MIDD Briefing Paper

ES 13b Domestic Violence Prevention Countywide Expansion
BP 56 Children's Domestic Violence Response Team

Existing MIDD Program/Strategy Review X☐ MIDD I Strategy Number 13b (Attach MIDD I pages)
New Concept X☐ (Attach New Concept Form)
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: MIDD Strategy 13b funds the Children's Domestic Violence Response Team (CDVRT), a cross-system collaborative model that teams mental health therapists and domestic violence advocates in providing early intervention for children who have been exposed to domestic violence and for their non-abusive parent. MIDD I funding currently supports one team based in South King County; a MIDD II New Concept proposal has been submitted to expand the CDVRT county-wide by funding two additional teams based in East King County and Seattle/North King County. Two small short-term pilot teams have previously been established here with non-MIDD revenue sources. A countywide CDVRT would provide a specialized collaborative program to address the needs of children and their non-abusive (survivor) parent that have been impacted by domestic violence in King County. The CDVRT is a cross system collaborative approach between Domestic Violence (DV) and Mental Health (MH) that meets the complex needs of children impacted by domestic violence and their non-abusive (survivor) parent. The CDVRT provides effective prevention and early intervention services to families impacted by DV. CDVRT provides a comprehensive package of safety planning and protection, advocacy, and mental health treatment to the families served in the program. The family is served by a team that consists of the non-abusive parent, child and a DV advocate and a mental health therapist. Currently, the CDVRT (Strategy 13b) is funded by the MIDD to serve 120 clients in South King County only.

Collaborators:

Name	**Department**

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	**Role**	**Organization**
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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

MIDD Briefing Paper

MIDD Strategy 13b funds the Children's Domestic Violence Response Team (CDVRT), a cross-system collaborative model that teams mental health therapists and domestic violence advocates in providing early intervention for children who have been exposed to domestic violence and for their non-abusive parent. MIDD I funding currently supports one team based in South King County; a MIDD II New Concept proposal has been submitted to expand the CDVRT county-wide by funding two additional teams based in East King County and Seattle/North King County. Two small short-term pilot teams have previously been established here with non-MIDD revenue sources. A countywide CDVRT would provide a specialized collaborative program to address the needs of children and their non-abusive (survivor) parent that have been impacted by domestic violence in King County. The CDVRT is a cross system collaborative approach between Domestic Violence (DV) and Mental Health (MH) that meets the complex needs of children impacted by domestic violence and their non-abusive (survivor) parent. The CDVRT provides effective prevention and early intervention services to families impacted by DV. CDVRT provides a comprehensive package of safety planning and protection, advocacy, and mental health treatment to the families served in the program. The family is served by a team that consists of the non-abusive parent, child and a DV advocate and a mental health therapist. Currently, the CDVRT (Strategy 13b) is funded by the MIDD to serve 120 clients in South King County only.

The purpose of the CDVRT program is to engage supportive parents in identifying the needs of their children and families, provide effective services and supports, and ensure that culturally competent approaches are employed to mitigate the risks of DV exposure with children. The key program outcomes are to:

1) Decrease trauma symptoms exhibited by children receiving the intervention;
2) Increase protective/resiliency factors available to children and their non-abusive parents;
3) Support and repair the relationship between the child and their non-abusive parent;
4) Reduce children's belief that domestic violence is their fault and help children correctly assign responsibility for violent behaviors;
5) Improve social and relationship skills so that children may access needed social supports in the future; and
6) Reduce children's violent behaviors and other behavioral problems as observed in school, community, and family settings; and
7) Increase awareness of supportive adults in the children's natural environment so that they may provide needed social supports when necessary.

The CDVRT model of service delivery is wholly unique in King County and beyond. While mental health therapy and domestic violence advocacy are available elsewhere in the County, there is no other service that integrates these two important survivor supports in a free, child-focused, intensely collaborative, wraparound approach. The ongoing communication, consultation, co-advocacy, and shared case management that are hallmarks of the CDVRT create services that are equally focused both on safety and the mental health impacts of domestic violence; this is a holistic, client-centered approach unavailable anywhere else. The CDVRT was the recipient of the 2013 Community Mental Health and Chemical Dependency Exemplary Service Award, awarded by King County Mental Health, Chemical Abuse and Dependency Services Division.

The CDVRT model incorporates the principles of "Wraparound Care[1]," a nationally recognized approach that emphasizes family voice/choice in all decisions and builds networks of community support that increase resilience and decrease reliance on formal systems. CDVRT team members meet every other week to address program needs and staff individual cases, and they receive a high degree of training and consultation in order to create the expertise necessary for working with this population. Treatment goals and services are guided by client voice and choice, with the survivor seen as the "expert" in her family, particularly regarding safety concerns. One unique aspect of the CDVRT treatment model is its focus on safety and safety planning throughout every intervention. Helping families whose lives have been shattered by domestic violence requires both ensuring the safety of the abused partner and children and providing treatment for the emotional effects of the abuse.

A therapist and advocate team meet together with the child and non-abusive parent when the family first enters service; at this meeting, the group reviews the family's history, strengths and needs, and service options, including the pros and cons of formal therapy and confidentiality protections. Depending on their needs and preferences, a family could participate in a combination of two or more services offered by the CDVRT (outlined below); the therapist/advocate team meets regularly with the family to review their progress and respond to changing needs for support. Immigrant and refugee families are served by staff trained in serving culturally diverse clients and have access to language interpreters. Families are welcome to work with their CDVRT team as long as they feel they have a need.

The CDVRT program elements include:

1) Specialized, trauma-informed, evidence-based mental health services that help children recover from the effects of exposure to domestic violence
2) Integrated domestic violence advocacy and services, including intensive safety planning, DV education, connection to community resources, legal and housing advocacy, support groups, and a wide range of other services all coordinated with mental health treatment, and
3) Services for survivors and their children together to repair the critical relationship between the child and the non-abusive parent, such as Kids Club and the In-Home Children's DV Program, described below.

Kids Club and its concurrent parenting group are offered for children and non-abusive parents who may not need or want more intensive mental health services, or for whom formal mental health services are a safety risk. Facilitated by a therapist and advocate team, Kids Club is a multi-week, evidence-based program in which kids exposed to DV talk and learn about abuse, safety, emotions, and boundaries. A parenting group for their non-abusive parent is run concurrently, and the kids and parents are then combined to learn and talk together. Kids Club reduces a child's sense of isolation and guilt, as they see that there are other kids like them and learn that the abuse wasn't their fault.

The CDVRT also supports the **In-Home Children's DV Program**, the only one of its kind operating in King County and one of only two programs in the nation that provide this service. This 10-week curriculum for children who have been exposed to DV is provided in the safe, comfortable environment of the

[1] "Wraparound is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams" http://nwi.pdx.edu/wraparound-basics/

child's home and addresses the child's healing and the relationship between the child and their non-abusive parent. The In-Home Children's DV Program is the work of one of the CDVRT's DV agency program partners and has been recognized as a national model of service.[2] [3]
For children and families needing a higher level of mental health treatment, child and family therapists use **individual, family, and group counseling**; the evidence-based therapies, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)[4]; and Parent-Child Interaction Therapy (PCIT),[5] are available.

> ***Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*** *is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences.*[6]

> ***Parent-Child Interaction Therapy*** *(PCIT) is an empirically-supported treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. PCIT utilizes a live-coaching model wherein parents are in a therapy room with their child while the therapist is in an observation room watching via one-way mirror and/or live video feed. The parent wears a 'bug-in-the ear' device through which the therapist coaches the parent live on the skills being learned in treatment.* [7]

Adult survivors can access **one-on-one domestic violence advocacy** for immediate and ongoing safety concerns, criminal and/or civil legal issues (including orders for protection), connection to community resources, housing, and peer support groups. Advocates prioritize survivor safety, empowerment and confidentiality, as well as an awareness of the client's mental health concerns.

