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Identifying and Responding to the Needs of Children in Domestic Violence Shelters: Final Report

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1. Executive Summary

The Domestic Violence Shelter Screening Project (DVSP) was a collaborative effort between the Center for Child and Family Health[1], the Center for Child and Family Policy of Duke University, and six North Carolina domestic violence shelters located in Caldwell, Guilford, Halifax, Robeson, Vance, and Wilson counties, which served as pilot sites. The project was funded jointly by The Duke Endowment and the Z. Smith Reynolds Foundation.

The pilot project took place between January 1, 2006, and December 31, 2006. The purpose of the pilot project was to develop, implement, and evaluate the effectiveness of a training protocol that improves the capacities of domestic violence shelter staff to screen, intervene, and refer child shelter residents experiencing distress related to their exposure to violence and other adverse events. Shelter staff was trained on the appropriate, reliable, and valid use of three screening tools to assess child and adolescent posttraumatic stress, psychological symptoms, psychosocial functioning, and child development milestones. Staff also received education in child traumatic stress, behavior management, and techniques to support effective parenting. As a first step, a needs assessment was conducted with shelter directors to identify current shelter practices related to children, facilitators of and barriers to providing mental health services for child residents, and to inform the development of the training curricula. The quality of the training sessions, level of engagement and response to training were evaluated using staff and facilitator process evaluation questionnaires, conference call notes, and through focus groups conducted with shelter staff at each site after training. Project impact in the form of changes in: (1) staff knowledge, attitudes, and beliefs about domestic violence and its effects on children; (2) staff use of behavioral management strategies to help parents and children; and (3) staff self-efficacy and ability to assess, score, and make appropriate referrals to community agencies was evaluated using pre and posttest questionnaires and an instrument developed to monitor the implementation of the screening measures.

A follow-up evaluation took place between January 1, 2007, and December 31, 2007, to assess project sustainability, i.e., the extent to which staff (1) continued to engage in new behaviors to support parents and children, (2) continued to screen and refer sheltered children, and (3) integrated screening and referral activities into the shelter's daily functioning in the absence of contact, consultation, or participation incentives from the project leaders. Project sustainability was evaluated using a posttest questionnaire administered to shelter staff six months after the intervention. Individual level sustainability was measured by the extent to which shelter staff remained confident to use screening tools to assess, score, and refer children to appropriate services. Site level sustainability was measured on 4 dimensions: (1) memory -- the human, material, and financial resources to support screening and referral; (2) adaptation -- routine activities at shelters modified to accommodate screening and referral; (3) value -- collective value placed on screening and referral; and (4) rules -- presence of written institutional procedures to guide screening and referral. In addition, the extent to which shelter staff continued

[1] A consortium of Duke University, the University of North Carolina at Chapel Hill, North Carolina Central University, and Child & Parent Support Services, Inc.

to refer and respond to the service needs of children was measured through face to face interviews with community partners.

Key findings from the pilot project are:

1. It is feasible to train staff working in domestic violence shelters to systematically evaluate children entering shelter using standardized screening tools addressing broad psychosocial functioning, developmental status, and traumatic stress symptoms. During the pilot, 40% (range 18%-71%) of eligible children were assessed using at least one of three screening measures. However, the fact that the majority of children were not screened highlights the difficulty of obtaining consistent implementation of such a procedure.

2. Through the use of standardized screening tools, shelter staff was able to identify mental health concerns among sheltered children, as well as concerns related to developmental status. Consistent with expectations, the assessments revealed significant levels of psychological distress, functional impairment, and developmental risk among a substantial number of child shelter residents. Almost half (45%) of children who received the screening scored in the clinically significant or at-risk range on at least one of the three screening measures.

3. Referrals to community mental health and other psychosocial resources for further evaluation following screening were more difficult to achieve. Under half (47%) of children with an elevated score on at least one of these measures was referred for follow-up services. Staff attributed this to the timing of the administration of the tools, as well as the time necessary to administer, score, and interpret the results of the tools. For example, brief lengths of stay and the acute nature of shelter admissions tended to decrease the likelihood of both screening and/or referral. The outcome of referrals was not a focus of the current evaluation. As discussed later in this report, partnerships between shelters and community agencies to which these referrals would most frequently be directed were largely non-existent or very weak at the beginning of the project. Consequently, promoting these partnerships became a project objective, as well as identifying and removing real or perceived barriers to those partnerships.

4. Staff viewed the screening tools as a positive strategy for engaging, educating, and supporting parents. Staff was able to identify both risk and resiliency factors in children and apply newly learned skills in behavioral management when teaching parents and interacting with children.

5. An explicit focus on providing developmentally informed and structured activities and care for children within domestic violence shelters represents a significant shift for shelters in terms of practice and philosophy.

6. Shelter staff members have relatively high levels of pre-existing awareness and knowledge about the effects of domestic violence on children. They are less familiar with

specific strategies related to managing behavior, improving parenting skills, and identifying psychological or developmental needs and related community resources.

Key findings from the follow-up evaluation of project sustainability are:

1. Shelter staff members' knowledge of the effects of domestic violence on children was comparable to that expressed at the outset of the project. This is attributed to the fact that staff knowledge about the effects on children of witnessing domestic violence was already fairly high to begin with and remained so over the course of this project.

2. An initial increase in staff application of behavior management strategies (i.e., educating parents about traumatic stress and assisting them in managing behavioral transgressions among their children) was not sustained during the follow-up period, perhaps due to the complexity of acquiring these new skills and the distinct nature of skills relative to the usual, adult focused practices within the shelters.

3. Shelter staff continued to use parenting support strategies that they learned as a result of training. They continued to report teaching parents about appropriate use of praise and active ignoring of negative behavior. In addition, staff increased their teaching of parenting skills related to use of effective commands and time out skills. One reason for the persistence of these skills may be that they fit best with the shelters' priority focus on acute stabilization and empowerment of mothers and other adult victims of domestic violence. Another reason may be that they are more readily incorporated into existing parenting classes that take place at the shelter pilot sites.

4. Despite some initial improvements, the shelters remained relatively isolated in terms of the partnerships with and referrals to other community resources. Increased referral to community, child-focused partners, such as Children's Developmental Service Administrators (CDSAs), Child Service Coordination (CSC) Programs, and the Local Management Entities (LMEs), were not sustained. However, recognition of key community partners as allies in their efforts to address the needs of children was sustained at follow-up. Increases in referral to legal aid and educational tutoring resources were also sustained at follow-up.

5. Staff members continued to report high degrees of self-confidence in their abilities to screen and refer children residing in shelters at follow-up. This is encouraging in light of the fact that staff reported difficulty learning how to administer and score assessment instruments during the pilot training year. Seventy percent of staff reported screening and referral to be a permanent activity at the shelter.

6. Screening and referral of children was partially sustained at the time of the follow-up evaluation. Shelters scored fairly high on the degree of resources allocated to continue screening and referral including assignment of a supervisor to oversee administrative responsibilities for screening, cross-training of multiple staff to conduct screening, and designation of a permanent position to conduct screening and referral. Shelters also scored high on the collective value placed on screening and referral, and on Internet capabilities to engage in follow-up training and/or use an electronic system to streamline screening and referral. Unfortunately, shelters scored lower on the modification of rules

and written procedures to accommodate screening and referral, which project staff surmised are more likely lead to a permanent adoption of new practices.

7. Multiple barriers continue to impede staff screening and referral of children to mental heath and other support services. A prominent challenge involves the combination of limited resources with frequent, recurring, and unpredictable admissions that necessitate a focus on urgent or immediate needs of adult shelter residents. As a result, shelters are limited in their ability to extend their efforts beyond present needs and concerns related to safety and stabilization. In addition, staff turnover is frequent and high among front line and administrative staff, which complicates efforts to institutionalize and sustain practice changes absent the ongoing involvement of external consultation or financial incentive.

Recommendations

The following are recommendations based upon the findings from both reports.

1. Domestic violence agencies and shelters can and should effectively serve as an assessment and triage point for children and their parents who receive services. The use of standard approaches to assessment and service planning will facilitate more effective planning and collaboration within and across agencies and service systems.

2. Affordable and accessible training should be made available to a broad range of professionals, including domestic violence program staff, who comprise the components of a de facto screening, intervention, and referral system. Where appropriate and feasible, the training should be available on-line to enhance its accessibility to a broad range of participants. Policymakers and funders should actively promote this training as a means of quality improvement for domestic violence related programs; these efforts may include offsetting of training costs, assisting with recruitment, and as appropriate, setting requirements for funding related to domestic violence and children.

3. The capacity of funding agents (or "funders") to promote evidence-based programming for children should be enhanced, as well as their ability to provide technical assistance to domestic violence programs offering services to children. Funders should consider: (1) providing incentives for standardized screening and referral at domestic violence shelters, (2) implementing standards for children's programming in domestic violence shelters and agencies, and (3) specifying and requiring program outcomes for children's programming.

4. Given that shelter admissions can be both brief and recurrent, with parent and child often returning to their home communities, shelters may be viewed as a component, albeit an important one, in a system of potential community services. To that extent, parents and children who enter shelter-based care may benefit from increased levels of partnership between shelters and other child serving systems. In particular, Child Developmental Service Agencies and Child Service Coordination Programs should be actively and intentionally engaged as partners with their local domestic violence shelters, as both offer

a means for attending to developmental risk and delay. Local management entities (LMEs) can play a valuable role in accessing mental health care for either parent or child. Departments of Social Services not only serve a child protective role but can also assist parents in obtaining public benefits and social services that may contribute to social stability. In each of these instances, and in others, the success of partnership will require more frequent contact and collaboration in the common service of parent and child well-being.

2. Introduction

The Domestic Violence Shelter Screening Project (DVSP) has consisted of a collaborative effort between the Center for Child and Family Health[2], the Center for Child and Family Policy of Duke University, and six North Carolina domestic violence shelters located in Caldwell, Guilford, Halifax, Robeson, Wilson, and Vance counties, which served as pilot sites. The project was funded by The Duke Endowment and the Z. Smith Reynolds Foundation. The purpose of the project was to develop, implement, and evaluate the effectiveness of a training protocol that improves the capacities of domestic violence shelter staff to screen, intervene, and refer child shelter residents experiencing distress related to their exposure to violence. The first part of the report summarizes findings of the pilot project which took place Between January 1, 2006 and December 31, 2006. The second part of the report summarizes findings of a follow-up evaluation of project sustainability that took place between January 1 2007 and December 31, 2007.

This summary report represents a collaborative effort with vital contributions from the following professionals: Robert Murphy, PhD (CCFH); Leslie Starsoneck, MSW (CCFH); Yvonne Wasilewski, PhD, MPH (CCFP), Margaret Samuels, MSW (CCFH); Donna Potter, MSW (CCFH), Jennifer Brobst, JD, LLM (CCFH), Audrey Foster (CCFP), and Lorrie Schmid (CCFP). The dedication and participation of shelter directors and staff members in Wilson, Halifax, Vance, Robeson, Guilford, and Caldwell counties has been invaluable.

2.1 Rationale and Purpose

Programs that provide shelter to families fleeing domestic violence have typically *not* been designed or funded specifically to respond to the needs of children. Children's mental health needs are often seen as secondary to those of their victimized parents, and are often expected to improve or resolve as the physical and emotional states of their victimized parents improve. This anticipated improvement is often predicated on the parent's exiting the abusive relationship, a situation that occurs only in some cases. As a result, attention to the needs of children in shelters has been limited and inconsistent in its scope and breadth, and children are left without the necessary assessment and intervention they may require. Many are at risk for developing a range of problems as a result of exposure to domestic violence, and the likelihood that they have experienced other forms of adversity that increase risk, i.e. maternal depression, parental substance abuse, poverty, disruption to their living situation, is significant.

The current project has challenged existing approaches to children in shelter, tested new methods for evaluating and responding to the needs of children in the context of current programming, identified barriers to adoption and sustainability, and begun to propose solutions. Its purpose is to develop, implement, and evaluate the effectiveness of a training protocol that improves the

[2] A consortium of Duke University, the University of North Carolina at Chapel Hill, North Carolina Central University, and Child & Parent Support Services, Inc.

capacities of domestic violence shelter staff to screen, intervene, and refer child residents experiencing distress related to their exposure to domestic violence.

The project posed the following primary questions: (1) Can shelter staff systematically evaluate children entering shelter using evidence-based screening tools? (2) Can domestic violence programs enhance the care that children receive in shelter by increasing their use of behavioral management techniques? (3) Can domestic violence programs develop consistent and meaningful partnerships with agencies in the community who have the necessary expertise and resources to further evaluate and respond to the needs of children?

2.2 Objectives

The project objectives were as follows: First, children residing in six domestic violence shelters were to receive routine screening for posttraumatic stress and related psychological, psychosocial, and developmental problems to clarify how they have been affected by domestic violence and to improve intervention and referral strategies for shelter and community based care. Three measures were selected for training and screening implementation: (1) the UCLA Posttraumatic Stress Disorder Index (PSDI; Pynoos et al., 2000), an extensively used instrument available in caregiver and child self-report versions that provides an assessment of posttraumatic symptomatology related to subjective distress, re-experiencing, arousal and avoidance symptom clusters; (2) the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), a general screening of child symptomatology and functional impairment; and (3) the Parents' Evaluation of Developmental Status (Brothers, 2007), a measure widely used in pediatric settings to query parents about developmental and psychosocial problems in younger children.

Second, use of brief screening methods was to be piloted and evaluated in order to assure feasibility and appropriate use by staff at domestic violence programs, and to develop strategies for potentially extending these strategies statewide.

Third, domestic violence programs were to receive training on the appropriate, reliable, and valid use of the screening tools, as well as their relation to program planning and collaboration with community provider systems. Shelters would participate in three, one-day training sessions designed to familiarize staff with selected screening measures, including administration, scoring, interpretation, and clinical applications to their shelter population. The didactic component would be supplemented with biweekly to monthly conference calls with project staff in order to facilitate implementation and integration into shelter operations.

Fourth, domestic violence program staff was to receive training through a learning community model designed to enhance best practices for responding to the immediate needs of children affected by domestic violence, with a particular focus on what providers can teach parents and how providers can respond directly to children in developmentally appropriate and effective ways. The project had as a central theme to help shelters develop the capacity to encourage and mentor battered parents, and to create a partnership with them to assist their children in overcoming the deleterious effects of domestic violence. The project was designed to include a training component for domestic violence providers to address the following topics:

- Information on domestic violence exposure and its effects on child development;
- Insight into the experience of children who live with domestic violence;
- Overview of childhood posttraumatic stress, including related problems of depression, externalizing behavior and social and relationship problems;
- Interpretation and management of common behaviors associated with domestic violence exposure in a shelter setting, e.g., creating opportunities for structure and establishing predictable schedules for children, engaging an anxious or wary child, de-escalating violence, and teaching self-soothing techniques;
- Information and support for mothers, e.g., ways to talk about violence with their children, responding to questions and concerns regarding the abusive parent;
- Clinically appropriate responses to child and parent disclosures of symptomatology and/or maltreatment; and
- Effective collaboration with local providers and care systems, including Local Management Entities (LMEs) and mental health clinicians.

Fifth and finally, project staff planned to develop a comprehensive plan for statewide implementation across state-funded programs operating domestic violence shelters. The dissemination plan would incorporate follow up data from 2007 related to screening and training protocols, funding and sustainability strategies, and strategic plans for dissemination of knowledge, practice guidelines, and public policy recommendations.

2.3 Organizations and Project Staff

The Center for Child and Family Health is a collaborative undertaking by the University of North Carolina at Chapel Hill, North Carolina Central University, Duke University, and Child and Parent Support Services, Inc. The primary mission of CCFH is to improve the lives of children and their families who are victims and witnesses of trauma and maltreatment through research, training, practice improvement and direst service provision. Direct services include primary and secondary prevention strategies, as well as community based treatment, education, and evaluation of intervention models.

The Center for Child and Family Policy at Duke University's Terry Sanford Institute of Public Policy brings together scholars from many disciplines, policy makers, and practitioners to address problems facing children in contemporary society. The Center is a national leader in addressing issues of early childhood adversity, education policy reform, and youth violence and problem behaviors.

Robert A. Murphy, PhD (CCFH) served as project director. Dr. Murphy serves as Executive Director for CCFH, Associate Professor in the Department of Psychiatry at Duke University Medical Center, and Adjunct Associate Professor in the Department of Maternal and Child Health at the University of North Carolina School of Public Health. Dr. Murphy has a background in services evaluation and intervention for traumatized and violence exposed youth.

Yvonne Wasilewski, PhD, MPH (CCFP), served as project evaluator. Dr. Wasilewski is a research scientist at the Center for Child and Family Policy and Adjunct Assistant Professor in

the Department of Health Behavior and Health Education at the University of North Carolina School of Public Health. Dr. Wasilewski has extensive experience designing, evaluating, and disseminating community and evidence based interventions for children and families in school, clinic, and worksite settings.

Margaret Samuels, MSW, (CCFH) provided clinical oversight and supervision of all direct training activities and curriculum development. Ms. Samuels has extensive experience in intervention and program development for children and families affected by domestic, community, and ethnic violence. She has worked domestically and internationally to develop and implement protocols for post-terrorism and post-disaster response to traumatized children and families.

Donna Potter, LCSW (CCFH) provided curriculum development and training in the effects of domestic violence on children and cognitive behavioral strategies of intervention. She has worked with evidence based trauma treatment models for over seven years, and provided training across the nation related to the use of implementation science in fostering the use of evidence based mental health practices.

Leslie Starsoneck MSW, (CCFH) led coordination and oversight of the project with a specific focus on policy implications, including funding and coordination with other statewide initiatives. Ms. Starsoneck serves as a consultant to the Center for Child and Family Health. She previously served as project director for the Child Well-Being and Domestic Violence project housed at Prevent Child Abuse NC and as the former director of the Domestic Violence Commission in the NC Department of Administration.

Jennifer Brobst, JD, LLM (CCFH) is Legal Director at CCFH and serves on the faculty of the North Carolina Central University School of Law. Attorney Brobst has focused her practice on domestic violence, sexual assault and child abuse, and provided training and consultation within the learning collaborative approach.

Audrey Foster, BS (CCFP), served as a senior research aide for this project.

Lorrie Schmid, BA (CCFP) served as a data analyst for this project.

2.4 Pilot Sites

Shelter	City	County
Southeastern Family Violence Center	Lumberton	Robeson
Wesley Shelter	Wilson	Wilson
Hannah’s Place	Roanoke Rapids	Halifax
Shelter Home	Lenoir	Caldwell
Area Christians Together in Service	Henderson	Vance
Family Services of the Piedmont	Greensboro	Guilford

Domestic Violence Shelter Pilot Sites were selected based on high county-wide rates of child and parent risk factors and efforts to engage sites that varied in size and locale. Domestic violence shelters in the six pilot counties of Wilson, Halifax, Guilford, Robeson, Vance, and Caldwell participated in this pilot project. Shelters in each of these counties implemented screening procedures, participated in the learning collaborative model of training and consultation, and in project evaluation.

3. Pilot Project

3.1 Collaborative Learning Model

The project team chose a Collaborative Learning Model that originated with the Institute of Health Care Improvement and has been extended and adapted to child traumatic stress through the work of the National Child Traumatic Stress Network in order to develop and implement this project. The Collaborative Learning Model is a powerful tool for accelerating improvement through consultation from trainers and short-cycle action periods between formal learning sessions. It has been used successfully by hundreds of health care organizations to improve health care processes and outcomes since its inception in 1996.

The model applies principals of adult learning theory that emphasize an interactive learning process and skill-focused learning. Key components of the model include: (1) in person group learning sessions, (2) follow-up consultation activities with feedback, (3) resources to support sustained learning, and (4) opportunities to practice new skills and share progress through the collaborative structure. We adapted key components of this model in order to develop the project components for the Domestic Violence Shelter pilot project. Project components included:

- Three Learning / Training sessions with pre-work;
- Bi-weekly to Monthly Conference Calls with consultation and feedback on content of training sessions;
- A half-day site visit with consultation and feedback;
- A Listserv to share resources and support sustained learning; and
- A Toolkit containing assessment, intervention, and collaboration resources.

During the three learning sessions, shelter staff was trained on the appropriate, reliable, and valid use of screening tools to assess child and adolescent posttraumatic stress, psychological symptoms, psychosocial functioning, and developmental concerns. Domestic violence shelter staff was also trained to develop the capacity to encourage and mentor battered parents and to create a partnership with them to assist their children in overcoming the deleterious effects of domestic violence.

3.2 Learning Objectives

By the end of training, we expected staff to be able to:

1. Recognize aspects of child development that can be affected by domestic violence;
2. Understand the experience of children who live with domestic violence;
3. Identify symptoms of childhood posttraumatic stress, including related problems of depression, externalizing behavior, social and relationship problems, and developmental status;

4. Interpret and manage common behaviors associated with domestic violence exposure that occur in a shelter setting;
5. Inform and support mothers in responding to their children (e.g., identify ways to talk about violence with their children, respond to questions and concerns regarding the abusive parent);
6. Engage in clinically appropriate responses to child and parent disclosures of symptomatology and/or maltreatment;
7. Collaborate effectively with the local providers and service systems;
8. Correctly and consistently administer the screening tools to parents and youth entering shelter;
9. Appropriately score and interpret the results of the tools;
10. Provide feedback to families based on results of screening; and
11. Use a toolkit that will serve as a training and reference resource for existing and future staff.

3.3 Logic Model

Project evaluation was guided by a Logic Model, in the form of a flow chart that conveys relationships between contextual factors and programmatic inputs, processes, and outcomes (See Appendix). It shows the links in a chain of reasoning about "what causes what," in relationship to the desired outcome and overall project goal. Hypotheses about program effects are described in our logic model, tested in a "theory-based" evaluation, and lead to "lessons learned."

3.4 Evaluation Methods

We used multiple methods to evaluate the project, as described below.

A **Needs Assessment** with shelter directors assessed current shelter practices related to children, identified facilitators of and barriers to providing mental health services for child residents, and informed the development of the training curricula. The Needs Assessment was supplemented with local, county, and statewide data to document the context or setting within which shelters work, i.e., social, economic, and environmental factors. We also collected qualitative data during learning sessions, conference calls, and half-day site visits.

Process Evaluation by shelter staff, facilitators, and the evaluation team assessed the quality of training sessions, the level of staff engagement, and response to training sessions. We used Staff and Facilitator Process Evaluation Questionnaires, Conference Call Notes, and the results of Focus Groups conducted with shelter staff at each site after training to achieve these objectives.

Outcome (Impact) Evaluation Our outcome evaluation focused on short term and medium term results of the project. These were grouped into changes in three areas: (1) staff knowledge, attitudes and beliefs about domestic violence and its effects on children, (2) staff use of behavioral management strategies to help parents and children, and (3) staff self-efficacy and ability to assess, score, and make appropriate referrals to community agencies. To measure

project impact, we used pre- and posttest questionnaires, and an instrument developed to monitor the implementation of the screening measures.

Process and outcome evaluation instruments are found in the Appendix of this report.

