Family Violence Institute:

Integrating Responses to all Forms of Family Violence

PROCEEDINGS

April 24, 2003

The Center for Human Services
UC Davis Extension
University of California

Sponsored by
Office of Child Abuse Prevention
California Department of Social Services

Contents

Preface

On behalf of my colleagues at UC Davis and the Office of Child Abuse Prevention of the California Department of Social Services, I am very pleased to present you with proceedings from the Family Violence Institute: Integrating Responses to All Forms of Family Violence.

This one-day Institute addresses the integration of responses to domestic violence and child maltreatment. We know that there is a strong correlation between violence experienced by women and children at home. To effectively address these shared concerns and support healthy outcomes for women, children and families, human services and law enforcement agencies must share knowledge of critical issues and skills for promising practices.

We address these issues in a unique intensive format that has three components:

Issue framing – Our distinguished keynote speakers and panel members outline the intersections between child maltreatment and domestic violence. Dr. Edleson gives an overview of practice and research in this area and Dr. Fontes addresses violence and diverse families. Panel one looks at the impact of family violence on children, families, parents, culture and conscience. Panel two considers the responses from systems such as child welfare, mental health, medicine, advocates, and law enforcement.

Exchange and sharing – Following each panel presentation, participants from the audience have opportunities to respond with questions or comments. The issue framing and exchanges are recorded in these proceedings that are published and distributed to all those who attended this institute.

Skill building - Participants are able to learn from the speakers and other practitioners in a consulting format. Models of practice are discussed and ideas exchanged.

Our hope is that the day is a fruitful exchange of knowledge and ideas that forward the field's integration of responses to family violence. Your participation is greatly appreciated.

Sincerely,

Michael Lawler, Director
The Center for Human Services
UC Davis Extension
University of California
April 24, 2003

About the Speakers

Bill Carter, LCSW, manages the California Institute of Mental Health's child and family services projects including the Cathie Wright Technical Assistance Center. Prior to this position, Mr. Carter worked in administrative and clinical capacities in a private child and adolescent psychiatric hospital, and in residential treatment, foster care, education and outpatient settings.

Niki Delson, MSW, LCSW, BCD, has spent over 20 years in clinical practice, specializing in interpersonal family violence, providing psychotherapy services and forensic evaluations for victims, non-offending parents, and perpetrators of physical and sexual violence. She was a training consultant for 11 domestic violence projects in California and teaches for several child welfare academies. She has testified as an expert witness in the areas of childhood trauma, forensic interviewing of children and attachment.

Jeffrey L. Edleson, PhD, is a professor in the University of Minnesota School of Social Work, and is the director of the Minnesota Center Against Violence and Abuse. He is currently a consultant to the National Council of Juvenile and Family Court Judges and has published over 80 articles and six books on domestic violence, group work and program evaluation. He has conducted intervention research and provided technical assistance to domestic violence programs and research projects across North America as well as in several other countries, including Germany, Australia, Israel, Cyprus, Korea and Singapore.

Lisa A. Fontes, PhD, has dedicated the last fifteen years to improving the ability of child welfare and violence against women agencies to serve the needs of diverse clients, especially Latinos. She edited the book *Sexual Abuse in Nine North American Cultures: Treatment and Prevention* as well as wrote and presented on related topics. Additionally, Dr. Fontes has conducted research on sexual abuse in Chile, and U.S. Latino and African Americans. She is an assistant professor of psychology at Springfield College, in Springfield, Massachusetts, where she directs the School Guidance Counseling Graduate Program.

Colleen Friend, LCSW, MSSA, currently teaches at the University of California, Los Angeles (UCLA) and coordinates the California Social Work Education Center (CalSWEC) Program. She was the first coordinator of Children's Institute International Child Abuse Treatment and Support Program (1986-1988) and served as the program director of the Los Angeles County Child Sexual Abuse Crisis Center. At the Crisis Center, Ms. Friend began a pilot project where deputy district attorneys and sheriff investigators collaborated with crisis center staff and children's services workers. She served as the director of Stuart House, a public/private partnership in Santa Monica that provides multidisciplinary investigation and follow-up treatment for children alleged to be sexually abused. Ms. Friend was recently awarded a Mandel Leadership Fellowship for her PhD studies in social welfare at Case Western Reserve University in Cleveland, Ohio, as well as a fellowship to conduct research on Case Western Reserve's Ability Based Learning Education project.

Rebecca Gaba, PhD, is a licensed Marriage, Family and Child Therapist with over 15 years' experience providing a range of therapeutic services to adult and child victims of violence. She is the senior director of clinical programs at Children's Institute International where she oversees the Children's Trauma Center and Domestic Violence Services. Additionally, Dr. Gaba is experienced in both community and family violence research and training, and is a frequent speaker at state, national, and international conferences addressing issues of family violence, child abuse and trauma.

Marilyn Kaufhold, MD, is a pediatrician who has been associated with the Child Protection Team at Children's Hospital, San Diego, since 1978. Currently, she is the assistant medical director, responsible for the Forensic and Medical Unit of the Chadwick Center for Children and Families. She received her medical education at St. Louis University School of Medicine and pediatric training at Jackson Memorial Hospital, University of Miami. Following a fellowship in developmental pediatrics, she worked in the field of developmental disabilities for 19 years. Working in these dual areas of abuse and developmental disabilities resulted in the development of a roundtable forum to advocate for developmentally disabled victims of abuse. For the San Diego Child Abuse Coordinating Council, she has chaired both the Physical Abuse Review Committee and the Sexual Abuse Review Committee. Also, she has been a member of the Child Fatality Task Force. She is a member of APSAC, the AAP Section on Child Abuse and the Helfer Society. She has been associated with the California Medical Training Center for the past five years and has been an instructor in the sexual assault, child sexual abuse and domestic violence domains.California Medical Training Center for the past five years and has been an instructor in the sexual assault, child sexual abuse and domestic violence domains.

Michael Lawler, LCSW, is director of The Center for Human Services at UC Davis Extension. He has worked in all areas of child welfare and has extensive experience in sex offender treatment. Under his leadership, The Center has become a national leader in quality continuing education and professional development for the human services. Mr. Lawler is also a board member of the National Staff Development and Training Association, an affiliate of the American Public Human Services Association.

Debbie Lee has been with the Family Violence Prevention Fund (FVPF) for over 20 years. She directs the organization's National Health Initiative on Domestic Violence (NHI) which seeks to strengthen the health care response to domestic violence through development and promotion of model training and response programs, public policy reform and health education and prevention efforts. Ms. Lee was the recipient of the first annual Helen Rodriguez-Trias Award for Excellence in Community-based Women's Health Leadership in 2002. She is a founding board member of the San Francisco-based Asian Women's Shelter, and is involved with the National Network on Behalf of Immigrant and Refugee women, California Alliance Against Domestic Violence and The Women's Foundation. She recently co-founded the Asian and Pacific Island Institute of Domestic Violence and currently serves on the board of Physicians for a Violence Free Society.

Rolanda Pierre Dixon, JD, is a deputy district attorney for Santa Clara County and is the county's expert on domestic violence. She has handled all types of criminal prosecution including drunk driving, assault and battery, robbery and juvenile and domestic violence. She established the first domestic violence unit in Santa Clara County in 1991 and has been the team leader of the unit since that time. In this capacity the unit members have prosecuted over 5,000 domestic violence cases per year and are considered to be one of the premiere units in California. She has chaired the Santa Clara County Death Review Team since its inception in 1994. Santa Clara County's Death Review Team was one of the first in the nation and its' yearly reports are requested nationwide. Ms. Pierre Dixon has presented on the formation of domestic violence units, domestic violence prosecution, victim advocacy and death review in over 15 states and all over California. She trains prosecutors, law enforcement officers, victim advocates, medical professionals, students and the public at large.

Barbara M. Stilwell, MD, has an extensive career in private practice, university teaching and community consultations. Community consultations include the Indiana School for the Blind, Indiana School for the Deaf, Indiana Girls School and Marion County Juvenile Court and Center. She also served as board president of the Department of Mental Health. Dr. Stilwell has always been particularly sensitive that the normal thread of development remains present in those suffering from psychopathology. Her studies in normal development and functioning of the conscience provided background for the concept, *psychopathological interference to conscience functioning.* This concept has been supported with empirical evidence in various projects. Her co-authored parenting book regarding normal conscience development, *Right Vs Wrong: Raising a Child with a Conscience,* was published by Indiana University Press in 2000.

Jill Walker, MPA, is a direct services director for Alternatives to Domestic Violence, a nonprofit agency serving western Riverside County. The agency assists victims of domestic violence and their families. She oversees its outreach programs and services that include individual and group counseling, legal assistance and other advocacy services. She also oversees the agency's Family Support Program, a program that targets families impacted by domestic violence reported to Child Protective Services, a teen anger management intervention program, and a domestic abuse intervention program for CalWORKS clients—a program that assists welfare recipients who are working to overcome barriers to employment and self-sufficiency. The program serves 11 Department of Public Social Services offices throughout western Riverside County. Prior to that she helped implement a family violence prevention program funded through the Office of Child Abuse Prevention in the city of Corona. The project is one of 11 similar programs that are the impetus for the creation of a resource manual (through UC Davis Extension) to assist communities in building similar collaborative models for responding to family violence (manual provided in conference materials).

Proceedings

Welcome

Michael Lawler

Good morning, everyone. My name is Mike Lawler, I'm director of the Center for Human Services at UC Davis, and it's a real pleasure to see you all here.

Family violence has a lot of different definitions, but for our purposes today, for those of you who work in elder abuse, and work in school bullying, and other family violence response issues, we're going to be talking about child maltreatment and domestic violence.

We're here today because we all have a pretty good idea that child abuse, child maltreatment, and domestic violence frequently coexists in the same families. So in the audience today we have an interesting collection of people. We have child welfare social workers, we have mental health clinicians, we have attorneys, we have researchers, and we have health care providers. But all of us, no matter which discipline we come from, know that we must come together to form a safety net that catches all people in a family and not just the individual members.

We know this, but we also know that it's really hard to do.

This past fall I was talking with a couple of people, Dr. Lynn Kaufhold, who's our chair of Panel One, who you'll meet in a little bit, and Dr. Connie Mitchell, one of our colleagues at UC Davis, who could not be here today because she's actually out of the country, but we were talking about a trend they were observing in their clinics, Lynn, in San Diego, and Connie here, in Sacramento. And the progress they had been seeing in family violence related to the cooperation between child welfare agencies and domestic violence agencies was falling off a bit.

And so we talked, and we thought about the reasons, and I don't think we came up with a solution. We mused about maybe the economic conditions of the time were part of it, but the truth is we just weren't sure, but we were troubled by it. And Lynn and Connie said, boy, Mike, that would be a really good idea to do something about that and I, of course, yes, it would be. And then about a half-hour later they said, Mike, that would be a good idea to do something about that, and I said, yes, it would be. And about the third time I said, yes, we'll do that. So I really want to thank Dr. Kaufhold and Dr. Mitchell for their inspiration for today.

During the same time we had been working at UC Davis with the Office of Child Abuse Prevention, of the California Department of Social Services, on collaborative family violence response teams statewide. They were generous in the conversation we had with them and they agreed to sponsor today's event.

And I know they're not all here, but I do want to recognize Susan Nisenbaum, Rose Bradley, Roberta Badal and Shirley Jacobs from OCAP, for their support.

In your UC Davis bag, you have copies of the curriculum guide for family violence response teams that came from OCAP, and I'm going to do a little flashing of items here. You have it in paperback form and you also have it in CD-ROM. So those of you who have entered the new age can take a look at it. I, of course, will be looking at the hardcover item here.

The primary authors of this curriculum are all with us today: Niki Delson, who will be joining you in the skill building consultation groups, Rebecca Gaba and Jill Walker are part of our faculty today.

Also in your packet is a description in blue paper, that talks about a summer institute on family violence response teams that is focused on this resource guide and curriculum that we've developed, and that is June 23rd to 27th. I encourage you to take a close look at that, especially in these times, because this institute is fully sponsored by OCAP. So if you're interested, please contact us, we'd love to have you. We'd love to have you spend a week with Dr. Gaba, Jill

Walker, and Niki Delson, and other faculty to talk about family violence response teams and how you might be able to implement that in your unities. (insert subhead)

Speaker Introductions

Family violence requires responses that address family needs. We know that. Relationships, stability, intergenerational connections, and cultural identity. We have two special guests today, who are examining U.S. responses to family violence and social welfare, and looking at how that could apply to their home country of Russia.

Dr. Peter Kabytov is First Vice-Rector, and Dr. Mikahil Goriatchev is Chair and Professor of Social Pedagogy at Samara State University in Russia.

Please join me in welcoming them to our institute and to our country today. They just arrived yesterday afternoon on an international flight, so I imagine they're quite tired.

(Applause.)

Michael Lawler: We have a terrific faculty for you today. We also have lots of resources for you.

Please flip to your green book here; and it's actually termed the green book in the field. This is a very important publication as a lot of things we're going to talk about today are related to this book, have been drawn from this book, and it's *Effective Intervention in Domestic Violence and Child Maltreatment Cases, Guidelines for Policy and Practice*. It was published by the National Council of Juvenile and Family Court Judges, based in Reno, Nevada.

The primary co-author is with us today, of course, Dr. Jeffrey Edleson.

Our Panel One will address the impact of family violence on children, on culture, on parents, and a special treat, the development of conscience.

Panel Two will look at system responses, including those from mental health, child welfare, advocacy, healthcare, and law enforcement.

Following each panel, and this is important to note, we will have a 20-minute session where the audience members will be able to make comments or ask questions, using the microphone there.

And it's important to note that this isn't really an option. This is what we've built into the program. When we do these one-day intensive institutes we throw a lot at you in large plenary sessions, and for the learning to take the next step, to be integrated, and to be challenged, it's important that we get reactions from all of you who are hearing this.

The other piece of it is that we are recording these proceedings. They will be edited, published, and distributed to you and to others throughout California.

Finally, these events were not possible or are never possible without terrific conference coordinators, and at the Center for Human Services we have terrific conference coordinators, and I want to recognize them. The primary coordinators, Kim Bauer, Janet Lee and Sandra Zacharias. And we have a number of other staff supporting us today: Mailinh Bui, Ken Ly and Dottie Paige.

Again, we are here today because we have a pretty good idea that child maltreatment and domestic violence frequently occur or coexist in the same families, and we know that together, only together, can we improve our responses to these families.

Family Violence: The Intersection of DomesticViolence and Child Maltreatment

Jeffrey Edleson

The first thing I like to talk about when I speak on this topic is how children are exposed to violence, in general. And, in fact, there's a whole initiative in the federal government to start studying, more carefully, children's exposure to all forms of violence.

And we do have a literature — actually, we have a fairly large literature — on children's exposure to violence in the media. And the more children are exposed to murders and violent behavior on screen, the more likely they are to use it in their own lives. And so — even though the Hollywood media lobby wouldn't want you to believe it — there is a fairly strong relationship between exposure to violence in the media and use of it in children's lives.

We also have a growing literature on the effect of witnessing violence in your community, in your school, on children's lives and the trauma that that causes for children.

We have about 25 years of research on children in conflicted marriage, and children living in homes where the marriage is in conflict — both violent and nonviolent. But often that literature doesn't separate the violent from nonviolent conflict. And it shows that children, particularly children that do not witness resolution of conflict, are negatively affected in their own lives. It doesn't matter if the parents are divorced, or they stay together, it's whether children see conflict that is unresolved or resolved that is the key in that literature.

And then, finally, we have this growing literature on children's exposure to domestic violence, and that's where I want to focus my one hour this morning.

We really don't have much information on how these all interact and we have very little research on the interaction between these. But just to put, this is the tableau on which violence in the home happens, there's a lot of other violence going on in children's lives.

Especially in the last several weeks there's plenty of violence. Even though our media has sanitized this war in a lot of ways, there's still plenty of violence and violent talk going on, on television. So this is the first diagram, from 1835. It comes from an anti-temperance almanac, or a temperance almanac, anti-alcohol. And you see the man of the home, holding a bottle. And then up here he's holding a baton.

The first book written on children exposed to domestic violence was by Maria Roy, only in 1988, called, *Caught in the Crossfire*. And if you see this infant over here, in the mother's arms, on the left, I think that's one of the experiences that many children experience, being held by the mom, being caught, possibly injured, accidentally, or maybe even intentionally, in the crossfire in the adult-to- adult domestic violence.

For about 15 years I facilitated batterer treatment groups, groups for men who batter. And one of the exercises we did during those years, was to talk about your first experience that you recall of using violence in your own family of origin. And almost to a man they've described this boy, who's standing there with his arms up, that when he was big enough, when he was 12, 13, or 14, and old enough to defend his mom, he would intervene and he would fight and try to beat up his father, the step-father, the male boyfriend, whoever it was. And that's most men's first recollection of using violence in their family, on their own.

And here they were, 10, or 20 years later in a batterer invention group, so it was very interesting.

And then the other child here, the young boy at the right, running for cover, is certainly another option that many children take, which is hiding. Running to their room, putting on a walkman, leaving the house, turning the TV up, hiding in the closet. There's so many different examples of children running away.

And so for me, even though this is 1835, which is what, about 170 years ago, it's still true today that children's multiple experiences, I think, are encapsulated in this one diagram of the accidental caught in the crossfire, the child who's actively, physically intervening and perhaps learning how to use violence in a family. And another child who's running away and trying to escape and provide safety for himself.

Interestingly, this is drawn at the Domestic Abuse Project in Minneapolis, where I've done a lot of clinical and research work over the last 20 years. This is the same diagram. It's what, 160 years later, and it's the same child standing there, intervening, saying no, no, drawn by a child who was at the agency in the Children's Program at the Domestic Abuse Project.

So for me, what these two slides, in contrast shows, that children have always been there. We know that children are there, are involved, witnessing, exposed to domestic violence. It's only, though, in recent years that we've defined children as possible secondary or even primary victims of adult-to-adult domestic violence.

And so I think that's just an important message to take home, that they've been there, they've always been there.

How Children Are Sometimes Used in Domestic Violence

In fact, if you look at the data on battered women's shelters, over a majority of the residents of battered women's shelters are not battered women, they are children, and women have always fled with their children. Often, primarily for their children's safety, even above their own safety.

And so children have always been there and we need to really address that group of victims in the issue of adult domestic violence.

So how are children exposed? Don't look at the next slide, just if you can — we don't have a lot of time — but do you have any ways that you think children are exposed to adult-to-adult domestic violence in the home? Lots of volunteers here.

In TV. No, but actually in their home? Hearing it. Has anyone ever heard a 911 tape of a domestic violence call? There are several of them that have been published and circulated, but they're very traumatized children who are often not in the same room. They're hearing what's going on, they're imagining what's happening, and they're very terrified by it.

Other ways that children experience domestic violence, adult domestic violence?

Seeing the after-effects. Do you want to give an example?

Okay, so mom comes to breakfast with a black eye the next morning, they're seeing the after-effects of that.

When I first started in this field I was a school social worker and I did a whole thing about school phobia, children staying away from home, and there's a whole literature on that. Never mentioned domestic violence, that children might be staying home [school?], taking care of the adult caregiver, staying home to protect mom from somebody else.

Well, you've named most of things I have on here. And one of the reasons I do this little exercise is I want you to expand your definition of children's exposure to domestic violence. It's not just eyewitnessing, it's not just seeing it. It's also hearing it. And sometimes hearing the violence going on, but not seeing it, can feel even scarier and more traumatizing for a child than being there and trying to actively do something about it.

One thing you didn't mention is being used as a tool of the perpetrator. Susan Schechter and Ann Ganley, in their National Curriculum from the Family Violence Prevention Fund, talk about this, how children are often used in threats. I'll take them away. I'll get the custody. I'll steal them, you'll never see them again. I'll take you out. I'll take the kids out.

When I lived in Singapore for a year, in the early 1990s, three different men tried, either succeeded or tried to kill themselves or kill children when their wives had left in a family violence situation, when their wives had moved out, separated. In fact, the army actually netted a 20th-floor apartment building window when the man was trying to throw his children out the window to get back at his wife. And that's not unusual.

In California I'm sure you have murder/suicides, where there are murders of battered women, murders of the children, sometimes, and suicides by the perpetrator, himself. It's not that uncommon, unfortunately.

So children are used in many ways, and those

are extreme ways. But also, I think of children used to monitor the victim. Men who batter often want to monitor, very closely, the woman, out of jealousy and fear of losing control, that they do a lot of things like calling her frequently, giving her a pager, she has to call back within a certain number of minutes, if he pages her, and really trying to track her. In many ways it's like stalking, but he's married to her.

Well, part of that, children being involved in that by interviewing the children at the end of the day. Where has she been, who did she talk to, who were you and mommy with during the day, to use the children as informants about the mother.

And so children are used in many, many different ways, involved directly or indirectly in adult-to-adult domestic violence.

A Variety of Children's Experiences

And then finally, as you mentioned, in the aftermath. And it's not just seeing a wounded mother, it may be seeing your father arrested and taken out of the house. It may be you and your mother going in a squad car to a shelter, and you've only seen on TV that anybody that gets in a squad car is being arrested. And you're taken in the squad car to a locked up facility, called a shelter, and that can seem for many children like being arrested, themselves, or their friends think that they're arrested and will tell them that when they see them in school the next day, or will tease them about it.

So there are a lot of aftermath impacts, as going to a shelter can be. Even though we try to make those very supportive environments, they can often be very chaotic and stressful environments for children. And leaving pets behind. There are a whole series of things in the aftermath that can be very traumatic for children. Least of which is appearing in court as a witness against your father, your step-father, or your mother's boyfriend.

As I talk about, then, children's exposure to domestic violence or experience, I've actually tried to talk my language. Instead of using witnesses, because I think that connotes eyewitnessing, I want to think about their experience and exposure.

How are children involved? And we have a number of research studies on children's involvement. The children, in homes where there are domestic violence, are eight times more likely to intervene in parental conflict than children in homes where there is not domestic violence. Even one- to two-and-a-half year olds respond with negative emotions, with efforts to scream, or throw a temper tantrum, or something to intervene to stop the violence.

And the children, the range of things that children do to involve themselves are from being actively involved, like that child who is standing up, and trying to intervene, and saying no, no, to distracting parents, doing something to distract them, to distancing themselves, to calling 911. I mean, I can't imagine how heroic, how much energy it takes for a young child to call 911 on their parent, or on this dangerous male who may be living in their household. It's really a heroic act on that child's part.

So there are many different ways that children are involved in domestic violence.

We recently finished a study, funded by the Packard Foundation, in Los Altos, California, and we studied four cities. San Jose was one of the four. Pittsburgh, the twin cities of Minneapolis, St. Paul, and Dallas were the other three locations.

And we found that of those 111 mothers we interviewed anonymously, they called on an 800 number, they didn't have to give out their identity, 44 percent of the mothers reported that their children watched the entire — at least one entire violent event; 83 percent heard it from another room; 78 percent saw the results of the aftermath of the violence. Half of the children were threatened with physical injury during the adult-to-adult domestic violence. A third of the children were accidentally injured. A quarter were intentionally hurt by the abuser when they tried to intervene. Like those children in the artwork, they tried to intervene to stop their mother's abuse.

Half of the mothers said that they were abused when they tried to intervene to stop the child abuse. A fourth of the children were forced to watch physical abuse of their mothers.

And there are other results, too, but I think this shows a great deal of involvement and exposure among children. However, I want you to look at these numbers, they're a half, third, a quarter. The flip side of that is there are other children that are not being exposed in these ways. And so one message I want to get across to you is there's

great variety in children's experiences, and we shouldn't assume that every child has the extreme negative experience, most extreme, most negative experience.

In terms of children exposed to domestic violence, our annual estimates are 3.3 million children to 10 million. I've seen 17 million. And Murray Straus has estimated a third of American children, from ages zero to 18 are exposed to at least one domestic violent event during their childhood. Whatever the correct number is, it's a lot of children every year.

And I'll talk about the overlap with child abuse in a few minutes.

The Exposed Child's Negative Emotions

One thing I like to do is show children's drawings, because I think they're actually the most powerful way to communicate what they're seeing and feeling.

This one says, "this is how I feel when my mom and dad fight." And in the green over here, if I can get my curser over here, it says "sad" and there's a crying face. There's another sad face crossed out here.

This light green one says "mad." And this one, in purple, says "scared stiff." This one says "scared." Down here there's another scared and frowning face that says "mad," "I don't like it when my mom and dad fight."

So there's just a ton of negative emotions drawn by this child. This is a child at the Domestic Abuse Project in Minneapolis, who's been exposed to a fair amount of domestic violence in the home.

This one, even though drawn in Minnesota, is probably more appropriate to California. It says "earthquake" on top, it says "dad" on one side, "mom" on the other side. And if you can see in the fiery crack in between, "kids." And sort of the kids falling down and caught in between.

"This is how I feel when I'm mad," a volcano exploding. Lightening exploding. It's very explosive. So in this drawing "mad" equals explosiveness. "Mad" equals something that's very scary, and explosive, and dangerous. There is an image in this child's view of what mad can be.

Again, lots of scary weather, tornados, every possible scary weather you could have.

This is from a five-year-old. "I hide under my bed when daddy hits mommy, I'm scared." And again, it's like that 1835 illustration of a child running for cover.

This is a very rageful drawing. A basketball player, the basketball's on fire, the hands are on fire, head on fire, every muscle in this boy's body is showed to be tensed. And for me, it looks very rageful.

This is an 11-year-old. "My mom was lying on the floor and my dad was jumping on her head and kicking her in the back. Me and my brother were trying to stop him." And she draws her brother, Luke, herself, at 11 years old, her dad and her mom on the floor.

And I think for Luke, Jennifer can be a protective factor, but certainly they're both witnessing a lot of domestic violence, at least as this child's relating it.

A very vivid drawing of a mom being hit by an adult male. This is mom before, on the left side, smiling, full figure. And then on the right side her face, and I don't know if you can see the two dots for an eye, dot for a nose, stitches, it looks like a baseball more than a face. But that's mom after, drawing by a child at the Domestic Abuse Project.

All of these in color are drawn by children at the Domestic Abuse Project, and they're available online, at the Web site I'll tell you about at the end.

These last two, this one says, "bam," b-a-m, "things may not get done, no one will listen." And it's a fist flying into a face and lots of blood.