The CDVRT has one primary long-term goal: to help break the generational cycles of violence—to decrease the likelihood that exposure to violence at home will lead to other forms of juvenile and adult violence by children who have been exposed to domestic violence.

The CDVRT's more immediate program goals are: 1) to ensure ongoing physical and emotional safety of children and families impacted by domestic violence; 2) to support emotional healing for children and adults who are victims and survivors of domestic violence.

> To deliver the CDVRT program, Sound Mental Health has partnered with leading domestic violence service providers, including Domestic Abuse Women's Network (DAWN), South King County YWCA, Lifewire, and New Beginnings. Through this collaboration, the partners are able to provide an integrated approach to serving children exposed to domestic violence—one in which mental health services (based on a medical or treatment model) and domestic violence support (based on a social service model) come together as mutually support activities of the

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[2] Edleson, J.L. (2004). Should childhood exposure to adult domestic violence be defined as child maltreatment under the law?
[3] Jaffe, P.G., Baker, L.L. & Cunningham, A. (Eds.) Protecting children from domestic violence: Strategies for community intervention (pp. 8-29). New York, NY: Guilford
[4] http://nctsnet.org/sites/default/files/assets/pdfs/tfcbt_general.pdf
[5] http://www.pcit.org/
[6] https://tfcbt.org/
[7] http://www.pcit.org/

program. The CDVRT Model relies on collaboration between mental health therapists and domestic violence advocates.

NOTE: Domestic Violence and/or Intimate Partner Violence is commonly defined as a pattern of intentional, abusive behavior that one person in an intimate relationship uses over another to gain power and control. Domestic violence – also called intimate partner violence, battering, relationship abuse, spousal abuse or dating violence – may include physical, sexual, emotional, economic and mental or psychological abuse. Domestic violence can happen to anyone.[8] Washington State law (Revised Code of Washington 10.99.020) includes the domestic violence laws.[9]

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

☐ **Crisis Diversion** ☒ **Prevention and Early Intervention**

☐ **Recovery and Re-entry** ☒ **System Improvements**

Please describe the basis for the determination(s).

Prevention and Early Intervention: This program aims to reduce the long term effects of domestic violence for children. DV is identified as one of the eight Adverse Childhood Experiences (ACEs)[10] that are highly correlated with mental health, behavioral health and criminal problems in later life. More than one-third of the children currently served by the CDVRT are under age six years of age at the time of intake. This demonstrates the high need of access for very young children who have experienced trauma associated with domestic violence. Early intervention has been shown to significantly reduce impacts in their later life.

The CDVRT provides a continuum of recovery services to address the needs of the families served. The impacts of DV vary depending on severity of the violence in the home, age and developmental stage of the child, and the ability of the primary caretaker to meet the child's needs. Children's symptoms range from mild (primary and secondary prevention) to severe impairments in functioning requiring intensive rehabilitation/treatment. Support groups such as "Kids Club" and its concurrent parenting group, are offered for children and non-abusive parents who may not need or want mental health services. For children and families needing a higher level of mental health treatment, child and family therapists use individual, family, and group counseling; Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)[11]; and Parent-Child Interaction Therapy (PCIT)[12].

System Improvement: Historically the MH and DV systems have not worked well together. The systems did not collaborate and survivors and their children were not well served. DV advocates were critical of mental health therapists who did not fully understand the safety concerns that arise in DV treatment. Since its inception, the CDVRT recognized the value of improved system collaboration to better meet the complex needs of children caught in the perplexing and often dangerous social problem. The Safe and

[8] http://www.kccadv.org/learn-more/about-domestic-violence/

[9] http://apps.leg.wa.gov/RCW/default.aspx?cite=10.99.020

[10] The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego http://www.cdc.gov/violenceprevention/acestudy/

[11] http://nctsnet.org/sites/default/files/assets/pdfs/tfcbt_general.pdf

[12] http://www.pcit.org/

Bright Futures planning project in 2007[13] recommended the development and implementation of a countywide program that would provide specialized counseling services that help children recover from the effects of exposure to domestic violence and integrate domestic violence advocacy and services with mental health treatment. For the past eight years, the CDVRT program has delivered this effective integrated model in South King County supported by the MIDD. A Countywide expansion of the CDVRT program to three teams, South, East and Seattle/North will significantly improve the systems response to children impacted by DV.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

The impacts of domestic abuse nationwide and locally are well documented: Domestic violence survivors and their children face immediate and ongoing physical safety issues in the threat of further and continuing violence. The chronic stress and trauma of domestic violence puts children at high risk for mental health and substance use disorders[14].

- Adults and children impacted by family violence are at risk for mental health disorders that include anxiety, depression, and post-traumatic stress. Fifty percent of all mental health care dollars are spent on adults who were abused as children.
- The strongest known risk factor for being a domestic violence perpetrator or victim as an adult is witnessing domestic violence as a child.
- Chronic stress is a recognized contributor to impaired executive functioning in children and youth, which is frequently manifested in aggressive and antisocial behaviors and poor school performance.
- Violence is prevalent among young people with untreated mental health disorders—in 2006, 1,455 youth were incarcerated in Washington's juvenile justice system.

The need: Though the incidence of domestic violence in families is generally on the decline[15], it remains a significant social issue with far reaching consequences for families and the community. Among low-income families, a number of factors—unemployment, homelessness, and difficulties faced by veterans returning from conflict—exacerbate the disastrous and dangerous impacts of domestic violence.

- Each Year approximately 39,064 to 78,129 children/youth living in King County are exposed to domestic violence each year (Based on national estimates of children's exposure to interpersonal violence (IPV) and 2000 Census data).
- An estimated 128,913 King County children/youth have been exposed to IPV sometime in their lives (Carlson, 2000).
- Statisticians estimate from U.S. Census data that more than 30 percent of youth under 18 currently living in King County have been exposed to domestic violence sometime during their lives.

[13] http://www.kingcounty.gov/~/media/courts/Clerk/docs/master_final_report.ashx?la=en
[14] http://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html
[15] http://www.bjs.gov/content/pub/pdf/ndv0312.pdf

Domestic Violence is a leading cause of homelessness. According to national studies:

- An estimated 38 percent of women who experience DV also become homeless.
- An estimated 92 percent of homeless women have experienced severe physical or sexual abuse at some point in their lives.
- An estimated 63 percent of homeless women have experienced DV as adults.

The Problem: The impact of domestic abuse is well documented:
Domestic violence survivors and their children face immediate and ongoing threat of further violence. For many survivors with children, post-separation battering continues related to shared custody and/or unsupervised visitation with the children.

Children impacted by family violence are at risk for mental health disorders that include anxiety, depression, and post-traumatic stress; fifty percent of all mental health care dollars are spent on adults abused or exposed to abuse as children.[16] [17] Untreated mental health disorders pose high risks for substance abuse, violent or self-destructive behavior, and suicide—the second leading cause of death among people under 24 years old. In the United States, 61 percent of men and 51 percent of women report exposure to at least one lifetime traumatic event, and 90 percent of clients in public behavioral health care settings have experienced trauma. If trauma goes unaddressed, people with mental illnesses and addictions will have poor physical health outcomes and ignoring trauma can hinder recovery. To ensure the best possible health outcomes, all care — in all health settings — must address trauma in a safe and sensitive way.[18]

- Chronic stress caused by family tension contributes to impaired executive functioning, manifested in aggressive and antisocial behaviors and poor school performance.
- The strongest known risk factor for being a domestic violence perpetrator or victim as an adult is witnessing domestic violence as a child.

