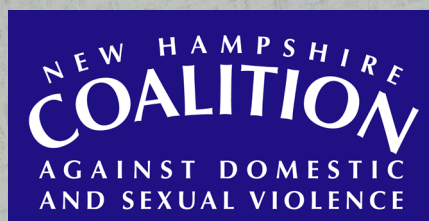


The Mental Health Needs of Children Exposed to Violence in their Homes



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*The Mental Health Needs of Children
Exposed to Violence in their Homes*

Jane G. Stapleton, M. A.
Kimberly G. Phillips, M. A.
Mary M. Moynihan, Ph. D.
Desiree R. Wiesen-Martin, M. A.
Abbie L. Beaulieu, M. A.

Presented to
Grace Mattern, Executive Director
New Hampshire Coalition Against Domestic and Sexual Violence

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Jane G. Stapleton and Mary M. Moynihan

Co-Coordiators

Prevention Innovations (www.unh.edu/preventioninnovations)

206 Huddleston Hall

73 Main Street

Durham, NH 03824

(603) 862-5023

Please direct any correspondence regarding this report to Jane G. Stapleton (jgs@unh.edu) or Mary M. Moynihan (marym@unh.edu)

About Prevention Innovations

Prevention Innovations: Research and Practices for Ending Violence Against Women on Campus, based in the College of Liberal Arts at the University of New Hampshire, is a consulting, training, and research unit that develops, implements and evaluates cutting-edge programs, policies and practices that will end violence against women.

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Mental Health Needs of Children Exposed to Violence in their Homes

A number of national studies have shown that exposure to violence in the home, as well as direct abuse of a child, has a detrimental effect on children, with a wide range of responses, including long term effects on mental health (e.g., Kitzmann, Gaylord, Holt, & Kenny, 2003; Finkelhor, Ormrod, Turner & Hamby, 2005). In addition, Edleson and his colleagues have estimated that up to 10 million children are exposed to incidents of domestic violence (DV) (e.g., see Edleson et al., 2007; Rossman, Rea, Graham-Bermann, & Butterfield, 2004) each year.

In light of these statistics, as well as state-level ones reported below, the New Hampshire Coalition Against Domestic and Sexual Violence (the Coalition) recognized that more formal support and advocacy services need to be developed for children of domestic and sexual violence victims who seek services at crisis centers. For that reason, the Coalition applied for and received funding from the New Hampshire Endowment for Health (NH-EFH) to create a comprehensive plan to strengthen the Coalition's provision of mental health services and support for children exposed to violence in their homes. In its application to the NH-EFH, the Coalition noted:

“One thing that I found is that it [exposure to violence in the home] has had a significant impact on my ability to carry out healthy relationship in my adult life. Not necessarily that I feel that I am at risk for being an abuser, but that I have trouble trusting partners.”¹

In New Hampshire in 2008, the member programs of the Coalition provided assistance to 430 children exposed to domestic violence, 161 child abuse victims, and 582 child sexual abuse victims. These figures only include children who received actual assistance, such as being sheltered with their mothers, or attending a structured activity at one of the programs. Many more children whom the Coalition's member programs assist do not receive direct assistance, but children could benefit from a comprehensive, integrated service delivery system to address the mental health needs of children

exposed to battering, if such a system were to be developed. For these reasons, the New Hampshire Coalition Against Domestic and Sexual Violence (the Coalition) and its 14 member programs recognized the critical importance to respond to the mental health needs of children exposed to violence in their homes, and focus groups conducted in conjunction with the Grafton County New Hampshire Greenbook Project likewise documented this serious problem.²

Thus, the Coalition and its member programs concluded that greater systemic support and increased advocacy services should be developed for children of domestic violence victims who seek services at crisis centers. The Coalition responded by re-organizing a staff position to include a focus on expanding member programs' capacity to provide child advocacy. In addition, several of the Coalition's member programs created child advocacy positions. In order to determine how to address these needs more specifically, the Coalition and its member programs designed a planning process to develop a more comprehensive system of attending to the mental health needs of abused children, children exposed to violence, and their non-abusive parents who access services.

This project was designed to develop regional and local strategies to improve the mental health outcomes for children and their families who are exposed to violence in their homes, as well as to identify ways to strengthen the systems of care for these children and their families. This project is concerned with exposure to all types of violence, including battering of a parent, physical assault of the child, and sexual abuse of the child. By engaging key stakeholders in a needs assessment of the mental health needs of these children, we have sought to

identify the current provision of the Coalition and community-based services and supports, as well as best practices and reimbursement models.

The project had three primary goals. The first was to identify national and state best practices, reimbursable service models and research on children who experience the trauma of domestic and/or sexual violence. The second goal involved completing a comprehensive needs assessment of the mental health services and support for children exposed to violence in their homes, and the final goal focused on documenting the planning process and disseminating results. The results of this planning project are documented in this report.

With regard to the first goal, an important component of this project was to identify current mental health and support services available in New Hampshire to children exposed to violence in their homes. To assess this, we spoke first with state and national experts in child trauma treatment. Next, we interviewed mental health practitioners and other professionals whose jobs involve working directly with children exposed to violence in their homes. Later in this report, we refer to this group as *direct service providers* and *primary-level gateway providers*. Additionally, we sought out professionals who, though their jobs do not directly require them to work with children exposed to violence in their homes, by the very nature of their work, interface with them. We refer to these professionals as *secondary-level gateway providers*.

Prior to our interviews with direct service and primary- and secondary-level practitioners, we held our first of two stakeholder meetings. Stakeholders at these meetings represented NH experts and professionals who oversee systems of care regarding or work with children exposed to violence in their homes and their offending and non-offending parents. In the first meeting, stakeholders provided feedback on the best practices and research we had conducted to date. Additionally, they suggested ways to redefine the types of professionals we would interview during the data collection phase of the project. We conducted the second stakeholder meeting after we completed data collection. We shared preliminary findings with stakeholders, and

they offered feedback and made systematic recommendations to best meet the mental health needs of children, and their families, exposed to violence in their homes.

Finally, we spoke with non-offending parents of children exposed to violence in their homes and young adults, ages 18-24, exposed to violence when they were children. In addition to providing important information about the needs of children as well as availability and access to services, these *consumers'* voices contextualized the data we gathered from national and state experts and direct service and gateway providers. The non-offending parents and young adults exposed to violence in their homes are at the center of our analysis and assessment.

The information presented in this report is inclusive of the data that we collected during the two-year project period. During this time, we conducted a thorough review of available literature on research and best practices. In addition, we present the findings from 200 hours of qualitative data collected from the interviews and focus groups with the 101 consumers, state experts, direct service and gateway providers. After describing the consumers, we summarize our findings into three broad, common themes: responding, trauma-informed services, and integrated community response. Under each theme, we present summaries of the data from which the themes emerged and offer discussion of the findings. Finally, we present recommendations, based on our findings, which the Coalition will use to strengthen their current provision of mental health services and support for children exposed to violence in their homes.

Children Exposed to Violence in their Homes: Research and Best Practices

Outcomes of Violence Exposure

The impact on children of exposure to violence in the home cannot be easily predicted, as outcomes depend on many factors. Not all children experience similar levels of violence, in terms of the nature and severity of the abuse, the frequency, and the length of time the child has been a victim or a witness (Edleson et al., 2007). Without regard to the

specifics of any one situation or environment, research has demonstrated that the most commonly reported problems fall into three categories: behavioral and emotional, cognitive and attitudinal, and long-term problems (Edleson, 2004). Behaviorally, children tend to either externalize, exhibiting greater levels of aggression, rule-violation, and acting out, or they internalize, suffering from increased anxiety, depression, and moodiness. Possible impairments to cognitive functioning may lead to difficulty in school and challenges in negotiating appropriate social relationships. Long-term effects of trauma exposure have been associated with depression, low self-esteem, and substance abuse in late adolescence and early adulthood. Despite these documented outcomes, not all children exposed to violence appear to struggle with negative sequelae (Edleson et al., 2007; Gewirtz & Edleson, 2007; Hughes & Luke, 1998).

When considering the heterogeneity of children's reactions and the sequelae of domestic or sexual violence exposure, researchers and practitioners look for the presence of various risk and protective factors. Wolfe and colleagues (2003) describe a developmental psychopathology framework in which the context of a child's adaptation to a maladaptive environment can be understood. They note, "[T]here are ongoing interactions between protective and vulnerability factors within the child, between the child and his or her surroundings, and among particular risk factors. These factors are processes rather than absolutes..." (Wolfe et al, 2003, p. 172). Protective factors can be grouped into three categories, including child factors, family factors, and extrafamilial factors (Wolak & Finkelhor, 1998).

Child factors include such aspects as adaptability, optimism, and coping style. Other elements may be the child's attribution and appraisal of events, personality, and locus of control (Kilpatrick & Williams, 1998). Protective family factors include the strength and nature of the relationship with the non-offending parent, or the presence and relationship with siblings and/or extended fam-

ily members. Extra-familial influences include the presence of other positive relationships and social support from peers or adults such as teachers, counselors, clergy, etc.

Regarding non-offending maternal relationships, the harm a batterer or abuser inflicts on a mother can be extended to her infant in the form of stress and disruption of the body's natural regulatory systems. For example, during infancy, babies rely on their mothers to regulate their temperature and other physiological processes, including adrenocortical activity – the body's response to stress (Hibel, Granger, Blair, & Cox, 2009). Even among slightly older children, parental stress constitutes the strongest predictor of child outcomes on some standardized instruments (i.e., the Child Behavior Checklist, CBCL) (Zerk, Martin, & Proeve, 2009).

Risk factors specific to exposure to violence could involve the co-occurrence of child maltreatment (estimated by Rossman and

colleagues (2004) to be present in 37-63% of cases), poor relationship with the non-offending parent, the frequency, severity, and chronicity of the abuse, and the degree to which the child intervenes or is directly involved (Edleson et al., 2007).

Responding to the Needs of Children Exposed to Violence

The complex issues of domestic violence, especially when children are also involved, make pursuit of safety a matter of utmost priority. Safety is unlikely to be achieved, according to Malik and colleagues, without involvement of domestic violence providers (Malik, Ward, & Janczewski, 2008). Other researchers agree that safety is the focus of best-practice models: "Other clinical interventions have their place only when the primary intervention of safety is addressed and established. This includes emotional and psychological, as well as physical, safety" (Cooley & Frazer, 2006, p. 472). In order to ensure safety and best meet the needs of children exposed to violence, service providers and re-

"I think you don't even realize the impact seeing the violence has. That's the way I grew up." ¹

searchers must consider the child's age and relevant developmental norms.

Preschoolers. Normal and healthy development of infants through preschool age depends upon secure relationships to caregivers. Disruption of this process, for instance by exposure to violence, can interfere with all aspects of children's development. More specifically, they may not acquire a healthy level of trust and autonomy (Osofsky, 1999). In infancy, secure attachment may be derailed, sleep and eating disturbances introduced, and even brain development may be altered (Carpenter & Stacks, 2009). Preschoolers are rooted in the present and lack the temporal anchors to recall the past or infer into the future (Pillemer & White,

[Preschoolers] need to hear that what happened was not their fault, that they are loved, and that important features of daily life will go on...

(Baker & Cunningham, 2005)

1989), and rely on caregivers for structure, as they have not achieved the ability to control their own emotions (Lundy & Grossman, 2005). Egocentricity at this age makes the child very susceptible to self-blame for the violent events (Lundy & Grossman, 2005; Wolak & Finkelhor, 1998). "Children this age need to hear that what happened was not their fault, that they are loved, and that important features of daily life will go on" (Baker & Cunningham, 2005, p. 20). Exposure to domestic violence can also result in less expression of emotion in a child's play (Osofsky, 1999). Carlson (2000) details some of the behavioral effects of violence exposure on children this age. She refers to ambivalence toward parents, acting out and whining, clinging or crying that may result from anxiety and post-traumatic stress. The maintenance or re-establishment of routines and the presence of comforting items such as snugglies or pets can reduce uncertainty and be reassuring for preschoolers (Baker & Cunningham, 2005).

School-aged children. Between the ages of 6 and 12, children begin to recognize normative stan-

dards and derive their sense of self from comparisons with others around them (Erikson, 1963). As such, they are sensitive to the approval and disapproval of others (Damon & Hart, 1982). Carlson (2000) documents the effects of domestic violence on latency-age children as leading to guilt and shame as well as anxiety and symptoms of post-traumatic stress disorder (PTSD). Externalizing behavior continues and can lead to patterns of disobedience. These children may begin to do poorly in school and peer relationships suffer. They may lack motivation or have difficulty concentrating due to intrusive thoughts (Osofsky, 1999).

Baker and Cunningham (2005) add that gender socialization is occurring at this age, and children are making judgments about fairness and appropriate means to having their needs met. Interventions targeting appropriate conduct in social relationships and focusing on self-regulating behaviors may be most appropriate for this age group. Possibly, school-aged children have a slight advantage over preschoolers in that they are better able to contextualize the circumstances of violence and may have more internal (more sophisticated cognitions) and external (school professionals and perhaps education about family violence) resources for coping (Lundy & Grossman, 2005). Groves (1999) urges non-offending parents and adults in support or service roles to directly discuss the occurrence of violence and the child's accompanying emotions. She warns that too often professionals have the misconception that honest discussion might re-traumatize children, when what they need is assistance in understanding and reacting to what they are going through.

Adolescents. The effects of violence exposure on adolescents can lead to depression and suicidal ideation, dating violence, delinquency, substance abuse, and use of violence as a control tactic (Carlson, 2000). Emotions may involve anger at the abuser and/or the mother, responsibility for the safety of younger siblings and/or the mother, shame, and a desire for vengeance against the batterer (Baker & Cunningham, 2005). Adolescence involves the active search for identity (Erikson, 1963), and a lack of guidance at this stage could lead to poor choices. Similarly, the sexual coming of age and onset of

The effects of violence exposure on adolescents can lead to depression and suicidal ideation, dating violence, delinquency, substance abuse, and use of violence as a control tactic.