And I think it speaks to a child being on the sideline and nobody's going to listen, nothing's going to be done, my needs aren't going to be met is, for me, the message that I get from this child, no one will listen.

And then this final one is very powerful for me. It's drawn by the little boy who's pictured himself here, and he's pictured the adult male with the gun, shooting, boom, the adult male smiling. It hit the woman in the heart, there's that big scribble of red. She has a very scared look. Even thought it's a stick figure, he's done a very good job of drawing a very startled look on her face.

And at the end of her long hair he's sitting there pulling on it and smiling. And I think he's really associated himself with the power figure in this

household, the male. So this young boy has already allied himself with the male in the picture. And he's written this comment next to his drawing that says, "Anger is the unwanted desire to beat the living crap out of some jerk who really deserves it."

So this little boy has already very well learned a lesson. First of all, "Anger is the unwanted desire to beat the living crap out of somebody." There's nothing in between about anger, anger is violence in this young boy's view, and it's to beat the living crap out of some jerk who really deserves it. I wouldn't have to do it if she didn't make me do it.

How many of you have ever worked with men who batter? Have you ever heard that comment before? This is the first three to four weeks of the groups I ran, this is pretty much what I had to listen to, she should be here, I don't need to be here. If only she would be changing her behavior, I wouldn't have to beat her up.

And so already this young boy has incorporated the cognitive structure of a batterer at a very young age, and I think it's a very simple drawing, but a very powerful one.

So let me move back a little to the research. Any comments or questions? I don't have a lot of time for comments and questions. Okay.

The Child Witness is Often Abused

We have almost a hundred studies, now, on the impact of domestic violence exposure on children. Only about a third of those studies separate abused children from children who have only witnessed or been exposed to domestic violence. That's a really important thing to think about because if they don't separate them, they might be saying these kids of witnessed violence, they have all these impacts, but they're actually also child abuse victims, and a lot of the impacts may be because they're a child abuse victim, not necessarily because they're just a witness to violence.

So I really only usually look at these third of studies that try to separate those groups of children, I think it's very important that we do that.

And in those studies generally it shows, on average, children exposed to domestic violence show a host of problems greater than comparison children in the studies, comparison children who have not been exposed to violence and are not, themselves, victims of child abuse.

Behavior and emotional problems, particularly boys showing much more aggressive, anti-social, external kinds of problems. Girls turning it more in on themselves, with psychosomatic complaints, anxiety, depression, eating disorders, and the like.

In fact one person who wrote an article about this called, "Boys Are Warriors and Girls Are Worriers". It works in this research that boys express the impact externally, in a negative way, in a warrior-like way, and girls express it internally, on themselves, in a worrier way. So even though I don't like those terms, they're pretty sexist, but they fit in this research.

We also find that children who have witnessed violence significantly more often than others hold pro- violent attitudes. They'll endorse the use of violence of families and relationships. They will also have a much harder time having empathy for the other, taking another's point of view.

And when I've worked with men who batter, one of the hardest things for them to do is take the victim's point of view. If they would understand and be willing to admit to the impact they have on victims, they might be able to better deal with their own violence and end it. But that empathy for the other is a very difficult thing for men who batter, and for children who have been exposed to violence.

And in studies of college-aged populations these problems go on at a significant level. Young adults exposed to domestic violence, who are not victims of child abuse, have greater problems around depression, anxiety, and other types of interpersonal problems into young adulthood.

We also have seen studies that link children's violent behavior in the community to their own exposure of violence at home.

In a study of boys incarcerated in a juvenile detention facility, Spaccarelli and his colleagues, the boys who were exposed to family violence were much more likely to hold the belief that acting aggressively enhances one's reputation or self-image, compared to other boys who were also incarcerated, but not exposed to family violence.

So those boys who were exposed believed much more so that acting aggressively is a positive for them.

And in fact, in some of the arrest studies, police arrest studies, we found that batterers, who have very little ties to their community, high levels of repeated unemployment, and long criminal careers, are the ones who actually escalate their violence in the face of arrest by police. And I believe that it's because of this cognitive set, that they believe that "I don't have much to lose in society, and I can probably enhance my reputation among my small peer group if I actually show that the police don't make a difference to me."

And so I think that study, for me, talks about that cognitive set.

And then Mark Singer, studying thousands of adolescents and teenagers in the Cleveland area, found that recent exposure to domestic violence at home was one of the significant predictors of using violence in the community.

Ties Between Domestic Violence and Child Abuse

We also find, in studies of the overlap between child maltreatment and adult domestic violence, that there's about a 41 percent overlap. The studies vary greatly by who's studied, how they ask the questions, where the families are in different systems. But most of the studies show from a third to two-thirds of the families where there's child abuse, there is also adult domestic violence occurring, and vice-versa.

So how many of you work with abused children? So the likelihood is that about half of the moms that you're working with are also victims of adult domestic violence.

And how many of you work with battered women or men who batter? And the likelihood of the children attached to those families is that about half of them are child-abuse victims.

And that has a lot to say for our intervention and what we do, and what today is really going to be about.

In reviewing studies over the last 28 years, we found that child fatality reviews in several states show that of the children murdered, when they look back at the families that, 40 to 43 percent of the mothers were severely being abused during that period leading up to the child's death, by the same person that murdered the child.

In studies of abused children we find very high overlaps, and in studies of battered mothers we do, too.

Now, I don't have time for small group exercises here, but I want to ask you, given the talk that I've just given to you, how many of you believe that child exposure to adult domestic violence is a form of child maltreatment? Okay.

Now, I heard that there's an effort underway right now, in California, to define children exposed to domestic violence as victims — making child witnessing child maltreatment.

How many of you think no, that it shouldn't be? How many of you think it is, but it should not be made that way under the law? There are a couple of hands going up on that one.

And I think that's sort of where I'm going to come out on this, but we'll get to that in a minute.

Who do you think's responsible? Most of you, about three-quarters of you defined it as child maltreatment, so who do you think is responsible? How many of you think the abusive male is solely responsible for that child's exposure to domestic violence? Two or three brave souls.

How many of you think the abusive mother is solely responsible? Nobody. The abused mother, sorry.

And I'm doing this in a fairly typical way, of an abusive father, abused mother. I do want to acknowledge, though, there are certainly mothers who are battered and then who abuse their children.

How many of you think both parents are responsible? Okay, most of you.

And others, anybody else responsible? Who? The community. Neighbors.

There was a great article written in the mid- '80s, by James Garbarino, that asks, "What Kind of Society Permits Child Maltreatment?" And I don't remember the contents of the article, but I remember the title. Because I think it's very true, if we don't give families the support they need — the men to be nonviolent, the women to be safe, the women and children to be safe — then I think we are all responsible for the children's exposure.

Well, let me tell you that I want to differ with most of you. And I think most people that I speak to across the country, and in other countries, tend to agree with you and take this train

of thought, that all children are harmed and at risk, or at risk by exposure to domestic violence. That mothers who stay with an abuser are endangering their children, are not providing safety to their children. That childhood exposure to violence should be defined as child maltreatment. And that, if so, we should use our child protective systems to intervene and protect those children.

Maltreatment Charges Will Increase

This is the train track that I think most of you are going down and I want to stop the train, because I think there's a problem with this. So I want to pull you back. And, unfortunately, I think a lot of my work over the last 10 to 15 years has sped the train up along the track that I don't want it to go along.

So let me talk about this, and let me just say that you're not alone. Across the country many laws are changing. Custody determinations, every state now allows domestic violence to be a consideration in custody determinations. Thirteen states, including California, have what's called rebuttal presumptions. If someone has a record of domestic violence in a custody proceeding, they have to rebut the presumption that they are not safe to have visitation or joint custody with the child. Under California law there are five different items by which a man or a woman can show that she's safe to have custody or visitation with the child.

And that's a very progressive law that you have. I don't know how well it's enforced, but it's a very progressive law.

Most states presume that both parents have the right and the ability to safely share custody and share visitation with their children.

In many states they're changing the laws, the criminal laws. In Oregon, a misdemeanor can be increased to a felony if minors are present during the adult domestic violence.

In California, you have a law that once convicted for domestic violence, an assailant can be given greater penalties if minors are present.

And in Utah they have a separate criminal charge. A perpetrator can be charged for the adult domestic assault, but also can be charged on a second charge for exposing a minor to domestic violence. It used to be it had to be two or more times, they just changed the law to be one, the first instance can be a charge.

And then, finally, some places have refined child witnessing as a form of child maltreatment in their civil laws.

Some of the concerns about those criminal charges and penalty changes is that prosecutors love to win their cases, and the fear is that children will be brought into court more often to testify, they'll be forced to be witnesses, to provide testimony, information, if you start to make the presence of a child more important.

Another piece is that prosecutors may ignore women who don't have children, battered women who don't have children, because they may choose, given limited resources, "I need to choose a case I think I can win, if there's a child present I might as well go for that case because I think I have more leverage there than I do with a woman without children." So there are fears around the country.

In fact, Utah has also now charged the first battered mother, under their law, for exposing her children to domestic violence. So it was written clearly, the attorney general at the time said this will never be used against women. She said that she was writing it clearly that it would be the perpetrator, but now, for the first time, it was applied against a battered mother for exposing her children to domestic violence.

So there's a fear that the failure-to-protect thinking will be applied to some of these criminal laws.

Let me tell you about Minnesota's experience. We, in 1999, after midnight, second to the last night of the year, in the legislative session, a very well-meaning senator inserted in our law a changed definition of child neglect. That children who witnessed family violence were now neglected children, under our laws.

That meant that anybody who knew of a child exposed to domestic violence would be a neglected child and must be reported, under law, by a mandatory reporter.

How many of you are mandatory reporters in California? Most of you in the room. So you would now have to report, by law, every single child exposed to domestic violence.

Do you think that would increase the number of reports you make to child protection? Yeah, there are a lot of smiles and nodding.

How much do you think it would increase yours? By 700 percent? Well, in Minnesota, in

the nine months following, the 65 of the 87 counties reporting had 50 to 100 percent increases in child maltreatment reports.

More Cases Reported, Fewer Families Served

Now, on the one hand you can argue that is great news, we are identifying vulnerable kids out there and reporting them for the first time in our state.

The bad news is that it was a change in language and no funding was provided. And our state child social service administrator's association estimated the cost of these new reports, of processing them and serving those children and their families was $30 to $50 million. Remember, we only have four million people in our state. So if you can multiply that by California, what, you'd be about close to ten times that. So you might have a $300 million impact on those states, if those numbers at all correlate to California.

Well, for the first time in the history of our state the child welfare administrators and the battered women's program directors got together unanimously and went to the state legislature, and got that law changed or repealed.

Now, there's a very sad downside to that, for me, because now all of these children were no longer being identified by law, there's no requirement to identify them. We turned our backs on those kids.

On the other hand, what was happening before, when all these reports went up, administrators were having to close down services to substantiated cases of child abuse. Families, where they had substantiated child abuse, they had to close down the back end services because, by law, they had to screen every case and they had to investigate a large number of them within a certain number of hours. And so they had to move staff from the back end services up to the screening and investigation.

And the end result, unfortunately, in Minnesota, was that many children, more were identified, but fewer families, even substantiated cases of child abuse, were served.

So while in the ideal world I would agree with you, I do not think children's exposure to domestic violence is healthy. I think for many children it may be maltreatment. It may not be. But for many children it may be. I think as a society we have a responsibility to respond to those children.

However, on the other hand, you know our legislature told our governor to come back with full funding. Do you know who our governor was at the time? Jesse Ventura. A little more colorful than your governor. Jesse Ventura didn't care about children, he cared about the license fees for his Porche, and his Lincoln Navigator, and everything. He didn't care about children and he never came back with a proposal for full funding.

That law stays on our books, but it's not enforceable. Under the law, it's not implemented.

So you may find in a search of laws that this law remains in Minnesota but, in fact, it's not implemented in Minnesota.

So for me, the sad reality is as a society we are not willing to give child protective services the resources they need to handle the cases they have today, much less to take 50 to 100 percent, or in her case a 700 percent increase, in cases. I don't think it would be that much, but it would be a lot.

But we don't have the resources. And so for me, the answer is something very different. It really needs to be a community-based, voluntary services set of responses that has to happen for the great majority of these children. Probably a third of these children would already be in the child protective system, and you, who are working in the child protective system, need to respond better to the needs of battered mothers in your caseloads. Absolutely. Those kids and their mothers are going to be there regardless of what we do about children's witnessing of domestic violence.

Resources Outside the Child Protection System Needed

But I would say probably 60 to 70 percent of those children who are exposed to domestic violence do not need to be in the child protection system. They should not be defined as maltreated children under your laws, but we do need to figure out resources, community-based resources, be they in child advocacy centers, be they in battered women's programs, be they in community-based child witness-to- violence programs, there are many options for us to take. But I think that's where those families need to be, the great bulk of them.

So I want you to step back, and step back from the train track I maybe put you on.

Between and Within Group Differences

But I want to talk about these items. First of all, in research we talk about between and within group differences.

Between group differences is what I was saying, on average there are significant differences between this group and that group, between witnesses and non-witnesses.

But, in fact, if you look within the group of exposed children, you see that upwards, in many of the studies where they document the variation in that group of children exposed to violence, upwards to 50 percent of those children do not show any greater differences than children in the non-exposed group.

So how do you explain that? Maybe we have crummy measures. Maybe we haven't followed those children long enough.

But I also want to argue that every child's experience, as you know, is different. With child abuse, every child's experience is different. With domestic violence that's true, too.

We know, from study after study, national survey after national survey, that the frequency, the severity, and the chronicity, how long the violence has gone on varies from family to family.

And I would argue, even, that every child in a family is different than his or her sibling in the level of exposure that they have to violence. So exposure will be different.

I think Jennifer and Luke, the 11-year-old girl and her younger brother, probably have different exposures to violence. And it probably impacts them differently. And it may impact them differently because I think on one level they probably have different coping skills. By age, and just child to child.

I was stuck in Washington, D.C., three blocks from the Capitol building, on September 11th, 2001, at, ironically, a violence prevention meeting. Fifteen of us were stuck there, in the hotel, for four days, not knowing what was going on, away from our families, and watching the variety of 15 adults reacting to that experience was incredible. We had one person, [about] who we were all concerned, was on the verge of a nervous breakdown and that we might need to hospitalize her, or get her crisis services. There were three or four others who were drinking Black Russians, White Russians, singing all night, playing cards. Which may or may not be a healthy response, I don't know.

Physical and Environmental Factors

So what I want to argue is that every child responds differently to stress, just like we all respond differently to stressful events. And we have to think about every child's internal capacity to cope with that stress, and I think they vary greatly.

And then, finally, protective, and I should say risk factors vary greatly for every child. Luke has different protective factors than Jennifer. Jennifer is a protective factor for her younger brother, Luke. I'm not sure he can be for her.

Battered mothers can be incredible protective factors for their children, even while they're being battered.

Neighbors, aunts, uncles, family members can all be protective factors, teachers. Even the physical environment can be a protective, [or?]a risk factor.

When I worked in Singapore for a year, most people lived in 20 to 30 story apartment buildings. It's a very different physical environment in terms of safety or risk for a child living on the 20th floor, in a one-bedroom apartment, with one exit. In fact, I took a safety plan. One of the recommendations on a safety plan in the United States is break a window so neighbors will hear you. Well, breaking a window of the 20th floor apartment building is not recommended. In Singapore, people were aghast that anybody would recommend that.

Well, leaving an apartment is very dangerous for a child, and it may be the one exit is blocked by the violence going on. Versus living in a single-family home, or one where you can easily exit from many different directions. So even the physical environment can be a protective or risk factor.

Mental illness or mental health issues among caregivers. Weapons in the family. There are a variety of different protective and risk factors in a child's environment.

So what I want to argue is that we need to be very careful not to assume every child is harmed,

every child has a negative impact on them. It's probably not a good experience for most of these kids, but some of them are very resilient. Some of them have great strengths, internally, and great protective factors in their lives, and they will respond differently to that experience of domestic violence, and we need to be very careful about assessing that.

We also, in our society, and this comes from Seth Kalichman's book, from the American Psychological Association, "We define child abuse very differently. I'm not sure if it's true in California, but the two forms of physical child maltreatment, physical abuse and sexual abuse, are often defined in dramatic, almost diametrically opposite ways."

Is that true in California, where child abuse is defined by injuries to the child, sexual abuse as acts of the perpetrator; is that true? Those are almost the diametrically opposite ways of defining abuse, even in our two most extreme forms of child maltreatment.

So I ask you where should child exposure to domestic violence fall, if we define it as child maltreatment, where does it fit?

It often fits in the neglect arena of failure to protect, and I'm going to talk about that in a minute.

I also want to argue, as a social worker, in my profession we have a code of conduct, a code of ethics, and 25 a value system, and social justice is very important to that. And I would say, in our society we allow physical hitting of children, it's called corporal punishment, spanking. That's legal. You do not have to report that, as a mandatory reporter, unless you believe it injures the child. Is that true, is that an accurate representation? I'm depending on the pediatrician from Children's Hospital.

Parental alcohol abuse. We allow parents to drink unrestricted, as long as it doesn't impair their functioning of care giving to the point that they are somehow neglecting their children.

We allow unrestricted secondhand smoke around children, even though we have much better scientific data to show the injury that secondhand smoke does to children's lungs, than we do about the injury that exposure to domestic violence has on children. But we permit that unrestricted and there's no movement, that I'm aware of, to make that child maltreatment.

We allow unrestricted violent media exposure and video games. How many of your children have a video game component, Play Station, Play Station II? Nobody's willing to admit that? Mine have a Play Station, a Play Station II, a Nintendo.

And how many of you can find a nonviolent game to buy for your children? Yeah, one of the few that you can buy, right? The most popular game right now is Grand Theft Auto Vice City, which is the second version. It actually has a pornographic film-making studio in it, and the whole goal is to rip off cars, shoot people, kill people. Before that it was 007. I have a 19-year-old and a 13-year-old boy, so I know what these games are.

They're terribly violent. Do we make that mandatory reporting? Should I be reported? Should I be reported for child maltreatment? We don't do that.

And who's responsible for children's exposure to community violence? Is it the mother, who's forced to live in a neighborhood where there are not adequate services with her children? Who should be reported for that?

So I ask you, as we start to include children who are exposed to domestic violence, why are we choosing this group to focus on, this group who will end up, the group that will end up in your child protection system will be primarily lower income, and primarily families of color.

And from a social justice perspective I ask then why not the parents who are smoking and exposing their children to secondhand smoke? Why not the parents who are buying violent video games, who subscribe to HBO, and all the Showtime, that have the highest violent rates of any videos shown on TVs.

So before we expand into children's exposure to unhealthy things, I'd just ask you to consider it's probably this group that doesn't have a big corporate lobby behind them, that we're saying we can make them mandatorily go and go into a sometimes coercive system, but these others we won't touch. And I don't think that's fair, I really just don't think that's fair.

What Family Member is Responsible for Violence in the Home?

And I want to come back to my question about who's responsible. I want to argue that the

person who creates the violence, and the potential for injury and fear in that family, is the one who is solely responsible for the exposure to a child. I think the adult male, in most cases, who's perpetrating, who's committing an illegal act in front of a child, against another adult caregiver, is totally responsible for his behavior and for the impact it has on others in the family.

I don't think it's fair, I agree mothers are mothers, they're adults, they're responsible for the caregiving of their children. But I think it's very unfair to saddle them with the responsibility for somebody else's act. And I think the reason many of you give her some responsibility for that is because you may believe that her staying with him is dangerous for the children and may expose the children to greater harm.

And I see some differences of opinion, I knew there would be. I want to have time for discussion, I'm going to try to move quickly to the end and get your responses.

The research on battered mothers who have stayed say that a battered mother's decision to stay is often based almost primarily on their children's safety. Not even on their own safety, but their children's safety. There are threats of greater harm. In fact 55 percent of the mothers, of the women killed in this country, by an intimate partner, are women who have separated from that partner. So she may know that if she pulls away from him, he's going to get scared and feel like he needs to up his control of her to the point of physically threatening her and possibly murdering her.

He has also threatened lengthy custody fights and he may have much greater resources to carry that out than she does to defend herself.

Many mothers believe children need a father. Children need two parents. The research is unclear on whether it has to be two parents of the same sex.

But many mothers, like many other people in our society, believe all children need a mother and a father, and they want that child to have that father.

And in times of greater and greater financial stress among these families, many mothers believe her children will have food, and clothing, and shelter if she stays, much better than if she leaves him.

So many mothers' decisions to stay are based on safety and the needs of her children. And I think it's incorrect to assume staying is dangerous and leaving is safe. Because, if you look at leaving, again remember 55 percent of women who are killed, are killed by men that they've separated from.

Children's safety. Now, they're seeing direct assaults on the children and the effects of witnessing violence. They believe children need a parent -"if I don't leave, I'm not going to be here, capable of parenting them, and he may be in jail for whatever he's done to me."

So I think battered women's decisions are very difficult. They go along a long pathway. How many of you have ever tried to go on a diet? It's hard to stay on that, Atkins, or anything else. But I think, you know, even harder is to arrange your life safe from somebody who may be a very persistent batterer.

So we have research, this is from Michigan's battered shelters, that women who had left and returned to their partner had left on an average of almost two and a half times. But women who terminated their relationship after leaving had left on an average of five times, and I've seen the figure seven times, in another study.

I think battered women have a long path to take. It zigs and zags. And we shouldn't make it — we shouldn't penalize them and say, she's gotten three orders for protection, gone to a shelter two times, she can't keep these children safe, I need to remove them.

I think, if anything, we should reevaluate her as providing great safety to those children, doing lots of different things, but that we, as a society, have failed to provide the necessary resources to continue that safety for her.

There are some mothers who will not continue and not be assertive in taking safety steps for their children, but I would argue the great majority of battered mothers want safety for themselves and their children, and try to take steps. Some of those steps are staying with their batterer. It may be temporary, and I'm not recommending that as a long term strategy, but it may be temporary that they need to do that.

So I would argue that the whole notion of endangerment, failure to protect, I think battered mothers' safety strategies are woefully under assessed, and battered women are often not

given credit for the many safety strategies that they try to use with their children. And we need to rethink what that process is and where we come into that.

And I do think that a major avenue for children's safety, and this is this next slide, is their mother's safety. You know that as a child protection worker, battered women's advocates know that, there's no argument there. Children's safety is best achieved by the caregiver who cares most for them, cares most about them, and it's the mother. But if you ignore the mother's safety, in trying to achieve the child's safety, you're going to, more often than not, fail in achieving the child's safety. You'll be much better off if you also work on mother's safety as well.

In closing, I want you to step back. My time is up, I think I have a few minutes before the panel. I want you to, hopefully, think about exposure not being defined as child maltreatment under the law. That not all children's experiences are the same. Some will be in your child protection system, probably a third or more of your children are already these children.

When we did a study in Hanapin County, 36 percent of the investigations found that children in their system — 36 percent of those investigations — included children exposed to domestic violence. They'll be there no matter what. They're also abused children.

But a lot of those children aren't. And I want us to develop, and if I had time, and I hope today, during the day, I know there are people here that can talk about, as part of their presentations, other alternatives to the child protection system as a place for many of these children.

So I mentioned some Web sites, that probably the best one for you to go to, where everything I've talked about today is online, is a special site on children and domestic violence that my center runs. If you add our center address and put link, that's there. We have a general electronic clearinghouse on violence and abuse. A specific one on battered women's issues that we run with the U.S. Department of Justice, Violence Against Women Online Resources. VAWNET has a great online library, and then this green book that you've received in your packet, also has a Web site of its own, that has model programs from the six federally-funded demonstration sites around the country.

So I want to entertain two or three questions. I know right over there, there are a cluster of people that disagreed with me, and so I wanted to give voice. Yeah, actually, come up to the microphone, yeah, we need to use the microphone. So anybody, I only have time for two or three. Go ahead.

Audience Exchange

Audience Member: My name is Jeff Greybill, I'm an attorney here in Sacramento, and I'm also a volunteer with the Children's Rights Council. And I've also read President Clinton's mother's autobiography.

Dr. Edleson: Yeah.

Audience Member: And I know she would be spitting in her grave at the gender biased nature of your approach to domestic violence because she grew up in a household where the mother was battering and abusing a father throughout the childhood. Her position, and she wrote this just a year or two before her death, was that you're missing a large part of —

Dr. Edleson: Yeah, can I respond to this?

Audience Member: Can I make one more point?

Dr. Edleson: Yeah.

Audience Member: Her position, and my position, is that a study published in the "Psychological Bulletin," which is pure unit research by the American Psychological Association, that shows that nearly between 36 and 40 percent of the victims of domestic violence are men and self-defense is not a factor.

Dr. Edleson: Okay, we need to talk about that. I just want to respond that "victim of domestic violence" and what you define as domestic violence are very important in this language. Study after study, including that study, talk about conflict tactics used between men and women. They don't talk about the impact of those conflict tactics.

If you look at homicides, women are six times more likely than men to be murdered by intimate partners.

If you look at arrests by police officers, 90 to 95 percent of arrests, by primarily male police officers, are of male perpetrators of violence.

If you look at hospital emergency room data, 90 percent of the injuries, the results of those conflict tactics, are men against women.

I agree with you, absolutely, that there are violent women and there are abused men. But if you look at the results of that violence, primarily it happens, the physical effects and the strength of those physical effects is that that's a power and control system. It's not about the use of conflict tactics, as much as it is about a system of coercive control and fear that take over a family.

And I think we have to be very careful, when we consume these studies, not to just look at — you have to look at who's reporting the violence, who's being interviewed in these studies, and you have to look at the impact of that violence. And overwhelmingly, in study after study, our data refutes what you just said. It doesn't refute what you just said, it acknowledges that women are using violence in relationships.

But if you look at the impact, look at who are the victims of violence in our society, it's primarily men. Men are much more often the victims of violence at the hands, primarily, of other men.

And if you look at our society, and you look at the messages in the media, I led a men's group during the bombing of Libya, in the Reagan administration, and we had to really process what was going on there because it was clear, even though we're a democratic country, we were using force, power, and control against others.

And I think the message is very clear. The hardest place for me to do training is in the Army, and in Singapore, which are both authoritarian societies. It's very hard to talk about sharing power and control when you're in a system that praises and gives, and really preaches power and control, central authority.

