the toolkit can be a reference guide for using the variety of appropriate assessment tools and a refresher for practicing your skills.
- For use as a quick referral guide, the toolkit can be easily used to quickly find appropriate community referrals for a variety of services for children related to mental health, social service, and legal service needs.
- As a training tool, the toolkit can be used again and again for training new staff and other community partners so that children and their caregivers can continuously receive high quality monitoring, support and care.



chapter 1: the impact of trauma on children

FAMILIES ENTER DOMESTIC VIOLENCE SHELTERS due to a variety of possible factors commonly associated with homelessness, including a possible lack of employment to ensure independent housing, transportation, and financial security. The primary reason for many, however, is the experience of frightening, traumatic, violent events. The impact of trauma on children can be addressed by many different domestic violence service providers, but the toolkit focuses somewhat on shelter staff members because they may have more of an opportunity to spend an extended amount of time with children. All of the resources within this chapter and throughout the toolkit, however, can be very useful for a variety of service providers helping both parents and children exposed to the trauma of domestic violence.

A **trauma** is an experience which is sudden, uncontrollable, and negative. It is a situation that overwhelms the coping skills of the child or adult experiencing the trauma and makes them fear for their safety and/or the safety of others. The trauma of domestic violence can have lasting negative impacts on the mental health and wellbeing of the infants, children, adolescents and adults exposed to or targeted by the violence.



Key point: Domestic violence is one of the most significant possible traumas for a child, especially a young child. Shelter service providers are in a unique position to help identify when children may be exhibiting signs of traumatic stress and need mental health services.



I. UNDERSTANDING THE IMPACT OF TRAUMA ON CHILDREN'S BRAIN DEVELOPMENT

Young children count on their caregivers to make the world a safe place and they believe their caregivers will be successful in this task. Children are therefore hard-wired to run to their caregivers if they feel terrified. The problem with domestic violence is that children end up in a situation where they feel terrified but they can't go to their caregivers for safety. This can cause them to doubt that the world is a safe place, and if they doubt it, they will not be able to explore and discover the world in the manner they need to developmentally. They also may not interact with others in positive ways because of the interference of some of the traumatic symptoms that arise in stressful situations. Living in shelter may be stressful in and of itself, given the fact that the family has been uprooted in a situation of crisis and danger. The combination of experiencing trauma and being in shelter may be especially challenging for both children and their caregivers.

Research has shown that trauma can impact children’s brain function and structure, altering their cognitive, emotional, and behavioral development. When faced with danger, a person’s nervous system responds with signals for adrenaline and other hormones to be released into the blood, increasing heart rate and blood flow to muscles. When a person is faced with danger all of the time, the body’s changes are more dramatic and become more lasting. In young children who have experienced early, chronic violence, particularly at the hands of their caregivers, their brains end up focusing their energy on survival instead of higher reasoning and learning. That means children may see a situation as very threatening when others don’t. They may then seem to “go off,” act out, or have tantrums for no reason. The reason is that their brains tell them to see a threat where those who have not experienced trauma would not.

Shelter service providers can help parents identify and understand the source of their children’s behavior and responses to domestic violence.

What does trauma look like in children?

- Memory problems (difficulty recalling experiences)
- Poor school performance or excessive absences
- Developmental delays, including:
 - Problems with receptive and expressive language (understanding what is being said by others and trying to express themselves)
 - Cognitive delays/difficulty learning
 - Poor fine motor coordination
 - Gross motor delays
 - Sensory integration problems (disorganized, doesn’t explore, clumsy, inability to calm)
 - Failure to thrive in infants (failure to gain weight and poor physical growth during infancy)
- Many other emotional and behavior issues that will be explored in this chapter

II. CHILD DEVELOPMENT

Children respond to trauma, including domestic violence, in different ways at different ages. It is important to have a basic understanding of development in order to put the trauma in context. Knowing how a child understands the

controlled studies show structural changes in the brains of children exposed to violence including:

- less brain mass and less brain tissue connecting the hemispheres of the brain
- less brain activity in higher reasoning and learning
- difficulty regulating affect (emotions) and behavior (actions)
- changes in the stress hormone systems of children exposed to violence
- delays in fine motor and gross motor coordination, language, and learning

world as a result of his or her developmental level will help parents recognize trauma symptoms better and make more sense of the child’s behavior. It will also help the parent figure out the best way to word things so that the child can understand and not be overwhelmed.

Stages of child development - At what ages will children do certain things?

0-5 years

In general, young children develop in the context of relationships and use relationships with caregivers to:

- calm themselves down/soothe;
- figure out how relationships work and how the world will treat them;
- as a secure base for exploring and learning about the world; and
- as a model for understanding acceptable behaviors.

Specifically, in the first three years of life, children are typically:

- Developing basic emotions.
- Developing simple words, then, sentences.
- Providing uneven receptive and expressive language. Children can usually understand things before they can say them. HOWEVER, they often appear to understand

much more than they actually do because they are very tuned in to their caregiver's emotions.

- Believe their caregivers know everything and can do anything they want. So, for example, if there is domestic violence, children believe the parents must have wanted it that way.
- Self-centered: "The world revolves around me. Everything relates to me." Therefore, if someone does something bad, the child may feel it was his or her fault.

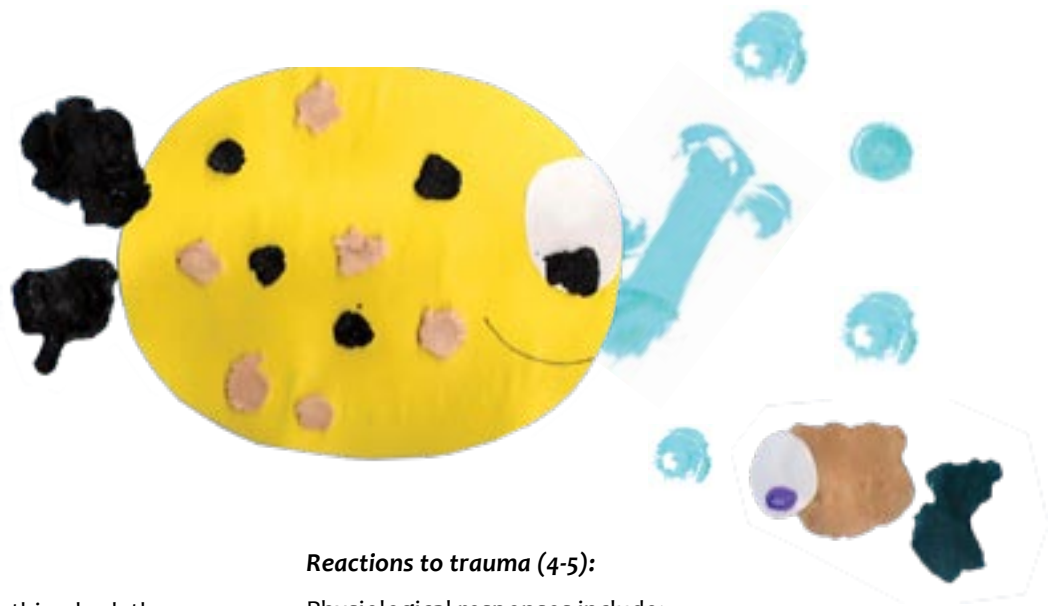
Reactions to trauma (0-3):

Because infants cannot talk, their trauma symptoms are physical. Even as they develop verbal language in their first three years, their first language is still their behavior and play. Physiological responses to trauma include:

- Difficulty being soothed
- Trouble with sleeping and eating regularly
- Trouble with body functions (e.g., they may become gassy or constipated)

In the fourth and fifth years of life, children are typically:

- Developing the ability to take another person's perspective
- Developing ability to soothe their own feelings and calm themselves down
- Developing more advanced language, telling stories, and asking questions. As they try to figure out what is happening, some of their stories may incorporate some truthful aspects with some more fantastical aspects. Or, they may incorporate things they have heard their parents say into their own story.
- Becoming very concrete in their thinking. Things are either good or bad, fair or unfair. They don't appreciate moral ambiguity or "gray areas" yet, so it is difficult for them to both love and fear the same person.
- Still wanting to be the center of the universe! Therefore, they still try to take responsibility for things that are out of their control.
- Very afraid their caregivers will stop loving them or will leave them. As a result, many tend to respond to scary situations by becoming very clingy.



Reactions to trauma (4-5):

Physiological responses include:

- Difficulty calming themselves down
- Trouble with sleeping and eating regularly
- Somatic complaints – (don't feel well, e.g., stomach aches, headaches)

Emotional and behavioral responses include:

- Aggression
- Fears
- Developmental regression (i.e., going back to an earlier stage of development) – e.g., a child who has been potty-trained may start to wet the bed again after witnessing a fight between their caregivers.
- Nightmares and night terrors
- Clinging to caregivers and being afraid of being left alone

6-12 years

Typically, children at this age are:

- Able to show more than one emotion at a time.
- Able to understand shades of meaning in words – e.g., "Your grandfather has passed away."
- Able to think logically and to understand cause and effect.
- Focused on becoming more independent at school and with their peers.
- Able to control their impulses more effectively than they had in preschool.
- Busy developing and trying to maintain friendships with their peers.
- Still concrete thinkers. They may have trouble with the idea that someone or something can be good and bad at the same time.

- Not aware of why they do what they do. Therefore asking “why did you do that?!” will only lead parents to feel frustrated!

Reactions to trauma

- Both internalizing and externalizing behavioral problems, including aggression towards peers, siblings, adults, and animals
- Verbal expression of distress, closer to that of adults
- Somatic complaints, e.g., stomach aches, headaches

13-18 years

Typically, adolescents at this age are:

- Able to behave according to their own internal standards, but are still extremely concerned about the opinions of others
- Beginning to figure out who they are as people and with whom they want to socialize.
- Thinking abstractly and logically about different problems and consider the future
- Concerned with intimate relationships (i.e., the emergence of hormones)
- Concerned with group identity or membership in a peer group, which becomes more important than identifying with immediate family members

Reactions to trauma

- Aggression towards peers, siblings, adults or animals
- Defiance
- Isolate themselves from caregivers and choosing peers over parents
- Substance abuse
- Self-blame
- Depression, suicide attempts, and other self-harming behaviors

III. GUIDELINES FOR TALKING TO CHILDREN ABOUT DOMESTIC VIOLENCE

Reaching out to children and their caregivers in shelters to focus on the children’s specific mental health needs is important to help not only the children, but the family as a whole. It may be the first time the caregiver has been given information on where to find services for their child or what symptoms of trauma look like in children exposed to domestic violence. Many parents may fear losing their children to social services if they admit to their concerns for their children, but entering shelter is a positive first step in keeping their children safe. For more information about confidentiality, the duty to report child abuse and neglect, and other legal concerns, please see Chapter VI.

Key point: Children may want to voice their concerns and fears and feel safe for the first time to do this now that they have escaped the violence in their home. Not talking about the violence at all (ignoring their questions or making something up) can leave children confused, scared, or feeling responsible for the violence. Although a child’s capacity to understand the violence, as well as what happens after the violence, may differ depending on age and development, identifying the needs and services for children is crucial to their wellbeing.

Some tips for talking to children (and their parents) about domestic violence

Infants and toddlers:

- Share basic information with the parent related to early child development, positive parenting skills (including information about the risks of shaken baby syndrome), and the impact of domestic violence on infants and toddlers (including identification of failure to thrive and developmental delays).
- Share information with the parent based on her own need for safety, consistency and maternal well-being. Babies and young children get their cues from their primary caregiver about how safe they are and how to respond to events in life.
- Let caregivers know that children at this age are likely to be fussy and difficult to soothe in this situation and that the parent should make every effort to maintain any possible consistency (e.g., keep the same bed time, sing the same songs, read the same stories).



Preschoolers and young school age children:

- Provide the parent with all of the information above and encourage the parent to do the following, but if they can't, you can help with their permission.
- Explain to young children that it is the parents' job is to keep them safe and that "grownups sometimes have big feelings and don't know how to handle them without help."
- Explain to the child that the shelter is a place of help for their family.
- Restore a sense of predictability for children, such as when they can expect to see certain family members again or under what circumstances, or what must happen first before a child can see the abusive parent.
- Say that there is a need for everyone to be safe.
- Make it clear that the violence and life changes associated with the violence (moving to a shelter, staying with a neighbor, changing jobs) are not the child's fault.
- Remind the child that their parent(s) and other caregivers love the child very much.

School age children:

- Encourage the parent to communicate information and reassurance directly, but if they can't, you can help with their permission.
- Explain to children that the parents could not be safe together and had to separate for the parents' and children's safety.
- Provide reassurance about the future and tell the children what will likely stay the same (e.g., school, ability to see friends or family members, parental care and love).
- Prepare the children for what might be different (e.g., home, school, rules, time with parents or other family members).
- Reinforce that the child is not responsible for what's happening and that the parent(s) and other caregivers love the child.
- Help the child identify what he or she did well when the violence occurred and/or during escape or entry into shelter (e.g., called police, informed another adult, left house, comforted another sibling, or went to a safer place in the house).

Young adolescents:

- Encourage the parent to communicate information and reassurance directly, but if they can't, you can help with their permission.
- Listen without judgment and provide accurate information.
- Talk about abuse prevention and what makes a safe/ healthy intimate relationship, including information on alternatives to angry responses.
- Make it clear that they are not in the role of parent or their parent's friend, although they may have some limited responsibilities.
- Reinforce that they are not responsible for what has happened and that both parents love them.
- Safety plan with adolescent and parent for in shelter and other settings (including discussion of healthy dating relationships – e.g., see resources from the North Carolina Coalition Against Domestic Violence in Appendix A)

IV. RESILIENCE

While domestic violence has the potential to have very negative effects on all aspects of children's lives and development, it does not affect all children in the same way. Human beings can be incredibly resilient, facing adversity with courage and perseverance. Resilience can come in many forms, and develops over time given a person's life experiences and support. The more resilience factors a child possesses, the greater the likelihood of positive outcomes in the child's life.

Key point: There are many things that shelter staff and especially parents can do to help children develop resilience factors and cope with the trauma of domestic violence. One of the most basic and most important is to provide physical, emotional and behavioral structure and routine. In order for children to feel emotionally secure, they need a warm, loving and predictable relationship with their parent.

What are Resiliency Factors?

Having a parent provide emotionally responsive caregiving is the best predictor for a child's healthy recovery from domestic violence exposure. Domestic violence shelter staff can help parents be more emotionally responsive to their children by helping them recognize the feelings their children

are having and helping children use words to express those feelings. Staff can also help by teaching parents how to give their children safe ways to cope with big and confusing feelings (see Chapter III).

Research has also indicated other resiliency factors to consider, such as: a child's positive self esteem; child's belief that his/her actions can change the outcome of his/her situation; average to above average cognitive, language and coping abilities; external attribution of blame for the domestic violence; family cohesion; extra-familial support; and mother's warmth and emotional stability.

IV. MENTAL HEALTH CONCERNS FOR CHILDREN EXPOSED TO TRAUMA

Once the family residents and shelter providers have shared an understanding of the potential for trauma in children exposed to or directly victimized by domestic violence and the assistance that the shelter staff can provide to the children's needs, it is helpful to identify whether there may be potential mental health concerns and a need for specialized services for the children.

What are the top mental health concerns for children exposed to trauma?