(Carlson, 2000)

sexual experiences may be adversely influenced by the results of violence exposure and the perpetuation of violent norms of behavior. It may be difficult for teens to get the appropriate style or level of help they need because the effects of exposure to violence may be masked by their own law-breaking or violent behaviors.

Trauma-informed Services

Recent research suggests that at least some components of a mental health response to children suffering exposure to violence ought to be specifically trauma-informed. Children with sustained exposure to violence at a young age frequently experience complex, as opposed to acute, trauma. Van der Kolk and Courtois (2005) describe this form of trauma:

Complex but consistent patterns of psychological disturbances occur in traumatized children as well as in adults who have been exposed to chronic or severe interpersonal trauma at any time in the lifespan. In particular, numerous studies have demonstrated the pervasive negative impact of chronic and cumulative childhood abuse and trauma on the developing child. (p. 385)

Symptoms include fundamental changes to stress-response and arousal systems, as the traumatized children avert their attention from developmentally appropriate stimuli and activities in order to maintain a hypervigilance against the threat of harm (Bath, 2008).

According to some authors, important contributions to the healing of traumatized youth need not

be limited to clinicians or those with specific therapeutic training. Bath (2008) outlines three pillars that are common to various approaches to treating trauma: establishment of safety that is sustained over time, healthy interpersonal connections with at least one close adult, and guidance in managing emotions and impulses. The aspects of treatment that Bath reviews are accessible to any practitioner or adult working with children, but training about trauma remains essential. Greenwald and colleagues (2008) explain the critical step of formulating a case from the perspective of trauma. They illustrate it as the only way for practitioners to understand the internal processes of the child, and they stress its importance for the well-being of both the child and the advocate who will likely struggle with the challenges the child presents:

[W]hen the helper is able to understand how trauma has contributed to the development and persistence of a client's problem behavior, the helper should have a better chance of (a) feeling less distress, (b) feeling more caring and compassion, and (c) feeling more of a sense of comfort and confidence in his or her helping role (Greenwald et al., 2008, p. 2).

Greenwald and his colleagues go on to recommend the specific trauma training protocol that they have developed, the Meaning of Behavior exercise (Greenwald et al., 2008), but of course, others exist.

Ko et al. (2008) noted that a young person, with whom child protection becomes involved almost certainly, by definition, has suffered from trauma. The researchers further explain that while child welfare providers (as an example that also may generalize to other disciplines) may be very familiar with the traumatic events a child has endured, they are far less likely to be trained in the linkage between a child's presenting behaviors and the experience of trauma. They call for trauma specialists and trauma screening and assessment tools at all levels of the child welfare system.

Evidence-based trauma-informed practice for service provision and interventions targeting children who experience violence in the home is an area

that has been the focus of much recent research and development. Many treatment models have been suggested, and the empirical evaluation of different methods and treatment protocols continues (e.g., Graham-Bermann & Hughes, 2003; Jouriles, McDonald, Stephens, Corbitt-Shindler, & Miller, 2009). These evaluations lead to recommendations for developing stronger therapeutic approaches. Assessment tools to screen for trauma symptoms are also available (e.g., Rossman et al., 2004).

Two recent publications describe three screening and assessment tools. Edleson and colleagues developed and tested the Child Exposure to Domestic Violence (CEDV) scale, a 42-item self-report questionnaire designed for children aged 10-16 (Edleson, Shin & Amendariz, 2008). The Child Welfare Trauma Referral Tool (CWT) assists caseworkers in assessing a child's history of trauma, linking the trauma with specific presenting behavior and symptoms, and referring to a specific treatment system (Igelman, Taylor, Gilbert, Ryan, Steinberg, Wilson, & Mann, 2007). The CWT has been extensively tested and utilized in southern California. A lengthier assessment tool reviewed by Igelman and colleagues (2007) is the Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP). This standardized battery of tests includes multiple interviews and observations of children and their caregivers. From the outcomes, symptoms discovered define the next series of assessments until a "Unique Client Picture" is formed and specific foci for therapy are determined (Igelman et al., 2007, p. 24). While various options such as those above exist in terms of formal screening and assessment, few cohesive procedures have been widely disseminated in the field.

Research from around the country points to the fact that while most agencies recognize a need for trauma-informed services, few actually have standardized practices in place. Further, most lack a common assessment tool and fail to share trauma history with other collaborating organizations even when a wraparound continuum exists (Igelman et al., 2007). As will become evident in the later parts of this report, much needs to be done in terms of making evidence-based treatment programs and trauma-informed services available to all the chil-

dren who need them, and this is as true for children in New Hampshire as anywhere else in the nation.

The three tools mentioned above serve as examples of a battery of instruments and resources that have become available over the last several years. Starting in 2001, the National Child Traumatic Stress Network (NCTSN) has been striving to raise standards of care and access to services for children who have experienced trauma (Ko et al., 2008; Pynoos et al., 2008). Seventy-seven centers nationwide offer services and conduct trainings for professionals from all disciplines. Offering extensive resources from assessment to intervention, they form a model of interdisciplinary collaboration on a grand scale (Pynoos et al., 2008).

Integrated Community Response

Research has shown that children who suffer trauma as a result of exposure to or direct forms of violence and abuse are maximally aided by "an integrated, collaborative community response that includes emphasis on prevention, public education, and coordinated intervention" (Baker, Cunningham, & Jaffe, 2004, p. 221). Community coordination involves "a formalized system of ongoing collaboration between professional service agencies within a community" (Pennington-Zoellner, 2009, p. 539). While the organizations and institutions that serve children within a community "differ in their responsibilities for meeting children's needs... the goal for all systems is to improve outcomes for children and to maintain excellent standards of care" (Ko et al., 2008, p. 397).

Many systems have contact with children who have been exposed to violence at home. While some children may interact with service providers only in one or two locations (e.g., school, pediatrician), others may cycle through many more (e.g., crisis centers, juvenile justice, mental health). Malik and colleagues (2008) note that, compared with child welfare and the court systems, for example, service providers specializing in domestic violence "are likely to have the capacity to be more agile and flexible in their approach to families than large state-funded systems. But they also have significantly fewer resources than the larger systems and may be

overpowered by them” (Malik et al., 2008, p. 934). In other words, while domestic violence experts are definitely “at the table” in terms of coordinated community responding, their voice can be “less powerful” (Malik et al., 2008, p. 948).

This constitutes a disadvantage for survivors and their children, as community-based domestic violence agencies are often the only providers adequately prepared to address issues specific to violence in the home (Macy, Giattina, Sangster, Crosby, & Montijo, 2009). Further, lack of familiarity with issues of domestic violence can impair the best intentions of other providers, such that uninformed responders “can be detrimental to survivors’ health and well-being” (Macy et al., 2009, p. 390). In contrast, studies in which domestic violence shelter services have been expanded show that survivors are more effective in accessing other needed community resources and that they experience higher levels of well-being that persist over a longer period of time (e.g., Allen, Bybee, & Sullivan, 2004; Sullivan & Bybee, 1999).

Domestic violence specialists’ understanding of the dynamics of in-home violence means that, in addition to offering a vital service to survivors and their children, they have valuable information with which to educate other disciplines. Recent efforts toward cross-training and collaboration between domestic violence specialists and child welfare have resulted in more effective screening for domestic violence among child protection workers and better screening for child maltreatment among domestic violence agencies (Malik et al., 2008). Efforts to continue and expand cooperation are still needed.

An obstacle to collaboration between child welfare and domestic violence specialists arises over issues of confidentiality. “Privacy and confidentiality are cornerstones of domestic violence advocacy with battered women. In contrast, child protection agencies are often bound by policies that mean that information contained in safety plans, service plans and case records may be accessible to perpetrators” (Spears, 1999, p.7). To alleviate these problems, Spears (1999) suggests, both disciplines need to work together to understand one another’s priorities and establish solutions that best meet the needs of each.

Even in cases where children are not direct victims of violence, child welfare sometimes becomes involved either because the situation rises to the level of child neglect or because of a failure of parents to protect the child (Edleson, 2006). The charge of failure to protect has been a point of contention between domestic violence advocates and child welfare services. Advocates for women worry that blame is wrongly placed on the mothers. Kohl and colleagues (2005) researched the responses of child welfare services to families in which domestic violence was known to co-occur. They found that child protection reports indicate a greater likelihood of harm to children in homes in which a history of domestic violence is present, but classifications of the type of maltreatment are similar to cases in which domestic violence is not substantiated.

Many times, situations involving domestic violence, maltreatment and child exposure to violence, rise to the level of needing court intervention. One of the roles of the judicial system most germane to children exposed to violence at home involves custody and visitation decisions. Jaffe and Crooks (2005) explain three possible reasons that domestic violence can be overlooked in custody proceedings:

First, women may not raise the issue at all or conversely, raise the issue but have difficulty proving the violence; second, the experience of domestic violence can affect the way in which victimized parents present in an evaluation; and third, even when domestic violence has been raised and validated, it may be overlooked in the decision-making process. (p. 7)

Jaffe and Crooks (2005) call for more specific training for all court personnel to improve their skills in responding to situations involving domestic violence. Regarding the award of custody, best practice calls for children to remain with their non-offending parent when direct attacks against the child are not perpetrated (Edleson, 2006). At the same time, domestic violence specialists could use further training on the judicial system and how these cases play out in court (Jaffe & Crooks, 2005).

Visitation is another area over which the court system has considerable influence, and benefits can

arise from cross-disciplinary coordination. Recent research by Parker, Rogers, Collins, and Edleson (2008) found that judges assigned supervised visitation only 25.6% of the time in cases with substantiated domestic violence, even though prior research had shown that 82% of court officials had said they favored supervised visitation when domestic violence was involved. Supervised visitation centers (SVCs) offer the possibility of continued contact between parent offenders and their children. Their success, however, in terms of safety for non-offending mothers and their children is largely determined by the careful training and oversight of center staff. SVCs do not guarantee safety simply by the fact of their existence. Further, SVCs could stand to be better coordinated with other community systems, including domestic violence services and batterer intervention programs (Parker, Rogers, Collins, & Edleson, 2008).

Of particular note for the present report, New Hampshire has been cited in the research literature for efforts to unify court proceedings for families whose members are involved with different branches of the judicial system, including juvenile justice, family court, and criminal court. New Hampshire is also referenced as one of the states that encourages training on the effects of domestic violence on children (Lemon, 1999). Nonetheless, gaps are often found to exist. Jaffe and Crooks (2005) have observed, "Although guidelines that underscore the importance of domestic violence have been developed for most court-related services and endorsed by various professional bodies, the widespread implementation of, and adherence to these principles has not been achieved." (p. 10)

Ko and colleagues (2008) acknowledge that first responders, such as law enforcement, fire departments, and emergency medical personnel, can play a critical role in establishing "a psychological scaffolding that is crucial to enabling traumatized children and families to regain hope and reorganize to deal with crises" (Ko et al., p. 399). To do so, these professions require training specific to issues involving domestic violence and traumatic stress. One community-based intervention described by researchers was based on the knowledge that individuals exposed to trauma benefit much more

from mental health services that are administered as soon as possible after the exposure, rather than later when sequelae have already developed (Drotar et al., 2003).

In describing the intervention, Drotar and colleagues (2003) provide a thorough and informative discussion of factors contributing to, as well as challenging, implementation of comprehensive community-based mental health service delivery. The focus of their work is the Children Who Witness Violence Program (CWWVP) of Cuyahoga County, Ohio. The program was designed with four basic components: provision of mental health services to children who have experienced violence and their families; a process and outcome evaluation of services; enhancement of community awareness of the impact of violence on children and families; and education of professional providers concerning the impact of violence on children. The list of collaborators on the project working on the comprehensive model was wide-ranging across the county and included public and private agencies that provide direct service and other forms of assistance to children exposed to violence (Drotar et al., 2003, pp. 191-192).

The authors provide a number of cautions about the implications of the design of the program regarding the treatment of children exposed to domestic violence. They state:

That domestic violence accounted for the majority of violence-related incidents in this sample has specific implications for the design of community-based mental health services for affected children: although domestic violence presents as an acute crisis, it often reflects a chronic, multifaceted set of problems that are difficult, if not impossible, to manage using a crisis intervention model alone. (p. 200)

The authors note that the strengths of the intervention mode include a broad-based coalition of community agencies; provision of mental health services by staff with extensive experience in providing home-based crisis interventions to children and families with a range of psychological problems; strong leadership; and integration of the program

evaluation component with mental health service planning from the outset (Drotar et al., 2003, p. 199). Challenges cited by Drotar and colleagues include, among others, a varied response from police across the county; the resource intensity of the service model in terms of time, energy and commitment from service workers; the great expense of the service model; and the requirement of program staff and collaborators to continually engage in fund-raising in order to support the program. Overall, integrative models require a great deal of cooperation, coordination and collaboration from a large number of sometimes-competing agencies and organizations (Findlater & Kelly, 1999; Drotar et al., 2003).

As the example above illustrates, coordinated community responses to children exposed to violence in their homes ought to involve gateway providers as well as direct service professionals. Nevertheless, gateway providers are not always recognized as partners that ought to be integrated into comprehensive models, and even the CWWVP described above did not include an expanded number of possible collaborators. Defined as those individuals who have direct contact with at-risk youth but are not representing an organization designed specifically to address the risks the child or youth faces, gateway providers may be from schools, health care settings, daycares, certain programs of juvenile justice, before- or after-school care, or even adult friends or family members (Stiffman, Pescosolido, & Cabassa, 2004). The importance of gateway providers cannot be overlooked.