4 Pilot Project Evaluation Findings

Results of the pilot evaluation in this report focus on

- Needs Assessment Findings
- Enrollment, Attendance, and Attrition Rates
- Qualitative Assessments of Training from Staff Process Evaluation
- Post Training Focus Groups with Shelter Staff
- Changes as a Result of Training in Shelter Staff:
    - knowledge about the effects on children of witnessing domestic violence
    - behavioral management strategies used with children
    - parental management strategies taught to parents
    - use of community resources for children
    - self-efficacy to use screening measures
    - screening and referral patterns

4.1 Needs Assessment

During the first quarter of the project, we developed and implemented a Shelter Director Survey to assess current shelter practices related to children and barriers to the receipt of services. The survey consisted of over 100 questions and covered ten content areas, and was administered face to face by the project director. Highlights of the survey findings are presented below. Results were tabulated by mean score and percent in order to shield the identity of the shelters. Open-ended responses are also included in quotes or after categorization and tabulation across sites.

Shelter Location

Shelter pilot sites were located predominantly in smaller urban areas with one in a rural location. Although directors' reported that half of the shelters have no published address and the location is well hidden, another half reported that even without a published address the location is well known to their community, highlighting the importance of shelter security. The range of security precautions at shelters varied greatly from reliance on police located nearby to surveillance cameras at the largest urban shelter and deadbolt locks at the most rural of shelter pilot sites. Shelter directors at all sites stated that safety at the shelter is the number one priority for their clients and themselves.

Shelter Living Environment

Within the shelter, space was often inadequate. Although each shelter had an average of five bedrooms, it accommodated an average of 7.2 families at any given time. As a result, multiple families often shared one room. The average length of shelter stay was 39.1 days (ranging from 9 to 90 days). Shelter directors reported that closeness of quarters in a new environment often

potentiated problems for children. They reported that behavioral issues such as aggression between siblings, non-siblings, or toward children by parents are a constant staff concern even when shelters are not at full capacity.

Admission Policies

Admission to a domestic violence shelter at the pilot sites is based on either "imminent danger" or "living in a DV situation." Four of the six shelter directors reported that "imminent danger" is the chief criterion for shelter admission; while two directors reported that their shelter will assist anyone in a domestic violence crisis. Girls under the age of 18 who are not emancipated and girls under the age of 18 who are not accompanied by a parent are restricted from admission. Women who are active substance abusers or present with symptoms of severe mental illness are sometimes referred to a local hospital for stabilization before admission. In cases where the shelter is full, families may be referred to homeless shelters within the county or to a domestic violence shelter in an adjacent county. If these are also full, shelters may arrange lodging in nearby hotels.

Male Children

Although shelter directors reported that the primary admission criteria for children are that they be under the age of 18 and accompanied by their mothers, in half of the pilot sites, boys are not eligible for shelter based upon their age. Two of the shelters do not permit male children over the age of thirteen to reside in the shelter with their mothers; one shelter does not permit males over the age of fifteen. Directors of two shelters evaluate the situation on a "case by case basis," and have taken some male children over thirteen when, for example, the shelter is not full and there is a separate bedroom for them.

Admission Procedures

In all cases, the telephone is the first contact that shelter staff has with mothers and 68% of staff conduct a brief intake interview at that time. A face-to-face intake interview follows in all cases and takes on average 58 minutes to complete (range 10—120 minutes). A short intake interview typically consists of recording basic information about the victim, names and ages of children, and the abuser's name. A longer intake interview might include an assessment of mothers' mental heath status, substance abuse, and more detailed information about the children. Five of the shelters collect additional information about children, but there is little consistency across sites regarding the type of information that is collected and its intended use.

Shelter Rules for Children

All shelters provide clients with a handbook of shelter policies and rules that has a section for children and teens. Parents are responsible for seeing that children adhere to these rules. Four rules are common to all shelters: (1) Mothers must be with their children at all times; (2) Children may not answer the shelter telephone or door, nor can they inform anyone of the shelter location; (3) Children have specific bedtimes, and (4) No corporeal punishment is allowed. Although these rules may seem straightforward, their implementation across shelters is less so

for a variety of reasons. Mothers are often physically and emotionally exhausted and in need of respite care when they first enter the shelter. Many feel diminished in their parental authority by their abuser and have little confidence in parenting. As a result, children may be ignored or disciplined inappropriately. Other children may take on the role of parent or become aggressive. All shelter directors reported that there is a great need for, and that staff would benefit greatly from, training in behavioral management strategies for children, especially how to coach mothers.

Characteristics of Shelter Children

A total of five hundred and nine children were sheltered across the six pilot sites during the 12 months prior to the project (range 32-144). Almost half (48.7 %) were of elementary school age, while 31.8% were infants and preschoolers and 19.5% adolescents. Of the total population, 55% percent were female and 45 % male (which may reflect differences in shelter policies regarding the admittance of males over 13). African-American and Caucasian children were represented almost equally across shelter sites, 37.8% and 31.2% respectively while 14.8% of children sheltered were Latino.

Children's Behavioral and Emotional Problems

In addition to recognizing that behavioral and emotional disturbances are common among children affected by domestic violence, directors reported a different constellation of problems by age group. Shelter directors observe more emotional problems and sleep disturbances in *infants and preschoolers* and more behavioral and emotional problems in *elementary school children.* They tend to view an explicit connection between exposure to domestic violence and mental or physical health problems as occurring elementary school years and beyond. An exception to these findings came from one shelter director who commented, "Children in all age groups have mental health issues because of witnessing domestic violence."

How Children's Problems are Addressed

All shelter directors stated that staff works directly with the mother when it is determined that a child has an emotional or behavioral problem. Only 50% stated that their staff works directly with the child. This is not unusual since the presently stated missions of the shelters are to first address the needs of the victim (i.e., parent). In general, directors believe their staff's responsibility is to empower mothers to reclaim their roles as parents. All directors reported that staff does this by conducting parenting classes at the shelter or by referring mothers to parenting classes at outside agencies. During site visits to shelters in July 2006, classes were observed to vary greatly in format and content.

Designated Children's Program Staff

Five of six shelter directors reported having a dedicated children's program staff at the shelter, along with training specific to meeting the needs of children. However, there is great variation in the kinds of help that staff offer to children. At one end of the spectrum are two shelters at which staff provide few structured activities for children and function primarily as child caregivers. At

the other end of the spectrum, one of the shelters has a full-time child therapist who provides crisis intervention and psychotherapy within the shelter. During our site visits we observed that all shelters have a dedicated space for children, however, none consistently provided activities that are structured to be developmentally appropriate to the children.

Shelter Staffing Levels

Staffing at shelter sites varied greatly with a range of 3 to 24 employees assisting families 24 hours a day for 7 days a week. In spite of the high demands of the job, high levels of stress, and limited resources, the average length of employment of shelter staff including directors at the time of the baseline needs assessment was 46 months. Several directors stated that staff longevity may be related in part to the fact that some staff are themselves survivors of domestic violence and have dedicated themselves to helping others.

Training to Meet the Needs of Children

Although five of the six shelter directors reported that a standard training program is provided to all staff members when they are initially hired, training content varies greatly across sites. Staff training ranges from an overview of shelter policies and procedures to a detailed curriculum of "Domestic Violence 101." Three of the shelters require staff training that is on average 20 hours in duration. One shelter director reported onsite staff training specifically related to the effects of domestic violence on children. Two shelter directors stated that staff has attended offsite workshops on the effects of domestic violence on children offered by the NC Coalition Against Domestic Violence. Although not mandatory, all directors reported that they encourage and support additional staff trainings at outside agencies. These trainings typically occur at state and local agencies and community colleges. Overall, shelter directors reported a strong interest in staff development through continuing education. Directors reported very high needs for child-related trainings on how to assist parents with children who witnessed domestic violence (all directors), how to use child screening measures (five of six directors); and how to access consultation services from mental health professionals regarding children (four of six directors). Similarly, four of six directors reported a need for additional resources specifically for parents.

Child Referrals for Services

Three shelter directors reported that they do not assess children for mental heath or physical health needs while at the shelter. Although directors report that both social and medical care services are available and generally accessible, only three reported making referrals to social services on a weekly basis. Similarly, half reported that referrals to medical care services occurred on a monthly basis. All directors reported that public health services were difficult to access and half stated that referrals are made only several times a year. None of the shelters directors reported assessing the educational needs of children.

Lessons Learned

Overall, there is a strong willingness on the part of directors to find ways to improve mental health services for children at the shelter. Most shelter directors describe staff as only "a little" or "somewhat" equipped to deal with children's emotional and behavioral problems. All shelter directors strongly recognize the need for additional and specific staff training related to the mental health needs of children. There is great variation in the kinds of services and activities offered to children at the shelter and beyond. Shelter routines are often not in place to address the developmental differences of children. Shelters have good relationships with many community organizations that help children, but do not know all that they can provide.

4.2 Enrollment, Attendance, and Attrition Rates

Enrollment

A total of 75 shelter staff from all shelters was eligible to participate in the project. Eligibility was defined as any staff member that works full or part time for pay. Staff at four of the six shelters had a 100% enrollment rate, i.e., took the pre-test that occurred at the beginning of the first session. Staff at the two larger shelters had lower enrollment rates (Table 1).

Attendance

Although 46 staff took the pre-test, only 35 (82%) attended the first session with the discrepancy attributable to staff who completed the pre-test prior to the training day. The numbers dropped precipitously for session 2 in which only 23 staff (53%) attended. The numbers rose slightly for session 3 which 27 (63%) attended. Thirty staff took both the pre- and post test. Thus the reassessment rate was 70%. Staff absenteeism and turnover accounted for a large amount of fluctuation in attendance. Although project staff tried to arrange the date and time of sessions to accommodate schedules, some of the staff that attended initially did not return because of barriers to their participation, for example, they worked \ nights (Wilson, Guilford), found the session location too distant (Guilford), or departed during training sessions to attend to matters within the shelter (Table 1).

Attrition

Attrition also accounted for fluctuation in attendance. The eight staff and one shelter director who left one of the shelters for other employment accounted for 21% of the staff who initially enrolled in the project (Table 1).

Table 1: Shelter Staff Enrollment, Attendance Attrition Due to Job Change

	Eligible		Pretest		Session 1		Session 2		Seession 3		Post Test		No Longer Employed	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Caldwell	8	100	8	100	8	100	8	100	5	63	6	75	1	13
Guilford	24	100	11	46	6	55	6	55	8	73	8	73	1	9
Halifax	4	100	4	100	2	50	3	75	3	75	3	75	1	25
Robeson	5	100	5	100	5	100	3	60	2	50	3	60	2	40
Vance	4	100	4	100	3	75	4	100	3	75	4	100	0	0
Wilson	30	100	11	37	11	100	3	27	5	45	6	55	4	36
Total	75	100	46	61	35	82	27	63	26	61	30	70	9	21

Figure 1 shows a breakdown of shelter staff attendance based on whether staff attended only one session over the course of the training; two sessions, or all three sessions. Eight staff (19%) attended only one of all three sessions, 19 staff (44%) attended two of the three sessions, and 20 staff (47%) attended all 3 learning sessions.

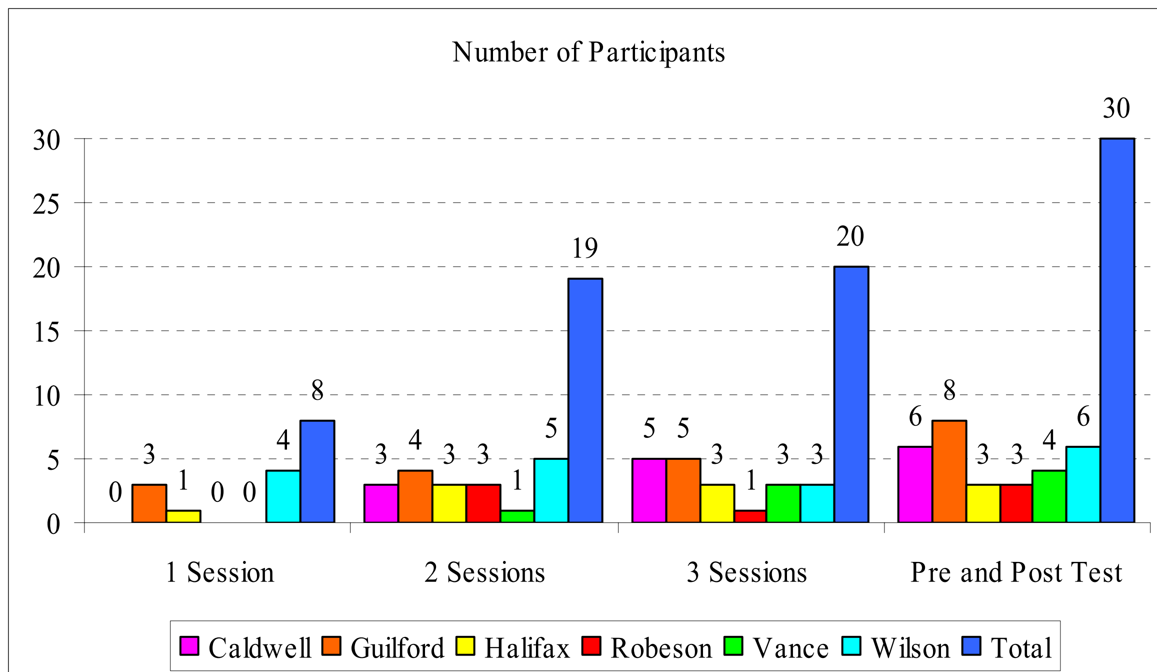


Figure 1: Number of Participants Attending 1, 2, or 3 Sessions

4.3 Characteristics of Shelter Staff Participants

A total of 46 staff including six shelter directors agreed to participate in the training. Staff was predominately female (95%) with an average age of 41 years. Fifty-one percent of staff identified themselves as White (N = 19), 41% as African-American (N = 15), 3% as Asian, and 2% as multi-racial. Thirty-nine percent of staff has a high school diploma or GED as their highest educational degree (N = 14); 47% (17) of staff has a Bachelor's degree and 14% (5) has a Master's degree. The average number of years worked at the shelter by staff is 4.3 years with a range from less than a year to 15 years.

4.4 Qualitative Assessments of Training from Staff Process Evaluation

A total of 29 respondents completed the shelter staff final feedback survey across eight dates in September and October of 2006. The results of this feedback are shown in Figures 2 through 5. The workshops were generally well received by participants as indicated by key self-report questions about quality of topics and instruction and personal value to participants. Virtually all (~100%) of participants strongly agreed/agreed that the facilitators were very knowledgeable about the training topics, while 89% strongly agreed/agreed that the topics were well chosen (Figure 2).

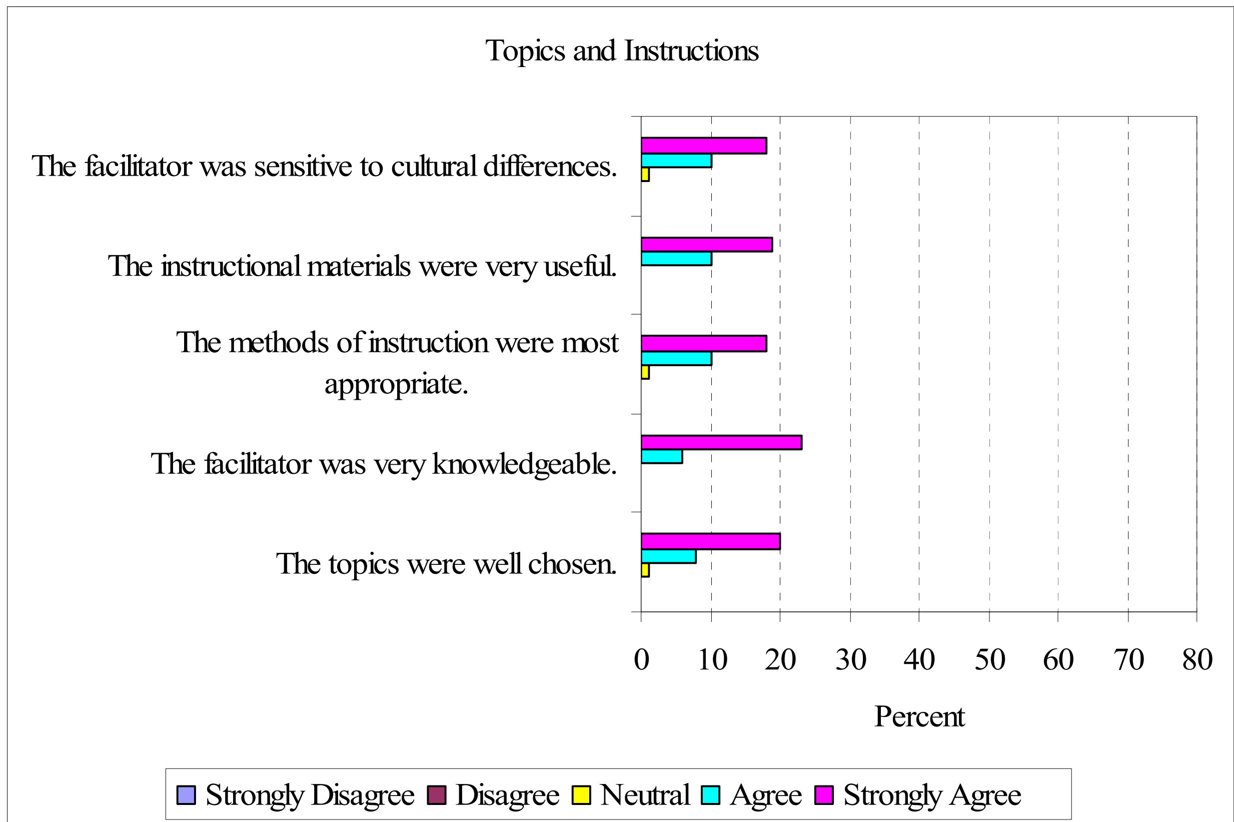


Figure 2: Topics and Instructions

Figure 3 shows responses for several key indicators of personal value. Those rated most highly were: (1) whether the staff had an opportunity to participate (100% strongly agreed); (2) whether the amount of interaction between the participants and presenter was ideal (79% strongly agreed), and (3) whether they would recommend the training to other colleagues (76% strongly agreed).

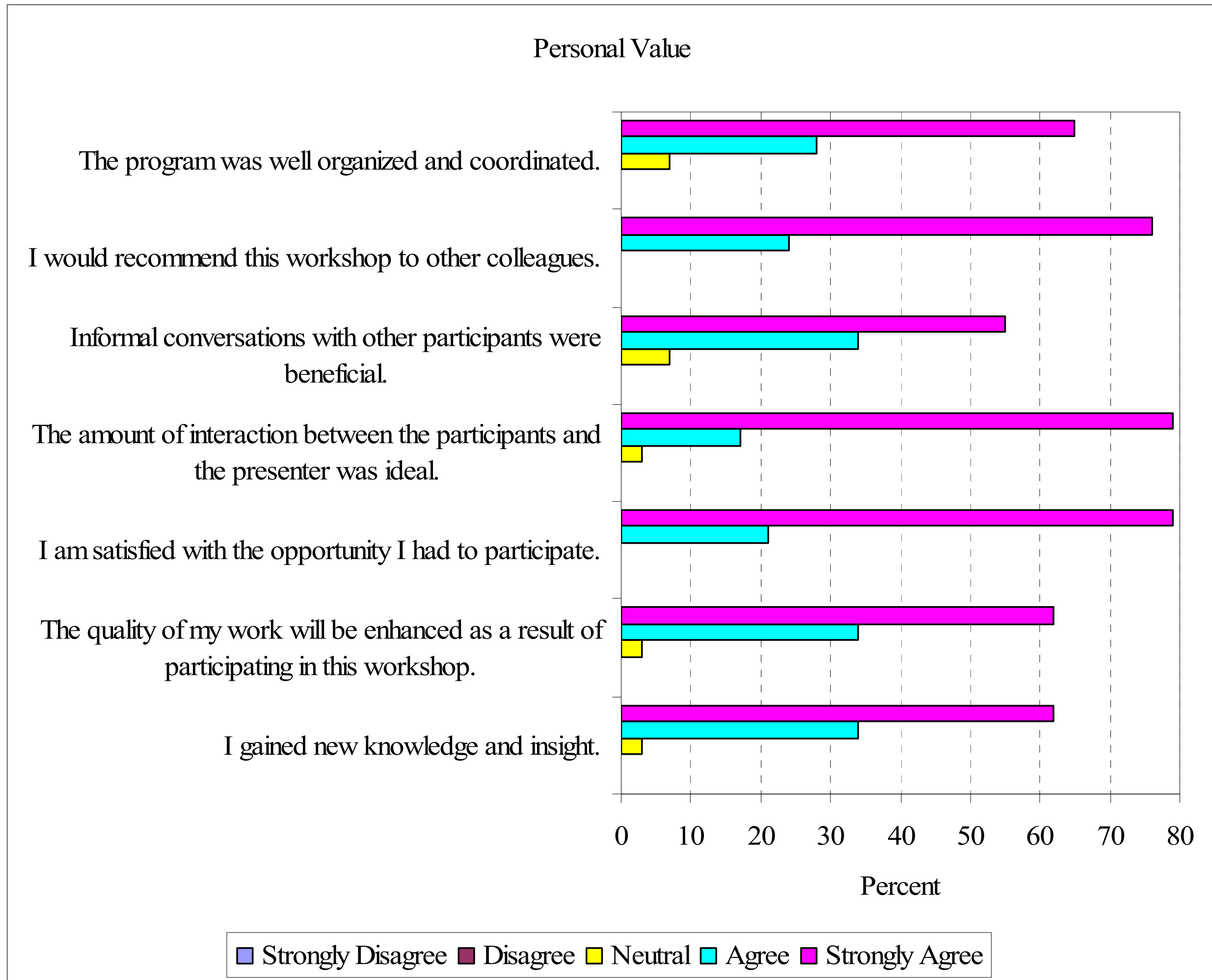


Figure 3: Personal Value

Staff offered slightly lower assessments concerning the organization and coordination of the training and the facilities in which it took place. While 65% of staff strongly agreed that the meeting facility was appropriate for the workshop, less that half strongly agreed that the length of the overall program was appropriate, and that the length of the individual sessions was suitable (Figure 4). In general, staff felt that the sessions were too long and preferred shorter more frequent sessions.