- Separation Anxiety Disorder
- Oppositional Defiant Disorder (ODD)
- Phobias (extreme fears)
- Posttraumatic Stress Disorder (PTSD)
- Attention Deficit Hyperactivity Disorder (ADHD)

- Sexualized Behavior
- Complex Trauma

Separation Anxiety Disorder

The most common mental health concern for children who have experienced domestic violence is separation anxiety. If the child has experienced a terrifying event, he or she will try to cope by maintaining close proximity to the caregiver, whose primary job is to keep the child safe. This can be difficult for parents, who may also be traumatized and irritable and desperately in need of services themselves.

Oppositional Defiant Disorder (ODD)

We often think of children in shelter as being "mad" at their moms. They tell her they don't have to listen to her. They might yell at her or treat her disrespectfully. This behavior impacts their functioning and can be diagnosable as a mental health disorder. Consider that often in a home where there is domestic violence the mother's authority has been undermined and the children have not had to comply with her commands at all. She may lack confidence and not know how to consistently and effectively provide rewards and consequences that can positively shape her children's behavior. It is also important to keep in mind that anger is often a response to fear as it can serve to protect us when we are threatened (the fight or flight response). Children's fear of being unsafe or of feeling their mother cannot protect them may contribute to oppositional behavior appearing angry.

Phobias (extreme fears)

If a child has experienced something extremely frightening, they will try to avoid having that thing happen again. One way to do that is to avoid people, places or situations that remind the child of the experience. This avoidance becomes a phobia. For example: if the child's parents always argued at night when the child went to bed, the child may develop a phobia of bedrooms or bedtime.



children's "bad behavior" in domestic violence shelters may not be "bad," but rather a cry for help. improving positive parenting skills, identification of children's and parent's mental health needs, and ensuring structure to keep children active and engaged during their stay are all ways to help children move beyond the trauma of domestic violence.

Posttraumatic Stress Disorder (PTSD)

Some children will develop Posttraumatic Stress symptoms from their domestic violence exposure, which means that they think about the trauma when they don't want to and that it causes their body to feel the same sensations of terror they felt at the time the violence was actually happening. Those sensations are so distressing that children will work very hard to avoid anything that will remind them of the violence.

Posttraumatic Stress symptoms can be categorized into the following symptom clusters:

- Re-experiencing
 - Difficulty staying awake or falling asleep
 - Biopsychological Distress
 - Secondary Reminders (e.g., intrusive thoughts, nightmares, flashbacks)
- Avoidance/Numbing
 - Emotional Numbing
 - Social Detachment
 - Memory Loss
- Hyperarousal
 - Anxiety
 - Irritability
 - Insomnia
 - Poor Concentration
 - Hypervigilance (feeling on guard)



Attention Deficit Hyperactivity Disorder (ADHD)

A lot of children who witness ongoing domestic violence in their homes become diagnosed with ADHD. They have trouble sitting still and concentrating in school and they get distracted easily. It is important to ensure that the child receives an accurate and thorough assessment by someone who understands the impact trauma can have on a child's behavior before measures are taken to address ADHD. Specifically, it is important for children exposed to domestic violence to be accurately diagnosed (and treated if necessary), given that ADHD and PTSD may have similar symptoms leading to a misdiagnosis.

Sexualized Behavior

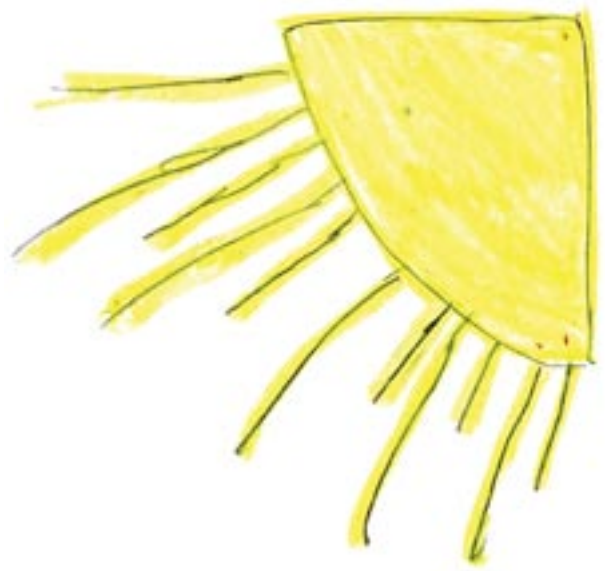
Some sexualized behaviors that do not involve being coercive to others, like masturbation, have been shown to be present in children who have chronic domestic violence exposure, even when there is no evidence the child has been sexually abused. However, it is important to remember that domestic violence and sexual abuse often go together. If you know a child is acting out sexually, the child should be assessed by experts to determine if the child has been sexually abused.

Complex Trauma

Complex trauma is a term that describes how children who have chronic early exposure to interpersonal violence and other traumatic events, particularly when it is perpetrated by caregivers, can have trouble regulating or modulating their:

- physical responses to their environment (their heart beats quickly and won't slow down if they hear a loud noise);
- emotional responses (they get very angry quickly and can't seem to calm down);
- behavioral responses (they have trouble controlling their bodies and their impulses); and/or
- relationships with peers and caregivers when children don't trust that people are safe or will do what they say they will do (children may be bossy and controlling with peers and have trouble making and keeping friends).

There has been tremendous progress in the area of research and reporting on the traumatic impact of children's exposure to domestic violence. Creating greater understanding among shelter service providers of what children are facing and how they are really doing can only enhance their work to empower families in the face of domestic violence. However, identifying the traumatic symptoms and behavioral concerns of children is only one step. Learning to use the tools of assessment that are now available to work with children (see Chapter II) is another. As will be discussed in subsequent chapters, accessing mental health resources that include expertise in understanding the dynamics of domestic violence along with the specialized needs of children's traumatic stress may be a challenge. However, your support and involvement with identifying and connecting families with the best community resources available will help give children and their parents and caregivers the attention they need and deserve. Providing this service to the youngest and most vulnerable of domestic violence victims is one of the most important steps in helping families break the cycle of violence.



chapter 2: trauma-informed identification and screening

DOMESTIC VIOLENCE SHELTER PROVIDERS are important first responders for children who may be experiencing symptoms of trauma. This is particularly true because many shelter staff members may spend more time with children than other first responders (e.g., hotline staff, police officers, health care workers, and mental health professionals).

As suggested in Chapter 1, exposure to domestic violence and other traumas can be associated with a host of outcomes ranging from a loss of resiliency to developmental delays to difficulties focusing in school. This module provides information about three basic screening tools or measures that shelter staff members can use to help identify some of the more common emotional, behavioral, and developmental symptoms of trauma in children.

These tools include:

- The UCLA Posttraumatic Stress Disorder Reaction Index (PTSD-RI),
- The Strengths and Difficulties Questionnaire (SDQ), and
- The Parents' Evaluation of Developmental Status (PEDS).



Key point: All of these screening tools are well established effective methods of assessing the needs of children exposed to violence. These particular tools were also those found to be effective in the pilot shelter programs participating in the initial Domestic Violence Shelter Screening Project which fostered this toolkit.



I. SCREENING CHILDREN IN A SHELTER SETTING

At first glance, it may seem like a difficult task to fit in formal screening tools with the other services provided to children and parents in shelter, but the benefits can far outweigh the difficulties. Screening and early identification are two of the most powerful tools in assisting parents in understanding how they can more effectively manage a child's behavior while also strengthening their parent-child relationship.

Information that is collected as part of the screening process can be used to lighten the load for shelter staff who often assist the parent with managing children's behavior. Furthermore, early identification and treatment of trauma related difficulties and symptoms can possibly prevent

additional problems down the road. Most importantly, children deserve to receive needed services so that they, like their mothers, can emerge from shelter a little stronger and happier, feeling both supported and confident. This in turn, can have a profound effect in stopping the intergenerational cycle of domestic violence.

screening information may ease the worries of parents who learn that their children are not permanently harmed by the violence, or they may find extraordinary or unexpected support when their children do need substantial services.

How to talk with caregivers about the need for screening their children

Parents deal with so many issues of their own in domestic violence shelters, including in some cases the fear that they may lose their children. They may be hesitant to work with staff charged with the task of screening their children. However, a compassionate advocate willing to discuss parenting and children can be extremely beneficial for parents in shelter.

Below are some tips for having the first conversation with parents in shelter about screening their children for symptoms of trauma, distress, or developmental concerns:

1. First work to develop a positive relationship and rapport with the parent and discuss her own emotional well-being and role as a parent, respecting and acknowledging that parenting differs widely by culture and belief.
2. Engage the parent in a general discussion about the child focusing on the child's strengths rather than the child's problems alone.
3. Ask about the child's school, peer relationships, and functioning.

4. Discuss how children are often deeply affected by the problems of their parents and caregivers, as well as by the move into shelter. These are generally very extraordinary circumstances for both children and their parents.
5. Explain that you want to ensure that the child is okay and that any services or assistance that the shelter can provide are available to her and her child.
6. Explain your shelter's policies and duties related to confidentiality and the duty to report abuse and neglect, but include a discussion about how use of the shelter is often seen as a positive step by the parent to protect her children (see Chapter VI).

When to administer and how to store screening measures

The screening measures should be administered at a time that is suitable for the parent or child and may be incorporated into the shelter's existing intake process. The measures can often be administered within the initial 24 hours of a shelter stay, however staff should be attentive to acute crisis states and important safety and practical needs

for assistance that take precedence over screening. In these latter instances, staff should administer screening measures as soon as it is feasible to do so. Screening measures should be treated as confidential information in a manner consistent with existing shelter policies.

The measures should be stored and retained either in the parent or family member's record or file, or, in a separate location in which all measures are stored together. In either instance, measures should be placed in a secure, preferably locked location. With written permission to release screening results, shelter staff may choose to provide screening results to other adult or child serving agencies. Although any record may be subject to disclosure pursuant to a court order, a subpoena alone will often be insufficient to access shelter records, including

measures and assessments, if the victim advocate privilege of communications covers the service (see Chapter VI).

summary of screening tools and measures in the toolkit:

UCLA PTSD Reaction Index – a self-report by parents and children (ages 7 and older) for PTSD symptoms

Strengths and Difficulties Questionnaire (SDQ) – Interview or self-report of parents with children (ages 3-17) for identification of general mental health and social concerns

Parent's Evaluation of Developmental Status (PEDS) – provided to assist parents in identifying their children's possible developmental delays

II. THE SCREENING TOOLS AND MEASURES

The screening tools and measures described below and used during the initial pilot phase of the project were selected because they are relatively easy to use, are free or very low cost, and are readily available from the internet. Minimal training is required to score and interpret these tools and all were designed for use and tested by individuals without formal clinical training. However, we recommend adherence to all guidelines suggested by the developers. Below is a brief summary of each of the three measures, including website links to access and download the measures' forms and specific instructions.

UCLA Posttraumatic Stress Disorder Reaction Index (PTSD-RI)

The PTSD-RI is an extensively used measure, available in caregiver and child self-report versions (for more information visit <http://kb.nctsn.org/SPT/SPT--FullRecord.php?ResourceId=1036>). This instrument provides an assessment of posttraumatic symptoms of distress (Pynoos et al., 2000). The measure is among the most widely studied assessments of child PTSD symptomatology and is correlated highly with a DSM-IV diagnosis of PTSD (Pynoos et al., 1998). Symptoms associated with PTSD include: (1) re-experiencing (e.g., recurrent and distressing thoughts/dreams, feeling like the trauma is happening again); (2) hyperarousal (e.g., sleep difficulty, irritability, anger outbursts, constant alert for threat, hyperactivity); and (3) avoidance/numbing (e.g., avoid thoughts, feelings, and reminders of the trauma, feeling detached from others, limited range of affect).

NOTE: The PTSD-RI assesses for a trauma severe enough that the respondent experienced intense fear, helplessness or horror and believed that he or she or someone else would be killed or seriously injured. This particular component of the measure was not utilized during the pilot phase of the project. In other words, the questions that were asked during the pilot phase were primarily related to the child's experience of witnessing domestic violence.

The following versions of the PTSD-RI were used during the course of the project:

Parent Report for children 7 years and older

- To be completed by parent (or primary caregiver).
- Caregivers can complete the PTSD-RI for each child age 7 or over.

- The measure can be administered to caregivers in an interview format, or they can be provided with initial guidance and given the form to complete on their own.

Child and Adolescent Self Report for children 7 years and older

- To be completed by the youth.
- Children 7 and over can complete the form by themselves, however, it is recommended that the form be administered in an interview format and/or read to the child.

Step 1 Administering PTSD-RI

1. Determine whether parent wants to read measure on their own or complete it as part of an interview. Be sure to be sensitive to any reading or comprehension difficulties. You may want to complete the first item together. This measure is also available in Spanish.
2. Review all instructions.
3. Attend to time frame noted in the instructions.
4. Provide and explain response options.
5. Encourage child or parent to answer all items (using their best "estimate" or "guess").

Step 2 Scoring, Meaning and Interpretation of PTSD-RI

1. Transfer responses to score sheet.
2. Calculate scale scores by adding together scores on each item indicated.
3. Child has screened in the concerning range and further action (referrals) should be taken if:
 - Total Severity is 2.0 or if the total score is 38.00 or above a referral may need to be discussed with the parent/caregiver.
 - Also discuss referral options with the parent/caregiver if any one of the symptom scales is elevated.

Step 3 Feedback to families after scoring PTSD-RI

Suggested script for talking to Mom: "This list of questions that we just went over and some of the comments you have made show many of the strengths of your child and family. There were 1 or 2 things that we talked about that I would like to spend a few minutes on given the results of the screening... ." Then describe specific areas of strength or concern.



Below is a brief description of the areas assessed as part of the PTSD-RI.

- Re-experiencing-feeling as if you are “reliving or living the bad thing that happened to you again”
 - Nightmares/flashbacks
 - Physiological Distress
- Avoidance/Numbing
 - Emotional Numbing-not wanting to feel anything
 - Withdrawing from friends, family, isolating self
 - Memory Loss/ Can’t remember specific details or events
- Hyper arousal - overly responsive to stimuli-“jumpy” and overly anxious
 - Exaggerated startle response
 - Irritability
 - Sleep problems
 - Poor Concentration
 - Hypervigilance



For purposes of the project the following versions of the SDQ were used:

- Parent Report for ages 3+
- Child Self Report for ages 11+

The Strengths and Difficulties Questionnaire (SDQ)

The SDQ, developed by R. Goodman (1997), serves as a general screening of child strengths, symptoms and impairments. All materials needed, including free computer scoring and interpretation, are available at <http://www.sdqinfo.com>. It includes 25 items that assess symptoms related to:

- Emotional disturbance (e.g., depression)
- Conduct or behavioral problems
- Inattention and hyperactivity
- Peer problems (social relationships)
- Prosocial functioning (positive behavior)

The SDQ has demonstrated high levels of reliability and validity and is available in parent, child and teacher report versions for ages 3 to 17 years. It features cut-off scores suggestive of clinical impairment. The SDQ has been used widely in national and international clinical and research settings. It features a normative sample of more than 10,000 children. The SDQ correlates highly with lengthier, well-known assessments of child symptomatology (i.e., Child Behavior Checklist).