As Stiffman and colleagues (2004) point out, the overall knowledge and awareness held by gateway professionals undoubtedly influences many children's pathways into services, including those needed to address exposure to violence. If the gateway providers' knowledge of resources does not match up with services actually provided or best-suited to the needs of the child, children may not be connected with the organizations that can offer them the most appropriate forms of assistance and treatment. Research has confirmed that "Gateway providers may be more likely to both identify youth's problems and refer youth to services when two pieces of information are in place: (1) knowledge of commu-

nity resources available to youth; and (2) knowledge of brief, accurate screening devices" (Stiffman, et al., 2004, p. 195). Further, if gateway providers do not know of resources or do not believe the resources they know of will be effective, they may fail to identify the problems at all.

As evidenced in the research cited above, many different disciplines have an important role to play in meeting the needs of children exposed to violence at home. Meaningful collaboration can enhance these roles. Moreover, failure to work toward multi-disciplinary cooperation leaves children and mothers vulnerable to a range of maltreatment and outcomes up to and including fatality. Baker and colleagues (2004) offer a snapshot of the risk involved:

Women and children are at risk for homicide when the criminal and family legal systems do not coordinate and share information.... Many times, community agencies that provide services to women and children are in a better position to understand the risk.... Collaborative training and program development can create a cross-pollination of skills to create a better service than any one professional group could provide in isolation. (p. 225)

In the research literature and across various disciplines, the integrated community response is the ideal approach. Edleson (2006) suggests that new systems of care for children exposed to violence can be centered in the community outside of child protection. He points out that this could engender the multiple benefits of reducing the overwhelming caseloads of child welfare agencies, expanding programming among domestic violence organizations, and sparking new collaborations among other community-based service providers.

Examples of Best Practice

Review of the research literature leads us to conclude that trauma-informed services and integrative models, though potentially expensive, hold the best promise for meeting the mental health needs

of children exposed to violence in their homes. Trauma-informed services constitute an effective evidence-based practice for addressing the impact and sequelae that many children develop following exposure to violence at home. Research shows that most of these children exhibit traumatic stress reactions and that empirically sound interventions and treatments are warranted (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007). Moreover, conventional treatments are not found to be as effective as those that are specifically trauma-informed (van der Kolk & Courtois, 2005).

Based on our examination of best practices, positive outcomes learned from evaluations of treatment programs give information about the efficacy of these programs. Four programs that have been empirically evaluated and combine treatment of children and mothers are 1) the Kids* Club program (and Moms' Empowerment), a community-based intervention for children exposed to intimate partner violence (IPV) (e.g., Graham-Bermann & Hughes, 2003). There are two versions of the programs, one for preschoolers and one for school-aged children;³ 2) Child-Parent Psychotherapeutic program (CPP-FV) designed for infants, toddlers and preschoolers exposed to domestic violence, physical abuse and physical neglect;⁴ 3) the trauma-focused cognitive-behavior therapy (TF-CBT) model Cohen, Mannarino, & Knudsen (2005) designed for treating children (and their non-offending parents) exposed to domestic violence and sexual abuse;⁵ and 4) Project SUPPORT, a program for mothers and children who have recently been in

a domestic violence shelter, with children aged 4-9 exhibiting clinical levels of elevations on externalizing problems such as disruptive, defiant behaviors, evaluated by Jouriles and colleagues (e.g., Jouriles et al., 2009). Particularly noteworthy for this report, the Cohen model of TF-CBT has been the focus of a statewide training and technical assistance program, coordinated by Dartmouth Medical School's

Dr. Stanley Rosenberg, for New Hampshire's Community Mental Health Centers (CMHCs) and among some practitioners for the Division for Children, Youth and Families (DCYF).⁶

In the next section of this report, we detail

our methodology, including our process for collecting data for this project, and describe the different groups with which we conducted interviews and/or focus groups that led to our findings, conclusions, and recommendations. The findings we present connect to many of the common themes that apply to interventions for children exposed to violence in their homes that demonstrate important aspects of integrated models (Feerick & Silverman, 2006). Feerick and Silverman's common themes include the need for a developmental perspective, an ecological approach, an understanding of resiliency and strength, a relational approach to treatment, safety, and measured policy responses (Feerick & Silverman, 2006), to which we add the need for training, co-training and cross-training. These common themes echoed through much of what we learned from the interviews and focus groups that we conducted.

Trauma-informed services and integrative models hold the best promise for meeting the mental health needs of children exposed to violence in their homes.

Method

Participants and Procedures

Interviews with National and State Experts

After conducting the literature review above, the research team constructed questions to pose to twelve national and state child trauma experts and six Coalition- affiliated crisis center directors, who work to best meet the mental health needs of children who experience violence in their homes. We asked them about exposure to all kinds of violence, including battering of the non-offending parent, physical assault of the child, and sexual abuse of the child. The accumulated information from these interviews informed the second phase of our research, conducting interviews/focus groups relating to the mental health needs of children exposed to violence in their homes. We conducted these interviews and focus groups with the other crisis center directors and child advocates at their centers, primary and secondary service providers from a variety of agencies and organizations across the state, and consumers of services (e.g., non-offending parents). The Institutional Review Board at the University of New Hampshire approved the procedures that we used to conduct the interviews/focus groups with the four different groups described below.

Interviews/Focus groups with Crisis Center Directors and Child Advocates

Not including the original six crisis center directors who helped to inform the interview/focus group protocols, we conducted interviews/focus groups with six additional crisis center directors and child advocates affiliated with the Coalition. Part of the work of the directors and a great deal of the work the child advocates do is to help the children of the non-offending parents to whom they provide center-related services connect with other agencies and organizations in their geographic area. Crisis center directors and child advocates spoke about the availability and access to trauma-informed services for children exposed to violence in their communi-

ties. They also provided us with an overview of the needs of these children who seek services with their non-offending parents.

Interviews/Focus Groups with Direct Service Providers and Primary-level Gateway Providers

We conducted interviews/focus groups with service providers from a variety of agencies and disciplines across the state. This first stage of interviews/focus groups was conducted with individuals from agencies and disciplines whose primary responsibilities include working directly with children, and their families, exposed to violence in their homes. Service providers may include, but are not limited to employees at crisis centers, Department of Health and Human Services, and Community Mental Health Care. Primary-level gateway providers are those individuals who, by the nature of their work, have a high likelihood of interfacing with children, and their families, exposed to violence in their homes and are knowledgeable about services for these children. However, these providers' primary responsibilities are not to address children's exposure to violence. This group of gateway providers includes practitioners from agencies and organizations such as the Department for Children, Youth and Families, Department of Juvenile Justice, and Head Start. We recruited direct service and primary-level gateway providers with help from our prior interview contacts, crisis centers, and the Coalition.

Interviews/Focus groups with Consumers

In addition, we conducted interviews/focus groups with non-offending parents whose children were exposed to violence at home, and young adults (18-24) who, as minors, were exposed to violence in their homes. We recruited these individuals with the help of professionals who worked with them from a variety of organizations around the state. Consumers received \$25.00 each for participating in interviews or focus groups with us.

Interviews/Focus groups with Secondary-level Gateway Providers

We used the information we received from the interviews/focus groups from the national and state experts, crisis center directors and child advocates, direct-service providers, primary-level gateway providers, and consumers to inform the questions we asked in our interviews/focus groups with community-based and secondary-level gateway providers. These secondary-level providers may encounter children, and their families, exposed to violence in their homes in some capacity, but the main purpose of their work focuses on a much broader community constituency. However, because they deal with children in some way, these providers may have among their various groups of clients or those in their care children exposed to violence in their homes. Their knowledge of services for or education about these children and their families varies but tends not to be as extensive as that of primary-level gateway providers. Examples of secondary-level gateway providers include clergy, school nurses, and guardians *ad litem*. Gateway providers, both primary and secondary ones, very often play key roles in helping children, and their families, gain access to services (Stiffman et al., 2004).

Not including the original informants (18 national and state experts and crisis center directors), 101 individuals (10 directors and child advocates from crisis centers, 53 direct service and primary-level gateway providers, 18 non-offending parents and young adult consumers, and 20 community-based practitioners/secondary-level gateway providers) participated in interviews/focus groups

with us. We conducted interviews/focus groups from November 2008 through September 2009. Interviews were conducted in person in a location or by telephone at a time selected by the participants.⁷ We received consent to participate in all cases, and individuals were informed that the session would be digitally recorded. In almost all cases, permission to record was granted, but when not, at least one member of the research team took detailed notes. Interviewers and focus group facilitators followed the interview schedule (i.e., list of questions) created for collecting information from each of the four separate groups. All recordings and notes were then transcribed. At least two members of the research team attended each focus group.

Stakeholder Meetings

As part of the planning process, we conducted two meetings, the first in September 2008 and the second in August 2009, with NH experts and professionals who oversee systems of care and/or work with children exposed to violence in their homes and their parents (both offending and non-offending). At the first meeting, stakeholders provided feedback on the best practices and research we had conducted to date and suggested professionals to interview during the data collection phase of the project. We conducted the second stakeholder meeting after we completed data collection and shared preliminary findings with stakeholders. They offered feedback and made systematic recommendations to best meet the mental health needs of children, and their families, exposed to violence in their homes.

Design and Procedure

Once all the interviews/focus groups were completed and transcribed, we began our qualitative content analysis of the data. We used NVIVO 8 qualitative research software for analyzing the interviews and focus groups that we conducted.⁸ After reviewing the interviews/focus group questions, two members of the research team who had also conducted a large number of the interviews and focus groups created broader codes based on the initial ones to organize the data. They then established new codes and organized data (answers to questions) based on these (new) broader codes. At that point, the senior researchers individually organized these broad codes into four comprehensive themes or clusters and reached full agreement on them. These are composed of one descriptive cluster (*Profile*) and three analytic themes, 1) *Responding*, organized into a) strengths and b) areas in need of improvement; 2) *Trauma-informed Services*; and 3) *Integrated Community Response*, also organized into a) successes and b) challenges. To conclude, the four themes/clusters arose from the content of questions, which we derived from the literature review and the interviews with national and state experts, as well as from the content of the answers from all the participants.

As noted above, the first cluster is descriptive rather than analytical. That is, codes relating to this theme describe, in some way, the children exposed to violence in their homes. These descriptors include those demographics most often seen (age, ethnicity, gender, socioeconomic status), impact of exposure, perceptions of the children's needs, and resilience.

Following the profile cluster are the analytic clusters or themes. The first analytic theme, responding, encompasses a broad area of information. Primarily this theme is composed of two principal components – strengths and areas in need of improvement – as defined by the research participants. Strengths

of responding includes having services in place that children need, addressing the needs of children in beneficial ways, providing appropriate age-specific services to children, easily accessible services, and having a response or action protocol that works well and is comprehensive. Areas in need of improvement (and in some cases these are limitations) includes issues such as not having services in place, not having a response protocol, lack of money, time, staff, education, and awareness of services.

The second analytic theme, trauma-informed services, focuses specifically on all issues relating to knowledge about, accessibility of, and training about trauma-informed service provision, which is recognized as the form of care most beneficial to children, and their families, who have been exposed to violence in their homes (e.g., Igelman et. al, 2007; Ko et. al, 2008, interviews with national and state experts). A specific number of questions in the interviews and focus groups with direct service and gateway providers were intended to determine their level of familiarity with, the performance of, and access for their clients to trauma-informed services. We also asked about practitioners' level of interest in receiving training about trauma-informed services.

The third and last of the analytic themes, integrated community response also focuses on a more specific issue that emerged from the literature review and interviews with national and state experts. Part of the purpose of the interviews and focus groups was to determine practitioners' knowledge, perception, and involvement in an integrated community response to children, and their families, exposed to violence in their homes. This is important as integrated community responses featured highly among recommendations from the literature (e.g., Allen, Bybee, & Sullivan, 2004; Baker, Cunningham, & Jaffe, 2004) as well as from interviews with national and state experts.

Findings

Interviews with National and State Experts

As part of our goal to identify national and state best practice research on child trauma treatment, we conducted 18 interviews with national and state child-trauma experts who work to best meet the mental health needs of children exposed to violence in their homes. We asked them about exposure to all kinds of violence, including battering or other forms of abuse of the mother (or non-offending parent), physical assault of the child, and sexual abuse of the child. Results of the interviews with national experts reflect much of what we have highlighted in the best practices section above. They note that effective approaches to providing support to children exposed to violence are ones that utilize community resources through an integrated model that puts the “child at the center” and include support for the non-offending parent.

We used the information gathered from interviews with state-level experts to inform the development of questions for direct service providers and primary- and secondary-level practitioners. Additionally, this information shaped the choice of which providers/practitioners to interview. Information gained from state-level experts builds on the common themes summarized by Feerick and Silverman (2006), which we subdivided into six categories of services provided to children exposed to violence in their homes. The categories are as follows: the primary needs of children exposed to violence; strengths in responding; trauma-informed care/services; community collaboration; obstacles and barriers to service provision; and resistance to collaboration/establishment or expansion of services.

The state experts indicated that, overall, services for children exposed to violence exist, and innovative programs and community collaborations occur

in some geographic areas of New Hampshire. For the most part, the more rural areas of the state are not as fortunate and lack awareness of any potential cooperating agencies or entities. Generally, services for children are highly variable depending on locale. In areas where grant funding has already allowed for the establishment of community connections, the groundwork seems to have been laid for increasing success in meeting the needs of children exposed to violence. Locations without such background have more challenges. Their ability to succeed depends in large part on outreach and training efforts in the dynamics and realities of families and individuals struggling with a history of or ongoing violence in the home.

State experts also emphasized that the good working relationship between DCYF and the Coalition will be helpful in reaching the goals of this planning grant. Each discipline has concrete ideas about their strengths in responding to the needs of children exposed to violence. These ideas could be a very useful mechanism for bringing the multidisciplinary team vision into reality. Emphasizing the

The primary goal is to eliminate violence from the lives of children; children need help facing what happened to them and learning not to repeat the violence.

strengths each has to contribute seems like a potentially positive way to open collaborative discussions.