Most people can imagine how a child's exposure to the violent assault of one parent by the other can create all sorts of emotional and psychological stressors for the child and disrupt the child's development. The CDVRT is a promising practice intervention that strives to address the needs of children caught up in post- separation, coercive control tactics employed by batterers long after the abusive relationship has ended. This creates a circumstance of chronic stress: Children react with severe depression, some are suicidal; and some children act out violently in reaction to the emotional verbal and physical abuse they have experienced in their homes.

The Opportunity: The number one recommendation of the Safe and Bright Futures planning project back in 2007, was to develop a countywide program that would 1) provide specialized counseling services that help children recover from the effects of exposure to domestic violence, 2) integrate domestic violence advocacy and services with mental health treatment, and 3) treat survivors and their children together. For the past eight years, the CDVRT program has delivered this effective integrated model in South King County supported by the MIDD. The MIDD II support of a County-wide CDVRT will

[16] Edleson, J.L. (1999a). The overlap between child maltreatment and woman battering. Violence Against Women, 5(2), 134-154.
[17] Edleson, J.L. (1999b). Children's witnessing of adult domestic violence. Journal of Interpersonal Violence, 14(8), 839-870.
[18] http://www.integration.samhsa.gov/clinical-practice/trauma

make this recommendation a reality, by ensuring sustainable funding for the expanded County-wide CDVRT.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

The Children's Domestic Violence Response Team (CDVRT) is a prevention and early intervention model that is part of a coordinated community response to meet the needs of children impacted by domestic violence. The purpose of the Children's Domestic Violence Response Team (CDVRT) program is to support children who have been exposed to domestic violence—and their non-abusive parents—in recovering from the trauma that result from exposure to violence. The current South County CDVRT and the two small pilot teams in Seattle and Bellevue have demonstrated the ability to provide effective services utilizing cross system collaboration, evidenced based treatment interventions, and safety oriented care coordination.

In the CDVRT program's first five years, it has been highly successful in decreasing trauma symptoms and improving emotional stability of children treated and decreasing aggressive and anti-social behaviors resulting from exposure to domestic violence. The anticipated short-term impact of the program is recovery, improved functioning, and safety of children and non-abusive parents treated by the program, evidenced by decreased trauma symptoms and increased relationship and coping skills. Anticipated longer-term impact is reduced recurrence of abuse within the same families, reduction in generational replication of domestic violence, and improved community response to domestic violence. We believe that ultimately the program will contribute to reduction in domestic violence overall.

Over the eight years the CDVRT has been delivered, the program has received overwhelming praise for this specialized approach from professional colleagues in other child and family serving systems (such as CPS, GAL's, law enforcement, family court attorneys, family court judges, CPS/DV Best Practices work group). All children impacted by domestic violence in King County deserve access to this specialized program.

The CDVRT supported by MIDD in South King County (Strategy 13b), has been highly effective in providing safe and effective services to meet the needs of children impacted by domestic violence and their survivor parents. The demand for services for children impacted by domestic violence is so high in South King County, that the CDVRT has served more than twice the number of children and non-abusive parents as contracted throughout MIDD I program years.

A pilot for CDVRT expansion to a countywide model was started and operated with funds from a federal grant from 2010 to 2013. Since that time the provider has obtained private funds to partially support the program and has blended these funds with MIDD funding and other resources. As a result, the CDVRT East and the CDVRT Seattle/North were able to serve nearly 200 clients in Seattle/North and East King in 2015. A capacity expansion from a .5 FTE advocate and .5 FTE therapist, plus program expenses to a 1.0 FTE advocate and 1.0 FTE therapist for each team, plus a program supervisor would allow the program to better meet the service demand and assure program stability. The current two small teams are not able to meet the demand in King County for a regional county-wide CDVRT program. Currently MIDD funding pays for the staff time spent in: cross system coordination and collaboration, systems improvement, safety planning, consultation, and specialized DV and Program training. Treatment services are reimbursed by Medicaid and private insurance. The MIDD II provides an opportunity to have sustainable funding for the CDVRT to serve all King County's children impacted by DV.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

The CDVRT was developed following recommendations from Safe and Bright Futures (SBF)[19], a federally funded systems improvement grant facilitated by Seattle/King County Public Health. The overall purpose and product for the SBF planning process was "to develop a comprehensive, county-wide strategic plan for infants, children, and youth exposed to domestic violence (DV)." This community process was guided and informed by the information gathered through a comprehensive needs assessment process, which involved an evaluation of existing quantitative data in provider databases. The needs assessment also included qualitative data obtained from: Two community stakeholder meetings attended by approximately 100 participants, 73 providers completed surveys at a 2005 children and DV conference; Meetings throughout the project by a 50 member SBF Advisory Board; 65 community providers participated in key informant interviews or focus groups; 42 DV survivors who were exposed to DV as children or were parents of children exposed to DV participated in interviews or focus groups.

Dr. Jeffrey L. Edleson, Ph.D., served as project consultant for the Safe and Bright Futures Grant. Dr. Edleson is a Professor at the University of Minnesota School of Social Work and Director of the Minnesota Center Against Violence and Abuse. Dr. Edleson has published over 90 articles and seven books on domestic violence, groupwork, and program evaluation. Dr. Edleson conducted intervention research at the Domestic Abuse Project in Minneapolis over the past two decades. He is a consultant to the U.S. Centers for Disease Control & Prevention and to the National Council of Juvenile and Family Court Judges. [20]

The CDVRT model is based on a Wraparound Care Approach: Families served benefit from principles of "Wraparound Care," a nationally recognized approach that emphasizes family voice/choice in all decisions, builds networks of community support that increase resilience and decrease reliance on formal systems. Immigrant and refugee families are served by staff trained in serving culturally diverse clients and have access to language interpreters.

According to the Washington State Legislative directive for mental health services provided to children, the CDVRT model incorporates *WA State approved* Evidence Based Practices (EBP's) into the program design. Children's mental health therapists in the CDVRT provide Cognitive Behavioral Therapy (CBT)[21], Trauma-Focused Cognitive Behavioral Treatment (TF-CBT), Parent Child Interaction Therapy (PCIT). These EBP's are integrated into a collaborative wraparound service plan together with the domestic violence advocacy services. These specialized interventions are demonstrated to be effective with

[19] http://www.kingcounty.gov/~/media/courts/Clerk/docs/master_final_report.ashx?la=en

[20] Edleson, J.L. (2006). A response system for children exposed to domestic violence: Public policy in support of best practices. In Feerick, M. & Silverman, G.B. (Eds.). Children Exposed to Violence. Baltimore, MD: Brookes.

[21] "Cognitive-behavioral therapy (CBT) is a form of psychotherapy that treats problems and boosts happiness by modifying dysfunctional emotions, behaviors, and thoughts. Unlike traditional Freudian psychoanalysis, which probes childhood wounds to get at the root causes of conflict, CBT focuses on solutions, encouraging patients to challenge distorted cognitions and change destructive patterns of behavior." https://www.psychologytoday.com/basics/cognitive-behavioral-therapy

children who are survivors of trauma; and/or children whose developmental trajectory has been disrupted by fear and trauma. The CDVRT program delivers mental health services that meet or exceed King County's Mental Health Plan for compliance with service delivery, as well as compliance with Washington Administrative Code (WAC 388-877A-0100) for mental health outpatient services[22]. The average program Performance Outcome is 150 percent of the original target (144 families served, 85 families was the target, 169 percent of target, MIDD 7th Annual Report[23]).