Panel One—Impact of Family Violence

Marilyn Kaufhold, Jeffrey, Edleson, Lisa Fontes, Rebecca Gaba and Barbara Stilwell

Dr. Kaufold

So I would like to talk about what I know best, which is domestic violence from the child abuse pediatrician's point of view. I have worked mostly in child abuse. I have not worked primarily in domestic violence, but none of us can escape that anymore since it coexists in so many cases.

The figures that we have, and which Dr. Edleson really explained in much better detail, and with their nuances, are that somewhere between three to 10 million children are exposed, annually, to domestic violence in their homes, and that the core morbidity with child abuse is somewhere between 30 to 60 percent.

And I think you said that averages out to 41 percent or so. The median is 41 percent.

Trauma's Impact on the Brain

Exposure to domestic violence is one type of trauma that can cause anatomic and physiologic changes in the developing brain, so a pediatrician perks up her ears at that.

And what does that mean? Well, when trauma produces brain changes, which I will attempt to explain a little bit in a minute, those brain changes are manifested in behavior changes. Which, in some individuals, who don't have the resilience to avoid the impact of domestic violence on them, leads to violence and self-harm in their own lives. And so that is an enormous consequence of exposure to domestic violence in childhood.

There's a wonderful study done by Vince Felitti, who is a physician in the Kaiser Permanente system, and located in San Diego. His adverse childhood experiences study looked at the health consequences in adults, in adult lives, from exposure to severe childhood experiences of trauma.

And the trauma that he decided to look at, in his large study, were when children were psychologically, physically, or sexually abused by their parents, so we're eliminating out-of-home abuse in these kinds of instances, or when in a household there was a substance abusing member, someone had mental illness, the mother was treated violently, or a household's member was in prison.

So those seven things were the things that he looked at in his study, and they did this by means of really an intake questionnaire, a questionnaire that they had developed for new patients at Kaiser. The mean age of the individuals participating was about 57, and there were 18,000 people. So it's a huge study.

And he then scored their responses. And depending upon how many of these seven kinds of traumas they had been exposed to, he gave them a score, and the higher the score was, the more likely these individuals were to engage in destructive behaviors in their own lives.

He puts "destructive" in quotation marks, because he sees those destructive behaviors, such as substance abuse, or engaging in dangerous behaviors as something which actually are solutions for the individual involved. But we, looking from the outside, often see them as destructive behaviors.

And these individuals are also more likely to die early from the diseases that kill most people, which are heart disease, stroke, and diabetes complications.

So now we have a link between exposure to childhood trauma and the physical conditions that occupy so many of the dollars, and so much of the energy of the health system in our country.

Now, I talked about trauma, I've used the word trauma, and I want to differentiate that from stress. Stress is an inevitable component of everybody's life. We can all go around the room and think of a different stressful situation, work deadlines, relationship problems.

But trauma is different from that. Trauma is defined as a psychologically distressing event, not in usual human experience. So it's outside

the normal human experience. And it is also characterized by, in the individual who's experiencing it, intense fear, terror, and helplessness.

Some of the pictures, in the stories that Dr. Edleson just told us, I think would fall into that category. The kids felt very helpless, very terrified, they hid. Even if they didn't get a scratch on their body from that incident that they were exposed to, they experienced it in a way which gave them this kind of an impact.

And it tends to be an intense and prolonged stress response, so it's not just one time. In a situation of domestic violence so often it is the way in which the family functions, they don't have another way to function and so it's repeated over and over again, as all of the stories tell us, too.

I don't know, how many cases can anybody think of where there is exactly, and provably, and documentably only one incidence of violence? I can't think of any.

Examples are not only the kinds of things that we're talking about here today, domestic violence and child abuse, but they're also war, natural disasters, kidnappings, other kinds of things which are life threatening, and the individual experiences tremendous fear.

During this Iraqi war, as pictures of Iraqi citizens and children have appeared in my morning newspaper, I just have to wonder how they're going to process nights with bombs, hiding in ditches, trying to get across the street with gunfire going on. I guess we'll find that out.

So I want to talk about how does it happen that these experiences, now, become so impactful in the individual who experiences them. And we probably all have learned about the brain pituitary adrenal axis, or also called the HPA axis, the hypothalamus pituitary adrenal axis. Stress, when it's perceived by the individual, and we'll have to say I'm talking about trauma or stress, because trauma is stressful in a much larger way. Okay, so stress, when it's perceived either internally or externally, when it's perceived by the organism, it sets up a message to the rest of the brain that we need to pay attention, that everything is not okay. And that is taken in pretty much by the autonomic nervous system, the reticular activating system, which is located in the midbrain.

And that communicates with the hypothalamus in the brain, also, and the hypothalamus produces CRH, part of a troubling releasing hormone, and that's carried by the blood stream down, through the pituitary, into the anterior portion of the pituitary, and there the pituitary gland releases ACTH, adrenal corticotropic hormone.

ACTH, then, is released into the bloodstream and that circulates throughout the body, but it's target organ is in the adrenal gland, the little gland that sits right on top of the kidney. And when it reaches that source, the adrenal gland outputs cortisol, and cortisol then has physiologic effects which are desirable.

This is the normal response of the body to stress. So if you're out running and you suddenly hear a big dog barking, probably this axis goes into operation. You want to run faster, you want to look where is that dog, is it free, is it behind a fence, am I threatened, what's the deal. And we can think of lots of other kinds of things. When you suddenly realize you have a deadline, or when you have to come up and speak, you know, a little bit of it goes into effect.

So heart rate and blood pressure elevates. You mobilize energy stores because you need energy for this heightened response that you're going to need to do, and it also modulates your immune response. And all of those things are good. This is the fight or flight. But it's self-limited, it's nicely arranged in your body so that when cortisol is released, and it gives all of these physiologic effects, it also provides a shutoff valve to the brain.

So when cortisol, which is circulating throughout your body, gets back to the hypothalamus it says, okay, done your job, cut off now, you know, you've mobilized the energy and we're ready to go on with the next thing. At that point in time your cortex takes over and you can think, well, okay, I've gotten this information now and I can make a rational decision. Do I go back? I avoid the dog. No, I've seen now where the dog is, I'm safe. I'll continue on my way, or whatever.

You may be driving along, the weather's perfectly fine, you're feeling happy, it's nighttime, there's not much traffic on the road, and suddenly you hit a very dense pocket of fog. The same thing is going to happen. You're going to slow your car down, and it happens before you can even think and plan. So it's a very automatic, autonomically initiated response of your body. It happens so quickly, and your cortex kicks in so quickly that sometimes you think that you're

dealing with it all from your head but, in fact, you're not, part of it has already happened before you even have time to think about it.

But what happens when, instead of having a normal response with a shutoff, the stress is prolonged and it's intense? In this instance, the axis becomes altered. And if this is happening to an immature individual, normal brain growth is actually impaired.

Cortisone receptors are not only in the hypothalamus, there to shut off the response, but they're also present widely distributed throughout the brain. And two of the areas in which this impact has been observed are the hippocampus and the amygdala. Now, the hippocampus has the effect or the job of converting short term memory into long term memory. It is responsible for context and story telling. It sets of a story in time. Auditory and olfactory memory is located there. And it's also responsible for our being able to verbally represent events, so we put language to the things that we've experienced.

So what happens when you have a lot of these kinds of very stressful events before you're even four years old? Four years old is the age at which we think that the hippocampus pretty much becomes mature. So it can't do all of these important functions and process this scary stuff that happens to you when you're too little.

And we know that we see this kind of hippocampal disfunction in adults who have been exposed to a lot of trauma as children.

And the amygdala, which is located close to that, processes, and interprets, and integrates emotional functioning. It's responsible for rage and love. It puts a value immediately on events that we experience, this is nice, this is horrible, this is scary, and this is terrific. It is responsible for our fear conditioning, so that we may respond very quickly if we experience something that we've experienced before. So in a case of domestic violence, where we begin to know the things that set it off, we begin to recognize the initiators of violent episodes. We know to remove ourselves and to expect to be fearful about what's going to follow a look, a comment, a gesture.

It's also in control of aggressive oral and sexual behavior, and that is certainly something which goes haywire many times in individuals who have experienced a lot of trauma in childhood.

The disruption of the stress axis and the stress that people experience, then, also gives us post-traumatic stress disorder. And nothing is a hundred percent in any case. Dr. Edleson talked about protective factors and resilience, and so not all individuals are ever going to respond in exactly the same way, but we do see this in a large number of cases.

It's very exciting, there's a lot of work going on in this area, and I think it is important to pay attention and stay in touch, because we're really beginning to understand the biologic basis of all of this. So it's not just like a bad book that we can toss out or sell in a garage sale and get rid of, it's becoming hardwired into the brain.

The long term consequence, then, is that people who have experienced traumatic events in childhood are at increased risk for a host of other problems, impacting all domains in functioning. And then impaired emotional, social, cognitive, and physiological functioning can result from childhood events.

Four Cases of Coexisting Child Abuse and Domestic Violence

Now, that's the part I don't know so much about. But the part I do know a lot about are the kind of cases that I see in my daily work, and I'm just going to introduce you to four of them very quickly, because in all of them we have the coexistence of child abuse and domestic violence. So it's very real and practical from my standpoint, I need to document this stuff, I need to make a statement about whether or not it could have occurred in the way that it's said.

Any of you who are CPS workers know how closely, hopefully, you've worked with physicians to get this kind of information and be able to move ahead with what you need to do, in a very practical, timely way, to get these kids taken care of or get some kind of resolution to the situation, so that there is safety ensured.

This is a five-year-old in a family where there is a long history of domestic violence. There were five kids altogether in this family. And it was time for school in the morning. This five-year-old was in kindergarten, mom was in the car, ready to take the kids to school. The five- year-old was sent back into the house to retrieve her lunch, which she had forgotten, she's only five, and her dad, who was there, began to strangle her. And when she didn't get out to the car, and mother returned to the house and found this kid passed out, with him just violently strangling

her. She managed to get him off, she said, "I don't know how I did that."

But this was the straw for her. It's like, okay, beat me up, but this is too much, this was it. So she put the kid in the car, pretended like she was just going to school, drove to her sister's, got a little support, went and reported this case.

And you can see this child has neck marks. She's really fine at this point, she seems to be, anyway. She's in the emergency room. She has petechiae over her cheeks. She has bruises on her neck. They aren't as bad as the experience would lead you to believe. And she has rotten teeth, which you can also see, so this is a child who's in a neglectful environment and not getting much help.

This is another little one. A nine-month-old was injured in an altercation between the parents. There are multiple abrasions on her face. What happened was that mom and dad had been separated for a while. Dad begged for an opportunity to talk to her, they went for a drive, he got upset, he turned onto a gravel road, he jumped out of the car. She also got out. At some point he went back to the car, he yanked this kid out of the carseat very roughly, and then mom grabbed the kid. Somehow the child fell into the gravel during this altercation.

So you can see that she has abrasions on her forehead, scrapes around her nose, on her cheek. She also has a broken leg, which may have occurred when she was yanked out of the carseat.

This mother had been trying to protect this child, she had separated from him, he was very persistent, but the baby was removed and she was said to have failed to protect the child.

Here's a 17-month-old. Just like the last one, not four years old yet — how's their amygdala and their hippocampus doing?

A 17-month-old who's injured in the mother's care. The parents are divorced because of the domestic violence by dad. Now, after that happened dad did complete his mandatory 52-week anger management class, he was doing well.

Mother now has a new relationship and she's said to have a severe alcohol problem. She denies domestic violence in her current relationship.

Okay, CPS, where would you put this child to be safe? This child has pattern bruises on the face, the side of the face, and some bruises on the side of the abdomen and the leg, and this is clearly from mishandling. These are not accidental kinds of bruises in a child this age.

The last one is a 15-year-old girl, who was physically assaulted in an alley. When asked who did it, she eventually told us that it was an agent or a friend of her ex-boyfriend. She came in, initially thinking that she might have been sexually assaulted, she had been unconscious in the alley for a while. Her clothing wasn't disturbed, though the person that assaulted her said he was going to rape her. So when she came to, and sat there for many hours during the night, until morning came, she came in.

She did not have an acute injuries, but when I examined her genital area she clearly had an old penetration kind of injury, yet she told me she had never been sexually active. Her pregnancy test was also positive.

So you know, after some long, it seemed like interminable time, trying to talk with her and gaining her trust, she did tell me — she separated from her ex-boyfriend because of his violence toward her and because he had been forcing her into sexual intercourse, and she did not want to do that.

Her family loved this boy, he came to the house, he was really nice, he was charming. And when all of this came out, her mother, after initially being angry at her, said, okay, okay, I understand, I understand. But we cannot tell her father, he will make her marry him.

Okay, so those are four studies, four cases in which domestic violence impacts the injuries that I'm asked to see, so it's very real for me.

So what are the practice implications? We need to recognize injuries and behaviors when they are associated with these, and we need to be good at that, so that we can ask the questions. Because interviewing, then asking the questions, with some comfort and skill is essential to getting an answer. People can deny, and deny, and deny, and all you've got is the denial, even though you may continue with the suspicion.

We need to report when children are injured or are in danger. I kind of like the optional thing, although we report almost every case when we know that there is domestic violence present.

Learning to use screening tools. In some studies women have said that they began to report after

they had been already asked to look at screening tools, or been asked a number of times, so it kind of prepares them. You never know when the screening tool you'll hand out might be the one that they'll check "yes" on and be able to get some help.

In a medical practice, or in anyone's practice, there's an opportunity for education in anticipatory guidance, and I think particularly of adolescents who get themselves into violent situations at the beginning of their adult relationships.

Domestic Violence is a Mental Health Issue

And then it's important to know what the resources are. And it's really a mental health problem. This is largely a mental health problem, even though I see it from the standpoint of injuries. Injuries may occur to the child's body, and I think we've seen that and we've looked at it. I'm going to zip along here.

Behaviors across a developmental continuum, and I think maybe Dr. Stilwell will even handle that a little bit better than I will, but you have this in your handouts, as well.

So you don't expect the same type of aberrant behaviors from an infant that you do from a teenager, but it all makes sense when you know what the input has been of violence.

And so the questions that I am left with is what will best help these kids, what will change the environment, what models of intervention work best, how do we distinguish when to give up and not to work for unification? How do we support parent victims? What will cure perpetrators, and what more research is needed? So I hope we answer all those questions today.

I am at the end of my talk, but I would like to reintroduce Dr. Jeffrey Edleson, and I don't think I need to go through his biographical data anymore, he's well-known to you. But I'll just add that from our center he's very popular because he has given generously of his time and wisdom to some of our programs and projects.

Dr. Edelson

I want to talk next about parenting and domestic violence. I've just written a paper for the Judicial Council of California on parenting in the context of domestic violence. I've written a review of the literature on parenting in the context of domestic violence, that's the topic of today's talk. It's a 40-page, single-spaced document that will be available in May, on the Judicial Council of California's Web site. So I'm just going to briefly go through.

I want to say that we have very limited research on parenting in the context of domestic violence. We do know that threats continue, and violence continues after separation, so separating from the perpetrator is not always a solution for safety for the mother and children.

We do know that in many cases the behavior of the perpetrator negatively affects the children. And the perpetrator, men who batter, more than other men use controlling and abusive parenting behaviors, and they often involve children, they actively involve their children in violent events.

And there's a great new book out by Lundy Bankroft and Jay Silverman, I think Lundy Bankroft was in town recently, called *Batterer as Parent*, from Sage Publications.

The studies of battered mothers, that we have, show them to be much more stressed, significantly more stressed than mothers who are not battered. But interestingly, when they study their mothering behavior, their mothering behavior is no different than other mothers, in several studies that have looked at it.

It is unclear whether they are more likely to abuse or not. In Murray Straus's national family violence surveys they found that battered mothers were twice as likely to abuse their children as non-battered mothers. But in Lenore Walker's study, of about 400 mothers, battered women, as the women moved away, and moved into safety, their violence actually decreased significantly over time.

So it's unclear exactly what's going on and how that's happening.

Perpetrators definitely are reported by battered mothers as interfering in their ability to parent the way they want to.

And we have, as professionals, a whole series of decisions to make about children. And I'm going to pass over some of these because I talked about them, but I definitely think we need a careful assessment of the level of violence, the child's exposure to it, the impact on the child, and the risk and protective factors in the child's life, and of the perpetrator's parenting, and the victim's parenting, as well.

We don't have good measures for that now. And I guess I would argue that in the best of all worlds we would report these kids to child protection. I don't think they shouldn't be screened, I just don't think we should overload a system that doesn't have the resources to do that screening right now, and we should create community-based resources to do that.

Violent Perpetrators and Visitation

There's very little research on assessing the future risk in any cases. We really cannot predict who's going to be dangerous or not. You know, we have red flags, but those tools really don't — the studies of risk assessment really don't show that we have a very good science of doing that; we need better tools.

There's a lot of safety concerns in our field about reporting of children exposed to violence; particularly in the domestic violence field people have argued that police officers should gather a lot of information on site. Yet, there's a great deal of debate about what police officers should do with children when they're exposed to domestic violence. Should they be interviewing the children, recording that information.

The danger in that is that that can become part of the public record, and the perpetrator, who's being reported, could turn against the child later on. So the safety and confidentiality about that information, and where it's going, and who's going to have access to it, is a major issue in assessing future risk and assessing the parenting, at least from the children's reports, as well.

The data that we have on child adjustment in separation and divorce is that it's really not about joint custody, but it's about each parent's capacity to parent that child, to caregive for that child, and their relationship to the child. And we need to be very careful about that, we shouldn't just assume that joint custody, per se, is the best outcome.

And I have seen repeated, time after time, perpetrators using custody proceedings and joint custody as an extension of their abusive behavior.

One woman, who was murdered in Minnesota, she was required to provide visitation, access to her children by her very violent husband. There were no supervised visitation centers available. She met him in a parking lot of a major mall with her mother and her sister every time, and he — actually, she wasn't murdered, he came on one of those exchanges, murdered her mother and sister. She only survived because she was behind the seat and behind her mother and sister.

But there are some very dangerous times. Even with visitation centers, a woman in Seattle sold her car, changed her location, and her car so he wouldn't know what kind of car she was driving to the visitation center. He stalked her, knew that she had to bring the children for visitation, and murdered her on her exit, after she dropped her children off at the visitation center.

So I think there are some perpetrators who may be too dangerous, too dangerous to even have visitation or any kind of joint custody or visitation with their children.

And I think the rebuttal presumption that you have in place here is a great law, but I wonder how well it's enforced.

In custody cases, in California, 30 percent of the cases entering custody mediation have domestic violence present, and 55 percent of those cases have current or former restraining orders.

So I think you have to be very concerned about the safety of the women, and even if there's a violation of the restraining order by doing joint mediation around a parenting plan.

I have serious concerns about mediation and required mediation for battered women. I think we need to figure out other ways of doing that. And luckily, in California, which is again, at least legislatively, a very progressive state, your state now requires separate — well, gives the option of separate assessments, the option of having advocates in the mediation sessions. It gives specialized training to custody mediators — they're now required, by California law, to have family violence training, even though it's minimal.

But there are a lot of things that they need to think about in carefully doing mediation.

Again, visitation centers. Some men, I think, are too dangerous even to use visitation centers. More and more, even though visitation centers were established for child abuse, more and more families in domestic violence situations are using them, and that requires that the centers take special precautions.

There are a great number of wonderful programs. And when I'm saying keep this out of the child protection system, I think there are some

great models around the country of programs for child witnesses to domestic violence. In fact, Children's Hospital has a great program for battered mothers and their children.

There are good programs for working with mothers around their parenting. Parenting groups for mothers, in- home visiting services for battered mothers and their children. Dyadic programs, San Francisco General, Alicia Leiberman, Patricia Van Horn do some work with mother/child dyads.

Services to under aged mothers. A lot of shelters won't take women under the age of 18 years old. But your case, that you just talked about, was a 17- year-old, now pregnant woman, who wouldn't have access to many shelters because of her age. So thinking about services to that group.

And there are many programs, specialized programs for mothers around their parenting. And mothers need a lot of help around their parenting in many different ways, we shouldn't ignore that.

And we shouldn't ignore the role that fathers will continue to play in their children's lives. And in that respect a lot of programs around the country are starting to provide specialized content for men who batter, usually as part of or as separate from a batterer intervention program, on the impact of child witnessing, on parenting skills, on how to be a collaborate parent with your former victim, which is a challenge, and on the future role of the father in the child's life.

There are some great models evolved in e Non-Violence Alliance in Connecticut. The Center for Human Development, right here in Santa Clara. All of them are developing programs for parents who are violent, and for adult victims who are parents, to work on their parenting with their children, with a particular focus on children in domestic violence.

Probably the more complete programs are the ones that actually follow the batterer program. Most states don't have 52 weeks required batterer intervention, like you do, in California.

The Wilder Foundation, in Minnesota, has developed a 12-week post-batterer group program for fathers, on particular domestic violence and parenting.

Mett-Kreager, and this is available online, has a 12-session program focused on communication, in Seattle.

Our Children in the Los Angeles Circuit District Court, I believe, has a 113-page curriculum available, and Kid's Turn, in San Francisco, has a 14- session [program] they're developing for fathers who are violent towards their partners, but about their parenting with their children.

So I wanted to be brief, to give other people more time. Just to tell you, this is all in your handout, this is where you'll be able to find the full length paper, in about three to four weeks, at the Judicial Council.

Dr. Fontes

I understand there's a group of students here, could you just raise your hand? I want to really welcome you, I'm so glad you're here. You are entering — if you're entering the field of family violence — you're entering a great field, it's going to be really challenging, and you're going to meet some of the smartest and most dedicated people, like my co- panelists, that you could ever possibly hope to meet. So I'm really glad you're here.

Anybody here a member of APSAC, American Professional Society on the Abuse of Children? And California has a great chapter, CAPSAC, a great series of chapters, California branches. You can look it up under www.APSAC.org. Great multidisciplinary organization. If you're interested in child abuse, I really recommend it.

I'm going to look with you a little bit not at the effects of family violence but, rather, at the effects of the systems of intervention. In other words, "What are the effects of what we do?"

And I'd like to thank Bernardine Dohrn, of the Northwestern University Center on Children and the Law, and Jacquie Boggess of the Center on Fathers, Families and Public Policy, in Madison, Wisconsin, who brought this issue to my attention.

I don't pretend to be a big expert on this particular area, but I think it is so incredibly important that I want to raise it with you anyway, and I really don't hear a lot of people talking about.

So the topic is how does the effect of the criminalization of family violence affect communities of color?

For the last 25 years or so activists in the movements against woman battering, and to a lesser extent child maltreatment, have been trying to get the legal and criminal justice systems to

respond seriously to acts of family violence. And there have definitely been changes in this direction. Some acts, which it may be hard for some of you younger people to believe, were not considered crimes 20 years ago, in many states, such as rape within marriage. It was not prosecutable in many states. Now they are considered crimes, and that's really a good thing.

We have a lot of laws and policies which up the criminal ante in terms of family violence, including mandatory arrest for domestic violence in many districts, and specialized domestic violence units in prosecutors' offices.

Jeff talked about this, also, in terms of the child witness laws, and how the criminal ante is being upped in terms of the likelihood that there are additional penalties if there are child witnesses to domestic violence, in many areas.

In child abuse we can see what I think is a similar trend. A lot of you, I'm sure, know what children's advocacy centers are, there's more than 400 of them across the country. And they're multidisciplinary centers where children can be interviewed and assessed, examined medically for evidence of child abuse. I think they're a great thing, don't get me wrong.

You avoid the situation where a child might be interviewed, literally, 14 or 20 times by different people, from the police, and a therapist, and a prosecutor's office, and so on, because they get one or two, however many they need, often one, but sometimes up to four really good interviews that are documented, often through videotape or audiotape. And so all the evidence and information is preserved from that initial interview, and they don't have to be interviewed multiple times, which is great.

Most of these centers receive their funding through the justice department. Okay, a lot of times they offer some therapy, they may offer a little bit of prevention. But they get their funding through the Justice Department. How is their success measured? It's usually measured by the number of successful prosecutions. Okay, so you can see where the tendency is there. Again, it's a criminal justice response to child abuse.

Now, I'm going to say something political, so if that offends you, you can just sort of space out for 30 seconds, okay, I give you permission.

As I look around me, in Massachusetts, where I come from, I see my local schools, mental health centers, substance abuse treatment programs, our state university, almost all public services absolutely devastated by budget cuts. Is that what you see in California? Okay, some of you are nodding.

So I have to ask where are my tax dollars going at this moment and what systems remain strong? In fact, what systems are growth areas? And they are, right now, the military, the criminal justice system, and jails, the construction of jails. In fact, many people consider the construction of new jails, in this era, when we have dropping rates of crime, they consider it really a jobs program for rural white communities, because that's what's happening is the jails are being built in rural white communities at great expense.

Do you think those expensive jail cells are going to sit empty because of lower rates of crime? Okay, I don't think so. So some people are going to end up in those jail cells and I think that is related to this conversation that we're having about family violence.

The Effects of Family Violence on African Americans

So I think it's the right time to ask what are the side effects of what we are doing in trying to get the criminal justice system to pay attention to issues of family violence, and are there other strategies that we should pursue in addition to the criminal justice response. And I'm going to address this question, today, particularly in terms of its effects on African Americans and immigrants.

And I apologize that there isn't better data, or at least I'm not familiar with it, on Latinos and members of other groups, but there's very solid data on African Americans.

What have we done about family violence in the past 25 years? Lots of people working in prevention, lots of people working in treatment, but most of what we've been able to do successfully, and get funded, is pull in the heavy hand of the law to deal with family violence. We've improved mechanisms for protective orders and arrests in a lot of areas.

Public policy that relies almost exclusively on punishment cannot prevent violence.

Bernardine Dohrn has some particularly disturbing information on the way these policies affect African American girls, and I'll tell you a little bit

about that. Girls' family conflicts are being criminalized in a variety of ways. For instance, a girl may run away from home to escape sexual abuse, which is often the reason she runs away from home. So then she may be charged with a status offense. A status offense is an offense that you wouldn't be charged with if you were an adult, like running away from home, like loitering in some cases, like truancy, being truant from school. A condition of her probation may be that she obey a 5 p.m. curfew, she get home every day at 5 p.m., and do what her parents tell her.