When it comes to providing for the mental health needs of children exposed to violence in their homes, the state experts suggested that best services cannot be offered in NH until everyone who needs training on trauma-informed services receives it or has equal access to it. Multidisciplinary response teams will also need to be trained in a common model of trauma-informed care to ensure that all members of the team speak the same language and share a vision of the goals and the best means of appropriate service provision.

Additionally, state experts noted that children exposed to violence in their homes need safety and support. The primary goal is to eliminate violence

from the lives of children; children need help facing what happened to them and learning not to repeat the violence. When possible, children need a good relationship with a non-offending parent or other close adult relative. Ideally, this adult can then assist (training may be necessary) the child with issues relating to behavioral conduct, emotion regulation, self-blame, self-esteem and depression, and referral to therapeutic services. Therapeutic service providers must be trained in the dynamics of family violence in order to successfully address the children's needs; clinical settings would do well to employ an empowerment model. Children also need to have a voice in decisions about seeing a parent who has perpetrated violence against the child or the other parent.

In the initial state-level interviews for this project, we learned that collaboration occurs between shelters/crisis centers and a number of other agencies, but that opportunities to collaborate tend to be of greater availability in urban areas and severely restricted in rural areas. Experts note that more collaboration is called for, especially regarding the accessibility of services to non-offending parents and their children in one location (under one roof) so that services are not fragmented (though not all interviewees agree that services should be centralized in the crisis centers). There is a general awareness of who needs to be "at the table," but very little actual time spent to get everyone there. Vastly more training for all disciplines not directly focused on domestic violence and/or sexual abuse must precede integration of services to children. Willingness to engage comes from every side. In other words, the "need to" is agreed, but the "how to" remains open-ended.

State experts indicated that in order to implement effective support and mental health services for children exposed to violence in their homes, more funding would be beneficial and is especially critical in helping achieve provision of widespread training and co-training around trauma-informed services. In addition, they note the need to implement standardized protocols, facilitate greater inter-agency cooperation, and create and implement adequate services in rural areas. Likewise, more

training and more public awareness is imperative. Some state experts felt that more accountability for perpetrators of violence (the criminal justice system) would have a positive impact on the ability of communities to credibly address domestic violence and/or sexual abuse. Despite the barriers cited, practitioners and providers representing different agencies all share a common goal: to reduce the risk and increase the protective factors and resilience of children exposed to violence in their homes.

State and national experts agreed that there are financial barriers to creating and sustaining services for children exposed to violence in their homes. In our review of national and state projects, it is clear that there are few, if any, standard reimbursable service models. Overwhelmingly, services for children exposed to violence in their homes, both nationally and NH-based, are dependent on grant funding. These funding sources are sparse and, if available, are oftentimes awarded on a competitive basis. The most sustainable projects are those in which services for children exposed to violence in their homes have been incorporated into the overall priorities of agencies/organizations. Sustainable funding prioritizes support and services for children exposed to violence in their homes on a systems level. Examples of this include reallocation of funds to make trauma-informed service part of the menu of services that agencies offer and creative use of funding to build agencies' capacity, through training practitioners, to provide support services, as well as organizations that pool limited resources to build collaborations that can support services for children. Armed with creative funding possibilities, the process of collaboration is likely to be smoother.

In our interviews with state experts, we learned of four coordinated and, in some cases, statewide trauma-informed services, training, and interventions aimed at increasing support for children and their families. They are as follows: child advocates in domestic and sexual violence crisis centers; a community-based collaborative providing a therapeutic program for children and their non-offending mothers; training and technical assistance on an evidence-based, trauma-informed therapeutic model to the ten Community Mental Health centers; and

cross-system collaboration between the Coalition, DCYF, and Child Advocacy Centers (CACs). We outline these examples in Table 1.

While these are not the only trauma-informed services in the state, we have chosen to highlight them in this report because they not only provide critical training, support and services throughout the state. They also illustrate ways to incorporate trauma-informed services on a systems level. Concurrent with the Coalition receiving this planning

grant from NH-EFH, the UNH Crimes Against Children Research Center was also working on a project funded by the NH-EFH. The purpose of their funding was to engage in a planning grant to strengthen Child Advocacy Centers’ (CACs) capacity in every NH county to enhance linkages to evidence-based mental health services for child abuse victims by engaging key community stakeholders in a collaborative planning process and identifying best practices for helping parents access evidenced-

Table 1. Trauma-Informed Services & Care

Trauma-Informed Services & Care for Children Exposed to Violence in their Homes	Description
Child Advocates in Domestic and Sexual Violence Crisis Centers	Three NH Domestic and Sexual Violence Crisis Centers have specific child advocate staff positions that have sole responsibilities to address the needs of children exposed to violence in their homes. Several other crisis centers have a staff member, whose title is not child advocate, but has child advocacy as one of their responsibilities. While child advocate positions and responsibilities vary among these crisis centers, they include coordinating concurrent child/parent support groups, advocacy in schools on behalf of children, acting as a resource person for children, working with the non-offending parent, etc.
Coalition for Domestic Abuse Recovery (CDAR)	CDAR, a Seacoast, NH collaborative of service providers from A Safe Place, Families First, DCYF, Seacoast Mental Health Center and the Coalition have been collaborating since 2007 to plan strategies to best meet the needs of children exposed to violence in their homes. They have recently received funding from the NH Endowment for Health to fund a pilot therapeutic program for children and their mothers. The program is based on the “groups for children and their mothers who have experienced domestic abuse, a therapeutic program for children and their mothers,” developed by The Children’s Aid Society of London and Middlesex, Canada.
Dartmouth Trauma Interventions Research Center (DTIRC)	Dr. Stanley Rosenberg, Ph.D. at the Dartmouth Medical School has received funding from the Substance Abuse and Mental Health Services Administration and the NH Endowment for Health, to train and provide technical assistance to the ten Community Mental Health Centers on a trauma-focused cognitive-behavior therapy (TF-CBT) model for treating children exposed to sexual abuse. Dr. Rosenberg’s training and consultation have also extended to DCYF clinicians.
Domestic Violence Specialists (DVS), DCYF, the Coalition and Crisis Centers	The DVS Program is cross-system collaboration between the Coalition, Crisis Centers, and DCYF. Domestic Violence Specialists, who are crisis center advocates, are placed in DCYF District Offices to work with abused mothers, and to consult on child abuse, including child sexual abuse, cases that involve domestic violence.

based services. The main objective is to find ways for CACs to enhance existing mental health service system linkages for abused children.⁹

State experts suggested that the next step in establishing an integrated community response is to identify the goals that are common to a variety of disciplines and to brainstorm the way to reach or approach those goals. State experts indicated that we might discover many differences of opinion on the availability and quality of services for children. However, they emphasized the importance of identifying the strengths that all providers and practitioners offer so that ultimately this planning process can help to create an atmosphere of respect in order to foster a collaborative agenda where children exposed to violence are *at the center*.

Consumer Profile

We conducted interviews/focus groups with non-offending parents whose children were exposed to violence at home and young adults (18-24) who, as minors, had been exposed to violence in their homes.¹⁰ Throughout this report, we refer to these individuals as consumers. Twenty-one consumers participated in interview/focus groups for this planning project. The information that they shared with us serves as an important reference point about the impact of exposure to violence in the home, survivors' resiliency, areas of strength or need, and suggestions for practitioners. An overview of this information is presented below.

When discussing the impact of exposure to violence in the home, an overwhelming theme was the effect it had on consumers' ability to trust others, particularly intimate partners. They talked about challenges involved in getting close to and trusting their partners. For example, a young adult noted that, "One thing that I found is that it has had a significant impact on my ability to carry out healthy relationships in my adult life. Not necessarily that I feel that I am at risk for being an abuser, but that I have trouble trusting partners."

Consumers also talked about the fact that exposure to violence affects every aspect of their or their children's lives. For many of the individuals that we interviewed or talked to in focus groups, the ef-

fect of exposure was always present. The ability to deal with anger was an issue they discussed. One non-offending parent noted, in speaking about her children, "How are you *not* impacted? It impacts every single thing in your life from how they manage anger with each other, how they perceive their own anger, how they cope with you being angry at them or displeased."

Another theme was the mental health impact of exposure to violence. Post-traumatic stress disorder, depression, and anxiety were mental health diagnoses that both non-offending parents and young adult consumers have experienced. In addition, non-offending parents pointed out that their children experience nightmares/night terrors.

Consumers shared the ways in which they coped with exposure to violence, both during and after exposure. Young adult consumers spoke about the importance of their siblings to their ability to cope with exposure to domestic violence. They serve as sources of support during and after exposure to violence. One noted:

I had my brothers and.... I always remember in my head having my brother right next to me. I was only eight or younger but having an older brother and having someone there with me was very important. I just always remember having a sibling there as a support and coping mechanism.

Other consumers, with no sibling support, said that they would retreat inward. One consumer disclosed, "Usually what I did was to stay in my room and not come out. Like a kind of out-of-sight, out-of-mind type thing to avoid the violence." A non-offending parent described how she compensated for the violence her husband perpetrated against her and to which her children were exposed: "The thing that I always did was I would compensate for his verbal abuse. I would, which I think my kids caught onto, I would wear my heart on my sleeve and give the kids everything they wanted."

Many of the consumers noted that they avoided telling anyone about the exposure to violence in their homes. Most often, they tried to downplay the

reality of their experiences to the people around them. One consumer observed, “It was kind of a secret. I just kind of carried on in my life in school and other areas as if it wasn’t happening at all.” Another reflected, “I think you don’t even realize the impact seeing the violence has. That’s the way I grew up.”

Other consumers indicated that they (or their children) coped with exposure by focusing on other areas of their lives, including school, after-school activities, and clubs/athletics. Receiving support from family and friends was a common thread discussed in many of the interviews and focus groups. The consumers also pointed to a number of programs and professionals that they have found supportive such as Big Brother Big Sister, Girls Inc., therapists, Girl Scouts, Community Action, and guidance counselors in schools. Many of the young adult consumers noted that while staff members at these organizations most likely did not have formal training on exposure to violence, they served as important sources of support and as people who were consistent in their lives and individuals on whom they could depend. One consumer shared:

Guidance counselor services, things like that at school, were useful in a more passive way for me, because even though I didn’t seek them out individually, just knowing that they were there was sort of a source of support. Because it was like I knew that the violence wasn’t normal and somebody else knew the violence wasn’t normal too, so in some sense that was supportive.

Consumers reported that their (or their children’s) activities both in and out of schools provided them with a refuge from the exposure to violence at home. Out-of-home activities offered a diversion, both in keeping their minds off exposure and literally providing a space that was free of the violence that was happening at home. One consumer reflected on a school-based program that was specifically for children exposed to violence, who were also not doing well in school:

It was really nice to be around [other] kids, and I was aware that they also had

experienced it. It was kind of unique. We didn’t talk about it; we didn’t talk about the violence at all. They didn’t want to get the negative feelings out, but it brought out our confidence.

Many of the young adult consumers also emphasized that despite the challenges they faced due to exposure to violence, they were quite successful in school and athletics, and they maintained strong connections to their friends and their friends’ families. Successes and positive relationships in these areas served as sources of support and coping mechanisms for the consumers with whom we talked.

When asked what would make it easier for consumers to seek support, the consumers commented on the need for affordable programs, insurance coverage for counseling, the need to start interventions early, and having domestic violence awareness become more commonplace. One interviewee suggested:

Start early, I guess. I mean, once I hit, like, a certain age, towards like eight, I think it was too late. I mean, I was afraid; my step-dad told me he would kill me if I told anyone, so... and once that fear settles in then [I was] pretty intent on not telling anyone. I guess just make it apparent earlier on, like, you know, when the innocence is still there.

Consumers also suggested that schools should address exposure to violence in the home as part of the regular health curriculum or once a year when the guidance counselor or crisis center comes into classes to talk about domestic violence and sexual assault. Consumers noted that these programs usually focus on students as the direct victims and rarely, if at all, address children’s exposure to violence in the home. One respondent we spoke with encouraged schools to address the issue of exposure with all students, not just those experiencing exposure to violence in their homes. As another consumer put it, when you single out those who have been exposed, “You feel like something is wrong with you.” Another discussant added, “I didn’t want to be like ‘Oh, that kid with the [abusive] parents...’”

Consumers reflected on what they would say to a child who was being exposed to violence in the home. One focus group member presented this response as if s/he were talking to her/himself as a child: "I would have definitely wanted to have me just talk about it and talk about the situation." Another consumer suggested that children exposed to violence should know that, "all the bad things that happen around aren't your fault; it's not because of you that everything is happening."

Non-offending parents discussed the use of counseling/therapy as a coping mechanism for their children. One noted, "The therapy part is really good because now if they have issues with their dad, I don't have to run interference or whatever." Consumers spoke frequently about the importance of the practitioner listening to the client. For example, an interview recommended, "So I would say to really listen, to not assume anything of what is going on in the situation." Consumers also suggested that practitioners need to do delve deeper when meeting with clients:

So you have this hard shell; you have to look like everything is okay. So when you go to a counselor or guidance counselor, you are like, 'I am fine', but on the inside you're really not, so you [counselors] really have to pry.

Consumers we spoke with discussed the necessity for practitioners to build an open rapport and to remember that the consumer is repeating her/his story to a stranger and that certain reactions on the part of a provider could make the consumer feel judged. An example of this was offered by one respondent:

It is hard enough to pick up the phone to come here for myself, let alone pick up the phone talking with someone who I don't know and having to repeat myself over and over about what is going on in my life and having that feeling again of being judged by someone who doesn't even know you.

