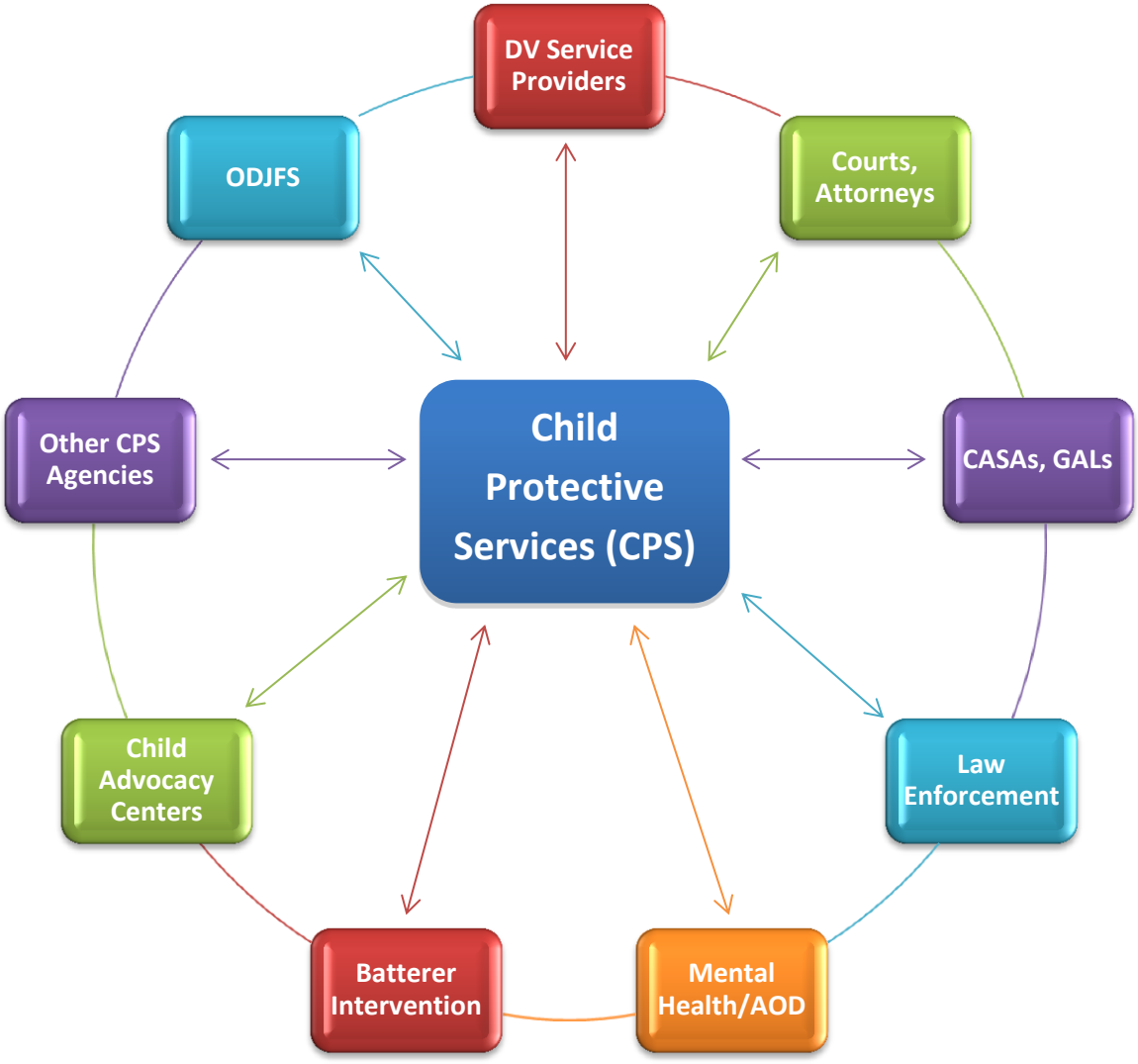
The Impact of Batterers on Children

An Ohio Model Community Response Protocol

July 2015

The Ohio Intimate Partner Violence (IPV) Collaborative
Statewide Planning Group



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Section I. Introduction

EXECUTIVE SUMMARY

The following model community response protocol has been designed for child protective services (CPS) agencies and all systems that may partner with CPS on cases in which perpetrators expose children to intimate partner violence (IPV). It is intended as a guide for communities in the development of a collaborative response, grounded in the *Safe and Together*™ model's critical components, from the first disclosure of domestic violence (DV) throughout the life of a case.

This protocol does *not* give equal attention to all systems partners, though concepts can be applied across systems. Partners can utilize this document to inform collaborations with CPS and learn how the critical components can aid practice generally.

BACKGROUND

In 2008, ten Ohio county child welfare agencies began an 18-month pilot of a Differential Response (DR) child protection model.

> ***What is DR?*** DR is a form of CPS practice that allows for more than one method of response to reports of child abuse and/or neglect. A DR model recognizes the broad variation that exists among child maltreatment reports and the simultaneous value of responding differentially. Ohio's DR model includes two pathways – a Traditional Response (TR) for reports of egregious harm, such as sexual abuse or severe physical abuse of children, and an Alternative Response (AR) assessment available for other types of reports that had not been opened already in TR. Central to each pathway is a focus on child safety through partnership with families, assessment of child and family strengths and needs, and provision of services. However, unlike AR cases, cases assigned to TR necessitate naming an alleged perpetrator and making a formal disposition (i.e. substantiated,

unsubstantiated, or indicated) that maltreatment has occurred or that the child is at risk of maltreatment. Families and CPS may choose to transfer their cases from AR to TR, but not vice versa.

As the pilot progressed from July 2008 through December 2009, the pilot agencies developed greater confidence in responding to various types of reports through the AR pathway. Over time, they found that a significant number of their AR families were experiencing domestic violence. Several of the pilot agencies requested technical assistance and/or training opportunities specific to the intersection of domestic violence and child protection concerns, particularly in the context of a DR system. In response to these requests, and recognizing the overall impact family violence has on children, Casey Family Programs extended its support to assist Ohio in developing a collaborative to expand agency and community capacity to serve families experiencing domestic violence.

The Ohio Department of Job and Family Services (ODJFS) contracted with the Family & Youth Law Center (FYLaw), formerly known as the National Center for Adoption Law & Policy (NCALP), to facilitate the Ohio IPV Collaborative. This multi-faceted project aims to build IPV response competency within CPS agencies; foster enhanced partnerships among child welfare, courts, DV service providers, and other stakeholders; and develop recommendations for a model community DV response plan with regard to child welfare. In 2013, the Collaborative's interdisciplinary, statewide Planning Group of 30+ members used these recommendations to develop a model community response protocol – based in David Mandel & Associates' *Safe and Together*™ model – to convey recommended practices in child protection cases with DV components and to include recommended collaborative responses from various service providers. (For a chart of progress updates on all Recommendations, see Appendix A.)

As of this writing, all of Ohio's CPS agencies have implemented a DR system, and nearly half have been trained in *Safe and Together*™, the State's chosen response model to children exposed to DV.

ACKNOWLEDGEMENTS

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Section II. Basics

Domestic violence means: (a) No person shall knowingly cause or attempt to cause physical harm to a family or household member; (b) no person shall recklessly cause serious physical harm to a family or household member; (c) no person, by threat of force, shall knowingly cause a family or household member to believe that the offender will cause imminent physical harm to the family or household member.
~ Ohio Revised Code § 2919.25

Domestic violence means the occurrence of one or more of the following acts against a family or household member: (a) Attempting to cause or recklessly causing bodily injury; (b) placing another person by the threat of force in fear of imminent serious physical harm or committing a violation of section 2903.211 or 2911.211 of the Revised Code; (c) committing any act with respect to a child that would result in the child being an abused child, as defined in section 2151.031 of the Revised Code; (d) committing a sexually oriented offense.
~ Ohio Revised Code § 3113.31

Domestic violence is "a pattern of abusive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners."
~ The Ohio Domestic Violence Network (ODVN)

TERMS

The Ohio Revised Code limits its definitions of domestic violence (DV) to physical harm or threats of physical harm. This protocol contextualizes any physical harm or threats as part of a larger pattern of coercive control. For the purposes of this document, **domestic violence** (or **intimate partner violence**) will refer to any behaviors one (current or former) partner in an intimate relationship uses to exert power and control over the other partner. This definition does *not* include any physical or other violence between intimate partners that does not involve this pattern, such as self-defense against a partner or isolated incidents of physical violence between partners.

Perpetrators' **patterns of coercive control** can include any number of behaviors, such as physical, sexual, emotional, spiritual, and economic abuse, as well as

intimidation, isolation, and stalking, among others. (See Appendix B for examples of coercive behaviors.) Anger management, mental health, and substance abuse issues may amplify the violence, but they do *not* cause domestic violence.

Children exposed to domestic violence will refer to children who have witnessed, heard, or felt any harmful effects of the DV. **Child maltreatment** will refer to violence specifically intended to hurt a child in the family.

Child welfare and **child protective services (CPS)** will refer to agencies charged with child protection. Families in which children are exposed to domestic (intimate partner) violence will include two partners, at least one of whom is the parent or guardian to a child in the home, regardless of biology. **Batterer** or **perpetrator** will mean the partner exhibiting patterns of coercive control. **Non-offending parent** will mean the partner who is the target of control, though **adult survivor/victim** and **protective parent** may be used occasionally. Finally, **(service) providers** will describe practitioners, professionals, and workers in any community partner system (e.g., courts, law enforcement, DV programs).

See Appendix C for a complete list of abbreviations and definitions.

IMPACT ON CHILDREN

Domestic violence is a parenting choice. Batterers choose to threaten their children's safety, whether through their choice to expose children to their violence against another parent, through direct physical maltreatment (with DV and child maltreatment co-occurring at a rate between 30% and 60%) (Edleson, 1999b), or by using a child as a weapon against the other parent. Its effects on the adult survivor's ability to parent can affect children – whether or not the children physically saw or heard the violence – due to the non-offending parent's resultant depression, anxiety, diversion of energy to the perpetrator, loss of authority, and/or isolation from supportive relationships, employment, and income stability.

In the most serious cases, DV perpetrators' patterns of coercive control can end in a critical incident or child fatality. A majority of children experience less serious but nonetheless concerning effects in the short-term or throughout their lives.

Children may react to domestic violence in a number of ways, including:

- Feeling hyper-vigilant or “walking on eggshells”;
- Interruption of normal routines;
- Freezing, hiding, running away, or dissociating;
- Becoming angry and intervening, threatening, or attacking the perpetrator;
- Feeling frightened and confused because they cannot go to parent(s) for comfort; and/or
- Blaming the non-offending parent or attempting to align with the perpetrator as a defense strategy (Stiles, 2002).

One possible effect of DV on children is a delay in child development. It takes energy for children to attain developmental milestones, such as walking, in the case of a one-year-old, or learning to negotiate peer relations, in the case of a preschooler or school-age child. Children who were developing normally sometimes regress when violence occurs or even once safety is re-established. Understanding developmental tasks a child is working through at a particular age can help service providers identify children who may need further intervention. Table 1 from the National Child Traumatic Stress Network (NCTSN) shows types of problems children might exhibit by their age.

Table 1: Reactions to Domestic Violence by Age (from NCTSN)

Age Birth to 5	Age 6 to 11	Age 12 to 18

• Sleep and/or eating disruptions
• Withdrawal/lack of responsiveness
• Intense/pronounced separation anxiety
• Inconsolable crying
• Developmental regression, loss of acquired skills
• Intense anxiety, worries, and/or new fears
• Increased aggression and/or impulsive behavior
	• Nightmares, sleep disruptions
	• Aggression, difficulty with peer relationships
	• Difficulty concentrating or completing tasks in school
	• Withdrawal, emotional numbing
	• School avoidance and/or truancy
		• Antisocial behavior
		• School failure
		• Impulsive and/or reckless behavior, e.g.,
		  ○ School truancy
		  ○ Substance abuse
		  ○ Running away
		  ○ Involvement in violent or abusive dating relationships
		• Depression
		• Anxiety
		• Withdrawal

Children do not all react to DV in the same ways. Their differing reactions are related to the severity and chronicity of the violence, how much the child has witnessed or been exposed to, other traumas the child has experienced, and resilience in the child (feelings of competence, good mental health, positive attachments with adults, strong faith connection, or cultural supports).

Safe and Together™ MODEL FRAMEWORK

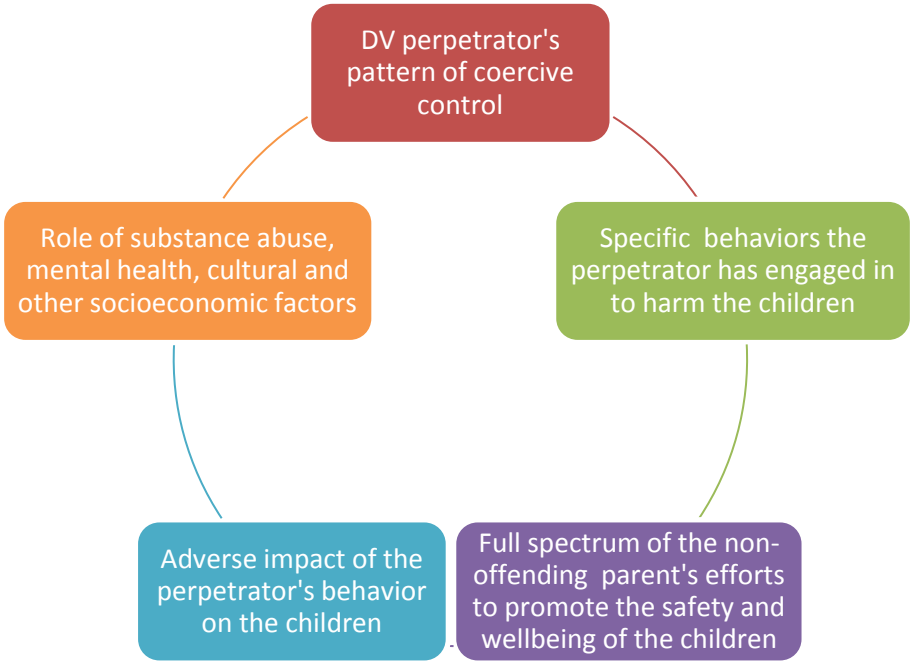
David Mandel & Associates' *Safe and Together*™ model has an extensive evidence base (see Appendix D) and is now trained across the United States and internationally. It is based upon the assumption that child welfare agencies need to address domestic violence effectively in order to achieve their core mission of safety, permanency, and wellbeing of children.