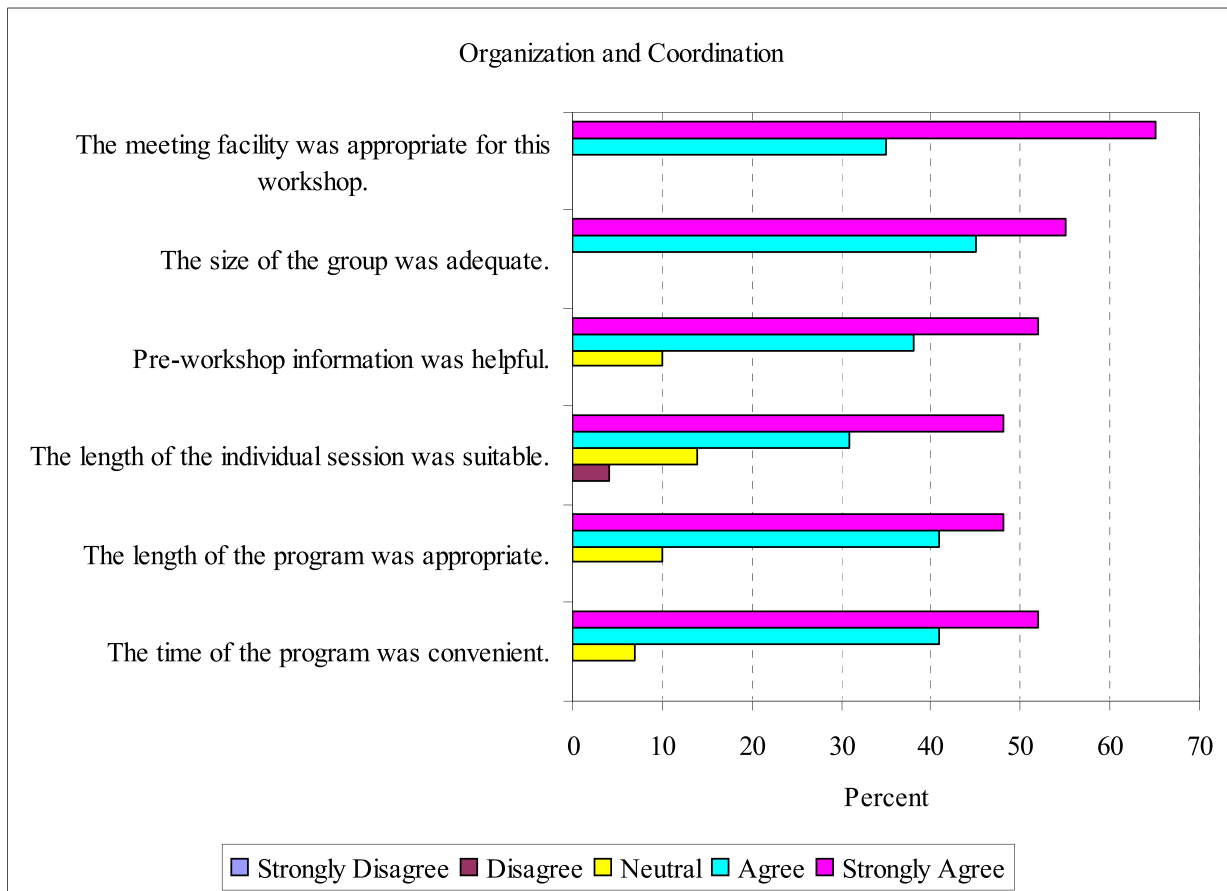


Figure 4: Organization and Coordination

Similarly, less than half of participants strongly agreed that the meeting facility was comfortable and that their personal needs were met (Figure 5).

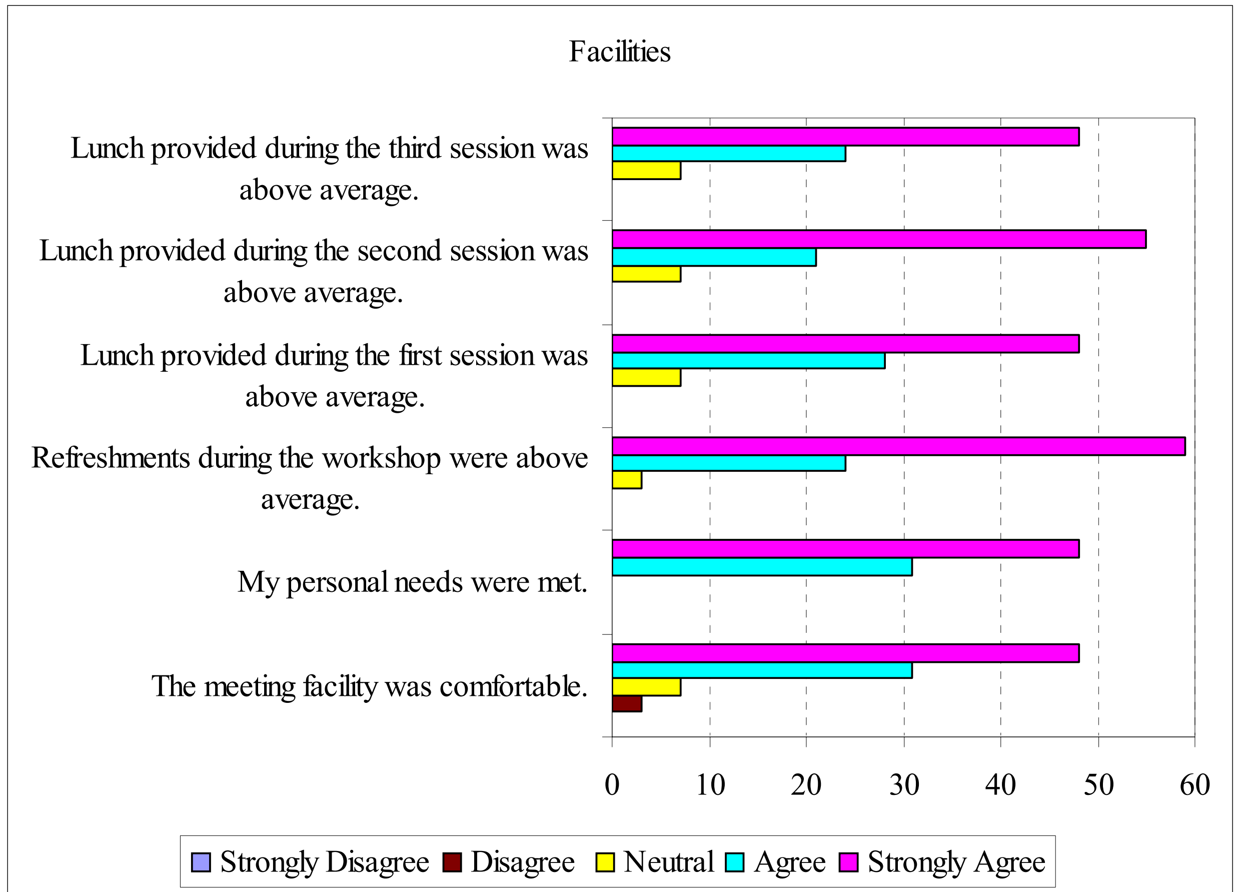


Figure 5: Facilities

Several open-ended questions were included in each of the process evaluations that followed the training sessions. These asked participants to comment on what they found most and least helpful about the training. We conducted a content analysis of these responses and the following themes emerged from an analysis of these comments.

Found to Be Most Useful

Consistently and most frequently mentioned across the three training sessions were aspects of course content. The information on child development and the effect on the brain of maltreatment and trauma were mentioned most frequently, as was the use of behavioral management strategies with children. This was followed by the use of case scenarios and examples to teach behavioral management strategies and the provision of information about the law and domestic violence. Least frequently mentioned was the teaching of parenting strategies to parents and the use of the screening measures.

Found to Be Least Useful

Participants offered significantly fewer comments on drawbacks associated with the training than was the case concerning benefits. Most frequently identified was the scoring of the measures.

Suggested Improvements

Some of the information arising from the written suggestions for improvement echoed the foregoing. Less time between training sessions was one of the suggestions. Another was that scoring and feedback of the measures be done by individuals other than shelter staff members. One shelter suggested a web-based administration and feedback system.

4.5 Post Training Focus Groups with Shelter Staff

After the completion of the pilot intervention, focus groups were conducted with shelter staff at each of the six shelters by independent evaluators. The purpose of the focus groups was to encourage shelter staff to provide candid, in-depth feedback on each component of the project including the quality of training, learning sessions, site visits, conference calls, and the use of the screening tools. Another purpose of the focus groups was to help identify additional barriers to implementation, ways to improve the project, and next steps. Finally, the focus groups were used as a way for shelter staff to share success stories and celebrate successful implementation of the screening tools.

Highlights of these findings are presented below:

Increased focus on children

One of the most prominent themes that emerged from the focus groups was that the information the training provided enabled the participants to focus more on the children. All participants acknowledged that, although unintentional, children were not a focal point of their respective

shelters. Participation in the project allowed the shelter staff to recognize and address issues relating to the children including an awareness of children as victims and the potential negative effects of witnessing domestic violence. One female participant noted:

> *It helped us become more focused off of the parents…and that's one thing all sites forget about: children, the unseen victim, or the forgotten victim. And this helped us realize that even though we thought we were doing a good job focusing on the kids, it helped us become more aware, like I said, of the kids, and make them an active part.*

Value of and applicability of information gained about effects of witnessing domestic violence on children

The staff members of all six domestic violence shelters agreed wholeheartedly that the project team provided invaluable information that served to improve their shelter's functioning, especially when interacting with children. As one participant commented:

> *Well, getting the information about how you can run the shelter more effectively as far as the kids. And the parenting materials, and then they went over the effects of trauma and just all that stuff was good and then having the tools because we never really tried to find anything to screen the children. And now we know, so they don't fall and not get any services.*

Focus group participants informed the moderators that they were able to apply the information they learned to other useful situations including classroom presentations, presentations for continued funding, and parenting groups. The information was also reported to have been useful with parents in classes sponsored by the shelters.

> *I used some stuff in the parenting group, and they seem to be receptive to it. We use the positive parenting, time out…setting limits, active ignoring—that kind of thing.*

Difficulties associated with administering the measures

Focus group moderators asked informants to discuss difficulties associated with implementing the measures. They consistently responded that the assessment tools were initially confusing, albeit less so as trainers provided increased consultation and guidelines to simplify scoring and feedback. Shelter staff found it difficult to discern the scoring mechanisms and became frustrated with the assessment tool usage.

> *Some of the measures were confusing at first, but once we got that straightened out, as it went on, they got better. I think the scoring part of it was probably the most difficult.*

Informants also expressed difficulty introducing the assessments to parents. One informant stated that project training should have included more practice and additional role play with feedback on how to better present the assessments to the parents and answer questions associated with initial findings. Another informant requested additional time to practice scoring the measures and making appropriate referrals based on results. A third informant suggested:

> *I think before they go statewide, they should put the tools on software or either web-based so you can compute or you just put in the scores or you can read it to them and they can tell you the answer and then instead of them circling it and writing it, you just put it right on the computer and it just calculates the score for you. And then that would save time and then maybe that would encourage people to do it more.*

The most common difficulty associated with administering the measures was time. This included short length of time mothers and children are at the shelters, finding the appropriate time to use the assessment tools, and not having enough time to use the tools because of other job obligations. They also acknowledged that the mothers are in crisis situations, and they may have other needs that conflict with assessing the children:

> *When mothers come here, they ask for clothing, food. They go out to look for jobs. The time is not there…time to settle, time needed to start drug treatment, kids need time; they change schools, settle down…and then they are gone. It's an emergency shelter; people don't stay long.*

Preferences

Of the three questionnaires that were introduced by the project team, the Strength and Difficulties Questionnaire (SDQ), the Parent's Evaluation of Developmental Status (PEDS), and the Post Traumatic Stress Disorder Inventory (PSDI), focus group participants at all shelters expressed an inclination toward the SDQ and PEDS. According to informants, these two provided the most useful information and were the easiest to administer.

> *The Strength and Difficulties—I love that! I thought that was really good. I like the way the questions were spread out. I found the PEDS measure to be most valuable, and there was an area that they (the parent) could comment and be more open to the problem.*

Although focus group participants acknowledged the value gained through the information provided by the PSDI, the use of this questionnaire brought about the most difficulty. The staff expressed confusion with using this questionnaire and also a concern that mothers were taken aback when assessed and directly queried about posttraumatic stress and traumatic experiences.

Increased community resource contact/increased number of referrals

As a result of participation in the domestic violence shelter project, almost all shelter staff responded that their interactions and communication with community resources improved. Shelter staff announced that they now make more referrals to community resources and make them more quickly after completion of the project. One staff informed the moderators, "We made more referrals." Another described the following scenario:

> *Now, we can jump in there within about 72 hours or so. We've got to get it done at least within that, and we've got a child advocate. We do the tool and get a much more in depth idea of the child's needs. We can jump on those referrals and actually be there to help mom implement them while she's still with us or if she's planning to relocate to another*

community, give her a written summary to take with her because if she's in crisis, she's not going to remember all the things we've discussed. This is the assessment tool that this pilot project designed.

Plans for future use

All shelters expressed a desire to continue using the measures. One shelter leader, during the focus group, made an executive decision that the measures would become permanent additions to the client intake process.

I do plan on using them. Like I said before, it's an easy way to sit down with the mom. I think they have definitely become a part of our program, and I think they're going to stay.

Length of training

A dominating preference was that there should have been more than three training sessions, but of shorter time durations than the three that the participants attended. Because domestic violence shelters are such small agencies, it was difficult for all staff to attend sessions without concerns of leaving the shelter insufficiently staffed.

Quality of the Training

Participants in all six focus groups agreed that project trainers were very well organized and prepared. The participants commented that, although a wealth of information was presented, the organization of the information allowed for easy digestion and comprehension.

Participants from all shelters agreed that the training team was highly accessible and that the answers to their questions were only a phone call or e-mail away. These groups commented on the speed with which they received answers to their questions, whether via phone message or e-mail message from the project team

The informants were also asked to discuss their level of comfort with expressing their ideas during the training. Five of the six focus groups' participants expressed confidence that their ideas were heard and that team members were open to feedback about how to improve the session.

4.6 Pre/Post Test Findings

Staff Knowledge about the Effects on Children of Witnessing Domestic Violence

Thirty shelter staff (70%) of the 46 participants who originally enrolled in the project completed the post test which was administered at each site immediately following learning session 3. Shelter staff scored moderately high in their knowledge about the effects on children of witnessing of domestic violence on the pre-test (mean of 14 out of 18 items correct). Therefore, it is not surprising there was no statistically significant increase in the overall mean score on shelter staff knowledge about the effects on children of witnessing domestic violence from pre-test to post test. However, there were positive and statistically significant changes from pre- to post test on two individual items:

- *Children who have been chronically exposed to DV from a young age are at risk for having a lower IQ than those who have not (p=0.001); and*

- *School age children who view their parents as scary are likely to take a controlling stance with peers (p=0.04). (Table 2).*

One of the primary learning objectives of the training was: Staff will show increased recognition of the impact of trauma on children's brains and its effects on their cognitive, social, emotional behavioral and social development. The findings above support the conclusion that this learning objective was partially met. High pre-test scores limited the potential for improvement in scores.

Table 2: Knowledge about the Effects on Children of Witnessing Domestic Violence

N = 30	Pre Mean	Post Mean	T test Results	P Value
Children who have been chronically exposed to DV from a young age are at risk for having a lower IQ than those who have not.	0.61	0.90	3.67	0.0012
School-age children who view their parents as scary are likely to take a controlling stance with peers.	0.74	0.93	2.13	0.0430

Staff Use of Behavioral Management Strategies with Children

A second major learning objective of training was that staff would recognize three pertinent emotional needs of children residing in shelters (i.e. the need for consistency and predictability, the need to address child trauma symptoms with the child, and the need for positive parent interactions). Consistent with this learning objective, shelter staff reported:

- *More frequent discussion with children about post traumatic stress and its effects (p = 0.026), and*

- *Less confrontation with children who make inappropriate comments (p = 0.14 trend) (Table3).*

Table 3: Staff Use of Behavior Management Strategies with Children

N = 30	Pre Mean	Post Mean	T test Results	P Value
Teach children about posttraumatic stress.	0.92	1.25	1.16	0.0261
Confront children who make inappropriate comments.	2.41	2.11	-1.49	0.148

Staff Teaching of Behavioral Management Strategies to Parents
A third learning objective of training was: Staff will increase their repertoire of and frequency with which they teach effective parenting strategies to parents. Shelter staff significantly increased their teaching of three behavioral management strategies to parents residing in the shelter from Time 1 to Time 2. These included:

- *Teaching parents how to actively ignore (p =<0.01) ;*

- *Teaching parents which behaviors are appropriate to ignore (p =0.056) ; and*

- *Teaching parents to praise the opposite of misbehavior (p = 0.03) (Table 4).*

Thus, shelter staff has successfully integrated several new and positive teaching strategies into the shelter to inform and/or coach parents in how to curb children's undesirable behavior through non-violent means.

Table 4: Staff Teaching of Behavioral Management Strategies to Parents

N = 30	Pre Mean	Post Mean	T test Results	P Value
Teach parents how to actively ignore.	0.77	1.85	4.71	<.0001
Teach parents which behaviors are appropriate to ignore.	1.37	1.93	2	0.0561
Teach parents to recognize times when children are not misbehaving.	1.85	2.37	1.56	0.1307
Teach parents to praise the opposite of misbehavior.	1.89	2.41	2.18	0.0396

Staff Use of Mental Health Resources for Children

One of the findings from the baseline survey was staff's limited knowledge of mental health resources in the community specifically for children. Project staff was aware of and participants referenced some of the effects that the state's overhaul of the mental health system had on their local communities, and, how those changes might be reflected in their knowledge of local resources. Nevertheless, project staff promoted as learning objectives raising staff awareness of the name and location of the Local Management Entity and the Children's Developmental Services Agencies, available services, and methods for accessing them. As a result of training staff reported:

- *More frequent referral to their local LME from Time 1 to Time 2 ($p = 0.04$)*
- *More frequent referral of children to the CDSA ($p = 0.13$ trend) and*
- *Increased use of screening tools to make decisions about children's shelter care ($p = 0.014$) (Table 5).*

These findings support the conclusion that the training objective to increase the frequency that staff interacts with and refers children to mental health resources was met.

Table 5: Staff Use of Mental Health Resources for Children

N = 30	Pre Mean	Post Mean	T test Results	P Value
How often do you refer to your local LME?	1.04	1.87	2.21	0.047
How often do you refer children to the CDSA?	0.81	1.25	1.56	0.1378
Use screening tools to make decisions about children's shelter care?	1.18	1.96	2.63	0.0147

Staff Self-confidence to Use Screening Measures

The fifth learning objective involved the goal that staff would report greater self-confidence in using screening tools to evaluate children exposed to domestic violence. To accomplish this objective, a considerable amount of time during each of the sessions was devoted to identifying barriers to using the screening tools and ways to overcome them. Barriers identified included: the length of and reading level of the screening tool, and perceived complexity of scoring. To address these barriers, the wording and scoring system related to some items was simplified and additional training time was spent demonstrating correct use of the measures, followed by practice and feedback during sessions, conference calls, and the site visit. On the post test as on the pre-test, staff was asked to indicate their level of confidence to use screening tools to evaluate trauma in children exposed to domestic violence before and after training using several Likert Scale questions. The response categories were: (1) not confident; (2) a little confident; (3) somewhat confident; (4) very confident and (5) completely confident.

There were statistically significant increases from Time 1 to Time 2 in staff self-confidence to:

- *Correctly administer, score, and interpret results of an instrument to measure PTSD in children ($p < 0.01$) and*

- *Correctly administer, score, and interpret results of an instrument that measures other symptoms of mental illness in children ($p<0.01$) (Table 6).*

In addition, staff reported increased self-confidence to recognize symptoms of mental illness in children due to exposure to domestic violence ($p = 0.006$). Thus the fifth learning objective was met as a result of training.

Table 6: Staff Self-confidence to Use Screening Measures

N = 30	Pre Mean	Post Mean	T test Results	P value
I can correctly administer an instrument that measures post traumatic stress in children.	2.22	3.65	5.86	<.0001
I can correctly score an instrument that measures post traumatic stress in children.	2.00	3.69	6.69	<.0001
I can correctly interpret the results of the score to make a behavioral management decision.	2.07	3.83	7.19	<.0001
I can recognize other symptoms of mental illness in children due to exposure to domestic violence.	2.81	3.57	2.94	0.0067
I can correctly administer an instrument that measures other symptoms of mental illness in children.	2.30	3.59	4.66	<.0001
I can correctly interpret the results of the score to make a behavioral management decision.	2.18	3.59	5.05	<.0001

4.7 Screening and Referral Findings

Sheltered Children

Four hundred and twenty-three children were sheltered at the six shelter sites over the course of the pilot project: January 1 2006 – December 31, 2006. The average number of children residing at each shelter per month was 5.9 (range 2.67 – 12.42).

- 56% of the children were female and 44% were male
- 35% were ages 0-3 years
- 23% were ages 4-7 years
- 24% were ages 8-11 years
- 18% were ages of 12-17 years

The ethnic breakdown was as follows:

- 22% African-American
- 32% white
- 12% Hispanic
- 8.1% multi-racial
- 6.0% not reported

Characteristics of Children Assessed

- *The average age of children assessed across shelters during the assessment period was 7.23 years (age range 0.6-17.5 years).*

- *There were no statistically significant differences in gender, ethnicity, or age between children sheltered during 2006 and those who also were assessed during the same period.*

Child Assessment and Referral Rates Any Measure

Table 7 shows the number of children eligible for assessment during the time that we monitored implementation of shelter measures by staff. Between June 1, 2006 and December 9, 2006, 273 children were eligible for assessment. This figure represents 65% of the 423 children sheltered across the 6 pilot sites during 2006. Of those children eligible,

- *109 (39.9%) were assessed using any one of three measures on which staff was trained.*

- *36.7% of those assessed were referred for follow-up services.*

Table 7: Child Assessment and Referral Rates Any Measure

Shelter	Eligible		Assessed		Clin.Sign./At-risk-Any Meas.		Referred/Assessed	
	N	%	N	%	N	%	N	%
Caldwell	64	23.4	36	56.3	18	50	23	63.9
Guilford	91	33.3	16	17.6	10	62.5	12	75
Halifax	20	7.3	7	35	5	71.4	0	0
Robeson	44	16.1	29	65.9	8	27.6	0	0
Vance	17	6.2	12	70.6	4	33.3	0	0
Wilson	37	13.6	9	24.3	4	44.4	5	55.6
Total	273	100	109	39.9	49	45	40	36.7

Shelter Variation in Assessment Rates, Any Measure

There was considerable variation among shelters in the number of children eligible for assessment and those actually assessed on any measure. The Guilford county shelter had the highest number of children eligible for assessment, yet their assessment rates were relatively low. Caldwell County, on the other hand, had many eligible children for assessment and shelter staff there was able to assess more than half those eligible. The Robeson and Vance county shelters also assessed more than half of its eligible children over the course of the assessment period. The Wilson county shelter assessed the least number of children eligible followed by the Halifax county shelter.

Shelter Variation in Referral Rates, Any Measure

Referral rates among the county shelters were moderately high for three of the shelters: Guilford referred 75% of children assessed on any measure; Caldwell referred 64% of children assessed on any measure, and Wilson referred 55% of children assessed on any measure.