Okay, now what are the odds that a girl, who's from an abusive family, which is usually the reason she runs away from home, not always, but usually, is going to be able to stick to the conditions of that probation? They're pretty slim.

So she violates her probation and then, because she's violated her probation, that can be a criminal offense, and that's called bootstrapping. So all of a sudden these girls are being criminalized and brought into the criminal justice system.

And, of course, African American girls are much more likely to be subjected to this than white girls. White girls tend to be diverted more and more into private systems, therapy, private centers for teenagers with problems, and so on.

Girls, and particularly African American girls, are more likely to be arrested than boys for non-injury assaults. So, for instance, a girl pushes her mother, or she pushes another girl, she's more likely to be arrested and prosecuted. Whereas with boys, well, boys fight, people think boys fight and they're more likely to not prosecute it.

The new family violence laws are giving police and prosecutors the framework to arrest teenagers for conflicts that might be better off being resolved through non-criminal means.

The Effects of Violence on the Poor

And, of course, these criminal justice interventions are disproportionately imposed on African Americans, and on poor people, who are treated more harshly at every step of the criminal justice system. So they're more likely to be arrested for similar crimes, they're more likely to be convicted, they're more likely to receive harsher sentences.

I can give you just a brief example of that. A number of years ago one of my colleagues, who's a rather well-known family therapist — I was teaching family therapy at the time — said to me, oh, I have this case, you'd like it, I'm sure. This teenager, this 16-year-old, her father tried to strangle her, he got really mad at her and he tried to strangle her, and her mother called the police. And the police came and they said if you don't get therapy, we're going to press charges against you. So they came to my office, as a therapist.

And I said, has there been previous violence, and he said, "no." Now, I said, I don't believe it. Go back and find out if there's been previous violence, I don't believe it.

Well, it turned out of course there had been previous violence. I mean, I have two teenagers, and I know they can be frustrating. But a man doesn't wake up one morning, having never been violent in his family, and suddenly decide to strangle his teenager to the point that his wife feels the need to call the police.

But what had happened here was the police didn't prosecute because this was an upstanding white family, a professional family, and this professional was much more likely to believe that there had been no violence. So you can see how this kind of bias enters in, in many steps along the way.

So what happens to men with a felony conviction, what happens to men with a conviction for domestic violence, even certain misdemeanors? Well, they're apt to lose their jobs. They have to spend a lot of time in court. Even if they're not incarcerated, they have to spend time in court, it interferes with their lives. They may be forever shut out of certain jobs because they have to list on their job applications that they have the conviction. They lose the time when they're incarcerated, they lose contact with their loved ones, and they may not be able to vote in certain states, if they have a felony conviction.

In addition, during their absence they can't provide support of any kind to their families, or have connections to their families.

And, I think worst of all, while they're in jail they're not apt to learn anything about how to be less violent. In fact, what do you learn in jail? You learn a system of power, and domination, and control, and even sexual power, and domination, and control.

So the criminal prosecution of family violence is just another arena in which African Americans, and particularly African American men, are penalized. By this, I don't mean by any way to say that we shouldn't be pursuing cases in certain communities, as much as others, because I think we should, I think it's really important to protect children and victims in all communities. But I'm just saying the criminal justice path should not be our only path.

The Effects of Family Violence on Immigrants

Let me just look at the situation of immigrants for a moment. Under many circumstances an immigrant, even a resident alien, can be deported for domestic violence or child abuse. There are actually provisions within the Violence Against Women Act that offer protections for people who witness crimes and cooperate in the investigation of those crimes, it's called the U-Visa. Are any of you familiar with the U-Visa?

Any of you work with immigrants? Okay, find out about the U-Visa, go online and find out about the U- Visa, there's information there. It's very important. Because a woman who is battered, or whose children are being abused, to take a typical scenario, if she cooperates even in the investigation of child abuse, can be eligible for the U-Visa. So it can actually help her application for better status in this country, although she thinks it's probably going to hurt it.

But, of course, most people aren't aware of this. Even those of us who work in the field, most of us aren't aware of it.

So very few immigrant women are going to reach out for help with family violence if they know the result could be the man's deportation. Or, if he claims that the violence was mutual and, of course, many women do fight back, perhaps she could even be deported.

Let me talk to you about one more case that I dealt with, just very peripherally. A defense attorney approached me one day and he said I need your help here

I'm working with a Haitian family, and it's a single mother and her five children, her five sons. And the seven-year- old son misbehaved in school and the teacher has called in the mother to talk to her about it. Well, the mother's understanding of what that meant was that she was supposed to punish the child. So she asked her oldest son, who was maybe 20 years old, to beat the child for her, because this was her understanding of what she was being asked to do by the system. So the oldest child beat the boy. The boy made a disclosure in school, and now there are deportation proceedings against the 20-year-old, who has lived here all his life, since he was born in Haiti, but he has never lived there. There are deportation proceedings against him for having committed an assault.

It doesn't sound to me like a great policy, I don't know how it sounds to you.

The criminal justice system is one really important element in the struggle against family violence, and I don't want to minimize that, it really is very important. But a system in which immigrants who have been violent are getting deported and immigrant families are living in fear of this deportation, and African American men who have been violent are being convicted and rendered virtually unemployable, this just doesn't sound to me like a long term strategy for making families safer.

To make families safer we need a variety of strategies, including community-based prevention and treatment programs. And I will say it, economic and social support for families to ease the stress.

So I don't want to abandon the criminal justice advances of the last quarter-century, but I hope we won't put all our eggs in the criminal justice basket, which is particularly unfair to African Americans and poor people.

And then let me just say, one more time, relying almost exclusively on punishment cannot prevent violence.

Dr. Gaba

My presentation this morning is going to be more of a practical nature. I'd like very much to take my time to speak about some of the things that I've learned along the way.

What I would like to address this morning are some thoughts about prevention and intervention, the involvement of systems in our prevention and intervention efforts, mostly in terms of goals and conflicts. Looking at family and community needs, and then looking at ways in which we, as professionals, and paraprofessionals, working in this field, can broaden the safety net for children.

Most of my work is based on a philosophical approach. I've been working with children and families for a number of years and in my practice, which has been primarily with child abuse, I have shared the experience that Dr. Edleson and others have spoken about this morning, of about a 50 percent crossover between domestic violence and child abuse.

What I began to see is, very common to everybody's experience, that there was very little crossover in terms of the prevention and intervention efforts that we were doing over the years. And now that this is an issue that's coming to the forefront, I think we all have a tremendous opportunity to step beyond the nine dots of the proverbial box and think of some more innovative approaches and different approaches to providing adequate services to our children and families, in a way that will make sense to them and perhaps alleviate some of the anxiety that they have when various different systems become involved in their lives.

Primarily, my philosophical approach is that of the ecology of the family, stemming from Bronfenbrenner's work, of the late seventies, in terms of prevention programs, and looking at the family, and work in family violence from a multi-systemic point of view.

Bronfenbrenner saw that the child's course of development is — he saw that as a complex process that was influenced by the family, and that the family, in turn, is influenced by the social and economic structures of the community in which they reside. And that the community, in turn, is also influenced by a variety of factors. For us locally, the state, our country, and the broader world.

And I think that right now, in our communities, we are all experiencing quite a bit of an economic crunch, which is having a downward spiral effect on the families and children that we're trying to serve.

Many models have been developed over the years, and some of them are described in the green book that you have in your handout, taking more of an ecological or multi- systemic point of view in terms of intervention programs.

And we also know that research, if we look into the American Psychological Association's Coordinating Committee on Child Abuse and Neglect, going back to the mid- nineties, research has shown that prevention and intervention programs that target single risk factors are not as effective as programs that assume an ecological model.

And why is this? It's because our families interface with many, many different systems in the course of their daily lives. And if we can create programs that make use of these different systems, then no one group has to shoulder the burden of all of the work. Okay. No one agency, no one system can solve the problem in and of itself. It really needs to be a network of a coordinated response that we are trying to build, develop, and maintain in our local communities.

When we look at identifying and linking systems together, we can have a number of adjectives that come to mind. One of them can be a really good sense of a community's ability to address complex problems within families, but the other can be more of the conflictual ideas, and comments, and adjectives that always come to mind, and we've addressed some of those here, this morning.

In our agency we developed a coordinated community response program that included law enforcement, child protective services, various different community agencies looking at the judicial system, and how we could be better informed by their work, and link and partner with them.

And we were able to provide not only crisis intervention services at the time when police were present in the home, being able to work with the adult victim, or the survivor, and being able to work with the children, but also beginning to talk, although briefly, with the offenders, themselves.

Our services included intensive follow up within 24 hours, and following up again in a week, and following up again after 30 days. And we were able to work quite closely with the families and develop good relationships with the different systems in which we were involved.

What I would like to propose is a model that kind of incorporates some of these ideas, but also is one that is sort of in between having an open case with child protective services and having no services at all. And this is where it gets kind of tricky, because if we have the child protective services system involved, there are certainly more services then that are available to the family.

A Crucial Issue: Keeping Victims Safe

But one of the thoughts that I had, and I've often come under criticism for saying this, so I will give a caveat about it first. The very first thing that has to happen is that the safety of the mom, or the adult victim, and the children is absolutely ensured. Which means that early on in our intervention programs we have to have the capacity to do fairly thorough assessments of the offender to be able to identify and screen out those situations in which we would not be able to safely provide services.

If we're able to do that, and we can create teams of people that include child protective services workers, maybe city attorneys, therapists, advocates, paraprofessionals that come together with the family, to do some serious assessment and planning around needs, and possibilities for intervention and different services in a multidisciplinary case conferencing, I think that this is one way in which to make a beginning around some of the ways that we can have more effective interventions.

This takes its model from the family preservation model that child protective services has had implemented in the state for several years now. And we've had the experience of working with families under the child protective system, in a family preservation model, families in which there has been domestic violence and child abuse. And we've experienced some rather remarkable success with these families, because with the family preservation model they're able to provide enough supportive services, for a long enough period of time, to be able to have inroads and effects with the family.

And that it isn't simply targeting the victims, it's not simply targeting the children, it's not simply targeting the adult victim of domestic abuse, because oftentimes these women are incorrectly charged with failure to protect, but also targeting the behavior of the offender and ensuring that adequate services are provided for the offender, and that there is ongoing evaluation of his or her response to those services.

This model also assumes that there would be regular team meetings on an ongoing basis, perhaps monthly, perhaps bimonthly, in which the team comes together again, with the family, the family members who are able to be there, including the children, to talk about their experience of the services, their ongoing needs if there are any other areas in which we might be able to provide services.

And one example might be this, for many of the women, and we work with a largely immigrant population, for many of the women the apartments that they rent are under their husband's names. And sometimes what happens is that landlords no longer want them to be there and they can no longer maintain that apartment because they are not the name on the lease. This has come up and there are a lot of different reasons why that happens.

But one of the things that we're able to do is to work with the housing authority to facilitate their entrance into section 8, or public housing, which is a really significant thing for them because their rents are much less and it produces much less of an economic strain.

The reason why I feel working with these types of programs is beneficial is because in looking at our population over the past several years fewer than one-and-a- half percent of our adult victims of domestic violence wanted to go to shelter. And there are many reasons for this. They did not want to remove their children from the schools that they were in. They didn't want to leave the local communities. They did not want to lose their personal belongings, things that they had worked very hard to get. They also felt that it was the offender's responsibility to be out of the home, if this was the choice.

The other thing that we found was that within a certain amount of time many of the offenders were back in the home, and this is a very common thing, it's everybody's experience. And most of this was because of economic pressures. And in some cases because women felt that it would be safer for them and their children if the offender was back in the home. But there was a tremendous economic pressure and also the belief that their children needed a father in the home and would also assist with parenting those children.

Wraparound Services for the Family

So if this is the case, then can we not think outside the nine dots and begin to develop and structure programs that offer more of a coordinated effort, wrapping these services around the family in a way that incorporates their own needs, as they see them, and also incorporates multiple points of intervention.

What I see in addition to this, especially for children, the multi-systemic approaches that have been shown to be very effective are ones that get people out of their offices and into the homes, into the schools, and into the communities. Okay. I think that for those of us who work in this field, this is a message that cannot be said loud enough. We have to get out of our offices, we have to get into the homes, we need to get into the schools, and we need to get into the communities to work effectively and create change in terms of exposure to violence in the family, as well as violence in the community.

I would agree with what another panelist had mentioned, earlier, that we don't see children who have one experience of exposure to violence. In fact, the opposite is quite the case. What we see are children and parents who are exposed to community violence. Parents who may have had histories and terrorism and war in their countries of origin, who have now come to this country, who are struggling with issues of acculturation, who are facing tremendous employment and educational challenges.

Children, who are exposed to violence outside their front doors, who are afraid sometimes to walk to school because of gang violence, who are bullied in the school community, and who have very few resources at their hands to help them with these problems.

Our assessments of families must include extensive histories of a lifetime exposure to different traumatic events, because these events will have an impact on how well not only the parents, but the children, are able to respond to various different treatment programs. So that is something that must, in my opinion, be done in all forms of assessment.

The community-based approach is a combination of professional and paraprofessional people, advocates. The work of advocates is a tremendous help with our families. And that we have therapists who are working, or counselors, or paraprofessionals, case managers, advocates, who are working in the schools with teachers and school counselors, with after-school recreational specialists, forming peer groups in the schools to address the issues of anger and anger management, social skills building, and also working on relationships with each other and in their families.

Our in-home programs can work on focusing on parenting skills. Modeling, also problem solving on day-to- day issues that may arise. Not only do we want to use individual and group therapy models, that are the traditional ways of looking at treatment, but also extending this to family therapy, and working with the abused or surviving parent, the survivor of abuse, and the children, conjointly in family sessions, but then also, at a point in time when it is safe and appropriate to do so, to include the offender in that process, especially if it's the desire of the family to reunify.

Obviously, if there are issues, such as alcoholism, and substance abuse, those issues need to be aggressively addressed. And again, if reunification is to take place, that those issues need to have been addressed and dealt with prior to that in order to ensure the safety of everyone.

One of the things that we are trying to start to do at this point, and actually have found a little bit of success with it, as we go along and develop it, are parent/child groups. So that instead of having parents in one group and children in another, what we're starting to do is work with children and their parents in the same group setting.

And this has been really a good experience for children who are ages, maybe, 12 to 14, because there are a lot of conflicts with kids this age, in this age group, as they begin to move on into adolescence, and they're transitioning out of childhood. But it's also a way to help facilitate the children's ability to express their needs to their moms, and vice-versa.

And then, finally, recreational activities. Many of the families with whom we work, because of just by the very nature of the level of stress that they are living under, are not aware of a lot of the recreational opportunities that are out there, and this is a very important thing. We've actually organized family groups, groups of families, and have organized activities for them.

For one example, we had organized a fishing trip for moms and their kids, in our domestic violence program, and we did this because there was — you know, we wanted to facilitate and foster interaction in a less structured way for moms and kids. And, actually, this was a very successful event, and for many of the moms it was the first time where they had been out of their local neighborhoods, in an area that they could easily access, and participating in some form of an activity with their children that was done, and could be done in other settings.

Another opportunity, there are several foundations out there, the Paul Newman Foundation being one of them, that had developed a summer camping program for moms and their children, that originally had been for substance abusing moms and their kids, but they've now expanded that into domestic violence.

And we were able to actually send 20 families, moms and their kids, to a camp together for a week, and have continued to do this every year. We engage different merchants out in the community, different department stores, and such, to donate equipment, such as sleeping bags, and bathing suits, and flashlights, and batteries, so that the children and the moms have everything that they need when they go to this experience.

Usually, we can send kids to camp, but when do we ever have an opportunity for the moms to be able to participate in something with their children, of this nature? And we try to send different families every year, we don't send the same families.

And the moms, in this experience, are actually served with their children at the table, and this is not something that is the normal practice in many of their homes. Their children are fed on the go, or they're serving the kids, and they kind of eat on their own. And this has been a tremendous experience for them, they then generalize this back into their home experience so that the dinner table, and eating together has become more of a regular practice, where they're able to talk about more of the daily issues that they have, together.

So I think that looking at some of the more innovative approaches, looking outside the nine dots of the traditional experiences, are ones that can actually foster those strengths that families often have, and identify them, and work with them, but also to be able to work in a more unified approach with this issue of family violence, domestic abuse and child abuse in a more collaborative way.

Dr. Stilwell

Good morning. I've very happy to connect with all of you persons of conscience. I'm not here to describe the deficiencies of conscience in family violence, because you already know what those are.

I am here to suggest how to go about assessing assets and deficiencies in conscience functioning in children or adults, perpetrators or victims, living within violence laden families.

Life begins with a moral demand. The infant of any species cries out, boldly, I am here and my needs ought to be met. Now, adults in most species honor this moral demand, responding to it with evolutionarily programmed behaviors. Humans respond to the demand with behaviors that are evolutionarily programmed, others that are learned, and some that are creative.

Parents may honor that demand very well, or they may honor it horribly, or they fumble around somewhere in between, (like you and me).

Parents also make moral demands of each other. And whether we adults honor moral demands skillfully or horribly, children grow up with a myriad of moralizing moments that shape their own conscience.

Now, what's a moralizing moment. I'll define this as an experience from which we define and punctuate our sense of good and bad, right and wrong. It stays with us, attached to a sense of oughtness.

I'll give you an example, one that hopefully reflects normal development. In my semi-retired life, I spend two days a week caring for a two-and-a-half-year-old grandson, Glen. Well, one day he enthusiastically came into the kitchen and bit me on the leg. No, the skin wasn't broken, but it did startle me enough that I yelped and said, "don't do that." Well, Glen was broken-hearted, he cried and cried. And I went to another room, and then I came back, and with him sobbing, and saying, "grandma," and I comforted and soothed him, and then when he was calm we proceeded to play. And after a minute or two he looked up at me and said, "no bite." And I said, that's right, no bite.

Now, moralizing moments are seldom planned. We just have to be ready to respond to them when they occur. Will Glen bite again? Well, maybe yes, maybe no. I'll bet he doesn't bite his grandma!

Domains of Conscience

Conscience is formed from a myriad of moralizing moments.

Now, it would have been a moralizing moment of another kind if Glen had been an angry child, who meant to bite me because of some very

important needs that were not being met, (his evaluation, of course.) If I had yelled, screamed, or physically beaten him, if I had bitten him back, if I had refused to interact with him and banished him to an isolated place, calling it a prolonged time out, if we had not restored emotional harmony between us, if I never let him forget it and continuously reminded him that he was a bad boy. It would have been a moralizing moment of a different kind if he had silently watched other family members bite each other or engage in other aggressive forms of behavior.

Now, members of violent families each have a conscience, a dynamic mental representation about right and wrong, good and bad. In minimalist form it is just an external structure, something out there in society, unimportant until one is in trouble, its influence emanating only from the power of others.

More likely, though, the conscience formed in a violence-laden family or environment is somewhat similar to the conscience of people growing up in benevolent environments, but it is more likely to be uneven in design, full of gaps, confusions, and distortions, very irregular in its influence. In extreme cases it may be organized around the deliberate pursuit and perpetuation of evil.

But in most cases it is probably organized around neediness, discomfort, and revenge, derived from hostile or absent relationships, emotional blocking, or disregulation, confused or underdeveloped values, and a threatened sense of personal power.

Conscience is a conscious mental structure, as opposed to the super-ego. Yes, it does draw on biologically unconscious processes and memories that are pre-verbal in nature, but it is the conscious conscience that can be self- examined, that can be subjected to remediation, that has the potential for becoming a person's ally in straightening out his or her contribution to family violence.

How do we encourage self-examination of the conscience. I suggest that we break it down into domains. I suggest that we inquire about, (1) moralizing moments with attachment figures, (2) how emotions are regulated around moral issues, (3) how moral values are weighted and balanced, (4) how autonomy is used to inhibit or act in behalf of moral values, and (5) how the overall power of these interacting domains helps a person create moral meaning in his or her life, what direction it gives to the person about how he or she ought to live.

Now, we'll detail these domains more carefully this afternoon. Your handout includes suggested inquiries in the semi-structured interview, called the Stilwell Conscience Interview.

And you will also find these questions in Niki Delson's manual, fresh off the press, adapted to working with sexual offenders.

Each domain of conscience addresses a bedrock value, a value vital to promoting survival and well-being in a world that requires moral meaning to make sense.

Moral attachment, we'll do them one by one, addresses strength and quality of moral connectedness, or disconnectedness to specific human beings, as well as their civil institutions and their sense of deity, in the past and presently.

These connections may be benevolent, loving, dominant, submissive, hostile, ambivalent, confusing, or a blend of many characteristics. And we ask people to draw pictures of their conscience, and some of these characteristics come through.

The second domain, moral/emotional responsiveness, addresses emotional harmony within ourselves and with each other. It encompasses the arousal and regulation of emotions in response to accumulating moralizing moments. It roots the conscience in underlying physiology, it makes that connection to the cortisol response and the autonomic nervous system. It provides impetus for processes of reparation and healing, when moral self-appraisal is sorrowful.

The third domain, moral valuation. This domain addresses the progressive search for rules for living. This search balances the moral needs of self with those of authority and the egalitarian other. It calls forth all of the executive functions and defensive strategies that the pre- frontal cortex will support. Moral valuation may be rule heavy or rule light, oriented toward the pursuit of goodness or the pursuit of badness. Moral valuation is open to mental trickery, applied to self and others.

Alternatively, moral valuation may be the foundation of personal integrity.

The next domain, moral volition. This addresses attention and motivation, how they empower the autonomous individual to inhibit or act, to carry

out mandates of conscience. It also addresses how the autonomous individual may direct his or her energies toward avoiding internal mandates, hiding from them, or executing evil mandates.

And then, when we tie those supporting domains together, we have the overall conceptualization of conscience. That domain addresses the summation and integration of the process of creating moral meaning.

The result is a dynamic mental structure that is continuously available to moralize new experience. Each person's conscience is unique and, yet, has universal characteristics. Like personality, itself, it's very stable, but yet amenable to change.

Violence Informs the Conscience

Adversity, including family violence, may shape the voice of conscience in ways that are developmentally delayed, or accelerated, aberrantly organized or dramatically disrupted. Disruption may be sporadic, intermittent, or continuous. When psychopathology is related to disruption, we use the term "psychopathological interference to conscience functioning." This concept was introduced through some empirical research that I had the pleasure of being a part of when working with a group in Los Angeles, studying the effects of the Armenian earthquake of 1988 on adolescents, with Dr. Armen Goenjian. And you will find a reference to that article in the *Journal of the Academy of Child and Adolescent Psychiatry*.

The relationship between conscience, psychopathology, normal development and adversity is open for exploration. How it may be related to not only PTSD, but to anxiety, depression, substance abuse, ADHD, and other psychiatric syndromes. Being a psychiatrist, of course I organize things around that DSM categorization.

A colleague of mine, Dr. Matt Galvin, in Indiana, performs conscience sensitive mental status evaluations every day within the business of a fast-paced psychiatric practice. If you have read mental status examinations, you know they read like carbon copies. They all sound alike, they're absolutely horrible. Where he introduces this element, this moral element of personality into it, people read them and say, well, I think I kind of know that person.

Dr. Galvin also directs conscience sensitive treatment groups. A sample of a routine conscience sensitive evaluation, including the patient's picture of her conscience, is included in your packet.

Exploration of the voice of conscience is wide open in the field of family violence and several other areas, and so is its remediation. I invite you to explore and remediate.

Audience Exchange

Audience Member: My name is Kareena Lerner, and I'm interested in your position to facilitate a Monterey County children's council that's focused on violence, a small task.

The council has department heads from the county health department, probation, education, and social services, a judge, community members, so it is following this model. So they sent me here to get a solution on how to build a new model.

So I guess my question would be—well, I have two questions. One, we talked a lot about intervention, and I know people already in the practice of social services are looking at now how to implement something new or to change what's existing.

But if I can look at policy, and making changes at a county level, at least, I want to look at methods and data of reducing violence with prevention in mind, as well, and so to all of you, and for anyone to speak with me later about ways of prevention and then, of course, into intervention, and needs assessment, all that.

And number two, basically being in this position, which I think is very unique, I have political will and commitment, I believe, within that county to make change. Depending on my success in this, what would be your advice on how to proceed based on there's going to be a lot of different perspectives being brought in, so consensus will be difficult, there's 25 members. But basically how, where to begin, and how to develop groups that can start to implement systemic change.

Dr. Kaufold: Okay, who?

Dr. Edleson: That's an easy one. My experience around the country, and doing the green book, which was about 40 people, they were very diverse and a lot of disagreement, and a lot of distrust when they started, was that you really

need three items, you need to do three things in your community when you're trying to do what you're doing, and I think other people have had this experience.

One is you first need to start communicating with each other. You need to learn each other's languages. You need to learn what each other does and cannot do.

When I did interviews of prosecutors, public defenders, judges, police, child welfare workers, battered women's advocates, all of them felt totally misunderstood by everybody else. It's really a cross-cultural experience because it's different languages and different cultures and you have to approach it as a cross-cultural experience.

I think, once you start getting cross- communication, doing cross-training together, getting people together to talk about cases, how they go about it, developing protocols that go across agencies, and how can you integrate your work together. Because at the end, most of the groups that you're working with, their goal is safety, stability, and well-being for whomever they're focused on. But in the end we're all focused on safety, stability, and well-being for everybody in the family. The perpetrator, the adult victim, the child, who's exposed to violence or a victim of child abuse.

So I really think you have to figure out how you can actually integrate the work together. So I see the cross-communication happening at your family violence council, but also between agency managers, and developing protocols of how you're going to handle cases together, and then sharing information at the very case level, direct practice work. It's really three different levels of communication, cross-training, and integration that have to happen.

And that's really what the green book is all about, in a way.

Dr. Gaba: I'd like to add just a couple of things to your comments, that I think it's important to include what every-day people in the community want to see happening. I think that the cross-communication, the different languages and limitations of all of the systems involved, sometimes people in the community have unrealistic expectations of what the various different systems are able to do. So I just wanted to offer that as also to include not only people on the county, professional levels, but also to include different groups, more of a grass roots community level as well, because you can generate a lot of support for what you want to do, just by doing that.

And then, also, a thing I think is important to look at—expanding on the issue of languages and the cultures—is being able to identify exactly what each part of that system is actually able to do by their own mandates, the limitations of what they are funded to do and, you know, the regulations around what they're able to do, and try to be able to develop your protocols around that.