To improve practice and create better outcomes for children and families exposed to a batterer's behaviors, the **principles** listed below can help guide practice.

- From the perspective of safety, healing from trauma, and stability, it is in the best interest of children to remain *safe and together* with the non-offending domestic violence survivors (or non-offending parent).
- Building partnerships with non-offending parents is the most effective and efficient way to promote the safety, permanency, and wellbeing of children exposed to domestic violence.
- Partnerships with non-offending parents need to be based on a comprehensive assessment of their active efforts to promote the safety and wellbeing of the children.
- Child welfare agencies can improve outcomes for children and families by increasing their capacity to intervene with domestic violence perpetrators.

Implementation of these principles in case practice is supported by identifying the following **critical components** of a case (referenced throughout this protocol):

Image 1: *Safe and Together*™ Critical Components



The model's focus on perpetrator behaviors, survivor strengths, and child safety allows for model application in a variety of intimate partner relationships, *regardless of the gender, sexual orientation, gender identity, race, ethnicity,*

culture, or socioeconomic status of either partner. (See Appendix E for more information on DV perpetrated by one partner against another in same-sex relationships.) The model encourages use of language that highlights strengths and behaviors over deficits and opinions, as demonstrated in Table 2.

Table 2: Terminology Encouraged in *Safe and Together*™

SUBJECT	SUGGESTED TERMS	TERMS TO DISCARD
Domestic violence	Battering, children exposed to battering, pattern of coercive control by perpetrator, specific behaviors	Battered woman syndrome, domestic violence situations, mutual combat/battering, partners "engaged in" DV
Person exhibiting coercive controlling behaviors over intimate partner	Alleged perpetrator, batterer, offending parent/partner, primary aggressor	Partner "engaged in DV"
Intimate partner targeted by coercive controlling behaviors	Non-offending parent, adult survivor, victim/partner	Alleged perpetrator

This language places accountability on batterers for the actual risk to children – batterer behaviors – rather than the inaccurate "failure to protect" paradigm under which systems have operated. Furthermore, it emphasizes that adult survivors are the *victims* of the violence, rather than instigators of violence or perpetrators by "failing to protect" their children. As noted on page 19 of the Greenbook by the National Council of Juvenile and Family Court Judges (NCJFCJ),

> "[B]laming a battered mother for being abused, for not leaving the domestic violence perpetrator, or for not stopping his violence is simply counterproductive. The battered woman cannot change or stop the perpetrator's violence by herself. If she does not have the adequate support, resources, and protection, leaving him may simply make it worse for her children. The battered woman and her children need the community's help."

This perpetrator pattern-based, behavioral model allows *Safe and Together*™ to be applied across cultures. (See Appendix F to rate your practice on David Mandel's Continuum of DV Practice.)

Section III. Continuum of Practices and Services

This section outlines a Continuum of best practices and services for child protection agencies and their community partners on cases in which children are exposed to domestic violence. It begins with the screening process following a report made to CPS. Every provider may consult these recommendations for their own practice or may use them to learn about the CPS process. (See Appendix G for additional guidelines on culturally competent practice.)

Image 2: Continuum of Practices and Services

CONTINUUM OF PRACTICES & SERVICES

Screening: *The process of receiving and recording information from a reporter to determine one or both of the following: (a) whether the information provided should be categorized as a referral of child abuse and/or neglect, dependency, or family in need of services; or as an information and/or referral intake; and/or (b) whether the information categorized as a referral of child abuse and/or neglect, dependency, or family in need of services should be screened in or screened out.*

Screening Decision: *The outcome of the screening process. (ORC § 5101:2-36)*

Screened In: *The public children services agency (PCSA) has accepted referral information as a report and assignment for assessment and/or investigation. (ORC § 5101:2-36)*

Screened Out: *The PCSA has not accepted the referral for assessment or investigation. (ORC § 5101:2-36)*

SCREENING DECISIONS

The screening function is the first point at which a judgment must be made about a child's safety. The information obtained from the reporter is used to make a judgment about the necessity to intervene and the speed and nature of the agency's response, in addition to pathway assignment decisions. Ohio's child protection system is state-supervised and county-administered. Thus, criteria for calling CPS, screening in a decision, and assigning a case to the Traditional or Alternative Response pathways vary by county. (Note the AR/TR decision is made prior to the county contacting the family.) Still, all counties must have the "burden of proof" in order to screen in and/or substantiate a case. Parenting choices that could be considered poor parenting do not necessarily meet criteria for child abuse, as defined in the Ohio Revised Code (ORC).

Individuals working outside CPS may become frustrated when a report is screened out when they believe it should be screened in. This can lead to tensions between agencies and among service providers as well as mistrust of CPS. Mandated reporters have a right to know whether or not their report was screened in and may call CPS to request some basic updates on the case. CPS agencies are strongly advised to communicate their screening decisions with community partners that made the report. This can be done within the parameters of CPS confidentiality rules. Making a phone call or sending a letter can have a significant, positive effect on interagency collaboration efforts, trust, and relationship-building. Additionally, CPS can use these communications to educate their community partners on reasons cases are screened in or out.

To **SCREEN OUT** a report, CPS must:

- Establish that reported concerns do not meet statutory requirements to accept for services.
- Record specific reasons the report did not rise to the level of risk/concern to accept for investigation/assessment.

A CPS decision *not* to accept a report at screening does not minimize the seriousness of DV. Behaviors and conditions may pose risk to a child without meeting criteria for child abuse and neglect. CPS and community partners may work together to ensure families are connected with supports that can mitigate risk of more serious behaviors.

To **SCREEN IN** a report, CPS must:

- Determine specific allegation(s), such as neglect, dependency, physical abuse, or emotional maltreatment.
- Determine pathway assignment – Traditional Response (TR) versus Alternative Response (AR).
- Determine roles of case parties. In IPV cases specifically, the batterer – ***not*** the non-offending parent – should be labeled as the alleged perpetrator/adult subject of report.

Per Ohio CAPMIS (Comprehensive Assessment and Planning Model – Interim System) Screening Guidelines, examples of screened-in reports related to DV as child endangerment are: (1) child receives injury as a result of DV incident; (2) pattern of DV in household and/or child witnesses incident(s); and (3) weapon or threat of weapon used in the DV incident.

When determining **pathway assignment**, CPS should consider:

- Batterer access to children;
- Severity of injuries;
- Access to weapons;
- Lethality factors (e.g., strangulation, harming pets, suicidality, mental health/substance abuse concerns, defiance of community controls like protection orders or probation);
- Chronicity; and
- Vulnerability of the children based on age, presence of a disability, level of dependence on caregivers, severity of harm done to children and non-offending parent, proximity to batterer (and unsupervised time with batterer), and history of DV.

Community partners who want to know more about the process are encouraged to (1) consult the Child Protective Services Worker Manual, found on the ODJFS e-manual website, and (2) set up a meeting or cross-training to learn more about their local CPS agency's screening and decision processes.

SCREENING PRACTICE RECOMMENDATIONS

All reports of child abuse/neglect reported to CPS should be screened for DV – patterns of coercive control by one partner over another – whether or not DV is the original reason for the initial report. The screener should explore the reporter's knowledge of family relationships, issues of power and control, intimidation, threats of harm, or actual harm to any household members or pets, weapons in the home, and threats of suicide or homicide. The screener needs to address lethality and risk factors that result from DV.

Screeners should request the following information from reporters:

- Batterer's relationship to non-offending parent and children;
- Nature of the violence – verbal (yelling, derogatory names, intimidation, threats), physical (hitting, pushing, strangulation, violence against property, people, pets), coercion/control (financial, basic needs of children, medical care), any current or previous use or threat of weapons;
- Children's presence in the home during the violence;
- Children's witnessing or having knowledge of the violence;
- Children intervening or their potential of being harmed during violence;
- Whether violence is current or historical;
- Whether batterer behaviors are isolated or patterned;
- Non-offending parent's ability to protect/specific protective capacities;
- Vulnerabilities of children, such as age, disabilities, development, number of children in the home;
- Informal support system, such as relatives, friends, cultural groups;
- Involved service providers;
- Compounding factors for each partner, including history of victimization/battering, substance abuse, mental health;
- Immediate safety information, including batterer's whereabouts, victim's/children's whereabouts (while protecting victim's confidentiality), batterer's access to victim, batterer's access to weapons, current injuries, safety plans in place, and safety concerns for CPS worker; and
- Knowledge of impact on the child's physical, social, emotional development.

Collateral information can greatly benefit screening decisions but is not always feasible to obtain in a short amount of time, including:

- Law enforcement/criminal records;
- Probation and/or parole involvement;
- Court records, no contact orders, CPO, TPO, active warrants; and
- Summaries of past CPS involvement, such as past allegations, DV/IPV allegations, and past harm.

A recommended sample screening script for DV is included in Appendix H. The Public Children Services Association of Ohio (PCSAO), the ODJFS, and the Ohio Child Welfare Training Program (OCWTP) also have sample scripts and guidelines.

In all cases, CPS should do the following:

- Revise and adopt a screening script that is DV-informed.
- Screen all cases for DV (universal screening).
- Screen all cases for direct child maltreatment, including sexual abuse.
- Identify the batterer as the alleged perpetrator (AP) in the screening decision. The non-offending parent should not be cited for "failure to protect" because of the perpetrator's violence.
- In the case of teenage parents, consider whether or not safety and assessment are enhanced by assigning different caseworkers to the non-offending teen parent and the teen's child.
- Make sure all parties are immediately safe.
- Separate the parties.
- Contact collaterals.
- Document the *Safe and Together*™ model's critical components.

CONTINUUM OF PRACTICES & SERVICES

Assessment: *Process to determine if a child's immediate safety is a concern and, if it is, to identify interventions that will ensure the child's protection while keeping the child within the family or extended family, if at all possible, (a) if child maltreatment has occurred; (b) if there is a risk of future maltreatment and the level of that risk; and/or (c) if continuing agency services are needed to address any effects of child maltreatment and to reduce the risk of future maltreatment. (Child Welfare Information Gateway)*

Protective capacities: *In the context of a DV case, survivors' protective capacities are specific actions taken by the adult survivor to promote the safety and wellbeing of the children. Survivors' protective capacities must be contextualized and assessed uniquely based on the behaviors of the DV perpetrator and the risk the perpetrator poses to children. These capacities can include, but are not limited to: physical or purposeful actions to protect, shield or safe-guard the children from harm; minimizing the exposure and/or impact of parenting strengths and skills; creation and implementation of plans that maintain child safety; emotionally supporting children's healing and wellbeing; providing for children's basic needs; and providing nurturance, love and consistency. (David Mandel & Associates)*

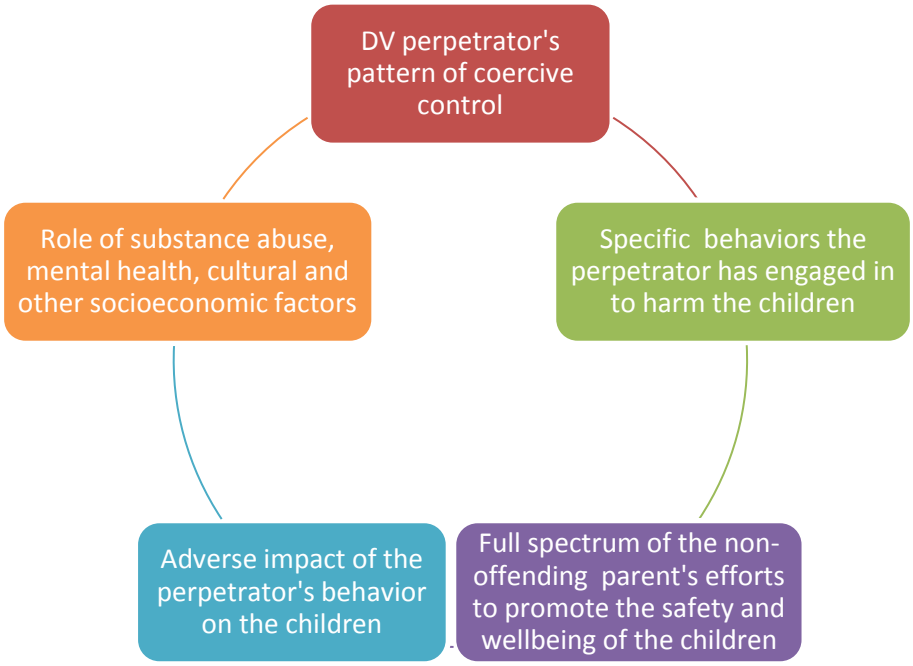
CPS ASSESSMENTS AND THE CRITICAL COMPONENTS

The Family Assessment gives a holistic overview of family dynamics, strengths, areas of concerns, and safety/risk factors, and it helps the agency determine what level of services that family needs. It also helps to determine if the family should remain involved with the agency for a longer period of time until the safety/risk factors are reduced or eliminated.

This section reviews the critical components in light of assessment, and then discusses the importance of DV-informed documentation. Assessors from any agency should be mindful of potential dangers in beginning an assessment with a

family. Ill-timed or poorly planned assessments can further jeopardize survivor and child safety.

Image 3: *Safe and Together*™ Critical Components



The *Safe and Together*™ model critical components (see Image 3) provide a framework to guide formal assessment processes. Below are some ways in which this has been done.

- Implement component-specific screening questions when receiving reports.
- Document critical components in Safety Factor 5 of the Safety Assessment. If a component has no information or impact, document why not.
- Use the critical components as subheadings in your documentation.
- Note children's statements that may fall under one or more components. For example, a child discusses not being able to attend school (adverse impact) because the perpetrator took the car keys from the non-offending parent (control).
- Use the critical components to inform case plans involving adequate supports and efforts to hold batterers accountable.

A number of benefits can result from using the components in these ways.

- Documentation provides a fuller picture of the violence in the home and how each component affects the others.
- Providers testifying in court can state facts within each section of the components to provide the court with a fuller picture of the violence. This can assist greatly when filing a long report as well.
- Batterers are skilled manipulators; use of the components can help keep interviews on track and focused on batterer behaviors and choices.
- Survivors are validated for protective efforts. This can be especially helpful to highlight when batterers pose such a high level of danger that children must be removed despite the survivor's best efforts to protect the children.
- Safety planning and case planning can be more informed.