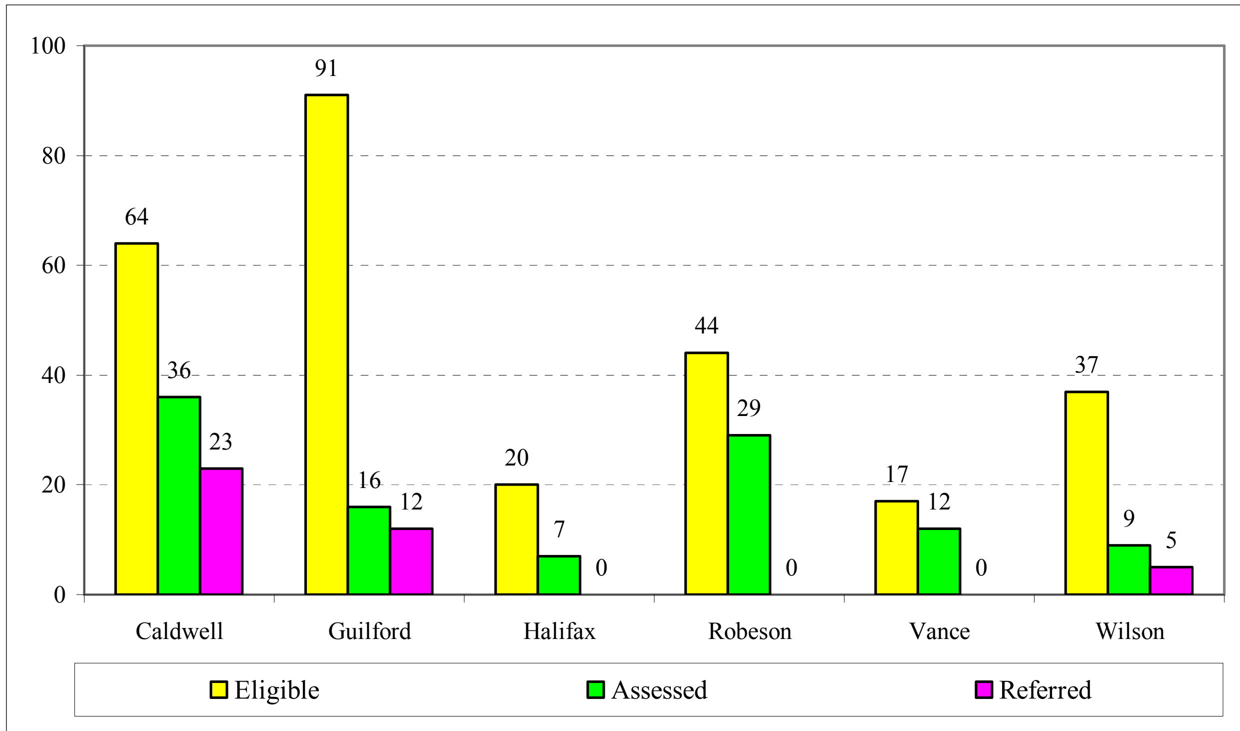


Figure 6: Graphic Representation: Child Eligibility, Assessments, and Referrals, Any Measure

Referrals of Children Clinically Significant/At-risk Any Measure

Table 8 shows the percentages of children that scored in the clinically elevated or at-risk range on any measures at each shelter, and their respective referral rates.

- *45.0% of children assessed scored in a clinically elevated or at-risk range on at least one of the three measures*

- *46.9% of children that scored in this range were referred for follow-up services*

There were considerable differences in referral rates by each county shelter. The Guilford county shelter had the highest referral rate (80%) of children that scored in a clinically elevated or at-risk range on any measure followed by Wilson (75%), and Caldwell (66.7%). One reason that Guilford County and Wilson County shelters had high referral rates may have been due to the presence of therapeutic services at these sites.

Table 8: Clinically Significant/At-risk Any Measure, Referred

Shelter	Eligible		Assessed		Clinical Significant/At-risk - Any Measure		Referred	
	N	%	N	%	N	%	N	%
Caldwell	64	23.4	36	56.3	18	50.0	12	66.7
Guilford	91	33.3	16	17.6	10	62.5	8	80.0
Halifax	20	7.3	7	35.0	5	71.4	0	0.0
Robeson	44	16.1	29	65.9	8	27.6	0	0.0
Vance	17	6.2	12	70.6	4	33.3	0	0.0
Wilson	37	13.6	9	24.3	4	44.4	3	75.0
Total	273	100	109	39.9	49	45.0	23	46.9

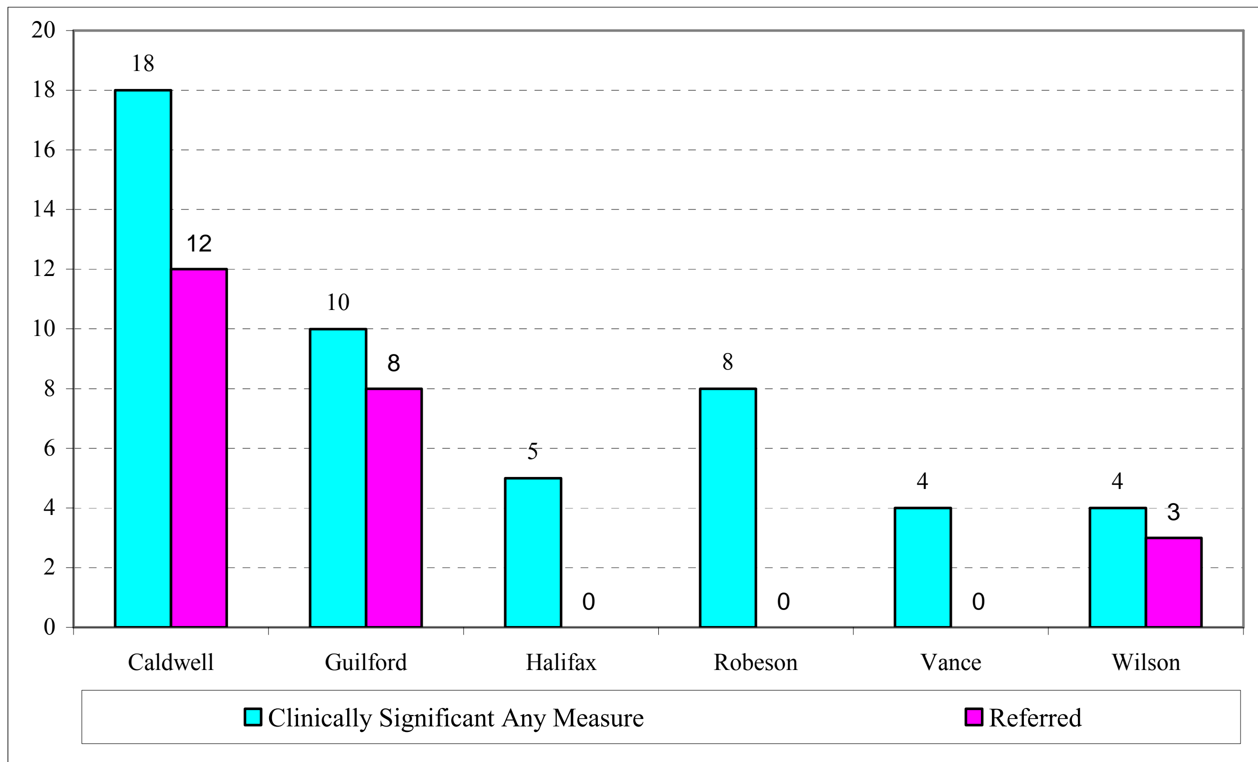


Figure 7: Graphic Representation: Clinically Significant/At-risk Any Measure, Referred

Assessments by County and Month

Figure 8 shows assessment patterns for each shelter by month starting in March. The greatest number of assessments occurred during the months of July and October. These months correspond to the months in which learning sessions 2 and 3 took place respectively.

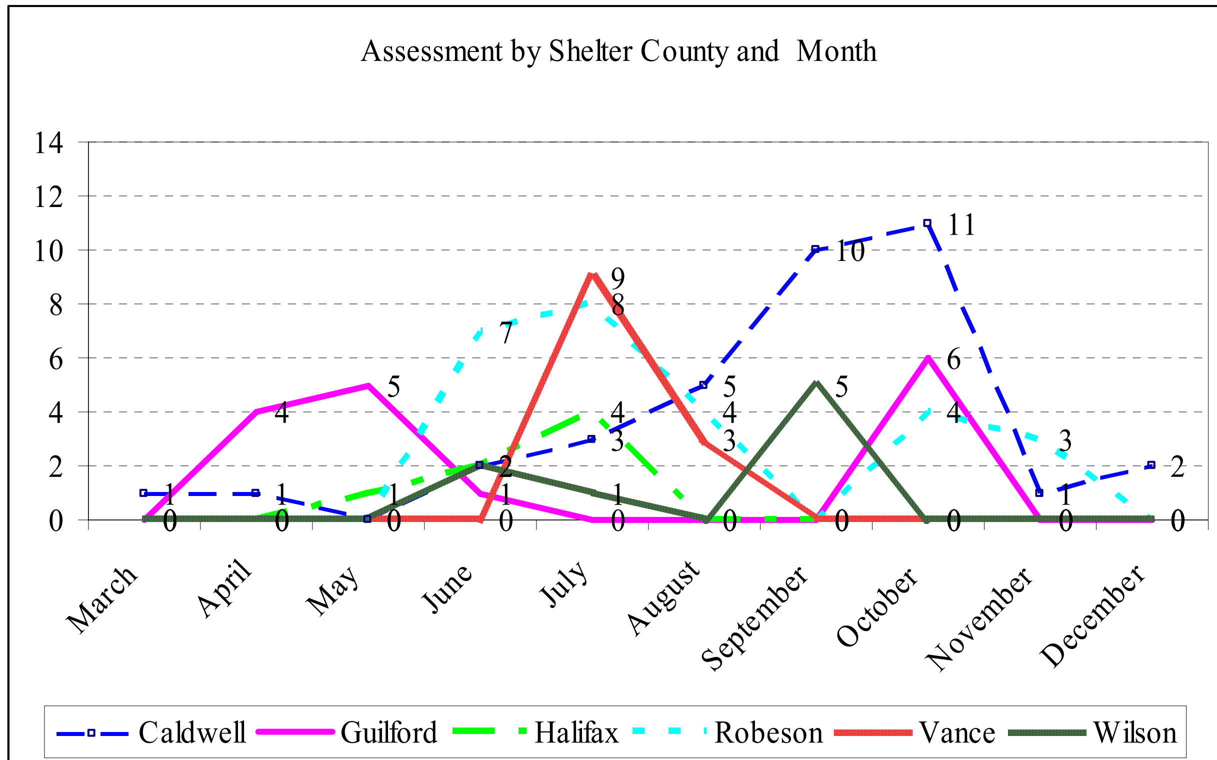


Figure 8: Assessments by Shelter (County) and Month

Table 9: Assessment by Shelter (County) and Month

2006	Caldwell	Guilford	Halifax	Robeson	Vance	Wilson	Total
Date	**N**	**N**	**N**	**N**	**N**	**N**	**N**
March	1	0	0	0	0	0	1
April	1	4	0	0	0	0	5
May	0	5	1	0	0	0	6
June	2	1	2	7	0	2	14
July	3	0	4	8	9	1	25
August	5	0	0	4	3	0	12
September	10	0	0	0	0	5	15
October	11	6	0	4	0	0	21
November	1	0	0	3	0	0	4
December	2	0	0	0	0	0	2
Total	36	16	7	26	12	8	105

Types of Referrals (N = 40)

Shelter staff completed only one cover sheet per child no matter how many assessment tools were administered on the child. As a result, if a referral was made, we were unable to link it to the specific measure that may have triggered the referral. In addition, some shelter staff referred children for follow-up services even if there was no clinically significant or at-risk score on a measure. Of the 139 children assessed, referral information was documented on 40 children (29%). Of these:

- Twenty-eight children (70.0%) were referred to a single agency;
- Eleven children (27.5%) were referred to two agencies;
- One child (2.5%) was referred to three agencies;
- Twenty-one children (52.5%) were referred to individual assessment and counseling at a mental health agency;
- Fourteen children (35.0%) were referred for family resources;
- Six children (15.0%) were referred for group counseling;
- Four children (10.0%) were referred to the health department;
- One child (2.5%) was referred to tutoring;
- One child (2.5%) was referred to DSS; and
- Five families (3.4%) were referred to parenting classes.

Assessments and Referrals: Strengths and Difficulties Questionnaire

One hundred sixty-four (60%) of children at the shelter between June 1, 2006, and December 9, 2006, were eligible for assessment using the Strengths and Difficulties Questionnaire. The eligibility criterion for this questionnaire was that children fall between the ages of 3 and 17 years. Of those eligible, 47.6% were assessed using the parent version of this questionnaire. Of those assessed,

- *35% scored in the clinically significant or at-risk range on the Total Difficulties Scale.*

- *44% of those in the clinically significant or at-risk range were referred for follow-up service (Table 10.)*

Table 10: Assessments and Referrals Total Difficulties Scale-SDQ

All Shelters	Eligible Children		Assessed		Clinically Sig/At-risk		Clinically Sig/At-risk Referred	
	N	%	N	%	N	%	N	%
Total	164	99.9	78	47.6	27	35.0	12	44.0

Assessments and Referrals: Posttraumatic Stress Disorder Index (PSDI)

Ninety-eight (36%) of children at the shelter between June 1,and December 9, 2006, were eligible for assessment using the PSDI. The criterion for eligibility was that children fall between the ages of 7 and 17 years. Of those eligible,

- *55.1% were assessed using the parent version of this questionnaire.*
- *7.4% scored in the clinically significant or at-risk range on the Overall Severity Score and 25% were referred for follow-up services (Table 11).*

Table 11: Clinically Significant or At-risk Referrals Overall Severity Score

All Shelters	Eligible Children		Assessed		Clinically Sig or At-risk OS		Clinically Sig or At-risk OS Referred	
	N	%	N	%	N	%	N	%
Total	98	99.9	54	55.1	4	7.4	1	25

Assessments and Referrals: Parents' Evaluation of Developmental Status (PEDS)

The Parents' Evaluation of Developmental Status Survey (PEDS) is designed for children who fall between the ages of 0 and up to age 8 years. However, we suggested that shelter staff use it to assess children from ages 0 to 3 years, an age group for which we initially had no assessment tool. The PEDS was not introduced until the end of learning session 2, and therefore was not available for use until August 1, 2006. One-hundred and six (39%) of children at the shelter between August 1, and December 9, 2006, were eligible for assessment using the PEDS. Of those eligible,

- *26% were assessed using the parent version of this questionnaire.*
- *50% scored in the clinically significant or at-risk range on one or more indicator of developmental delay.*
- *All (100%) that scored in the clinically significant range were referred for follow-up evaluation services (Table 12).*

Table 12: Clinically Significant and At-risk Referrals PEDS

All Shelters	Eligible Children		Assessed		Clinically Sig/At-risk		Clinically Sig/At-risk Referred	
	N	%	N	%	N	%	N	%
Total	106	99.9	28	26.4	14	50.0	14	100.0

Additional findings regarding patterns of mental health by child's age and developmental status can be found in the Appendix in Tables 13 – 23.

5. Follow up Evaluation of Project Sustainability

5.1 Methods

We used the **RE-AIM** model as the basis for developing our follow-up evaluation of project sustainability/maintenance (Glasgow, 2002). The central thesis of the model is that public health programs require evaluation on five dimensions, which interact at different levels, in order to determine their overall public health impact. These dimensions are:

- **R**each: Participation rate and representativeness of the participants;
- **E**fficacy: Effects on primary outcomes of interest including quality of life and negative effects;
- **A**doption: Participation rate among possible settings; representativeness of settings;
- **I**mplementation: Extent to which the program was delivered as intended; and
- **M**aintenance: a) Individual-level - long-term effects of the program (≥ 6 months); and b) Site level - extent of continuation or modification of the program into structure and function of the setting.

During Year 1 of the Domestic Violence Shelter Screening Project, we evaluated the project's reach, efficacy, adoption, and implementation. During Year 2 we evaluated program maintenance/sustainability which we defined as the degree to which the project has been integrated into the shelter's daily functioning at the individual and site level.

At the individual level, we sought to determine the extent to which shelter staff continued to:

1. Demonstrate increased knowledge of the effects on children of witnessing domestic violence;

2. Use new behavioral management strategies with children;

3. Use new parenting strategies with parents;

4. Work with new community partners (e.g., Children's Developmental Services Agencies (CDSAs), Child Service Coordinators (part of every county Health Department), and mental health services (Local Management Entities) in order to refer and respond to the service needs of children;

5. Remain confident in the ability to use the screening tools to assess, score and appropriately refer children to services; and

6. Apply screening and referral measures in the shelter setting.

At the site level, we sought to answer the following questions:

1. To what extent has screening and referral been integrated into the structure and functioning of the shelter?

2. How have screening and referral procedures been modified over time?

3. What barriers continue to impede the integration of screening and referral into the shelter's functioning, and what do shelters do to address them?

To answer these questions, we contacted shelter pilot sites in January 2007 requesting their continued participation in the project. In June 2007 shelter directors and staff at all six sites were re-consented and administered a follow-up survey (See Appendix). We also collected demographic data on children sheltered and measures administered between January 1 and June 30, 2007.

5.2 Data management and analysis

All quantitative data was analyzed using the Statistical Analysis System, Version 9.1.3. Descriptive data was used to summarize the demographic characteristics of staff in the follow-up evaluation. Data from the post test questionnaire was examined to re-assess staff use of behavioral management strategies with children and parents, staff referral of parents and children to community services providers, and staff self-efficacy to screen and refer children for services. Mean scores for each variable were calculated within and across sites. ANOVA was used to assess differences in mean scores on survey items from pretest/baseline (Time 1), to post test (Time 2) and six-month follow-up (Time 3). To assess site level maintenance we rated each shelter on each of six dimensions of sustainability drawn from the organizational literature and created a dimensional and total score for each shelter. To measure barriers to and additional factors thought to promote sustainability, we analyzed open and closed ended questions also drawn from the organizational literature.

6. Follow-up Evaluation Findings

6.1 Attrition and Participation Rates

A significant loss of staff occurred at the shelters between January 1, 2007, and June 30, 2007. During that time, three of the sites had a turnover in directors; one of those sites experienced turnover twice in the director's position. Additionally eight staff across the 6 shelter sites left their positions for a total loss of 12 staff between January 1, 2007, and June 30, 2007. The attrition rate during year 2 was 26%; during the previous pilot year of the project the attrition rate was 21%. Thus, during the 2 years that this project took place, nearly 50% of the original staff turned over.

Nineteen (41%) of the original 46 shelter staff members and directors completed the project questionnaire at 3 time points – at pre intervention (Time 1) , post intervention (Time 2) and 6 months after the post intervention assessment (Time 3). The findings reported below are drawn from the follow-up survey administered at Time 3 and are based on reports from these 19 individuals.

6.2 Individual Level Findings

To what extent did staff continue to demonstrate changes in knowledge about the effects on children of witnessing domestic violence?

As in previous assessments, there was no statistically significant change in the mean score on the index of staff knowledge of the effects on children of witnessing domestic violence at the time of the follow-up survey. This was primarily due to a high mean index scores at baseline. One item remained statistically significant at follow-up: Children who have been chronically exposed to DV from a young age are at risk for having a lower IQ than those who have not ($p<.05$ (Appendix, Table 24).

To what extent did staff continue to use new behavioral management strategies with children?

Shelter staff was taught a variety of new behavioral management skills to use with children during the training. At the end of training, we found statistically significant and positive changes in staff use of two behavioral management strategies with children: (1) teaching children about posttraumatic stress; and (2) confronting children who make inappropriate comments. These findings were not sustained at follow-up (Appendix, Table 25).

To what extent did staff continue to use new parenting strategies with parents?

Many parenting strategies taught to staff during training were sustained at follow-up. These included teaching parents: (1) how to actively ignore children; (2) which behaviors are appropriate to ignore; and (3) how to praise the opposite of misbehavior. Two strategies showed a trend toward statistical significance at follow-up: (1) teaching parents how to give effective commands; and (2) teaching parents how to use time out (Appendix, Table 26).

To what extent did staff continue to work with new community partners to refer and respond to the service needs of children?

Increases in staff referral of children to their local mental health entities (LMEs) and Children's Developmental Services Agencies (CDSAs) were not sustained at the time of the follow-up evaluation. Staff referral of children for legal aid services and referral of children for tutoring were the only referral activities that showed sustainability at the time of the follow-up evaluation (Appendix, Table 27).

To what extent did staff remain confident in the ability to use the screening measures?

Staff continued to report high self confidence to (1) correctly use an assessment measure to identify post traumatic stress (PTSD) in children, (2) correctly score an instrument that measures PTSD in children, and (3) correctly interpret the results of the score in order to make a behavioral management decision at the time of the follow-up evaluation. Staff also continued to report high self-confidence to correctly interpret the results of scores on an instrument that measures other symptoms of mental illness in children in order to make a behavioral management decision (Appendix, Table 28).

To what extent did staff continue to use screening and referral measures at the shelter?

Staff from five of the six shelters reported that screening is still ongoing. However, despite frequent contact and encouragement, only two of the shelters submitted documentation to validate use of the screening measures. While we have no reason to doubt their reports about use of screening tools, we have noted inconsistent documentation of programmatic activity across shelters that include screening, intake results, and other aspects of shelter care. Nonetheless, we lack the documentation to verify the reports of screening use in the other four shelters.

6.3 Site Level Findings

To what extent has screening and referral been integrated into the structure and functioning of the shelter?

In our original proposal we planned to ask site level questions about sustainability only to shelter directors at each pilot site. However, due to the large turnover of shelter directors, we decided to extend the questions to "key informants" (e.g., individuals at the shelter who had assumed positions of authority in the absence of a director or individuals who were most likely to have familiarity with the administration of the screening measures). As a result, three individuals were surveyed at Caldwell, three individuals at Guilford, two individuals at Halifax, three individuals

at Vance, five individuals at Wilson and only one individual (the sole staff member) at Robeson for a total of 17 individuals answering site level questions.

For each item, shelter staff was asked "…to circle the degree to which it was "like" your shelter." The range was a four point scale (0 = Not at all; 1 = A little; 2 = Somewhat; and 3 = A lot). The results were calculated as means with standard deviations in parentheses below the mean for each subscale and for the total scale.

We used Pluye and colleagues' model of program sustainability in order to develop a scale to assess the level of sustainability of screening and referral at the shelter level (Pluye et al., 2004). Pluye and colleagues proposed that it is the presence of "routinized activities" that promote sustainability and that these activities have four characteristics: *memory; adaptation; values*; and *rules.* The first four sub-scales of our sustainability scale ask questions about these characteristics as they apply to the integration of screening and referral into the shelters' daily activities. We added a fifth sub-scale to measure the level of integration of *community partners* into the shelters' screening and referral activities, and a sixth sub-scale to measure the degree to which shelters have *internet capability* (in order to gauge the potential for future use of the internet as a shelter resource for screening and referral). All scales were tested for internal consistency using Cronbach's Alpha and had moderate to high scores ranging from 0.68 to 0.95. Our site level findings for these six dimensions of sustainability are summarized below. Detailed findings for items comprising each sub-scale can be found in Appendix, Tables 29-35).

Shelter Memory

We defined shelter memory as the degree to which **human, material and financial resources** (support and maintenance functions) are in effect at the shelters to conduct screening and referral. The items we developed to measure shelter memory are:

- *The budget includes separate funds to employ key personnel necessary to carry out screening and referral.*
- *There is a permanent position designated for screening and referral.*
- *We have more than one person trained to do the screening.*
- *We have an interpreter to make sure screening can be implemented with non-English speaking families.*
- *There is a supervisor assigned to oversee administrative responsibilities for screening.*

To what extent are human, material, and financial resources in effect at the shelter to conduct screening and referral?

Figure 9 shows that four of the six shelters had mean memory scores above 2.0 indicating a fairly high degree of resources committed to continue screening and referral. Two key training objectives: (1) cross training of multiple staff; and (2) a supervisor assigned to oversee

administrative responsibilities for screening was reported by 4 of the 6 shelters at the time of the follow-up survey. Three of the shelters reported that a permanent position had been designated for screening and referral. However, only two shelters reported that a budget was somewhat in place that included separate funds to employ key personnel necessary to carry out screening. An unanticipated finding was that all shelters reported an interpreter in place to make sure that screening could be implemented with non-English speaking families. We did not inquire whether this staff was trained specifically to administer the measures or serve more generally as a translator for other personnel (Appendix, Table 29).