Another consumer discussed the need for mental health practitioners, and everyone else, to receive or increase their level of education around the area of interpersonal violence and its impacts. Several consumers mentioned that they specifically ask for counselors who have training in domestic violence. Guardians *ad litem*, judges, hospital personnel, and school staff were mentioned as examples of provider domains where more training would be useful. When asked whether the practitioners actually had received training, the overall feeling was that they had not. Two quotes from young adult consumers illustrate their thoughts about providers' training: "If they [had], they were really bad at it," and "I would highly doubt that anyone I came into contact with did."

While some consumers cited positive interactions with mental health practitioners, others did not. One young adult respondent described the following:

I went to a counselor. My mom was worried about our well-being, and I think it was a lot of guilt, and so she brought us to a counselor. I remember only going once or twice and them pretty much saying, [s/he's] fine and not even talking about it, not even getting me to talk about the situation.... And they just sent away my brothers as well, and my brothers were not fine.

When asked what services are lacking consumers described long waiting lists, programs not returning their calls, lack of support for mental health issues, having to work with programs that have bad reputations, and not getting the attention they needed to adequately address the issue. One of the most prominent concerns articulated by several consumers centered on the importance of keeping children at the center of all interventions.

Consumers emphasized that children exposed should be one of the highest priorities, if not the first, of those responding to incidents of violence and child exposure. One consumer described disillusionment when s/he and siblings were ignored by first responders to an incident of violence to which they were exposed:

The professionals and the police officers that were there, they just sat us on the stairs and they pretty much acted like we weren't even there, and afterwards they left, and we were with our mom, and we talked about it and stuff, and my dad left for the last time. It was really weird they didn't even [acknowledge us], they just thought of us on the side [and] made sure they [we] don't get in the way.

Summary of Consumer Profile

Consumers indicated that they employ multiple strategies to cope with the exposure to violence in their homes. For many consumers, having a sibling who shared the exposure served as a source of support. Outside of the home, sources of support include school personnel, after-school activities, friends and their families. Despite the negative impact of exposure, many consumers talked about their (or their children's) ability to succeed in school, sports, and organized activities. These successes helped consumers survive and cope with the children's exposure to violence in their homes.

Children's exposure to violence in the home affects multiple areas of consumers' lives. They spoke most often about the effect on their intimate relationships, specifically in trusting their partners, and their ability to trust people close to them. Young adult consumers talked about the desire to have specific educational programs about healthy relationships, for them, as adults.

Members of the focus groups also talked about the important role that practitioners, including direct service, primary- and secondary-level gateway providers, play in their lives. Practitioners who specifically work with children exposed to violence (direct service and primary-level gateway providers), should receive training on domestic violence, sexual abuse, and child trauma treatment. In therapeutic settings, multiple visits are needed to gain the trust of a child and it is important that services start shortly after exposure to violence occurs.

Secondary-level gateway providers are in a prime position to recognize children exposed to violence and should have knowledge regarding children ex-

posed to violence and what services are available for children exposed to violence. Programming in schools can help to de-stigmatize issues surrounding violence in the home and should be presented in regular intervals, disseminated to all children, not just those who have been identified as exposed to violence. Programming about building healthy relationships is important, especially as the child grows older and begins to date.

Consumers indicate that mental health counseling has the potential to provide support and relief to children exposed to violence in their homes. They emphasize that mental health counselors should have training on domestic violence and child trauma treatment, and they stressed the importance of easy access, including the reduction of financial barriers, to counseling services.

Finally, consumers agreed that children must be at the center of all responses, including law enforcement intervention, support services, and mental health counseling, to children exposed to violence in their homes. In many cases, the consumers we interviewed spoke of instances where they, or their children, were not the focus of interventions. For support to be truly helpful, children must serve as the foundation of all responses.

Responding

Participants in focus groups and individual interviews answered several questions regarding their response to children and families in which domestic violence and/or child maltreatment occurs. At the outset of the interviews or focus groups, we informed participants that we were asking about exposure of all forms of direct violence as well as witnessing of violence, such as battering and abuse of mother, physical assault of the child, and sexual abuse of the child. We asked them how well their discipline addresses the children's needs, what kinds of strengths and/or obstacles they face in offering services, and what kinds of resources exist or are missing. In this section of the report, we describe the nature of their comments, including quotes from participants. We divide the findings on *responding* into two main categories, strengths and areas for improvement. Within each of the two main

components, findings are summarized according to the three groups of providers we interviewed: 1) crisis center directors and child advocates, 2) direct service and primary-level gateway providers, and 3) secondary-level gateway providers.¹¹

Responding: Strengths

Crisis center directors/child advocates. The primary strength that crisis center directors and child advocates reported was their ability to work with the non-offending parent. Several respondents described their dedication to helping adult survivors of violence to regain power in their lives, thereby indirectly helping the children. One summarized, “At crisis centers, our strength is the ability to connect with parents and empower them to help their kids.” As part of this effort, the centers provide many services. Some help by “hooking moms up with parenting classes, budgeting, getting kids into Head Start, as necessary.” One interviewee listed some types of support their center offers, saying, “We do response to [Child Advocacy Centers] and provide advocacy in the schools. We go with parents and kids to Head Start, IEP meetings, 504 meetings,¹¹ and we work with families on issues of custody or divorce.”

Even in those centers that do not have child advocates on staff or provide child-specific programming, their locations are child-friendly. Toys and age-appropriate games are available, and staff members sit and talk with children. Though not trained clinicians or therapists, advocates at crisis centers can offer an informal but useful “filtering process to see if there is a need for further mental health or other kinds of services.” Those centers with a Domestic Violence Specialist (DVS), a staff liaison between crisis centers and DCYF, felt the presence of that individual to be a definite strength.

Crisis center staff said that they try to keep the lives of the children as normal as possible while they are living in a shelter. They help to create a “safety plan and a sense of stability.” They work with mother and child together as a unit most of the time. Even in centers where children’s groups are routinely provided, the parents’ groups are normally

concurrent, and the parents rejoin the children to talk about the child’s group at the end.

When possible, the crisis centers offer much-needed transportation to mothers and their children, and car seats are kept on hand for this purpose. In other cases, crisis center directors and child advocates have found their mobility within the community to be a strength. By entering systems where non-offending parents are required to be, such as CACs, the crisis centers feel they can save the parents the extra step of trying to seek out services, finding the center’s phone number, and so forth. One participant mentioned that meeting the parents “where they’re at” means a “better chance of getting them connected and then getting their children connected.”

For crisis centers with child advocates and specifically child-centered programming, they see giving children a voice as a significant strength. In groups, children meet and discuss experiences with other children in similar situations, which allow them to be more open about their exposure to violence and to feel less isolated. According to child advocates and crisis center directors, group work helps children form attachments and see that they are not alone; this helps children feel more normal and have better self-esteem. Some centers’ youth programming also includes outreach and prevention education in middle and high schools.

Overall, the crisis centers perceive themselves to be providing an essential safe haven for non-offending parents and their children. A non-judgmental atmosphere and the assurance of patience, tolerance, and support are available to families twenty-four hours a day, seven days a week at the centers. Within this framework, crisis center staff can help parents understand the needs of their children. One interviewee said it is “hard to help them work through the denial that there is, in fact, an impact on the kids. This is a barrier for parents getting kids to groups; it is so overwhelming for parents to take on anything beyond surviving what they’re already going through.” As far as being ready to see how the children are affected and to get them help, crisis center personnel realize that it “takes a while for non-offending parents to get to that point.”

Direct service and primary-level gateway providers. In general, direct service and primary-level gateway providers saw trends of improvement in many areas of their ability to respond to children exposed to violence at home. One interviewee commented, regarding the impact of violence on children, “There is more awareness now than what there was years ago.” Staff education and professional upgrading of staff were seen as other areas where continuous advancements were being made.

In some places, good screening tools are used to help identify children with particular needs, and as a result, one participant noted the goal of “trying to screen more and more children.” Indeed, several individuals in the mental health field spoke highly of computer-screening tools as helping them to detect greater numbers of affected children. One provider noted a greater probability of disclosure, saying, “Kids are more honest to a computer than they are to a human. When you interview kids, they say ‘Yes, I am fine.... I have never thought of killing myself.’ However, when they take the screening tool on the computer they indicate that they do consider suicide.” Another participant indicated that use of a screening tool was not limited to children who could use the computer, but that staff members could work with younger children to answer the questions as well.

Many respondents referred to the help they offer children indirectly, as a result the work they do with parents. Where home visitations constitute a part of an agency’s programming, providers reported that they are making efforts or that they are aware that efforts are being made to “educate parents on if your child does witness violence or fighting and how the negative effects on their development and their behavior can affect them long-term and short-term.” Similarly, supervised visits, where an alleged or known offending parent can visit with children in a safe and neutral setting, were viewed as an important opportunity for providers to be in touch with parents and, when needed, to intervene on children’s behalf. Staff members at visitation centers are sometimes able to “teach the parents how to interact appropriately and positive[ly].” They can also assist parents in dealing with negative behav-

iors that the children display and can point out the link between children’s behaviors and the violence they have witnessed. One provider elaborated about visitation centers, saying:

They make it safe for kids to be around abusive non-custodial parents. Even if the child isn’t the target... makes it safe for the other parent. Emotional or verbal abuse can’t go on at a visitation center – someone there will intervene and stop the visit. [The perpetrators] don’t get to probe, don’t get to hurt, just spend non-stressful time with the child....

Guardians *ad litem* (GALs), according to several participants, offer essential services in terms of advocating for children who are exposed to violence and making recommendations to the courts. Most interviewees who spoke about GALs believed that they have useful credibility with the court. Moreover, individual GALs who have developed strong referral networks through years of experience “can bring some of those services together and in the interest of or the benefit of the children.”

For other participants, strengths in responding to children’s needs include their duty as mandatory reporters. Many individuals spoke of their mandate to report instances of abuse of children and most indicated a seriousness regarding this responsibility. CACs were noted as facilitating services by some other agencies. A representative from one particular organization felt empowered that they could “provide services to any family in our community with young children. They don’t have to qualify in terms of income or other specifications, so that’s helpful that we don’t have to fit into a little box.” When asked why they were able to be “very flexible” and why they could “get what families need,” the interviewee answered, “It’s mostly due to our director and our philosophy – we make it a priority.”

Service providers able to coordinate or integrate their response as part of a collaborative team, frequently considered that cooperation to be a fortunate benefit. Where coalitions could be formed or agencies brought “together to share resources,” ef-

fectiveness was felt to be enhanced. A member of one focus group spoke about strengths in terms of communication. S/he said, "I think that we very much offer a team approach, and I think that's a key to resolving a lot of these issues that the kids go through."

Finally, some participants believe they do a good job of ensuring children's immediate safety by employing out-of-home placements. "If we have a juvenile who says to us that they don't want to go home, then we are pretty quick to respond. When they are advised to get out to the home, we are pretty quick at that."

Secondary-level gateway providers. Secondary-level gateway providers named several areas of strength in their response to children exposed to violence. At times, strengths were viewed as conditional, in that perhaps they pertained only to a specific locale, a certain agency, or even a designated individual who had fostered personal connections or established a "good network of resources" over a number of years on the job.

In general, respondents spoke of mandatory reporting (of abuse of children) as a strength. Participants from programs that have been able to offer peer support groups and/or youth mentoring spoke highly of those services. One interviewee said, "The majority of our work is letting the kids do the supporting of each other, getting them to exchange resources." A provider from a different setting commented, "...a lot of the programs I see available for youth are to keep them busy and off the streets, which isn't really naming the problem; and this is one of the few unique programs where kids are getting to talk about what is going on in their lives...." Regarding youth/adult mentoring, one respondent felt, "The mentoring piece here has been a useful tool also. The kids have a role model who builds them up and with whom they have a positive relationship and whom they can emulate."

Where collaborations exist and people work together, providers viewed the coordination of services as an important enhancement in agencies' abilities to meet the needs of children impacted by exposure to violence. Often, we heard members of collaborative teams express their sense of good for-

tune that they were assisting or coordinating with one another. The caveat they spoke frequently of was the knowledge that such team responses are few and geographically limited in this state.

Some respondents felt that a continuum of care was in place to meet the needs of children exposed to violence. Providers believed long-term involvement with families to be preferable to limited visits or lack of time. One scenario we recorded explains:

With our agency, what we try to do is provide continuity in our care with parents and kids and therapist, et cetera. When they are discharged, we can stay on with that family for three months, and then we hand the baton to someone else in the community. I can't tell you the number of kids who come back here and just come to hang out.... Yeah it's really neat.

In other areas, the effort to offer wraparound services was seen, but following through was fraught with difficulty. According to one individual, "...our Community Mental Health Center system, they really do try to do wraparound through intake and assignment of a therapist, a social worker, sometimes a home visitor...and involvement with a psychiatrist, as necessary." S/he then added the following stipulation: "if [the family] can get there and they have the stamina to get through the waiting period."

Other elements that respondents saw as strengths in the care and services provided included parenting classes, where they have been offered, and resource officers and guidance counselors in schools. We were told that "in some places" the state has "well-trained and well-supported foster care providers." Visitation centers were also seen as generating vital opportunities to monitor interactions between parents and children impacted by violence. Particularly for teens, who may be reticent to open up to their parents, we heard that "having some sort of family therapy or mediated family time is a great tool... some kind of mediator to get those lines of communication opened; that has been really helpful."

Finally, many of those we talked to reported that their greatest strength was their presence: their ability and willingness to listen and make referrals. One

participant said, “We try to empower the children as much as we can,” and “Safety is a big issue, and it’s important that we help kids feel safe.” Another noted, “[A]t the very basic level, I can be there for them to listen; be there to help them connect.”

Summary of Strengths in Responding

Overall the findings from the three different provider groups presented above indicate a great deal of agreement about a number of areas of strengths in responding to the mental health needs of children exposed to violence in their homes. Many spoke of the importance of being able to provide services and help non-offending parents as a primary, yet indirect, way to help children. Several providers cited the ability to collaborate with others, provide wraparound services or a continuum of care, or make referrals to other providers as a key strength in responding to the children’s needs. Additionally, the availability of visitation centers came up in the interviews/focus groups as ways of keeping children safe by monitoring interactions with non-custodial/offending parents.