The CDVRT Domestic Violence Partners are highly regarded in the DV community, recognized to deliver culturally informed services for survivors with diverse ethnic and cultural backgrounds.

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an:** Promising Practice**. Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

Promising Practice - The CDVRT is a "promising practice" on pace to become an evidence based practice (EBP) for children impacted by domestic violence. See above for justification, based on research and best practices utilized by the program. The program was developed in a collaborative process, facilitated by a local expert; and includes a well-researched program manual. Additionally the evidence/data collection done as part of the CDVRT is contributing to the body of evidence on responding effectively and safely to the needs of children impacted by domestic violence. The CDVRT supports the field's collective progress toward the development of an EBP for children impacted by domestic violence and contributes to the body of knowledge about what helps children recover for DV.

The program includes a number of clinical measures (pre-test and post test scores) to document improved outcomes and functioning in children served by CDVRT.

Measures used include:

- The Pediatric Symptom Checklist-17 (PSC-17): The Pediatric Symptom Checklist (PSC) is a brief screening questionnaire (17 item version for both parents and youth) that is used to improve the recognition and treatment of psychosocial problems in children.[24]
- Child Post-traumatic Symptom Scale (CPSS): The CPSS is a 26-item self-report measure that assesses Post Traumatic Stress Disorder (PTSD)[25] diagnostic criteria and symptom severity in children ages 8 to 18[26].
- Moods and Feelings Questionnaire (MFQ): The ***MFQ*** consists of a series of descriptive phrases regarding how the subject has been feeling or acting recently. Codings reflect whether the

[22] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877A-0100

[23] http://www.kingcounty.gov/~/media/health/MHSA/MIDD_ActionPlan/Reports/150616_MIDD_Seventh_Annual_Report.ashx?la=en

[24] http://www.massgeneral.org/psychiatry/services/psc_home.aspx

[25] PTSD: When in danger, it's natural to feel afraid. This fear triggers many split-second changes in the body to prepare to defend against the danger or to avoid it. This "fight-or-flight" response is a healthy reaction meant to protect a person from harm. But in post-traumatic stress disorder (PTSD), this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they're no longer in danger. PTSD develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers. http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml

[26] http://www.ptsd.va.gov/professional/assessment/child/cpss.asp

phrase was descriptive of the subject most of the time, sometimes, or not at all in the past two weeks. The target population for the screener is 8-18[27].

- SCARED Anxiety Scale: The ***SCARED*** is a child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder, and social phobia. In addition, it assesses symptoms related to school phobias.[28]

Demonstrating progress in treatment recovery for children impacted by domestic violence is challenging because of disruptions related to on-going traumas that occur in post separation battering and coercive control tactics used by the batterer. Children improve, but are easily set back when new threats or abuse occurs. The CDVRT has a chance to make a significant contribution to the field regarding what helps children impacted by family violence.

References for Section 4:

- Website on children exposed to domestic violence at http://www.mincava.umn.edu/link
- Dunford-Jackson, B.L. (2004). The role of family courts in domestic violence: The US experience. In Jaffe, P.G., Baker, L.L. and Cunningham, A. (Eds.) *Ending Domestic Violence in the Lives of Children and Parents: Promising Practices for Safety, Healing, and Prevention* (pp. 188-199). New York, NY: Guilford Press.

Following three papers are online at http://www.futureofchildren.org:

- Lemon, N.K.D. (1999). The legal system's response to children exposed to domestic violence. *The Future of Children, 9,* 67-83.
- Mathews, M.A. (1999). The impact of federal and state laws on children exposed to domestic violence. *The Future of Children, 9,* 50-66.
- Weithorn, L.A. (2001). Protecting children from exposure to domestic violence: The use and abuse of child maltreatment. *Hastings Law Review, 53(1),* 1-156.

5. What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?

Children and DV survivors living in King County, needing mental health services to recover from the impacts of domestic violence will have access to and receive effective, high quality, collaborative services that address the complex needs of families impacted by domestic violence. If fully funded, the County-wide CDVRT would serve up to 600 individuals annually.

Below are the service totals for the time period July 2014 through June 2015, provided to reflect what the MIDD II dollars would enable by supporting a County-wide CDVRT.
The combined CDVRT (Including the two pilot expansion teams) served during the period.

- Total Number Served: 432 children and 257 non-abusive/survivor parents; 45 percent of the clients served are ethnic/ cultural minorities
- Total Service Hours provided = 9,232 hours of specialized services
  - Kids Club = 456 hours
  - Family Team/Wraparound meeting = 290 hours

[27] http://www.cebc4cw.org/assessment-tool/mood-and-feelings-questionnaire-mfq/
[28] http://www.cebc4cw.org/assessment-tool/screen-for-childhood-anxiety-related-emotional-disorders-scared/

- In-home services = 634 hours
- Mental Health treatment = 3,360 hours
- DV Advocacy = 4,489 hours

Anticipated short-term impact of the CDVRT program is safety, recovery, and improved functioning of children and parents treated by the program, evidenced by decreased trauma symptoms and increased relationship and coping skills. Longer-term impact is reduced recurrence of abuse within the same families, reduction in generational replication of domestic violence, and improved community response to domestic violence. Ultimately, the program will contribute to an overall reduction in domestic violence.

Benefits to children and families served by the CDVRT program are:

- Decreased trauma symptoms, depression, and anxiety
- Reduction in children's aggressive and violent behaviors and other behavioral problems in school, family, and community settings
- Improved social and relationship skills and Increased resiliency factors
- Improved relationships between exposed children and their non-abusive parents
- Increased social support from adults in the children's school and social environments

The CDVRT uses the Pediatric Symptom Checklist-17 (PC-17), and the Child Post Traumatic Symptom Scale (CPSS) to measure symptom changes and outcomes. The outcomes measured are reductions in symptoms and /or problem behaviors, and improved functioning, coping skills and relationships. Work is on-going to refine outcome measurement tools and protocols. Anecdotally, the participants and the staff have many success stories of resiliency and recovery. Data using these measures are reflective of the pattern of trauma, stabilization and re-traumatization that these children experience. The Program Outcome Survey shows that participants rated the program "excellent," and "very good" in regards to effectively addressing the concerns on the treatment plan, and with regards to increasing participant's sense of safety and mastery. Some sample quotes from the survey include:

- "My daughters and I communicate in a healthy manner since becoming part of this beautiful collaboration in the support of my family's growth as a team."
- "The program has calmed me, drastically! It has helped me let go of any negativity."
- "Though in the early stages of therapy, I have made wonderful progress in better relating with my children with positive, healthy results."
- "With every obstacle, I have been offered a resource within my community to help me succeed in my recovery."

6. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☒ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☒ **Children 0-5**	☐ **Black/African-American**
☒ **Children 6-12**	☐ **Hispanic/Latino**
☒ **Teens 13-18**	☐ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☐ **Adults**	☒ **Immigrant/Refugee**
☐ **Older Adults**	☐ **Veteran/US Military**
☒ **Families**	☐ **Homeless**

- ☐ **Anyone**
- ☐ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☐ **GLBT**
- ☒ **Women**

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

The recipients of the services are children who have been impacted by witnessing and/or experiencing violence in their homes, and their non-abusive (survivor) parent. Domestic violence occurs in all social, educational and economic strata. The CDVRT primarily serves low income individuals. 2015 data show 45 percent are ethnic and cultural minorities, including a significant number of immigrants and refugees; 101 of the children served are very young, birth to age 5 years, and another 179 are under age 10 years.

Survivors of domestic violence often have PTSD and other concerns that are the direct result of trauma from domestic violence.

Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection:

County-wide **–**

The demand for effective services to meet the need for services for children impacted by domestic violence is well documented. The combined MIDD Strategy 13b plus the pilot CDVRT expansion served nearly 500 individuals in 2015. Demand for the program is greater than current capacity. The mental health provider has Child and Family service locations in Auburn, Tukwila, Bellevue, Redmond, Seattle and Northgate.

The program is delivered in partnership with DV advocacy organizations throughout King County: DAWN (Domestic Abuse Women's Network) and YWCA in South King County, Lifewire in East King County, and New Beginnings in Seattle/North. Collaborative agreements are in place and all three teams are trained and functioning well.

2. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

   The program is delivered in Partnership with the four geographically located DV advocacy organizations: DAWN and YWCA in South King County, Lifewire in East King County, and New Beginnings in Seattle/North King County. Additionally the CDVRT has strong relationships with The Child Protective Services -CPS/DV Best Practices Work Group, the Coalition Ending Gender-Based Violence; King County Family Court Services; the Guardian Ad Litem Program; Division of Children and Family Services (DCFS); the Protection Order Program; a number of legal advocates and attorneys, plus a whole host of community resources. Collaborative relationships and referral relationships are in place.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?

The program drivers are: The huge demand for services and the challenges of providing safe and effective services in families impacted by DV; The legislation to provide evidenced based practices for children; The CDVRT embraces wraparound values and concepts and is able to address both prevention and early intervention; and the need for system improvement in response to children impacted by domestic violence.
Feasibility – Implementing a full countywide CDVRT program is highly feasible, given the success of the CDVRT for the past seven years (MIDD strategy 13b.) and the fact that two small expansion teams with Lifewire and in New Beginnings are already developed.

2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

No barriers. The program will need to hire additional therapists and subcontract with advocates for the expansion teams and hire a program manager to oversee the countywide program. Training is ongoing and can occur as soon as staffs are hired.

3. What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?

The only consequence is that the current program is not designed/nor intended to serve the abusive parents/batterers. Best practice dictates that for physical and emotional safety, survivors of violence should not be served by the same program that serves the abuser. Abusive parents are referred to other services and providers.

4. What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?

If the Countywide CDVRT is not implemented, the current effort to sustain the CDVRT county-wide effort will falter without sustainable funding and the current South team would not have adequate resource. The small Eastside team and Seattle/North teams are at risk to discontinue. The remarkable accomplishments noted above will not be repeated. The consequence would be that the current and increasing numbers of children and survivors of DV would not have access to this specialized program.

5. What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?

This program merges existing mental health treatment as usual, with integrated DV advocacy and safety planning. The CDVRT incorporates Wraparound principles and values. The whole is greater than the sum of the parts.

E. Countywide Policies and Priorities

1. How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?

The work of existing MIDD strategy 13b aligns closely with the goals, objectives and planned outcomes for a number of King County initiatives including the following:

- **Committee to End Homelessness** – although this MIDD strategy does not directly provide housing for DV survivors (who are at higher risk for homelessness), it does support the goal of addressing crises as quickly as possible, assessing needs and connecting people to supportive services to address identified needs, achieve stability and prevent further escalation of the crisis.

- **Health and Human Services Transformation Plan** – the provision of MH and SUD services to DV survivors is directly related to the Health and Human Services Transformation Plan's vision of increasing community health and well-being by "focusing on prevention, embracing recovery and eliminating disparities." As previously discussed, provision of trauma-informed, culturally responsive, MH and SUD services on site to domestic violence survivors regardless of funding and without need to meet larger system "access to care standards" supports this initiative's planned outcome of "improving access to person-centered, integrated and culturally competent services when, where and how people need them."

- **King County Strategic Plan (2010)** – the KCSP prioritizes the "need to provide safe communities and accessible justice systems for all." MIDD strategy 13b exemplifies this goal by offering DV survivors psychosocial resources to help end the cycle of violence. In addition, the systems coordination portion of this strategy strengthens linkages and collaborations within cities and communities in improving partnerships within the DV response system.

- **Best Start for Kids (2015) –** the BSK prioritizes prevention services to children and young adults and includes domestic violence prevention, which this strategy fits well with, as it provides the prevention/early intervention services to children/youth who have experienced DV.

Strategy 13b also aligns with the King County **Equity and Social Justice Initiative** (see #3 below for specifics).

2. How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?

Recovery and Wraparound values and principles; combined with a trauma-informed care approach.

MIDD strategy 13b provides behavioral health services in accordance with the 2012 King County Recovery and Resiliency Ordinance that promotes service delivery within a "trauma-informed, recovery and resiliency focused system that offers respect, information, connection and hope."

When seeking mental health services through the DV/MH programs supported by this strategy, survivors are generally viewed as experiencing psychiatric symptoms that are "understandable responses to terror and entrapment that are likely to resolve with safety and support" rather than long-term pathology or specific deficits within the victim. Assessment begins with a "what happened to you" vs. "what is wrong with you" approach.

3. How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?

This will serves a high proportion of ethnic minorities, including refugees and immigrants. Domestic Violence work is social justice work.

King County's Fair and Just Ordinance 16948 (2010) requires that organizations intentionally consider equity and integrate it into decisions and policies, practices, and methods for engaging all communities. The County is committed to serving all residents, regardless of race, culture or disability, by promoting fairness and opportunity, eliminating inequities and working to remove barriers that limit an individuals' or a community's ability to fulfill their full potential.

MIDD strategy 13b aligns closely with this mission as it is designed to improve access to MH and SUD treatment for DV survivors by eliminating some of the barriers that exist in the current behavioral health system. Clients can access treatment within the same program where they are receiving other advocacy and supportive services and do not need to meet access to care (diagnostic/functional) requirements or be eligible for Medicaid funding to receive services.

Strategy 13b also targets populations with a high degree of need for services to address individuals dealing with domestic violence and other significant trauma history, i.e. persons of color, refugee/immigrant, persons with disabilities, etc. and prioritizes services to survivors in their own language. Emphasis is also placed on cultural responsiveness in addressing the unique perspectives and impact of DV within different populations

F. Implementation Factors

1. What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program (staff, physical space, training, UA kits, etc.)**?**

The requested MIDD II funding will pay for staffing (up to 7.0 FTE) and program expenses for three geographic CDVRT teams: South, East and Seattle.

- Each team consists of the *full time equivalent of 1 FTE therapist* and 1 FTE DV Advocate. This is a ratio of 1:1, Mental Health Clinician to DV Advocate. For example: 1 FTE provides 40 hours a week of therapist time to provide services and participate in program activities. There are eight therapists on CDVRT East, each spending approximately 5 hours a week in CDVRT activities (i.e. 4 hrs/mo. team meetings; travel; screening/engagement with survivors, safety planning, consultation, community

education and outreach) that are not reimbursable by Medicaid Mental Health Plan or Health Plans. The current model (if it were to be fully funded) is 1:1, Mental Health Clinician to DV Advocate.
- Note: In this model, the MIDD funding pays for the non-reimbursed time it takes for a clinician to coordinate care, collaborate/safety plan and ensure best practices for children impacted by DV.
- Treatment services are paid for by Medicaid and commercial insurance.

Countywide CDVRT - Total: 7 FTE
- 3.0 FTE MH Clinician (1 each for South, East, and Seattle/North)
- 3.0 FTE DV Advocate (1 each South, East, and Seattle/North)
- 1.0 FTE Program Manager/Supervisor – Oversees and coordinates the county wide CDVRT Program, including managing hiring, training, supervision, administrative requirements and reporting.