Step 1 Administering the SDQ

1. Determine whether parent wants to read measure on their own or complete it as part of an interview. Be sure to be sensitive to any reading or comprehension difficulties. You may want to complete the first item together. This measure is also available in Spanish.
2. Review instructions.
3. Attend to time frame.
4. Provide and explain response guide.
5. Encourage child or parent to answer all items (using their best “estimate” or “guess”).

Step 2 Scoring and Interpretation of SDQ

1. Transfer responses to score sheet.
2. Calculate scale scores by summing relevant items. Below are the various subscales and sample items. Free computer scoring is also available on the web.
 - Total Difficulties Score
 - Emotional Symptoms Scale
 - Often complains of headaches, stomachaches, or sickness
 - Often unhappy, depressed or tearful

- Conduct Problems Scale
 - Often loses temper
 - Often fights with other children or bullies them
- Hyperactivity Scale
 - Restless, overactive, cannot stay still for long
 - Easily distracted, concentration wanders
- Peer Problems Scale
 - Picked on or bullied by other children
 - Generally liked by other children
- Positive Behavior (Prosocial) Scale
 - Helpful if someone is hurt, upset or feeling ill
 - Kind to younger children
- Impact/psychosocial functioning
 - How long have these difficulties been present?
 - Do these difficulties upset or distress your child?
 - Do the difficulties interfere with your child's everyday life in Home Life, Friendships, Classroom Learning, and Leisure Activities?
 - Do the difficulties put a burden on you or the family as a whole?

Step 3 Feedback to families after scoring SDQ

Suggested Script: “This list of questions that we just went over and some of the comments you have made show many of the strengths of your child and family. There were one or two things that we talked about that I would like to spend a few minutes on... .” See below for areas of concern; and emphasize one or more strengths before focusing on concerns.

- Review extreme items
- Review prosocial score and strengths
- Review scales with high scores
- Feedback to parent &/or child
- Referrals
 - If Total Difficulties Score is 14 or Higher a referral may need to be discussed with the parent/caregiver.
 - If Total Difficulties Score is 13 or below BUT two of the subscales are At-Risk or Significant, a referral may need to be discussed as well.

Parents' Evaluation of Developmental Status (PEDS; Glascoe, 2006).

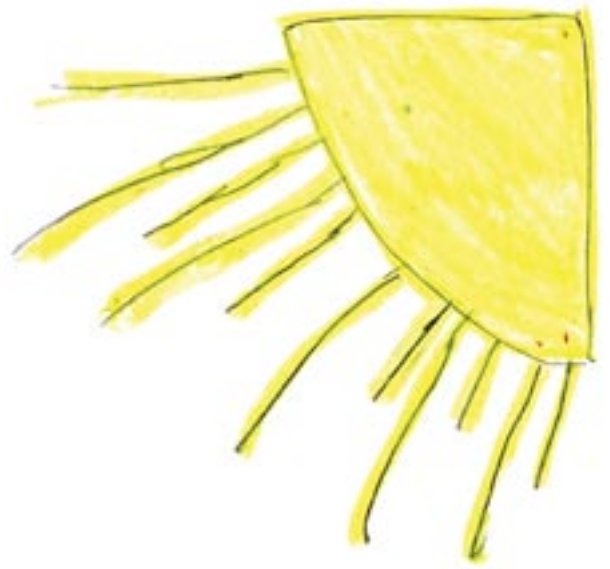
Below is a summary of the PEDS measure. Please access the full training manual and guide at:

<http://www.pedstest.com/index.php>

- 10 questions
- Identifies 74%-89% of early developmental delays
- Shaded boxes predict disabilities
- Areas of Assessment:
 - Global/cognitive
 - Expressive language
 - Receptive language
 - Fine motor
 - Gross motor
 - Behavior
 - Social/emotional
 - Self help
 - School
 - Other

Remember that initial screening results to identify the needs of children in shelter can assist shelter service providers in steering parents and children toward appropriate services in the community. Referrals should be based on initial screening results to address the specific needs of the individual child. Potential referrals are numerous (see Chapter V), including those for:

- Developmental Evaluation (including speech/language, physical/motor skills, and occupational)
- Mental health (psychological) evaluation and/or treatment
- Mental health case management
- Medical
- School related services including academic, cognitive, and achievement testing
- Legal needs of the child to access the above services or address the source of the traumatic effect



chapter 3: positive parenting skills and behavior management

BY VIRTUE OF THEIR DECISION to seek assistance, parents in domestic violence shelters have made enormous and courageous strides to keep their children safe. However, given their age, children may not be able to easily understand the positive nature of this serious transition. Some children may see the move to a shelter as a very negative experience, given that their mother or other parent has taken them away from their familiar world and perhaps from someone they love. Living in a home with domestic violence creates challenges for both the offending and non-offending parent to raise the children in a safe and developmentally appropriate way.



Key point: Children in shelter can act out for a number of reasons: as a symptom of trauma, fear of change and the unknown, anger at either or both parents, and normal developmental stages associated with the children's ages. Teaching parents in shelter positive parenting skills can alleviate the stress of both parent and child by helping them to more easily address the safety, practical, and emotional concerns that the domestic violence has caused.

I. TEACHING PARENTS PARENTING SKILLS

They say “you can’t teach an old dog new tricks,” i.e., that adults resist being taught. However, Adult Learning Theory has given us new ways of ensuring that adults can indeed learn new methods and improve their skills, and research has now developed evidence-based practices in teaching parenting skills. In North Carolina, organizations such as the Center for Child and Family Health and Prevent Child Abuse North Carolina can provide resources and offer evidence-based training in parenting skills in local communities (see Appendix A). Below are four key principles of Adult Learning Theory that you can put into practice as you help build the parenting skills of parents in shelter. These approaches can be used to teach parenting skills one-on-one with individual parents, or in group settings.

1. Active Learning

Research shows that adults remember 20% of what they hear, 40% of what they hear and see, but 80% of what they discover for themselves (what they hear, see and DO). Therefore, giving parents an opportunity to both observe and practice

what they've learned is perhaps the most important adult learning principle. It is difficult if not impossible to learn any new skill without actually practicing it. Parenting is the same. Parents need an opportunity to see skills in action and to do them for themselves.

For example:

- Demonstrate and use role-plays to show what child management skills you are explaining.
- Try different settings for your role-plays to make them more “real.” Do them in the kitchen, bedroom, yard, playroom, in a public place, with and without other people around.
- Allow the parent to play the role of her child first, with you demonstrating how the parent should respond, then let her play the role of herself with you as the child. While you are playing the child, you should also be available to coach her in her parent role.
- During a role play, always wait for the parent to answer before suggesting solutions. Only add solutions not provided by the parent after the parent has had a chance to respond. Remember that there may be many right answers and the parent may come up with a new and creative solution. Your role is to facilitate the problem solving process, not “quiz” the parent on the one right answer.
- Be specific with your comments and suggestions. E.g., “Did you notice how quickly your child did what you asked her to do when you gave only one simple command and waited for her to do it?” or “I love the way you just praised your little boy for picking up the toys! Look how fast he is picking up the rest now that you did that!”

2. Repetition

Repeat the most important lessons and practice skills more than once. Repeat the most important lessons and practice skills more than once. Repeat the most important lessons and practice skills more than once!

For example:

- Teach the methods in a series over time with some review from the previous lesson to allow the new skills to sink in.

Four Key components of adult learning:

1. Active Learning
2. Repetition
3. Encouragement
4. Respect the Learner's Experience

- Use a variety of hypothetical “what if” examples for each skill to have the parent brain-storm how to apply them in different circumstances. Make the hypothetical examples increasingly challenging.
- Summarize at the end of each lesson what the main points to be learned were.

3. Encouragement

Be sure to encourage and praise the parent or caregiver you are working with. Both adults and children respond and learn better through praise, rather than criticism, warnings and pressure to improve. Particularly in a domestic violence shelter setting, parents may be feeling self-conscious about their parenting skills if the abuser criticized their ability or they are now living surrounded by other residents and shelter staff after a period of social isolation.

Key point: The more you demonstrate praise and allow the parent to feel the positive impact of praise for themselves, the more likely they will want to use the strategy with their children on a daily basis.

For example:

- Restate the parent's response using her own words and refer to her by name. This way she knows that you noticed her improvement and effort.
- Allow the parent to express her concerns about why a certain skill may be difficult to apply in practice, and offer support to help her overcome those barriers rather than minimizing why her concern does not appear important to you.
- “Sandwich” a piece of constructive criticism between two pieces of positive feedback.

4. Respect the Parent's Experience

All parents have had a variety of life experiences that make them unique and that influence how they see the world and their relationships. It is far more empowering for parents if you respect their existing abilities to parent, and to learn from and praise their skills. Shelter residents may have far more experience with parenting than the shelter staff

member who is providing guidance on parenting skills. However, sharing the parenting skills listed in this toolkit and from other experienced resources is not only a means of sharing evidence-based best practices with a parent in crisis, but also a way to ensure that the child's needs are identified and met.

II. PARENTING SKILLS AND BEHAVIOR MANAGEMENT OF CHILDREN IN SHELTER

Mothers enter domestic violence shelters with a set of parenting skills and practices, which may be influenced by a variety of factors including practice, family tradition, parenting classes, religious custom or instruction, and the necessities of avoiding violence in the home. Parenting skills learned and practiced in a violent home are often very different from those found in a peaceful home.

Some research indicates that mothers who are domestic violence victims are more likely to use harsh physical discipline and corporal punishment than mothers who are not domestic violence victims. This may be because the batterer requires it, because the mother was raised with harsh discipline, or because the mother is trying desperately to keep the peace to avoid angering the batterer when the children misbehave. Nevertheless, parents often change their parenting following trauma, either becoming more lenient (the child has already been through so much) or too rigid (I don't want anything else to happen to the child). Adopting more positive parenting skills and patterns in these cases may not be easy, but are ultimately very worthwhile for both parent and child.

The ABCs of Behavior Management

ABC stands for Antecedent, Behavior, Consequence. In behavior management theory, behavior continues when it is reinforced in some way. Sometimes it's clear what is reinforcing the behavior. At other times, it isn't. It is helpful to study the behavior to figure out what happens before (the antecedent) and what happens after (the consequence) to see what is influencing the behavior to continue or not.

The first thing caregivers need to understand is that there are three rules to behavior management.

1. Whatever behavior gets reinforced will increase. It doesn't matter if the reinforcement is positive or negative.
2. When behavior does not get reinforced, it will decrease and eventually stop. This can be tricky because the attention the child gets from the parent - yelling, bargaining, pleading or praising - may serve as reinforcement. There are some behaviors that are out of the parents' control and are self-reinforcing. For example, a child picking his or her nose may feel good. The parent doesn't need to praise the behavior or yell about it to make it continue. And, if the parent ignores it, taking away the attention, the behavior won't stop because it still feels good to the child. For behaviors that are self-reinforcing, the parent must be able to monitor very effectively and have rewards for not engaging in the behavior that are even more satisfying to the child



it makes sense that families embarking on a new life free from violence would need to develop, practice, and adopt a new set of parenting practices.

than the behavior itself. Some behaviors start out as self-reinforcing but become even more frequent because they have the added benefit of driving the parent crazy. Consider again the example of nose picking. In that case, the parent has to be especially careful about providing rewards and consequences in a calm manner.

- Behaviors that are reinforced some of the time will be the hardest to get rid of. Therefore, it is very, very important to **BE CONSISTENT!!!!!!**

Once parents understand the basic rules of behavior management, they need to understand the tools they have at their disposal. These tools look different at different ages, but they are the same principles regardless of age.

examples of parenting skills that positively impact children's responses to domestic violence:

- Use of calm and consistent parental behaviors and predictable routines teach children trust and an appropriate sense of safety
- Parental understanding of child development and the impact of domestic violence and other traumatic incidents on children's behavior to avoid misinterpreting children
- Encouragement of and praise for children's positive behavior, including teaching children to acknowledge their own positive qualities and behaviors

Understanding the Behavior in the Context of Trauma

- Children who have been traumatized may feel threatened or be reminded of the traumatic event in a situation that looks harmless to someone else, even their parent. If parents understand this and don't take it personally, they will be able to more effectively deal with the situation. One example of this might be a child's extreme response to a parent raising her voice (either his or her own or another parent in the shelter). While the parent may only have been trying to get the child's attention, the child may have been triggered to remember a domestic violence altercation in his or her home. When children

are reminded of their trauma by something in the environment, their bodies respond with fight, flight or freeze for protection as if they are back in the dangerous moment. Hormones and chemicals are fired in the brain. **Children cannot think clearly at that point (they are having a physical and emotional reaction to the trauma trigger and can not sort the conflicting feelings and thoughts).**

- Crying, wanting to be held, and seeking proximity are communications of need, not signs that the child is "spoiled."
- Children want to please their parents and respond well to praise.
- Separation anxiety is an expression of love and fear of loss, not a manipulative ploy.

Using Praise, Rewards, and Attention as Behavior Management Tools

Praise needs to be:

- specific
- immediate
- given without "buts" and other back-handed comments
- consistent- given every time the desired behavior is demonstrated by the child

Rewards need to be:

- immediate
- creative
- small
- motivating - refocus on positive behavior and praise what you want to see in the future

Attention needs to be:

- Focused on the positive. This is MUCH more effective than focusing on the negative. The warmer the relationship between parent and child, the more motivated the child is to do the right thing
- 80% positive and 20% negative. Typically, parents practice the reverse - 80% negative; 20% positive - and don't get good results
- Refocus on positive behavior – praise what you want to see in the future

Differential Attention & Ignoring

- What behaviors can you ignore and what behaviors can't you ignore? Do they feel impossible to control or too dangerous to ignore?
- What happens when you give in after a period of ignoring? **INCONSISTENT REINFORCEMENT IS THE MOST POWERFUL WAY TO KEEP A BEHAVIOR!!!!** Children may learn that they can outlast their caregivers if they simply continue the bad behavior long enough.
- Model the opposite of the behavior you are ignoring or want to go away. For example, if you want the child to stop whining or back-talking then respond in a more age-appropriate voice or with respectful language.

Key point: Any behavior you pay attention to **WILL INCREASE**. Praising behavior you want and actively ignoring behavior you don't want is the most effective combination.

Natural & Logical Consequences

- **A Natural Consequence** is the natural result of your behavior. For example, you didn't wash your uniform last night when I told you to, so now you will need to wear a dirty uniform to the game. Or, you left your bike outside when I told you to bring it in and now it is rusted from the rain.
- **A Logical Consequence** is still related to the behavior, but used when a natural consequence is not safe or practical. For example, you went down the street when I told you to stay in front of the house so now you must play inside. Or, you threw your toy so now you can't play with it for the day. A consequence should be as directly related to inappropriate behavior as possible.

How to Develop and Give Effective Commands

- Use Statements vs. Questions. For example, "It's time for bed" vs. "Are you ready to go to bed?"
- Use a calm voice
- Offer meaningful choices, where either response is acceptable. For example, "Do you want to wear your blue pants or your red pants?" vs. "Do you want to get dressed now?"
- Give one command at a time, simply stated and phrased positively. For example, "Suzy, please put all these blocks

in the bucket." vs. being vague: "Clean up this mess." or issuing too many commands at one time: "Put those blocks away and get your clothes hung up and make your bed."

- Provide praise after each act of compliance, particularly with younger or oppositional children. That means praise the children during the actions, rather than waiting until the very end when the entire task is completed. For example: "You have ten blocks in the bucket already?! You are doing a great job listening!"
- Describe in advance the positive consequences of compliance. For example, "We can read this book together as soon as the books are put away" or "Once you take out the trash, I can take you to the mall."