Mandatory reporting when a child is abused is another strength cited by practitioners in two of the three groups (direct service and primary-level gateway providers and secondary-level providers), particularly in that mandatory reporting provided access to services that children may otherwise not receive, such as support groups and youth mentoring. Whether in relationship to mandatory reporting or not, many providers across the three groups agreed that being able to provide children access to group meetings and /or support groups counted as a fundamental strength.

Other strengths cited not as frequently but noted by some providers include having the availability of regular trainings. A smaller number of providers cited use of screening tools (by direct service and primary-level gateway providers) as helpful in their work with children to detect better children who may be contemplating harming themselves. Many direct service and primary-level gateway providers also found the availability of well-informed guardians *ad litem* to be a strength in considering their power as advocates to make recommendations to

the courts that may have great impact on the outcome of the children’s future.

In most, if not all cases, the importance of providing safety for children was the objective that unified the strengths noted by all three types of providers. In the following section on areas of improvement, respondents note some of the challenges they face in trying to provide safety for children exposed to violence in their homes. As will be made apparent, the ever-present apprehension about child safety can be distressful for providers at all levels.

Responding: Areas for Improvement

Crisis center directors/child advocates. Crisis center directors and child advocates spoke of two main areas as obstacles to their ability to respond to children exposed to violence at home. The first included those factors that make it difficult or unlikely that non-offending parents would seek services. The second dealt with barriers to the effective provision of services from the centers’ side.

Participants cited several circumstances as reasons that parents might not seek help for their children. Echoing findings from Kopiec and Kaufman Kantor (2003), lack of transportation – with the exception of a few locales – was a widespread complaint, as was lack of financial resources and/or lack of health insurance to access services outside the shelters. Regardless of finances, survivors may be intimidated to seek help due to “the stigma, the isolation” they feel. One interviewee said, “A lot of women...are judged for not being able to provide for their children on their own.” Other concerns followed:

Another barrier is that they must provide extensive documentation to access services, but the abuser may be the only one in control of all such paperwork. So, like the checking account and other stuff. So, they don’t have that kind of access...

Non-offending parents may be fearful or face continuing threats from their perpetrator. Whether or not they still live under one roof, “it might put them in further jeopardy if their abusive partner knows they are seeking services.”

Finally, from the caregiver's side, confusion about "where do you go and who do you go to?" may be an issue. One individual explained, "The disciplines that are very well-meaning and concerned about kids – DV, medical, CAC, CPS [Child Protection Services] – we've all...been taught to do our work with... the philosophical umbrellas we operate under." But the result may be that consumers receive "mixed messages."

An immediate problem from providers' points of view is that few of the state's crisis centers have a child advocate on staff or have the ability to do programming specifically for children. Beyond this, they elaborated upon other obstacles. Crisis center directors and child advocates explained that, in order to work with children, they need to have access to children, and that can be complicated. Adults may deny that exposure to violence at home impacts their children. As one respondent put it, "If the parent doesn't recognize the child's need for services, the child doesn't get services." They saw a lack of education for parents regarding child development and children's needs.

A tremendous distress voiced by crisis center personnel concerned inherent limitations on their ability to ensure children's safety. For example, "Even in a supposed safe place, they're not safe because sessions can be sabotaged by an abusive parent." Also, parents have access to all records pertaining to their minor offspring. "Things children say can be used against them by abusive parents. It keeps the kids very unsafe." A specific scenario in which children become very vulnerable is in court. "Lack of education on the part of the judicial sector" is seen as causing a tremendous gap "because women who are victimized are usually forced to send their children to visit with the perpetrators alone." As in cases of child sexual abuse, child disclosure is very complicated, and without a clear disclosure, judges do not act, according to some respondents: "So, again, we're encouraging the child 'tell, tell' and they tell as much as they can and end up going right back with their abuser."

"Things children say can be used against them by abusive parents. It keeps the kids very unsafe."

Representatives from the crisis centers suggest more education for specific sectors (courts, schools) and communities at large, and they wish for more resources for prevention and outreach. One reason given that some centers do not have good access to schools, for example, is denial that violence and sexual abuse happens locally. Also, "people are fearful of what we might talk about; parents might see it as controversial." Like some of the direct service and primary-level gateway providers below, crisis center directors and child advocates echoed, "Children are devalued in our society, and it's tough to give them voices."

Direct service and primary-level gateway providers. While many in this group cited increased education and training – both for the public and among social service staff – as strengths, at

least as many participants felt strongly that more was needed. When asked about training within particular professions, one provider answered, "The training has been very spotty over the years.... There is no consistent response or reaction to kids that have experienced violence in the home." A member of a different focus group agreed there was a lot more to be done "in terms of more formalized training, allowing staff to be exposed to more education."

Unsurprisingly, funding and financial resources were on the tip of many respondents' tongues. One stated, "Other than the budget, I don't know if we have obstacles or barriers." Another articulated, "Even in times of good funding, it is stressful for all staff members to not know when the funding will end." Programming resources were another area of concern.

One participant lamented, "The mental health system is broken." Long wait lists for children to receive counseling at the Community Mental Health Centers were an extremely common cause for concern among the interviewees. There are too many obstacles for parents to get their children to counseling and "a lot of the services they say are provided are not." Services available for the entire family would help assess needs better. More mental health

counselors are needed, and the ancillary providers that do exist are expensive.

Once access to mental health services is achieved, the limited number of visits becomes a problem. Providers sometimes focus on aggression as the presenting problem, when it is often only a coping mechanism for being exposed to trauma. Time or the number of allowed visits can run out before symptoms of post-traumatic stress disorder (PTSD) can even be addressed. The area of evidence-based practice for children exposed to trauma is under-assessed and underreported. Participants say the needs of children are not always understood, and “mental health services aren’t adequate in a global sense and kids’ needs aren’t being met.”

Some gateway providers were critical of DCYF, and a few interviewees voiced frustration that the agency is not perceived to respond adequately when reports are made. One respondent commented, “It takes a lot for them to get involved” and “even though I have a mandate under the state statute to report ... they don’t take it seriously at all.” Another said, “There’s an attitude at DCYF that is not helpful... they don’t want to share information.” We think these representative comments illustrate a perception of the Division that is common to some gateway providers and indicate that more awareness of and access to DCYF could be useful for this sector of practitioners, in general. Further, we suppose that a richer repertoire of resources and services to refer to would alleviate frustrations among this group and help them to feel they do have the power to act on behalf of children with needs stemming from their exposure to violence.

Time is another necessary resource that sometimes falls short: spending too much time in court or having to do large amounts of paperwork for funding largely keeps participants from being more active in the community. Changing priorities over the years has made some individuals feel that there is “more of a focus on keeping families together than there used to be and less to protect kids.” Along these lines, one respondent said, “What’s provable in court and what’s safe for kids are very divergent.” Participants also discussed how GALs are limited in addressing issues with children: “The defense attor-

ney wants to stay focused on the charge rather than the larger picture.” One of the guardians *ad litem* who was interviewed talked about the recent closing of some supervised visitation centers as a significant loss. Other centers, s/he noted, charge fees that make them inaccessible for some families.

Service providers spoke of other general areas that could be improved. Sometimes, staff members struggle with the feeling that “children do seem to be set up to fail.” One individual admitted “[My] main gripe about work with kids is that they have no official rights. This whole society believes that they’re just incidental.” Another noted that schools can refer to services, but it must be the parents who call to do intake for the children. Unfortunately, participants report, parents are not always aware that their children really need services.

Finally, participants advocated for the need for more efforts toward prevention. A lack of prevention is reducing providers’ ability to address the issues of children exposed to violence. One said, “Once they get in our system, they are damaged goods.” Another corroborated, “It is past the point of crisis; we are getting information that violence is in the home in the past tense.”

Secondary-level gateway providers. Secondary-level providers that we interviewed reported a number of areas that they defined as in need of improvement to best meet the needs of children who are exposed to violence at home. Time and money were but two of the challenges they described. Common concerns cited by these providers include lack of health insurance, no transportation, and the fact that non-offending parents get confused and overwhelmed. Many interviewees discussed the dearth of well-trained mental health care professionals for children and the frustratingly long wait lists at CMHCs. A representative comment we heard was, “If we had more money, and we could increase the hours.... we can only do one hour per week per family and we have a two-month waiting list.”

The availability of therapists and mental health counselors with understanding of children’s issues particular to trauma and their exposure to violence is lacking, according to participants. As a result, staff who are not counselors or therapists some-

times find themselves in a difficult position. One respondent explained, “We can offer open ears, open hearts, but we are limited – we can’t counsel them.”

Several providers spoke about the difficulty of maintaining rapport and trust with children when mandatory reports need to be made. An interviewee explained, “We also try to keep the child connected to us even though we must report it. We try not to let it ruin the relationship, so they don’t feel betrayed by us.” Another echoed “it’s always a fine line to keep our rapport with the child while we continue to make sure they are safe.”

We heard complaints from participants about a lack of follow-up on the part of DCYF when reports are made. One participant told us, “I have a lot of kids living [in homes where they are] exposed to violence. From what I’ve experienced, DCYF has not shown that to be a concerning issue at all.” Another respondent specified, “I see follow up on cases in which the child is hurt directly, but if they just have a bruise or they witness, it is not followed up on.” Without involvement/assistance from DCYF, one participant felt “the therapist is just on their own to try to coordinate services for the child. So how well that goes depends on how much time the therapist has to devote to it.”

Coordination of services was reported by some individuals as a strength, as we stated above in the section on strengths of responding, however, others claimed to see no evidence that a continuum of care was in place. One interviewee described the gaps s/he perceived, “[A]s soon as they leave us and they’re out of the system, they seem to drop. There’s no aftercare in place.” Inter-agency collaboration was on the wish list of many respondents. One participant spoke of the simultaneous difficulty and desire for integrated services, saying, “Everyone is kind of territorial and has their own agenda, and it is really the breakdown of our society and it isn’t going to get better unless we work together.” S/he then asked, “...with thoughts to funding and cost containment, how can we really reduce replication of services but provide the best services we can for children?”

Participants complained that priorities sometimes seem misplaced. One respondent wanted to see more of “mak[ing] the other parent responsible

for their behavior, rather than putting the sole onus on the non-offending parent... more of holding the perpetrator accountable for the care and protection of their children.” Another observed, “I hear a lot about mandatory groups for offenders but not as much about open groups for people who are victims or witnesses.” Age-appropriate groups were seen as lacking, both for youth suffering exposure to violence and for the co-occurrence of substance abuse among this population. Also, respondents perceived a gap in services “that allow the child to voice their feelings and opinions to the parent in a judgment-free zone.” One staff member said, “I have worked with numerous children who have said that if they had the chance to tell the parent how they felt about the violence they witnessed, it would make it easier to cope and move on.”

Participants raised the topic of out-of-home placement several times in the interviews and groups we conducted. A respondent said, “It’s hard to help the children heal when the family lives like this and sees this as normalcy.” Another commented, “The state is making decisions about sending the kids home way too early before things have totally diffused in the house... [it’s] going to compromise the care that kids and families are going to get...” On the other hand, providers did not always recommend removal from the home. One spoke of “the unfair situation of being plucked out of their home and still be a victim and not a perpetrator... It’s not their fault, but they’re being punished by being removed... it’s hard for them to wrap their head around that. It’s almost like secondary trauma.”

Finally, participants wished they had more resources to recruit and retain good staff. They widely agreed that, if resources were available, they would increase efforts toward prevention and education. We heard, “...it is our responsibility to educate other providers on the growing issue of children witnessing violence.” One participant named his/her priority, “I think number one, prevention. Our huge thing is getting to these kids at the beginning.” Another told us, “It would be nice to have more preventative stuff going on.... We always address where the fires are, and we don’t address where the sparks are that need to be put out before they turn into a fire.

Summary of Responding: Areas for Improvement

Practitioners presented themselves as keenly aware of several issues that pose obstacles to improving their abilities to help children exposed to violence in their homes. Concern for children's safety echoed throughout responses. Just as providing safety for children unified many answers focusing on strengths of responding from all three groups of practitioners, apprehension about children's safety and well-being appeared to be at the core when practitioners spoke about the barriers they faced.

Among the issues most frequently heard as in need of improvement was non-offending parents' needs for access to more services for a greater length of time, lack of education on the part of parents and other providers charged with ensuring the safety and well-being of children, and lack of age-appropriate services for some children. Additional areas for improvement included the downside of mandatory reporting, or the lack of a continuum of care or true inter-agency collaboration rather than concerns about territoriality. Not surprisingly, the lack of time and/or money was an often-heard refrain, as were the wish for more resources and staff. Finally, a number of practitioners cited a desire for prevention programs to stop the violence before it begins.

Some gateway providers noted frustrations with DCYF. Despite advances that this agency has made in working with families where the co-occurrence of child abuse and domestic violence and exposure to domestic violence occur, the perception of some gateway providers is that DCYF still needs to do more in their response to children exposed to violence in their homes. This may be a result of some gateway providers not being informed about DCYF's responses in areas of children exposed to violence or the need for DCYF to be more responsive in these cases. Providers agreed that more trauma-informed services are required to respond to the needs of children exposed to violence in their homes.

Trauma-Informed Services

Research over the last several years has demonstrated that "many, if not most, maltreated and violence-exposed children have experienced multiple forms of trauma" (Cohen, Mannarino, Murray, & Igelman, 2006, p. 738). Therefore, we wanted to ask participants in our focus groups and interviews about their knowledge, practices, and/or training specific to trauma-informed care as an evidence-based intervention with children exposed to violence in their homes. Further, we asked the direct service and primary-level gateway providers additional, more specific questions about trauma assessment, and services, as their roles most frequently require them to work directly with children at risk. We asked the secondary-level gateway if they had conducted, attended, or knew of trainings focused specifically on children exposed to violence. We present the answers we heard from both direct service and primary- and secondary-level gateway providers below.