2. Estimated ANNUAL COST. Provide unit or other specific costs if known.

$501,000-$1.5 million
The current award for CDVRT South (Strategy 13b) is $224,000 annually. To allow for inflation and program management: $250,000 per team X 3 teams = $750,000
Less funding will result in less staffing, and fewer being served.

3. Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.

Current CDVRT funding includes $60K from United Way of King County, and approximately $100K in Foundation Grants. Prior funding included the Federal Office of Juvenile Justice and Delinquency Prevention.

"Best Starts for Kids" is another promising potential for new funding as it focuses on prevention.

4. TIME to implementation: <u>Currently underway</u>
- **a. What are the factors in the time to implementation assessment?**
- **b. What are the steps needed for implementation?**
- **c. Does this need an RFP?**

No RFP is needed. The service is efficient and it will be cost effective to continue to utilize existing organizations that have piloted the expansion to continue to develop the integrated model of DV/MH and SUD services within community based DV advocacy organizations. The steps of expansion efforts may be focused to include organizations that have the capacity to provide DV core services (as defined by the DV network and key stakeholders). They include: legal, housing, medical, social service and community advocacy, safety planning assistance, crisis intervention and support, information and referral, advocacy-based counseling and parenting support, professional training, community education and outreach. Agencies should also evidence a commitment to partnership within the network to provide mental health services to DV survivors within an integrated, trauma-informed framework.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

The current CDVRT services to implement MIDD Strategy 13b has high performance outcomes throughout MIDD I years.

Please review the preceding pages before completing this form.

Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

#56

Working Title of Concept: CDVRT Countywide Expansion

Name of Person Submitting Concept: Susie Winston
Organization(s), if any: Sound Mental Health
Phone: 206-302-2340
Email: Susiew@smh.org
Mailing Address: 1600 e. Olive St, Seattle WA 98122

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Expand the Children's Domestic Violence Response Team (CDVRT) to a countywide service by adding two more MIDD supported teams: one team in Seattle/North King County with New Beginnings; and one the Eastside with Lifewire. A countywide CDVRT would provide a specialized collaborative program to address the needs of children and their non-abusive (survivor) parent that have been impacted by domestic violence in King County. The CDVRT is a collaborative cross system model that provides effective prevention and early intervention services to families impacted by DV. CDVRT provides a comprehensive package of safety planning and protection, advocacy, and mental health treatment to the families served in the program. The family is served by a team that consists of the non abusive parent and a DV advocate and a mental health therapist. Currently, the CDVRT (Strategy 13b) is funded by the MIDD to serve 120 clients only in South King County.

The purpose of the program is to engage supportive parents in identifying the needs of their children and families, provide effective services and supports, and ensure that culturally competent approaches are employed to mitigate the risks of DV exposure with children. The key program outcomes are to: 1) Decrease trauma symptoms exhibited by children as a result of intervention. 2) Increase protective/resiliency factors available to children and their non-abusive

parents.
3) Reduce children's belief that domestic violence is their fault and help children correctly assign responsibility for violent behaviors. 4) Improve social and relationship skills so that children may access needed social supports in the future. 5) Reduce children's violent behaviors and other behavioral problems as observed in school, community, and family settings; and increase awareness of supportive adults in the children's natural environment so that they may provide needed social supports when necessary.

The children's mental health clinicians on the team provide mental health services, including evidenced based practices (EBP's), and other mental health treatments coordinated within a team context. This functioning as a cross-system team seems to be the best way to effectively address the complex needs of children impacted by domestic violence, and their survivor parent. By combining best practice interventions and cross systems collaboration between two systems, the domestic violence advocacy system and the children's mental health system, the CDVRT is effecting systems improvement. The survivors, therapists and advocates all report high praise for the program.

To deliver the CDVRT program, SMH has partnered with leading domestic violence service providers, including Domestic Abuse Women's Network (DAWN), South King County YWCA, Lifewire (formerly EDVP), and New Beginnings. Through this collaboration, the partners are able to provide an integrated approach to serving children exposed to domestic violence—one in which mental health services (based on a medical or treatment model) and domestic violence support (based on a social service model) come together as mutually support activities of the program. The CDVRT Model relies on collaboration between mental health therapists and domestic violence advocates.

2. What community <u>need, problem, or opportunity</u> does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

The impacts of domestic abuse nationwide and locally are well documented: Domestic violence survivors and their children face immediate and ongoing physical safety issues in the threat of further and continuing violence. The chronic stress and trauma of Domestic violence puts children at high risk for mental health and substance use disorders.

- Adults and children impacted by family violence are at risk for mental health disorders that include anxiety, depression, and post-traumatic stress. 50% of all mental health care dollars are spent on adults who were abused as children.
- The strongest known risk factor for being a domestic violence perpetrator or victim as an adult is witnessing domestic violence as a child.
- Chronic stress is a recognized contributor to impaired executive functioning in children and youth, which is frequently manifested in aggressive and antisocial behaviors and poor school performance.
- Violence is prevalent among young people with untreated mental health disorders—in 2006, 1,455 youth were incarcerated in Washington's juvenile justice system.

Each year approximately 39,064 to 78,129 children and youth living in King County are exposed to domestic violence, according to the 2000 US Census and national estimates of children's exposure to adult domestic violence. From these figures, statisticians further estimate that approximately 130,000 children and youth—more than 30% of children and youth under 18 currently living in King County—have been exposed to domestic violence sometime during their lives. Exposure to adult domestic violence in a child's life is identified as one of eight adverse

childhood experiences (ACE's), including exposure to substance abuse, mental illness, incarcerated family members, and all forms of abuse and/or neglect. The effects of DV exposures on infants, children and youth can be mitigated. Children are resilient, recovery occurs with support or therapy to address the trauma, but also services to help repair the relationship with the non-abusive parent. Children impacted by DV benefit by opportunities to develop and maintain positive and healthy relationships with supportive caregivers and other support systems.

The MIDD II provides a unique opportunity for expanding the CDVRT to a sustainable countywide service. Currently SMH has delivered the CDVRT services to more than 300 children and survivors in South King County, more than doubling the contract expectations. In 2009 with support from KCCADV and a Federal Juvenile Justice grant, SMH Subcontracted with New Beginnings and Lifewire to deliver the CDVRT in Seattle/North and East King County respectively. SMH successfully performed on the contract. Those funds were expended more than three years ago, and SMH is still providing CDVRT in Seattle with New Beginnings and in Bellevue with Lifewire. The opportunity is that MIDD II funding would secure this unique and specialized service for all of King County's children who are impacted by domestic violence.

3. How would your concept address the need?
Please be specific.

Children can recover from the effects of exposure to domestic violence through specialized support and counseling, support for their abused parent, ongoing interaction with knowledgeable and protective adults, and the opportunity to live in a non-violent home. In the King County region, there is a broad range of services available to adult victims and adult perpetrators of domestic violence, as well as mental health services for adults and for children. Until the advent of CDVRT, however, there were no specialized counseling services in the King County region to help children recover from the effects of exposure to domestic violence or counseling services that treat children and their abused parents together.

The Children's Domestic Violence Response Team (CDVRT) is a prevention and early intervention model that is part of a coordinated community response to meet the needs to children impacted by domestic violence. The purpose of the Children's Domestic Violence Response Team (CDVRT) program is to support children who have been exposed to domestic violence—and their non-abusive parents—in recovering from the trauma that result from exposure to violence. The current South County CDVRT and the two small pilot teams in Seattle and Bellevue have demonstrated the ability to provide effective services utilizing cross system collaboration, evidenced based treatment interventions, and safety oriented care coordination. The purpose of the program is to engage supportive parents in identifying the needs of their children and families, provide effective services and supports, and ensure that culturally competent approaches are employed to mitigate the risks of DV exposure with children.