DETERMINING THE PRIMARY (OR PREDOMINANT) AGGRESSOR

Often, DV allegations are brought against both parents. IPV victims may fight back and be charged with assault. Look beyond the initial incident to assess family dynamics and determine which party is the primary/predominant aggressor. Assess for patterns of power and control in allegations that appear to be mutual violence. Specifically, look for the following:

- Are injuries defensive wounds (e.g., bite marks, scratches)?
- Which partner, if either, is afraid of the other?
- What were the intent and level of the violence? Was it self-defense or intended to punish or retaliate?
- Which partner is effectively exerting control over the other?
- What is the impact of the violence?
- Who historically has been the dominant aggressor, regardless of who the first aggressor was in the current incident?

Some tactics batterers may use with service providers include (adapted from Hamilton County Protocol):

- Presenting as the victim;
- Expressing guilt or remorse in order to avoid consequences;
- Describing the non-offending parent's protective actions as ways to hurt him/herself;
- Presenting as the calm, more stable partner;
- Denying or minimizing abusive behaviors;
- Blaming the non-offending parent for the abuse (e.g., "S/he knew s/he wasn't supposed to do that.");
- Blaming substance use, mental health issues, or stress for the abuse;
- Alleging substance use or mental health issues of the non-offending parent; and/or
- Presenting the non-offending parent's behaviors negatively in order to garner the favor of service providers.

Remember that adult victims commonly claim responsibility for the violence in order to protect themselves, their partners, or both.

Service providers should not make assumptions based on gender stereotypes. For example, do not assume that the more "masculine" partner in a same-sex relationship is the abuser. Instead, and in all cases, look for *behavioral* indicators of battering. The *Safe and Together*™ model can help illuminate biases that may result in our assessments by encouraging the identification of specific behaviors and patterns batterers display, regardless of race, ethnicity, socioeconomic status, sexual orientation, or gender. Providers should look for intent behind behaviors, noting that some behaviors are not controlling in light of cultural or situational factors. Reflective supervision can be a useful tool in checking biases toward clients and avoiding culturally incompetent practice.

ASSESSING A BATTERER'S LETHALITY

A batterer's lethality can be indicated by many factors. Consider the following:

- Patterns of power and control with current/past partners;
- Criminal history;
- Failed community controls and how the batterer responds to authority figures (e.g., law enforcement, probation/parole, CPS);
- Severity of specific behaviors (e.g., spitting, kicking, and pushing are not as lethal as strangling, using or threatening to use a weapon, threatening to kill, abuse during pregnancy, or violence toward the children);
- Stalking;
- Sexual violence;
- Separation or estrangement (often the most dangerous time);
- Access to weapons;
- Loss of employment;
- Severe isolation;
- Restraining, kidnapping, or abducting;
- Escalating behaviors (e.g., previously ensuring no observable marks and bruises but then leaving bruises and being more forceful);
- Untreated mental health and substance abuse, which could potentially lead to a feeling they have less to live for and do not care about their actions; and/or
- Contempt for non-offending parent and children.

Three useful lethality assessment tools are the SARA (Spousal Assault Risk Assessment), the Ontario Domestic Abuse Risk Assessment, and Jacquelyn Campbell's Danger Assessment (see Appendix I).

BATTERERS WHO ARE NOT THE CHILDREN'S BIOLOGICAL PARENTS

Many times batterers are intimate partners of non-offending parents without being biological parents of non-offending parents' children. This should not

change the focus of CPS assessments of safety and risk to the children, the documentation of perpetrators' patterns of coercive control, and the full spectrum of the impact perpetrators' behavioral choices have on the children. Perpetrators' behaviors are *still* the safety threats. CPS should make all efforts to engage perpetrators in voluntary services and consult their legal counsel should perpetrators refuse the services necessary to address the risk they pose to children. It is essential that CPS educate and inform adult survivors of court processes and discuss how such action may impact their safety. When court action is necessary to address the behavioral actions of perpetrators, CPS should document in any court complaints the actions each non-offending parent has taken to protect the children and the continued risk to the children resulting from the perpetrator's pattern of coercive control despite the non-offending parents' protective efforts.

INTERVIEWING

Before beginning assessments, all interviewers should consider safety of the children, non-offending parents, CPS staff, and other providers. Use of collateral contacts and/or reports (e.g., Child Advocacy Center reports, law enforcement records) may help inform safety decisions as well as assessments in general.

A list of suggested questions for children, non-offending parents, and perpetrators can be found in Appendix J. Engagement strategies can be found in Appendix K.

Interviewing Children

Children may feel more secure if their non-offending parent is present during interviews. Interviewers should ask open-ended, trauma-informed questions and assess how safe the children currently feel in the home. Knowing how the children perform socially, academically, physically, and emotionally – as well as their access to supports – will allow interviewers to develop a broader understanding of how the violence has affected the children. (Of course, in a crisis, gathering this information is secondary to responding to immediate safety threats.)

Interviewing Non-offending Parents

Survivor-centric assessments require providers to acknowledge survivors' expertise on their own situations and assess their protective capacities of their children without judgment. Sharing information about the DV may be very difficult for non-offending parents or may seem unsafe. They may fear that they will lose their children and may lack trust in CPS, law enforcement, and courts. They may need time to process their situations, so it may be necessary to slow down the interview. Allowing non-offending parents to have a support person with them during the interview – as well as validating their actions to protect their children – can help. Interviewers should interview non-offending parents apart from batterers, inform them about who else will have access to information that is shared, and discuss the limitations of confidentiality. Open-ended and strengths-based questions should be used. Language, tone, and body language that appear to blame the non-offending parents for the battering will likely make partnering and engagement even more challenging. Non-offending parents are the ***best*** sources of information about their situations; still, listening for patterns of minimization, resulting from batterers' control tactics, may be helpful. *Minimization or seeming "lack of cooperation" may be a survival or protective strategy or trauma reaction that requires sensitive, trauma-informed responses.*

Sometimes non-offending parents recant allegations, which can be incredibly frustrating to providers trying to help them. However, providers should *not* assume that non-offending parents are just "being difficult," that they were lying initially, or that they do not understand how to be in healthy relationships. Rather, consider the reasons for which they might be recanting (e.g., fear, safety, wanting a second parent for their children, harmful responses by systems in the past, immigration status, concern about shaming their families, community isolation, finances). These reasons may also prevent non-offending parents from calling law enforcement or cooperating with prosecutors. Providers need to reflect on the question, "If put in the position of this parent, with these barriers, might it make sense to take these actions?"

Interviewing Batterers

For safety purposes, service providers who are not law enforcement should be supervised when interviewing batterers. The batterer's previous criminal history, access to weapons, threatening behavior, and stalking tendencies are all great indicators of the batterer's level of danger. Additional tips are listed below.

- Interview batterers and non-offending parents separately.
- Introduce child welfare concerns in a non-judgmental, respectful manner.
- Do NOT share information learned from other interviews.
- Recognize any minimizing, denying, or victim-blaming as tactics to escape responsibility for the violence. Do NOT engage in discussions with the batterer that blame the victim for batterer behaviors.
- Focus the interview on known facts from police reports, medical reports, probation records, or witnesses.
- Focus the interview on the impact of the DV on the children. Ask the batterer about the children's doctors, teachers, and interests. This may reveal deficits and/or motivations to change.
- Look for patterns of power and control in the batterer's relationships.
- Discuss with supervisors in advance what information you are required to share and withhold. You may decide that specific information (e.g., non-offending parent's location) may be dangerous to share with the batterer.

Defense attorneys will likely advise batterers not to talk with CPS. Regardless, CPS can use collateral contacts and information that they otherwise would have sought from batterers.

"Accountability and Connection with Abusive Men" by F. Mederos contains useful information on how to hold batterers accountable.

DOCUMENTATION

The importance of documentation cannot be overemphasized, especially in child welfare cases with IPV components. Intentional, accurate documentation can mean the difference between child safety and child endangerment. The tips

below are strongly encouraged in the *Safe and Together*™ model and in good practice generally for all service providers. See Table 3 for specific tips on documenting the critical components of the *Safe and Together*™ model.

Table 3: Documenting Critical Components

Critical Component	Example
Perpetrator's behaviors, noting any patterns observed	*Mr. S. threw a chair at Mrs. S. Mr. S. often hides the car keys so Mrs. S. cannot leave when he becomes violent.*
Perpetrator's actions to harm the children	*Mr. S. threw a chair at Mrs. S., which hit Tommy when he stepped in front of Mrs. S. Tommy fractured his collarbone as a result.*
Non-offending parent's efforts to protect the children	*Mrs. S. told Tommy to go to his room before Mr. S. started throwing things. Mrs. S. comforted Tommy as they drove to the emergency room.*
Impact of perpetrator's behaviors on the children	*Tommy was crying when Mr. S. threw the chair at Mrs. S. He runs inside the house when Mr. S. comes home from work, and his grades have been slipping ever since Mr. S. started yelling at Mrs. S. and throwing things.*
Role of substance abuse, mental health, culture, and socioeconomic factors	*Mr. S.'s physical violence – throwing things, hitting Mrs. S. – escalates when he gets intoxicated on weekends.*

General Documentation Tips

CPS staff should consult their agency's legal counsel about permissible ways to document safety plans and other information that could endanger non-offending parents and children if viewed by the batterer. Two examples of agencies addressing this concern are (1) documenting safety plans in areas that are not mandated to be released, such as supervisor conference notes, and/or (2) including language in documentation that reads, "The following information must be redacted from all records released due to significant safety concerns."

- Be specific. **Who did what to whom?** Use details, facts, and quotes. Write down explicitly any derogatory names or words used. If you are a first responder, what did you find at the scene?
- Note the children's and survivor's reactions.
- Note the perpetrator's demeanor, behavior, and statements.

- Document the critical components, as described in Table 3.
- Note any evidence of trauma that may be linked to the violence.
- Focus on non-offending parents' strengths.
    - Example: "Ms. Smith has been able to get out of two violent relationships," versus "Ms. Smith keeps getting into violent relationships."
- Avoid language that shifts accountability *for the DV* from the perpetrator to the non-offending parent, such as:
    - Language that raises doubt (e.g., alleges, claims, denies);
    - Descriptions of DV as a couple's issue (e.g., domestic dispute, relationship problem, "parents deny the violence");
    - Legal terms (e.g., assault, battery);
    - Descriptions without mention of the batterer (e.g., "Mrs. Smith hit her head"); and
    - Irrelevant, unnecessary, or damaging information (e.g., "Mrs. Smith has a history of prostitution").

CONTINUUM OF PRACTICES & SERVICES

Safety, as defined by CPS: *For all children assessed, there are no active safety threats present, or protective capacities of the family are controlling any identified safety threats.*

This protocol will distinguish between CPS safety plans and DV safety plans as described in this section. CPS staff and other providers must consider their own safety when working with families and develop exit strategies in case a situation goes awry. As mentioned previously, CPS staff should consult their agency's legal counsel about permissible ways to document safety plans and other information that could endanger non-offending parents and children if the plans are viewed by the batterer.

When creating or supporting CPS and DV safety plans, all providers should remember:

- CPS and DV safety plans have important differences.
- Trained DV providers are best qualified to assist survivors in developing DV safety plans.
- Leaving is not always the safest strategy nor does it guarantee the violence will stop. In fact, level of danger is greatest when non-offending parents leave abusive relationships. Safety planning can occur and be useful even in the context of staying.
- Legal options may not be safe options.
- Survivors may not always identify their biggest concerns immediately.
- Every action has consequences for adult and child survivors.
- Any option may result in an escalation of violence.

- Safety planning should accommodate the unique needs of diverse groups of people. As examples, LGBTQI survivors may fear being "outed," immigrants may fear being deported, and people with developmental delays may have difficulty accessing CPOs.

CPS SAFETY PLANS

CPS safety plans are specific, concrete, and short-term strategies for controlling threats of serious harm to children or supplementing protective capacities, which CPS implement immediately when families' protective capacities are not sufficient to manage immediate and serious threats of harm. (Refer to ODJFS policy 4.03 CAPMIS Safety Planning.) They must include provisions to control batterer behaviors that threaten the safety and wellbeing of the children. Non-offending parents' input is critical to ensure safety plan activities actually promote safety instead of posing additional harm. CPS and DV service providers benefit from working together in this process.

DOMESTIC VIOLENCE SAFETY PLANS

In contrast, **DV safety plans** are continually evolving strategies and tactics to ensure the safety of survivors and their children by analyzing the situation and available resources. Skilled DV advocates generate DV safety plans in partnership with adult survivors and their children (when developmentally appropriate). Survivors know their situations best and have a sense of whether or not batterers will follow through on threats. Safety planning must encourage and respect the choices survivors make. This helps to reinforce their autonomy and empower them with the understanding that they can successfully live outside the violent relationship. DV programs are *not* supposed to impose restrictive conditions on survivors in order to receive services (e.g., seeking an order of protection, attending counseling, calling law enforcement).

The Ohio Domestic Violence Network offers a set of Safety Planning Standards on its website www.odvn.org, which can assist in identifying providers qualified to safety plan with survivors. DV safety planning can be an excellent opportunity for CPS and DV advocates to partner for the safety of their clients.

When generating DV safety plans, DV advocates and survivors:

- Identify and analyze the risks generated by the batterer (e.g., abusive behaviors, direct abuse of and impact on children, loss of legal status);
- Identify life-generated risks (e.g., employment, finances, housing);
- Complete a risk review in which DV advocates seek to understand the survivor's perspective, check their own perspective, and try to form a shared perspective;
- Explore a victim's strengths, resources, options, and potential consequences; and
- Develop a mutual understanding of the plan and steps for implementation.

SAFETY PLANNING WITH CHILDREN

Safety planning with children requires unique skill and considerations. It can increase safety and provide children with a sense of preparedness, empowerment, and relief. When possible, providers trained in child safety planning should work with non-offending parents and their children to develop, practice, and update child-specific safety plans to include strategies for physical and emotional safety. Children need to be reassured that the violence is not their fault, that they are not responsible for stopping the violence and should not intervene in violent incidents, and that they are not going to be in trouble if they cannot complete the safety plan as practiced. Consider the following when safety planning with children:

- What are the child's feelings about the violence?
- What is the child's comfort level with safety planning?
- Are the strategies age-/developmentally/culturally appropriate?
- Is the child able to recognize violent or unsafe behavior?
- What role does this child play in the family (e.g., hero, target, caregiver, comforter, extrovert or introvert)?
- What kinds of strategies would this child be most comfortable using?
- Is this child comfortable and safe leaving the situation to seek help?