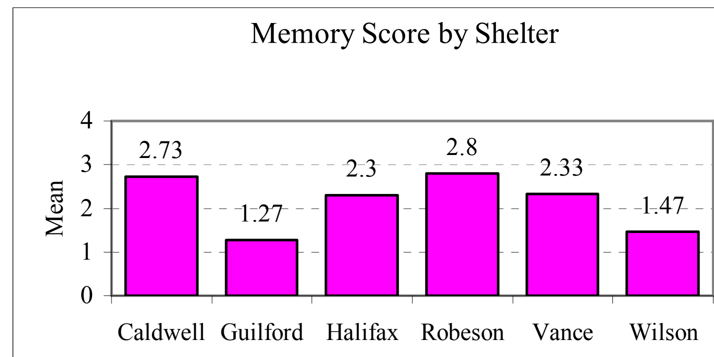


Figure 9: Memory Score by Shelter

Shelter Adaptation

We defined adaptation as the degree to which routine activities at the shelter have been modified to accommodate screening and referral activities. The items we developed to measure shelter adaptation are:

- *We have made changes in our intake procedures to incorporate screening into the shelter's daily functioning.*
- *We have made changes in our client records to document screening results and referrals.*
- *We have incorporated the results of screening into our annual report.*
- *We have changed the staff's schedule in order to implement the screening procedures.*
- *We have adapted the use of the screening tools to the comfort level of the staff.*
- *We have identified ways to reduce the time it takes to screen children.*

To what degree have routine activities at the shelter been modified to accommodate screening and referral activities?

Figure 10 shows that shelters consistently scored lower on the degree to which routines were modified to integrate screening and referral into daily activities. Only one shelter (Halifax) had a mean score above 2.0 on this sub-scale. The only measure of adaptation that was reported by most of the shelters was client recordkeeping to document screening and referrals. Four of the six shelters reported modifying their shelter routine to integrate this practice. Three shelters reported making changes to intake procedures to incorporate screening into daily functioning and to adapt the use of the screening tools to the comfort level of the staff (Appendix, Table 30).

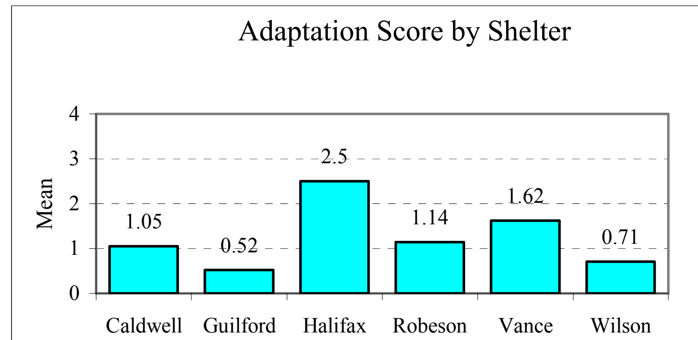


Figure 10: Adaptation Score by Shelter

Shelter Value

We defined value as the degree to which screening and referral is positively and collectively valued at the shelter. The items we developed to measure value are:

- *The shelter director supports the use of the screening tools.*
- *We have incentives or rewards that encourage our staff to carry out screening and referral.*
- *We continue to implement screening in spite of cost in terms of time and effort on part of staff.*
- *Our relationships with other agencies in the community have been enhanced as a result of screening and referral.*

To what degree is screening and referral positively and collectively valued at the shelter?

Figure 11 shows that four of the six shelters had a mean value scores above 2.0 indicating a fairly high collective value was placed on screening and referral. In particular, staff across four of the six shelters reported high degrees of shelter director support to use screening tools and staff commitment to continue to implement screening in spite of cost in terms of time and effort. Staff across all shelters reported few incentives or rewards to carry out screening and referral, which diminished the mean overall value score (Appendix, Table 31).

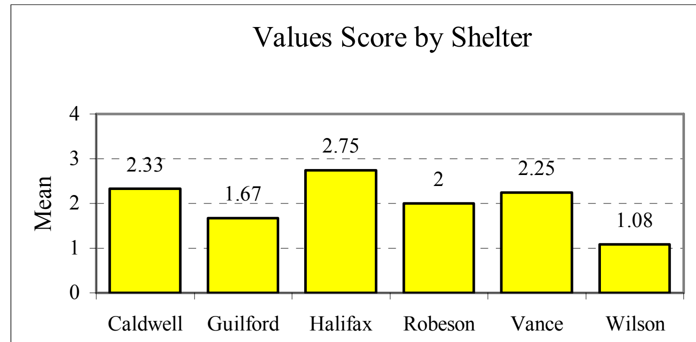


Figure 11: Value Score by Shelter

Shelter Rules

We defined shelter rules as the written procedures governing decision-making and action that account for "…the way things are done" at the shelter. We limited most of the rules questions to the use of the DVS Toolkit that was provided to each shelter at the end of training. The items we developed to measure rules are:

- *The Tool Kit has been viewed by all staff at the shelter.*
- *We use the Tool Kit to train all new shelter staff.*
- *The Tool Kit is used as a reference resource by existing shelter staff.*
- *We hold meetings periodically related to screening and referral.*
- *A protocol has been written by our shelter that describes how screening should be conducted.*

To what extent has the DVS Toolkit been integrated into the structure and functioning of the shelter?

Figure 12 shows that three of the shelters had rules somewhat in place about the use of the Tool Kit. Among those with rules somewhat in place at the time of the follow-up evaluation, the tool kit was routinely viewed by staff, routinely used to train new shelter staff, and routinely used as a resource for screening and referral (Appendix, Table 32).

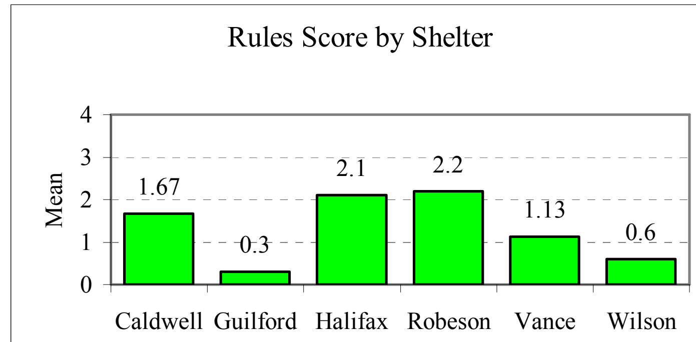


Figure 12: Rules Score by shelter

Community Partners

The items we developed to measure routines related to use of community partners for follow-up after screening are:

- *Key community service providers are aware of the screening program.*
- *We have met with key community service providers to discuss ways to work together to meet the needs of children.*
- *Community service providers are supportive of our screening and referral of children to their organizations.*
- *We have or are developing targeted information for our key community service providers about screening and referral.*
- *CDSAs are among our key community service providers for children under three.*
- *Child Service Coordinators in the Health Department are among our key service providers for children under five.*
- *Mental health clinicians are among our key service providers for children.*
- *LMEs are among our key service providers for children.*
- *DSS is one of our key service providers for children.*

To what extent has the use of community partners for follow-up after screening been integrated into the structure and functioning of the shelter?

Figure 13 shows that shelters scored high on the degree to which they recognize key community partners as allies in their efforts to address the needs of children. For example, all of the shelters

reported that community service providers are supportive of screening and referral of children to their organizations. Four of the six shelters had met with key providers to discuss ways to work together to meet the needs of children. Four of the six shelters reported that CDSAs are among their key community service providers for children under three, and that Child Service Coordinators in the Health Department are among their key service providers for children under five. These findings are particularly significant because prior to training, neither of these resources had been tapped by shelters to assist with children's mental heath needs (Appendix, Table 33). However, these findings do not provide information on the extent to which the use of these resources has been integrated into the shelters' daily routines.

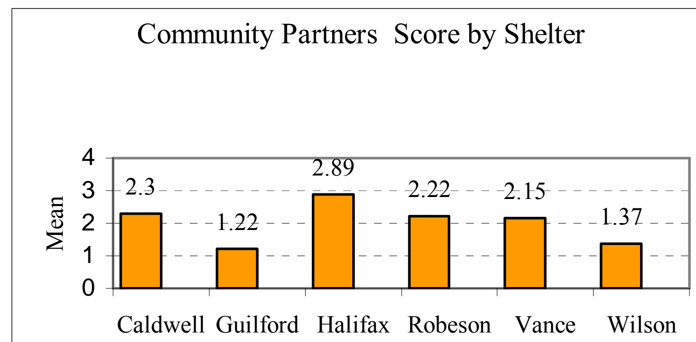


Figure 13: Community Partners Score by Shelter

Technology

We developed the following items to measure the extent to which technology is in place at the shelters to carry our future activities related to screening and referral:

- *Our supervisors have ready access to PC's with CD-ROMs, audio and privacy.*
- *Our supervisors have access to the Internet through a high speed, broadband connection.*
- *Our supervisors have access to email.*
- *Supervisors have taken computer based training in the past for clinical, administrative, or compliance purposes.*

To what extent is technology in place at the shelter that could be used for future activities related to screening and referral?

Figure 14 shows that all shelters had high sustainability scores on all technology items indicating that, at the supervisory level, capacity exists to engage in web-based training, and to conduct screening and referral over the internet (Appendix, Table 34).

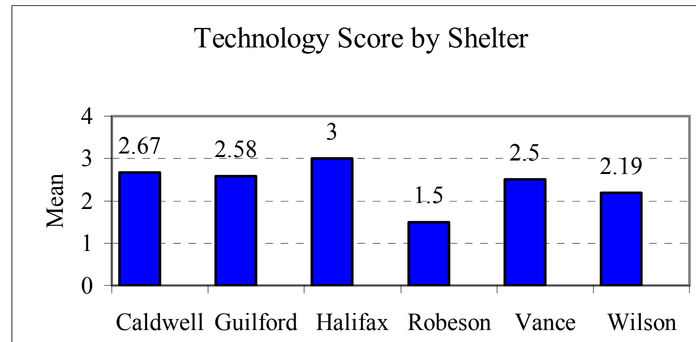


Figure 14: Technology Score by Shelter

Overall Sustainability

We summed the scores of the six sub-scales by shelter in order to ascertain a mean sustainability score for each. Means scores above 2.0 indicate that shelters were somewhat engaged in routinized activities that enhanced screening and referral. Figure 15 shows that only two shelters scored above 2; while two scored only slightly lower than 2. Finally, two sites scored lower than 1.0 indicating that they were not substantially engaged in activities that enhanced the sustainability of screening and referral (Appendix, Table 35).

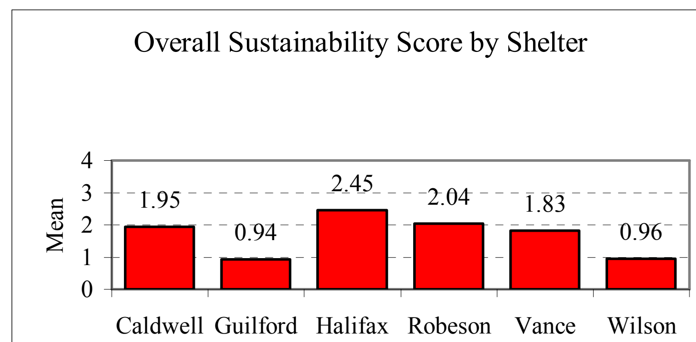


Figure 15: Overall Sustainability Score by Shelter

Substantiating Sustainability

In order to substantiate levels of shelter level sustainability that appeared to be in effect at follow-up we requested that shelters provide us with de-identified copies of all measures administered between January 1, 2007 and June 30, 2007. Only two shelters provided us with copies of measures completed during this period of time. Therefore we are unable to substantiate the degree to which screening and referral are taking place at the shelters, nor the degree to which screening and referral have been integrated into the daily functioning of each shelter as of this writing. At best we can interpret the responses to sustainability questions as intentions.
We added several semi-structured questions to the follow-up survey in order to shed light on continuing barriers to sustainability and activities in which shelter staff was engaged to address them. The results of these questions are found below.

6.4 Barriers That Continue to Impede Sustainability

Loss of Staff

The loss of shelter directors and others in leadership positions appears to be the most salient factor affecting sustainability of screening and referral at the shelters. As the shelters continued to function at reduced capacity, new activities such as screening and referral simply fell by the wayside. For example, one shelter lost all of its staff members except one, who became the new director. Although trained to administer the measures, until additional staff was hired there was simply no time to do this. At another shelter only one staff member was trained to administer the measures. That person left the shelter before training her replacement; and as a result, administration of the measures ceased. Yet another shelter went through a complete administrative upheaval losing its director and child health coordinator. A new child health coordinator was trained and was administering the measures; however, her duties were combined with other major responsibilities that made it difficult to find the time to administer the measures. The remaining three shelters had no changes in staff over course of the follow-up evaluation, and for that reason were theoretically in a better position to continue with the measures. However, only one of those three shelters provided us with copies of completed measures at Time 3 to verify their reported practices.

Length of Time Children Sheltered

When asked, why they were unable to provide us with additional measures at Time 3, four of the six shelters indicated that it was due to the transient nature of families and their brief stay at shelters. Shelter staff continues to report that because of the brief time that families stay at the shelter, the focus of the stay is frequently to provide respite care for mothers. As a result, screening is postponed until the latter part of the stay, or no screening is conducted at all. Even after children are screened, a referral may not be in place by the time families leave, and follow-up by shelter staff after discharge is not a routine part of shelter protocol.

Length of Time from Referral to Appointment

For mental health services, mental health reform can represent a source of confusion for shelter staff that often is not clear about the current role of LMEs as access points for treatment and services and the possibility of referral to directly enrolled providers for psychotherapy. Further concerns were voiced about the timely availability of providers, an issue that might be addressed through closer linkage with LMEs and the mental health provider community. Finally, the sometimes transient and disrupted day-to-day lives of families contending with the aftereffects of domestic violence can make utilization of traditional, clinic-based service challenging. The availability of community based services warrants further exploration.

6.5 Factors Promoting Sustainability

Fit with Shelter Mission

Although shelter staff cited many barriers that continue to impede screening and referral, staff at four of the six shelters continues to report that screening and referral fits with its mission and objectives. Still others reported that the desire to help children has always been a part of the shelter's mission, but until the screening tools were made available, they had no concrete means to do so. Staff also reported that use of the tools made it easier to determine where best to refer children for follow-up services.

Commitment of Key Staff at the Shelter

Several staff reported that it was the commitment of key staff at the shelter (either the shelter director or children's program manager) that led to continued use of the measures. At one shelter, responsibility for administering shelter screening is now written into the job description for the children's program coordinator (CPC). Other staff members are trained on how to administer measures but the CPC is responsible for maintaining records, making referrals, and ensuring each parent/child that enters the shelter is asked to complete screening.

Integration of Screening and Referral across Multiple Activities at the Shelter

Finally, screening appears more likely to be sustained when it is integrated across multiple activities at the shelter. For example, at one shelter, screening is addressed at multiple time points, including monthly parenting groups, during routine intake, and in the context of formal and informal counseling.

7. Summary and Conclusions

1. Shelter staff members' knowledge of the effects of domestic violence on children was comparable to that expressed at the outset of the project. This is attributed to the fact that staff knowledge about the effects on children of witnessing domestic violence was already fairly high to begin with and remained so over the course of this project.

2. An initial increase in staff application of behavior management strategies (i.e., educating children about traumatic stress and confronting inappropriate verbal behavior) was not sustained during the follow-up period, perhaps due to the complexity of acquiring these new skills and the distinct nature of skills relative to the usual, adult focused practices within the shelters.

3. Shelter staff continued to use parenting strategies that they learned as a result of training. They continued to report teaching parents about appropriate use of praise and active ignoring of negative behavior. In addition, staff increased their teaching of parenting skills related to use of effective commands and time out skills. One reason for the persistence of these skills may be that they fit best with the shelters' priority focus on acute stabilization and empowerment of mothers and other adult victims of domestic violence. Another reason may be that they are more readily incorporated into existing parenting classes that take place at the shelter pilot sites.

4. Despite some initial improvements, the shelters remained relatively isolated in terms of the partnerships with and referrals to other community resources. Increased referral to community, child-focused partners such as Children's Developmental Service Administrators (CDSAs), Child Service Coordination (CSC) Programs, and Local Management Entities (LMEs), were not sustained. Increases in referral to legal aid and educational tutoring resources were, however, sustained at follow-up. It is worth noting that the partnerships that were not sustained were all "new" partnerships introduced and promoted by project staff, whereas the partnerships that were sustained existed prior to the project.

5. Staff members continued to report high degree self-confidence in their abilities to screen and refer children residing in shelters at follow-up. This is encouraging in light of the fact that staff reported difficulty learning how to administer and score assessment instruments during the pilot training year. Seventy percent of staff reported screening and referral to be a permanent activity at the shelter, though project staff was unable to document this.

6. Screening and referral of children was partially sustained at the time of the follow-up evaluation. Shelters scored fairly high on the degree of resources allocated to continue screening and referral including assignment of a supervisor to oversee administrative responsibilities for screening, cross-training of multiple staff to conduct screening, and designation of a permanent position to conduct screening and referral. Shelters also scored high on the collective value placed on screening and referral. Shelters scored

lower on the modification of rules and written procedures to accommodate screening and referral.

7. Multiple barriers continue to impede staff screening and referral of children to mental heath and other support services. These same barriers keep the shelter in a persistent state of flux and crisis. Staff turnover is frequent and high among administrative and direct service positions.

8. Shelter staff functions with courage and dedication. It is a testament to their strength of spirit that they wish to take on even more responsibility by engaging in screening and referral. Staff strives to increase their effectiveness with both parents *and* children and now recognize the significance of identifying and addressing the mental health needs of children early. But, their frustration is palpable as they try to keep staff in place and provide quality services. In this regard, the precarious position of the shelter mimics the precarious position of the clients who frequent it.

8. Recommendations

1. All shelter-based staff should receive ongoing accessible training in child development and behavior management techniques.

Although certain responsibilities will necessarily be assigned to specific staff, the project team believes that all shelter-based staff should receive training and understand the program's objectives and approach to assessing and responding to the needs of children. Most sites do not have a shared philosophy on children's exposure and their needs, which undermines any program strategy that might be employed. For example, all shelter-based staff should understand the need and support for creating structure and predictability for children in shelter. Their interactions with the family should be informed by the teaching of positive coping strategies to increase compliance with parental direction and enhance the parent/child relationship. Too often, those staff with the least amount of training spend the most (unstructured) time with families and most often work by themselves, i.e., night and weekend staff. The project team is piloting such training through the North Carolina Area Health Education Center network in 2008 and 2009.

2. Those resources that are currently dedicated to addressing children's issues should be streamlined and prioritized to focus on assessing children's needs (using the measures), maximizing resiliency factors, and providing carefully titrated case management services.

While not abundant, resources do currently exist in programs for children. The project team believes these resources should be re-directed and organized in a way that maximizes their positive effect on families. Currently, positions within programs can have a variety of functions including providing childcare, parent education, advocacy, and therapeutic services. The experience and credentials of staff delivering these various interventions is generally inadequate, leaving staff feeling overwhelmed, ineffective, and marginalized from the rest of the program.

3. Efforts should be made to enhance the overall stability of the state's domestic violence shelters and agencies.

It will continue to be a challenge to establish standard practices for evaluating and working with children in settings where other standard practices are not widespread. The challenge is compounded by limited resources for professional development and the unpredictable nature of shelter stays. The project team will continue to work with funders and advocacy groups to encourage changes in practices, however, the changes that are necessary are long term. For example, funders should consider creating financial incentives and disincentives as a mechanism for creating standard programming, and improving the efficacy of services for children. Several major funders of these programs are currently engaged in standards development, and in the process of developing a standardized data collection system. Discussion about children and services for children within these initiatives are at their infancy and should be expanded and treated as an integral part of program standards and an automated data collection system (which both can lead to and support the establishment of program outcomes).

While care in shelter is important, sustaining such an intervention can be challenging because of the factors noted above. This makes connections to the community especially important. In addition, families sometimes do not stay in shelters for very long, so connecting to a resource that can follow the family back into the community, provide continuity of care, and serve as a monitor to the family's well-being, is important. The project team has identified a number of key community partners. Each is described below.

4. Efforts should be made to integrate these findings with policy established by the state Division of Social Services, including training initiatives, and funds administered by the Division, e.g., TANF and Family Violence Prevention funds.

It is apparent that the funds allocated by the General Assembly for use by local Workfirst offices within county Departments of Social Services to respond to the needs of domestic violence victims have fostered some important relationships between domestic violence programs and county Departments of Social Services. However, the historic disconnect between Child Protective Services and domestic violence programs, despite a variety of statewide initiatives to improve communication and establish shared goals, appears to still be present. Child Protective Services' domestic violence policy was still not widely known or understood among many pilot site staff members, for example. The reporting of suspected child abuse and neglect varies significantly across the sites; the frequency of reporting ranges from as often as several times per week to almost non-existent. Interestingly, the concerns raised early on by sites anticipating mothers' reluctance to complete screening measures and address their children's needs due to concerns about mandated reporting of suspected maltreatment did not materialize.

5. Efforts should be made to engage schools more routinely around children's learning needs as it relates to the effects of trauma.

Communication between schools and pilot sites is often limited to arranging for transportation. The majority of children do not transfer to new schools upon entering shelter. In some cases, the details of domestic violence protective orders are shared with the schools, but not as a matter of routine. The time and expertise to conduct this thoughtful planning do not appear to exist with any regularity on the part of the pilot sites or the schools, although we hope for and expect that there will be notable exceptions.

6. Enhance and strengthen partnerships between domestic violence programs and agencies responsible for early intervention services for young children.

Often unknown to one another, these relationships are being established. The project team has met with the state directors of the Children's Developmental Services Agencies and the Child Service Coordination Program and has fostered direct meetings at each of the 6 pilot sites as an effort toward improved partnership and dissemination of information regarding available services. For both CDSA and CSC services, the Parent's Evaluation of Developmental Status may facilitate initial screening that determines service eligibility. The Department of Public

Instruction (DPI) is also relevant in their new responsibilities to conduct developmental evaluations for 4 and 5 year olds.

7. Identify ways to increase shelter and family access to the local LME and mental health services.

Because of the status of mental health reform in North Carolina, pilot sites view the processes and the inventory of mental health services for adults as well as children as confusing. Generally speaking, all programs acknowledge the need for these services for adults – referrals of children for mental health were uncommon for most sites – and are negotiating the logistics locally. Pilot sites recognize the value of using the measures (and in some cases sharing the measures) when making mental health referrals.

In addition, efforts should be made to collect standardized data at LMEs in order to document the incidence of domestic violence and a presenting or contributing factor at intake, capture referrals to providers with expertise in addressing domestic violence as it relates to mental health concerns, and finally, provides outcome data on those referrals and treatment.

8. Develop a resource for domestic violence shelters that identifies and answers key legal and policy questions pertaining to children as well as adults.