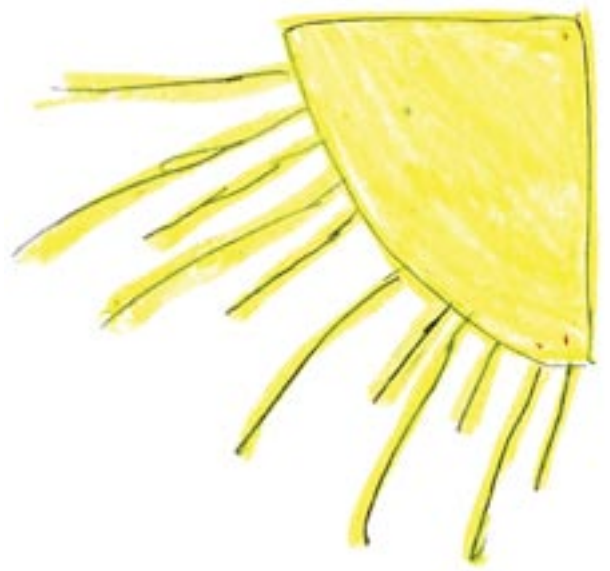
Preventing Aggression and How to De-Escalate

What makes kids aggressive?

- Perception of threat (feeling like they need to protect themselves)
- Environment – if kids don't have enough space to move around and do different activities (e.g., children of all ages grouped together watching TV in a small room and one child wants to dance)
- Shelter rules dictating that parents must be with child at all times
- Insufficient resources – if kids don't have enough resources, it generates competition and frustration (e.g., one game controller for 10 kids)
- Boredom – not enough to do or no activities planned (do NOT wait until children complain or are aggressive before changing activities or play opportunities!)
- Previous traumatic events can influence a child's perception of being threatened in current fairly non-threatening situations

What can we do about it? Given your knowledge of child development, parenting skills, and children's responses to trauma, please consider the following practical options:

- What can we change about the shelter environment? (e.g., add toys, structure activities, brainstorm with children and parents about improvements)
- What can we change about the shelter rules? (e.g., monitoring of children, support of parents)



chapter 4: the impact of trauma on parenting

IT HAS LONG BEEN RECOGNIZED that women in domestic violence shelters may have a range of mental health concerns. However, it is important to consider the mental health impact of domestic violence on mothers and caregivers in particular, and how this may impact their relationships with their children and their ability to parent. For many mothers to effectively learn the parenting skills that shelter staff members can share, they must also receive attention for their own mental health needs.

Key point: When shelter staff help mothers access needed mental health resources, it allows mothers to improve their parenting and respond to the needs of their children as well.



This chapter includes a discussion of two key mental health concerns common to women in domestic violence shelters which may significantly impact their ability to parent, along with recommended interventions: Posttraumatic stress disorder (PTSD) and Depression.

I. COMMON MENTAL HEALTH CONCERNS FOR WOMEN IN SHELTER

There are a number of factors that may contribute to mental health concerns among women who have experienced domestic violence. In fact, research has long indicated that women who experience domestic violence are at increased risk to develop both PTSD and depression. Studies have shown that the risk for PTSD as well as depression was almost four times more likely among women who experienced domestic violence when compared to women who did not experience abuse.

Posttraumatic Stress Disorder (PTSD)

In the context of parenting, each of the factors of PTSD may influence a mother's ability to parent her children. For example, children may trigger a parent's trauma memories or symptoms simply by playing a game that reenacts some of their experiences (e.g., siblings fighting over toys or aggressive pretend play). The parent, as a result, may attempt to avoid the child at these times or may become overly reactive and angry. Similarly, parents may trigger a child's trauma memories/symptoms by using corporal punishment, which can lead to the child avoiding, distrusting and/or fearing the parent.

It is equally important to understand how difficulty managing feelings and emotions is associated with PTSD, including irritability, fear, and anger that can impact a parent's ability to manage child behaviors, and provide the child with guidance and support. Parents struggling with managing their feelings may be perceived by their children as unpredictable and unapproachable. This may impact their bond, the parent's ability to detect and respond to the needs of her children, and have a negative effect on other interpersonal relationships. This pattern may be further complicated by disturbances in sleep, additional stressors related to being in shelter and preparing for the future for both parent and child.

as described in the previous chapter, PTSD includes:

re-experiencing – feeling like the trauma is happening again, recurrent distressing thoughts/dreams

avoidance/numbing – avoidance of people, places and things that serve as reminders of the trauma; withdrawing, and feeling detached from others

arousal – e.g., sleep difficulty, irritability, anger outbursts, constantly feeling on alert/jumpy

Assisting the parent or caregiver in shelter with an understanding of common symptoms of trauma will not only reassure the adult as to the source of her own feelings, but will help her parenting skills and her ability to understand the potential trauma symptoms exhibited by her child.

Depression

A diagnosis of depression generally includes several symptoms that last for two weeks or more. Depression can affect the parent's ability to parent predictably, supervise, be responsive to cues, participate in activities, and discipline consistently. This may be particularly true when parenting very young children and infants, resulting

in attachment problems and developmental delays in the child. Depression can also interfere with a parent's ability to attend to her own needs, which is very difficult for a shelter resident who is transient, coping with crises that not only involve physical danger but often the need to attend to many difficult practical needs, including housing, employment, school district changes, and legal concerns.

symptoms of depression include:

- *loss of interest*
- *weight loss/gain*
- *sleep disturbance*
- *fatigue*
- *poor concentration*
- *feelings of hopelessness*
- *thoughts of death*

It is with this understanding of the common mental health concerns of both parent and child that staff can better identify and recommend potential intervention services to minimize the negative consequences for adult and child residents in shelter.



Key point: Just as mental health referrals for children in shelter are an essential service, so are similar referrals for the child's mother or other caregiver. A joint approach to services and referrals for both parent and child is the most promising strategy for helping the family break the cycle of domestic violence.

II. INTERVENTIONS TO ADDRESS PARENTAL PTSD AND DEPRESSION

When providing mental health services in shelter or making a referral for parents and children who have experienced domestic violence there are some general guidelines that may prove to be effective, including a focus on referring families to “evidence-based mental health services” and “evidence-based parenting skills training.” Generally speaking, evidence based practices are those interventions that have been shown through research to be effective for treatment of psychological and behavior disorders. That is, there is some scientific evidence to support our knowledge that the treatment works and people do get better.

Although there are many possible types of mental health interventions, this section focuses on what to look for when identifying good referral sources. Given that some of the most common mental health needs for shelter residents are those associated with the trauma of the domestic violence itself, trauma-focused treatment is often an appropriate form of referral.

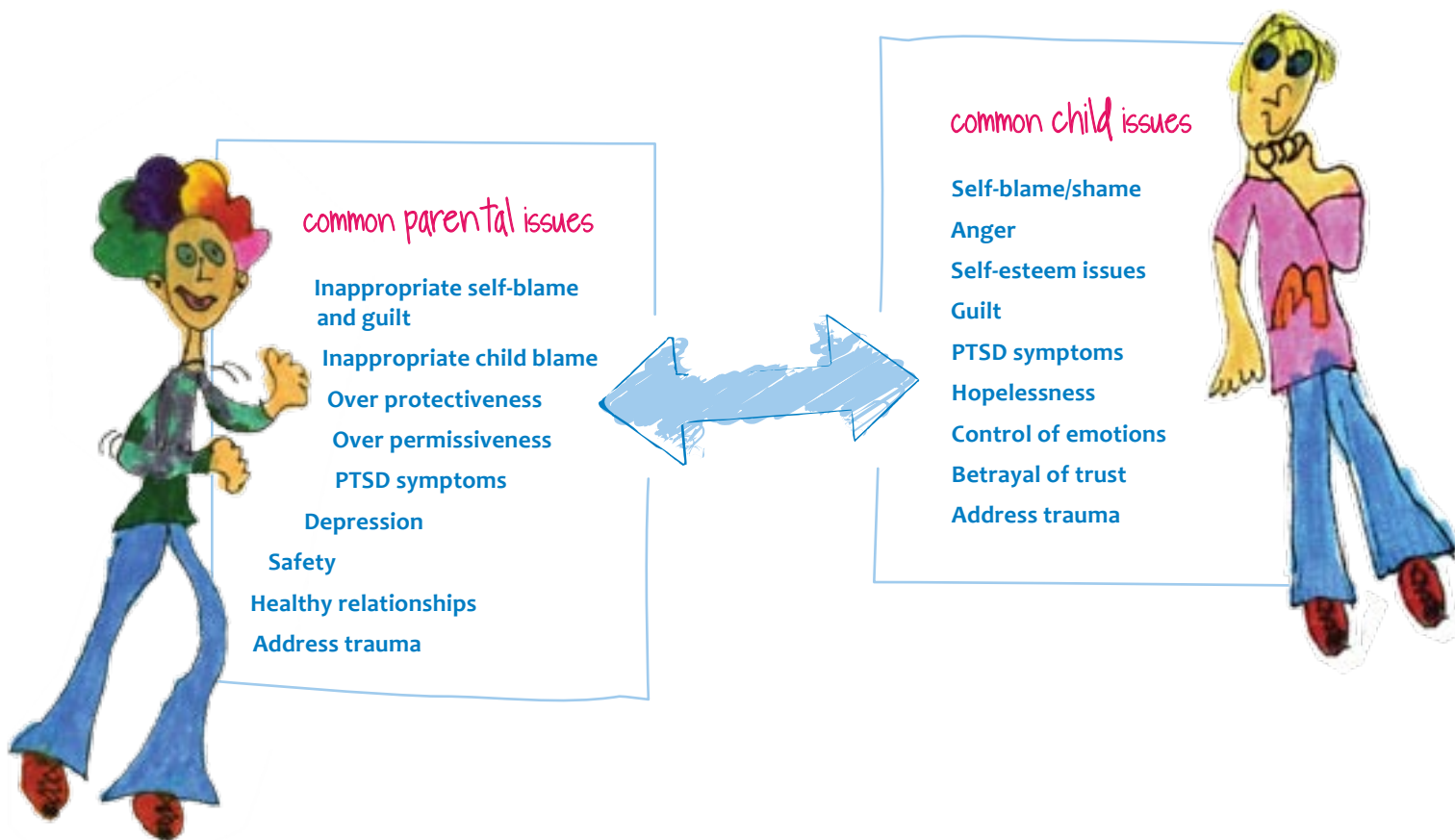
General Aspects of Effective Trauma-Focused Treatment

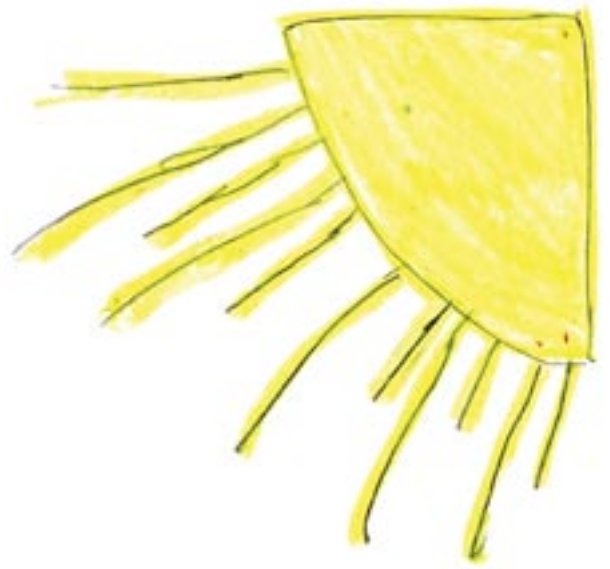
- Establishes a safe environment
- Establishes a therapeutic alliance
- Sets guidelines for client boundaries and safety
- Establishes a relationship of trust with client
- Addresses traumatic experiences
- Addresses traumatic reminders
- Addresses difficulty with emotional regulation and consistency
- Address post-trauma stressors and adversities
- Considers developmental impact (particularly for adolescent parents)

some examples of evidence based interventions include:

- Trauma Focused Cognitive Behavioral Therapy
- Abuse-Focused Cognitive Behavioral Therapy
- Parent Child Interaction Therapy
- Child Parent Psychotherapy

Some trauma treatment approaches work with both parent and child simultaneously. This is due to the fact that there may be an overlap in concerns displayed among parents and children’s responses to trauma, or that one family member’s response influences the response of the other as shown below.





chapter 5: child service community partnerships and referrals

THIS CHAPTER IS DESIGNED to familiarize you with some agencies that should be specifically included in your network of partners in working with children in shelter settings, and provide some guidance on your approach to collaboration with those partners. Keep in mind that relevant community partners are frequently noted throughout this toolkit. For instance, Chapter II includes information about how the results or scores of some standardized measures for evaluating children will indicate that a mental health referral (Local Management Entity or “LME”) or a referral for early intervention services (Children’s Developmental Services Agencies or “CDSA”) should be made. Understanding the need for child specific legal referrals and what referrals would be appropriate are included in Chapter VI. Finally, Appendix A includes additional state and national resources related to children and domestic violence and information on child traumatic stress, and Appendix C includes a helpful Self-Assessment Checklist to ensure that you have identified relevant community partners in your area.



Key point: Establishing working relationships with local child-serving agencies is a key component to building a good service system for children and youth who have lived or are living with domestic violence. There are a variety of agencies that should comprise a community’s network – some are available only in certain parts of the State of North Carolina or in certain communities, and others are available in every county. You likely will have more to add to the list – see the Self-Assessment Checklist in Appendix C.



The partners noted in this Chapter include:

- Core Child Service Agencies
 - Children’s Developmental Services Agency (CDSA)
 - Child Service Coordination Program (CSCP)
 - Department of Social Services (DSS)
 - Local Management Entities (LME)
 - Child Advocacy Centers (CAC)
 - Child and Family Support Teams/Schools
 - Child Care Resource and Referral
- Health Insurance

Core Child Service Agencies

Children’s Developmental Services Agencies

What They Provide

Each state has what is called an Early Intervention system that is provided for under federal law for young children with special needs, aged birth to three years. The name of that federal law is The Individuals with Disabilities Education Act (IDEA), Part C. Section 635 of this law directs the state early intervention lead agency and its local agencies to make special efforts to locate and provide services to infants and toddlers with disabilities who are homeless, and their families. For these purposes, children living in domestic violence shelters are considered homeless.

In North Carolina, the program that serves 0 – 3 year olds is called the Infant-Toddler Program. Agencies called Children’s Developmental Services Agencies (or CDSAs) provide services, including assessment and treatment to infants and toddlers who “have or are at risk for developmental delay or established conditions that are very likely to lead to developmental delay.” CDSAs were formerly named Developmental Evaluation Centers. These agencies are managed at the state level through the Division of Public Health in the Department of Health and Human Services. Every county is served by a CDSA either through a main or satellite office.

The state has a separate program for 3 to 5 year olds, called the Pre-School Program which is managed by the Special Program Section in the Exceptional Children’s Division at the Department of Public Instruction.

Children’s Developmental Services Agencies evaluate and provide or coordinate treatment for children as described above. Examples of their services include things like speech therapy, services for hearing-impaired children, and physical therapy.