- Consider places, times, and circumstances that could increase danger (e.g., unsupervised visitation, custody exchanges, activities away from the home, going to and from school, or where isolated from others).

Useful points to make with children include these examples:

- "[Batterer's behavior] is not okay, but you are not responsible for fixing it."
- "How are you feeling?" Listen for anxiety, feelings of being overwhelmed, resentment, fear, reassurance, and encouragement.
- "Help is available; how can I help?"
- "Does anything worry you? It is okay to talk about it."
- "What do you think would work best for you?"

Here are some sample strategies for children that could be used in safety plans, depending on their situation.

- Practice multiple escape routes.
- Leave safely and designate a meeting place.
- Prepare a "jump bag" (e.g., cash, treats, comfort item, eyeglasses, medications, phone numbers).
- Avoid batterer and retreat to safer rooms or hide (if safe to do so).
- Lock doors.
- Call or signal for help (i.e. 911, neighbors, trusted and helpful adults).
- Practice self-soothing or calming techniques.
- Pretend to sleep.
- Stay close to others.
- Use code words and signals (e.g., flash lights, pound on common wall/floor/ceiling).

CONTINUUM OF PRACTICES & SERVICES

Case plan: *A set of action steps agreed to by the service provider/agency and family that sets expectations for behavioral changes.*

CASE PLANNING WITH BATTERERS AND FAMILIES

Special considerations must be given to case planning with families experiencing IPV. There is no "one size fits all" plan or recommendation to achieve resolution. These case plans need to be:

- Safety-informed (Could any aspect of the case plan jeopardize non-offending parent and/or child safety?);
- Trauma-informed (Are case plans for non-offending parents appropriate given any trauma they and their children may suffer?);
- Accountability-oriented (Do case plans place full responsibility for ending the violence on the batterer?);
- Matched with appropriate services and/or referrals (Are batterers referred to services that hold them accountable for behavior changes?); and
- Culturally competent (Are families linked with services in which interpreters may be made available?).

If the batterer is not a custodial parent or caregiver of the child(ren), the case plan should still follow these guidelines.

Safety-informed Case Plans

Safety tips related to case planning are listed below.

- Separate case plans for batterers and non-offending parents are ideal (1) to address different expectations providers should have of the batterer and of the non-offending parent and (2) to protect the non-offending parent from

possible batterer retaliation. In high-risk cases, batterers should not have access to non-offending parents' case plans because this may provide them with a means of stalking the non-offending parents.

- If it is not possible to create a separate case plan for each partner, then ask non-offending parents if adding redundant items to their case plan would help or hurt them (e.g., "Ms. Smith will continue to take the children to school every morning.").
- Do NOT make non-offending parents the sole enforcers of case plans. They may be responsible for their own actions but not those of batterers.
- If necessary, say to batterers, "This case plan is based on *my* assessment," so as to deflect batterer retaliation away from non-offending parents.

To maintain safety and create stability, it is critical to (1) enlist non-offending parents' ideas on what would promote safety in this family and (2) engage and assess the batterer from the beginning of the process.

Trauma-Informed Case Plans

Parents who are involved in the child welfare system often have childhood as well as adult trauma histories, which may have gone untreated. As the National Child Traumatic Stress Network (NCSTN) explains,

> "Traumatic events in childhood and adolescence can continue to impact adult life, affecting an adult's ability to regulate emotions, maintain physical and mental health, engage in relationships, parent effectively, and maintain family stability. Parents' past or present experiences of trauma can affect their ability to keep their children safe, to work effectively with child welfare staff, and to respond to the requirements of the child welfare system."

CPS and other providers are advised to use a trauma-informed approach to case planning with families experiencing IPV. The basic premise of trauma-informed approaches is that psychological trauma impacts the beliefs, emotions, feelings, and behaviors of individuals. Providers must be aware of psychological trauma(s) individuals may have experienced and have an understanding of how this trauma

affects them. Not having an understanding of the effects of trauma could result in inaccurate diagnoses and treatment, secondary trauma, and inappropriate or harmful recommendations for batterers, non-offending parents, and children.

Accountability-oriented Case Plans

DV perpetrators are solely responsible for child safety concerns related to the DV. Case plans must reflect batterer accountability regardless of batterers' relationships to the children. Batterers may be co-parents or otherwise still involved in a relationship with non-offending parents, so planning for safety and stabilization needs to recognize and proactively address this reality without blaming or placing undue pressure on the survivor. A dual focus on holding batterers accountable and motivating change is needed. Case plans should include CPS and other providers' expectations for behavioral change on the part of batterers. Providers need to remember that services do not necessarily lead to behavior changes. Very specific case plan requirements should be used for batterers (e.g., "Mr. Smith will return the family car in full operating condition to Mrs. Smith so she can take the children to school.").

Case Plans Matched with Appropriate Services and Referrals

For Batterers. Studies have shown that batterer intervention programs (BIPs), when following best practices, are the most effective intervention for perpetrators of domestic violence. If a BIP is not available, other means of effective intervention could include, but are not limited to: the use of probation, cross-system accountability measures, and courts. Case plans may include measures of behavioral change on the part of the batterer. See Lundy Bancroft's *Assessing Batterers Risk of Harm to Children* for examples.

Batterers may have substance abuse and mental health issues, which should be addressed at the same time the DV is addressed. Remember that substance abuse and mental health issues are not causal factors as to why a batterer is violent; however, they create additional layers of complexity in DV cases and can further threaten child safety. See Table 4 for examples of recommended services for batterers.

For Non-offending Parents. Appropriate services and/or referrals must reflect the individual needs of non-offending parents and allow them to exercise their right to make decisions about their relationships in the context of their life, culture, and assessment of what is best for their children. Focusing on voluntary support systems may be helpful when case planning with non-offending parents. Providers or CPS workers utilizing survivor-centric practices do the following with non-offending parents:

- Attempt to understand their needs, resources, perspectives, and cultures;
- Build a working relationship or partnership;
- Share resources and knowledge;
- Respond compassionately;
- Foster maximum self-determination of non-offending parents;
- Accept their stories without judgment; and
- Respect their right to confidentiality and privacy.

With this approach, non-offending parents are more likely to engage in planning and services. This is critical for safety because non-offending parents know best their abusers' cycles, triggers, and when to take threats seriously. Providers are more likely to gather more complete information and be more effective.

Non-offending parents may need to (re-)establish routines in order to create and sustain safety for themselves and their children. Communities frequently may meet non-offending parents' needs for shelter or advocacy, but the availability of therapeutic services is frequently a critical gap. Sometimes the non-offending parent may have co-occurring substance abuse or mental health issues. When this occurs, service provision should include a thorough assessment of the impact the trauma of the DV has on any substance abuse or mental health issues. See Table 4 for examples of recommended services for survivors.

For Children. Following a traumatic event, children need a sense of normalcy, including educational stability, the support of their peer group, and an opportunity to return to the routines and structure of daily life. Linkages to services are not appropriate in all cases and need to be grounded in a holistic and

integrated assessment with parent and child. Some children may not need any services but only need for the battering to stop. See Table 4 for examples of recommended services for children.

For more resources on evidence-based practice in IPV cases or trauma-informed care, visit www.dvevidenceproject.org or www.odvn.org.

Family Violence Option Waiver. Especially in families with CPS involvement, service providers should ensure that families experiencing DV receive resources that may be helpful in mitigating risk. Non-offending parents and children exposed to batterers may benefit from the Family Violence Option (FVO) Waiver available through Temporary Assistance to Needy Families (TANF), as described below.

> "Ohio has adopted a domestic violence waiver program in accordance with the provisions set forth in 42 U.S.C. § 402(a)(7). The program became effective January 1, 2008, and includes the federal definition of domestic violence. Ohio's domestic violence waiver program includes universal notification, screening, referral and waiver of certain program requirements...Waiver of OWF/TANF eligibility requirements is possible if cooperation or compliance with the eligibility requirement would make it more difficult for the individual to escape the domestic violence or unfairly penalize the individual. OWF eligibility requirements that may be waived due to domestic violence include cooperation with the child support enforcement agency, participation in a work activity, and time limits for receipt of TANF cash assistance."

The FVO Waiver temporarily excuses the non-offending parent's work requirements and child support cooperation, and it extends the 36-month time limit for Ohio Works First cash assistance. CPS and other providers should screen carefully for a family's suitability for the FVO Waiver.

Table 4: Recommended Services for Batterers, Children, and Survivors

Batterers	Children	Survivors
Batterer intervention programs (BIPs) meeting standards (see Section IV)	Trauma-informed assessments and interventions	Referrals to DV programs for voluntary services, such as safety planning, legal advocacy, financial literacy, and individual and/or group support
Probation, court directives, and supervision	Visitation centers (if appropriate)	DV shelters meeting ODVN standards, housing
Parenting classes (if appropriate)	Multi-modal treatment approaches (i.e. combining more than one type of treatment, such as individual, family, and advocacy services)	Civil protection orders *if the survivor thinks one will increase safety (CPOs should* **not** *be mandated.)*
Substance abuse and/or mental health treatment, if needed, to be undergone *during* BIP intervention (Note that substance abuse and mental health issues do NOT cause batterers' coercive, controlling behaviors.)	*For information on specific, evidence-based practices, see the U.S. Department of Justice and U.S. Department of Health & Human Services "Evidence-Based Practices for Children Exposed to Violence: A Selection from Federal Databases."*	Trauma-informed assessments and interventions, substance abuse and/or mental health treatment if needed

These services should NOT be used with batterers:

- *Anger management (for batterer only): Batterers do* not *batter their partners because of an anger problem. If anger were responsible, then batterers would treat other people the same as they treat their partners. Requiring batterers to attend anger management does not hold them accountable for their coercive and controlling behaviors and may even teach them more effective ways of hiding or excusing their battering.* ***See Appendix L for a comparison of anger management and BIPs.***
- *Couples counseling (for batterer and non-offending parent): Survivors are not responsible for their partners' behaviors. Couples counseling fails to place entire accountability on batterers and provides them an outlet to further victimize their partners through a counseling professional.*
- *Mediation (for batterer and non-offending parent in criminal cases): Mediation places responsibility and negotiation power on both partners, rather than holding batterers fully accountable for their coercive and controlling behaviors. It can also be used as a means through which batterers can further manipulate and victimize their partners. In contrast, some adult survivors may find mediation more empowering than litigation. Mediation may be used with extreme caution and skilled facilitation in some cases.*

Culturally Competent Case Plans

The fifth critical component considers how culture may impact the tactics a batterer uses against adult and child victims, protective capacities of the non-offending parent, and the impact of the batterer's behavior on the child's wellbeing. While historic oppression may also impact help-seeking behaviors of non-offending parents (e.g., calling law enforcement in communities of color), culturally identified supports may positively impact safety, trauma recovery, and batterer accountability. See Appendix E for LGBTQI-specific information and Appendix G for cultural competency guidelines.

FAMILY TEAM MEETINGS

Family Team Meetings (FTMs) are excellent ways to include families in decisions regarding their children's safety and wellbeing. Often, family members are more invested in case plans and goals when they have taken an active role in developing them. (Providers should be aware, however, that including batterers and non-offending parents in the same FTM is ill-advised and may facilitate batterers' control over their partners, preventing non-offending parents from providing their input.) At FTMs, non-offending parents may benefit from inviting support people, such as a domestic violence advocate, lawyer, family, or friends. Children's developmental ages may be important in determining whether or not they, too, should attend. FTMs encourage participants to identify supportive individuals or family members to assist with safety planning and monitoring or to serve as placement options for children if needed.

PARTNERING WITH OTHER PROVIDERS

Families with DV and open cases in CPS are often involved in other systems as well. Case planning is an ongoing process requiring regular communications among CPS, other service providers, and families. It is important to inform all providers in the case plan of their respective roles and to negotiate those roles as necessary. An exchange of report templates can be helpful to service providers and to CPS workers so that they know the type of report to expect. Discuss with service providers and partners in advance the questions listed below.

- What information do you need and when?
- What are the criteria for services?
- What confidentiality rules (HIPAA or VAWA) accompany these services?
- How will you determine service effectiveness in children? In adults?
- How will you monitor client progress or regression?

Discuss with service providers and partners the questions below related to each individual family.

- What barriers exist for this family with this service?
- Is the client progressing or regressing? How do we know?
- Is the violence continuing (physical, emotional, financial, other)?

Team Decision-making. Community partners may wish to practice team decision-making (TDM) to enhance interagency collaborations when responding to families experiencing DV. TDMs are meetings in which CPS and other providers come together with the family they are serving to make decisions regarding a case. According to the Family to Family Project of the Annie E. Casey Foundation, eight essential elements contribute to successful TDMs:

- Teamwork;
- Consensus;
- Active family involvement;
- Skillful facilitation;
- Safety planning;
- Strengths-based assessment;
- Needs-driven services; and
- Involvement of the community into long-term support networks.

Providers may consult http://aecf.org for more information.

Warm Handoffs. Families are less likely to follow through on referrals when the referring provider gives them a name and number to call on their own. For more successful referrals and as a family engagement strategy, providers can make the referral connection *with* the family. This does not mean that providers do the work for the family. Rather, providers can sit with the family while making a call or walk the family down the hall to a referral's office. This is referred to as a warm handoff and can make families' navigation of complex systems less intimidating.

CLOSING A CASE

Families experiencing DV require special considerations prior to CPS closing their case in order to promote safety. When appropriate, CPS should:

- Link to services;
- Help the non-offending parent think of additional ways to protect the children;
- Safety plan (see guidelines in Safety Planning section);
- Determine how to communicate case status to the batterer and collaterals;
- Minimize information given to the batterer; and
- Invite the non-offending parent to reach out to CPS if future help is needed.

REMOVALS

Removal should be the option of last resort in child welfare cases, especially cases involving DV. Promoting safety and stability for children by supporting a nurturing relationship with non-offending parents is ideal. When all efforts to maintain child safety with non-offending parents have been exhausted, court action for children's removal may be necessary. In DV cases, the decision to remove children is *not* the fault of non-offending parents. It is important to discuss this with non-offending parents and to document accordingly. Ideally, non-offending parents will partner in this decision given their desire to keep their children safe.