These issues include the child's emergence as a client in his or her own right and carry with it the various laws and policies governing their privacy, parental access to records, and parental input to service provision. Most domestic violence programs limit their contact with the court system to accompanying adult victims to District Court in order to apply for, amend, or extend domestic violence protective orders. Because two of the pilot sites are in districts where a Family Court model exists, we have examined some of the issues related to improved service planning for families, based in part on the new and improved information domestic violence programs collect. The project team is currently considering recommendations for information sharing with the court and is acutely aware of the caution with which this information should be treated, particularly because of a desire by parties to a civil lawsuit or criminal proceeding, or their legal representatives, to utilize this information for purposes of assigning culpability and effecting decisions regarding the care and placement of children.

9. Use standard approaches to assessment and service planning in order to facilitate more effective planning and collaboration within and across agencies and service systems.

Domestic violence agencies and shelters can and should effectively serve as an assessment and triage point for children and their parents who receive services. The use of standard approaches to assessment and service planning will facilitate more effective planning and collaboration within and across agencies and service systems.

10. Ensure that affordable and accessible training is available to a broad range of professionals, including domestic violence program staff, who comprise the components of a de facto screening, intervention, and referral system.

Where appropriate and feasible, the training should be available on-line to enhance its accessibility to a broad range of participants. Policymakers and funders should actively promote this training as a means of quality improvement for domestic violence related programs; these efforts may include offsetting of training costs, assisting with recruitment, and as appropriate, setting requirements for funding related to domestic violence and children. This training is currently being piloted through North Carolina's Area Health Education Centers.

11. Enhance the capacity of funding agents to promote evidence-based programming for children and their ability to provide technical assistance to domestic violence programs offering services to children.

Specifically, funders should:

(a) provide incentives for standardized screening and referral at domestic violence shelters,

(b) implement standards for children's programming in domestic violence shelters and agencies, and

(c) specify and require and measure program outcomes for children's programming.

9. Appendix

9.1 Literature Cited

Pynoos, R.S., Rodriguez, N., & Steinberg, A. (2000). PTSD Index for DSM-IV. Los Angeles. University of California Los Angeles.

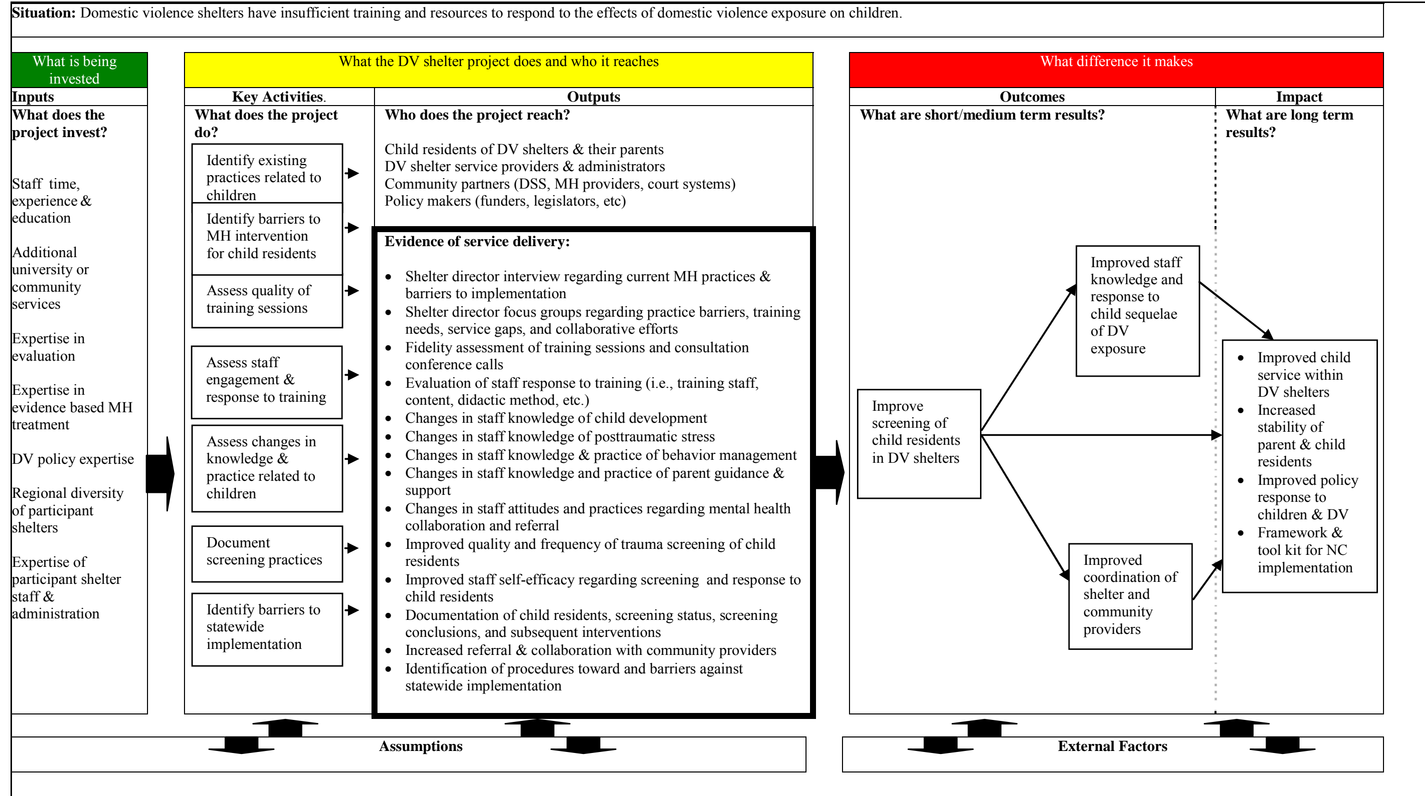
Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology, Psychiatry, and Allied Disciplines, 38*(5), 581-586.

Brothers, K. B. (2007). PEDS Developmental Milestones: A new measure for developmental-behavioral surveillance and screening. *Ambulatory Pediatric Association Newsletter, 43(*3), 21-22.

Glasgow, R. E. (2002). Evaluation of theory-based interventions: The RE-AIM Model. In K. Glanz & Rimer (Eds.), *Health Behavior and Health Education: Theory, Research, and Practice* (pp. 531- 544) . San Francisco: John Wiley & Sons

Pluye, L. Potvin, J. Denis, L., & Pelletier, J. (2002). Program sustainability: Focus on organizational routines. *Health Promotion International, 19*(4), 489-500.

9.2 Logic Model



9.3 Instruments

Pilot Evaluation

Final Feedback Survey Shelter Staff

This critique will be used in assessing the overall effectiveness of the 3 session training in which you have participated. Circle the response that best reflects your opinion for each item.

1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree NA=Not Applicable

TOPICS AND INSTRUCTION

1.	**The topics were well chosen.**	SD	D	N	A	SA	NA
2.	**The facilitator was very knowledgeable.**	SD	D	N	A	SA	NA
3.	**The methods of instruction were most appropriate.**	SD	D	N	A	SA	NA
4.	**The instructional materials were very useful.**	SD	D	N	A	SA	NA
5.	**The facilitator was sensitive to cultural differences.**	SD	D	N	A	SA	NA

Comments, explain your answers:

PERSONAL VALUE

6.	**I gained new knowledge and insights.**	SD	D	N	A	SA	NA
7.	**The quality of my work will be enhanced as a result of participating in this workshop.**	SD	D	N	A	SA	NA
8.	**I am satisfied with the opportunity I had to participate.**	SD	D	N	A	SA	NA
9.	**The amount of interaction between the participants and the presenter was ideal.**	SD	D	N	A	SA	NA
10.	**Informal conversations with other participants were beneficial.**	SD	D	N	A	SA	NA
11.	**I would recommend this workshop to other colleagues.**	SD	D	N	A	SA	NA
12.	**The program was well organized and coordinated.**	SD	D	N	A	SA	NA

Comments, explain your answers:

ORGANIZATION AND COORDINATION

13.	**The time of the program (month, day, hour) was convenient.**	SD	D	N	A	SA	NA
14.	**The length of the program was appropriate.**	SD	D	N	A	SA	NA
15.	**The length of the individual sessions was suitable.**	SD	D	N	A	SA	NA
16.	**Pre-workshop information was helpful.**	SD	D	N	A	SA	NA
17.	**The size of the group was adequate.**	SD	D	N	A	SA	NA
18.	**The meeting facility was appropriate for the workshop.**	SD	D	N	A	SA	NA

Comments, explain your answers:

FACILITIES

19.	**The meeting facility was comfortable (temperatu setup, etc.)**	SD	D	N	A	SA	NA
20.	**My personal needs were met (handicap access, special diet, etc.)**	SD	D	N	A	SA	NA
21.	**Refreshments during the workshop were above average.**	SD	D	N	A	SA	NA
22.	**Lunch provided during the first session was above average.**	SD	D	N	A	SA	NA
23.	**Lunch provided during the second session was above average.**	SD	D	N	A	SA	NA
24.	**Lunch provided during the third session was above average**	SD	D	N	A	SA	NA

Comments, explain your answers:

25. Name the specific strategies that were most important or most helpful to you:

26. Name the specific strategies discussed in the training that were least helpful to you:

27. The following topics should have received more time:

28. The following topics were not discussed and I would like to know more about them:

29. Please give any other suggestions to improve the training?

Pilot Evaluation
Pre/Posttest Shelter Staff

1. These questions are intended to indicate how often your shelter uses certain techniques and resources with CHILDREN at the shelter. Please complete every item by choosing the response that most closely reflects Your shelter's use of the intervention. Describe level of use:
DK=Don't Know
N=Never
S= Sometimes
O= Often
A= Always

a.	Teach children about the effects of DV on children.	DK	N	S	O	A
b.	Teach children about posttraumatic stress.	DK	N	S	O	A
c.	Provide opportunities for children to confidentially discuss their experiences of domestic violence or trauma.	DK	N	S	O	A
d.	Use shelter routines to provide structure and consistency for children.	DK	N	S	O	A
e.	Use time-out (ages 2-7).	DK	N	S	O	A
f.	Use privilege removal (ages 8-18)	DK	N	S	O	A
g.	Focus on positive behaviors of the children.	DK	N	S	O	A
h.	Reward small improvements toward desired behavior.	DK	N	S	O	A
i.	Use a behavior plan that provides children with choices and consequences for their choices.	DK	N	S	O	A
j.	Use logical and natural consequences .	DK	N	S	O	A
k.	Assist children in identifying coping skills and behaviors they may want to learn.	DK	N	S	O	A
l.	Use diffuse techniques (e.g. proximity, eye contact, humor, explaining the impact of misbehavior) in response to inappropriate behavior.	DK	N	S	O	A
m.	Focus on how to find solutions rather than causes of problems.	DK	N	S	O	A
n.	Maintain calmness when faced with an aggressive or disruptive child	DK	N	S	O	A
o.	Confront children who make inappropriate comments.	DK	N	S	O	A
p.	Model dignity and respect at the shelter	DK	N	S	O	A
q.	Teach and encourage children to use self-calming techniques	DK	N	S	O	A
r.	Handle problems privately with individual child(s).	DK	N	S	O	A
s.	Use group problem solving for and with other children.	DK	N	S	O	A
t.	Consult with another shelter staff member for advice.	DK	N	S	O	A
u.	Consult with shelter administrators for support.	DK	N	S	O	A
v.	Consult with a counselor for advice.	DK	N	S	O	A
w.	Make referrals to a counselor or mental health worker.	DK	N	S	O	A
x.	Use screening tools to make decisions about children's shelter care	DK	N	S	O	A

2. These questions are intended to indicate how often your shelter uses certain techniques and resources with PARENTS at the shelter. Please complete every item by choosing the response that most closely reflects your shelter's use of the intervention. Describe level of use:
DK= Don't Know
N=Never
S= Sometimes
O= Often
A= Always

a.	Teach parents about the effects of DV on children.	DK	N	S	O	A
b.	Teach parents about posttraumatic stress.	DK	N	S	O	A
c.	Teach parents how to actively ignore.	DK	N	S	O	A
d.	Teach parents which behaviors are appropriate to ignore.	DK	N	S	O	A
e.	Teach parents to recognize times when children are not misbehaving.	DK	N	S	O	A
f.	Teach parents to praise the opposite of misbehavior.	DK	N	S	O	A
g.	Teach parents how to give effective commands.	DK	N	S	O	A
h.	Teach parents how to use time out effectively.	DK	N	S	O	A
i.	Teach parents how to use logical and natural consequences.	DK	N	S	O	A
j.	Teach parents how to create predictable structures and routines for children.	DK	N	S	O	A
k.	Teach parents how to focus on positive interactions between parents and children.	DK	N	S	O	A
l.	Teach parents how to identify and respond to sexualized behavior.	DK	N	S	O	A

3. Using a 5-point scale, select the point on the scale that indicates your current level of confidence about the use of screening tools to evaluate trauma in children exposed to DV.

		Not Confident	**A Little**	**Somewhat**	**More than Somewhat**	**Very**
a.	I can recognize the symptoms of post traumatic stress in children due to exposure to domestic violence.	1	2	3	4	5
b.	I can correctly administer an instrument that measures post traumatic stress in children.	1	2	3	4	5
c.	I can correctly score an instrument that measures post traumatic stress in children.	1	2	3	4	5
d.	I can correctly interpret the results of the score to make a behavioral management decision.	1	2	3	4	5
e.	I can recognize other symptoms of mental illness in children due to exposure to domestic violence.	1	2	3	4	5
f.	I can correctly administer an instrument that measures other symptoms of mental illness in children.	1	2	3	4	5
g.	I can correctly interpret the results of the score to make a behavioral management decision.	1	2	3	4	5

4. These last questions are intended to indicate how often you use certain resources for parents or children at the shelter. Please complete every item by choosing the response that most closely reflects your use of the resource. Describe level of use:
NA=Not Applicable
N=Never
S= Sometimes
O= Often
A= Always.

a.	How often do you refer to your Local Management Entity (LME)?	NA	N	S	O	A
b.	How often do you get children mental heath case managers?	NA	N	S	O	A
c.	How often do you refer children to the Children's' Developmental Services Agency (CDSA)?	NA	N	S	O	A
d.	How often do you refer children for counseling?	NA	N	S	O	A
e.	How often do you refer parents for counseling	NA	N	S	O	A
g.	How often do you use your local legal aid?	NA	N	S	O	A
h.	How often do you refer clients for consumer credit counseling?	NA	N	S	O	A
i.	How often do you attend LME, DSS, or CDSA meetings?	NA	N	S	O	A
j.	How often do you refer clients to section 8?	NA	N	S	O	A
k.	How often do you refer children for tutoring?	NA	N	S	O	A
l.	How often do you consult with DSS about maltreatment?	NA	N	S	O	A
m.	How often do you file maltreatment reports with DSS?	NA	N	S	O	A
n.	How often do you refer children for court advocacy?	NA	N	S	O	A
o.	How often do you consult with police re: children?	NA	N	S	O	A

5. During the past 2 years, have you participated in any professional development activities that focused on child development and/or the management of children exposed to domestic violence, that does not include the DV Shelter project? (Check all that apply)

a. I did not participate in any activities
b. Attended a university course
c. Attended a workshop, conference, or training
d. Presented at workshop, conference, or training
e. Participated in a regularly scheduled mentoring program

6. If so, How many hours of this type of training did you have during the past 2 years, that does not include the DV Shelter project?

a. None, I did not participate in any training
b. 8 hours or less
c. 9 to 16 hours
d. 17 to 32 hours
e. 33 or more hours

Thank you for your time!

Pilot Evaluation
Coversheet DVS Measures

INSTRUCTIONS: Complete only one coversheet per client.

Today's Date: __ __ / __ __ / __ __ __ __	**Child's Ethnicity check (√)** _____ White __ Asian/Pacific Islander ____ Native American __ African-American _____ Multi-ethnic __ Hispanic _____ Other: please explain
Child's D.O.B: __ __ / __ __ / __ __ __ __	
Child's Gender check (√) ___ **Male** __**Female**	
Shelter Name ___________________________	**Date of Entry to Shelter** __ __ / __ __ / __ __ __ __
Staff Position ____________________________	**Date of Departure** __ __ / __ __ / __ __ __
ENGLISH MEASURES COMPLETED __ **PSDI Parent Report** __**SDQ Parent Report** __**PSDI Youth Report** __ **SDQ Youth Report** __ **PEDS**	**SPANISH MEASURES COMPLETED** __ **Sp PSDI Parent Report** __ **Sp SDQ Parent Report** __ **Sp PSDI Youth Report** __ **Sp SDQ Youth Report** __ **Sp PEDS**
□(√) **ALREADY RECEIVING SERVICES:**	**Type of Agency/Service:**

REFERRED TO:		
Name of 1st Agency:	**Type of 1st Agency:**	**Purpose of Referral:**
Outcome:		
Name of 2nd Agency:	**Type of 2nd Agency:**	**Purpose of Referral:**
Outcome:		

EXAMPLE		
Name of 1st Agency	*Type of 1st Agency*	*Purpose of Referral:*
Joe's Place	*Private Counseling Center*	*Evaluate behavior and speech concerns*
Outcome: *Made appointment but didn't keep; left shelter*		

Follow-Up Evaluation
Shelter Staff Survey

Introduction

We would like to know the extent to which staff at your shelter is continuing to assess and refer children, use the behavior management strategies with children and the parenting strategies with parents, and work with new community partners for the purposes of referring and responding to the service needs of children. To do this we would like you to answer some of the same questions that we asked in the pre and post test.

We'd also like to know the degree to which screening and referral has been integrated into the structure and functioning of your shelter, as well as any barriers to screening and referral that remain.

Please answer all questions to the best of your knowledge. There is no right or wrong answer to any of them. All answers will be kept confidential and will not be shared with anyone either at your shelter or anywhere else.

THANK YOU!

1. Please complete every item by choosing the response that most closely reflects your UNDERSTANDING OF TRAUMA AND ITS EFECT ON CHILDREN.
Answer:
T=True
F=False

a.	If children are in another room, they will be less impacted by the violence	T	F
b.	Children who witness domestic violence (DV) may have problems with memory, even for non-traumatic events.	T	F
c.	Children who witness a lot of parental DV have trouble understanding things that are said to them (receptive learning problems)	T	F
d.	School-age children who view their parents as scary are likely to take a controlling stance with peers.	T	F
e.	Older children are more severely affected by witnessing DV than younger children.	T	F

f.	Babies who have been exposed to DV won't remember it so will not be affected.	T	F
g.	Children who have been chronically exposed to DV from a young age are at risk for having a lower IQ than those who have not.	T	F
h.	Children can not be diagnosed with (Post Traumatic Stress Disorder (PTSD).	T	F
i.	In terms of risk and resiliency factors, domestic violence is more harmful than poverty.	T	F
j.	Children are more likely to develop PTSD from being physically abused than from witnessing parental DV.	T	F
k.	Children in homes where there is intimate partner violence are more likely to be physically abused by both parents.	T	F
l.	Children who have a secure attachment to their caregivers are less likely to suffer PTSD symptoms following an incident of DV.	T	F
m.	Children who witness DV are more likely to develop PTSD in the future following another traumatic event.	T	F
n.	Parents should try never to talk about DV that has occurred with their children.	T	F
o.	Witnessing domestic violence in childhood can lead to alcoholism and substance abuse in adulthood.	T	F
p.	Children who witness domestic violence are at increased risk for sexual abuse.	T	F
q.	Just because children exhibit age-inappropriate sexual behaviors does not mean that they have been sexually abused.	T	F
r.	Children that witness domestic violence often act aggressively because they are identifying with the aggressor.	T	F

2. These questions are intended to indicate how often you/your shelter use certain techniques and resources with CHILDREN at the shelter. Please complete every item by choosing the response that most closely reflects you/your shelter's use of the intervention.

	Never	**Some-times**	**Often**	**Always**
Teach children about posttraumatic stress.	N	S	O	A
Provide opportunities for children to confidentially discuss their experiences of domestic violence or trauma.	N	S	O	A
Use time-out (ages 2-7).	N	S	O	A
Use privilege removal (ages 8-18)	N	S	O	A
Focus on positive behaviors of the children.	N	S	O	A
Reward small improvements toward desired behavior.	N	S	O	A
Use logical and natural consequences.	N	S	O	A

Focus on how to find solutions rather than causes of problems.	N	S	O	A
Maintain calmness when faced with an aggressive or disruptive child.	N	S	O	A

Confront children who make inappropriate comments.	N	S	O	A
Model dignity and respect at the shelter.	N	S	O	A
Teach and encourage children to use self-calming techniques.	N	S	O	A
Handle problems privately with individual child.	N	S	O	A
Use group problem solving for and with other children.	N	S	O	A
Use screening tools to make decisions about children's shelter care	N	S	O	A
Use shelter routines to provide structure and consistency with children	N	S	O	A

3. These questions are intended to indicate how often you/your shelter use certain techniques and resources with PARENTS at the shelter. Please complete every item by choosing the response that most closely reflects you/your shelter's use of the intervention.

	Never	**Some-times**	**Often**	**Always**
Teach parents about the effects of DV on children.	N	S	O	A
Teach parents how to actively ignore.	N	S	O	A
	N	S	O	A
Teach parents which behaviors are appropriate to ignore.	N	S	O	A
Teach parents to praise the opposite of misbehavior.	N	S	O	A
Teach parents how to give effective commands.	N	S	O	A
Teach parents how to use time out effectively.	N	S	O	A
Teach parents how to use logical and natural consequences.	N	S	O	A
Teach parents how to create predictable structures and	N	S	O	A

routines for children.				
Teach parents how to focus on positive interactions between parents and children.	N	S	O	A

4. Using a 5-point scale, select the point on the scale that indicates your current level of ONFIDENCE ABOUT USING THE SCREENING TOOLS to evaluate trauma in children exposed to DV. (1=Not Confident, 3 = Somewhat Confident, 5=Very Confident). Remember there is no right or wrong answer.

	Not Confident	**A Little**	**Somewhat Confident**	**More than somewhat**	**Very Confident**
I can recognize the symptoms of post traumatic stress in children due to exposure to domestic violence.	1	2	3	4	5
I can correctly administer an instrument that measures post traumatic stress in children.	1	2	3	4	5
I can correctly score an instrument that measures post traumatic stress in children.	1	2	3	4	5
I can correctly interpret the results of the score to make a behavioral management decision.	1	2	3	4	5
I can recognize other symptoms of mental illness in children due to exposure to domestic violence.	1	2	3	4	5
I can correctly administer an instrument that measures other symptoms of mental illness in children.	1	2	3	4	5
I can correctly interpret the results of the score to make a behavioral management decision.	1	2	3	4	5

5. These last questions are intended to indicate how often you/your shelter use certain RESOURCES FOR PARENTS OR CHILDREN at the shelter. Please complete every item by choosing the response that most closely reflects your/shelter's use of the resource.