The CDVRT staff work in close collaboration across the DV and MH systems for the families served by the team. Although their roles are different, advocates and therapists each bring a unique role and perspective is vital and complementary. There is an equitable balance of power and shared decision making among team members in all program activities. The team consults regularly to ensure coordinated care. The mental health clinicians provide treatment/therapeutic consultation and support; the DV advocates ensure the attention to safety and empowerment of the survivor.

In the CDVRT program's first five years, it has been highly successful in decreasing trauma

symptoms and improving emotional stability of children treated; and decreasing aggressive and anti-social behaviors resulting from exposure to domestic violence. The anticipated short-term impact of the program is recovery, improved functioning, and safety of children and non-abusive parents treated by the program, evidenced by decreased trauma symptoms and increased relationship and coping skills. Anticipated longer-term impact is reduced recurrence of abuse within the same families, reduction in generational replication of domestic violence, and improved community response to domestic violence. We believe that ultimately the program will contribute to reduction in domestic violence overall.

One of the most significant aspects of the CDVRT is the team's ability to navigate the multiple systems and other challenges that are common for families who have experienced domestic violence. The CDVRT model ensures that all care is coordinated through a lens of safety, with physical and emotional safety for children first and foremost at all times. The criminal court and family court systems complicate domestic violence cases in such a manner that it becomes necessary for advocates and therapists to receive specialized training and consultation to effectively work with survivors of violence and their children. Over the 8 years since we have been delivering the CDVRT we hear overwhelming praise for this specialized approach from our colleague professionals in the other child and family serving systems (such as CPS, GAL's, law enforcement, family court attorneys, family court judges, CPS/DV Best Practices work group). All children impacted by domestic violence in King County deserve access to this specialized program.

4. Who would benefit? Please describe potential program participants.

An Expanded Countywide CDVRT could serve 600 children and survivors of domestic violence living in King County. The CDVRT program serves families living in King County, who have been impacted by domestic violence. This includes 1) children ages 0-17 who have been exposed to domestic violence and 2) their non-abusive parents. The Team program serves families referred by domestic violence service providers; King County Public Health; Washington State Division of Child and Family Services (Child Protective Services/Best Practices Group); schools; the justice system; churches; and nonprofit child serving community organizations. Racial/ethnic demographics of individuals served to date include nearly 50% people of color. All families served are low-income; the majority is eligible for Medicaid.

There are overwhelming social, financial, and psychological stressors effecting families impacted by domestic violence. These families are often in shelters or transitional housing after fleeing the abuse. Home life is chaotic, and or highly stressed as survivors and their children attempt to adjust. Many of the families are in real danger and are in hiding from the abuser. Some families abruptly move out of county or out of state to flee the batterer. Other families go through cycles of abuse related to contact with the batterer. The children's behavior reflects a series of improvements during safe and peaceful times, and evidence of trauma and fear when post separation battering occurs. For example, a family may have stabilized and then go into crisis after becoming re-traumatized by a new episode of violence.

Benefits to children and families served by the CDVRT program are:

- Decreased trauma symptoms, depression, and anxiety
- Reduction in children's aggressive and violent behaviors and other behavioral problems in school, family, and community settings
- Improved social and relationship skills and Increased resiliency factors
- Improved relationships between exposed children and their non-abusive parents
- Increased social support from adults in the children's school and social environments

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Successful Implementation of a Countywide CDVRT would have three CDVRT teams: CDVRT-South with DAWN and YWCA, CDVRT-East with Lifewire; and CDVRT-Seattle/North with New Beginnings. Each team staffed with a 1:1 ratio of Advocate to Therapist.
Each team will serve 150-300 participants. Estimate 600 clients served per year.

Anticipated short-term impact of the CDVRT program is safety, recovery, and improved functioning of children and parents treated by the program, evidenced by decreased trauma symptoms and increased relationship and coping skills. Longer-term impact is reduced recurrence of abuse within the same families, reduction in generational replication of domestic violence, and improved community response to domestic violence. Ultimately, the program will contribute to an overall reduction in domestic violence.

The CDVRT uses the Pediatric Symptom Checklist-17 (PC-17), and the Child Post Traumatic Symptom Scale (CPSS) to measure symptom changes and outcomes. The outcomes measured are reductions in symptoms and /or problem behaviors, and improved functioning, coping skills and relationships. We are working to refine our outcome measurement tools and protocols. Anecdotally, the participants and the staff have many success stories of resiliency and recovery. Our data using these measures are reflective of the pattern of trauma, stabilization and re-traumatization that these children experience. The Program Outcome Survey shows that participants rated the program "excellent," and "very good" in regards to effectively addressing the concerns on the treatment plan, and with regards to increasing participant's sense of safety and mastery. Some sample quotes from the survey include:

- "My daughters and I communicate in a healthy manner since becoming part of this beautiful collaboration in the support of my family's growth as a team."
- "The program has calmed me, drastically! It has helped me let go of any negativity."
- "Though in the early stages of therapy I have made wonderful progress in better relating with my children with positive, healthy results."
- "With every obstacle, I have been offered a resource within my community to help me succeed in my recovery."

The CDVRT data for the South team has been submitted as per contract. We have seven years of program data.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

MIDD Briefing Paper

The CDVRT is an early intervention and prevention program that contributes to positive health and mental health outcomes for the families who participate. The CDVRT is a specialized program for children and survivors of domestic violence. Children impacted by violence in the home, and survivors of domestic violence are persons living with mental health or substance use disorders; or are persons at high risk of developing mental health or substance use disorders. The purpose of the CDVRT program is to engage supportive parents in identifying the needs of their children and families, provide effective services and supports, and ensure that culturally competent approaches are employed to mitigate the risks of DV exposure with children. The CDVRT fits within the MIDD II framework in the following ways:

Improved Health - We know from the ACE's Study that domestic violence is one of the 8 adverse childhood experiences that correlate directly to poor health and mental health and substance use disorder outcomes. Children impacted by domestic violence suffer all sorts of poor outcomes including becoming a perpetrator of violence, psychiatric/mental health problems, substance use disorders, and are high utilizers of jails and prison systems. The CDVRT strives to provide culturally relevant and diverse services. Our data show that the majority of CDVRT participants are persons of color or other minorities.

Prevention/Early Intervention – From its inception, the CDVRT included a strong prevention/early intervention component. The DV advocates felt strongly that it was important to offer an intervention to the parents and children that did not require a mental health assessment and diagnosis, since same were associated with survivors being stigmatized as mentally ill and loosing custody of their children.. The CDVRT includes "Kids Club," a social/emotional educational curriculum to help children who may live in violent families and/or communities. It teaches kids that violence is never OK, and is the responsibility of the person who uses violence. The group format uses activities and art to teach safety skills. "Kids Club" has a concurrent parenting component that empowers parents to talk with their kids about what happened in the home, and provides coaching on positive parenting. This intervention helps kids get back on the right track toward recovering from the fear and chaos of DV. The CDVRT is both preventive of developing post trauma symptoms, and an early intervention for the young children who have been already negatively affected.

Social and Justice Outcomes - Families impacted by DV are often homeless or in shelters, their lives are disrupted. Children moved abruptly from their schools, etc. Many are in hiding. Unfortunately, the trauma of domestic violence is often compounded by the failures in the system's efforts to intervene in a way that increases survivor's safety and autonomy. Failures with the prosecution of DV perpetrators, failures in Batterers Intervention Treatment, and failures in the family court system that grants "shared custody and decision making" to two parents where one parent is afraid of the other parent. In the majority of these situations, this fear is a literal fear for their life. From a social justice perspective these failures in general reflect an appalling lack of understanding of domestic violence, and about what happens to the human psyche when one intimate partner is the victim of the other partner's abuse. Domestic violence includes coercive control tactics, the dynamic where abuse victims are controlled by the impending threat of further abuse. A dirty look or a certain tone of voice triggers panic and survival response in the victim. Victims come to tolerate a lot of abusive remarks and derogatory comments, often in front of their children.