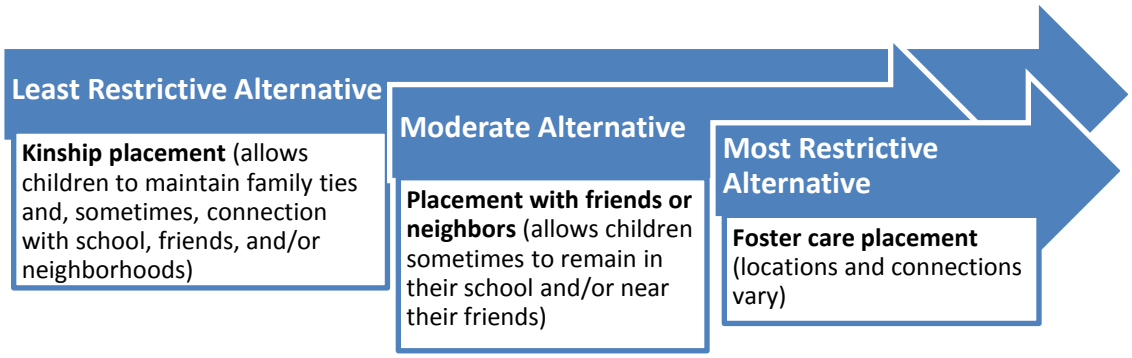
> **Example documentation:** *"Despite Mrs. Smith's best efforts to protect the children, Mr. Smith is creating conditions that are a safety threat to the children."*

Oftentimes removal may be necessary due to multiple safety threats at once. Though non-offending parents are *not* responsible for effects of any coercive control exerted over them and their children, they are still accountable for any abusive or neglectful parenting choices they make apart from the DV.

CPS may consider a number of options when placing children, as seen in Image 4. Ideally, least restrictive alternatives, such as placement with a relative, are

explored before children are placed in foster care. Any placements with kin, friends, or neighbors should be assessed for safety and batterers' accessibility and influence. (For example, CPS should not place the children with the batterer's parents if this increases the batterer's access and minimizes the non-offending parent's access.) Other assessment considerations include support for the children, mental health concerns and any trauma associated with the DV, financial stability, and ability to support visitation, among others. CPS may support child healing by keeping siblings together if at all possible.

Image 4: Placement Options



Technically, Ohio law does *not* require courts to terminate both parents' rights; however, there is no precedent in Ohio for doing that. Until there is a precedent, the only advisable actions are to (1) document thoroughly per the recommendations given in the subsection on documentation and (2) create separate case plans for batterers and non-offending parents.

Children may be returned to one or both parents following a removal, may continue to live in foster care, or may find themselves available to be adopted after termination of parental rights. Whatever happens, parents and children should have the opportunity to process what is happening, understand why it is happening (e.g., safety re-established at home, continued safety threats posed by batterer), and receive appropriate services as needed.

VISITATION

Visitation is a critical element in case planning when children are out of the care

of one or both parents. Contact with the non-offending parent and siblings keeps children connected to their families and aids the reunification process. Ideally, visitation with the non-offending parent should occur as frequently as possible or permitted. (Often, due to scheduling and volume, visitation is more restricted when held at a visitation center or when the CPS worker is the visitation supervisor.) Safety and wellbeing of all involved are paramount when developing visitation plans. Specific details to address are determining a visitation site, the level of supervision needed, how to accommodate visitation with the batterer (if appropriate), and safe exchanges.

Visitation with batterers may be contingent upon court orders (e.g., CPO, court-ordered visitation for batterer) and should be supervised, at least as long as the batterer continues to pose risk to the children and uses manipulative, controlling tactics on the children. Batterers and non-offending parents should have separate visits, even in cases where the adults remain in a relationship or cohabitate.

When coordinating visitation for batterers, visitation supervisors must have an understanding of DV and be apprised of pertinent information regarding the batterers' tactics (e.g., intimidation, coercion, threats). Visitation supervisors must also be aware of any other concerns regarding batterers, including substance abuse and mental health issues. These factors may affect arrival, entry, parking, and other considerations related to child and non-offending parent safety. Visitation centers should provide CPS ongoing information, observations, documentation, and progress reports for each visit.

Visitation may need to be terminated if:

- The safety of the children or non-offending parent is compromised;
- The batterer attempts to use tactics previously used against children;
- A new court order prohibits contact; or
- A service provider makes a therapeutic recommendation that the visits be stopped or temporarily suspended due to the emotional health of the child. This may necessitate a court filing if visitation is court-ordered.

Section IV. Community Partners

This section applies the *Safe and Together*™ model to different systems partners and addresses needs and expectations CPS may have of these partners.

BATTERER INTERVENTION PROGRAMS

CPS and other providers must thoroughly review batterer intervention programs (BIPs) before making referrals. BIPs and referring providers should discuss what types of batterers are most appropriate for a BIP and general eligibility criteria. Batterers can change, but it is unlikely they will stop the abuse on their own or without professional help. Batterers are accustomed to getting what they want through abuse. The power and control gained from their behaviors are often more appealing than the idea of giving them up. However, the idea of losing their relationships with their partners and/or children motivates some batterers to change. The following is a checklist by Lundy Bancroft (2007) specifically for assessing change in men who abuse women:

- Admitting fully to what he has done;
- Stopping excuses;
- Stopping all blaming of her;
- Making amends;
- Accepting responsibility (recognizing that abuse is a choice);
- Identifying patterns of controlling behavior, admitting their wrongness;
- Identifying the attitudes that drive his abuse;
- Accepting that overcoming abusiveness will be a decades-long process, not declaring himself cured;
- Not starting to say, “so now it’s your turn to do your work,” not using change as a bargaining chip;
- Not demanding credit for improvements he has made;
- Not treating improvements as chips or vouchers to be spent on occasional acts of abuse (e.g., “I haven’t done anything like this in a long time, so why are you making such a big deal about it?”);

- Developing respectful, kind, supportive behaviors;
- Carrying his weight;
- Sharing power;
- Changing how he is in highly heated conflicts;
- Changing how he responds to his partner's (or former partner's) anger and grievances;
- Changing his parenting;
- Changing his treatment of her as a parent;
- Changing his attitudes towards females in general; and
- Accepting the consequences of his actions (including not feeling sorry for himself about those consequences, and not blaming her or the children for them).

BIPs in compliance with the Ohio Domestic Violence Network's (ODVN's) BIP Standards – and in alignment with the *Safe and Together*™ model – must:

- Be at least six months in duration;
- Follow written curricula nationally recognized as best practices (consult ODVN for more details);
- Be open to feedback from local DV programs (including shelters);
- Have a coordinated community response (hold positions on boards, councils, committees focused on addressing DV issues);
- Welcome service providers to observe groups; review curriculum, policies, procedures; and/or offer constructive criticism;
- Have batterer accountability as the foundation of the program and refute victim blaming;
- Provide written documentation to referral sources regarding program compliance, and/or testify in court;
- Refuse to provide anger management, couples counseling, or mediation, in lieu of batterer intervention; and
- Terminate non-compliant individuals in a timely way, and inform the referral source.

For batterers who also have problems with substance abuse, it is ideal for both treatments (for the DV and for the substance abuse) to occur simultaneously. Dealing with IPV should not be delayed due to substance abuse treatment.

Most batterer intervention programs charge a fee. The fees vary based on programs. Typically, the batterer should be responsible for the payment of services, as this promotes accountability. Still, when assessing financial means, there may be other considerations, such as: indigence; under employment or no employment; burden on non-offending parent and/or children; and/or delay in receiving services, resulting in heightened risk to family. Each community should evaluate based on resources (e.g., Families can only afford $20 or less).

Options are available if the immediate area does not have a good BIP.

- Neighboring counties oftentimes have programs that will accept referrals.
- ODVN maintains a statewide database of BIPs and can provide general information about each.
- If there are not any viable programs in the area, a counselor trained on DV could be considered to provide individual counseling. ODVN has offered technical assistance to counselors working with batterers.
- This protocol's Case Planning section offers alternatives to BIPs.

Appendix L contrasts BIPs with anger management. Appendix M contains additional information on BIPs, particularly relating to marginalized communities.

COURTS AND LEGAL PROFESSIONALS

> ***"Judges play a leadership role in ensuring that the court sends a consistent message that domestic violence will not be tolerated. This can be accomplished by implementing processes and practices that are culturally appropriate, account for perpetrator manipulation and monitor compliance. Judges should not allow proceedings to become a manipulative tool for the perpetrator."***
> *~ The Checklist to Promote Perpetrator Accountability in Dependency Cases Involving Domestic Violence, NCJFCJ*

Court Responses

All courts should understand victim behavior in the context of the court, recognizing that less than half of all victims report abuse to the police; that many victims recant, minimize, or deny what happened; and that victims often lack documentary evidence of their abuse. Additionally, courts must understand dynamics of domestic violence (DV) and the victim and the batterer in the context of parenting. Courts must determine the DV perpetrator's parenting capacities (or lack thereof), taking into account whether the batterer admits the abuse and works to change, has a desire to improve parenting skills, and can be redirected to focus on the needs of the children rather than on controlling the victim.
Any proposed caretakers for the child, including relatives or foster parents, should be assessed for child maltreatment, criminal history of violence, DV, substance abuse, and willingness to work with the court, social service agencies, and non-offending parents concerning the needs of the children (NCJFCJ, 1998).

Courts should consider the experiences of the non-offending parent's victimization when introducing case plans and reunification plans, recognizing that such plans should be established as soon as possible. It is important to make certain that non-offending parents' plans are not burdensome or bound for failure. Separate case plans must be developed to address child and victim safety.

Juvenile judges and professionals in the juvenile court system must be aware of related court proceedings and agencies that work with the courts, so as to coordinate court proceedings, such as civil protection orders, criminal proceedings, and domestic relations/family court matters. All members of the

court system should adopt practices for managing cases involving child maltreatment and DV. When sharing information, caution must be taken not to share the location of the non-offending parent and children. Courts should also promote the use of victim advocates to aid the non-offending parent in navigating the court system and encouraging input in the development of case plans.

Juvenile courts have unique and influential tools at their disposal to hold batterers accountable. They can shift expectations for behavioral change from non-offending parents to batterers and, thus, help keep children and non-offending parents safe. Some tools to consider include:

- Crafting parenting plans best suited to protecting children and non-offending parents, including safe exchanges and visitation locations;
- Identifying service needs that support the safety, wellbeing, and stability of children and non-offending parents;
- Appointing a GAL or CASA with experience working with DV and CPS;
- Appointing separate attorneys for each parent;
- Using (*not mandating*) civil protection orders (CPOs), depending on their appropriateness and effectiveness in each individual case;
- Asking CPS and service providers to identify batterer's specific behaviors;
- Ordering batterers to complete batterer intervention programs that meet standards (see Section IV on Community Partners, BIPs);
- Using probation or parole to monitor behaviors;
- Requiring batterers to make behaviorally specific changes as part of court/case plans; and
- Using cross-systems accountability measures.

Anger management and couples counseling are *not* appropriate interventions in DV cases. Mediation may be ill-advised depending on the case because batterers can use mediation to further control and manipulate non-offending parents. (See Section IV and Appendices L and M for more information on batterer interventions.) Any programs ordered by the court must be tracked for compliance of any parent ordered to participate in such services. Batterers should

not be released from these obligations until (1) the behaviors have stopped and (2) they can articulate the impact their behaviors have had on the children.

All court interventions should give careful consideration to the critical components of the *Safe and Together*™ model:

1. Batterer's pattern of coercive control;
2. Specific behaviors the batterer has engaged in to harm the children;
3. The full spectrum of the non-offending parent's efforts to promote the safety and wellbeing of the children;
4. The adverse impact of the batterer's behavior on the children; and
5. The role of substance abuse, mental health, cultural, and socioeconomic factors. (All courts are required to provide access to interpreters under Title VI of federal law.)

Specifically, courts should work with child welfare agencies (CPS) to determine how the batterer's behaviors harm a specific child and the adverse impact these behaviors have on a particular child. Courts should prioritize removing an abuser rather than a child from the non-offending parent (Edleson).

In determining whether courts should remove the child from the non-offending parent, courts should consider the non-offending parents' willingness to seek help, parenting skills, and use of safety factors. Courts should also consider the child's age and developmental stage; positive relationships with the non-offending parent, siblings, other family members, and neighbors; and any actions they have taken during the violence that might put them in danger. Courts should only remove children from non-offending parents when the batterers' behaviors are so dangerous that the non-offending parents' best efforts to protect the children will not sufficiently mitigate risk.

<u>In all DV cases, courts should do the following</u>:

- Consider potential safety threats that could result from various court actions. Judiciously protect adult and child victims' information from batterers' access.

- Permit victim advocates to accompany non-offending parents to court if they wish.
- Focus expectations for behavioral change related to the DV and court orders on the batterer, not the non-offending parent.
- Mandate or refer batterers to a local batterer intervention program (BIP). If no BIP is available, consider other strategies, such as those listed above, in holding them accountable and keeping families safe.
- Listen to non-offending parents' and children's concerns related to any particular course of action.
- Create clear, detailed visitation guidelines that allow for safe exchanges and safe visitation spaces.
- When possible, collaborate with custody evaluators, CASAs, GALs, DV advocates, culturally specific providers, and others who have expertise in domestic violence best practices. Consult the Greenbook and NCJFCJ for additional cross-collaboration resources.
- Be prepared to support pro se litigants, as self-representation is becoming increasingly common among non-offending parents and batterers. ODVN has thorough resources on this topic.

Attorney Resources

Attorneys *appointed for the parties* in a DV case should:

- Have an understanding of DV dynamics;
- Consider the impact of historical and on-going violence on children and non-offending parents;
- Understand the type, intensity, and duration of the exposure;
- Assess for co-existing adverse factors as well as protective factors;
- Consider safety risks to the non-offending parent and children; and
- Attempt to differentiate DV from high conflict. (DV is characterized by a pattern of coercive control exerted by one partner over another. See Section I for a more complete definition of DV.)

All attorneys should:

- Routinely screen for DV;
- Identify the non-offending parent and the batterer (see section on Determining the Primary Aggressor); and
- Assess for coercive control, lethality and dangerousness (see Appendix I for Jacquelyn Campbell's Dangerousness Assessment), imminent danger, risks the DV creates for the children, and parenting ability of each parent. (See Jacquelyn Campbell's Dangerousness Assessment in Appendix I.)