Among the direct service and primary-level gateway providers to children exposed to violence at home, responses regarding what trauma-informed services are currently offered in New Hampshire ranged from none to many. For example, one interviewee perceived, "We've got nothing in this state." On the other hand, a different participant shared that, "In our area, there are a lot of private therapists who do trauma work," but lack of health insurance on the part of families was seen as a barrier to accessing therapy. A third said, "There are a handful of people that focus on this area," but s/he continued, "I am not sure that it is as good as it ought to be because I fear that the number of children exposed in this way is very high. I think it is unacceptably high."

The types of trauma-informed services that we heard about from direct service and primary-level gateway providers included trauma-focused cognitive-behavior therapy, play therapy, and dialectical behavior therapy, as well as trauma-related training for parents of children exposed to violence. The parents' training involved "how to talk to kids, how to respect their space and privacy, how to advocate for services, offer resources and information." Sometimes respondents spoke of domestic violence

services that may be useful with children affected by violence at home, such as safety planning or assessing for the presence of DV. For trauma-informed care, they refer to CMHCs, CACs, or DV crisis centers. In one case, a participant spoke about the forensic interviewing/training that happen at CACs, but a fellow member of the same focus group pointed out, “It is more evidence-based, not trauma-based.” S/he continued, “There is a sensitivity to trauma, but not trauma-focused. [Trauma-focused care] is something that the assessment worker would follow up with after the interview.”

In general, as demonstrated in the last quoted comment, we found that participants were not always certain about what constitutes trauma-informed care. For example, we were asked more than once what it was and one respondent answered, “We don’t provide trauma-informed services.... I’m not sure what that is.” Another respondent’s statement provides a possible reason that the question often seemed difficult for participants to answer; s/he felt that many providers operate with “an intuitive understanding of what trauma is” but that they lack formal training or desirable qualifications.

Just as when we asked direct service and primary-level providers what trauma-informed services are available, we heard a range of responses from secondary-level gateway providers when we posed questions regarding how they screen for or recognize the need for trauma-informed care. One participant told us trauma “is something that we do screen for. There is an awareness that we have to do this.” But a member of a different focus group admitted, “Frankly, we don’t have a formal assessment process.” Similar to the comments of other respondents, s/he explained, “We observe kids, and those who concern us because of outburst, inappropriate play, things we hear, information from a referral service... those are all reasons we would consider evaluating a child.”

Knowledge of where trauma assessment tools might come from also varied. While one participant told us, “DCYF is in the process of developing these screening tools...” Another said that individual practitioners “pursue these questions on their own [to] help them to know what kinds of questions to

ask a child in an interview and... to ask for kinds of questions that might be appropriate if there is any concern about the child being exposed to violence.” Echoing the idea that formal trainings are sparse in some areas, one primary responder wished for “more highly trained professionals; more education for members of the community who have contact with kids and may have had an indicator of violence long before it comes to the attention of [practitioners specifically trained in this area].” S/he indicated that

[A]ll of the stakeholders are good at getting the overt signs but are not as knowledgeable about those who are displaying signs of trauma but it isn’t outwardly recognizable as such. For example, [gateway providers] who say, ‘oh yeah, they’ve been acting out like that for a year and a half.’ Well, a year and half ago, it was a completely different problem.

As noted in the introduction to this section of the report, we asked the secondary-level gateway providers questions about training but not specifically about trauma-informed services. Representative responses indicated that training was mostly self-sought and infrequently mandatory. For example, one interviewee said, “We see trauma and exposure to violence commonly, regardless of whether people are coming specifically for that or for other things – so we encourage clinicians to get training on exposure to violence and to keep up on training.” Another respondent said that their agency does offer training specific to exposure to violence but that other organizations seem to have more available: “We don’t dig as deep as they do. We try to aim our staff to manage what they hear and to pass it along to agencies that handle it more exclusively, like DCYF or CASA [Court Appointed Special Advocates].”

We heard from several interviewees that they or their agencies try to organize trainings as the need for education in various areas becomes clear. Some have regularly scheduled hours for staff development: “We have about 20 hours a year that we have to go for trainings [on topics such as] safety, rec-

ognizing substance abuse, exposure to DV, disgruntled parents, etcetera. We do this training in various ways.” Several participants in our focus groups and interviews cited the annual conference sponsored by the Governor’s Commission on Domestic and Sexual Violence and Stalking as well as DCYF-organized educational training. Many providers noted that they would appreciate more training if it were available; however, they also indicated potential obstacles to receiving the type or amount of training they desired. We heard that it can be difficult to motivate volunteer staff, that cost can be prohibitive, and that evening hours would be preferable to daytime scheduling.

In general, respondents declared that efforts to receive appropriate training exist, yet more opportunities are indicated. Regarding trauma-informed services specifically, one practitioner summarized as follows:

Working with children with trauma is a training that should be mandated when working with children who have witnessed violence in their homes. These children tend to be ‘wired’ differently, and knowing what sets them off and makes them tick is a great way to know how to work with them, in many different settings.

Summary of Trauma-Informed Services

Overall, both direct service and primary- and secondary-level gateway providers have varying degrees of comprehension regarding the meaning of trauma-informed services. There was agreement that children exposed to violence in their homes experience trauma resulting from exposure and that this trauma manifests in multiple ways. However, providers’ knowledge of the impact of this trauma varies considerably. Direct service and primary-level gateway providers, perhaps because of increased training opportunities, seem to have more knowledge of the impact of exposure on children, as well as greater awareness of the availability of trauma-informed services. Additionally, because they are more likely to have greater contact with children exposed to violence, they indicate that they imple-

ment more trauma-informed care strategies than secondary-level gateway providers. Whereas both levels of providers have varying degrees of need for and current access to training on trauma-informed services, the majority of our interviewees expressed strong interest in attending more trauma-informed trainings. Secondary-level providers seemed particularly interested in having access to resources and information both on the effects of exposure to violence on children and trauma-informed services.

When reflecting on the types of trauma-informed services available throughout the state, primary- and secondary-level gateway providers have mixed responses regarding access, availability, and quality. When trauma-informed services exist, private practitioners are sometimes the only available option, and this is prohibitive for children/families with limited health insurance. Additionally, as indicated in the previous section on responding, while all ten CMHCs have been trained in the TF-CBT model, the model is specifically for adolescents and does not address the needs of young children. Furthermore, in some CMHCs only one practitioner has been trained in this trauma-informed service. Thus, in some areas of the state, there is high demand and a limited supply of practitioners to meet the needs. This shortage results in longer-than-anticipated waiting lists at CMHCs for trauma-informed care.

Integrated Community Response

Participants in the interviews and focus groups answered questions about the nature of collaborations they currently have or desire to have with other community agencies. Because the research literature suggests that a multi-disciplinary team response is best suited to meeting the needs of children who have been exposed to violence in their homes, we wanted to learn what elements of such a team respondents considered to be working or lacking. Below, we describe what we heard from participants. The following sections separate the nature of participants’ comments into two general areas. First, we report what respondents viewed as existing collaborations or elements of existing collaborations that worked well. Second, we address those issues

that participants expressed as challenges, meaning that cooperative work among providers was either not taking place, was not perceived to be effective, or was desired.

Integrated Community Response: Successes

Crisis center directors /child advocates. Crisis center directors and child advocates had positive things to say about community collaborations, particularly in some locations throughout the state. One told us, “Our relationships could always be stronger, and we could always be at the table more often, but given the resources we have, we are very strong.” We heard that, at one center, trainings for police departments are offered routinely, and representatives from other centers spoke highly of the collaborative relationships between the DVS and DCYF. Other respondents valued the connections they were able to make with CMHC, such that one center director/advocate said, “if we call... they try to help us first, knowing that there is usually an imminent situation.... It’s not – can I wait three months to get in.”

Cooperative responses and/or trainings were also mentioned to exist with several schools, and one area noted that they had “just begun working with guardians *ad litem* to give more of a domestic violence lens for them to view behaviors of mom, child, perpetrator....” A unique example of a community partnership took place between a crisis center and a local dog walkers association. The center used the opportunity “to raise awareness of pets as weapons and victims of domestic abuse...” and to send the message to the public about some of the unfortunately horrible things families and children endure.

Positive comments were sometimes heard about crisis centers’ relationships with the court system, and several centers talked about doing outreach and prevention in schools and other community locations. Addressing collaboration with child welfare and the issue of confidentiality that was discussed in the literature review section of this report, one respondent shared that “We have an advocate who is placed at health and human services, but she has

crisis center confidentiality for when child abuse and domestic violence are co-occurring.” In at least some areas, crisis center directors and advocates also felt they had good connections with health care, Child and Family Services, and CACs.

Direct service and primary-level gateway providers. Among direct service and primary-level gateway providers, one participant defined what s/he believed to be the elements of a successful integrated community team: “maintaining a dialogue with judges, police, service providers; educating these folks and doctors, et cetera about the fact that a child can be abused even if there isn’t severe physical trauma.” Another commented that collaboration was likely on everyone’s mind, as funders want to see integrated response teams. S/he said, “so that has pushed us... to form coalitions.” In one particular county, respondents told us that they had reached an understanding, as providers, not “to get in each other’s way to try to serve these families and kids.” They described having done trainings together, and said, “we talk informally; we share each other’s numbers and extensions so you don’t have to wait, as an example.”

Respondents from one self-described small community felt they were doing a good job of providing wraparound services to families. When asked how that was achieved, they said that whether it be the CMHC, DCYF, or DV services, whoever is working with a client that is common to all of them will initiate communication about “what’s happening in the treatment and the family there.” The police department will also become involved, they said, if a youth or teenager commits a misdemeanor or an offense that does not rise to the level of needing court involvement. The police bring the incident to the table, and the providers step up to say what they can offer in terms of help or resources. This group takes the extra step of tracking the cases they discuss, so that they can follow up with the agencies and organizations that have been involved.

Some interviewees felt that collaborations tended to be strong in cases where child abuse and/or neglect were substantiated. Participants said that, in those instances, DCYF successfully rallies an integrated response. One interviewee described the

chain of events in the following way: “[the courts] bring in DCYF, DCYF brings in counseling, in-home family support, the school district, and all of those things....” In the general area of family law, however, this kind of integration was not necessarily seen.”

Other services provider agencies were sometimes mentioned by interviewees as meaningful contributors to community collaboration efforts. As an example, one respondent was pleased that “We have a site at a local housing project. It has become a great community center.” Members of another focus group spoke highly of diversion programs and the drug-related courts in New Hampshire. One primary-level participant eloquently summarized the importance of cooperative service provision, saying:

We know that we all need to contribute to help kids and families be safe. We lack the sense of competition.... People around the table want to do what is right. We know that if we aren't doing something, then who is? ...Not one of us has the whole answer, but together we can provide better services. If we don't work together, then it isn't going to happen.

Secondary-level gateway providers. Secondary-level gateway providers largely agreed with direct service and primary-level gateway providers regarding cooperative efforts to respond to children exposed to violence at home. Variations existed across agencies and locales, but the list of cooperating organizations included primarily some, or occasionally all, of the following: DV services, law enforcement, therapists, attorneys, crisis centers, DCYF, physicians, childcare, schools, CACs, probation/parole, drug treatment, and family resource centers. One respondent saw the value in collaboration particularly “within the context of legal case[s]... we don't want to mess with any reporting by asking the child the wrong questions. We have to distinguish between facts of the case – legally speaking – versus feelings of the child....” Overall, participants felt it was important to have a hub or to provide some case management for families; otherwise, “The availability of services directly to the family may be more limited or harder to access.”

Integrated Community Response: Challenges

While participants were generally pleased with the collaborations in place, they also described several challenges. Some of the challenges stemmed from lack of resources, such as number of staff or hours in the day. On other challenges, providers shared their wishes for cooperative partnerships that had not yet been forged, leaving an unfortunate gap in responding to children's needs.

Crisis center directors /child advocates. Participants from crisis centers generally agreed that professionals from other disciplines tend see domestic violence as important but not necessarily as a priority. One participant suggested that other community responders might not “be able to see the value of our work. We have to kind of prove ourselves.... How do we work with people in order to help them feel that we're not invading their space? That's a big part of the reason we might not get referrals....” Another respondent echoed the wish to generate more referrals to encourage “schools, coaches, child care, parents, community members, pediatricians... to reach out to us.” During a different conversation, an interviewee wondered, “how to get people to buy in and *stay* engaged.” S/he added that the buy-in exists, though it is not the majority, and “It dissipates pretty quick.” One provider from a crisis center pointed out that other members of a cooperative team “didn't see the need to be so hyper-vigilant...” when a situation didn't rise to the level of police involvement but a child was “slowly slipping because of the dynamics of power and control.”

Direct service and primary-level gateway providers. Direct service and primary-level gateway respondents named several challenges regarding cooperative community responding. One commented on the need for more staff to follow up with clients and “develop relationships in the community, knowing what centers and what therapists are going to work best with these kids and share information, and we just aren't able to do that.” Some participants noted that their caseloads would need to be smaller in order for them to coordinate treatment better. One interviewee told us, “My case load

now is so huge, I can't breathe."

Several participants brought up cross training as an area of need. Sometimes professionals from one discipline become frustrated by the lack of understanding of other disciplines ("they are frustrated; they don't understand"), and other times visions of what neighboring institutions do are "not accurate, so they need to be educated." Misunderstanding or misinformation aside, some participants felt that they, or others, lacked awareness of available resources. One respondent suggested:

...if there were a database somehow within the state where all of the programs that work with families and children that have these kind of issues would be aware of each other... we don't know that they're in existence, and ... the kids and the families are really missing out.