For a description of specific services and eligibility criteria, go to the home page for Early Intervention Services at <http://www.ncei.org/ei/index.html>

To access a library of materials designed for parents or professionals working with children who have special needs, go to <http://www.ncei-eclibrary.org/>

There are a variety of services available under the Pre-School program. More information can be found at <http://www.ncei.org/ei/preschool.html>

To contact the state’s Early Intervention branch about the Infant-Toddler Program by phone, call (919) 707-5520.

To contact the North Carolina Office of School Readiness in the Department of Public Instruction about the Pre-School Program, by phone, call (919) 981-5300.

Where They are Located

For a list of Children’s Developmental Services Agencies, by county, go to <http://www.ncei.org/ei/index.html> (the home page for Early Intervention Services) and enter the name of your county under Children’s Developmental Services Agencies, on the right side of the page. Pre-School Program services are provided through each School District.

Child Service Coordination Program

What They Provide

North Carolina has a program called the Children’s Service Coordination Program (CSCP). This program is available at every county health department in North Carolina. The CSCP is a case management program for children who are aged birth to five years who are at risk or diagnosed with special needs. Case management services can take a variety of forms including things like help finding housing, applying for health insurance or finding a doctor, or enrolling a child in school.

For a description of the Child Service Coordination Program, including definitions and criteria for eligibility, go to: <http://www.ncdhhs.gov/dma/babylovechild/1m1.pdf>

For an explanation of services and information regarding eligibility, go to the home page for Child Service Coordination Program at: <http://www.ncdhhs.gov/dma/cscconsumer.html>



Where They are Located

Every county health department has a Child Service Coordination Program. There are also a few programs that are located outside of the Health Department.

For a list of Child Service Coordination Program providers, go to: <http://www.ncdhhs.gov/dma/babylovechild/cscpProvDirectory.pdf> To contact the Child Service Coordination program by phone, call your local county Health Department.

The county Health Department is another important resource when it comes to children's health. Each Health Department must provide medical care for children who are poor, or, coordinate the delivery of that care in the community, which means each county could do things very differently. For example, in one county, the Health Department might provide immunizations to children. In another county, a medical provider in the community might be responsible for immunizations. Call the Health Department to find out how it works in your own community.

Partnership Considerations for working with CDSAs and CSCPs

Cross Training and Information Sharing

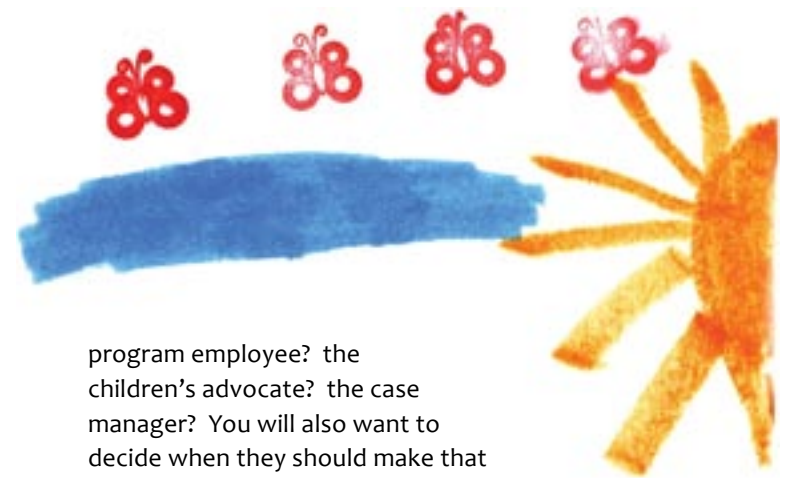
- The providers of CDSA and CSCP services noted above are concerned with the developmental and behavioral health needs of children. These providers may or may not be familiar with how domestic violence can be implicated in a child's development and overall mental health. You may be in a position to teach them about these effects, or, to learn about them together.
- One tip for working together is to provide these agencies with current information about the needs of the children you serve. In addition to anecdotes about the families you serve, you can also share with them reputable, concise public resources about child development and domestic violence. Remember that understanding the impact of domestic violence on children is a fairly new area of research and public outreach for most service providers. For examples of easy-to-read and informative materials you can share with your staff and community partners, see:

- "The Impact of Trauma on Child Development" by Frank W. Putnam, *Juvenile and Family Court Journal* (Winter 2006) http://www.partnershipforsuccess.org/uploads/200702_winter2006putnam1.pdf
- "Young Children's Exposure to Adult Domestic Violence: Toward a Developmental Risk and Resilience Framework for Research and Intervention" by Abigail Gewirtz, Ph.D. and Jeffrey Edleson, Ph.D. http://www.uiowa.edu/~socialwk/paper_6.pdf
- "7 Steps to Protecting Our Children: A Guide for Responsible Adults" (online booklet addressing child sexual abuse signs and responses) from nonprofit agency Dark to Light (<http://www.darkness2light.org/docs/Final7steps.pdf>)
- 6 part paper series on Children and Domestic Violence and the role of law enforcement (University of Iowa, 2004) (<http://www.uiowa.edu/~socialwk/publications.html>)
- In turn, these agencies can provide valuable resources to you and other staff or volunteers about child development. They can also share parent-friendly brochures and other materials for you to use in your work.



Sharing information through meetings or presentations can build trust and give each of you ideas on how you should be working together for the benefit of the families you serve.

- As a provider of domestic violence services, you should be familiar with the criteria for evaluations and services under both of these programs, but should not feel the need to be an expert. The criteria for services under the CDSA and the CSCP can be a little confusing. Clarifying eligibility and how the local service system works is important.



Decision Points and Referral Systems

- There are decisions you and the CDSA and CSCP will want to make about how to access each other's services. Because of the extent to which the systems are interwoven, local planning efforts should include the Children's Developmental Services Agency (birth – 3 years old), the Child Service Coordination Program (birth to 5 years old), and the local educational agency, especially the preschool disabilities program (3 - 21 years old).

cdsa and cscp evaluations and sometimes services, can often be delivered at your service site (in your office or at your shelter), removing the need to provide or coordinate transportation for the family.

- The scope, services, and criteria for the CDSA, the Child Service Coordination Program (CSCP) and the local school system preschool disabilities program are different. The ease with which families can be referred back and forth between the CDSA and the CSCP are based on working relationships, confidentiality processes, and what would most minimize the burden to a family. Because of these many variables, the CSCP staff, the CDSA staff, preschool disabilities program staff, and domestic violence program staff in each community should develop an individualized plan for processing referrals.
- One of the things you will want to decide is who in your program will be responsible for referring families to the CDSA or CSCP programs. For example, will it be every

program employee? the children's advocate? the case manager? You will also want to decide when they should make that referral. For example, when there is a concern by staff or parent? And finally, you will want to decide who the family should be referred to and under what conditions? For example, should all families be referred to the Child Service Coordination Program first and the CSCP will refer on to the CDSA if the family is in need of those services? Or, will the family be referred to the CDSA and if they are not eligible for those services, they'll be referred to the CSCP?

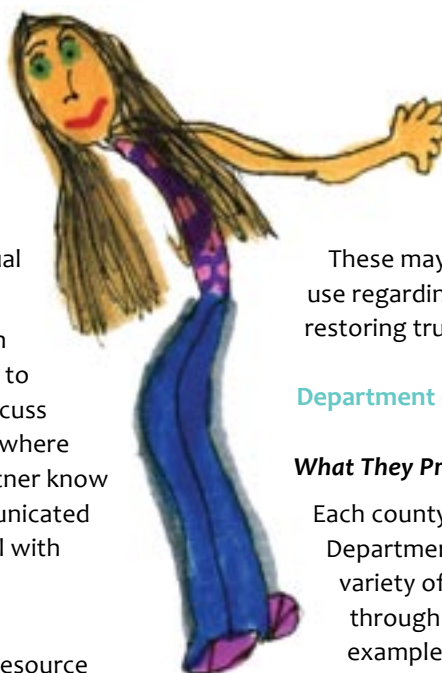
- Certain processes exist between the CDSA and CSCP related to the sharing of information between agencies. One such process is that parental consent is not required in order for the CSCP to refer to the CDSA. However, information that is shared is minimal and is designed to connect the family to the agency.¹ In contrast, parental consent is required to refer a child from the CDSA to the CSCP.
- Services provided under these programs are designed to be delivered in the child's "most natural setting" which usually means that staff can go to the family's home to evaluate the child or deliver services, or a location agreed upon in consultation with the family.

Confidentiality and Privacy

- As is true of many of your community partnerships, managing confidentiality and privacy is perhaps the most important component of planning that should occur locally. It is important to explain to your new partners that the families you serve are sometimes fleeing dangerous and potentially lethal living situations. The planning in those cases might have different details than planning for families that do not face the same type of threat.
- It is important to know that in cases where domestic violence protective orders and temporary custody have

¹ The information that is shared is name, address, and date of birth of the child, phone, and general reason for the referral.

been ordered, these orders may not override a parent's right to access the records of their minor child(ren). In the absence of such orders, and in view of the confidentiality requirements of the Family Education Rights and Privacy Act (FERPA), both parents would have a right to equal access to the records of a minor child.



- Parents also have rights to consent to evaluation and/or treatment, to know details/progress, and to access the client (child's) record. You should discuss how these situations would be handled in cases where safety is a factor. How will each community partner know when safety is a factor? How will that be communicated with other partners? How will each partner deal with these situations?
- The North Carolina Attorney General's Address Confidentiality Program (or ACP)² is a valuable resource to discuss with these agencies. Aside from the referrals that you make to them, they may also see families that could benefit from the program and sometimes the program may provide the necessary protection for a family wishing to receive services. Because the ACP is designed to cloak the physical location of victims of domestic violence and sexual assault victims by allowing the use of a substitute address, this might be the tool or one of many tools they can use to protect the family and provide services. This program may be an important part of a local agreement where the contact information for a parent living in shelter is contained in a file. Note: Application to become a participant in the Address Confidentiality Program must be made through the local domestic violence or sexual assault agency.³
- Additional strategies for cloaking the whereabouts of a victimized parent might also be used. Using the domestic violence program address as the parent's address; coding the file to indicate it should be treated with sensitivity to privacy because of domestic violence; and developing a clear and detailed protocol for documenting and releasing information in these circumstances are among these strategies.
- Finally, there will be instances in which the family reconciles and the CDSA will provide services to children living with both parents, including a parent that

perpetrated abuse. While limited, there are emerging resources designed to re-engage offending parents with their children after domestic violence has occurred.

These may be helpful for CDSA staff to access and use regarding family dynamics and strategies for restoring trust and safety in these relationships.⁴

Department of Social Services

What They Provide

Each county in North Carolina has a local Department of Social Services (DSS). There are a variety of programs & initiatives that are offered through local departments. They include, for example, Adoption Services, Child Protective Services, Child Support Enforcement, Emergency Assistance, Energy Assistance, Foster Care, and Food and Nutrition Services, Child Care, and WorkFirst. Often, domestic violence agencies find themselves most familiar with or most commonly involved in matters related to Child Protective Services (CPS) and WorkFirst, which administer TANF (Temporary Assistance to Needy Families). The focus of this section is on the Child Protective Services section.

North Carolina has a mandated reporter law, which means that every person is required to report, anonymously if they wish, suspicions that a child is being abused or neglected. For training about the reporting of Child Abuse and/or Neglect in North Carolina, contact Prevent Child Abuse North Carolina at 1-800-CHILDREN, or (919) 829-8009 or to view current training opportunities, view their website at www.preventchildabusenc.org.

The policy manual governing Child Protective Services is available on line. It can be accessed at <http://www.dhhs.state.nc.us/dss/local/index.htm> In 2004, North Carolina joined many states in the rest of the country by adopting a policy on domestic violence for child protection cases. That section is Section 1409 in the manual. It is important for domestic violence programs to be familiar with this policy since it spells out how the local Departments of Social Services respond to child protection cases when

² Information about the North Carolina Attorney General's Address Confidentiality Program can be found at http://www.ncdoj.com/about/about_division_address_confidentiality_program.jsp

³ A list of state-funded agencies can be found at www.doa.state.nc.us/cfw/cfw.htm under "Programs."

⁴ The Family Violence Prevention Fund, located at www.endabuse.org has a number of initiatives related to Fathers and their children, including a program entitled, "Fathering After Violence."

there is domestic violence. The policy includes, for example, a definition of domestic violence, intake processes, a child protective services assessment, guidelines for interviewing the non-offending parent/adult victim, children, and the alleged perpetrator of domestic violence, safety planning and case decision. There are also five attachments to the policy that include interviewing tools for DSS to use when interviewing adult victims, adult perpetrators, and children. These are also available online.

Where They are Located

To find your local county Department of Social Services, go to <http://www.dhhs.state.nc.us/dss/local/index.htm> or call the main number at the state Division of Social Services at (919) 733-3055.

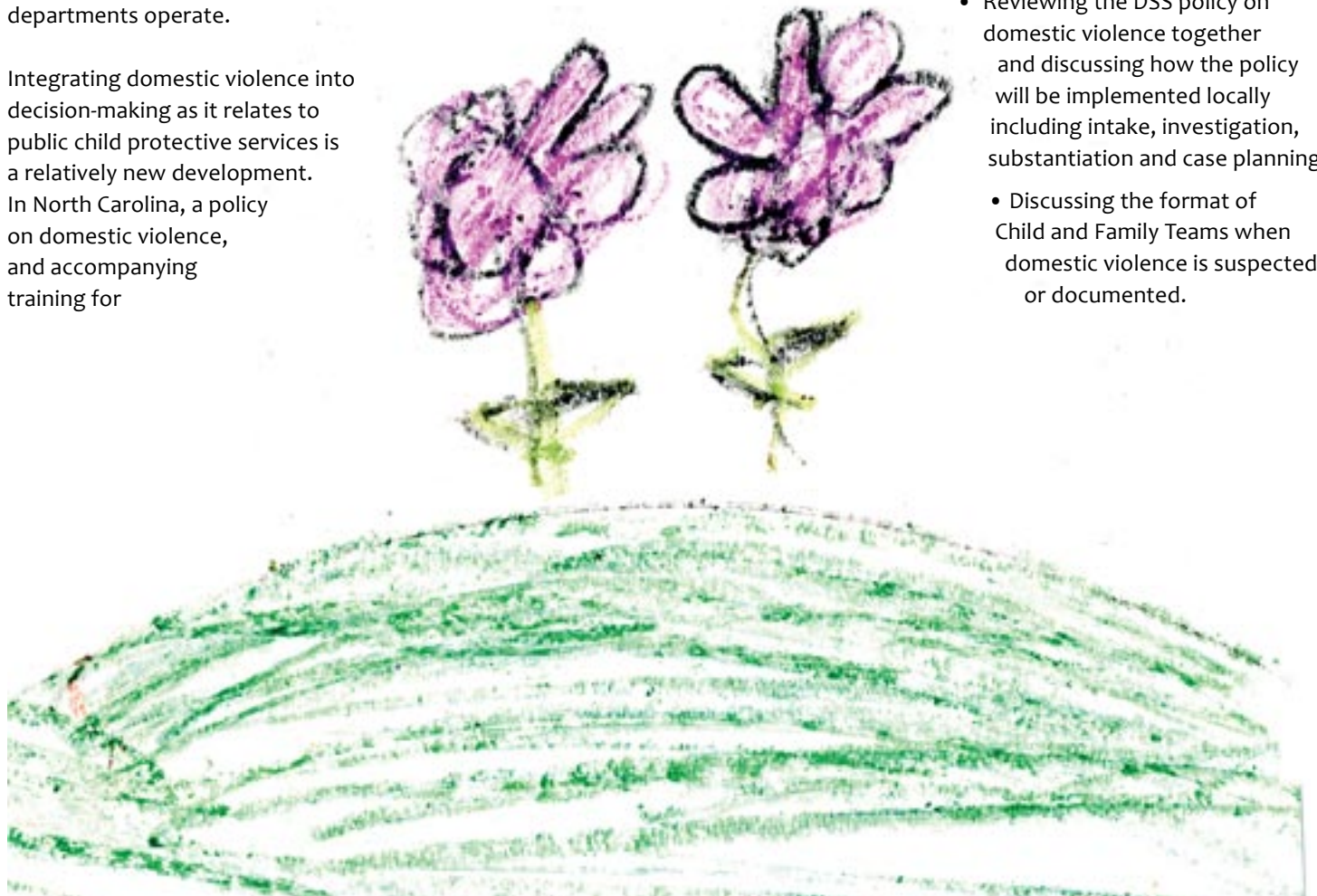
Partnership Considerations

North Carolina’s system of public child welfare is state-organized and county-administered. There are State as well as local policies that govern how local departments operate.