All attorneys should be able to answer the following questions:

- What are the immediate safety risks to the non-offending parent and the child? What future safety risks does the DV create?
- What is the specific pattern of assaultive and coercive tactics used by the batterer? To what degree does the batterer use and enforce these behaviors?
- What are the specific risks to the victim or child posed by the batterer?
- What are specific risks to the parenting ability of the non-offending parent?
- What are the non-offending parent's and child's protective factors specific to the DV?
- What co-occurring disorders exist for either parent?

Additionally, attorneys should be able to differentiate child abuse from parental discipline and reasonable corporal punishment. They should understand that not all DV exposure is the same nor does all DV exposure place a child in great risk of harm requiring social interventions. Attorneys have a duty to understand that there is great variability in children's experiences with DV. The impact on a particular child may be based on:

- Level of violence;
- Degree to which the child is exposed;
- Other stressors unrelated to DV;
- The harm the DV produces;

- The unique coping skills of each child; and
- Other protective factors.

To the extent possible, prosecutors should rely more on physical evidence (e.g., medical reports, photographs of injuries or property damage) and third party testimony (e.g., witnesses' observations) to prepare their cases than on the testimony of non-offending parents. Requiring non-offending parents to testify about the violence in open court is likely to jeopardize their safety. This follows the principles of evidence-based prosecution in DV cases, which is a well-documented strategy to prosecute cases where the victim's full participation is dubious due to the history of coercive control shared with the defendant (Kessler, 2009). In those cases, charges are filed against the batterer and the case is prosecuted without the victim's testimony. Remember, the non-offending parent may recant allegations of abuse (1) due to misplaced loyalty or sympathy to the batterer (Bonomi, 2011); (2) as a protective measure due to ongoing control by the batterer (Bailey, 2009); (3) because of disempowering, biased, or harmful experiences with past systems' involvement (Alken & Murphy, 2000; Bailey, 2009); and/or (3) due to discrimination based on race, cultural oppression, sexual orientation, or immigration status (Bailey, 2009).

Training Legal Professionals and Systems

All participants in the court system should be trained in the dynamics of DV, the meaning of "DV exposure," the impact of DV on adults and children, and the most effective and culturally responsive interventions in these cases. Cross-training opportunities for legal system stakeholders will enhance their understanding of how legal system decisions impact the effectiveness of interventions by child welfare and the DV community.

The Columbus Bar Association, Ohio GAL Continuing Education Series, Ohio Judicial College, the Ohio CASA Conference, the Franklin County CASA Program, and the Ohio Domestic Violence Network (ODVN) regularly provide training opportunities for judicial and legal professionals. ODVN can provide training information on probation as it intersects with DV and child protection.

DOMESTIC VIOLENCE PROGRAMS

In addition to training on the dynamics of DV, DV program staff (advocates or otherwise) should be familiar with child development and the effects of DV on children. DV program providers, supervisors, and administrators should intentionally discuss as a staff:

- How can our program protect children from child abuse?
- How can we best protect them from effects of being exposed to DV?
- What can we do to help non-offending parents and children heal after DV?
- How can we support non-offending parents in their parenting?

DV program staff should also discuss general responses to the diverse scenarios in which child safety may become a concern, such as:

- Past behaviors or threats to child safety by batterer, non-offending parent, or others prior to family involvement with the program;
- An active CPS investigation or ongoing case;
- Threats to child safety occurring while the non-offending parent or child is in shelter or participating in non-residential DV services;
- Child safety concerns upon leaving a DV shelter, such as subsequent exposure to the batterer and/or other harmful adults; or
- An imminent risk to the child's safety or wellbeing.

Child Abuse Reporting Requirements

All DV programs should establish and implement protocols on mandatory reporting requirements (see ORC §2151.421 and ORC §4757.01-02) and agency confidentiality requirements (e.g., through VAWA, FVPSA). DV programs should create releases of information, in conjunction with CPS and other providers, in order to share information on behalf of clients.

When advocates suspect or become aware of child abuse, they should allocate most of the responsibility of the CPS call to non-offending parents, *if possible and safe to do so*. Having non-offending parents place the CPS call empowers them to take charge of their own family when power has been taken away from them in

the DV relationship. This will only be possible when advocates are physically present with the parents and can call with them.

Expected Practices

In all cases, DV programs should:

- Communicate with CPS and other service providers about services available, appropriate referrals, and information sharing;
- Screen non-offending parents and children for immediate safety threats;
- Provide voluntary services without requiring participation in programs or waivers of confidentiality in order to receive safe shelter or support; and
- Support child safety and wellbeing by:
  - Supporting non-offending parents' parenting, such as how to talk to their children about the violence and how to help children cope with feelings and changes in their families' situations;
  - Exploring participants' fears about future violence and responses or interventions that could worsen their situations;
  - Developing safety plans for each family member;
  - Offering children's programming, play therapy, or art therapy;
  - Providing information to non-offending parents on possible impacts of DV on children;
  - Offering general advocacy services and explaining non-offending parents' rights;
  - Offering legal advocacy beyond criminal courts;
  - Assisting with access to safe shelter or transitional or long-term housing;
  - Assisting with daily living needs (e.g., food, transportation, utilities);
  - Referring to a broad array of culturally appropriate services for non-offending parents and children, including child care, crisis intervention, educational or financial empowerment, trauma-informed counseling and substance abuse services, and other affordable health services;
  - Complying with mandated reporting requirements in cases of suspected, known, or observed child abuse or neglect;

- Preparing non-offending parents for engagement with CPS when a concern meets the statutory requirement for a mandated report;
- Accompanying non-offending parents to appointments with CPS and other entities addressing child's needs and wellbeing;
- Preparing victims for possible engagement with intervention services delivered to batterer (e.g., BIPs, probation, substance abuse or mental health treatment, fatherhood programs);
- Participating on the non-offending parent's behalf in collaborative Team Decision-making or Family Team Meetings regarding their case;
- Documenting case records through a culturally competent, safety-oriented, trauma-informed lens; and
- Releasing case information at the direction and with the authorization of non-offending parents.

GUARDIANS AD LITEM

In Ohio, Guardians ad litem (GALs) are certified by the Supreme Court of Ohio to represent the best interests of children in abuse, neglect, and dependency cases, in addition to Domestic Relations divorce and post-divorce cases (ORC § 3109.04). (See Appendix N for more complete information on civil statutes and GAL responsibilities.) IPV cases can precipitate a filing of a juvenile court abuse, neglect, or dependency case – or can occur during a pending matter – both of which should be treated with equal importance.

Critical Components Applied to GALs

DV-informed GALs understand that children experience DV differently and that children may suffer from trauma and other effects of the DV. GALs are advised to learn to identify the *Safe and Together*™ model's five critical components of DV.

1. The domestic violence perpetrator's pattern of coercive control:
   A perpetrator's pattern of coercive control may include physical abuse, name calling and humiliating, maintaining sole control over the finances, and more. (See Appendix B for specific behaviors in the Power and Control Wheel.) GALs should consider and document these specific behaviors, which can inform their understanding of how the children may be impacted and can assist them in making more informed decisions.

2. Specific behaviors the perpetrator has engaged in to harm the children:
   Such harmful behaviors can include constant depreciation of the child's value in the family or of the child's love of the non-offending parent; threats of or actual physical, mental, and/or emotional harm to the child, non-offending parent, or pets; or manipulating situations so that the non-offending parent's and child's basic needs are entirely dependent on the perpetrator. Other examples may include incidents in which the child receives abuse directed toward the non-offending parent (e.g., perpetrator throws a plate at non-offending parent but misses and hits child instead).

3. Full spectrum of the non-offending parent's efforts to promote the safety and wellbeing of the children:
   GALs should investigate all of the non-offending parent's efforts to keep the child out of harm's way. Such efforts can include: arranging for the child to stay with relatives or family friends to limit exposure to the violence; preparing meals in advance so the child can access food if the perpetrator prevents meals from being made at mealtime; and preparing an emergency suitcase packed with the child's essentials and storing it in a safe place.

4. Adverse impact of the perpetrator's behavior on the child:
   Examples of this may include truancy, medical neglect, sleep deprivation, and anxiety, among others. *When appropriate,* GALs should advocate and arrange for trauma-based therapy for children involved in DV cases. Qualified mental health providers can identify and provide appropriate services for each child's individual needs. The non-offending parent may be part of this therapy as recommended by the therapist.

5. The role of substance abuse, mental health, cultural and socio-economic factors that may impact domestic violence:
   DV is not excused or explained by any of these factors; however, they can exacerbate the violence and must be addressed for the child's safety and best interests.

Additional Recommendations

An extensive outline of GAL authority and responsibilities can be found in Appendix N. Some recommendations are highlighted here.

- Seek out training opportunities in DV dynamics and impact on children. Responding to DV requires extensive training to protect the rights of children and to ensure their health and safety.

  - ODVN may suggest and/or provide specific trainings child advocates may attend, and must demonstrate understanding of, prior to being assigned cases involving DV.
  - The Ohio IPV Collaborative offers training in the *Safe and Together*™ model, which values non-offending parents' protective efforts and works to engage batterers to learn from the consequences of their actions and to stop the violence.
  - GALs must have training in how to interview children and communicate with them, especially when they are experiencing crisis. Such techniques as getting down to the child's level, choosing appropriate settings, building rapport, and training on basic child interviewing techniques are vital to learn so as to understand the child and to foster communication between the child and the GAL.
  - GALs may benefit from training in report writing so as to provide objective, fact-based reports, with recommendations based on evidence rather than opinion, especially regarding DV. The Ohio Supreme Court training curriculum, ODVN, and the Ohio IPV Collaborative may provide training on this topic.
- Monitor case plans and dispositional orders regarding provision of services and their effectiveness for children, non-offending parents, and batterers.
- Connect with the child's CPS caseworker, communicate necessary information, and consider participating in team decision-making (see section on Case Planning, Team Decision-making).
- Observe caregivers with the children when appropriate, using the *Safe and Together*™ model as a guide for identifying critical components. Use the critical components to support children remaining with their non-offending parents and to avoid unnecessary removals.
- Communicate privately, confidentially, and immediately with the child after exposure to – or impact from – the DV. Participate in safety planning for the child and explain to the child how the child – and the people and pets for whom the child may be afraid – will be kept safe. (See section on Safety Planning with Children.)

- Assess whether more frequent communication with the child is advisable.
- Consult with DV experts regarding issues related to the impact of DV on children. Contact the Ohio Domestic Violence Network (ODVN) for direct consultation or for a referral to an appropriate resource.
- Recommend that the court restrict access to reports or portions of reports in order to preserve the confidentiality and safety of the child.
- Receive notification of and attend all mediation sessions. The appropriateness of mediation must be considered in every case in which DV has occurred, as batterers can use mediation to manipulate non-offending parents. Also consider the appropriateness of psychological evaluations in DV cases. Non-offending parents may be suffering from trauma and anxiety associated with the DV, so psychological evaluations will not necessarily reflect their true capacities to parent. Batterers typically present well on psychological evaluations because battering is not a mental health issue.

LAW ENFORCEMENT

Law enforcement play a critical role in child safety. The impact of their response to DV carries repercussions far beyond the on-scene investigation. Officers typically have a short window of time to respond to DV calls, and they have different mandates from child protective services (CPS) and other systems, but there are still a number of steps law enforcement can integrate into their roles to enhance outcomes for children and families. Recommended practices to promote victim and witness safety include:

- Risk/lethality assessment and on-scene crisis safety planning with victims/witnesses (see Jacquelyn Campbell's Dangerousness Assessment in Appendix I);
- Referrals to DV shelters/programs, advocacy and victim assistance, CPS, and medical, mental health, and trauma services as appropriate;
- Documentation by investigating officers, *including detailed information on where the children were and how they were affected*;
- Understanding how various community partners interpret reports;
- Minimizing witness intimidation;
- Protective, sensitive, reassuring, and culturally competent interactions with the child witnesses/victims and adult victims during the investigation to help minimize trauma impact;
- Proper supervision of investigations and officer responses to identify training needs, prioritize responses, effectively assign casework, and avoid weaknesses or cultural bias in investigative reports;
- Collaboration and cross-training between law enforcement agencies and DV Task Forces, as well as participation in case-specific Multi-disciplinary Teams with other responders; and
- Standardizing departmental policies, such as safety and accountability audits, mechanisms for monitoring protocol fidelity, and procedures for supervision and training.

The late national DV expert Ellen Pence said that the responses by the victim to these three questions are the most meaningful for assessing risk:

1. Do you think [batterer] will seriously injure or kill you or your children? What makes you think so? What makes you think not?
2. How frequently and seriously does [batterer] intimidate, threaten, or assault you? Is it changing? Getting worse? Getting better?
3. Describe the time you were most frightened or injured by [batterer].

A teamed approach at the scene between CPS and law enforcement would ensure the collection and documentation of all immediate information relative to the safety and security of children and avoid lost time to address trauma and emotional impact experienced by children. Additionally, DV advocates or other service providers may be present at the scene and may be able to help.

First responders are highly encouraged to take advantage of the suggested tool kit in Appendix O. A first-response tool kit can be a useful means through which to achieve more effective responses to DV. It may detail local, state, and national resources, guides, and a statement of survivor and child rights that promote interdisciplinary and interagency knowledge and communications. It may also include information for batterers – such as laws regarding the violation of civil protection orders – as well as coloring books, crayons, or other items for children.

Training

Intensive, regular training rooted in best practice may help law enforcement officers identify the primary (or predominant) aggressor, understand the batterer's history of violence and coercive control against the family, understand the batterer-generated and life-generated risks associated with help-seeking behaviors by non-offending parents and children, and understand trauma reactions and the use of resistive violence in the face of an imminent attack against non-offending parents and their children. For instance, arresting a non-offending parent for resistive violence (i.e. violence used to protect oneself against the batterer) may expose children to escalated danger and trauma upon separation of the non-offending parent or interruption of parenting time

(custody). It requires an advanced skill set to account for the complex impact DV calls and responses may have on children. Each situation is unique and requires the combination of training, experience, effective supervision, and coordinated responses to support child safety.

<u>In all cases, law enforcement should do the following</u>:

- Adopt protocols in collaboration with DV shelters and other experts, as required in ORC § 2535.032.
- Dispatch two officers to the scene where DV is a concern.
- Contain immediate safety threats.
- Call appropriate partners (e.g., CPS, emergency medical services). Develop processes to share information crucial to the case (e.g., police reports, 911 call recordings, photographs).
- Note children's location and physical, verbal, or emotional reactions.
- Interview victim and offender separately. Use supportive interview techniques with the victim and avoid statements of judgment, such as "Why didn't you press charges the first time this happened?"
- Determine the primary/predominant aggressor (defined in Appendix C).
- Document behaviors as specifically as possible. For example, instead of writing "Joe and Sally were engaged in DV," write "Joe shoved Sally on the ground in the presence of their children."