Dr. Fontes: I'd like to make a couple more points as well. I didn't hear you say whether it was only family violence your mandate urges, or is it violence in general.

Audience Member: Well, it's a youth council, so it's violence. But, of course, you can't stop with just youth violence.

Dr. Fontes: All right, so it is broader than family violence, and I think that's great. I think it's really important that we know this, and we pay attention to it, and we address our interventions to the violence that link up in many ways with violence that happens in the family.

One thing, I noticed you saying was that if you're successful X, Y, Z. I think it's important early on that there aren't going to be any real facile measures of your success. That, you know, in two years they're not going to expect to see a drop in rates of whatever, and that they may even see it go up, as consciousness and issues are raised in the community there could be more reports, rather than fewer. So you don't want to get trapped into something where you're going to be found unsuccessful because of the measures that they're using. We need to look at a long-term approach to interventions.

I also really wanted to encourage you to go into places where children are. Go into schools, work with the mental health personnel in schools, guidance counselors, school social workers, and so on, Head Starts, churches, and make them key players in your prevention efforts and education.

Dr. Kaufold: Thanks, Dr. Fontes. I'd like to add just a word, from the medical standpoint, is include the medical community. One kind of prevention is secondary prevention, and that means you've identified cases, so that identifying children who are injured, or women who are

injured, and finding out, helping them to establish a link is a way of prevention. And the medical community doesn't come by this easily, they really need to be drawn in to feel like players at that council, as well, and then they'll work to educate others in the community.

Anybody else want to say something?

Dr. Gaba: I also wanted to just mention that the institute that's being planned for the last week of June is going to—a very strong component of that institute is developing coordination among the community system, so I would encourage you to try to attend that.

Dr. Kaufold: Okay, Dr. Stilwell, did you have a comment?

Dr. Stilwell: Look for moralizing moments of cooperation and sing out.

Audience Member: Yeah, hi, my name's Carlos, and I'm a UC undergrad and EMT instructor, and I just have a question. I find that working in the emergency response field that it's under utilized as a factor in the community, as pre-existing in the homes, more specifically. And I just want to ask, as a panel, what do you feel would be something you would want to communicate to the next generation of emergency response personnel?

Dr. Kaufold: Who would like to handle that? Could you rephrase the question, maybe elaborate a little bit.

Audience Member: What would you like me to pass on, as an instructor to the next generation of those working and first to respond in the field, being those who initiate the reports, in some cases, on domestic violence, and child maltreatment, and such, by what means could you better utilize that position?

Dr. Edleson: I think the emergency medical response is very important, just like a variety of other first responders, for identification, initial safety planning, and referral. I don't know that you can do extensive safety work, but at least to know where are the places to go, to try to do some quick assessment, some connecting of particularly victims with safety resources, and moving them to other people.

So I really see you as a bridge to a wide array of services, and it's really important for you, as an emergency medical technician, or a responder, to know what those resources are, to know what the cues about domestic violence are in a family, to do a quick assessment, to try to provide a little bit of safety planning, but not to feel that you have to do it all, and that there are others who can do it better and move these families onto those people.

And I think that's true of all first responders, it's not just emergency medical. But I think you are in a very key location for being the first connection for many of these people.

Dr. Fontes: I'm going to speak about this at lunch, so it's going to be a teeny little preview, but I think you really can set the tone for everything that comes afterwards, and it's a really important role.

And I'll just give you one example that was given to me, by somebody in a position like yours. I said, what do you think is different when you work with immigrant families, and nonimmigrant families, and he said, well, if we go into a home with fluent speakers of English, we're more apt to say, hey, lady, you got to get the guy out of here. But if the family doesn't speak English fluently, they're more apt to go in there and be formal, and not take the extra steps to set the tone.

But I'll talk about that at lunch.

Dr. Edleson: I just wanted to say, also, it's important that they feel that they can go back to you in the future. That it may take repeated times of using your service, and other people's, before it works to a safer place for these families. So it's really important.

I know a police officer that gave a card, and it wasn't until five years later that the woman used that number. So just think of yourself as a farmer here, at UC Davis, think of yourself as an Aggie, that you're planting seeds, and those seeds will grow in ways that you cannot predict.

Dr. Kaufold: In order to respond, you know, the first responders need a lot of education, a lot of information. A lot of information on what resources might be utilized in the community further on down the line.

I know, sometimes as, not a first responder, but close to the front end — I don't always know what happens to the people that I see further down the line, and I'm anxious for them to get genuine help, I'm anxious to have faith in my own system at what's out there.

And also, to take care of yourself as a first responder. I think the immediacy is different at

that point, and having opportunities to even discuss your colleagues, who do the very same thing, could be very helpful in terms of just not letting it get to you and take it home.

Audience Member: I have a question for Lisa Fontes, in particular, and then one for the panel, in general.

Ms. Fontes, I don't know whether you noticed the irony of one of your stories, about the 20-year-old boy who was ordered by his brother to beat up his younger brother, and who paid the price for that.

The question that I have for the panel, in general, is what outreach strategies are there for male victims of domestic violence, other than the attempt to ignore, minimize, trivialize, and outright deny the reality of male victims of domestic violence perpetrated by females?

Dr. Fontes: I am actually happy that you've raised that issue. I have an uncle, who's since died, but he was bipolar, and he would get into a very depressed state, where he was almost catatonic, and his wife would inflict bruising on him, all of his body, by twisting his skin, and that was awful.

I also have another friend, who's in a wheelchair, and for a while he was threatened by his girl-friend, who had a knife, she would threaten him and control him.

So these things certainly do happen, and they're awful when they happen. We also know that they're not what mostly happens, but they certainly are issues of concern.

And the people who I know, who work in the battered women's movement, which is most of what we're talking about, do a lot of outreach to men. They may not allow them in their facilities, it may be that they need other facilities, but I have seen an incredible level of consciousness about same sex battering, and about other people in violent situations. I don't see anybody else doing that work, in particular, so I do think it's a problem worth addressing. But as I said, it's a smaller scale. For those people who are victimized, it's certainly hard. But it's not most of what we're seeing, and it is also used by the backlash, certainly, to say intimate partner violence is not a gender issue.

And we know it is a gender issue. People who work in emergency rooms know it's a gender issue. When you get the usual situation, a 180 pound man, and a 130 pound woman, even if both punch, and it looks on a contact scale that they both punched, we know who's going to end up in the emergency room.

Dr. Gaba: I also wanted to respond to that. On our family violence response team we have several young men, who are counselors, who are working as intervention staff. Because we're called in when the police are there, we've had the opportunity to work with some men who have been victimized, and we work with them in exactly the same way that we do with women who are victims, and we offer them the same range of services that are offered to women who are victims.

We have identified some male victim groups in our local community and many of the men to follow up and try to go into those groups.

We also have a very strong fatherhood program, so several of those men, over the course of the years, have gotten involved in that, and have found it to be quite helpful.

Dr. Kaufold: Thanks. Okay, I think maybe we have time for one or two more questions.

Audience Member: How would you suggest working with family court, in which the judges place the children, of women who are fleeing domestic violence, with the perpetrator, and place the victim on supervised visits?

Dr. Kaufold: Who would like to tackle that? Jeffrey, would you?

Dr. Edleson: Sure, I'd love to. Ellen Pence and Martha McMahon, who wrote a chapter on visitation centers, talked about how, in our society, mothers have responsibilities and fathers have rights. And it's been my experience that there are—in fact, I would agree with the gentleman who questioned me earlier, that there is a gender bias. There is a huge gender bias in our society, and in particular in child welfare systems, that men are invisible. I think it's a huge problem.

I do think it's a huge problem that men's domestic violence is not taken into account in the courts, in deciding on custody.

The case that was just mentioned, I've heard something called parental alienation syndrome, PAS. Has anybody heard of that before? I've heard that actually applied in cases like that, where a battered mother, who's claiming, you know, that she's been battered, and the batterer

goes in and says she has alienated the children from him, therefore should be separated from the children, he should have custody and she should only have visitation, and some judges use that.

But, frankly, that's been debunked, it's a guy in Wisconsin, Gardner, I think it's Richard Gardner. If you look on websites, you'll find them all over the internet. But there's some very good critical articles of the parental alienation syndrome, that it's not based in real life and it's not based in science.

I do think it's a problem. I think it's a problem of attitudes, attitudes of judges. I think it's an understanding of the dynamics of domestic violence and what's occurring in those families. I think it's a matter of evaluating what are mother's behaviors, and how they impact children, and what are the abusive father's behaviors and how they're impacting the children.

It's problematic, I hear about these cases frequently, and I think the bottom line is it's about the judge's attitudes about the case, and how a judge assesses that information.

But I do think we shouldn't ignore fathers, and I think it's very important that we reach out, and that we not just look at fathers as having rights, but they have responsibilities for their children. And we really need to not ignore their parenting and the continued parenting that they do with children, even when they don't have custody, and even minimal visitation with them, and we really need programs to reach out to them. When they can be safe with their children, reach out with them and work on their parenting.

So I don't know if I answered it exactly, but those are my thoughts about it.

Audience Member: Well, how do we impact the judges?

Dr. Edleson: Well, a lot of judges are elected, so there's an electoral process. I don't know in California if they are or not. A lot of training. The National Council of Juvenile and Family Court Judges does excellent training for judges, all over the country.

But again, the judges have to be willing, just like doctors and anybody else, have to be willing and interested in going to that training, and those are the judges, probably, that won't come up with a ruling like that.

Dr. Fontes: Just as a long term strategy, maybe some people in this room can become judges. I'm serious.

Dr. Kaufold: Good idea.

It looks like there's two more questions, you and then did you have a question? Okay, and then maybe that will do it.

Audience Member: I just want to add to the comments that were made in terms of how to affect judges. I think one of the things that battered women lose, or battered persons, whoever's in the courtroom, is that they come in wholly unprepared. As an attorney, I'm a prosecutor, and I obviously get involved in all of these cases, preparation and documentation, number one. There can always be a big hit about what society doesn't do, and what programs don't do, and et cetera, but the biggest problem is that the documentation is not done. And we need to talk more to those individuals that are out there, working one- on-one with victims, to get them to put things down in writing. Many women go into these courtrooms unprepared, no attorney. That does not mean that they cannot be heard, but if their information is not written down, it's not readily available, they get into a position where they can't tell the court what it is they need, and they end up being a loser.

So that's what I spend every single day telling victims to do. So that's one comment.

Dr. Kaufold: You can tell the medical community to be part of that, as well.

Audience Member: That's right. Because you have to document, and people just don't seem to understand that. And the person on the other side comes in, they have their paperwork, they hand it to the judge, who's the judge going to listen to? Okay, that's the reality.

The other thing around children, and children as witnesses, as a prosecutor we certainly have to get to that point where we bring children in the courtroom. But one of the first things I want individuals to realize is that these children have seen what has happened in that home. And as that wonderful cartoon, or caricature that you showed earlier, that child has a right to be heard and should be.

Dr. Kaufold: Anybody else have comments?

Dr. Edleson: I just want to say that child has a right to be heard, I just hope we do it in a sensitive way. And there are prosecutors I've

heard that aren't as sensitive as you, and who just sort of want to use the child as their tool in any way they can.

Dr. Kaufold: Okay, last question.

Audience Member: Thank you. My name is Tina Bakley, and I'm a recent psychology graduate, who has switched from desiring to be a Ph.D. in psychology, working with abused children, to being a special education teacher.

And so my question is how can we broaden the relationship to include teachers. I hear that—I know all about the psychologists, and I'm really grateful that Dr. Gava has her folks go out to the schools, to talk to the teachers, but teachers spend 35 hours, on an average a week, with these children, 50 percent of whom are abused in some manner or fashion.

But I would do anything to have pounds and pounds of energy to have somehow either get it so our teachers are educated in how better to be working with these children, because in the classroom, I hate to tell you, it is not fun to have a good third of the kids acting out, so that the one quarter who are really there for an education—you know, so that goes into the whole education model.

But the other thing, in my Pollyanna, you know, coming into my life's passion late in life, is we really need to be educating children, in the classroom, to be good parents, so that those generations down the road will know how, even if they've had the other done to them. So how can I help?

Dr. Kaufold: Okay, how can we educate the schools and how do we reach the children in the schools?

Audience Member: The teachers, the teachers.

Dr. Gaba: Thank you so much for that comment, because I think that you are a hundred percent right. I think that if most schools did a survey of their children, and discovered what those children have really been exposed to, they would be shocked. And I think that they would also be shocked at the impact that that level of exposure has had on them.

And I'm not talking just about child abuse or family violence, I'm talking about the whole array, from the experience and the impact of violence in medium on down the line.

I think starting to work with teachers around recognizing, and you're in a really good position to do this because you've had the training, but identify people, if not yourself, who can provide in-service training for teachers in the school on how to recognize symptoms of possible exposure to violence, what that's going to look like in children. And there's different ways in which that's going to manifest itself.

Sometimes kids act out, they're oppositional and aggressive. But other times kids are very withdrawn, turned in on themselves, and these are the children who aren't always identified as having significant problems until at some point later on down the line.

And then looking at what the needs of the children in the school are, and working with the administrators and school counselors, like I mentioned before, to develop short term groups. You can do groups in a classroom, educating on violence prevention. There are a lot of very good prevention programs out there, and some that have been used in elementary schools, junior high schools, and high schools. So I would fully support that.

But doing training with teachers during staff in-service times, that I know that they have on a regular basis.

Dr. Kaufold: Dr. Stilwell?

Dr. Stilwell: I am imagining you having sixth graders. Do you have sixth graders?

Audience Member: I've had them all.

Dr. Stilwell: You've had them all. I'm also imagining or advising pep talks, in a very soothing way, about what I call the valuational triangle, respect for self, respect for authority, and respect for each other. And then I bring in anecdotes from the day, or the day before, to support where this has positively been shown.

And I have found that particular message to be very strong and very useful, and very useful in getting the kind of calmness that then promotes learning for some of them.

Dr. Kaufold: Do you want to say anything?

Dr. Edleson: Sure.

Dr. Kaufold: Okay.

Dr. Edleson: First, I think there are a number of excellent set of materials that have been developed around the country, and in Canada as well,

for teachers and school systems. I think you have to think about the environment of your school and how does the school respond to incidents of violence.

There are a lot of peer-to-peer mediation programs going on. Those virtually have nothing going on around domestic violence, yet a lot of times in high schools those are male/female relationships that are being mediated in those systems. So I think attention to where are the points of intervention that are going on.

I would say ditto, what I said to the emergency medical folks, that you are a first responder to be able to identify, to provide immediate safety planning for a child, and to make referral is very important for you.

And then, in the curricula that people mentioned, the London Family Court Clinic, in London, Ontario, Canada, Peter Jaffe has done excellent work and developed—and David Wolfe, who was worked with him—have done excellent work around whole schoolwide efforts, including school-based curricula, classroom-based curricula on domestic violence prevention.

Now, the family violence prevention fund, in San Francisco, has excellent materials available that are prevention oriented, and could be used by teachers in a lot of different ways, as well.

So I think there are some really good materials out there and people doing good work for that kind of piece. But you also need to be a first responder and think about your role there.

Dr. Fontes: I train guidance counselors, now, and I spend a lot of time in schools, Intercity, Springfield, and Holyoak, and Suburban, and everything inbetween, and it's a great source of frustration for me, what you're talking about. You'll meet teachers who say I've been in the field 40 years and I've never had to report a kid for abuse. And so you know, gee, have they somehow not had any of these kids in their classroom? Not likely.

Many states, and I assume California as well, have a required element as of the training for teachers, that you have to have a unit on child abuse and neglect, am I right? But usually it's on reporting. Reporting's a good start, but it's not everything.

In addition to what's been said, I just wanted to recommend two articles from the Journal of Counseling and Development. One was on working with abused and neglected children in schools, and the other is one that I wrote on working with children exposed to marital violence in schools, both in the *Journal of Counseling and Development*.

Because in addition to the whole reporting question, there is the question of how do you help them handle their behavior so they have a sphere of success in life.

And then I would just say it sounds like you're in a perfect position to educate your peers, not only in your school, but at conferences and so on, and they're lucky to have you.

First Response: Speaking about Violence in Diverse Families

Lisa Fontes

Today I'm going to be talking about first response, speaking about violence in diverse families, and let me tell you half an hour is not going to do the trick. But I am going to leave here in half an hour, and you can throw food at me if I talk a minute longer, because I know that you've had a lot of people talking at you today.

I'd like to ask you to take a few seconds to think about dedicating your participation during the rest of the day either to somebody who you worked with, and were not able to serve as well as you wish you could have, maybe because there was a cultural difference between you and that person and you just didn't know how to bridge it, or maybe for some other reason. Or to dedicate the rest of your participation to a mentor that you've had in the field, who's been important to you.

So we'll conjure up all of those wonderful spirits into this room and remind ourselves why we keep going about the work that we do.

What are some of the barriers to communication across cultures? These are just a few of them. One of the barriers is fear. We may be fearful of the people who we are working with. I think that the recent post-September 11th events have raised this issue, that people from the U.S. have suddenly, many of them, become fearful of people who look like they're Arabs, or look like they're Muslims, or look like they're from the Middle East. And whether they are or not, there's a level of fear based just simply on how somebody looks.

Cultural Sensitivity Can Help

Language differences can make it hard, certainly, to communicate across cultures.

Cultural differences. So that when you're a first responder, and you're walking into a house, and a house may have a smell that you're not used to, you may have a physical reaction to that smell. I mean, you may feel that it's not hygienic, or that it's disgusting. And that smell could just be a smell of a food that you're not used to, a strong food smell that you're not used to, but it colors how you react with the people who you're working with.

Cultural differences are huge, and we're going to look at them, basically, throughout this whole presentation.

Oppression issues are tremendous, as well. Most of us, in this room, have been in the position of both being in the superior position in terms of different social categories, and being in an inferior position in terms of how much power we have.

So, for instance, when I communicate with my students, I have the power to influence their grades, so I have power over them, and that will influence how they respond to me.

On the day that they do their class evaluations they have a certain amount of power over me, and they know that, although that's not an oppression issue.

So where we are in the power hierarchy certainly influences how we work with people and how they respond to us. If you are coming into a situation as a first responder, you're probably going in there with quite a bit of power. The people you're working with might not know how much. They might not know if you have the capacity to arrest them or not, if you have the capacity to deport them or not. But your status at that moment, from your position, gives you some power over them.

What is culture? A set of beliefs, attitudes, and behaviors shared by a group of people. Of course, there are a lot of definitions of what culture is, but I like this definition because it acknowledges that we all participate in different cultures at the same time.

So I'm a New Yorker originally, for instance. And any other New Yorkers here? Yes. Okay, see we love each other already. And as a New Yorker we have certain norms about, you know, how much in each other's face you can be. And when I go home I like it. It still feels like home, even though I've been living away for 20 years.

I also participate in culture as a psychologist. So I've learned a certain vocabulary as a psychologist, and a certain way of viewing the world. That's a culture.

I also participate in ethnic cultures. I'm Jewish, by origin, and that has given me a certain frame on the world, a certain way I see things as being natural and normal. I've married into a Portuguese family, for 22 years, and we speak Portuguese at home, and I'm very comfortable in Portugal, and with Portuguese things and Portuguese people.

I also am close to many, many Latinos, and have done work in Latin America, and have many Latinos who are regularly part of my world.

So I participate in multiple cultures. Why am I saying this? Because many of you participate in multiple cultures as well, and your clients do, too. We never can take off our cultural lenses.

So if we see as normal a certain parent/child behavior, and as abnormal another parent/child behavior, for instance, we can't stop seeing it that way simply because we're professionals at the moment. Our own cultures are still going to influence our judgments.

Importance Of Cultural Competence

What is cultural competence? This is Veronica Abney's definition. I don't know if any of you know Veronica Abney, but she is a jewel of California. She works in L.A., and she wrote the chapter on African Americans, in my book, *Sexual Abuse in Nine North American Cultures*. She's been very involved in CAPSAC, and was president of APSAC. And her definition of cultural competence is the ability to serve culturally diverse clients well by understanding their world view and their lives, and adapting our work accordingly.

So the first part of that definition, understanding their world view and their lives, that's like where we go and we get a book on different cultures and we learn, oh, this is where Cambodians come from, and this is what they bring with them, historically, and these are their customs.

It's the second part which I think is more difficult, how do we adapt our work accordingly, and that's really what I focus my work on and what we'll be looking at.

Why is cultural competence important for first responders? Number one, it can help to avert or de-escalate crises.

I spoke once with a policeman, who's Puerto Rican, and in my area many of the Latinos are Puerto Ricans. And I aksed "What difference does it make when you're coming onto a domestic violence scene, the fact that you're Puerto Rican?" And he said, "It makes all the difference in the worldbecause when we open that door, or we bang on the door, and there is a Latino man, let's say, with a knife to his wife's throat, and I say (in Spanish) — 'Okay, we're the police, you know, drop the knife and lift your hands' — that he will feel like there's some chance he's going to be heard and that I'm on his side. It will instantly relax him."

Whereas if somebody does the same thing and doesn't speak his anguage, and says it all in English, he'll want to know what they're saying if he doesn't speak English, and he may be very frightened by that encounter.

So being culturally competent you could know how to approach people in such a way to minimize their fear and maximize their cooperation.

Also, as I said earlier, the first responders set the stage for all future interventions. It's really the first responders who put the frame around what the incident is. Is the incident a craziness, is it a criminal incident, is it a family problem, maybe, that could be resolved through other means? So first responders really decide whether the situation is going to develop into one of trust or suspicion, in terms of authorities. Are the clients going to trust authorities or are they going to be suspicious of authorities? Are they going to cooperate with services or are they going to reject services? Are they going to believe, if it's a case of child abuse, for instance, are they going to believe the child or are they going to be in denial about what's going on?

I was just in Puerto Rico, I actually got in last night, where I was doing some training. In Puerto Rico they still have a system where sexual offenders are not removed from the home, children are removed from the home. If a child discloses sexual abuse in the home, and is believed, then the child is removed from the home, and the offender will stay there with other children.

Even so, those first responses with the non-offending mothers can really determine how the

mother will treat that child, whether she is set up to believe her child and to proceed with services and cooperate.

Okay, and it's also just fair, ethical, and professional to be culturally competent. Sometimes people say, "I don't want to bother. Listen, I've got enough to do already." And you all have enough to do, and you're all overworked, and I know that there are too many cases and not enough time. Okay, that's clear.

Cultural Competence Can Effect Outcomes

But cultural competence is just as much a matter of competence as any other kind of set of skills. It's not an option, it's not an add on. It's what's right for best practice.

It's a challenging topic. A lot of times people argue with me, don't like what I say. And if you speak up for cultural issues, like cultural minority issues in your workplaces, you might find yourself getting a little bit targeted, too.

Are any of you in that situation? Okay. You know." "Oh, there she goes again." Or something has come up that is clearly an issue of bias, and everybody in the room turns to the one person who usually opens their mouth about it, to open their mouth about it.

Or people rely on the professionals of color to intervene, when it really is everybody's business to intervene in issues of bias.

Ethnic culture can influence the violent acts themselves. Just to give you a few examples, for instance, the forms of punishment that are used in families, and sometimes can become abusive, vary somewhat by culture. And these are generalizations, of course. But there is one study done by Showers and Bandman, in a hospital in Ohio, and they tracked a hundred consecutive cases of children admitted to the emergency room for abuse inflicted in disciplinary measures. And they found that the white families were more likely to use a hand, which still can be abusive, if it's applied harshly even fatal, if it's applied hard enough. White people were more likely to use a paddle, or a paddle wrapped in a towel, a wooden spoon, or a stick.

The African American families were more likely to use something that resembles a whip, such as a belt, a switch, or an electrical cord.

So the violent acts, themselves, can vary by culture, and it's important to keep that in mind. The family's interpretation of what happened certainly varies by culture So that if a girl is abused sexually, is she seen as being a victim of crime, is she seen as having been a slut, or promiscuous? Is she seen as having been ruined and brought disgrace upon the family? The interpretation will vary with the family's culture.

How the system responds varies by culture. I spoke about that a little bit earlier in terms of the criminalization of family violence. But you know, you hear about this at every level and in every situation.

I once gave a presentation and a police officer from the West Indies stood up, and he works in Chicago, and he said, "My colleagues and I know how to take notes when we go to a crime scene so either the charges will stick or they won't stick." And I have seen my colleagues write different kinds of notes depending on the family, and that holds in domestic violence, as in everything else.

The Family Response

How the family responds to professionals varies by culture: I mean, does this family see you, you intimidating authorities, even though I know you're nice people. But in your professional roles do they see you as a helper? Do they see the professional systems as generally being on their side, or do they see the systems as being there to oppress them and keep them down? And this will really determine the course of the future actions with the systems, and which interventions and styles fit with the family's culture.

It's important to join with the family. One way is to acknowledge existing hierarchies. Now, clearly, the gravity of the situation and how severe it is at that moment, how acute it is, will determine on how you do this. But a lot of times you want to acknowledge older people, first. A lot of times you want to ask permission of older people to speak with children, even though maybe you could do it whether you had their permission or not, but you want to at least say, "I'd like to speak with your children, now."

You clarify the need to have separate conversations: "I need to speak with your wife alone, now, and then I'm going to speak with you alone."

Elicit the caretaker's encouragement of truth telling. With children, a lot of times non-offending parents may not believe their children, but

they may be willing to tell their children, "Yes, you can speak with him or her and it's important that you tell the truth."

It's important for us to keep in mind what the family has at risk if they cooperate with you. And it's important to explain confidentiality and its limits.

People might not cooperate with you because they think that whatever they tell you is going to be broadcast on the evening news. They may think that it may be on real TV. They may think that it's going to go right to the "*La Migra*," to immigration. They may think it's going to go to the housing authorities if they admit that they have certain people living in their home, who aren't supposed to be living there. So it's important to explain where the information goes and where it doesn't go.

I encourage people to be warm. In Spanish it's "*personalismo*:" the idea that you're establishing a personal contact, not that you're just presenting yourself as a friendly person. Oh, I'm a do-gooder type, friendly person. But rather, that you show a specific caring for the individual. So you learn their name, you learn how to say their name correctly, and you communicate that respect for that particular individual.