How often do you refer to…?	**Never**	**Some-times**	**Often**	**Always**
Local Management Entity (LME)?	N	S	O	A
Child Mental Heath Services?	N	S	O	A
Children's' Developmental Services Agency (CDSA)	N	S	O	A
Other Child Counseling Services?	N	S	O	A

Parent counseling?	N	S	O	A
Local legal aid?	N	S	O	A

How often do you refer to…?	**Never**	**Some-times**	**Often**	**Always**
DSS about suspected child abuse/neglect?	N	S	O	A
Child Tutoring?	N	S	O	A
Child to Court Advocacy?	N	S	O	A
Consult with the Police about children?	N	S	O	A
How often do you attend LME meetings?	N	S	O	A
How often do you attend DSS meetings?	N	S	O	A
How often do you attend CDSA meetings?	N	S	O	A

6. During the past 2 years, have you participated in any professional development activities that focused on child development and/or the management of children exposed to domestic violence, that does not include the DV Shelter project? (***Circle all that apply)***

a) I did not participate in any activities
b) Attended a university course
c) Attended a workshop, conference, or training
d) Presented at workshop, conference, or training
e) Participated in a regularly scheduled mentoring program

7. If so, How many hours of this type of training did you have during the past 2 years, that does not include the DV Shelter project? (***Circle one answer****)*

a) None, I did not participate in any training
b) 8 hours or less
c) 9 to 16 hours
d) 17 to 32 hours
e) 33 or more hours

8. At this point in time, how permanent do you think that screening and referral is at your shelter?
*(**Circle one answer**)*

1) No longer delivered
2) Not at all permanent
3) Moderately permanent
4) Very permanent

9. Which of the following describes how screening and referral has evolved since if t first began?
(**Circle one answer**)

1) Not changed at all
2) Undergone minor modifications
3) Undergone major modifications

9a. If major modifications, please describe: ____

____

10. Since you began conducting screening and referral have there been any changes in the conditions or structure of the shelter that affected screening and referral significantly? (**Circle one answer.**)

1) Yes 2) No 3) Not Applicable

10a. If Yes, please describe: ____

____

11. Since you began conducting screening would you say that there have been many, some or few changes in the staff (staff turn-over)? (**Circle one answer**.)

1) Many 2) Some 3) Few 4) Don't know 5) Not applicable
11a. If some or many, please describe:
____
____

12. Does the shelter have one or more program champions – someone in the community who strongly advocates for the continuation of screening and referral? (**Circle one answer**.)

1) Yes 2) No 3) Not applicable

12a. If Yes, who? ____

13. Would you say that staff has been adequately trained to carry out screening and referral.
(**Circle one answer**)

1) Yes 2) No 3) Not applicable

14. Before participating in the DVS Screening Project, had the shelter had been involved in screening children to determine their needs? (**Circle one answer**)

1) Frequently 2) Occasionally 3) Never

	Strongly Agree	Agree Somewhat	Disagree
15. Staff knew about and agreed in advance to participate in the DVS Screening Project.			
16. Staff was involved in making decisions about how screening and referral would be carried out during and after training.			
17. Screening and referral fits with the mission and objectives of the shelter.			

For each item, circle the degree to which it is "like" your shelter. The range is from "Not at all" like to "A lot" like your shelter.	**Not at all**	**A little**	**somewhat**	**A lot**
18. Memory				
a. The budget includes separate funds to employ key personnel necessary to carry out screening and referral	1	2	3	4
b. There is a permanent position designated for screening and referral.	1	2	3	4
c. We have more than one person trained to do the screening.	1	2	3	4
d. We have an interpreter to make sure screening can be implemented with non-English-speaking families.	1	2	3	4
e. There is a supervisor assigned to oversee administrative responsibilities for screening	1	2	3	4

19. Adaptation				
a. We have made changes in our intake procedures to incorporate screening into the shelter's daily functioning.	1	2	3	4
b. We have made changes in our client records to document screening results and referrals.	1	2	3	4
c. We have incorporated the results of screening into our annual report.	1	2	3	4
d. We have changed the staff's schedule in order the implement the screening procedures.	1	2	3	4
e. We have adapted the use of the screening tools to the comfort level of the staff.	1	2	3	4
f. We have identified ways to reduce the time it takes to screen children.	1	2	3	4
g. Screening and referral is now written into our training manual.	1	2	3	4

20. Values				
a. The program or executive director supports the use of the screening tools.	1	2	3	4
b. We have incentives or rewards that encourage our staff to carry out screening and referral.	1	2	3	4
c. We continue to implement screening in-spite of cost in terms of time and effort on part of staff.	1	2	3	4
d. Our relationships with other agencies in the community have been enhanced as a result of screening and referral.	1	2	3	4

21. Rules				
a. The Tool Kit has been viewed by all staff at the shelter.	1	2	3	4
b. We use the Tool Kit to train all new shelter staff.	1	2	3	4
c. The Tool Kit is used as a reference resource by existing shelter staff.	1	2	3	4
d. We hold meetings periodically related to screening and referral.	1	2	3	4
e. A protocol has been written for our shelter that describes how screening should be conducted.	1	2	3	4

22. Community Partners				
a. Key community services providers are aware of the screening project.	1	2	3	4
b. We have met with key community service providers to discuss ways to work together to meet the needs of children.	1	2	3	4
c. Community service providers are supportive of our screening and referral of children to their organizations.	1	2	3	4
d. We have or are developing targeted information for our key community service providers about screening and referral.	1	2	3	4
e. Children's Developmental Service Agencies (CDSA's) are among our key community service providers for children under age 3.	1	2	3	4
f. Health Service Coordinators in the Health Department are among our key service providers for children under age 5.	1	2	3	4
g. Mental Health Services are among our key service providers for children.	1	2	3	4
h. LME's are among our key service providers for children.	1	2	3	4
i. DSS is one of our key service providers for children.	1	2	3	4

23. Technology				
a. Our supervisors have ready access to personal computers with CD-ROM drives, capability for audio, and some degree of privacy for computer-based learning purposes.	1	2	3	4
b. Our supervisors have access to the internet through a high speed, broadband connection.	1	2	3	4
c. Our supervisors have access to E-mail.	1	2	3	4
d. Supervisors have taken computer-based training in the past for clinical, administrative, or compliance purposes	1	2	3	4

25. What is the biggest factor that has led to the continued implementation of the measures at your shelter?

26. What barriers do you continue to face in implementing screening and referral?

27. What have you tried to overcome them?

28. What additional help/actions needed?

9.4 Additional Tables and Figures

Patterns of Children's Mental Health Problems by Age Range and Measure

Strengths and Difficulties Questionnaire (SDQ)

Tables 13 through 18 show assessment, clinical significance, and referral rates of children by age range for each subscale of the Strengths and Difficulties Questionnaire (SDQ).

The SDQ was administered most frequently to parents of children ages 8-11 years (44.4%), followed by children ages 3- 7 years (34.8%), with the lowest administration to parents of children ages 12-17 years (17.8%). Although several children ages 12 – 17 years self-administered the SDQ, these questionnaires are excluded from the current analyses in order to preserve uniformity of reporting.

As seen below, younger children ages 3-7 years scored in the clinically significant range at higher rates on all scales with the exception of the peer problem sub-scale. It is interesting to note that although few younger children scored in the clinically significant range on this scale, all that did were referred for follow-up services. In contrast, children ages 8-11 that scored in the clinically significant range on the hyperactivity and conduct problems scale had higher rates of referral compared to children ages 4-7.

Table 13: Age Range by Total Difficulties Scores SDQ

Age Range	Eligible		Assessed		Clinically Sig TD		Referred	
3-7 years	66	100.0	23	34.8	8	30.0	3	40.0
8-11 years	54	100.0	24	44.4	6	25.0	3	50.0
12-17 years	45	100.0	8	17.8	0	0.0	0	0.0
Total	165	100.0	55	33.3	14	25.5	6	42.9

Table 14: Age Range by Emotional Symptoms Scale SDQ

Age Range	Eligible		Assessed		Clinically Sig ESS		Referred ESS	
3-7 years	66	100.0	23	34.8	9	39.1	5	55.6
8-11 years	54	100.0	24	44.4	6	25.0	2	33.3
12-17 years	45	100.0	8	17.8	0	0.0	0	0.0
Total	165	100.0	55	33.3	15	27.2	7	46.7

Table 15: Age Range by Conduct Problems Scale SDQ

Age Range	Eligible		Assessed		Clinically Sig CPP		Referred CPP	
3-7 years	66	100.0	23	34.8	7	30.4	4	57.1
8-11 years	54	100.0	24	44.4	2	8.3	2	100.0
12-17 years	45	100.0	8	17.8	0	0.0	0	0.0
Total	165	100.0	55	33.3	9	16.4	6	66.6

Table 16: Age Range by Hyperactivity Scale SDQ

Age Range	Eligible		Assessed		Clinically Sig HS		Referred HS	
3-7 years	66	100.0	23	34.8	7	30.4	2	28.6
8-11 years	54	100.0	24	44.4	5	20.8	4	80.0
12-17 years	45	100.0	8	17.8	1	12.5	0	0.0
Total	165	100.0	55	33.3	13	23.6	6	46.2

Table 17: Age Range by Peer Problems Scale SDQ

Age Range	Eligible		Assessed		Clinically Sig PPS		Referred PPS	
3-7 years	66	100.0	23	34.8	3	13.0	3	100.0
8-11 years	54	100.0	24	44.4	4	16.7	1	25.0
12-17 years	45	100.0	8	17.8	1	12.5	0	0.0
Total	165	100.0	55	33.3	8	14.5	4	50.0

Table 18: Age Range by Prosocial Scale SDQ

Age Range	Eligible		Assessed		Clinically Sig PSS		Referred PSS	
3-7 years	66	100.0	23	34.8	0	0.0	0	0.0
8-11 years	54	100.0	24	44.4	0	0.0	0	0.0
12-17 years	45	100.0	8	17.8	0	0.0	0	0.0
Total	165	100.0	55	33.3	0	0.0	0	0.0

Post Traumatic Stress Disorder Index (PSDI)

Tables 19 through 22 show assessment, clinical significance, and referral rates of children by age range for each subscale of the Post Traumatic Stress Disorder Index (PSDI). Parents of children ages 8-11 were assessed at approximately the same rate (39%) as parents of children ages 12 – 17 (37.8%).

Children ages 12-17 had higher overall severity scores on the PSDI compared to younger children. Also of note is that older children had higher clinically significant rates of avoidance compared to children ages 8-11 whose parents reported no avoidance behaviors at all in this age group. Older children also had higher clinically significant rates of arousal compared to younger children. In contrast, younger children had higher clinically significant rates of re-experiencing compared to older children. Children in this younger age group were also referred most frequently for follow-up services.

Table 19: Age Range by Overall Severity Score PSDI

Age Range	Eligible		Assessed		Clinically Sig/At-risk OS		Referred OS	
8-11	53	100.0	21	39.6	1	4.8	0	0.0
12-17	45	100.0	17	37.8	2	11.8	0	0.0
Total	98	100	38	38.7	3	7.8	0	0

Table 20: Age Range by Re-experiencing Sub-scale PSDI

Age Range	Eligible		Assessed		Clinically Sig/At-risk RE		Referred RE	
8-11	53	100.0	21	39.6	4	19.0	2	9.5
12-17	45	100.0	17	37.8	2	11.8	0	0.0
Total	98	100	38	38.7	6	15.8	2	33.3

Table 21: Age Range by Avoidance Sub-scale PSDI

Age Range	Eligible		Assessed		Clinically Sig/At-risk Avoid		Referred Avoidance	
8-11	53	100.0	21	39.6	0	0.0	0	0.0
12-17	45	100.0	17	37.8	3	17.6	0	0.0
Total	98	100	38	38.7	3	7.8	0	0

Table 22: Age Range by Arousal Sub-scale PSDI

Age Range	Eligible		Assessed		Clinically Sig/At-risk Arousal		Referred Arousal	
8-11	53	100.0	21	39.6	2	9.5	0	0.0
12-17	45	100.0	17	37.8	3	17.6	1	5.9
Total	98	100	38	38.7	5	13.1	1	20

Parents' Evaluation of Developmental Status (PEDS)

Table 23 shows assessment, clinical significance, and referral rates of children by age range for the Parent's Evaluation of Developmental Status Scale (PEDS).

Younger children ages 0-3 years were assessed more frequently than older children ages 4-7 years. Of those assessed, younger children were found to be in the clinically significant or at risk range on one or more developmental milestones.

Although younger children were found to be n the clinically significant or at risk range, older children were referred for services at a higher rate (100%) compared to younger children (70%).

Table 23: Age Range by PEDS

	Eligible		Assessed		Clinically Significant/At-risk		Referred	
Age Range	N	%	N	%	N	%	N	%
Ages 0-3	63	100.0	15	24	9	60	7	78
Ages 4-7	42	100.0	9	38	5	56	5	100
Total	105	100	24	23	14	58	14	100

Follow-up Evaluation of Sustainability – Individual Level Findings

Table 24: Changes in Parental Knowledge about the Effects on Children of Witnessing Domestic Violence

	Pre	Post	Follow Up	F Score	P value	Differences in Means Using F Tests
If children are in another room, they will be less impacted by the violence.	0.94	0.84	0.78	2.31	0.13	
Children who witness DV may have problems with memory, even for non-traumatic events.	0.94	1	0.95	1	0.33	
Children who witness a lot of parental DV have trouble understanding things that are said to them.	0.94	1	1	1	0.33	
School-age children who view their parents as scary are likely to take a controlling stance with peers.	0.71	0.88	0.67	2.03	0.17	
Older children are more severely affected by witnessing DV than younger children.	0.94	0.94	0.84	2.14	0.16	
Babies who have been exposed to DV won't remember it so will not be affected.	1	0.94	0.95	1	0.33	
Children who have been chronically exposed to DV from a young age are at risk for having a lower IQ than those who have not.	0.53	0.89	0.83	6.35	0.01	1 See below
Children can not be diagnosed with PTSD.	1	0.89	1	2.13	0.16	
In terms of risk and resiliency factors, domestic violence is more harmful than poverty.	0.06	0.05	0	1	0.39	
Children are more likely to develop PTSD from being physically abused than from witnessing parental DV.	0.88	0.79	0.89	1	0.39	
Children in homes where there is intimate partner violence are more likely to be physically abused by both parents.	0.65	0.56	0.68	0.24	0.79	
Children who have a secure attachment to their caregivers are less likely to suffer PTSD symptoms following an incident of DV.	0.41	0.37	0.47	0.91	0.43	

Table 1: Continued

	Pre	Post	Follow Up	F	P value	Differences in Means Using F Test
Children who witness DV are more likely to develop PTSD in the future following another traumatic event.	0.88	0.89	0.95	0.64	0.54	
Parents should try never to talk about DV that has occurred with their children.	0.82	0.89	0.89	0.23	0.8	
Witnessing domestic violence in childhood can lead to alcoholism and substance abuse in adulthood.	1	0.94	0.89	2.13	0.16	
Children who witness domestic violence are at increased risk for sexual abuse.	1	0.75	0.79	2.8	0.09	
Just because children exhibit age-inappropriate sexual behaviors does not mean that they have been sexually abused.	0.88	0.74	0.79	0.5	0.62	
Children that witness domestic violence often act aggressively because they are identifying with the aggressor.	0.19	0.05	0.05	1	0.39	
Sum of correct responses	14	13.71	13.63	0.18	0.84	

(1): Differences in Means (Using an F test):

- Pre – Post: $F = 12.25$; $p = 0.035$ (significant)
- Pre – Follow-up: $F = 3.03$; $p = 0.1038$ (not significant)
- Post – Follow-up: $F = 3.50$; $p = 0.0824$ (not significant; trend)

Table 25: Changes in Staff Use of Behavioral Management Strategies with Children

	Pre	Post	Follow Up	F Score	P value	Differences In Means Using F Tests
Teach children about posttraumatic stress.	1.07	2.74	1.5	1.78	0.21	
Provide opportunities for children to confidentially discuss their experiences of domestic violence or trauma.	2.44	2.53	2.63	0.37	0.7	
Use time-out (ages 2-7)	1.88	2.68	2.05	0.68	0.52	
Use privilege removal (ages 8 – 18)	2.11	2.74	2.24	0.95	0.43	
Focus on positive behaviors of the children.	2.67	2.79	2.89	1.05	0.37	
Reward small improvements towards desired behavior.	2.44	2.32	2.37	0.28	0.76	
Use logical and natural consequences.	2.11	2.32	2.42	0.13	0.88	
Focus on how to find solutions rather than causes of the problems.	2.33	2.84	2.75	2.73	0.1	
Maintain calmness when faced with an aggressive or disruptive child.	2.67	2.68	2.84	0.94	0.41	
Confront children who make inappropriate comments.	2.5	2.11	2.32	1.2	0.32	
Model dignity and respect at the shelter.	2.76	2.84	2.79	0.06	0.94	
Teach and encourage children to use self-calming techniques.	2.17	2.11	2.37	0.98	0.4	
Handle problems privately with individual child.	2.5	3.05	2.63	0.96	0.4	
Use group problem solving for and with other children	2	3	1.79	2.38	0.12	
Use screening tools to make decisions about children's shelter care.	1.39	2.26	2.24	3.59	0.06	2 See below
Use shelter routines to provide structure and consistency with children	2.71	2.32	2.58	1.38	0.28	

(2): Differences in Means

- Pre – Post: F= 5.40; p= 0.0346 (significant)
- Pre – Follow-up: F = 7.06; p = 0.0179 (significant)
- Post – Follow-up: F= 0.06; p = 0.8172 (not significant)

Table 26: Changes in Staff Teaching of Behavioral Management to Parents

	Pre	Post	Follow Up	F Score	P value	Differences in Means Using F Tests
Teach parents about the effects of DV on children	2.5	2.32	2.79	6.46	0.009	3
Teach parents how to actively ignore	0.65	1.89	1.67	9.23	0.003	4
Teach parents which behaviors are appropriate to ignore	1.5	1.89	2.26	4.2	0.034	5
Teach parents to praise the opposite of misbehavior.	1.83	2.44	2.68	5.66	0.015	6
Teach parents how to give effective commands.	2.11	2.26	2.63	2.87	0.086	7
Teach parents how to use time out effectively	2.11	2.37	2.63	3.38	0.06	8
Teach parents how to use logical and natural consequences	2.06	2.37	2.37	0.63	0.543	
Teach parents how to create predictable structures and routines for children.	2.24	2.32	2.42	0.45	0.647	
Teach parents how to focus on positive interactions between parents and children.	2.44	2.42	2.63	0.4	0.677	

(3): Differences in Means

- Pre – Post: F= 0.65; p= 0.4299 (not significant)
- Pre – Follow-up: F = 1.51; p = 0.2355 (not significant)
- Post – Follow-up: F= 11.77; p = 0.0032 (significant)

(4): Differences in Means

- Pre – Post: F= 19.74; p= 0.0005 (significant)
- Pre – Follow-up: F = 10.86; p = 0.0049 (significant)
- Post – Follow-up: F= 0.81; p = 0.3828 (not significant)

(5): Differences in Means

- Pre – Post: F= 11.81; p= 0.0037 (significant)
- Pre – Follow-up: F = 5.29; p = 0.0362 (significant)
- Post – Follow-up: F= 3.46; p = 0.0825 (not significant; trend)

(6): Differences in Means

- Pre – Post: F= 11.81; p= 0.0037 (significant)
- Pre – Follow-up: F = 5.29; p = 0.0362 (significant)
- Post – Follow-up: F= 3.46; p = 0.0825 (not significant; trend)

(7): Differences in Means

- Pre – Post: F= 11.81; p= 0.0037 (significant)
- Pre – Follow-up: F = 5.29; p = 0.0362 (significant)
- Post – Follow-up: F= 3.46; p = 0.0825 (not significant; trend)

(8): Differences in Means

- Pre – Post: F= 11.81; p= 0.0037 (significant)
- Pre – Follow-up: F = 5.29; p = 0.0362 (significant)
- Post – Follow-up: F= 3.46; p = 0.0825 (not significant; trend)

Table 27. Changes in Staff Use of Referral Services for Children

	Pre	Post	Follow Up	Score	P value	Sign?
How often do you refer to your LME?	1.18	1.9	1.41	0.97	0.432	
How often do you get children mental health case managers?	1.33	1.31	1.61	2.14	0.1681	
How often do you refer children to CDSA?	0.88	1.23	1.35	2.86	0.1158	
How often do you refer children for counseling?	1.65	1.81	1.76	0.33	0.7283	
How often do you refer parents for counseling?	1.82	2	2.17	2.14	0.1602	
How often do you use your local legal aid?	1.59	1.73	2.33	7.37	0.0082	9
How often do you refer children for tutoring?	1.13	1.38	1.53	3.44	0.0661	10
How often do you refer children for court advocacy?	0.79	0.64	1.18	1.56	0.2618	
How often do you consult with police regarding children?	1	0.94	1.22	2.16	0.1551	

(9): Differences in Means

- Pre – Post: F= 0.10; p= 0.7522 (not significant)
- Pre – Follow-up: F = 11.41; p = 0.0049 (significant)
- Post – Follow-up: F= 13.44; p = 0.0028 (significant)

(10): Differences in Means

- Pre – Post: F= 1.92; p= 0.1894 (not significant)
- Pre – Follow-up: F = 6.07; p = 0.0285 (significant)
- Post – Follow-up: F= 1.37; p = 0.2631 (not significant)

Table 28 Changes in Staff Self-confidence to Use Screening Measures

	Pre	Post	Follow Up	F Score	P value	Sign?
I can recognize the symptoms of post traumatic stress in children due to exposure to domestic violence	3.11	3.42	3.73	2.97	0.0798	11
I can correctly administer an instrument that measures post traumatic stress in children	2.22	3.42	3.47	8.49	0.0038	12
I can correctly score an instrument that measures post traumatic stress in children	2.06	3.53	3.24	9.73	0.0026	13
I can correctly interpret the results of the score to make a behavioral management decision	2.17	3.79	3.47	14.53	0.0004	14
I can recognize other symptoms of mental illness in children due to exposure to domestic violence	2.67	3.47	3.17	1.8	0.199	
I can correctly administer an instrument that measures other symptoms of mental illness in children	2.33	3.42	2.88	3.86	0.0461	15
I can correctly interpret the results of the score to make a behavioral management decision.	2.33	3.42	3.18	5.69	0.0156	16

(11): Differences in Means
- Pre – Post: F= 0.65; p= 0.4299 (not significant)
- Pre – Follow-up: F = 6.25; p = 0.0229 (significant)
- Post – Follow-up: F= 1.91; p = 0.1853 (not significant)

(12): Differences in Means
- Pre – Post: F= 15.38; p= 0.0014 (significant)
- Pre – Follow-up: F = 13.97; p = 0.0020 (significant)
- Post – Follow-up: F= 0.00; p = 1.00 (not significant)

(13): Differences in Means
- Pre – Post: F= 20.79; p= 0.0004 (significant)
- Pre – Follow-up: F = 11.37; p = 0.0046 (significant)
- Post – Follow-up: F= 2.50; p = 0.1362 (not significant)

(14): Differences in Means
- Pre – Post: F= 24.48; p= 0.0002 (significant)
- Pre – Follow-up: F = 23.71; p = 0.0002 (significant)
- Post – Follow-up: F= 0.79; p = 0.3883 (not significant)

(15): Differences in Means

- Pre – Post: F= 8.00; p= 0.0127 (significant)
- Pre – Follow-up: F = 2.45; p = 0.1380 (not significant)
- Post – Follow-up: F= 5.95; p = 0.0276 (significant)

(16): Differences in Means

- Pre – Post: F= 11.81; p= 0.0037 (significant)
- Pre – Follow-up: F = 5.29; p = 0.0362 (significant)
- Post – Follow-up: F= 3.46; p = 0.0825 (significant)

Follow-up Evaluation of Sustainability - Site Level Findings

Each question was answered on a four point scale (0 = Not at all; 1 = A little; 2 = Somewhat and 3 = A lot). The results below are shown as means with standard deviations in parentheses below the mean. The alphas for each scale follow this set of tables.