MEDICAL SYSTEMS

Doctors, nurses, and other medical providers work in a variety of settings in which they can receive first disclosures of DV by the adult survivor and/or child. In hospitals, medical personnel may discover a bruise the child suffered when the batterer threw a chair at the non-offending parent and missed, inadvertently hitting the child. They may uncover further evidence of abuse or neglect that is linked to the DV. In transit via ambulance and in emergency rooms, medical first responders can see firsthand the immediate physical – and possibly psychological – side effects of the violence. In doctors' offices, medical personnel may get to know their patients well and recognize the first signs of a problem or secondary medical condition. Even in school settings, nurses or nurses' aides may learn of the violence through a child speaking about it by discovering physical marks.

It is imperative that medical personnel document and report these indicators of child abuse, neglect, and/or DV impacting the children to the county child protection agency in which the family lives. Additionally, these patients may need to know about local resources and services they may access and when to call law enforcement, CPS, and/or another provider.

<u>In all cases, medical providers should do the following</u>:

- Create a safe space for patients to disclose DV.
- Interview patients in privacy.
- Use culturally and linguistically appropriate interpreters whenever possible. Do NOT use other family members, friends, or children to interpret for you.
- Assess for any immediate safety threats.
- Identify cultural ideas about discipline and child-rearing that may require education on acceptable practices under Ohio law.
- Consult the Ohio DV Protocol for Health Care Providers mentioned above for detailed tips in various health care specialties.

MENTAL HEALTH/SUBSTANCE ABUSE SERVICE PROVIDERS

In domestic violence cases, mental health and substance abuse (hereafter "MHSA") providers must consider the safety of children and families as well as:

- Mandated reporting requirements;
- Coordinating care;
- Using a trauma lens; and
- Scope and ending services.

Mandated Reporting Requirements

Generally, MHSA providers inform families of limits to confidentiality at the beginning of treatment during the consent process. Families experiencing DV often experience other types of abuse, too. MHSA providers need to report to CPS suspicions or disclosures of other types of abuse/neglect. They should consider whether or not involving perpetrators in therapy or providing them information about therapy might further endanger the children and/or non-offending parents.

Coordinating Care

MHSA providers should develop a mechanism for more effective cross-agency information-sharing so they have a clear understanding of systemic issues that may be worrying or affecting the child, such as changing placements or schools. This will help providers target areas of difficulty for the child and will also help them assist the child in establishing feelings of continuity. Communications with schools – teachers, social workers, administrators – can be especially useful.

Using a "Trauma Lens"

Non-offending parents and children may be suffering effects of trauma exposure, which can affect their perceptions, emotions, and behaviors. By using a "trauma lens," MHSA providers can help them heal and avoid causing re-traumatization. MHSA providers should have training and be proficient in standardized trauma assessment measures and evidence-based trauma treatment so they are better able to assist children and families in coping with trauma. More information on

trauma-informed practice can be found by visiting the National Child Traumatic Stress Network (NCTSN) website.

Scope and Ending Services

If providers consider what is being requested of them to be outside their role or scope, or if they believe the requested action could escalate danger, then they are advised to inform the CPS caseworker or supervisor immediately and suggest possible alternatives.

> **Example:** *CPS worker asks for a psychologist's recommendation in regards to which parent should have parenting time. The psychologist has provided mental health services for the treatment of Post-Traumatic Stress Disorder to the adult victim and has never met the batterer. The psychologist explains to the worker that this is outside the scope of services because the psychologist has not conducted a custody evaluation, but the psychologist agrees to send a report on the adult victim's progress in treatment and any mental health barriers to parenting.*

Service providers may decide to end services for the child(ren) or non-offending parent while the CPS case is still open. Reasons for this may include: the family may not show up for services; they may have completed services or do not need services anymore; the family may not want services; or the family may not be appropriate for services. Regardless of the reason, when a provider ends services while a CPS case is still open, the provider should contact CPS. (Confidentiality procedures should be followed.) Service providers must also consider any protocols addressing the type of communication recommended and information to share.

Service providers have a variety of issues to consider when deciding whether or not to terminate services.

- Who is the client? If the child is the client, who has custody – the non-offending parent or CPS?
- Was the non-offending parent or child referred to the provider by CPS?

- Has the service provider already been in contact with CPS? Is there already a release of information (ROI) on file?
- Was the service on the CPS case plan?
- What is the most trauma-informed plan of action?

The non-offending parent may be worrying about these considerations.

- If CPS knows I ended services, will this hurt me somehow? Will this delay my getting back my children?
- What will the provider tell CPS about why I ended services?
- Will my (ex-)partner find out and use this information against me?

Providers must carefully consider all pertinent issues before making a decision about how to proceed. In the best case scenario, they will involve non-offending parents in the decision-making, even if they are not the direct clients, and even if they do not have full parenting time when the children are the clients.

> **Example:** *The mother and service provider have decided to end services for herself and her children. The mother has custody of her children, so the service provider gets permission to send a letter or call the CPS worker to let her know that they have decided to end services and why. The provider and mother discuss in advance what the provider will say in that phone call or letter to CPS. If the mother does not have custody, the service provider would not need the mother to sign a release of information, but it would still be advisable to follow the same plan if the mother is involved in services with her children, unless otherwise indicated.*

SCHOOLS

Schools have a dual role in supporting children exposed to DV. First, they must meet their standard obligations to provide educational services for children; this obligation can be complicated by the presence of DV in a student's family. Second, schools have an obligation to protect the safety of their students, staff, and property; therefore, schools must consider how perpetrators of DV and/or child maltreatment might compromise safety in school settings. *The Guide for Developing Higher-Quality School Safety Plans* from the United States Department of Education cites DV and abuse as risk examples of human-caused threats.

Provisions under the federal McKinney-Vento Homeless Education Act can help children displaced from their home by DV retain access to educational services within the district they last attended or in the new district where they temporarily reside. Provisions include immediate enrollment, despite missing records or paperwork; access to the same special programs and services that are provided to other children, including special education, migrant education, and vocational education; and the same public education that is provided to other children, including preschool. A guide for parents and a Frequently Asked Questions sheet for schools are available at http://education.ohio.gov/Topics/School-Improvement/Federal-Programs/No-Child-Left-Behind/Program-Information/McKinney-Vento-Homeless-Children-and-Youth-Program/McKinney-Vento-Resources-for-Awareness.

Schools can support safety for children exposed to DV by doing the following:

- Make mandatory reports of suspected child abuse/neglect, and monitor for new or ongoing concerns.
- Request training from the local child protection agency (CPS) on making mandatory reports and on circumstances where caseworkers may/may not interview children at school without the permission of parents/guardians.
- Participate in Family Team Meetings (see Case Planning section) with CPS.
- Review school policies and Ohio law that dictate or restrain the release of children and their educational records (e.g., in Ohio, a father's name on a

birth certificate when the biological parents are not married does not establish custodial rights of the named father to the child).

- Work with family members, foster parents, and community partners like CPS and DV programs to support personal safety plans of students (based on batterer-generated threats), if requested. A safety plan can be in place with or without orders of protection.
- Exercise due diligence for school-wide safety of children, parents, foster parents, and staff when protection orders are in place. Properly communicate plans for safety during school hours, on buses, and at extracurricular activities, while respecting the privacy of the family.
- Request training from local DV programs or the Ohio Domestic Violence Network on the educational and developmental impacts of DV on kids.
- Support healing and trauma recovery by identifying possible trauma triggers and children's emotional and physical responses to trauma (e.g., behavioral/developmental regression, withdrawal, distraction, acting out, self-harm, tiredness, clinginess, worry and fear). Suggest appropriate referrals. Schools can play a critical role in trauma recovery simply by offering stable routines, healthy distractions from the violence, and supportive circles of friends and adults.

SUBSTITUTE CAREGIVERS

In this protocol, "substitute caregivers" will refer to foster, adoptive, kinship, and residential caregivers. When children have been removed as a result of safety issues from batterers' behaviors, substitute caregivers should be a supportive resource to the children. Children may begin to talk to their caregivers regarding the violence they witnessed at home or may display behaviors as a result of the trauma they experienced. Caregivers should document what is being said by the children in their care – as well as their behaviors – and report immediately to their caseworkers. Caregivers should listen to the children but *not* conduct interviews. Caregivers should not push the children to discuss the concerns but allow the children to talk to them openly and freely about their trauma. A child witness of DV may need various therapies, including trauma therapy for them to heal while in substitute care. Any information relevant to the child's experience of the DV should be provided to caregivers at the time of placement so caregivers can help promote healing.

When children are placed, they are likely to have supervised or unsupervised visitation scheduled by the CPS agency with their parents. Any new behaviors or disclosures that result from ongoing visits children have with batterers should be documented and shared with each child's caseworker. An ongoing assessment of the children's safety during visits is necessary. This information is key to ensuring the visits are occurring safely and do not become an opportunity for batterers to further abuse or coerce the children.

<u>In all cases, substitute caregivers should do the following</u>:

- Document what children in care say as well as their behaviors that may relate to DV.
- Report any disclosures about DV immediately to caseworkers.
- Remain loving and supportive listeners.
- Seek out training on trauma and DV's impact on children.

Section V. Community Collaborations

Examples of community collaborations explored in this section include:

- Information-sharing through memoranda of understanding (MOUs), releases of information (ROIs), and making referrals to CPS;
- Joint service models, such as co-located advocacy or family justice centers;
- Use of local child advocacy centers (CACs) and DV Task Forces;
- Joint funding applications;
- Local protocols for responding to children exposed to DV;
- Community assessment and data collection; and
- Cross-training opportunities.

INFORMATION-SHARING

Finding ways to share information ethically and safely between agencies can be one of the most challenging barriers to effective collaboration. Information-sharing is one way of collaborating but does not necessarily entitle collaborating parties to full access. Community partners should have direct conversations with one another about any constraints they have in information-sharing and how they can either (1) work to change information-sharing policies that do not serve families' best interests or (2) work together while respecting those constraints. Suggested confidentiality policies, memoranda of understanding, and releases of information are described below.

Confidentiality

All systems must work together while respecting one another's confidentiality requirements. Having a place in each community where DV victims can speak freely without judgment and in confidence is crucial to their safety and the safety of their children. Clearly communicated and accepted confidentiality policies build the trust relationship needed for more meaningful engagement in services and better outcomes for non-offending parents and their children. All collaborating

agencies need to be aware of their own mandated reporting and confidentiality requirements.

Making Referrals to CPS

Providers should call police when an immediate response is needed due to an act of DV in progress or imminent danger to family or community. Law enforcement should refer to CPS to complete a thorough assessment of the safety and risk in the family.

Whenever there is reasonable suspicion to believe that a child has been harmed by DV occurring in the home or family (e.g., exhibiting signs of trauma or neglect), a report should be made to the appropriate CPS agency with all relevant information as it is learned. (All providers should become familiar with confidentiality and mandated reporter laws that govern their practice.) Providers should offer the following information regarding the current situation, including:

- Names of all parties;
- Dates of birth of the parties;
- Address of where the violence occurred;
- What medical interventions, if any, were needed;
- Address of where the children are currently residing and with whom;
- Police reports;
- Photos;
- Current risk to the children;
- Children's school district; and
- Whether or not the caller is a mandated reporter.

Callers/reporters can expect to be asked the questions listed below as well.

- Who is involved in the DV?
- Who is the primary aggressor? (See definitions in Appendix C.)
- What exactly has happened?
- Describe the behaviors of the primary aggressor.
- When did this occur?

- Was the victim injured or harmed?
- Were any weapons used?
- Was anyone under the influence of alcohol and/or drugs?
- Where were the children? How were they impacted?
- Have the police been out to the home for DV?
    - If yes, who called the police?
    - Were charges filed? Against whom?
- Have there been verbal threats? By whom, to whom?
- Is there a pattern of DV (versus first incident)?
- How does the aggressor display any patterns of control over the partner?
- Has a child been injured as a result of DV?
    - If yes, how so?
    - How did it happen?
    - Who was the aggressor during this incident?
    - What was occurring prior to the incident?
- How else has the child been affected by the batterer's behaviors?
- Has the victim ever previously pressed charges?
- Have there ever been orders of protection? When?
- What have been the victim's efforts to promote the safety and wellbeing of the child (other than leaving or contacting police)?
- Is the perpetrator on probation? Has the perpetrator served time for DV?
- Have you witnessed the violence firsthand?
    - If not, how did you learn of this incident?
- Can you provide us with additional names and numbers of persons having knowledge?
- Do you know of any reason or have any belief that the CPS investigation would pose harm to either the children or the non-offending parent?

Mandated reporters (see definition in Appendix C) have the right to request the status of the case reported. Information contained therein may include (a) whether the agency has initiated an investigation of the report; (b) whether the agency is continuing to investigate the report; (c) whether the agency is otherwise

involved with the child who is the subject of the report; (d) the general status of the health and safety of the child who is the subject of the report; and (e) whether the report has resulted in the filing of a complaint in juvenile court, criminal charges in another court, or civil protection order (ORC § 2151.421(K)(1)(a-e)). CPS may notify involved courts, prosecutors, and law enforcement of its decision to open a case when the matter is still being investigated.

Memoranda of Understanding

Partnerships between and among agencies can be greatly enhanced with the creation and acceptance of jointly created memoranda of understanding (MOUs). These can be developed between CPS and local DV programs, CPS and law enforcement, and many other partners. Broadly, MOUs should address what, with whom, how, and when information can be shared. Specifically, they can address:

- Assessment;
- Reporting and referrals;
- Investigations;
- Releases of information;
- Confidentiality;
- Liaisons;
- Resolution of conflicts; and
- Interagency training.

MOUs should be clearly communicated to all partners and staff so that collaborations may occur system-wide where appropriate. A list of recommendations when developing MOUs is below (Richard, 2004).

1. Procedures should comply with state statutes and case law governing what information CPS can share with whom and the information other providers can share. Attorneys familiar with governing statutes, case law, and local agency policies should review these provisions.
2. MOUs should include provisions that articulate the regulations governing confidentiality for each agency, including the types of information on families that will be shared between the child protection agency and other programs.
3. Providers should offer information up front to victim/survivors about confidentiality and reporting policies. Advocates can assist survivors by

being as specific as possible about what child abuse is and what gets reported. Advocates could benefit from training on specific phrases to use in these situations.