Integrating domestic violence into decision-making as it relates to public child protective services is a relatively new development. In North Carolina, a policy on domestic violence, and accompanying training for

child protective services staff, was developed by the state Division of Social Services in 2004. Because of the relative newness of the policy and training and due to the complexities of intervening with families when child abuse or neglect are suspected or at issue, establishing ongoing dialogue with your local department is very important. The nature of the relationship between your agency and the local department of social services will vary by location. Here are some suggestions for talking with your local department about issues related to children and families and domestic violence.

- Sharing basic information about the services your agency provides with the local Department of Social Services (DSS), especially if you offer services specifically for children, i.e. case management, assessment/screening, counseling, or therapy.
- Discussing how information will be shared between your two agencies when a family you are providing services to has been referred or reported to the local department of social services.
- Reviewing the DSS policy on domestic violence together and discussing how the policy will be implemented locally including intake, investigation, substantiation and case planning.
- Discussing the format of Child and Family Teams when domestic violence is suspected or documented.





- Determining and regularly re-visiting a process for referrals of children, adult victims or adult perpetrators between your agencies.

Some of the same considerations for working with CDSAs and CSCPs, including confidentiality and privacy, also apply to working with DSS partners. See Chapter VI for discussion of the mandatory duty to report a suspicion of caretaker child abuse or neglect to DSS.

Local Management Entities

What They Provide

Local Management Entities, often referred to by their initials “LMEs” are agencies that “are responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities and substance abuse services in the catchment area served. LME responsibilities include offering consumers 24/7/365 access to services, developing and overseeing providers, and handling consumer complaints and grievances”.⁵



⁵ From the DHHS website.

Mi familia

Where They are Located

For a list of local LMEs, the counties they serve, and contact information, go to <http://www.dhhs.state.nc.us/MHDDSAS/lmedirectory.htm> Or, call the state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The Advocacy and Customer Service Section can be reached at 919-715-3197. Or, call the Department of Health and Human Services CARE-LINE at 1-800-662-7030.

Partnership Considerations

As a domestic violence program, you will undoubtedly have times when you will refer either an adult or a child for mental health services. You may suspect that a mother is depressed or that a child suffers from severe anxiety, for example, and believe that an evaluation or consultation with the Local Management Entity is appropriate.

Many communities are still feeling the effects of a reform of North Carolina’s mental health system that began in the early 2000’s. Because of the changing nature of this system, it is important to have current information about the inventory of services available in your community, and the logistics of accessing them. For example, you should know:

- Who the providers are in your area specializing in mental health services for adult and child victims of domestic violence. (To locate a therapist trained in an evidence-based mental health treatment for traumatized children and families, and to read more about how to bring this treatment to your community, go to: <http://www.cfar.unc.edu/Home/Index.rails>)
- How your agency can be involved in local planning efforts for mental health services.
- What the most effective way is to make a referral to the LME (i.e. have the parent call, have an employee facilitate or make the call, provide collateral information)
- What the typical timeline is for an individual to be interviewed by the LME, referred for services, seen for treatment.
- Whether there is information your agency can provide that would help to facilitate evaluation, referral, or treatment.

Child Advocacy Centers

What They Provide

Child Advocacy Centers or “CACs” are a model of interagency coordination for child victims. Some centers focus exclusively on sexual abuse of children; others focus on severe physical abuse, or both. There is a national accreditation process for Child Advocacy Centers that is administered by the National Children’s Alliance. According to the National Children’s Alliance, “the purpose of Children’s Advocacy Centers is to provide a comprehensive, culturally competent, multidisciplinary team response to allegations of child abuse in a dedicated, child-friendly setting. The team response to allegations of child abuse includes forensic interviews, medical evaluations, therapeutic intervention, victim support/advocacy, case review, and case tracking. These components may be provided by Children’s Advocacy Center staff or by other members of the multidisciplinary team.”⁶

community multidisciplinary teams, such as domestic violence response teams and child abuse teams, can form useful partnerships

Where They are Located

As of this writing, there are 20 accredited centers in North Carolina and 5 provisional centers according to the North Carolina Child Advocacy Center, a Chapter of the National Children’s Alliance. For a list of those centers, the counties they serve, and contact information, go to <http://www.cacnc.org/locator>

Partnership Considerations

As noted above, there are a variety of functions performed by the multidisciplinary teams that provide a response to allegations of child abuse. These functions can either be provided by the CAC, or, by a member of the multidisciplinary team. Therefore, it is important to determine who provides these services through your local CAC.

Perhaps the greatest benefit to a partnership between your agency and the CAC is the opportunity to provide training to each other. Because of the chances that various forms of victimization overlap with one another, it is important for providers to know how to assess and respond to other types of victimization. For example, a domestic violence shelter may provide services to a family where a child has been

physically or sexually abused and seek the consult or make a referral to the CAC (in addition to DSS); or, the CAC may be providing services to a family that is experiencing domestic violence.

Sharing policies on confidentiality and privacy rules is also important, as is true of any partnership.



⁶ https://www.nca-online.org/pages/page.asp?page_id=4032

Schools & Child and Family Support Teams

What They Provide

Child and Family Support Teams are a joint initiative between the Department of Health and Human Services and the Department of Public Instruction. Each team is comprised of a school nurse, school social worker, parents and community service providers.

Eligibility for the services is described this way by the program: “Any child in a school that has a CFST nurse and social worker team and who is having trouble passing school or living in his or her home may be helped by the team.”



The services provided by the team are free – however, there may be costs related to services that are recommended as a result of the Team’s work.

To read more about this resource, go to <http://www.ncdhhs.gov/childandfamilyteams/index.htm>

Where They are Located

As of this writing, there are 103 schools in 21 school districts in North Carolina that are home to a Child and Family Support Team. For a list of these Districts and schools, go to <http://www.ncdhhs.gov/childandfamilyteams/contacts.htm>

Partnership Considerations

Including the domestic violence program in a team approach to a child’s plan for well-being, including succeeding in school, is a very good idea. Reach out to the school social worker or school nurse to let them know about the services you provide, how to make a referral, and to discuss how you can work together. You can also help develop mutual policies and protocol that govern identification, referral, and services for children, and talk about cross-training opportunities.

All school systems in North Carolina, regardless of whether or not they have a Child and Family Support Team, are governed by both local policy as well as some state and federal laws. It is important to know how your local school system implements certain provisions. For example, the North Carolina Department of Public Instruction houses a “Homeless Program.” To read about key provisions from the federal law (the McKinney-Vento Homeless Assistance Act) that is a governing policy for the education of homeless children, including children living in domestic violence shelters, and, to find out how this federal law is implemented in North Carolina go to <http://www.ncpublicschools.org/program-monitoring/homeless/> Or, call the main switchboard at the Department of Public Instruction and ask for the Homeless Program coordinator at (919) 807-3300.

Another related partner is the group of the School-Based and School-Linked Health Centers. According to the North Carolina School Community Health Alliance, “School Health Centers provide access to affordable, quality physical and mental health care. They provide early identification and treatment of disease and injury. Centers are linked to a decrease in health-related tardiness and school absences, decreased discipline problems and suspensions, and a reduction in school drop-out rates. They focus on prevention so that health problems and risky behaviors can be caught early or prevented altogether.”⁷ To locate a School Center, which are NOT located in every school, go to <http://ncscha.org/centers.php>.



⁷ <http://ncscha.org/centers.php>

Child Care Resource and Referral

What They Provide

The Child Care Resource and Referral Program is a part of the Department of Health and Human Services' Division of Child Development. The Child Care Resource and Referral:

- Works with parents, child care providers, businesses, and community organizations to help promote the availability of quality child care services
- Provides parents with child care referrals and information on choosing quality child care, plus resources on various parenting issues
- Offers providers access to valuable training and support services for new and established programs⁸

Where They are Located

Each county has a Child Care Resource and Referral. If you go to this web page: http://ncchildcare.dhhs.state.nc.us/parents/pr_parentcontacts.asp you will see that you can submit a query in order to determine who the local contact for Child Care Resource and Referral is in your county.

The toll-free number for the Division of Child Development in Raleigh is (800) 859-0829 (in-state calls only).

Partnership Considerations

One of the primary functions of this service is to locate high quality child care which may be of particular concern and interest to the families you see. In addition, these and other partners can be particularly important as consultants to your program as you design your services for children. They can help you design your program to be child-friendly. You can, for example, talk to them about helping you to set up play spaces for children of all ages, or developing structured activities within your program or through referral in the community.

Health Insurance

It is very important to determine whether the children and families you see are insured and to guide them through the process of applying for health insurance if they are interested in receiving that help. Most of the services described in this

section are free, low-cost or provided for under Medicaid. We urge you to consider making this a routine part of your intake process if it is not already. Having insurance increases the number of referral possibilities for children and families.

sometimes children have greater health insurance options than their parents.

Applying for public health insurance

To learn about public health insurance for children in North Carolina - Health Check (Medicaid for children) and NC Health Choice - go to http://www.nchealthystart.org/outreach/PartnershipPage/HC_NCHC%20Orientation.ppt

For access to applications in Spanish and English, an Online Catalog of materials including posters and materials for you to supply to the families you serve, go to:

<http://www.nchealthystart.org/outreach/PartnershipPage/index.htm>

To contact the North Carolina Healthy Start Foundation, call (919) 828-1819. Or, to apply for public health insurance, go to the local Department of Social Services.

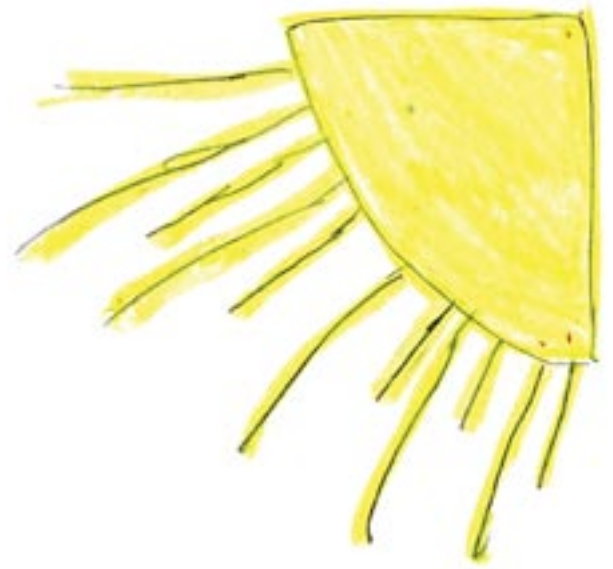
The Community Care Networks

The Community Care of North Carolina program (formerly known as Access II and III) is building community health networks organized and operated by community physicians, hospitals, health departments, and departments of social services. By establishing regional networks, the program is establishing the local systems that are needed to achieve long-term quality, cost, access and utilization objectives in the management of care for Medicaid recipients.⁹

There are 14 different networks in North Carolina. To see which network serves your county, go to <http://www.communitycarenc.com/>

⁸ http://ncchildcare.dhhs.state.nc.us/parents/pr_sn2_ov.asp

⁹ From the Community Care website at <http://www.communitycarenc.com/>



chapter 6: legal considerations when serving children in shelter

IN ALMOST EVERY CASE of domestic violence there will be a legal impact. When children are involved the legal impact is even more complex. As domestic violence shelter staff improve their responses to the needs of children in shelter, including the assessment of trauma symptoms, it is helpful to be aware of what legal resources are available to all members of the family.

Key point: Shelter staff members have compelling reasons for educating themselves on the legal needs of child residents. Legal concerns, such as complex custody disputes and criminal trials, may have a long lasting impact on the ability of families to cope with trauma and find the strength and time to seek mental health services and shelter services. Shelter staff can provide more effective community referrals generally if they are aware of the potential legal needs of their clients. Even if specialized court victim advocates are designated to provide legal information to clients, shelter clients may have practical barriers in reaching court advocates or they may feel more comfortable speaking with the shelter staff members they know.

The information below is designed to supplement current knowledge of potential legal actions. It should not be used as the sole information in working with clients. Also, this is only legal information; it cannot constitute legal advice. Shelter staff and agencies that have specific concerns about their liability in individual cases should always seek the counsel and advice of a licensed attorney. For additional information, please consider obtaining or accessing the resources noted at the end of this section for use in your domestic violence shelter, and those you identify in the Self-Assessment Checklist in Appendix C.

Common Types of Legal Issues for Children and Adult Residents in Shelter

Child residents in shelter will inevitably be impacted by the legal concerns of their parents. They may see the stresses that the legal system causes their mother, or it may practically impact their own lives and safety if an abuser is sent to jail or a court determines who has custody of the children.

Potential legal issues for adult survivors of abuse may include criminal court proceedings (as victims and defendants), and a variety of civil court proceedings, including:

- civil protective orders
- divorce and distribution of property
- small claims court
- name and identity changes
- immigration and deportation
- civil suits against the perpetrator (e.g., personal injury)
- creation of wills and trusts (when a high lethality is present)
- employment discrimination and harassment
- worker's compensation
- social security and public benefits appeals (including disability)
- landlord/tenant and public housing
- credit disputes (e.g., joint spousal liability, tax appeals and bankruptcy court)
- Recouping the financial costs of the abuse through restitution in criminal court, crime victim's compensation (including rape victim's compensation), or medical/property insurance claims

In addition to the potential legal needs of adults that impact the lives of their children, children themselves may have specific legal needs, including:

- juvenile court (as victims and defendants)
- DSS adjudications
- family court (child custody and adoption)
- child support collection
- school suspension and disciplinary proceedings
- disability determinations for benefits and school services
- appointment of a legal guardian

- emancipation
- adoption
- receipt of specific medical/mental health care without parental consent



Key point: Children should be seen as potential individual clients when they receive legal and other services. Simply serving the mother's legal needs may not sufficiently address the legal concerns of the child. This is seen most clearly when the interests of the mother and child conflict (e.g., adolescent child wishes to live with abuser or mother wants to know what free medical services the shelter has referred her child to but the child wishes it to remain confidential).