Don't rush, if you can possibly help it.

Remember how difficult the material is. There was a time when I was doing work with child sexual abuse full time, with children, with families, and with adult survivors, and I was spending all my day asking people to tell me the most intimate, and violent, and horrible things that had happened to them, and I have to say I was actually getting kind of used to it.

Has that happened to any of you? Okay.

So then I went to the dentist, and the dentist asked, "How often do you brush your teeth, and how often do you eat sweets? And when did you have your last medical checkup?" And I thought, well, he's getting a little personal here.

(Laughter.)

And then I realized, you know, I was just getting used to how difficult the material is. But for our clients, it's probably one of the first times they've spoken about it.

There are cultural components to questioning about family violence. It's a strange experience to bring these issues out into the public. Most cultures have some version of "children are to be seen and not heard."

In Puerto Rico they say, "*Los niños hablan cuando las gallinas mean*." or "Children speak when hens pee." Apparently hens don't pee. As I said, I'm from New York, I don't know.

(Laughter.)

So the idea is that children are really not to speak. Don't wash your dirty laundry in public. Pressure to be a model minority. Oh, if people find out what's going on here, it's going to reflect badly on my entire people.

And those people here, who are from minority groups, know, I think, what I'm talking about. That when the O.J. Simpson case came out, it was taken to be some reflection on African Americans, in general. When Woody Allen was accused of molesting his step-son, I think, as well as marrying his step-daughter, for Jewish people we said, "Oh, my gosh, here it is, we all look bad."

That's a pressure that people from the majority group don't usually experience. When Timothy McVey was arrested people didn't say, "Oh, no! Now, all WASPS are going to be under suspicion." Right?

So this is another pressure for people not to speak with you and not to cooperate with you.

In Japan there's a saying, "the nail that sticks up gets pounded down." In other words, don't make waves, don't stick up for yourself, don't attract attention.

And then the services that you may be offering, either offering or imposing on a family, may be services that don't exist in their families of origin.

Language and Cultural Differences

I mean, in Spanish there isn't even a word for foster care, or foster mother. I mean, people improvise them, but there isn't a term. So if there isn't in Spanish, think about some languages which are even further removed from English.

So the services that you're offering may either not exist, or they may be only used in the very most severe cases. So the people you're working with may not really understand, even though they may be nodding their heads and smiling, what it is that you're talking about.

It can be hard to get basic demographic information from immigrants. Have you ever found this to be true?

I bring my mother-in-law to the doctor sometimes, and I interpret for her and I'm filling out the forms and I ask, "When's your birthday again?" And she answers "which birthday?" And that's because in Portugal, when she was born, there was a law that you had to register your kid's birth within two months of when they were born. But she lived far from the city where you did the registering, so her parents brought her when they got around to it, and they said she was only two months old. So she has one official birthday on her passport and her documents, and then she has the birthday that we all celebrate.

It's not that she's a liar, a horrible person, it's just that's the way things happened. And that's true for many families I'm sure that you work with, that for one reason or another, they've had to change their birthdays.

It's important to get people's names right when you're addressing them. Chinese names begin with the surname and end with what we would call the first name. So I don't speak Chinese, so please correct me on my — I mean, don't correct me, but pardon me, my pronunciation's going to be awful. But if somebody's name is Lo En Haw (phonetic Chinese), she would be called "Haw" and she wouldn't be called "Lo," or she would be called "Mrs. Lo."

So make sure you're calling people how they want to be called.

Maria Theresa might want to be called Maria Theresa, or "Maritere." She may not want to be called just Maria. Obviously, if it's an emergency, that's not going to be your top priority. But see if you can call people by their proper names.

It may be hard for you to understand family relationships. In many families from Asia, friends of the family are called aunt and uncle, or auntie when they're not really blood relatives. The kid may have a Papi and a Papa. You know, one is the father and one is the step-father.

Or they may have mama and mommy. And mama is the grandmother and mommy is the mother.

So remember, you need some clarification here, and families may not fit into the neat categories that you're expecting.

Concerns for Immigrants

Special concerns for immigrants, in terms of giving you basic demographic information. I knew a family, when I lived in Indiana, from Liberia, and they had fled the war in Liberia. This couple had taken three or four cousins and said that they were their own children. [They] had taken the wife's sister and said she was her mother. They had to change all the birthdays, and so on, so they would fit, and brought them with them to the United States. Now, they saved their lives, okay, so I can't condemn them for that. Okay, it's a technical violation of immigration law. They saved their family's lives. In my opinion they did the right thing.

But it would certainly make a problem if you were going into your home as an official of some kind, or they see you as an official of some kind, and you're trying to get a fix on who's who, and when were they born, and how they're related and all that, you might see people start lying and equivocating, and it's really not relevant to the issues of violence. So they might feel that they have a lot to lose if they tell you the truth, because they could be deported.

Just very quickly, what are some options if you don't speak the family's language? Well, you could do everything in English, and plenty people do that. But, of course, a lot can be lost if the people don't speak English as well as they say they do.

And just to give you one example, the rates of poisoning, or overdosing, or misdosing among immigrants is way higher than that of non-immigrants, because the doctor says you take this, this, this, and these are the conditions, and it's written on the bottle, and the family nods and smiles, and they may not understand at all.

So you definitely lose a lot if you do only English. Using an interpreter is very complicated, we don't have time to talk about it now.

But later, we're going to have this small group thing, which I think is way cool, and I'm going to have some handouts of articles that I wrote, so if you want to come over to my table at 3:30, I'd be glad to speak more with you about that.

And bilingual interviews are absolutely the way to go. Those of you who are bilingual, great. Those of you who speak a little bit of another language, learn more. Those of you who are in the position of hiring, hire more bilingual people. I can't emphasize that enough.

Nonverbal issues, gestures. We can't learn all the gestures from all cultures, but if you work consistently with people from a certain culture, learn their gestures. There are articles written on it. Make friends with people from the culture, so you have experience with people from the culture who are not in a state of crisis: you can tell what's normal and what's not normal.

Just to give you some examples, and from what I understand, in Chinese culture, and I've heard it's also true in the Philippines, this is how you call animals to come, this is how you call children, and this is how you call adults. (Gestures) And if you go like this to a Chinese person, it's like saying (verbal sounds), okay, it's very insulting, you don't want to do that.

Other gestures: a lot of people from the dominant culture pat kids on the head. Many African American and Asian children find this offensive.

Sometimes men sit with their legs spread. And sitting with their legs spread for people, in some cultures, where their genitals are essentially exposed, although we hope they're wearing pants, but still you get the idea, is also considered offensive.

For people from many Muslim countries, to sit with your legs crossed in such a way that the sole of your foot is showing is also considered insulting.

Physical expressiveness and facial expressions really vary by culture. To get back to the New York thing, you know, those of us from New York, we use our hands a lot and tend to be very expressive. But it really varies by culture.

Japanese people tend to use their eyebrows very little, their lips very little when they speak. And for people who are not from the culture, they may wonder, "Are they lying? Are they depressed? But really it's just a cultural difference.

Veronica Abney talks about how she's often called down to the emergency room and they say, there's an hysterical black woman here, can you help us? And she goes down and there's a woman who's upset because her son's in the ER. But the woman's loud gestures, and her loud voice are interpreted as being something out of control, whereas they're really not, it's just a cultural variation.

Eye contact, you've probably thought about. But a lot of us, in our training, learn to make eye contact with people, and we learn that if people make contact with us, they're not lying. Okay, not true. Good liars look you right in the eye and lie.

But eye contact can be seen as very threatening for people from some cultures. Particularly women and children, may be taught to look down. And so if you insist on making eye contact with people, they can experience you as quite threatening.

Just be careful with touch in general. What you mean to do to be comforting to someone, and offering them a hug, may not be interpreted that way at all. I'm reminded of when I once had a wonderful massage. I haven't had very many in my life, but I've had one. And after this massage I put on my clothes, and the woman who gave me it, I paid her, and then she said "hug." And it was horrible. Because I mean she just touched me all over. But even though I really appreciated it, I was her massage client. I mean, she wasn't trying to make a move on me or anything, but still it just was not appropriate for the context, for me. From her perspective, it was fine. But I was the client, so I was the one whose needs should have been taken into account.

So in general, with touch, I would say unless you've got some reason to do it and to know it's okay, avoid doing it, especially when we're talking about family violence. As you know, you can reach to pat somebody on the shoulder and they can startle because that kind of touch, or any reaching for them can stimulate memories.

Pace and silence: People from different cultures allow different lengths of time between utterances. Okay, in my family, if you didn't interrupt the person who came before you, you didn't get heard.

But there are other families, where one person speaks, and there's a little bit of silence, and then another person speaks. So if you're interviewing somebody, and there's a little bit of silence, allow that silence to happen. Don't think you necessarily have to come right in and be helpful by filling in for them, because you may actually be silencing them, rather than being helpful.

Okay. It's important to give people information about what comes next, and to establish links, help them establish links with possible sources of support, both formal and informal. So you may give them the formal referrals, but then you can also say, listen, who do you call when you're

having a problem? Who's been helpful to you in the past? And that may be an informal source.

We're not going to really have time to talk about this, but there are a lot of other issues involved in culture and family violence, and I've got some great resources I'd be happy to share with you on that.

I don't think I need to say anything more about child abuse in the context of woman battering, and woman battering in the contest of child abuse, because Jeff, and others, have spoken so eloquently about that this morning. Except just to say, where you see one, look for the other.

And finally, prejudice and discrimination. Each of us has biases. I hope we're all aware of them and we do what we can to overcome them, and to learn more about them all the time. If you find that there's a certain group of people who you really can't work well with, then you really should either get over it, find a way to get over it, or stop working with that group of people, because it's unfair.

And similarly, if you see that people in your agency are behaving in a way that's unethical, it's really unethical for you to be silent about it. So the question is how do you build the allies you need to challenge that unethical behavior?

Achieving cultural competence is a life-long, difficult process that can be really gratifying. I know that my life has been incredibly enriched by all the ways in which I've been able to participate in and learn from other cultures, and I would wish for you the same.

Panel Two—System Responses to Family Violence

Colleen Friend, Rolanda Pierre Dixon, Debbie Lee, Bill Carter, Jill Walker

Ms. Friend

My task today was to identify five controversies in the area of child welfare systems, as it relates to domestic violence, and also to think about five promising practices.

This was a good challenge because I think there are a lot more controversies and a lot more promising practices than I picked out. But I picked them out with a certain rhyme and reason, and let's see if it all makes sense to you.

I'll also open my presentation by telling you that one of the reasons why I'm up here, speaking to you, is because I am a child welfare worker. I started out as one, and I have a firm belief that once you are one, you remain one. And although I am a social worker by training, I was much surprised to hear my first supervisor say to me, "You're doing pretty well in this job, would you like to go to social work school and learn how to become a social worker?" And I was surprised because I thought I already was one. So then I found out about Title IV training programs, which is what I do full time, and we'll talk about that in the context of our current controversies and promising practices.

Should Children be Removed?

The first item I have is the question, "Should children who witness a single incidence of intimate partner violence be removed from their battered mother?"

And this is a very good question, and I don't know that I actually have the answer, but I have a local answer. I have an answer from New York City and New York State. And I'll describe that by way of explaining to you, under my first bullet, in the handout, the Nicholson v. Williams case.

Some of you may have heard of this, a very famous case in New York City where, actually, a large group of advocates and attorneys brought this class action, saying that the ACYS, which is what they call public child welfare in New York City, was discriminating, in an unconstitutional way, against women who had been battered. The advocates and their attorneys demonstrated that there had been a pattern of removing their children. The response on the public child welfare side was that they in fact don't have a policy.

The judge thought differently and thought that their practice constituted a policy, and that they had removed children often enough to be called on the carpet for it, so to speak, and have to come up with a corrective action plan. Now, they're still engaged in this. One of the interesting things that came up about this case, in the last month I think, was that the original jurisdiction court for one of the lead plaintiffs, who was Nicole Garcia, the original jurisdiction court said that in fact children's exposure to domestic violence was neglect.

But in the appellate case, that just came down last month, they overruled that decision, and said two things that I think are really important in the area of controversies about child welfare. The first one is, if a parent is attacked in front of the child, unexpectedly, this is not neglect. So they overruled the original jurisdiction court. They also said something else really important, and I'm going to come back to this later on, that the simple act of not cooperating with CPS does not, in and of itself, constitute neglect. So courts cannot make a finding, at least in New York, because of this fact, alone.

But the court held open the possibility that there is a distinction here about one time exposure to domestic violence, which many of us in the field feel is an oxymoron, as it doesn't typically happen one time. And the court said they may have made another decision if there would have been proof that there was ongoing history of domestic violence here.

Family Group Decision Making

So that's an interesting controversy, and I want to move on and ask a related second question here, in my limited time frame. Can family group decision making be safely utilized for

families with a history of intimate partner violence?

Now, this is a really interesting question because it seems like the public child welfare system in California has embraced this as a novel practice in the area of public child welfare practice. Just to give a brief, and probably unjustified overview of what that is, that's the first bullet here, it's a gathering of the extended family, who develop a protective plan for a family involved in the child welfare system based on the family strengths, and they come up with a way to have the family enforce the plan. That's a simplistic way of describing it.

And many of my DV colleague friends feel that this is an aberration, and when I look at their reasons for objecting to it, I feel much the same way that I felt in the area of child sexual abuse, which was one of my first areas of practice. We used to say, oh my gosh, you can't have these cases go to mediation, the mediator doesn't know anything about the power dynamics. The similarity here is the worry that the mediator and the family doesn't know anything about the abuse dynamics.

The parent, that is the non-offending parent, is afraid to speak. The family might be involved in the violence, as well. There's also the issue here of possibly setting aside some of the protective orders in order to have the family be able to get together and enforce whatever plan they come up with. There is also a very real objection that the research that we've done so far, in family group decision making, involves small samples of rural populations. And so a good question is, does family group decision making work with urban populations involved in domestic violence?

So I think the jury is still out on this, but I raise it as a controversy because I think in many ways it is the TAO (meaning "the way") of things. That public child welfare administrators, and taxpayers, and funders are looking for less expensive, I won't use the word cheaper, so lets call it "less expensive" ways to deliver services. Hence, I raise the question with this group, what do we need to do about that? If we really think it's an ethical violation, we need to speak up. If we think it is the TAO of things, to moving to less expensive ways of delivering services, we ought to find out how we can assure they get the kinds of things that are mandated in California for mediators. They have to have specific DV training, they have to be trained in the dynamics of child sexual abuse, and so forth.

The Police and Cross-Reporting

I raise third controversial issue here. Should the police cross-report every instance of partner abuse to child protective services?

And how about this one, should child protective services workers be accompanied by the police when they go out, when the child welfare worker goes out and makes home calls? Interesting question.

Well, what's the pro for it? Well, it would bring a lot of kinds into the system's awareness. We may have a crack at doing something about it early, early intervention.

What's the downside? Well, many people feel that when you add the police into the equation, especially into communities of color, that we do change the dynamics, and I actually think that that is true.

The other issue that's raised by many DV advocates, is where's the information in the police report going to go? Many times this does not end up being confidential and it may end up hurting the victim and, also, there's the ever-present fear of the child's removal.

Welfare Reform

My fourth area of controversy is around welfare reform. Has it had an impact on child maltreatment? I might defer because I know one of my other panelists is talking about the CalWORKS project here, and I might go very quickly over this. But there's some preliminary analysis here, and I think it impacts child welfare and also the area of domestic violence, suggesting that the lifetime limits of TANF, and also the restrictions that come with the sanctions, that these have led to a higher level of not only substantiated child abuse reports, but also, specifically substantiated reports of child neglect. These reports have led to a higher incidence of children being removed from their homes, so more kids have entered foster care. Now, there are some caveats with this research, but I'm going to defer to my colleague, who's going to talk about CalWORKS.

Flexible Funding Streams

Now, my last controversy here is: Should current

federal funding streams, especially for Title IV-E, Medicaid (which is known as Title 19) and HeadStart, should they be abandoned in terms of what the Bush Administration has called, "flexible funding streams?"

Those of us who have been around for a while, we know this as block granting. So blessed are those who have seen block granting, because they understand what the sequelae of this is. And I raise it for this very learned group's collective countenance, about whether or not we want to move from open-ended federal entitlements to buying into the carrots that sometimes the federal government will give so that they could slowly pull out.

Right now it looks very delicious, because the State of California, and other states as well, are facing huge social service budget cuts, and so this looks very enticing. Take the block grant, take the cap on it. But we, who have been around a while, know that usually the service need expands to fill the amount of money that you have now. It doesn't happen right away, it happens in a couple years, and then, miraculously, the training money that's in all those block grants get usurped by the direct service need.

So we just raise it for your awareness here. And some of the strategies are to try to get the state spending maximized for Title IV-E and Medicaid right now, so that if the caps come on, people can live within those constraints. I want to raise this group's awareness and, hopefully, put it on your radar screens.

Promising Practices

In the last few minutes I want to talk quickly about promising practices. First, guidelines for conducting, and the first two promising practices I have speak to are what I call the TAO of things, the family group decision making, because I think it may be here to stay, because it economizes on the public child welfare intervention and it also brings the family into taking more responsibility for outcomes in the child welfare case.

And there are some guidelines, that are up on the web, that I actually think might answer some of the issues that are raised, by some of the advocates, about the use of family group decision making, and I have the citation here: http://endabuse.org/programs/display.php3?DocID=159 .

The other piece about this is that I have two colleagues at Cal State Stanislaus who are doing some really innovative research here on family group decision making. Granted, they have a very small sample. And they are looking at implementing a feminist model of involving the clients in deciding how about this for a novel concept: What the outcome should be. Wow, that has never been done in public child welfare—including clients in a legitimate determination of what the outcomes should be and making them full partners in trying to figure that out.

The other thing is, instead of being the subjects and being studied, they're conducting the study, too. This is wild. It's a wild new concept in public child welfare, but it will get me into something else that I want to talk about later, and that's about involving clients in understanding their level of satisfaction for public child welfare. I have my contact, Paul Sivak's, e-mail address: psivak@toto.esustan.edu in case anybody wants to stay in touch with this novel way of conducting research.

And you know, the interesting part about this is, it's really empowering to clients. Once clients get involved in research, and see what it can do, and how you can get further funding if your research — depending on how it turns out, they get involved and they want to do it. Instead of being the study, they're participating in it, and they become very good spokespersons for the cause, as well. So just a thought for consideration about a promising practice.

The next thing is the growing awareness of accountability on the part of child welfare and children's protective services. And that is, I think, one of the main reasons that has come about because of ASFA, the Adoptions and Safe Families Act, ASFA. And if these acronyms are new to you, or you're thinking what is that about, this is the federal legislation that's driving public child welfare services right now, everywhere in the country.

If you're not sure what the ASFA legislation is about, I can tell you that you can find out what it is, I know where it is. I have summarized the legislation on my own school website, so if you go to UCLA, and I'll tell you the process for clicking, if you click on academics, and then you click on professional schools, and then you click on School of Public Policy and Social Research, then click on social welfare, then click on

courses. If we're not totally lost, you can probably just click on Google, and usually I do that and find my way there.

But under the course that I teach, which is called 231, on week one, I've summarized the ASFA guidelines. And I think this is important for people to know who works hand-in-hand with public child welfare. Because what the ASFA guidelines have done is they've given the states the need to report back, make periodic reports on certain issues, and they have posed rewards and incentives for the states to do the three things that ASFA is all about, which is child well-being, permanency, and child safety, those three things. And there's a strong focus on adoptions. Once you know this, and know some of the lingo that child welfare works with, it's much easier to understand why they operate the way that they do.

But what this has done is it's really driven the whole child welfare machinery to try to look at: Our outcomes, and consumer satisfaction with what we're doing.

Consumer Satisfaction

And one of the things I want to leave you with on consumer satisfaction is this: I don't think we should be afraid to research consumer satisfaction. Because in the limited, few studies that are out there, Randy Megan did a study in 1995 and he asked, "was it okay that your worker asked you directly if you experienced domestic violence?" Eighty-five percent of the women said that they were glad that the worker had asked them directly.

So I think when child welfare gets timid and reaches into these murky waters and says, "Are we doing okay?" we need to remember that we have gotten information back that says, "Yes, you are." And in a study by Donald Bross, in 1997, he asked the question, are you better off because of your public child welfare worker involvement, and 70 percent of the families said yes. Now, who would have thought that? So I think that consumer satisfaction and understanding their vantage point is really the wave of the future for public child welfare.

Another big innovation, also known as the stakeholder's process, led by our State Department of Social Services, is a California initiative. It's called the CWS, Child Welfare System, redesign. Now they have six working groups, and I'm actually involved with the permanency and child well-being task force. We are looking at doing business a new way in California over the next few years. There are going to be evaluation projects attached to this, because they are going to do things not on best guess, or best practice, or somebody's version of best practice, but they're going to base it on research, real research outcomes.

My take on it, from my perception of working in that group, is we're really looking at doing a competent and comprehensive evaluation for children removed from their homes, right at the gate. The second thing is we are looking at client participation in outcomes, and also client level of satisfaction and involvement.

And the third thing we're looking at, which I think is really dramatic, and we need to do more of it, is look at the welfare of emancipating teenagers, who come to OK age under the child welfare system.

The last thing I want to say about my promising practices are these Title IV-E partnerships. Now, aside from California, there's 39 other states that actually are working on this, and I think we have far to go here. For example, these public child welfare training partnerships, that prepare MSW students to work in public child welfare, and also conduct the training in public child welfare agencies, they have to do more to show that they've been valuable. I would ask you, who are colleagues of public child welfare practitioners, if you see a difference in outcomes, and in worker competency since they've initiated public child welfare, Title IV-E training for their workforce.

In sum, I would wrap this up by saying this conference is a wonderful opportunity for you to think about new questions. Jeff asked some this morning. Is exposure to domestic violence in and of itself child maltreatment? I've asked some about family group decision making. I've asked you to think about some of the funding streams, what are the consequences if we move away from them. Those are some of the controversies and the promising practices. And I hope that this issue of flexible funding will stay on your radar screen, and that you'll give some conscious thought about the kind of service that you've gotten from the public child welfare system in your area.

Roland Pierre Dixon

You don't know how hard it is for a prosecutor to sit and wait until it's their turn. And as you can see, this morning I didn't quite make it. I almost made it, but I didn't.

I'm going to talk to you about some of the work that we do in Santa Clara County, and I'm going to try to leave the last half of my talk for death review. And even though death review sounds like a very depressing topic, I'm going to tell you right away it is not. It is some of the best and most important work I think that I do, and the members of my committee do, because it gives us answers about how we can change systems to make sure that we save lives.

Santa Clara's Domestic Violence Statistics

I'm going to start at first by giving you some statistics from my county, so let's put that up, so you have a general idea that I know a little bit about what I'm talking about here.

Those are our statistics from last year, in Santa Clara County. During a one-year period of time we issued 2,975 misdemeanor complaints of domestic violence. Those are your lower level complaints, usually a pushing, shoving kind of case. Usually, anywhere from 10 days to 30 days in the county jail would be a first time domestic violence misdemeanor and, of course, the 52-week batterer treatment program. And in our county we ask for three years formal probation, and I'm going to talk about how we accomplish that.

We also issued 544 felony complaints. Those are the more serious complaints. Someone was injured badly, they went to the hospital, extensive suturing, loss of a fetus, cases of that nature.

We looked at another 1,777 cases that we did not end up bringing criminal complaints against, so that sort of goes against that idealogy that all us DA's out there to do is just file everything that we see. We use common sense, we use the law, we use our understanding of what domestic violence is and what it's about to determine whether or not criminal charges will be brought.

We understand that when the system gets involves in someone's lives it will change, and I make no apologies for it.

If you are abusing someone in your home, number one, it is a crime and we will deal with it.

Because those individuals, you will see at a later date, a wife, a girlfriend, a husband, a family member, a partner, then we also ask that we look at other things in terms of counseling.

But don't get me wrong, I am a prosecutor, domestic violence is a crime, and when I can prove a case beyond a reasonable doubt, it will be charged.

For a total of 5,296 cases in a year period of time. What that equals to is about 101 brand-new cases of domestic violence every single week that we review in our community.

Now, our community's about a million and a half people. I don't see people knocked down and dragged on the street every single day it is a pretty peaceful community, but it just goes to show you how insidious domestic violence is and how much it is in our communities.

And if we ask the right questions, we have the right folks out there working, we're going to dig it out. So this number of 101 new cases doesn't sound like a lot to me. In fact, I think it's probably only about a third of what's going on, on any given day. But it's certainly, for me, a good number, because I think we're making inroads into getting people to feel safe about reporting the violence that's going on in their homes.

Of the cases that are issued, 3,519, that equates to 67 brand-new cases of domestic violence every week that actually end up going through the court process. Our policy is, once we sign a complaint, we want to see it through until its end.

I supervise a team of eight full-time felony DAs, three misdemeanor DAs, a full time paralegal, a full time victim advocate and, two full time investigators, plus we use a host of other investigators, and certainly we rely on our investigative police officers, as well, of whom are here today.

Most of our cases are domestic violence against partners, but we also pick up child abuse, we pick up elder abuse, and we do our own homicides on the DV unit.

Those numbers in the middle of the overhead, just to give you an idea, we had 21 strike cases, so those are individuals that have had previous felony convictions, and in three-strike cases that's 25 to life, and we had eight of those on the unit last year. We sent one defendant 52 years to life. It sounds harsh. The good news, his victim is alive.

Children present, 1,090 cases. That is not 1,090 children. That is 1,090 cases. Most moms and dads in our community have about three children. So if you multiply that by three, you see how many children on a yearly basis, in our community, are witnessing, are there, know what's happening in their homes around domestic violence, and I think that's quite frightening.

Same gender cases—36. I continue to work with officers and continue to do police training around asking the right questions, getting out there and finding out what's going on in these homes, because we don't want to make the mistake of thinking they are just roommates. Because if their case is not handled appropriately, and we don't know what the actual relationship is, that victim could end up with less protection because we did not ask the right question.

Injury cases—2,016. So you can see the majority of cases we see there's been some kind of injury. And people have to understand, when someone picks up that phone, I heard it earlier today, and calls 911, it is never the first time. So we know, when we get called into these cases, that invariably violence has occurred before, and oftentimes there's an injury as a result, and that prompts the person to finally reach out for help.