4. Documentation should be precise with objective, factual information. Safety, trauma, and cultural considerations are important as well.
5. *In the case of mental health providers,* duty to warn situations do not require consent to release. These include threats to harm someone, threat of suicide or homicide, and child abuse.
6. MOUs should articulate procedures for DV programs that will be used when CPS or law enforcement seek the whereabouts of a particular survivor.

See Appendix P for a sample MOU. Also see ORC § 5101:2-33-26 for compliance on MOUs between CPS and community partners.

Releases of Information

Releases of information (ROIs) should be addressed within an MOU between service providers and CPS. ROIs should be:

- Consented to by the person for whom the information is about;
- Time-limited;
- Written, *not* oral;
- Separate for each agency with which information is being shared; and
- Specific as to the nature of the information to be disclosed.

For more guidelines on releases of information, read "Survivor Confidentiality and Privacy: Releases and Waivers at a Glance" by the National Network to End Domestic Violence (NNEDV), 2008.

Some examples of co-constructed releases are available in state model protocols (e.g., Florida's); however, a universal release may be difficult to find as many CPS agencies consult with their legal counsel on developing forms and accepting another agency's release. A sample ROI template can be found in Appendix Q. Though this sample is for DV shelters or programs, it can be adapted for others' use.

Parents should be made aware of their right to information in CPS records, their right to have their information released to other agencies with a signed ROI, and the parameters of what CPS cannot share (e.g., redacted information for safety purposes, sources of referrals).

JOINT SERVICE MODELS

Some Ohio communities have undertaken a thorough investigation of cost-to-benefits and an examination of required infrastructure to establish locally designed joint service models. For example, the YWCA of Greater Cincinnati and the Hamilton County Department of Job & Family Services (HCDJFS) partnered to facilitate the inclusion of DV advocates in HCDJFS offices. This can increase communication, trust, and collaboration between advocates and workers for the benefit and safety of families. Similarly, Montgomery County Children Services (MCCS) implemented a co-located advocacy model with Artemis Center (Artemis), a local DV program, to house an advocate at MCCS part-time and at Artemis the rest of the time. In both cases, the advocates are employed by their local DV programs and, thus, are subject to those programs' policies. MOUs and confidentiality agreements are important pieces of ongoing discussions in these efforts. Multiple examples of advocacy- and child welfare-focused joint service models can be found nationally, in addition to these two Ohio-based examples of co-located services.

Family justice centers (FJCs) are another example of a joint service model. FJCs are collaborations in which various legal service providers create one place to which families can go for the services they need. Collaborating partners may include police officers, prosecutors, advocates, chaplains, counselors, medical professionals, and others. See the Family Justice Center Alliance at http://www.familyjusticecenter.org/ for more information.

Appendix U lists several suggested resources for communities interested in exploring joint service models in more detail.

CHILD ADVOCACY CENTERS

According to the National Children's Alliance (NCA), a children's advocacy center (CAC) is:

> "a child-focused, facility-based program in which representatives from many disciplines work together to conduct interviews and make team decisions about investigation, treatment, management, and prosecution of child abuse cases. The primary purpose of the CAC is to ensure that children disclosing abuse and their non-offending caregivers are not further victimized by the systems intended to protect them."

See The Ohio Revised Code § 2151.426 "Children's advocacy center – memorandum of understanding" for additional information and standards.

Child advocacy centers (CACs) can be excellent examples of interagency collaborations benefiting children and families. The following standards must be in place for a CAC to be considered a *fully* accredited member of the NCA:

- A child-appropriate/child-friendly facility;
- A multidisciplinary investigation team (MDT) and coordinated forensic interviews;
- Case reviews and case tracking;
- Medical evaluation, therapeutic intervention, victim advocacy services; and
- Written interagency agreement.

The organizational structures of the CACs in Ohio are heterogeneous, including independent not-for-profits, CACs embedded in governmental agencies, and hospital-based CACs. This reality results in varied methods of child abuse assessment, documentation, and referrals. CACs are most commonly accessed for allegations of sexual abuse. However, neglect, physical abuse, and exposure to DV can also be identified during this process, and resources may be dedicated to those purposes. CACs can offer comprehensive intervention responses for children experiencing multiple forms of victimization, especially for the co-occurrence of child abuse and DV.

The CAC child abuse strategy provides a unique opportunity to support a comprehensive approach to complex family violence issues that can be present in some families who present to the CAC for a child abuse evaluation. Serious efforts to address DV in any community can be enhanced when the CAC is understood and utilized to its maximum potential. It is imperative that service providers in each community become informed about the practice patterns of their particular CAC so that they can both influence and benefit from their services.

The Ohio Network of Child Advocacy Centers (ONCAC) has dozens of CAC members throughout the state and can be an excellent resource for those seeking information on Ohio's CACs.

DOMESTIC VIOLENCE TASK FORCES

The Supreme Court Domestic Violence Task Force Recommendations of 1996 support the establishment of protocols for a Coordinated Community Response. Communities that do not already have such a group should consider establishing – or reconvening – a DV Task Force, DV Fatality Review Team (DVFRT), consortium, or other body of community partners working on local policies and practices. Smaller communities may wish to combine with neighboring counties. Ideally, these groups would include representatives from law enforcement, DV experts, CPS, courts, legal practitioners, medical and mental health providers, and school personnel, among others. Collaborative groups should intentionally recruit leadership and representation from organizations serving culturally specific groups (e.g., Jewish Family Services, LGBTQI alliances) or groups traditionally over-represented in child welfare (e.g., African-American, Native American). The group may wish to begin by highlighting one another's common goals and addressing the myths and realities working within each discipline or subgroup.

CAPACITY-BUILDING

All Capacity-Building sections – Data Collection, Funding, Policy, and Training – are needed to support an ideal community response.

Data Collection

Among essential elements for sustaining the impact of DV-focused work are the abilities to demonstrate the need for it, establish it as a priority, and recruit broad community support. Having an accurate local picture reflecting the overlap between DV and child welfare will help to attract collaborative partners and better leverage local resources. The collection of culturally informed data can help identify disparities, build access to culturally appropriate services, and address overrepresentation in responding systems. Utilization of accurate statewide and local data is crucial to improving outcomes for families experiencing IPV. Useful state and local data to collect may include:

- Number of families involved in CPS and experiencing DV;
- Number of people accessing various interventions (e.g., BIPs, CPOs);
- Interventions' availability and utility, especially for underserved groups;
- Success rates of interventions;
- Recidivism rates;
- Co-occurring child maltreatment issues (e.g., sex abuse);
- Co-occurring mental health and/or substance abuse issues in families;
- Child and adult fatalities related to DV; and
- Typical trajectory of DV civil and criminal court cases.

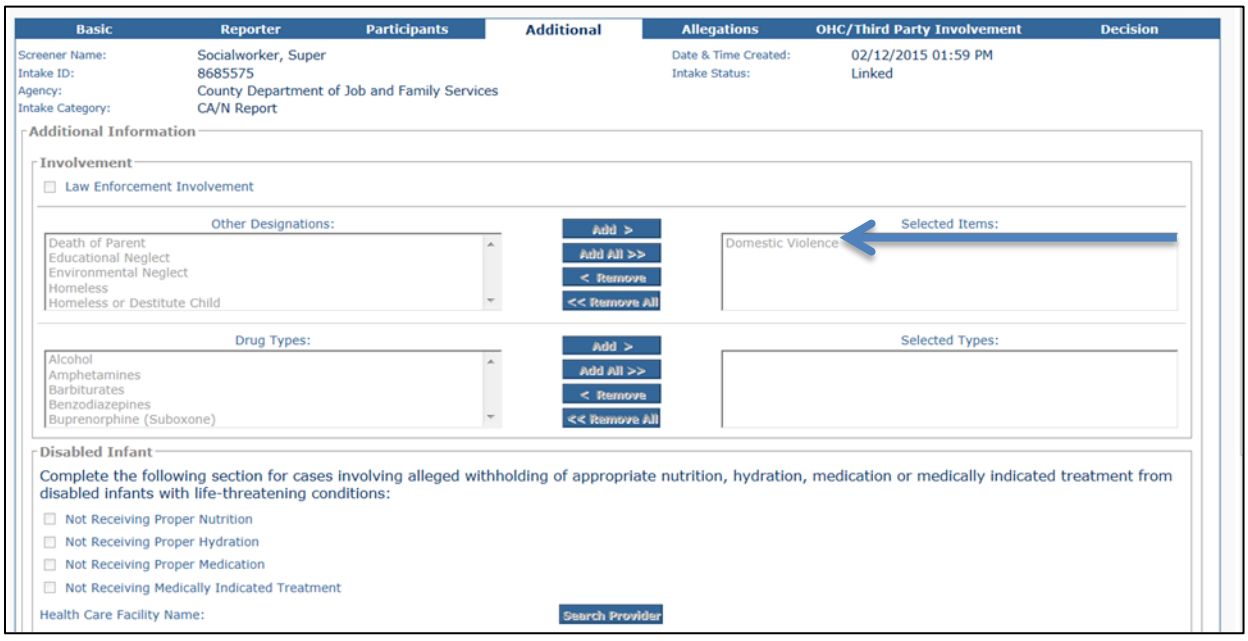
Many good sources of data currently exist, such as:

- Statewide Automated Child Welfare Information System (SACWIS);
- Health Policy Institute of Ohio's Family Violence County Profiles;
- Public Children Services Association of Ohio (PCSAO) Factbooks;
- Law enforcement reports to the Ohio Attorney General's Bureau of Criminal Investigation (BCI) and open case investigations (OCIs);
- Courts;
- Batterer intervention programs (BIPs);
- Visitation centers;
- Agencies that serve oppressed populations (e.g., LGBTQI); and
- A community readiness assessment tool found in Appendix R.

Additional data sets would, at a minimum, build community awareness of IPV, strengthen community support of IPV- focused programs, allow for enhanced service coordination, and provide maximum opportunity to establish funding for local and state initiatives aimed at the intersection of DV and child maltreatment.

Recognizing the need for internal and statewide data collection, ODJFS has designated staff to address the need for user-friendly data collection in SACWIS (i.e. setting up a specific checkbox for IPV in screening and throughout the life of a case). (See Image 5 for an image of SACWIS.) These data would allow CPS agencies, ODJFS, and community partners to grasp the extent of children's exposure to IPV in specific geographic regions. Additional opportunities for DV identification are found in the CPS Safety Assessment and Family Assessment (see Appendix S). While these efforts are in process, a number of CPS supervisors and administrators have figured out ways to extract this data from the system.

Image 5: DV Identification in SACWIS at Screening Intake



Funding

Many community partners and agencies may wish to respond to children exposed to battering in an "ideal" way but are prevented from doing so due to lack of sufficient funds. This is a real issue that can prevent meaningful policy and

practice changes. Appendix T lists a number of potential sources of local, state, and national funding to support this important work in services and programming.

Fund-seekers will want to consider the tips below when looking for funding.

- Collaboration is *strongly* considered in many applications. Spell out explicitly how you are working in community and across counties. Be innovative in your collaborations and interagency relationships.
- Select evidence-based practices and offer a compelling theory of change.
- Thoroughly understand the grant maker's requirements, mandates, and budgetary or programmatic exclusions.
- Avoid duplications. If another agency is already addressing a need or providing a service, determine what may be missing from the service that you can provide or contribute.
- Include costs of interpreters and accessibility of facilities and materials.
- Implement equal opportunity hiring practices and policies that affirm, attract, and recruit culturally diverse employees and candidates to various direct service and leadership positions.
- Establish a good relationship with the state coalition. The Ohio Domestic Violence Network (ODVN) can provide well-founded advice to agencies and community partners seeking to establish IPV resource capacity when children are exposed to violence.

Policy Considerations

Policies and procedural frameworks among community partners should prioritize and support efforts to keep children together with non-offending parents to avoid the secondary emotional trauma of separation and placement. At the local level, policy and procedural infrastructure frequently pose barriers to this goal, which is critical to child safety and wellbeing. For example, current internal policies of many local emergency (non-DV) shelters prohibit accepting mothers and their children if there has been a recent history of DV. In addition, policies may not serve to hold batterers accountable for their actions. For example, in DV charges, pleading down from misdemeanors to disorderly conduct may miss the

opportunity to hold perpetrators accountable for repeat offenses, as several misdemeanors can lead to a felony charge. Agencies are encouraged to work with their community partners to establish local protocols on responding to DV.

Training

State partners recommend cross-training among the following disciplines: CPS workers, supervisors, and administrators; DV program staff and administrators; law enforcement; attorneys, GALs, CASAs, judges, and other court personnel; school personnel; medical personnel; community service providers; mental health/AOD providers; foster, adoptive, and kinship caregivers; group home and children's residential center staff; culturally specific service providers; faith-based leaders; and any other entity that may work with children exposed to DV. ODVN can facilitate this but does not have an officially developed curriculum.

Cross-training opportunities are crucial for understanding system roles, regulations and constraints of various systems, and implications for children and families. In states and communities that have undertaken successful collaborative ventures, significant effort has been devoted to overcoming initial mistrust and miscommunication through cross-training opportunities. Training can also aid in the establishment of effective first response protocols. Ongoing opportunities for skill-building are needed to institutionalize such practices within communities.

> **Example:** *A local domestic violence shelter received training to help them understand CPS processes, thereby (1) helping their clients with fears of losing their children and (2) strengthening relationships and understanding between the two agencies. Their next cross-training opportunity will allow the local DV shelter to help CPS understand the shelter's processes.*

Understanding various service providers' core training requirements may help communities structure cross-training opportunities more effectively. It is imperative to ensure that management – administrators and supervisors of any agency or entity seeking to improve practice – receive DV training and be prepared to support all staff in implementation. This can be an especially useful strategy when resources are limited and sustainability is of concern.

Section VI. Conclusion

Systems' connections in responding to DV can create significant and lasting foundations that support the safety and wellbeing of children. More effective coordination likewise benefits those same systems and service providers by enhancing their effectiveness and efficient use of resources. This protocol has provided a number of guidelines, examples, and suggestions to facilitate community collaborations and connections in child welfare cases with domestic violence components. Providers consulting this protocol are urged to seek out continuing education and support on this topic by contacting any of the Ohio IPV Collaborative partners and by consulting the resources listed in Appendix U.

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