Another participant agreed, "if you had a clearinghouse for information with regard to what therapists are available, what programs are available, what temporary shelters are available, that type of thing... if there were some way I could get that information..."

Respondents from the primary level also said that core values and the culture of certain agencies and organizations could be an obstacle to collaboration. One said, "Communication and trust are two big things." Other times, providers cited the challenge of gaps in services. For example, one participant felt the court "needs to provide some coordination and integration in the community response." Another wanted to "see more involvement with physicians." A third interviewee commented, "Sometimes other programs just can't help with certain things because it's not under the umbrella of what they do."

Secondary-level gateway providers. Some secondary-level gateway respondents felt that, although they were willing to engage in collaborative response teams for children exposed to violence at home, they were not certain how to get connected. One said, "...we are putting ourselves out there on a regular basis... and we are ready to present whenever somebody asks. But I can't say that we are working beside anyone consistently..." Another interviewee

replied they "collaborate loosely, I would say." Others told us they cooperated regularly with other agencies, but one participant added the following condition: "Yeah, but we have been in the community... our program director... for [a very long time], so [s/he] has a lot of good connections.... I don't know what it would be like for someone else, but I think because of the history that we have.... I think that helps us in getting assistance."

Summary of Integrated Community Response

Participants in our focus groups and interviews told us that efforts to create an integrated community response to children who are exposed to violence in their homes has been and is currently underway in many areas, and they widely agreed that more cooperation and coordination is needed and desired. Where cross-trainings have occurred and connections have been forged, participants believed them to be a source of significant advantage. Relationships built among professionals from different agencies give providers the needed sense that the priorities and goals of each – in best meeting the needs of children – are heard and respected by colleagues from other disciplines. Whereas it seemed to participants that interpersonal connections could be fruitful, when those relationships had not yet been established, interviewees told us that a lack of understanding of the realities of domestic abuse stood as a barrier to successful collaboration. Providers specializing in meeting the needs of children exposed to violence felt that referrals to their services did not extend from certain sources, and gateway providers agreed strongly that they were not adequately aware of services that do exist and how to access them.

Where participants have a good understanding of how each member of a multidisciplinary collaboration needs to function relative to one another, teamwork supersedes territorial competition. Where interdisciplinary communication wanes, competition over service provision and whose roles fall under which "umbrella" can impede cooperative efforts. Funding sources have both encouraged collaboration, as coordinated teams are those most

likely to acquire funding at the present time, and hampered it, as resources are generally scarce and organizations feel protective of the small amounts they have. With increased understanding of how agencies and organizations are able to assist each other and strengthen, rather than diffuse, each other's ability to respond to children who have been exposed to violence, collaborative team responses are less likely to be viewed by providers as a repeat of services. Additionally team responses are likely to be viewed as another task in an already too-busy day, or a loss of control over frighteningly meager funds. Such responses can be embraced more broadly as a means to more easily, effectively, and economically achieve a common goal (children's well-being) and offer the best kind of wraparound care to families.

Stakeholders' Reflections

As noted above, we held meetings with stakeholders who represented NH experts and professionals who oversee systems of care regarding or work with children exposed to violence in their homes and their offending and non-offending parents. We held the first meeting in September 2008 before we started data collection and the second meeting upon completion of our final planning project objectives and activities. We believed that it was important to share our initial findings with the stakeholders again. We presented our preliminary findings during a meeting in August 2009.

During this latter meeting, stakeholders were very engaged in our presentation of preliminary findings regarding responding, areas of strengths

and improvement, trauma-informed services, and integrated community response. The overview that we presented to them was familiar to them and reflected what many of them encounter daily in their work as direct service providers and administrators who work in the field of child trauma treatment and children exposed to violence in their homes.

While the stakeholders agreed with many of the common themes presented in the above findings and the recommendations noted below, stakeholders made systematic reflections about the need for next steps in a comprehensive response to children exposed to violence in their homes. It is important to note that their recommendations reflect a more "systems level" of analysis and action. This level of analysis was rarely, if at all, present in the interviews/focus groups with consumers and direct service, and primary- and secondary-level gateway providers. This macroscopic view of the needs of children exposed to violence in their homes provides an important reference point for the Coalition and their partners as they work together to create services and supports for children, and their families, exposed to violence in their homes. The stakeholders' suggestions for systems-level action include the need: to place children at the center of all responses, both on the programmatic and systems levels, for an integrated programming/service model; for an integrative funding model; for advocacy on the systems level; for a forum across the state to talk about the mental health needs of children exposed to violence in their homes; and to continually maintain the capacity to provide services to children, and their families, exposed to violence in their homes.

Recommendations and Conclusion

This report presents the results of the Mental Health Needs of Children Exposed to Violence in Their Homes planning project conducted by University of New Hampshire's Prevention Innovations: Research and Practices for Ending Violence Against Women for the New Hampshire Coalition Against Domestic and Sexual Violence. Findings from this planning project are presented in the common themes of responding - strengths and areas for improvement, trauma-informed services, and integrated community response. The following recommendations incorporate the comments and suggestions made by the consumers, direct service providers and primary- and secondary-level gateway providers that we interviewed. Additionally, we contextualize the recommendations based on our review of research, literature and best practices on child trauma treatment, our interviews with national and state experts, and feedback from key stakeholders. We present recommendations in broad categories and offer specific actions that the Coalition and its partners can implement to strengthen their current provision of mental health services and support for children exposed to violence in their homes. In all cases, fulfilling these recommendations will require collaboration and creative funding solutions to implement systems-level changes where children are at the center of trauma-informed training, services and support.

Keep Children "at the Center"

All interventions, both formal and informal, should keep children at the center. This means that children's safety and well being must be prioritized and of the utmost importance. Children's support systems, from non-offending parents, direct service, primary- and secondary-level providers, friends and non-offending family members must be supported and, to the extent possible, trauma-informed. Research shows, and the consumers and state and national experts we interviewed concur, that healthy relationships with at least one adult (e.g., preferably a non-offending parent, but also another relative,

teacher, coach, clergy, for example) constitute an integral resource for children, bolstering resiliency and positively influencing the outcomes of children who have been exposed to violence in their homes. Efforts are warranted to strengthen the relationships children have with caregivers and/or positive adult role models. In some instances, children can be best aided by engaging in therapeutic work with the non-offending parent and child together. Interventions with non-offending caregivers can help the adults recognize the impact of violence on children and can help them learn how best to help their children with regulating emotions, appropriate behavior, and issues of trust and safety. Supervised visitation centers offer an important arena for ensuring the safety of children and their non-offending parents by preventing harmful speech or behavior on the part of offending parents. Keeping staff well-trained at visitation centers is essential, so that threats to children can be easily recognized and assistance offered to adults regarding how to have positive and appropriate interactions with their children.

The dynamics of family violence are complex, and understanding how dangers manifest toward children and their non-offending parents is essential in order to keep children (and their non-offending parents) safe. All intervention efforts must be predicated upon safety in order to be effective, and research demonstrates that organizations specifically dedicated to serving those who have survived violence are uniquely prepared to comprehend the safety needs of child and adult survivors. Crisis centers should be equipped with staff and funding to offer more training to other professionals in the dynamics of violence and the specifics of safety. Part of this effort means ensuring that crisis centers' "voice" has adequate volume among all relevant state systems, including Courts and law enforcement, for example. Collaborations such as those between crisis centers and DCYF are a beneficial model and should be guarded and replicated within other agencies.

- Offer more trainings to professionals in the dynamics of violence and the specifics of safety.
- Provide safe places for children to interact with their non-offending parents.
- Educate caregivers on the impact of violence on children, and support their efforts to help children cope and heal.
- Provide safe places (i.e., visitation centers with well-trained staff) for children to interact with offending parents.
- Strategize ways to better safeguard children's voices by offering them more confidentiality to disclose information that cannot be brought back to hurt them by offending parents.
- Give children a say in matters of custody and visitation when exposure to violence is substantiated.

Establish a Culture of Collaboration among Providers

Research shows that an integrated community response is the best practice for meeting the mental health needs of children who are exposed to violence in their homes. A culture of collaboration can be fostered by increasing efforts to train, co-train, and cross-train professionals from different disciplines in the basic demands and goals of each other's unique roles. Communication among agencies and organizations with vested interest in child and family well-being is essential, and intentional pathways through which information is disseminated among them should be clearly defined and encouraged. Possibilities for blended funding streams must be investigated, such that limited resources may be combined and not constitute sources of competition. Working relationships can take time to develop, and time is not always plentiful. Planting the seeds of communication and mutual respect through training, co-training, cross training, and information-sharing can fertilize the growth of collaborative team responses.

- Increase efforts to train, co-train, and cross-train professionals from different disciplines in the basic demands and goals of each other's unique roles.

- Increase communication and collaboration between agencies and organizations with vested interest in child and family well-being.
- Develop integrated community responses to providing a strong support system to children and their families exposed to violence in their homes.

Increase the Provision of Trauma-Informed Services

Primary responders to children who have been exposed to violence in their homes must be trained to offer trauma-informed care, as research shows that symptoms of trauma underscore the impacts of exposure to violence. Programs and collaborations that specialize in trauma-informed service provision have been forged in NH, and awareness and access to them needs to be extended to more regions and more providers. Trauma-informed specialists should coordinate to ensure that NH professionals have access to evidence-based practices that have been evaluated and are shown to be successful in treating children. Protocols for recognizing trauma symptoms and the need for trauma-informed care must be established among all levels of service providers, and a common definition of what constitutes trauma-informed service needs to be disseminated. Young-adult and non-offending parents that we interviewed indicated that they have much to gain from support and mental health services that are trauma-informed.

- Widely disseminate training on trauma-informed care for direct service providers and primary-level gateway providers.
- Increase the number of therapeutic programs for younger children.
- Ensure that trauma-informed services are available throughout the state and that availability is not dependent on one provider in a geographic area.
- Direct service and primary-level services providers should develop protocols, or implement existing ones from their field, for recognizing trauma symptoms in children.
- Through reallocation of financial resources, systems of care can develop integrative funding models to support trauma-informed services.

Disseminate Knowledge about Children Exposed to Violence in their Homes and Trauma-Informed Services

All practitioners, including gateway providers, require a common language with which to discuss trauma and the services that best suit children exposed to violence in their homes. Consumers specifically talked about the important role that gateway providers play in their everyday survival and resiliency against the impact of violence in their homes. Therefore, the more we can provide primary- and secondary-level gateway providers with information, training, and resources about child exposure to violence, the more it will benefit the children who need support the most. In addition to a common language, a database and/or clearinghouse

should be created so that resources for referral are centralized, categorized, and easily available to every service provider. Knowledge of this clearinghouse must be effectively distributed throughout the state.

- Develop a centralized, categorized, and easily-accessible database and/or clearinghouse resource containing basic information on children exposed to violence, basic facts about services that best suit children experiencing trauma, basic definitions of trauma-informed services, and a list of state-wide referral resources.
- Actively broadcast the existence of the clearinghouse/database to direct service and primary- and secondary-level practitioners, so that all may use it a resource and a map for referral to services most needed by children.
- Increase knowledge of existing trauma-informed services throughout the state.

Conclusion

These recommendations are based on data from a comprehensive needs assessment that we conducted, and research and best practices that we gathered, during a 2-year planning project. The suggested actions speak to the acute need for more resources for children, and their families, exposed to violence in their homes: increased training and resources for practitioners, creation and expansion of coordinated community responses to children and their families, and the establishment of referral networks for gateway providers. As the Coalition and its member programs consider our recommendations,

we encourage them to keep children at the center of their implementation plans. To successfully do so, it is essential to seek community-based partners (many of whom we talked with during the planning process) to share the responsibility of ensuring that children, and their families, exposed to violence in their homes have access to safe, reliable, competent, and trauma-informed services and supports. Indeed, providing apt and ample support to these children and families is a common goal of tremendous importance.

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Endnotes

- 1 From an interview with a young adult who had been exposed to violence as a child.
- 2 The Greenbook Project was a federal project established to bring together the court system, child protective services and domestic violence agencies to enhance the response to the needs of children and their families when domestic violence and child abuse co-occur. Grafton County was one of six locations picked to take part in this endeavor to improve system responses. http://www.casaforchildren.org/atf/cf/%7B9928CF18-EDE9-4AEB-9B1B-3FAA416A6C7B%7D/0410_family_violence_issue_0011.pdf.
- 3 Information about this program can also be found at <http://www.sandragb.com/intervention.htm>.
- 4 Information about the program can be found in the following online document from the National Child Traumatic Stress Network (http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/CPPsychtherapyforFV_21105.pdf).
- 5 Information about this therapy can also be found at the National Child Traumatic Stress Network web site (http://www.nctsn.org/nctsn/nav.do?pid=hom_main).
- 6 For detailed information on the above and other programs, we recommend the California Evidence-Based Clearinghouse (CEBC) for Child Welfare website: (<http://www.cachildwelfareclearinghouse.org>).
- 7 Contact the researchers to see copies of the interview/focus group schedules.
- 8 See http://www.qsrinternational.com/products_nvivo.aspx for more information about NVIVO.
- 9 Personal correspondence with Wendy Walsh, Ph.D., Crimes Against Children Research Center, April 29, 2009 and October 29, 2009.
- 10 Based on our interviews with Crisis Center Directors and Child Advocates, the children they see most often come to the shelter with their non-offending parent. They are mostly Caucasian and from a variety of economic levels. They vary in age and gender. Most shelters see mainly younger children (age 0-7), although a few crisis centers see a wider range of ages, from infancy to teenagers. While most children are Caucasian, certain areas see variation in ethnicity. Southern NH crisis centers note the most ethnic and racial diversity in children and Northern NH crisis centers noted usually poverty or below poverty level and rural families.
- 11 See the Methods section below for definitions of each of these categories of providers used this report.
- 12 Individualized Education Plan (IEP) and 504 plan meetings are two levels of special education intervention.