The CDVRT mental health therapists and advocates receive specialized training on the intersection of DV, Family Court, and Parent Rights. The CDVRT collaborate and consult extensively across systems in order to effectively intervene to help the plight of a DV survivor and her children. One of the more challenging aspects of CDVRT service delivery is the volume of non-abusive parents who are forced to rely on the family court system to protect their children from further abuse; or parents who are being persistently harasses and taken to court by their ex to disrupt the visitation schedule or get full custody.

8. What types of organizations and/or partnerships are necessary for this concept to be successful?
Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

To deliver the CDVRT program, SMH has partnered with leading domestic violence service providers, including Domestic Abuse Women's Network (DAWN), South King County YWCA, Lifewire (formerly EDVP), and New Beginnings. The CDVRT Model relies on collaboration between mental health therapists and domestic violence advocates. SMH and its partners have well developed collaborative and referral relationships with Family Court System, CPS, DV shelters, legal advocates, and many child serving organizations.

SMH frequently works in collaboration with other organizations to achieve the greatest possible collective impact and to ensure the best possible care to the largest possible number of clients. SMH has strong collaborative relationships with DAWN, YWCA, New Beginnings, and Lifewire. As partners, these organizations have demonstrated a commitment to delivering the CDVRT program model.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation:	**$ 275,000 per year, serving 180 people per year**
Partial Implementation:	**$ 500,000 per year, serving 360 people per year**
Full Implementation:	**$ 750,000 per year, serving 600 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

Strategy Title: Provide early intervention for Children Experiencing Domestic Violence and for Their Supportive Parent

Strategy No: #13b – Domestic Violence Early Intervention/Prevention

Policy Goal Addressed:

- A reduction in the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

Approximately 60,000 children in King County are exposed to domestic violence (DV) each year. In King County, there are a broad range of services available to adult victims and adult perpetrators of DV, as well as mental health services for adults and for children. However, there are no specialized counseling services in the King County region to help children recover from DV.

Children who experience DV are at great risk for becoming aggressive, antisocial, withdraw, or fearful and for having poor social skills. They often experience high levels of anxiety and depression and other symptoms of trauma. The strongest known risk factor for becoming a DV perpetrator is witnessing DV as a child. A study conducted in King County found that increased exposure to violence was associated with lower cognitive functioning and that exposed children were more likely to be suspended from school.

The Safe and Bright Futures project was a two-year federally-funded community planning project involving several community partners led by the Health Department and the Department of Judicial Administration. The project conducted a needs assessment and developed recommendations to improve regional responses to children affected by DV in King County. The priority recommendation of the plan was to develop and implement a Children's DV Response Team to provide direct services to children who experience DV.

A very small pilot project was begun in South King County 2007 through Sound Mental Health (Tukwila office), Domestic Abuse Women's Network, and the South King County YWCA. This pilot currently serves 10 families at a time. MIDD funds would allow for program expansion to families throughout South King County, where there is the greatest need for services.

◊ *B. Reason for Inclusion of the Strategy*

Currently there is no integrated mental health and DV advocacy service in King County to meet the unique needs of children who experience DV. Provision of these services will help to reduce the negative mental health impacts on children who experience DV, strengthen the child's relationship with their supportive parent, and their linkages to other supportive people in their lives. In addition the project has potential to reduce the risks of future battering, victimization and associated behavioral problems among children served, thereby reducing the prevalence of DV in the community in the long-term.

◊ *C. Service Components/Design*

A team will provide mental health and advocacy services to children, ages 0-12 who have experienced DV, and support, advocacy and parent education to their non-violent parent. The team will consist of a children's mental health therapist, a children's DV advocate, and other team members as identified by the family (including supportive family members, case workers, teachers, etc.). Children will be assessed through a parent and child interview, and use of established screening tools. Children's treatment will include evidence-based Trauma Focused Cognitive Behavioral-Therapy, as well as Kids Club, a tested group therapy intervention for children experiencing DV. Children and families will be referred through the DV Protection Order Advocacy program, as well as through other partner agencies.

◊ *D. Target Population*

Children who have experienced DV and are identified by their parents, teachers and providers as needing services, and their supportive parents, who are residents of King County.

◊ *E. Program Goal*

Develop and maintain an evidence-based intervention for children who experience DV and their supportive parent.

◊ *F. Outputs/Outcomes*:

Team members will provide ongoing services annually to approximately 85 families with 150 children. Services will include one or more of the following: therapeutic intervention, service coordination and connection, and advocacy and support.

Projected outcomes to include:

- Decrease trauma symptoms exhibited by children.
- Reduce children's externalizing behaviors as observed in school, community, and family settings.
- Reduce children's internalizing behaviors.
- Increase protective/resiliency factors available to children and their supportive parents.
- Reduce children's negative beliefs related to the domestic violence, including that the violence is their fault, and/or that violence is an appropriate way to solve problems.

- Improve social and relationship skills so that children may access needed social supports in the future.

- Support and strengthen the relationship between children and their supportive parents.
- Increase supportive parents' understanding of the impact of domestic violence on their children, and ways to help.
- Increase the awareness of the impact of DV on children among other supportive adults in the children's natural environment so that they may support the family in positive change.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
September-December 2008	Start-up (Hire, train and orient staff), develop subcontracts and begin providing services	$70,000
	Total Funds 2008	$70,000
January-December 2009	Provide services to children and their supportive parent 1 FTE lead children's mental health clinician at Sound Mental Health 1 FTE children's DV advocate at DAWN 1 FTE children's DV advocate at the South King County YWCA	$200,000
Ongoing Annual	**Total Funds**	**$200,000**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and type of providers* (and where possible FTE capacity added via this strategy):

This strategy involves one provider and its two subcontractors who were involved in regional planning for this project, and in a small ongoing pilot to initiate services in 2007-2008: (Sound Mental Health, Domestic Abuse Women's Network (DAWN) and the South King County YWCA). One lead clinician will be added at Sound Mental Health. Two FTEs children's DV advocates will be added at the subcontractors.

◊ *B. Staff Resource Development Plan and Timeline* (e.g. training needs, etc.)

A pilot team from these three agencies has already begun providing services to a small number of families in South King County. Program protocols were developed through a small start-up grant in 2007.

Dates:	Activity:
September- December 2008	Funding to Sound Mental Health and the two

	sub contractors. Hire and train program staff. Update and expand program protocols. Coordination with referral sources to generate additional referrals.
January 2009-December 2009	Services provided to children and families.

◊ *C. Partnership/Linkages*

This strategy will involve a partnership between the three listed agencies, as well as the DV Protection Order Advocacy Program, schools, Child Protective Services, Safehavens Supervised Visitation Center at the Regional Justice Center, and other relevant agencies. Staff will consult with and refer to staff of the Mental Health Services for Domestic Violence Survivors program described in strategy 13b.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline:*

Staff identified, hired, and trained September-December 2008

Services begin January 1, 2009

◊ *B. Procurement of Providers*

MHCADSD already contracts with Sound Mental Health. A contract amendment would allow for funding of this program.

◊ *C. Contracting of Services*

See previous

◊ *D. Services Start date*

Services to children and families will begin January 1, 2009.