Table 29: Memory Sub-scale

Item	Caldwell N = 3	Guilford N = 3	Halifax N = 2	Robeson N = 1	Vance N = 3	Wilson N = 5
The budget includes separate funds to employ key personnel necessary to carry out screening and referral.	2.67 (0.58)	0.00 (0.00)	1.50 (2.12)	2.00	1.67 (0.58)	1.25 (0.96)
There is a permanent position designated for screening and referral.	3.00 (0.00)	0.67 (0.58)	1.50 (2.12)	3.00	2.33 (0.58)	1.25 (0.96)
We have more than one person trained to do the screening.	3.00 (0.00)	2.33 (0.58)	3.00 (0.00)	3.00	2.33 (0.58)	1.50 (0.58)
We have an interpreter to make sure screening can be implemented with non-English speaking families.	2.00 (1.00)	2.00 (1.73)	2.50 (0.70)	3.00	2.67 (0.58)	2.25 (0.96)
There is a supervisor assigned to oversee administrative responsibilities for screening.	3.00 (0.00)	1.33 (1.16)	3.00 (0.00)	3.00	2.67 (0.58)	1.00 (1.00)
Mean – Overall Memory Score	**2.73 (0.31)**	**1.27 (0.61)**	**2.30 (0.71)**	**2.80**	**2.33 (0.42)**	**1.47 (0.64)**

Table 30: Adaptation Sub-Scale

Item	Caldwell N = 3	Guilford N = 3	Halifax N = 2	Robeson N = 1	Vance N = 3	Wilson N = 5
We have made changes in our intake procedures to incorporate screening into the shelter's daily functioning.	1.67 (1.53)	1.00 (1.00)	3.00 (0.00)	2.00	2.67 (0.58)	1.00 (1.16)
We have made changes in our client records to document screening results and referrals.	2.00 (1.00)	0.67 (1.16)	3.00 (0.00)	2.00	2.67 (0.58)	1.00 (1.00)
We have incorporated the results of screening into our annual report.	0.33 (0.58)	0.00 (0.00)	2.50 (0.71)	0.00	0.00 (0.00)	0.50 (0.71)
We have changed the staff's schedule in order to implement the screening procedures.	1.00 (1.00)	0.00 (0.00)	1.50 (2.12)	2.00	1.00 (1.73)	0.67 (1.16)
We have adapted the use of the screening tools to the comfort level of the staff.	1.00 (1.00)	1.33 (1.16)	3.00 (0.00)	2.00	2.33 (0.58)	0.75 (0.96)
We have identified ways to reduce the time it takes to screen children.	1.33 (1.53)	0.33 (0.58)	2.50 (0.71)	0.00	2.33 (0.58)	0.50 (1.00)
Screening and referral is now written into our training manual.	0.00 (0.00)	0.33 (0.58)	2.00 (0.00)	0.00	0.33 (0.58)	0.50 (1.00)
Mean – Overall Adaptation Score	**1.05 (0.79)**	**0.52 (0.46)**	**2.50 (0.51)**	**1.14**	**1.62 (0.22)**	**0.71 (1.01)**

Table 31: Value Sub-scale

Item	Caldwell N = 3	Guilford N = 3	Halifax N = 2	Robeson N = 1	Vance N = 3	Wilson N = 5
The shelter director supports the use of the screening tools.	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3	3.00 (0.00)	1.00 (1.16)
We have incentives or rewards that encourage our staff to carry out screening and referral.	0.33 (0.58)	0.00 (0.00)	2.00 (1.41)	1	0.67 (1.16)	0.75 (0.96)
We continue to implement screening in spite of cost in terms of time and effort on part of staff.	3.00 (0.00)	2.33 (1.16)	3.00 (0.00)	3	3.00 (0.00)	0.67 (0.58)
Our relationships with other agencies in the community have been enhanced as a result of screening and referral.	3.00 (0.00)	1.33 (0.58)	3.00 (0.00)	1	2.33 (0.58)	1.33 (1.53)
Mean – Overall Value Scale	**2.33 (0.14)**	**1.67 (0.38)**	**2.75 (0.35)**	**2.00**	**2.25 (0.43)**	**1.08 (0.95)**

Table32: Rules Sub-scale

Item	Caldwell N = 3	Guilford N = 3	Halifax N = 2	Robeson N = 1	Vance N = 3	Wilson N = 5
The Tool Kit has been viewed by all staff at the shelter.	2.33 (0.58)	0.50 (0.71)	2.00 (0.00)	3	1.00 (1.73)	0.33 (0.58)
We use the Tool Kit to train all new shelter staff.	2.67 (0.58)	0.00 (0.00)	2.00 (1.41)	3	0.33 (0.58)	0.67 (1.16)
The Tool Kit is used as a reference resource by existing shelter staff.	2.00 (1.00)	0.50 (0.71)	3.00 (0.00)	3	1.00 (1.73)	1.00 (1.00)
We hold meetings periodically related to screening and referral.	1.00 (1.00)	0.50 (0.71)	1.50 (2.12)	2	2.33 (0.58)	1.25 (1.50)
A protocol has been written by our shelter that describes how screening should be conducted.	0.33 (0.58)	0.00 (0.00)	2.00 (0.00)	0	1.00 (1.00)	0.33 (0.58)
Mean – Overall Rules Scale	**1.67 (0.31)**	**0.30 (0.42)**	**2.10 (0.71)**	**2.20**	**1.13 (0.81)**	**0.60 (0.53)**

Table 33: Community Partners Sub-scale

Item	Caldwell N = 3	Guilford N = 3	Halifax N = 2	Robeson N = 1	Vance N = 3	Wilson N = 5
Key community service providers are aware of the screening program.	2.33 (0.58)	1.00 (0.00)	2.50 (0.71)	1	1.67 (0.58)	0.75 (0.96)
We have met with key community service providers to discuss ways to work together to meet the needs of children.	2.33 (0.58)	1.33 (1.53)	3.00 (0.00)	1	2.00 (0.00)	2.00 (1.41)
Community service providers are supportive of our screening and referral of children to their organizations.	2.33 (0.58)	2.33 (0.58)	3.00 (0.00)	2	2.00 (0.00)	2.00 (1.41)
We have or are developing targeted information for our key community service providers about screening and referral.	2.00 (1.00)	0.33 (0.58)	2.50 (0.71)	2	1.67 (0.58)	1.50 (1.00)
CDSAs are among our key community service providers for children under 3.	2.33 (1.16)	0.67 (0.58)	3.00 (0.00)	3	2.33 (0.58)	1.75 (1.26)
Health Service Coordinators in the Health Department are among our key service providers for children under 5.	2.33 (1.16)	1.00 (0.00)	3.00 (0.00)	3	2.00 (0.00)	1.75 (1.26)
Mental health services are among our key service providers for children.	2.00 (1.00)	1.67 (1.16)	3.00 (0.00)	3	2.67 (0.58)	1.50 (1.29)
LME's are among our key service providers for children.	2.00 (1.00)	0.67 (0.58)	3.00 (0.00)	2	2.67 (0.58)	1.33 (1.16)
DSS is one of our key service providers for children.	3.00 (0.00)	2.00 (1.00)	3.00 (0.00)	3	2.33 (0.58)	1.75 (1.26)
Mean- Overall Community Partners Scale	**2.30 (0.67)**	**1.22 (0.33)**	**2.89 (0.16)**	**2.22**	**2.15 (0.13)**	**1.37 (1.20)**

Table 34: Technology Sub-scale

Item	Caldwell N = 3	Guilford N = 3	Halifax N = 2	Robeson N = 1	Vance N = 3	Wilson N = 5
Our supervisors have ready access to PC's with CD-ROMs, audio and privacy for computer based learning.	2.33 (1.16)	2.33 (0.58)	3.00 (0.00)	2	2.67 (0.58)	2.00 (0.80)
Our supervisors have access to the internet through a high speed, broadband connection.	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	2	2.67 (0.58)	2.50 (0.58)
Our supervisors have access to email.	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	2	2.67 (0.58)	2.75 (0.50)
Supervisors have taken computer based training in the past for clinical, admin. or compliance purposes.	2.33 (1.16)	2.00 (1.00)	3.00 (0.00)	0	2.00 (0.00)	1.50 (1.00)
Mean – Overall Technology Scale	**2.67 (0.29)**	**2.58 (0.38)**	**3.00 (0.00)**	**1.50**	**2.50 (0.43)**	**2.19 (0.52)**

Table 35: Overall Sustainability Score

	Caldwell N = 3	Guilford N = 3	Halifax N = 2	Robeson N = 1	Vance N = 3	Wilson N = 5
Mean – Overall Sustainability Scale	**2.06 (0.18)**	**1.04 (0.06)**	**2.60 (0.40)**	**1.97**	**1.97 (0.05)**	**1.07 (0.98)**

Table 36: Alpha scores of the subscales and total sustainability scale.

N = 19	Alpha
Overall Memory Scale	0.77
Overall Adaptation Scale	0.88
Overall Value Scale	0.71
Overall Rules Scale	0.74
Overall Community Partners Scale	0.94
Overall Technology Scale	0.68
Overall Sustainability Scale	0.95

Table 37: At this point in time, how permanent do you think that screening and referral is at your shelter?

Shelters	N	No longer delivered		Not at all permanent		Moderately permanent		Very permanent	
		N	%	N	%	N	%	N	%
Caldwell	3	0	0.0	0	0.0	0	0.0	3	100.0
Guilford	3	0	0.0	1	33.3	0	0.0	2	66.7
Halifax	2	0	0.0	0	0.0	0	0.0	2	100.0
Robeson	1	0	0.0	0	0.0	0	0.0	1	100.0
Vance	3	0	0.0	0	0.0	0	0.0	3	100.0
Wilson	5	1	20.0	0	0	3	60.0	1	20.0
Total	17	1	5.9	1	5.9	3	17.6	12	70.6

Table 38: Which of the following describes how screening and referral has evolved since it first began?

Shelters	N	Not changed at all		Undergone minor modification		Undergone major modification	
		N	%	N	%	N	%
Caldwell	3	0	0.0	3	100.0	0	0.0
Guilford	3	1	33.3	2	66.7	0	0.0
Halifax	2	0	0.0	0	0.0	2	100.0
Robeson	1	0	0.0	1	100.0	0	0.0
Vance	3	0	0.0	3	100.0	0	0.0
Wilson	5	1	20.0	2	40.0	0	0.0
Total	17	2	11.8	11	61.1	2	11.8

Comments:

- Used for children's advocacy center (CAC) as well as domestic violence support group for women in community (Guilford)
- Implemented it - every child upon entry is screened. (Halifax)
- All staff is being trained so it will be done at intake. (Halifax)

Table 39: Since you began conducting screening and referral have there been any changes in the conditions or structure of the shelter that affected screening and referral significantly?

Shelters	N	Yes		No		Not Applicable	
		N	%	N	%	N	%
Caldwell	3	1	33.3	2	66.7	0	0.0
Guilford	3	2	66.7	1	33.3	0	0.0
Halifax	2	1	50.0	1	50.0	0	0.0
Robeson	1	1	100.0	0	0.0	0	0.0
Vance	3	1	33.3	2	66.7	0	0.0
Wilson	5	1	20.0	0	0.0	2	40.0
Total	17	7	41.2	6	32.3	2	11.8

Table 40: Since you began conducting screening would you say that there has been many, some or few changes in the staff (staff turnover)?

Shelters	N	Many		Some		Few		Don't Know / NA	
		N	%	N	%	N	%	N	%
Caldwell	3	0	0.0	0	0.0	3	100.0	0	0.0
Guilford	3	2	66.7	1	33.3	0	0.0	0	0.0
Halifax	2	0	0.0	0	0.0	2	100.0	0	0.0
Robeson	1	1	100.0	0	0.0	0	0.0	0	0.0
Vance	3	0	0.0	0	0.0	2	66.7	1	33.3
Wilson	5	1	20.0	1	20.0	0	0.0	1	20.0
Total	17	4	23.5	2	11.8	7	41.2	2	11.8

Comments:

- Agency is going through structural changes which affects directors; which affects direct staff. (Guilford)
- Has been high turnover with staff which can be the nature of the human services field (Guilford)
- Shelter coordinator, weekend shelter staff, children program coordinator, crisis counselor, ED (Robeson)
- Shelter staff seems to stay on about a 50% rotation where approximately 50% of shelter staff positions quit and others are hired. (Guilford)
- Significant staff turn over and no training to new staff re: these measures (Wilson)

Table 41: Does the shelter have one or more program champions – someone in the community who strongly advocates for the continuation of screening and referral?

Shelters	N	Yes		No		Not Applicable	
		N	%	N	%	N	%
Caldwell	3	1	33.3	0	0.0	2	66.7
Guilford	3	3	100.0	0	0.0	0	0.0
Halifax	2	1	50.0	0	0.0	0	0.0
Robeson	1	0	0.0	1	100.0	0	0.0
Vance	3	0	0.0	2	66.7	1	33.3
Wilson	5	1	20.0	0	0.0	2	40.0
Total	17	6	35.3	3	17.6	5	29.4

Comments:

- Case managers and child therapists have worked and continue to work to get this service consistently delivered (Guilford)
- DSS is aware that we are using for CAC- some social workers are referring clients just for assessment (at least). (Guilford)
- DSS, LME, court system (Halifax)
- Our board is supportive. (Caldwell)
- Shelter supervisor, director of victim services, case managers (Guilford)
- Therapists (Wilson)
- Some what (Caldwell)

Table 42: Would you say that staff has been adequately trained to carry out screening and referral?

Shelters	N	Yes		No		Not Applicable	
		N	%	N	%	N	%
Caldwell	3	3	100.0	0	0.0	0	0.0
Guilford	3	2	66.7	1	33.3	0	0.0
Halifax	2	2	100.0	0	0.0	0	0.0
Robeson	1	1	100.0	0	0.0	0	0.0
Vance	3	3	100.0	0	0.0	0	0.0
Wilson	5	1	20.0	3	60.0	0	0.0
Total	17	12	70.6	4	23.5	0	0.0

Table 43: Before participating in the DVS Screening Project, had the shelter been involved in screening children to determine their needs?

Shelters	N	Frequently		Occasionally		Never	
		N	%	N	%	N	%
Caldwell	3	1	33.3	2	66.7	0	0.0
Guilford	3	0	0.0	1	33.3	2	66.7
Halifax	2	0	0.0	0	0.0	2	100.0
Robeson	1	0	0.0	0	0.0	1	100.0
Vance	3	0	0.0	2	66.7	1	33.3
Wilson	5	2	40.0	0	0.0	1	20.0
Total	17	3	17.6	5	29.4	7	41.2

Table 44: Staff knew about and agreed in advance to participate in the DVS Screening Project.

Shelters	N	Strongly Agree		Agree		Disagree	
		N	%	N	%	N	%
Caldwell	3	3	100.0	0	0.0	0	0.0
Guilford	3	3	100.0	0	0.0	0	0.0
Halifax	2	0	0.0	0	0.0	2	100.0
Robeson	1	1	100.0	0	0.0	0	0.0
Vance	3	3	100.0	0	0.0	0	0.0
Wilson	5	2	40.0	1	20.0	0	0.0
Total	17	12	70.6	1	5.9	2	11.8

Table 45: Staff was involved in making decisions about how screening and referral would be carried out during and after training.

Shelters	N	Strongly Agree		Agree		Disagree	
		N	%	N	%	N	%
Caldwell	3	2	66.7	1	33.3	0	0.0
Guilford	3	2	66.7	1	33.3	0	0.0
Halifax	2	2	66.7	0	0.0	0	0.0
Robeson	1	1	100.0	0	0.0	0	0.0
Vance	3	2	66.7	1	33.3	0	0.0
Wilson	5	0	0.0	3	60.0	0	0.0
Total	17	9	52.9	6	35.3	0	0.0

Table 46: Screening and referral fits with the mission and objectives of the shelter.

Shelters	N	Strongly Agree		Agree		Disagree	
		N	%	N	%	N	%
Caldwell	3	3	100.0	0	0.0	0	0.0
Guilford	3	3	100.0	0	0.0	0	0.0
Halifax	2	2	100.0	0	0.0	0	0.0
Robeson	1	1	100.0	0	0.0	0	0.0
Vance	3	3	100.0	0	0.0	0	0.0
Wilson	5	2	40.0	1	20.0	0	0.0
Total	17	14	82.4	1	5.9	0	0.0

What barriers do you continue to face in implementing screening and referral?

- Staff turnover has resulted in no training from this project being provided to new employees. (Wilson)
- The fact that families do not stay long enough to get results (Wilson)
- I make referrals to staff therapists so there are very few barriers on my level. (Wilson)
- Language barriers transportation confidentiality issues (Wilson)
- Willingness on part of participants (Vance)
- Most don't have but some need time for explain few children taken away (Vance)
- Mother admittance (Vance)
- Lack of participation (Vance)
- Transient nature of sheltered families (Guilford)
- Scheduling of children's and staff's availability (Guilford)
- Referrals are actions that require mom's to go out into the community to unfamiliar territory- sometimes there is resistance. (Guilford)
- Shelter stay brief: Therapist may have conflicts scheduling rather than case manager. (Guilford)
- Mothers often protective and hesitant to consider impact of DV (Guilford)
- Clients in shelter not staying long enough for an initial screening and the clients who have been screened lack of follow through with referrals (Guilford)
- Funding (Caldwell)
- Length of stay with clients. Some enter and exit before tools can be used (Caldwell)
- The biggest barrier is not in the screening or the referrals. The agencies we work with are awesome. It's in mom's ability to follow up. All the referrals in the world won't help if mom won't make the appointments. (Caldwell)
- Staff turnover and lack of experienced providers for children who have experienced domestic violence. Most children we see have Medicaid and must go through the LME's screening and referral process. This process often takes a month or more from initial phone call to an appointment with a therapist for therapy services. (Robeson)

What have you tried to overcome them?

- Tried to determine what was used and how it was administered to clients (Wilson)
- Haven't been able to (Wilson)
- Provided interpretation transportation get to know the clients (Wilson)
- We just spend the time explaining to the parent that the info is not going to be used to harm children in any way. (Vance)
- Talking to the mother (Vance)
- Explaining to the parent and children exactly what the tool is for (Vance)
- Unclear about how to overcome (Guilford)
- Identified scheduling strategies and available staff (Guilford)
- Working to develop community relations to the extent that referred clients are received with overt welcoming behavior (Guilford)
- Schedule ASAP delivery of results crucial (Guilford)
- Communication with shelter staff depending on clients consent (Guilford)
- Maintained close contact between shelter staff case manager therapist and any other collateral people (Guilford)
- Discuss in detail the effects of domestic violence on children at the initial case management meeting (Guilford)
- Also, continue to follow-up with mothers of children in shelter about how children are doing with shelter adjustment, living, etc. and relate that to the assessments/measurements in identifying risk factors. (Guilford)
- Beg and divert other fund to children's program (Caldwell)
- Get with the patient quicker if she's mentally and emotionally ready (Caldwell)
- The biggest thing that I have done is to build the agencies up. I explain the services each agency offers. Explain the positive benefits of collaborating with these agencies for the children and continue to be accessible for questions as time goes on. I don't necessarily know how the outcomes go but am hoping this will help. (Caldwell)
- We have made the responsibility of screening a part of the CPC job description and formal intake processes. We currently have our own children's therapist who is paid from a grant. This works well because children who we referral can be seen the next week in most cases. This grant runs out in September. We applied for another grant to pick up these services, but we were not approved for funding. We will continue to seek funding in order to maintain our own counseling services. When the parent is not interested in therapy or formal counseling services we offer our children's support group in lieu of or in conjunction with other services. This group is a topic group where issues such as self-esteem, safety, and identifying feelings are discussed. (Robeson)

What is the biggest factor that has led to the continued implementation of the measures at your shelter?

- N/A as measures are no longer being used (Wilson)
- The fact that we lost the staff screen that was implementing the measures and now we have staff that want to continue it (Wilson)
- To help with awareness early intervention and the prevention of further or long term effects on the child (Wilson)
- Our desire to help children we provide services to (Vance)
- To help the children (Vance)
- Our desire to provide the best care that we can to help our clients (Vance)
- It has been the staff person's compassion for enhancing services to children that has kept this project going. (Guilford)
- In time leadership will begin to see the model and will understand more about supporting. (Guilford)
- Therapist has been involved to establish rapport and encourage family to continue therapy. (case manager has taken over assessments again) (Guilford)
- During initial case management meeting clients are informed that they can participate in measures (Guilford)
- It has assisted us in better understanding the moods, reactions and actions. (Halifax)
- We had never focused on children before and now we have decided that we need to focus more on children. (Halifax)
- Commitment by director (Caldwell)
- Support from board of directors (Caldwell)
- Having a children's program manager (Caldwell)
- The ease of using and scoring and the ability to identify problem areas quickly (Caldwell)
- The needs of children. The tools help to identify their needs and with the screening sheets it is easier to know where to refer. Since coming on board, I have attempted to do the screenings early on in the stay so we have time to let the agencies come in if mom agrees. It's working great. (Caldwell)
- Current ED is the only person who began with the shelter screening project who remains employed at the agency. ED feels project is valuable and is taking steps to ensure the project is maintained. Responsibility for administering shelter screenings is now written into the Children's Program Coordinator's job description. Other staff members are trained on how to administer measures but CPC is responsible for maintaining records, making referrals and ensuring each parent/child that enters the shelter is asked to complete screening. Also, screening is discussed in each parenting group once a month to solicit parents who are interested in completing assessments. The parenting groups are also led by the CPC. We have 3 parenting groups with approximately 10 parents attending each week in each group. Parents attend the groups for 8 weeks. By discussing the tools in each group monthly every parent should get the opportunity to complete a measure. During our normal intake process we inquire bout counseling and children's services. At that time if the parent or child has concerns we offer the assessment. (Robeson)

What additional help / actions needed?

- Training for new staff and contact lists for new or continuing staff to ensure continuation of measures use in shelter and guidance for when issues or concerns arise between any training opportunities (Wilson)
- Time (Wilson)
- Continued awareness (Wilson)
- Training to work better and serve better the clients developed programs for clients doesn't have legal documentation to get some services for mental health only provided (Wilson)
- Occasional updates and training (Vance)
- Director input (Vance)
- Staff person at each shelter maybe a therapist position would work (Guilford)
- Understanding from agency that therapist and/or case manager is doing assessments (does take time to complete) (Guilford)
- Results from parents' perspective didn't always match shelter staff/ therapists concerns for family's well being- maybe another adult (teacher/shelter staff) could complete assessment to get more info/ another perspective. (Guilford)
- Come up with written requirements into shelter policies and procedures for the assessment tools to be offered to every client. Provide more training to all shelter staff about the tool kit. (Guilford)
- Continued training (affordable and on our level) in child witness to domestic violence (Caldwell)
- Web based for forms, question and answers, support (Caldwell)
- We will be taking the following actions by December 2007: make the screenings a part of our training manual meet with local providers to make them aware of the screening tools we administer write a protocol for screening use include information about screenings and tool kit in monthly staff meetings ensure that all staff are trained on screening tools and information in tool kit ensure that shelter staff is intervening when they observe parenting concerns and use interventions suggested in tool kit ensure that all staff have access to tool kit (Robeson)