Pregnant victims is a number that I also keep, and have kept for a number of years, probably 16 or so, because of some work I did with the March of Dimes around children and birth defects. The bottom line with most women: many are battered for the first time while pregnant. And I wanted to continue to keep this number and continue to see how it was reflected in our community. Last year we had 95 such victims. There's only 52 weeks in a year.

So bottom line, even at her most vulnerable, women are still the victims of domestic violence. And these pregnancies are women who are *very* pregnant. I do not have my officers take every woman into a separate room and say, now, are you pregnant. This is if she's six months, probably eight months, and showing, or she says the violence was as a result of her relating the good news about being pregnant. So I'm sure that number is even much higher. But even at 95, that gives us pause.

And then teen victims, 70. Why do I keep that number? Because of the death review work that I do. We found year after year, since 1994, when we started our death review team, that we saw consistently, every year, anywhere from two to three victims who died, who met and began dating their partner as a teenager.

Okay. So if you know anything about power and control and how that dynamic works, as I always tell students when I get out and talk, it may be easy for that batterer to grab a person at 30 and 35, and say do what I want you to do. But how much easier is it to get that person at 14, 15, 16 years of age. And, invariably, the culprit is years older. So that's why we do a lot of work in my office and, hopefully, we can continue to do it in the face of budget cuts, around unlawful sexual intercourse. Because the bottom line is that 10 years and 20 years down the road those young women, who had those babies at 14, 15, and 16 are the ones who end up dead at 28, when they finally realize that they need to get out. That's why I keep that number.

Starting a Domestic Violence Unit

Now, I want to tell you a little bit about how it works in Santa Clara County because people hear me talk about all these numbers and they go, oh, we don't have anything like that. The reality is we started with nothing, too. I have been a prosecutor for over 21 years. I started in the DA's office in 1981. We did not have a domestic violence unit, but I kept asking for one. It took me until 1990 to get it. And when I got it in 1990, I also went back to my boss and said, hey, I want to be the supervisor.

(Laughter.)

Ms. Dixon: And he said, well, okay, you can be the supervisor. And I went home and I told my husband, and we went out to dinner, and we thought what a great thing, and I got to work that Monday morning and I had a DV unit, and I was the supervisor, and I was also the only member of the unit.

(Laughter.)

Ms. Dixon: So needless to say, you can start from nothing and move on up, okay. So I throw that out there so that you realize you have to start somewhere, and having that sensitivity that something is going on in the community, that you can make a change, will make a change.

How did I do it? I began to identify those individuals in different professional groupings that had the same thought process that I did. I hit somebody up in probation and said what are

you guys doing about DV? Not much, but you know I'd love to do more, come on and talk. How about the judiciary, how about this area, how about pre- trial services.

Law enforcement, I would say I will come in, I will do the training, and other DAs in my office said we'll do it, too, we'll go out. And that's how we started it, and we got that ball rolling. And the first year in the DV unit we were looking at 50 new cases a week, and as you can see now, we're twice that and the unit has grown over time.

We work with our Domestic Violence (DV) Council. I staffed that council for over ten years in terms of bringing all these professionals together and making the changes systemwide changes, because we had people sitting at the table who could make those changes.

For years people have come in and seen our DV council, and they admire it. They think it's great, and they always say, well, Rolanda, we don't see you on the membership list. I'm not on the membership list. I'm staff to the council because I want my boss to be on the list, the DA, because who is going to make those changes okay? So that's how you can do things, and talk individuals into getting involved, and bring about positive change.

I have worked with battered treatment groups. And people are like, a DA working with batterer treatment, what do you know about it? Nothing, at first. But I can tell you we have a 52-week batterer treatment program because we all got together, learned what was needed, talked, explained, communicated and, hopefully, along with a lot of other good people, brought about some change in the state for the betterment of victims and their children.

Death Review

Now, I want to talk a little bit about death review for you, and I'd like you to put that slide—oh, he's got it there for me. I'm going to talk about that and then I'll wrap up.

Every single year we look at every single death that occurs in our community as a result of domestic violence, whether it's an out-and-out murder, one person kills another. Whether it's a murder/suicide, the person kills another and then kills himself. Whether it's murder, suicide, and infanticide, so he kills his significant partner, kills the children, kills himself. Whether it's a suicide, perpetrator just kills himself or herself, or suicide of a victim, or an accident case.

And I have to explain accident, because people go how do you fit accident into this? We were kind of with you until you got to that. Over the years we've had three cases that we've identified as domestic violence-related deaths that were actually as a result of an accident.

One of my favorite stories—and of course, after I tell this story you'll know I have a warped sense of humor—this particular perpetrator knew that his wife had gotten away, she had changed her address, changed her phone. Changed her job, which most victims can't do, but she was able to accomplish. She got a restraining order, which is what we tell victims to do on a daily basis, and under 136.2 of the Penal Code we make sure our courts give out these restraining orders on every single criminal case. She had to come back into town to get some stuff out of her locker that she had there, out of one of these storage things. And he waited, I don't know how many days, because he knew one day she was finally going to show up, and sure enough she showed up. He was there, on his motorcycle, ready to hit her in the head. She saw him coming, she takes off in her car, she gets on the phone, because she's got this wonderful emergency phone, which we also provide in our county. The police respond, they're chasing him down the street. Mr. Perpetrator, on his motorcycle, decides he's going to slow up the police by throwing his helmet at them. Well, while he's turning around, throwing his helmet, he doesn't see the curve. So that became a death review case, all right. The victim survived, he did not.

And then two other such accident cases. Why do we look at these cases? We try to look at them from the ultimate end, which is the death, and then work backwards. Pulling all the police reports, all the medical records, CPS reports, any other reports that any of these 27 professionals, sitting around this table, may have. And we discuss what happened with this particular person and their significant other, or their family, that may have led to their death.

Now, will that save the people who died in that case? No. But it will and it might save the lives of others.

So at the end of each year then we put out a report to the public. We remove names, we make sure it's kept anonymous, and you should all get a copy of that report today, and then put out

there for the community what they need to pay attention to. What are some of the red flags that we see when we do death review. I'm going to go over those with you.

The first one there, at the top, everyone close to the victim and the perpetrator knew that something was very wrong in their relationship, but did not intervene. Does anyone know what the most important word is in that sentence?

Did not. Anybody else? Intervene. Anything else? Knew. Anything else?

Everyone. Okay, when we go back and look at these cases after the fact, and talk to those family members a week, a month down the road, what do we find out? I knew something was very wrong, but I didn't know what to do. She was wearing those longsleeves and it was the middle of summer, and I knew something had happened but, geez, I never thought he'd kill her. She was really unravelling and she was acting crazy, she wasn't sleeping at night, she was doing stuff, she bought a gun. I knew about it, but I didn't tell him, I didn't know she'd kill her whole family.

The bottom line with this, and what we push to the public, is that everyone around these families, if they open their eyes, and open their ears, will know that something very bad is going on and it is their obligation, as a member of the community, to speak up.

Now, that doesn't mean dive right in the middle of a bullet, but it certainly means getting out and getting yourself educated, finding out what's available, getting these folks into services, doing what you can to help prevent the ultimate from happening.

In the 18 cases that we looked at, as you can see, some of the things we came up with threats of homicide, and/or suicide in 16 cases.

And it's unimaginable to me that you would have a person say to you, well, yeah, he threatened to kill himself if I left him, but you know I don't take that seriously. What are you talking about? You see how we get used to things over time? These are the kinds of questions you need to start asking those victims when they walk into your office, and when they're talking to you. Is this going on in your relationship? Has he made these threats? Has he threatened to kill you? Yeah, all the time. Okay. A red flag. Let's start paying attention, let's not forget these things.

A victim was talking about divorce and separation and the perpetrator couldn't handle it, 12 out of 18. That wonderful question, why doesn't she just leave? Because leaving can get you killed.

So the bottom line is to talk about a safety plan, and what you need to do ahead of time. As I tell many victim's group, when I go out, and community groups, what you need to do (tongue-in-cheek) is get up in the morning, how you doing, honey, here's a wonderful breakfast, enjoy it. Talk nicely, you later wave, as they go down the driveway, and then grab those kids and get out the back door, okay. You cannot ease away from a batterer, it cannot be done.

And what a rational person thinks they can do, they cannot do when they're talking to an irrational person. If that victim says to the batterer you can come by, you can see the kids, we're through but I want you to still have this connection with the children, I want you to do these things. What is the batterer hearing? Not the, "We're through." part. It's the, "I still got a chance. She wants me." part. Or "He wants me." part. Okay. So, really, we have to make some good deviding lines.

Unraveling, I think that speaks for itself, loss of job, loss of sleep, buying guns. What we have really pushed in our community is making sure that under 12028.5 of the penal code law enforcement gets the guns every single time they go into a domestic violence home, every time. Whether or not that handgun or gun was used. Ask the question, is there a gun in this house? If so, I'm taking it. If later we don't issue the case, oh, well, we have to return the gun. But if we do, even a misdemeanor conviction of domestic violence means you cannot own or possess a weapon for up to 10 years.

We had 18 domestic violence related deaths last year. Anybody want to guess how many of them were gun related? The answer? Seventeen out of 18. Okay. The guns have to go.

Also, in terms of children in those numbers, six of those were children. A year and a half of age up to 12 years of age. And when I spoke earlier about giving children the right to have their voices heard, I meant it. These children never had an opportunity. Five of the six were killed in their sleep by the perpetrator. Two of them were killed by their mother. Okay. One of them, wide awake, eyes wide open as she's shot in the stomach by her mom.

The bottom line is we have to listen to children, we have to interview these children. There are laws around child accommodation that we can use in terms of the court system to make sure that these children are protected if, and when, we have to bring them in to testify. I always talk to my deputies about children as witnesses and what we need to do.

We just received a first degree murder conviction last week on a case because the 16 and 19 year old daughters came in and painted a real live picture of their mother for the jury. Not the drug addict, drunken, invested, blah, blah, violent woman that the defendant tried to project, and they (the jury), with tears in their eyes, brought back a first degree murder conviction. Yes, it was difficult for those girls. Yes, they're going to have counseling. But guess what else they also got, they got justice.

Debbie Lee

I'd like to first of all ask how many of you work in the healthcare system? Okay, only a few. All right.

And I want to also ask how many of you, as patients of the healthcare system, have ever been asked about domestic violence? Have you ever been hurt, hit, or threatened in your home? About three or four of you.

Well, that's interesting because I definitely believe that that is where we're at as far as the healthcare system. I was becoming a little—in coming here today, I know that because this is put on by Davis Medical Center, there were a lot of physicians that spoke today.

But I really want to bring to you, all of you who work—obviously, you all are champions, working in your communities, trying to address this on a community level, in an interdisciplinary way. I want to just say to you that the healthcare system is a very important place for us to be intervening. It's a place in which we can begin to intervene at an earlier stage.

And that intervention, the focus of that work really has to start by transforming the healthcare system, first of all.

The American Academy of Pediatrics issued a position statement, declaring that abuse of women is a pediatric issue, and so we start there. It was 1989, which was just recently. Actually, it was a little bit later, it was 1998, excuse me.

Two years ago, what we decided to do was to bring together the various different associations, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the National Association of Prenatal Nurse Practitioners.

And in this effort we developed the national domestic violence consensus recommendations for child and adolescent health, and this is in your packet.

Now, I understand that most of you, very few of you are healthcare providers, so I'm going to ask you to take action, to take these very valuable guidelines, which are for pediatricians, they're in your plastic bag, and these guidelines, which are consensus guidelines for general health providers, and to give them to somebody in your community who are healthcare providers. In fact, to take it to your own healthcare provider to show them that there is guidance here for practitioners to actually intervene in this problem.

As far as the recognition of domestic violence as a public health issue, even though only three people, or four people in this room have ever been asked about domestic violence, when going to the healthcare provider, it has been recognized for quite some time.

The Surgeon General declared domestic violence is a leading public health issue, in '85. The American College of Obstetricians and Gynecologists, the ANA, and American Medical Associations, the Public Health Association, family practitioners, pediatricians, psychiatrists, and nurse practitioners have all issued statements and resolutions regarding the importance of intervening in this setting. And most recently, as you may have heard, the World Health Organization.

Beyond just asking healthcare providers to add another silo to their yet very busy and demanding role in society, we believe that actually another very important thing to recognize is that eight of the 10 leading health indicators for healthy people, 2000, those leading health indicators are associated with domestic violence.

So this is an argument and a viewpoint that we really need to bring to healthcare providers. That while you may perhaps not believe that domestic violence is an issue that you should care about, if you care about various different health indica-

tors of patients today, you have to bring up domestic violence because there is a direct connection with domestic violence in the area of tobacco use, substance abuse, injury and violence, mental health, responsible sexual behavior, access to healthcare, immunizations, and overweight and obesity. It's even been linked that women, who are victims of domestic violence, don't get mammography and pap smears, as much as women who are not victims.

Elements of the Clinical Response

So the healthcare system plays a pivotal role in the early identification and prevention of domestic violence. Because virtually we all know that all women interact with the healthcare system at some point in their lives, for routine health maintenance, pregnancy, childbirth, illness and injury, and bringing her children to a healthcare setting. So it's a very important place to reach out to women who have never gone to the criminal justice system, who have never called a shelter.

As an advocate at San Francisco General Hospital, for about 12 years, in my mind I would say about 85 percent of the time I was speaking to women who I was—I felt like I was a great advocate, but that 85 percent of the time that those women were not going to be seeking other assistance in the near future, and that what I was about to talk to them about, and what I was going to say in that brief time, which might have only been a couple minutes, that's the only impact that I was going to make, was just that conversation, so that was the most important piece, and secondarily to the referral.

The healthcare provider's direct discussion about safety at home tells the family that it's a topic that belongs in the realm of pediatric and family practice. And I'd say that family practitioners are really, there's still a lot of resistance by practitioners, in the child health setting, that this, in fact, is their role.

So what are the elements of the clinical response? I think most of you probably know some of this, but it's basically, I would say these four elements, to screen, to assess, to intervene, and document.

And these first three, I would argue that you can do this in two or three minutes. And once in a while, yes, just like a heart condition, it may blow your day, but the majority of times patients understand your limited amount of time that you have.

In these consensus recommendations, what we are recommending are to screen new patients, at new patient visits, to screen at least once per year at well child visits, and thereafter, whenever they disclose a new intimate relationship, and also ask when signs and symptoms raise concerns. And to ask very direct questions that are specific and easy to understand, like have you ever been hurt, hit, or threatened by someone at home. And inform the patient about confidentiality.

For adolescents, are you seeing someone, what happens when you disagree with them? A lot of kids or teens, actually, who are seeing somebody, or hanging with a boyfriend or girlfriend, don't actually see themselves in a relationship, so you may have to alter your language.

In assessment, what we're talking about is assess for the immediate safety, at the minimum, and to talk about the impact of domestic violence on the patient's health, given what health concerns they have currently, problems that have arisen, and the pattern of history and abuse.

And most important through all of this, I would say, if you were only to ask the question, the one other thing that I urge providers to do is to validate. Just to say, you don't deserve this, and there's assistance out there, and I'm concerned about your health.

I want to tell a story of a colleague of ours. I think some of you may have heard her name, Vicky Coffee. She's now quite an advocate and works at the national level. She was battered over the course of I think nearly five years. And she's been to the hospital, and to her own primary care clinician many times. After one occasion she ended up in the hospital with quite severe injuries. In fact, her face was fairly disfigured. She'd never been asked about domestic violence, but this—I'm sorry, she had been asked about domestic violence on several occasions, but had never talked about it with any clinician.

But this time the clinician said to her, who did this to you? And for some reason, those few words really resonated for her.

And what she says, more than anything else from this story, is that she never knew the name of that clinician. She has tried many years to find out the name of that physician. And, more importantly, that physician has never known her

or the result of his intervention.

And I want to tell that story because of, I think one of you as a first responder had come to the mike, I think it's just a very, very important story for first responders to understand and really think about. Because I think there's so much frustration out there for us, as providers, be that if you're a clinician or a first responder, that we feel like what good are we doing.

And she argues that we are doing a great deal. But particularly in the healthcare system oftentimes we don't see the come around story, the ending story, the success story at the end.

The other elements of intervention are to discuss the probability of escalating violence, to respond to some safety issues and, of course, to make some simple referrals.

Defining success

Our job in the healthcare system is not to fix domestic violence or tell victims exactly what to do, though we definitely want to give advice. But again, what you're trying to do is walk that fine line of not pushing so far that that patient will not want to come in again. Because again, with clinicians, a lot of victims are going to the healthcare setting because they aren't ready to go to the justice system, because they aren't ready to pick up the phone to talk to a shelter, but they do need some relief.

Our role is to help victims by understanding their situation and recognizing how abuse can impact health and risk factors. And success is measured by providers' efforts to reduce isolation and improve options for health and safety.

Again, not to fix it, not to get her out, but to get her to reduce that isolation and improve, and to let her know what her options are.

There are many challenges that face pediatricians and family practitioners, in particular, and this book, that we brought to you, goes to many of those issues.

And I'm not going to go into detail about this, because most of you aren't providers, but there is always the question about do I ask with the child in the room, or the child—or do I try to get the child out of the room. Well, it's very difficult for providers in busy settings, and in private settings, to get children out of the room, because there's no one else to take care of them.

So we need to be sensitive. We do believe that you can ask an initial, vague question, and if the caregiver does indicate that something is happening, you can talk about it at a later time or, in fact, use a written query, question on a history form.

As far as documentation, the experts, and there were about 30 clinicians, pediatricians, family practitioners, with all of the societies represented, who came together, and what we came up with is really that there isn't consensus because, of course, of the fear that the batterer, who might be the biological or custodial parent, will have access to those records. And the suggestion was to use nonspecific terms to indicate the presence of IPV, in other words, domestic violence, it stands for intimate partner violence, in the child's chart.

I'm not going to cover reporting issues. I thought Rolanda, my friend here, Rolanda, was going to cover them. I have to just tell the story that Rolanda and I are oftentimes asked to speak because we stand on different sides of the room around domestic violence reporting, but we're pretty good friends.

MS. DIXON: We still are, yes.

MS. LEE: Anyway, so as far as reporting issues, we've covered very well, already, child abuse, and childhood exposure to domestic violence. But I do want to mention, as many of you already know, that healthcare providers are required to report domestic violence of adults. And the California law says that we're required to report if we provide medical services to a patient that we know or reasonably suspect is suffering from physical injury, and that we're treating a physical injury at that time.

With this mandatory reporting law of adult domestic violence, the question comes up, if a family physician or a pediatrician is seeing a child, does this law apply?

Our attorneys say, in a pediatric setting, where the pediatrician's only patient is that child, that the parent is not your patient, so you would not have to report.

In a family practice setting it is a little less clear but, also, our attorneys would argue that because that the adult is not your patient at that moment, that you would also not have to report.

I think I've mentioned this already, that the healthcare system provides a role in primary

prevention. And I think that a whole public health approach really should be much more dedicated to preventing domestic violence, doing campaigns, providing public education. And, unfortunately, I think it's a time that's very difficult for public health departments to do this kind of work, given financial and budgetary reasons.

But the healthcare system, even though there are women who absolutely you suspect that domestic violence is going on, but they aren't disclosing, you are providing— the healthcare providers play a very significant role in bringing that message to families where domestic violence is happening, whereas no one else has ever talked to them before about domestic violence.

So it plays a primary and secondary prevention, as well as the fact that we are working and speaking to children, and adolescents, we are getting to a whole generation very early.

So as far as a public health response at a systematic level, I would say, and this may be controversial given I know we've been talking a lot about coordinated community responses, but given what I've just asked you all, when I first got up here, how many of you have ever been asked about domestic violence in your healthcare setting, I would argue that if healthcare providers out there, and that you are working with healthcare providers, that the message that I bring to them is it's most important to get your house in order. That's the first step. We need healthcare providers and healthcare institutions to really systematically implement systems so that their providers feel supported to do this kind of work, and that screening takes place consistently throughout a hospital or a clinic population.

To do that takes the beginning of just one champion to make that change, to establish policies in those health settings. To develop, and implement, and monitor those protocols.

We are working with, actually, Family Pact, here in California, in which we are training Family Pact providers, and we are looking at coding issues of reimbursement, such that, hopefully, this will really get institutionalized.

We're also beginning to work with CPSP, the perinatal program, and WIC. I haven't yet touched Safe Start, and if any of you have connections there, we'd really like to move there. Because, again, those are places where families already turn, so we need to integrate domestic violence into those systems.

Of course, integrating domestic violence curriculum in schools of public health, nursing, and medicine, and you, as physicians, well all of you may be surprised, but there's very, very little as far as education that's institutionalized within the medical school curriculum, as of yet.

And it's actually students, medical students who have been the biggest promoters of this change in medical schools to bring curriculum, to bring domestic violence into those curriculum.

And I would just argue that I know that there are many, many justice people out there in the audience here, as well as shelter people, and I would just really urge you to think about—I know I focused on the healthcare system as a way to get upriver as far as addressing domestic violence at an early stage—is we really need to have funding. There basically is no funding, there is no federal funding that is going towards the healthcare system's response to domestic violence.

And we need to develop social marketing campaigns. Jeff was mentioning that my agency, the Family Violence Prevention Fund, we have a very large prevention/public education department, and we have been working with the AD Council over the course, since 1993. And right now our newest campaign is Coaching Men to Boys, focused on teachers and coaches, male coaches.

And so, lastly, I'd just leave you our number. I urge you to, if you have any champions out there, in your communities, I urge you to give them our number, to call us, to go onto our website. We have numerous materials, clinical tools. We have a new training video, which is up for an award, I believe it's the best in the field, with some scenarios to train clinicians. So even if you have never trained clinicians on domestic violence, I urge you to get into this area, use our video. And you probably can talk about the dynamics of domestic violence. Start working with a nurse, or social worker, or a clinician. Young clinicians, who are looking to make this area their career.

But this kind of training needs to happen at the very grass roots level. Community clinics are great places, which have a lot of enthusiasm and perspective, that this would be an issue that they should address.

We also have a variety of policy papers on coding. And I actually just wanted to share that I just am returning from Chicago, so we're hoping very much to change the coding system in which clinicians get reimbursed, which would be another incentive for providers to actually intervene.

Bill Carter

The California Institute for Mental Health does training and technical assistance and policy development for the public mental health system. I'm going to talk about two of our project areas this morning. One is our CalWORKS research project, and the other is regarding evidence-based mental health practices for children who have been harmed by violence.

CalWORKS Research Project

CalWORKS is the California version of welfare to work, or TANF. This is when we got tough on folks a couple years ago and said you need to get to work, and only have benefits for a brief period of time. And this program, of course, is generating mixed results.

Early on, we were very interested in the impact of mental health problems, alcohol and other drugs problems, and domestic violence problems on families who were in this, served by CalWORKS. We anticipated, and it has since been borne out, that these are the folks that are going to have the hardest time getting back to work and getting off of welfare, and we were interested in understanding that and helping county service systems better design their systems to respond to that.

So you can see the goals of the project are listed here, to understand how those issues impact the clients, to understand how assessment and treatment recovery services can be organized and delivered to overcome these barriers. We wanted to do training and technical assistance with the counties.

And we're also doing some research. We have this longitudinal study of a number of single mothers served in Kern and Stanislaus Counties, that we've been following over the last two, three years.

This project is collaborative of the California Institute for Mental Health and Children and Family Futures, whose specialty is in the area of alcohol and other drug services, and the Family Violence Prevention Fund.

What we are finding, nothing's surprising, but it's always nice to get the numbers for real, it's nice to get California numbers. I think the research we're doing is fairly unique across the nation. But high prevalence of alcohol and other drug service needs in CalWORKS families, in those two counties, very high mental health needs, and the highest needs were in the areas of domestic violence.

We're also interested in what's happened with those folks that have more than one of these problems. And as you can see, more folks in the CalWORKS program, in these two counties, have a problem in one of these areas, than don't. But 34 to 38 percent have a problem in one area, 19 to 26 in two of the areas. And then there's 8 percent of folks—or 2 percent in one county, 6 percent in another county, excuse me—who are having significant problems in all three areas.

And by the way, I'm just going to give you kind of the preview. This is the car chase and explosions preview for you to see the real report on the net. And in fact, there's probably more reports than anyone would want to read.

Most recently, the reports being generated are relative to the impact of alcohol and other drugs in domestic violence on the children in these families. Earlier on all of the work was keyed toward the mothers.

This will give you a sense of the overlap. And I think the bad news here is this shows that if you have a problem in one area, or a vulnerability in one area, it increases your likelihood of having a vulnerability in another area, and so then you just see these things kind of piling up on these families, and these are going to be the folks that are going to have the hardest time when time limits are closing out on them.

You know, the effects on child well being, of mental health, alcohol, and domestic violence problems, there's an increased physical, emotional, social, and cognitive impairment. The research, beyond this project, is fairly consistent with that. And poverty increases the risk to children to experience maltreatment, as well.

Aggregate threats of child well being. We took a look at a number of child health areas, child care areas, frequency they've missed meals, school problems. And I'll give you an example, there's

about 51 indicators we collected information on and aggregated them into three different areas, which is family material threats, homelessness, food unavailable, direct threats, and child behavior outcomes, by parent report, and by report through the Ohio Behavior Scales.

And the findings were that mothers with mental health or domestic violence service needs were significantly more likely to have six or more threats towards their child's well being. It was not a significant finding for the alcohol and other drug families. There's only one to two areas where we didn't find a significant connection. One was there and the other was child behavior problems with families that have domestic violence problems.

In comparison to the overall population, and by that they mean the overall TANF population, or CalWORKS population, almost getting close to double the need in the area of mental health needs. If you're having a mental health problem, this means that you're much more likely to have six or more of these threats accruing in domestic violence needs, as well. This is for Kern County.

And just about the same findings in Stanislaus County, with 23 percent of the families with mental health service needs and 24 percent with domestic violence needs, having six or more threats to child well being.

So in summary, and again I'm going to send you to the report, for those fellow mental health/ social services nerds, you can get all of the tables and stats. But some of the more basic implications are that the data shows that children, with mothers with alcohol, and other drug, mental health, and domestic violence service needs have significantly more threats to their well being. This is an incredibly vulnerable group of children in our communities.

The counties have to effectively integrate alcohol, and other drug, mental health, and domestic violence services to adequately serve families enrolled.