Protective Orders for Minors in North Carolina

Minors may obtain protective orders through application by an adult guardian ad litem or parent. Potential cases where this is needed could include dating violence, child abuse (sexual, physical, emotional), threats by a parent to the child but not to the spouse, or a teenage parent who is abused by the child's other parent. Note that when civil actions

are instituted by minors, such as a civil protective order complaint for dating violence or child sexual abuse, North Carolina generally requires the Court to appoint a guardian ad litem (GAL) for the child in order to proceed. Appointment of a GAL may involve a fee for the family, although in DSS cases the GAL is a free service paid for by state government.

In addition, when adults seek protective orders, North Carolina permits 50B domestic violence protective orders to include provisions for children, including:

- custody of the child
- no contact with the child
- child support
- no contact with the child's school or daycare
- obtaining passports, birth certificates, social security cards and identification information of the child

how do you identify legal concerns?

- Remember the child has legal concerns too, e.g., educational concerns, immigration law, DVPO
- Listen carefully to how the caregiver and child explain their barriers to safety and stability
- Remember a family's legal needs are often criminal AND civil, such as housing rights, civil rights, employment rights, personal injury, etc.

Even if the child is threatened by others not in the 50B relationship categories, remember that a 50C protective order for sexual assault or stalking may be obtained.

Protective order custody provisions are only valid for up to one year, unlike no contact provisions for adults which may be renewed continually. The rationale for this difference is that the courts expect the parents to use the protective order for custody only temporarily, followed by the parent going into Family or District Court with a more in depth hearing to obtain a permanent custody order. General child custody orders may also be obtained on an emergency basis, with a process very similar to the protective order process (e.g., ex parte order followed by a hearing for a permanent order).

School notification of DVPOs: Note that North Carolina under Chapter 50B now requires notice to school personnel by the Sheriff when a protective order includes a provision that prohibits the abuser from being present at the child's school or daycare. However, if the child changes schools or daycares, the sheriff is not required to continually send new notifications, therefore the parent should ensure that the school is notified.

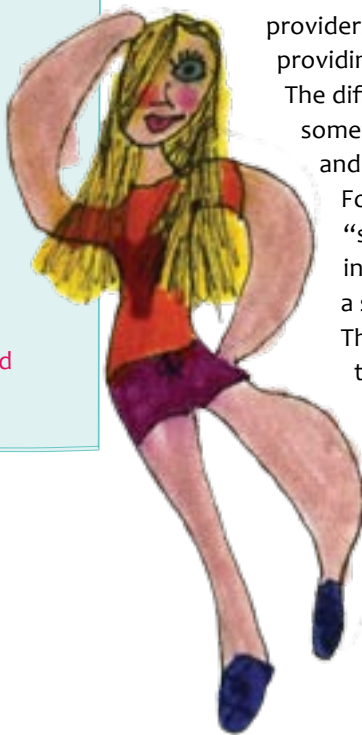
Key point: Although minors may obtain protective orders through the representation of a court appointed guardian ad litem or parent, be careful about encouraging protective orders for children or adults. This should always be the client's decision. There are serious potential legal ramifications for persons who later change their story in court or drop orders of protection, such as potential false reporting criminal charges or being held in contempt of court or developing a reputation for a lack of credibility, even if the reasons for a change of heart are fully justified. There is also the risk of engaging in the unauthorized practice of law when a non-lawyer makes a recommendation to an adult or minor client to proceed with a legal action (see right).

Avoiding the Unauthorized Practice of Law

As shelter staff members increasingly discuss available legal options with their adult and child residents, there is always the risk that the information will shift into legal advice. Because shelter residents are often in serious crisis, they may aggressively ask the shelter staff members to provide such advice, especially if they are teen parents or caregivers fearful for their children's safety. However, it is very important that shelter staff members do not provide legal advice to their residents as this would constitute the unauthorized practice of law (see N.C.G.S. § 84.2.1 et seq.).

The unauthorized practice of law in North Carolina is a misdemeanor crime, similar to the unauthorized practice of medicine or holding oneself out to be a psychologist without having such a license. Although many service providers have a good understanding of domestic violence law and experience with the court system, the prohibition against the unauthorized practice of law helps to ensure that if damaging or dangerous results occur as a result of inaccurate or inappropriate legal advice, then the client at least has the recourse to file a complaint for malpractice or a grievance for unethical conduct with the relevant licensing board. The purpose of licensures is to protect the public through required monitoring and standards in areas of practice that have a greater risk for harming the health and well-being of the public.

Shelter staff and other non-attorney service providers, however, can be very helpful in providing legal information to their clients. The difference is that legal information is something that could be provided to anyone and no specific recommendation is made. For example, saying "generally" or "sometimes" or "some of the options" indicates that you are not recommending a specific course of action to an individual. The unauthorized practice of law includes: telling a shelter resident whether to respond to a subpoena, explaining what their legal rights are, filling in legal forms (including protective order complaints), or interpreting a legal document for them.



One of the safest ways to provide shelter residents with detailed legal information is to provide them with information and/or brochures created by attorneys or legal agencies, such as the Legal Aid website or the local District Attorneys Office. The North Carolina Bar Association has numerous free legal information brochures that you can distribute to your residents, including those on the rights of minors, domestic violence, child custody, divorce and separation, wills and estates, and HIV/AIDS.

what if my client can't read or write english?

If your client cannot speak or read the language on a legal form, then advocates may generally read it out loud or write down the client's responses word for word to ensure that it is only transcribing rather than providing a legal service. It is often helpful if you sign and date the form, explaining your role as transcriber to avoid questions in court.

Examples of Legal Advice vs. Legal Information

Legal Advice:

- You should go down to the Magistrate's Office and file criminal charges right away.
- It sounds like you're in danger. I think you should call 911 immediately.
- What just happened to you could be charged as felony sex offense.
- I think the document you've shown me is a petition for child custody. This provision here says he wants all rights to the kids.
- I would recommend you get a protective order for yourself and your kids.

Legal Information:

- If you are interested in filing criminal charges you can go down to the Magistrate's Office and try to do this.
- It sounds like you're in danger. If you feel you need to, you can always call 911.

- What happened to you might be criminal. If you like, I can help you to meet with a law enforcement officer about possible charges, and to tell you about the confidential blind reporting policy in our community.
- I'm not an attorney and I can't give legal advice, but it looks like this might have something to do with child custody. If you are unsure about what it means and want to get some advice, I would recommend that you speak with an attorney directly and I'm certainly happy to provide you with some referrals.
- One of your options to increase your safety is to obtain a protective order. Although you can generally get one without a lawyer, I would recommend that you seek the advice of Legal Aid or another attorney if you can before filing for one. They can give you advice about what the legal risks might be.



Key point: Be particularly careful to avoid the unauthorized practice of law. Aside from the legal liability risks for the shelter and its staff, important legal decisions should be the clients' decision and it is far more empowering for them to make these decisions themselves. Also, it is dangerous to assume the legal system is always a safe and protective course of action for victims. Only a client can determine the safest course of action in his or her particular situation. When working with children, ensure that the rights that they do have are fully respected. Just as we seek to empower adult domestic violence survivors, we should give child survivors as much of a voice as possible in the legal system. For example, children can write their own victim impact statements in a criminal trial, or write to the judge in a custody hearing, or ask to speak with the attorney in a protective order hearing to express their wishes and concerns.

Who is the Client? Avoiding a Conflict of Interest and Providing Confidential Victim Advocate Services to Children

One of the greatest public benefits of domestic violence and rape crisis center services is that the victim may seek information, counseling and support in a nonjudgmental confidential setting (see also discussions on confidentiality and privacy with community service providers in Chapter V). Ensuring confidentiality is essential for many victims to feel safe enough to seek help. Most victim advocates

are comfortable with assuring their adult clients that their confidentiality is secure. However, when children are involved, mandatory reporting laws may pierce the wall of confidentiality and require the reporting of abuse and neglect (see below). When shelter staff members provide increased services to children, they may be developing legally protected confidential relationships with children covered by the victim advocate privilege described below. If victim advocates are licensed mental health clinicians, their ethical rules of their licensing board may have additional provisions related to confidentiality and minors. Finally, individual agencies may establish internal policies related to whether they will protect or disclose confidential matters, which should be made clear to a client of any age prior to engaging in private discussions.

In general, confidentiality with a client, whether an adult or child, would be established if no third parties are present (including parents), the conversation relates to direct services, and the client expects the conversation to be confidential. Sometimes a conversation continues to be deemed confidential by the courts if a third party is present, but only if the third party is considered a “necessary” third party (e.g., caregiver of a very young child, or assistant to a person with a severe disability, or a language interpreter). In working with very young children, the parent may be deemed a necessary party to the conversation and the communication with the child would still usually be confidential.

However, it is important to be aware that any child may disclose instances of conduct that might constitute reportable neglect or even abuse on the part of a parent that is a victim of partner domestic violence, whether it relates to acts by the adult domestic violence victim or to sibling violence. In these cases, even if confidentiality is respected for conversations with both children and adults, a conflict of interest might develop for the shelter staff member who is providing services to both caregiver and child. For example, a mother and child might separately report abuse concerns about each other to the service provider. The shelter should seriously consider terminating one of the service relationships and refer one or the other resident to external mental health services to avoid any conflict of interest, and involve DSS when legally required.

Although everyone can make an effort to maintain confidentiality with others, North Carolina law protects information from being used as evidence in court when

it arises in certain relationships, such as: doctor-patient, attorney-client, psychologist-client, priest-penitent, licensed social workers and counselors and their clients, among others. Victim advocates are included among the professions that permit legal protection of confidentiality. Under N.C.G.S. § 8-53.12, domestic violence and sexual assault victim advocates who have had at least 20 hours of training, can assure their clients (both adult and child) that their private conversations have greater protections of confidentiality. Nevertheless, the privilege of confidentiality may be broken with the victim/client’s consent or waiver, by court order, or if there is a legal duty to disclose the information. Victim advocates cannot lawfully break confidentiality and disclose client information on their own; the privilege belongs to the client. Even aside from legal concerns, breaking confidentiality adds to the distrust many child and adult residents feel toward the legal and community support system, and inhibits the ability of residents to heal and move forward, whether the resident is an adult or a child.



Key point: At the beginning of the victim advocate-client relationship, shelter staff members must be very clear with their residents of all ages regarding the shelter’s willingness to establish confidential relationships with both minor and adult residents. This impacts both client safety and the ability of clients to trust shelter staff.



Regarding confidentiality for minors in medical matters, the Federal Health Insurance Portability and Accountability Act (HIPAA) laws will protect clients from disclosure of health information for which electronic billing is provided, although most shelters would not provide fee based services. Keep in mind that there are many exceptions to HIPAA protections, including some specifically related to child abuse and cooperation with law enforcement. Additional federal confidentiality protections exist for substance abuse services and information and those related to sexually transmitted diseases. Therefore an agency required to comply with HIPAA should obtain legal advice to ensure their policies are compliant with federal law.

More important to a typical domestic violence shelter setting, minors have certain rights in North Carolina to obtain medical testing and treatment from a physician without parental consent, but only for the following (N.C.G.S. § 90-21.5):

- Sexually transmitted diseases (including HIV/AIDS)
- Pregnancy
- Substance abuse
- Emotional disturbance (e.g., psychiatric services)

Otherwise the general rule is that minors must obtain parental consent for medical treatment. For teenage parents, this can be a complex issue because both parent and child are minors. It is recommended that shelter staff be very aware of the confidentiality and treatment policies of medical clinics and health departments when they refer minors to their services.

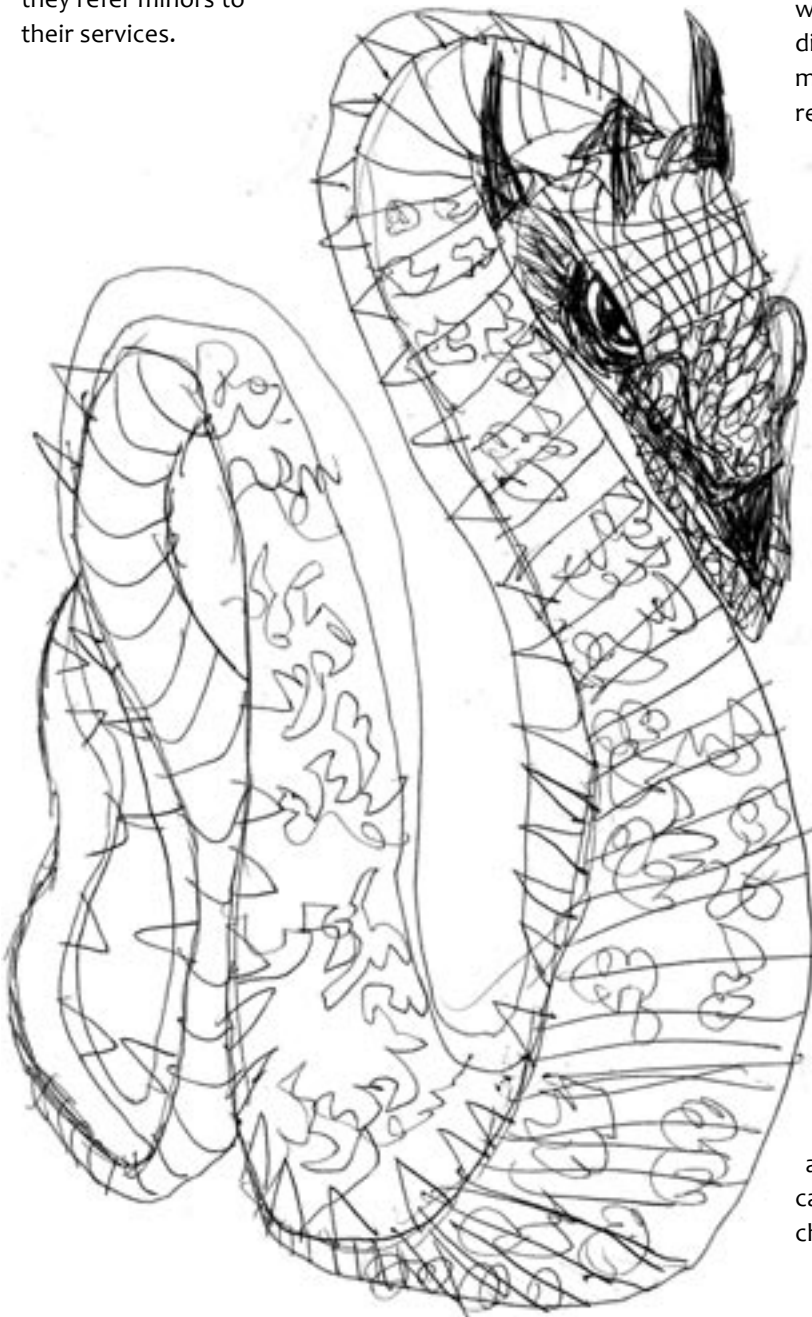
Note that if your shelter has staff members who have obtained professional licenses, such as a licensed clinical social worker or a licensed professional counselor, then these staff members may be more limited by their licensing requirements and ethical rules than unlicensed victim advocates. That is, licensed staff members may be required to obtain parental consent and disclosure of children's services to parents as a requirement of their licensure. In contrast, unlicensed shelter staff members who are not limited by licensing provisions may have more freedom to provide minor residents with confidential services under North Carolina law. Shelters should clearly identify whether their policy towards children's confidentiality is divided differently among staff licensed and unlicensed staff members; or whether it is the same for all staff members regardless of licensure.