And I'm not sure the audience here, if you're from some of the health areas, and someone was an EMT trainer, it may not be obvious to you that on your state and local level the collaboration between these three areas has not been wonderful, and those services aren't integrated. And really, through our experience with the project, talking with domestic violence at all was something relatively new. This is a group of programs that are primarily grass roots, not governmentally funded programs has been the history.

And so CalWORKS comes up and there's some money there to support mental health, and alcohol, and other drug services, and this really was no link to that. So it's really been a new experience and the meetings have become much less rowdy than they were early on.

And the counties serving families enrolled in the CalWORKS must address child needs. There was really a big split, as well, in social services and mental health. At the local level, there's a big split between adult services and child services, and that's even a bigger split in social services between CalWORKS and child services. So we, in our wisdom, have made this incredibly complicated.

And reports regarding the CalWORKS project can be found at the CIMH website, at the address listed, and I believe you have this in your handout. I'm not sure if it made it to your handouts or not. But relative to child well being, The CalWORKS Project Policy and Practice Brief Number 3, June 2002, "Multiple Risk Threaten Children of TANF Recipients With Alcohol or Other Drug, Mental Health, and Domestic Violence Issues." And the *Executive Summary*, published 2003, has the detailed results of the studies in these areas.

Mental Health Services for Children

The second area of presentation I wanted to offer you regards mental health services for children. Of course, violence is one of the things that places a child at risk for having mental health problems. And we, at the Institute, over the last couple of years, in our strategic planning functions, had taken a look at some of the areas we really want to make sure we are incorporating in all of our trainings, and one of them is evidence-based practices, which is a standardly understood term to mean those practices that have high levels of research science behind them.

Now, that wasn't simple enough for us. We decided to call it CIMH values-driven evidence-based practices, reflecting either how complicated this issue really is, or the fact that we have way too much time on our hands at the Institute.

And what that means is this, just taking a look at implementing evidence-based practices in, and of itself, has not been a helpful conversation, nationally, we feel, as well in California. There

are a number of folks that don't like the idea of focusing on science as our source of information about services and relying on those services. Consumers, who have had a bad experience with science, and the government, and "the man," don't like evidence-based practices. Families are worried that a lot of the gains they've made in family-run services, that don't have research support, are going to be left behind. Practitioners, who have been trained in other practices, that aren't showing up so good, aren't so happy about this, either.

And so acknowledging those realities, we're saying we're not promoting just the wholesale adoption of those things that have scientific research. We are saying that you should take a serious look at what research shows us about services. But rather than just looking at the highest level of research, integrate the whole continuum of those. So research design impacts the scientific value of a service.

Take a careful look at the target population. Just because research shows it works for one group, doesn't mean it works for another group. A lot of research is not included, ethnic minorities. There's a real gender bias towards boys, who are a lot easier to measure things on in mental health, because it's loud, and noisy, and messy, usually.

Efficacious and effective. Efficacious is a term used for those practices that have only been shown to be effective in controlled research settings. So those of you who say, those aren't my kids, you know, those are college kids from Columbia University, or something. If those practices are supported by that kind of research, it's efficacious. But there are a number of practices that have been shown to be effective in the real world, and those practices are distinguished as effective.

And to realize that there are other levels of evidence we need to pay attention to, so that we are developing innovative practices, that we are paying attention to practices that are perhaps nontraditional practices, utilized by ethnic communities, recognize them, and to help establish their scientific state of things.

But as well as looking at science, that practices we adopt need to be consistent with stakeholder values. They need to support stakeholder values. And they need to be consistent with the resources that we have at the local level.

So are talking to system planners about kind of taking a common sense approach to apply evidence-based practices, which is to be aware of what is effective and what is efficacious. So pay attention to those things that have been established in the real world. And if they're not, if they're efficacious, just be aware that you may be trying something in a situation that has not shown that to be effective.

Be clear about the issue of adopting versus adapting. Adopting means you do this with a high level of fidelity, that this practice is established, as it was researched, you're following all the rules, you're not giving it your own name and doing things a little bit differently. And you're going to adopt if you're going to get the outcomes that the research showed.

But if you adapt it, because you have to, because it hasn't been researched with a certain community, or you don't have nine people to put on a case management team, you adapt it. But be aware, you're going to have to evaluate it to check out what your outcomes are, how they stack up against the research.

Involve family caregivers and youth in selecting interventions, whenever possible, to make sure that it's consistent with the values that we need to pay attention to. Whenever possible, use a model program. Otherwise, use a proven approach, that's the nine-people-on-a-case- management-team example I just gave.

Consider risk when you're choosing something that doesn't have strong research, particularly in this area of child abuse. The consequences of a practice you use may impact a child or family's safety, as many of the speakers have stated today.

And if, barring all those other things, prove— if you don't want to use a proven practice, prove what you use, instead of being grumpy, and being in your office and saying you know how to do it, prove it. And at least stop using those things that are unsuccessful and harmful. Because one of the things we're learning from research is there are a number of things that we do that, not surprisingly, don't have much positive effect. And there are even things that we continue to do, with a passion, that are not good for kids.

In choosing evidence-based approaches, look at assessments, and look at assessments that target those things that happen to kids when they are

exposed to violence. They have post-traumatic stress disorder, it certainly is the most direct cause, but they can have, experience depression, anxiety, and a number of other mental health problems.

It impacts their cognition, the thoughts they have. There was an excellent example given today, during one of the pictures, of somebody shooting somebody, and I think the comment was "that person deserved it," and that's an example of the way that being a victim of abuse can affect how you think of things. Which then, of course, affects your values, and your moral development, and your behavior.

Problem behaviors come up because of this. Poor peer relationships and school functioning is a clear risk factor and an indicator for someone having trouble. You've got to assess, as well, the family relationships between the parent and child, and within the family, as well, and the impact an incidence of violence has had on the whole family.

And take a look a parental mental health, and alcohol, and other drug disorders, because this predisposes kids to have more problems.

I took a look at the *Child's Physical and Sexual Abuse Guidelines for Treatment*. This is one of the many guides that are being promulgated right now to give you all easy access to what works, what doesn't work, and what you should be using.

If you're not a mental health practitioner, but you're an advocate, if you're a case manager—I don't know how the EMTs are going to work this in, you're going to have to tell me about that. But if you're not someone who's not directly providing mental health services, you should be advocating for this. If you're involved with children, you should be asking about the services and looking for some of these services.

If you're a mental health person or social services person, you should look at delivering some of these services. And, actually, if you're a professional in any of the health or social services fields, the great thing about a lot of the evidence-based practices is they are delivered by non-mental health professionals, and by paraprofessionals.

The child physical and sexual abuse guidelines finds two practices with high levels of research. So this should be simple, a short discussion. Trauma Focused Cognitive Behavioral Therapy.

Cognitive behavioral therapy is the idea of affecting the thoughts that drive our interpretation of the world and our behaviors, helping us develop mastery over the things that cause us to react in a way that's maladaptive. Impacting our behaviors, cognitive reframing, stress management, those kind of things are generally coming out a lot better in the research, and this is an example of one of them. So this comes out with one of the highest research ratings. And that one was child focused. So in this area, you know, practices could be divided by child focused, child and family focused, or offender focused.

The second one, which is the only other one that comes up with very high scores in the analysis for children, in this area, is Adult/Child Molester Therapy. So this is offender directed. And if you're someone who believes these folks can never be helped, things can never be better, this may be research challenging that idea and offering us some good news. But, again, individual or group.

It's not just cognitive behavioral therapy. We've got monitoring. We're keeping an eye on the folks. It's a long-term treatment, which is unusual in cognitive behavioral therapies, and probably reflects the chronicity of the problem and the nature of the problem.

And then you'll see a list of cognitive behavioral interventions that are a part of this, which is helping them understand personal accountability, increasing victim empathy, identifying and developing strategies to interrupt the offense cycle.

Social sexual education is skills building. Skills building is a big part of a lot of the cognitive behavioral therapies. Don't just take something away, but replace it with a skill that allows somebody to function better and build on their success.

Resolution of traumatic relationship, and then treatment for their mental health, or alcohol, and drug problems.

One way to use the research to help you out with planning is to look at those practices that have strong supporting research, but maybe have not been researched with exactly this population. This is a list of practices that have extremely strong research support for children with acting-out behaviors. Families with communication problems and parental conflict.

These practices, researched largely in the juvenile justice and mental health areas, address a lot of the risk factors and protective factors that are consistent with families who experience domestic violence, as well. So there's a good reason to bet on these guys.

Behavior parent training, cognitive processing, so there's your cognitive behavioral again.

Multi-systemic therapy. This is a turbo-driven, wraparound, case management model that has an incredible amount of research behind it.

Parent/child interaction therapy gets two stars because it's UC Davis oriented. And I've moved it up the evidence scale just because I'm a little arrogant, and because I think it has better evidence than these guidelines indicate.

And then wraparound I put in there. It wasn't in any of the reports I looked at, but as far as I can tell wraparound is one of the practices that have worked with children in the child welfare system, foster children, who are often victims of violence.

More strong evidence with other populations. And this comes from the Center for Study of Violence Prevention, Blueprints Project, *Incredible Years and Nurse/Family Partnership*. This is, "go the public health nurses." This has incredible results in terms of long-term savings, long-term positive parenting, keeps kids out of the juvenile justice system. They're treated when they're babies, for a brief time, over a couple of years.

"Fast Track" is in italics because it's a promising practice.

Functional Family Therapy is a systemic therapy model that's incredibly effective, and one that can be delivered by folks other than mental health professionals.

Multi-dimensional Treatment Foster Care is the only out-of-home placement alternative that has strong evidence.

These are a number of therapies that you can take a look at, that have moderate empirical support for the child abuse population.

This one here, I probably shouldn't have run out of time before I talked about this. This is all of the things that don't have really much research support, and this is what we do most of. This is one to avoid, children get hurt when they do this.

And then I have a list of the websites where you can get the descriptions of the practices, and summaries of what's effective, from the various institutions that have published them.

Jill Walker

Well, the good news is I'm the last presenter, and the bad news is I'm the last presenter. So if you give me 15 to 20 minutes, I want to try and leave you with something, I want to try and leave you with a sense of hope.

We've talked about a lot of pretty difficult issues, and we've talked about how much needs to be done, but I believe we are making an impact.

I wanted to speak about two programs that I've been involved in, and also to introduce you to someone, who I work very closely with, and who is an excellent researcher for all of you.

Community-based Family Violence Response Teams

I have been, I've had the privilege of being involved with two family violence response teams. These were community-based programs. One was funded through the Office of Child Abuse Prevention, what, seven years ago, and it was actually driven by a funding mandate, so that made it unique in a sense.

And the second one was a community collaborative that came together based on the need, and was not driven by funding. They had been working for several years to get an intervention team going, and have successfully done that. And I came on board after they had already done all the tough work. So I started working with them in July.

And I'm not going to go into details about each program, but what I am going to tell you, that in your manual, the family violence response team and, of course, a good way to get a plug in for this, on page 14 is the law enforcement FVRT model, which is the Corona Project, which I'm going to talk about, briefly. And then on page 17 is the multi-disciplinary team model that is the Safe Team, that I'm going to talk about.

Is anyone here from Shield, in Westminster? Okay. The Safe Program, that I'm going to speak about, is based on the Shield program. So if any of you have heard of that program, that is the multi-disciplinary post-incident model.

I believe the biggest impact, and we talk about change and systems, it's very difficult. It's difficult to take agencies, with their own philosophies, their own way of doing things, and ask them to work with another group or another agency that has very different beliefs, ways of doing things.

And law enforcement is one of those agencies. And I think, traditionally, we've had, as an advocate agency and as, you know, community-based agencies, there's been an adversarial relationship way in the past, and that has changed dramatically. And I think that is probably one of the biggest changes I have seen, since I've been doing this, and it is exemplified through these two models that I'm going to talk about.

The Corona Project was started through a grant, and it started as a community-based family violence prevention program. We put together a team, dating violence curriculum, and we started implementing it in the schools. We were teaching kids about dating violence, and healthy relationships, and all of that. We started a mentoring program. We started doing a lot of training.

We did one of the first clergy conferences in the state, where we brought clergy together and talked about domestic violence, family violence.

We trained law enforcement, the courts, professional social workers, healthcare providers. We trained fire fighters, because we knew that fire fighters were going out on medical aid calls. And I remember that one told me that he had been to a home six times, and the woman had fallen down the stairs six times, and now he realized it was a domestic violence call. Okay.

So we try to do a lot of training. Education is, I believe, the most powerful tool in addressing family violence. It is one of the critical elements, and that's why we're all here.

The Corona Project, that started as a community-based response, actually grew into a family violence response team. That was an unintended outcome. That's not what our grant told us to do, our grant told us to do all this other stuff.

And what happened was we formed this collaborative, a very strong collaborative, had a lot of support.

And how many of you have heard of the trauma intervention program? Oh, nobody. TIP? Okay.

The trauma intervention program is a grass roots program. Actually, the founder is based in San Diego. And it is volunteers that are trained to respond to traumatic incidents with law enforcement and fire departments. They go out on accidents, unattended deaths, suicides, you name it, and they are there to provide crisis counseling in a paraprofessional manner, to the victims, witnesses, family members. They help them by telling them, okay, this is what's going to happen next, is there anybody you need me to call, okay, is there anything I can do for you? They do a wonderful, wonderful job.

Well, in the City of Corona we have, what I believe, is one of the most successful TIP programs in the country. And Becky Gunnoe, who I'm going to ask to stand right now, is the director, and she is not paid. She is literally running this program 24/7, and does not get paid for her efforts. She has a volunteer base of 30 people that are on call, they spend 12-hour shifts on call every month, none of them are paid.

So when Becky became involved with this family violence response team, we thought what would happen if we trained the TIP volunteers to go out on domestic violence calls, and provide basically referrals, just that crisis assessment, just very brief assessment and referrals to our agency. And we started that, and the calls immediately doubled, tripled. They are now responding to domestic violence calls with law enforcement. It has received a very positive response. It is the only TIP program in the country that is doing domestic violence, and Becky goes all over the country training other programs to implement this.

Because what we're finding is we need to get those services to the victims. And often, as all of you know, law enforcement does not have time, they're dealing with the arrest, and all of that, so this provides them a very valuable tool to provide help to the victim.

There was a client, a couple years ago, who had come to our group, I just want to share this with you, quickly. She came to our group, and her perpetrator, she had a restraining order against him, and he was stalking her, he was calling her, he was doing all these things to harass her, and she always called the police. And she had just numerous reports with law enforcement, but she was very diligent. You know, he was violating that restraining order, so she called, and called, and called.

He drove by our agency at the time she was in the office, before group. So we called the police, and a police officer came, and he was a rookie, and I left them to speak, for her to do what she needed to do, and for him to do, and all of a sudden I started hearing their voices raise, and it was getting louder, and louder, and louder. And finally I thought, this is not good, they are screaming at each other.

And so I walked out into the lobby, and I just literally had to get in between them and say, what is happening. And the officer was saying, ma'am, if I could go out and find him, and take care him myself, I would do it, but I can't, because I have to do this, and I have to do that. And he was so angry, and frustrated. And then she was saying, you never do anything, you won't respond. I can't get any help, he's going to hurt me.

Okay, so here these two are, and I realized it is so frustrating for law enforcement, and I hear this time and time again, to go out on domestic violence calls. For one thing, they are probably the most dangerous call to go out on. For another thing, they often go back to the same house and do the same thing, okay, over and over. That is frustrating.

So one of the things that the TIP program has done, and what a response team has done, is provide a way for officers to help. That has made a tremendous impact in the City of Corona and with law enforcement.

Changing Law Enforcement's Response to Family Violence

There's another program called SAVE, it's Stopping the Aftermath of Violence Effectively, and that's the multi- disciplinary team model that I was talking about, on page 17 of your manual.

And that program is it's law enforcement focused, but it's a collaborative of agencies that all get together and they review cases. It's very similar to what Dr. Gaba was talking about, earlier.

That program has also had a very positive impact on the way law enforcement looks at how they respond to domestic violence.

And what I wanted to do is read a speech from one of the—he's a corporal, with the Hemet Police Department, his name is Butch Newman. And he initially volunteered for this assignment, to be on the SAVE team. And the City of Hemet, the police department actually—the officers, they fill out a SAVE card, it's a referral card, and then the SAVE card goes to the SAVE coordinator, and then the team reviews the card, and then we assess what they need, and we provide them services. They usually will get services within a week or two, depending on the severity.

If they need services right away, if they need shelter, then one of the team members calls me, and we get them into shelter, and we do all that.

We meet every two weeks, and there's a lot of follow-up involved. So if we can't get to a family, if they refuse services, we always follow up with a call, and we try to continue to offer them services.

So these officers are saying things like, you know, I filled out a SAVE card and that family got help. And you know what happened when I told the SAVE coordinator about this, she came over and she did this, and this, and this. And so they're seeing results.

This particular corporal was asked to present at the Safe From the Start, it was a Safe From the Start conference. It was actually for projects throughout California that have Safe From the Start funding, and it was actually a month ago.

And I just want to read you part of his speech, and I will finish up with this. Corporal Newman is a 17- year veteran of the Hemet Police Department. He's worked in narcotics, he's done just about everything. He's probably one of the most cynical law enforcement officers, typical law enforcement officers you would meet, and I'm not saying anything behind his back, he would tell you that. And this is his presentation. He talks about:

"From the beginning of an officer's career, academy training and field training, the focus is on officer safety. How to make an arrest, write a report, drive safely in emergency situations, and testify in court. We are taught how to perform the rudimentary aspects of protecting ourselves and the public. As I look back on the training I have received to

serve and protect, I cannot remember anything in my academy training, or recent training, that has taught me how to deal with children who are either witnesses or victims at critical incidents, such as domestic violence calls. The standard has always seemed to be to put them in the back of the police car until the situation was resolved, regardless of how it was resolved. New officers are trained to achieve one goal, make the arrest, and that was my goal. It didn't matter what type of call it was. When I worked for narcotics for nine years, my goal was the same, search the house, locate the dope, locate the money, seize the property, make the arrest. My goal was the same whether there were children present or not. Children were a distraction, an inconvenience, a nuisance, they were in the way when I was trying to do my job. How could I make an arrest when I had to fill out extra forms, or call CPS, or a relative to come get the children. I had to babysit them until somebody came to deal with them. I didn't have time for this. After all, I had crooks to put in jail, I had cases to brag about, I did not have time to deal with these children, they were a nuisance."

Now, let me just say, Dr. Stilwell, that this was his moralizing moment, okay. He attended the Safe From the Start conference in March of 2000, and this is when he volunteered for the intervention team. And during the conference he was shown how one child had more than 90 contacts with law enforcement between the time he was four years old and up until he was 17, and some of you may be familiar with that.

"The boy went from being an innocent bystander, in an abusive home, to a victim of the abuse, then on to being a career criminal. After hearing this I thought, what would have happened if on just one of those 90 contacts someone, anyone had said, I can help. I thought back on all of those kids I had seen while serving search warrants, or on domestic violence calls, children that had gone unnoticed during a search because they were sleeping under a pile of soiled clothes to keep warm. Children who I had actually found sleeping in dog feces. Children whom, upon seeing me, a total stranger in a uniform, would cling to my leg. I would literally have to pry them off of me so I could 'do my job, make the arrest.' Quite frankly, I became ashamed of myself for this, I still am. I was actually part of the cycle of violence when I should have been part of the solution. I wonder how many of those children are now committing crimes, themselves. I am now arresting children whose parents I have arrested in the past. Of course, now I'm dealing with their children. These are the same children I considered a distraction a generation ago. The cycle continues."

He talks about how being a part of this intervention team, his work on the team, the impact it has made and, also, just being involved with the education part, learning about what happens when kids are exposed to violence.

This was his sort of transformation, and he says:

"Now, I look at it as a rescue mission. I still want to make the arrest, of course, because that is still my job, but now I want to get to that child, I want to stop that cycle of violence. I want that child to experience things a child should experience, a good night's sleep, clean clothes, a decent meal, a safe environment. Not things like knowing where to hide when dad starts hitting mom."

And he talks about the SAVE program, and explains it, and closes with:

"The most impressive thing about SAVE is that these families get help quickly, there is no waiting period, no 'let me run it by my supervisor.' They are put in direct contact with the agency or person who is going to assist them. And the officers have the confidence that when they fill out their referral cards, and tell that person or family that SAVE can help, that they will get help. I'm hearing more and more from officers that say SAVE came through. As a police officer, I am reminded from time to time that since I carry a gun I have the power to take a life. While that may be true, I also have the power to save a life, which is far more rewarding. SAVE makes that helping process a little easier."

So in addition to him being part of this intervention team, he's also getting a lot of kudos where he works. The officers call him Corporal SAVE. And he has these tricky little things that he does to try and get more officers to keep filling out the cards. He'll send emails out. And one of the e-mails he sent talked about—it was information that he took from the research that is out there, and we talked about we need to look at children as the primary victims, not secondary victims, and how important it is to factor in what these children need, and all of that. And when he sends out the emails, he said that people were starting to delete them because they would know that they were from Corporal SAVE, and they were about SAVE, and they were just deleting them.

So he would try, with catchy ideas, he would say something in the subject line like "free," you know, or "training idea" or something, and then he would say "gottcha." And he would always say "think SAVE."

So I just wanted to share this with you, to show how much of an impact this program has made, not only on this corporal, but also on the Hemet Police Department. Seventy percent of our SAVE referrals are from Hemet PD. And since July 1st of 2002, we have provided services to 500 children as a result. And we projected serving about 100 children, so we're far exceeding our goals.

I would encourage all of you, if you do not have a family violence response team, or a family violence collaborative, I would encourage all of you to start one. You can. It's work, but it can be done. It doesn't matter if you have funding, or not. And Becky and I will actually be in the skills building tables, I guess, afterwards, and we'd be happy to provide assistance, and also at the institute in June.

So I thank you very much.

Audience Exchange

Ms. Walker: Does anyone have any questions at this point?

Audience Member: Dr. Kristine Ann Lawson has written a book called, *Understanding Borderline Women*, and in it she cites statistics from her profession, which indicate there are about 4 million borderline women, that's women who have borderline personalities in this country, and there are about 400,000 in California, which means they populate this County of Sacramento.

And they're described in the DSM4. They're also described by the Duluth Power and Control Rule. Every characteristic of this person is on

that power and control rule. And my question—and they're twice as likely to be borderline personalities as men. That means they're predators, they're violent, and the statistics about child abuse, and child neglect in this country, are that two- thirds or more of it is committed by women.

It seems to me that your gender biased approach to domestic violence is ethically challenged. I hear your statement that it's supposed to be geared toward protecting children. Let me suggest to you that there is something you're overlooking, and I wonder, from the panel members, how you're going to deal with this ethical challenge.

Ms. Walker: Okay. Before we answer the question, I would like to ask the audience, how many of you only serve women as victims of domestic violence?

Audience Member: You mean that we see or—

Ms. Walker: How many of you can only serve women, how many of you have to turn away males who are victims?

Does that answer your question?

Audience Member: No, it does not. What kind of outreach do you have to male victims when they're caught in this crime?

Ms. Walker: Sir, I think everyone here in this room acknowledges that males can be victims of domestic violence. I know in our agency we do serve males, and we serve them the same as females. I don't think anyone in this room does not serve males, and does not acknowledge that males can be victims of domestic violence, as well.

Audience Member: How do you do that without the outreach?

Ms. Walker: Well, I do outreach because when I speak to groups, and I speak to a lot of groups, I always say he/she, I always acknowledge that males can be victims, as well.

Audience Member: I didn't hear that.

Ms. Walker: Well, I didn't talk about—I didn't really talk about victims, I was talking more about the law enforcement response to it.

Did you want to comment?

Ms. Dixon: Sure. Maybe you didn't hear my discussion, or you were out of the room when I talked.

Audience Member: Oh, no, I heard every word.

Ms. Dixon: Did you hear every word? Then if you heard it, then you heard about female perpetrators that committed homicide, as well. We don't turn a blind eye to whoever does what, if it's a crime, it's a crime. And if it's reported to us, we handle the cases.

We look at well over 5,000 cases a year. I've done that for over 12 years. The bottom line is 95 percent of the time the perpetrator's a male, 5 percent of the time they're female. I can't get past those numbers for you. These people call us, they tell us what's going on. But the bottom line is 95 percent of the time the perpetrator is a male. These calls are coming into us on a 911 line. We're not out there saying women call us only, or men call us only. We are saying victims of domestic violence give us a call.

Ms. Walker: Thank you. Niki?

Audience Member: I have a question for Debbie. I'm wondering if there's any research regarding the impact of the change in the mandatory reporting rule of requiring healthcare providers to report domestic violence, if there's any — I know there's concern, but is there any research showing that women are more reluctant now to talk with healthcare providers about domestic violence as a result.

Did I ask the right question on that?

Ms. Lee: Sure, but you can't just ask me that question. As far as I know, that there are no studies that have been done to show what impact has been made. I think we'd all like studies to find out how it's helping women. I mean, there are many different elements of looking at how mandatory reporting is impacting domestic violence. Is it making women safer? Clearly, yes, it's had an impact on the justice system. But my argument is, you know, whether— what we really want to look at is which women does it help, because clearly it does help some women. But, clearly, it also, and I think Rolanda would acknowledge, that there are those women, too, that it has a chilling impact on women coming into the healthcare system, as well. But we need to look at those numbers, as of yet.

And the IOM, the Institute of Medicine, has recommended that studies be done. But as you know, studies these days cost money, of which there isn't a lot.

Audience Member: I just have one quick follow- up question to that. Are you required, then, to let—as a healthcare provider—to let women know that if they tell you this, that they will be reported? Like you do in terms of child abuse, that if you disclose this, it will be reported?

Ms. Lee: With the new HIPAA regulations, you are now required to disclose that you have mandatory reporting law and, therefore, you should disclose that before asking. HIPAA's pretty clear.

We have a paper on HIPAA, that you can find on our website, it goes through quite a bit of detail.

And also, it sounds like there's a number of shelters out there, in the audience, who are also coming out with some guidance about a lot of you have been asking us how your programs fall under HIPAA, and we have a paper, a simple paper, actually, that you can understand, that will help guide you, and your healthcare providers who are demanding these forms from you.

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