How the Duty to Report Child Abuse Impacts Confidentiality

Under North Carolina law, every person has a legal duty to report a suspicion of child abuse or neglect by a caretaker. This duty overrides the privilege of communications including the victim advocate privilege. Keep in mind that despite the fact that many

the duty to report only covers caretaker abuse and neglect. some common examples of non-caretaker abuse in which there may be no mandatory reporting required include: when a child is harmed by another child at school, dating violence, when a neighbor or family acquaintance harms a child, and harm by a stranger such as a store clerk.

professionals generalize about the duty to report "any" child abuse, the law only requires a duty to report caretaker abuse of children or dependent adults with disabilities. There is no duty to report non-caretaker abuse or neglect. The reason that only caretaker abuse and neglect are covered by mandatory reporting is that if a caretaker is responding reasonably to the fact that his or her child has been abused and there is no indication of neglect by



the parent, then the State (DSS) has no need or legal right to intervene. Constitutional law presumes that all parents are fit unless proven otherwise, and provides them with the legal rights and duties to care for their children in the manner they see fit without intervention by the State.

Can a minor get a protective order?

Yes, however an adult (parent or guardian) will need to file the claim on the minor's behalf. Sometimes the minor's legal case is stronger than the parent's, e.g., the mother may have been threatened by her spouse but her child sustained injuries from severe parental discipline.

In some circumstances, DSS may consider a caretaker's refusal or inability to leave a domestic violence relationship to constitute child neglect (for placing or permitting the child to remain in a dangerous setting (see Chapter V)). For example, a mother would likely be considered neglectful if she knew of the abuse but did not act to protect her child or even allowed the abuse to continue. Another example is if she permitted child visitation with an abusive father when she knew the father had serious mental health or substance abuse issues that could endanger the child. For shelter residents, their family's presence in shelter may often be a positive sign that the caregiver is actively seeking to keep her children safe from domestic violence; which may in turn help a caregiver avoid the risk of having Child Protective Services intervene and remove the children from her care.

When is a Lawyer Especially Needed in Child Cases?

Many domestic violence victims and their children enter the court system without the use or need of an attorney representing them. For example, in a criminal proceeding the State of North Carolina will generally prosecute the offender and handle the case and its costs. However, keep in mind that in criminal cases, the State is not the victim's attorney, but rather represents the community as a whole and its interests in safety and justice. Thus the prosecution will generally decide whether the case proceeds regardless of the victim's wishes, and may try to have the victim witness held in contempt if he or she recants.

In 50B (and often 50C) civil protective order hearings, federal law requires that the victim be permitted to proceed pro se (i.e., without an attorney) and that there be no filing or court costs. Other common hearings where the victim may not need an attorney is in a Small Claims Court proceeding. Occasionally a victim may seek divorce or custody without an attorney, although this is difficult in many domestic violence cases when the parties cannot agree to terms, which is often the case when child custody is at stake.

However, in all of the above cases, an attorney may be very helpful even if not required. Just as batterers may be unpredictable and dangerous at home, their behavior may also be unpredictable or dangerous in court. In some cases, an attorney is especially needed if there is an increased risk to adult or child victims. For example:

- a victim who does not have legal citizenship or residency status should seek legal representation if at all possible before any court proceeding in order to avoid deportation;
- family or district court proceedings such as custody and visitation, can result in permanent court orders that have long-term impacts on children;
- domestic violence situations with high lethality, such as threats to kill or commit suicide or the use of firearms, may need legal advice to determine the safest legal remedy (e.g., escape and identity/address changes rather than a heated court battle where the offender is required to appear).

Useful Legal Referrals

Key point: Shelter staff members are in an ideal position to refer residents, both adult and child, to appropriate legal services in their community and throughout the state. Although most domestic violence service providers are aware of Legal Aid's local services and offices, Legal Aid of North Carolina also has a number of statewide offices that serve domestic violence victims for free statewide, including some specifically for children. Do NOT assume that because the parent or legal guardian does not have a need or ability to obtain legal assistance that the child does not. Also, the child may need or be able to access legal services that the parent or legal guardian cannot.



Below are three of the specialized Legal Aid/Legal Services agencies that may be of assistance to children.

The Battered Immigrant Project (1-866-204-7612)

As part of the Domestic Violence Prevention Initiative, this project provides battered immigrants with legal assistance with DVPOs, family law issues, public benefits, and immigration issues. Petitions for stay of deportation and other immigration law actions may be made on behalf of child victims of domestic violence alone, even if the parent does not have a legal claim. Note that the immigration status and needs of children may be very different from their parents, and both have a right to access legal information and representation as needed.

Advocates for Children's Services (see Legal Aid website for regional office contacts)

This project provides free legal representation for children who are in need of medical, psychiatric, special education and foster care/adoption services to which they are entitled under state and federal law. They also focus on minors in the juvenile justice system and children who have been denied an equal education on the basis of their race and community status.

Indian Law Unit (1-910-521-2831)

This unit focuses on providing legal representation to four of the six state-recognized Indian tribes (Lumbee, Haliwa-Saponi, Coharie, and Waccamaw-Siuoan), including work with housing, economic development, and other issues relating to their status as a non-federally recognized Indian tribe.

There are many other legal resources throughout the state that can assist children and their parents, such as the North Carolina Justice Center or Disability Rights North Carolina. Becoming familiar with the local bar association, or other law associations such as the North Carolina Association of Women Attorneys or the North Carolina Association of Black Lawyers, is useful for pro bono or low cost referral sources. Law schools often have free legal clinics, and many provide services across the state, such as the HIV/AIDS Legal Clinic at Duke University or the School Suspension Legal Clinic at North Carolina Central University. Another resource is to contact other statewide advocacy organizations, such as the North Carolina Coalition Against Domestic Violence, the North Carolina Coalition Against Sexual Assault, Prevent Child Abuse North Carolina, and the Center for Child and Family Health's Legal Program, as they often have attorney members or contacts with a sincere interest in helping families at risk of abuse.

Key point: Referral to a legal clinic or attorney does not mean there has to be a clear cut legal case or that the client must have a great deal of money. There are a number of free legal clinics that will represent the legal needs of children and adults (see the Self-Assessment Checklist in Appendix C to identify resources in your area). Consider not only your local legal resources, but the statewide resources available, particularly if your local resources are limited. Trust your instincts and lean toward a legal referral if you feel the client's situation is unfair or their rights have not been respected. Finally, for those services that do require payment, such as a complex custody dispute, sometimes even an initial one-time consultation can be very helpful in providing a client with information to protect their family as well as the peace of mind that knowledge brings.

appendix a. additional resources

The resources below have easily accessible free information for the public, and both clinical and non-clinical service providers, related to the impact of domestic violence on children and local, state and national referral sources. For more specific resources related to chapter topics, please see resources listed within each chapter.

Child Traumatic Stress Organizations

Center for Child and Family Health

www.ccfhnc.org

Medical University of South Carolina National Crime Victims Research & Treatment Center

www.musc.edu/ncvc

National Center for Posttraumatic Stress Disorder

www.ncptsd.va.gov

National Child Traumatic Stress Network

www.nctsn.org

Child Victimization and Abuse Prevention Organizations

Prevent Child Abuse North Carolina

www.preventchildabusenc.org

North Carolina Coalition Against Sexual Assault

www.nccasa.org

North Carolina Coalition Against Domestic Violence

www.nccadv.org

Child Advocacy Centers of North Carolina

www.cacnc.org

National Center for Victims of Crime

www.ncvc.org

National Coalition Against Domestic Violence

www.ncadv.org

RAINN – Rape, Abuse, & Incest National Network

www.rainn.org

appendix b. research references

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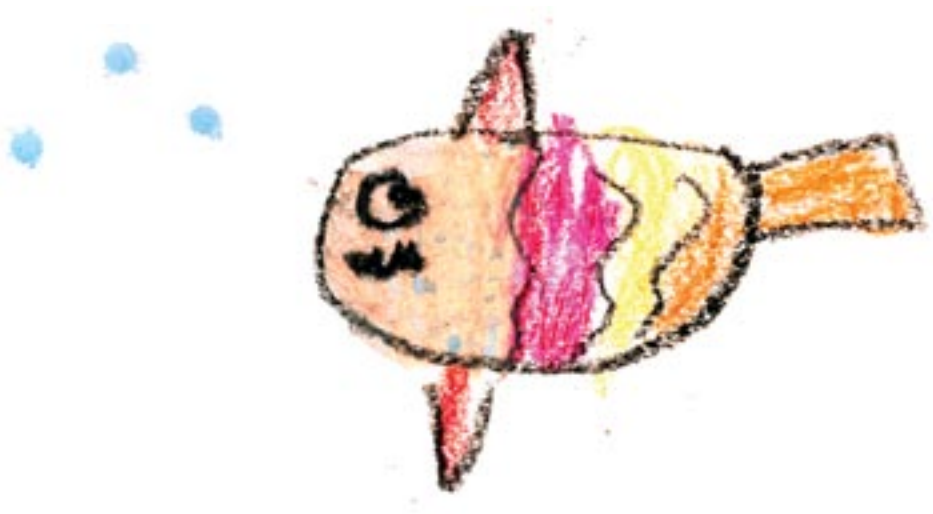
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appendix c. self-assessment checklist for community partnerships

CHILDREN'S DEVELOPMENTAL SERVICES AGENCY (CDSA)

- I have a contact at the local CDSA that I call regularly to refer clients or ask questions about CDSA services.

Contact: _____

- I make referrals to the local CDSA when I suspect that a child has a developmental delay, like delayed speech or hearing.
- I have offered to the CDSA that they conduct evaluations at our agency to avoid having to transport families, and because it might be more comfortable.
- I have invited one of their staff to come make a presentation to our staff about their services.
- We have brochures in our offices about their services.

CHILD SERVICE COORDINATION PROGRAM (CSCP)

- I know the name or names of the CSCP staff at my local Health Department.

Contact: _____

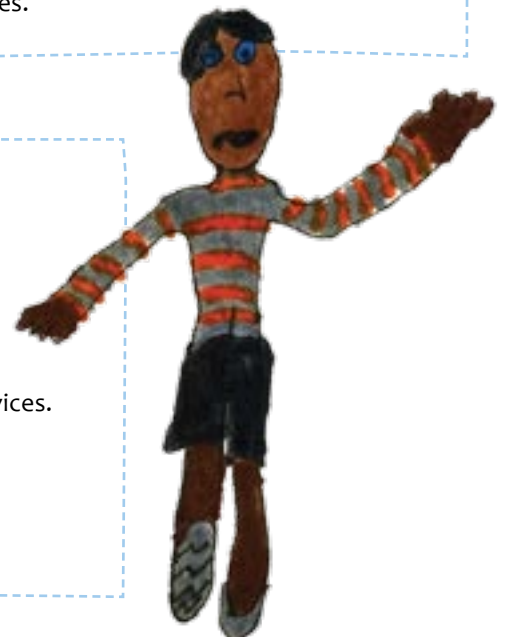
- I have referred families to the CSCP for case management services.
- I have met with or offered to meet with CSCP staff to describe our services and find out more about theirs.
- I know how old children have to be to be eligible for these services.
- We have brochures in our offices about their services.

CHILD ADVOCACY CENTERS (CAC)

- I know where the closest CAC is to my office.

Contact: _____

- I can describe what a CAC is, what they do, and who is eligible for their services.
- I have called my local CAC for information or support.
- My local CAC is aware of the shelter's services and policies.



DEPARTMENT OF SOCIAL SERVICES (DSS)

- I have a contact at my local DSS who I call if I have questions or concerns, or to make a referral.

Contact:

- I know whether my local DSS holds Child and Family Team meetings.
- I am familiar with the DSS Child Protective Services domestic violence policy. I could describe how domestic violence is addressed during an assessment, how DSS evaluates safety and risk as they relate to domestic violence, and how a service plan addresses it.
- I know whether or not my local DSS has social workers and supervisors trained on the domestic violence policy.
- I know when I should make a mandated report of child abuse or neglect to the local Department of Social Services.
- I understand the confidentiality rules that DSS operates under and they understand the confidentiality rules and policies that I operate under.

LOCAL MANAGEMENT ENTITIES (LME)

- I have a good idea which kids need to be referred for a mental health evaluation.
- I know whether or not we have mental health treatment providers in our area that are trained in Trauma-Focused Cognitive Behavioral Therapy.

Contact:

- I have referred children to the LME in the past year.
- I have referred adults to the LME in the past year.
- I have a contact at the LME who I can and do call if I have questions or need information or am making a referral.

Contact:

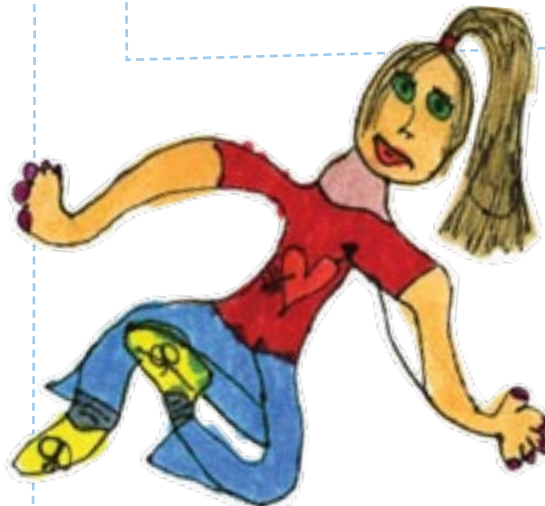
- I have participated in developing a local plan for mental health services, through the LME, in order to advocate for my clients' needs.
- I know how long it usually takes after a call to the LME before a child or adult is evaluated.
- I know how long it usually takes after an evaluation at the LME before treatment begins.

CHILD CARE RESOURCE AND REFERRAL

- I know my local Child Care Resource and Referral line.

Contact:

- I have referred families in order to locate childcare.
- I have called the Resource and Referral line to ask questions about setting up our shelter play space or about different programs we can use at the shelter or refer to in the community.



MEDICAL INSURANCE

- I have downloaded applications for Medicaid off of the Internet.
- I have read the materials about Health Check and NC Health Choice.
- I know which Community Care network covers my county.
- We have brochures and other materials about applying for insurance in our waiting rooms or offices.
- I know whom to contact at DSS is to apply for Medicaid.

Contact:

LEGAL REFERRALS

- I have contacted my local State Bar office and the court clerks to inform them of our shelter's services.
- I have read the materials related to confidentiality, duty to report, and the unauthorized practice of law.
- I have downloaded the latest court forms for protective orders in English and Spanish from the NC Administrative Office of the Courts website.
- I know which private local attorneys specialize in juvenile law, domestic violence, family law, and personal injury.

Contact:

CHILD AND FAMILY SUPPORT TEAMS (CFST)

- I know whether the school district I'm in has a Child and Family Support Team in one or more of the schools.
- I have talked to a member of this Support Team before.

Contact:

- I have attended a Child and Family Support Team meeting.

- I have invited my local Legal Aid attorneys to visit the shelter.
- I have a contact for each local multidisciplinary team that may address child abuse, domestic violence, and/or sexual assault.
- We have both local and statewide brochures and other materials about civil and criminal legal services and legal information.







center for
CHILD & FAMILY HEALTH

411 W. Chapel Hill Street , Suite 908 * Durham, NC 27701

(919) 419-3474 * www.ccfhnc.org

