



Final Report

Comprehensive Assessment and Recommendations for the Integration
of Domestic Violence Service with Child Welfare Services

Limited Scope Assessment and Initial Recommendations for the
Integration of Domestic Violence Services with Mental Health and
Substance Abuse Services

Sponsored by FCADV and the State of Florida, Department of Children and Families.

This project was supported by Contract No. LN966 awarded by the state administering office for the STOP Formula Grant Program. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the state or the U.S. Department of Justice, Office on Violence Against Women.

Table of Contents

Content	Page Number
Background Information and Executive Summary.....	3
Introduction.....	8
Community Readiness Assessment Overview.....	9
Data Analysis: Domestic Violence Center Participants.....	10
Data Analysis: Child Welfare Agency Participants.....	19
Summary of Survey Results: Managing Entities.....	30
Recommendations: Domestic Violence and Child Welfare Service Integration.....	31
Conclusion and Next Steps.....	39
Appendices:	
Appendix A: Electronic Map of Florida’s Domestic Violence and Child Welfare Agencies	
Appendix B: Locations of Florida’s Child Protection Investigation Units	
Appendix C: MOU and Protocol Submission Analysis Spreadsheet	
Appendix D: Sample MOU for Domestic Violence and Child Welfare Partners	
Appendix E: Sample Protocol for Domestic Violence and Child Welfare Partners	
Appendices F1 and F2: Maps of Survey Respondents by Circuit	

Background Information and Executive Summary

Protecting children from the effects of domestic violence is a mutual priority of the Florida Coalition Against Domestic Violence (FCADV), the Department of Children and Families (DCF), and the Office of the Attorney General (OAG). 'Family violence threatens child' is one of the highest maltreatment offenses reported to the Statewide Florida Abuse Hotline. With this in mind, and the knowledge that children in the foster care system often have poor life outcomes, FCADV, DCF, and the OAG worked together to create a groundbreaking program focused on reducing the removals of children from the non-offending parent in domestic violence cases. In 2000, FCADV and DCF engaged in the first initial effort to bridge contentious relationships between the DCF district child welfare and Domestic Violence (DV) Center staff. The organizations created a statewide advisory committee comprised of leadership from DCF and Florida's 42 Certified Domestic Violence Centers. The committee interviewed child welfare and domestic violence advocates as well as leadership in the child welfare and domestic violence arena. Information obtained through that process served as the foundation to create the first model Memorandum of Understanding (MOU) between DCF district offices and local Domestic Violence Centers. DCF Domestic Violence Program Office and FCADV staff spent four years providing intensive technical assistance working with the districts, regions, and Domestic Violence Centers to improve the outcomes of families where the co-occurrence of domestic violence and child abuse exist. In 2006, a few years after the Florida Legislature privatized child protective investigations to seven Sheriffs' Offices and created the Community Based Care Lead Agency model, DCF hired David Mandel, a national trainer who created the *Safe and Together Model*, to conduct training for DCF child protective staff in select districts. This model is touted throughout the country as best practice for domestic violence cases in the child welfare system. Input from the field was overwhelmingly positive regarding *the Safe and Together Model* and the DCF and FCADV adopted such as best practice.

Building upon the training and promoting this model, FCADV and DCF utilized Americans Recovery and Reinvestment Act (ARRA) funding in 2009 to initiate seven pilot Child Protective Investigation (CPI) projects. Each Certified Domestic Violence Center was funded to employ full-time domestic violence advocates, co-located within the seven Sheriffs' Offices, where the Legislature privatized the CPI functions. In one year, the CPI projects produced an approximate \$9,400,800 in savings to the State of Florida by creating a seamless system of wrap around services to keep the child in the home with the non-offending parent, thus reducing the cost of foster care services to the state. This highly successful pilot program provided expert consultation in cases involving domestic violence to child protective investigators; while providing case management services to families that support permanency, safety, and the well-being of children. This immediate intervention, sometimes within hours of a child abuse report, helped to stabilize the crisis and increase protective factors in the home.

During this first year of the project, advocates met monthly with Sheriff's Office CPI Unit supervisors in their respective service areas to discuss their local goals and to review challenges and successes as they worked hand in hand to develop the protocols and guidelines for the collaboration. Each Domestic Violence Center developed a Memorandum of Understanding, referral documents, and releases that were necessary for information sharing with their partnering Sheriff's Offices. Additionally, the partners

identified best practices in the interest of children and families involved in the project. At the end of the ARRA funding period, FCADV partnered with the OAG to secure replacement funding to continue this tremendously successful project. Since that time, FCADV has worked with the OAG and DCF to allocate funding for and provide intensive training and technical assistance to service providers implementing these programs. The remaining projects from the initial pilot cohort include:

- The Spring of Tampa Bay and the Hillsborough County Sheriff's Office;
- Community Action Stops Abuse and the Pinellas County Sheriff's Office;
- HOPE Family Services, Inc. and the Manatee County Sheriff's Office;
- Salvation Army Domestic Violence Program of West Pasco and the Pasco County Sheriff's Office;
- Women in Distress of Broward County, Inc. and the Broward County Sheriff's Office; and
- Citrus County Abuse Shelter Association, Inc. and Citrus County DCF Office (previously the Citrus County Sheriff's Office).

In 2011, when Governor Rick Scott transitioned the Services, Training, Officers, and Prosecutors (STOP) funding to FCADV, the organization utilized the dollars previously used for administrative functions to expand to six additional counties to replicate the highly successful CPI projects. The organization utilized the model to expand and provide funding for four additional sites serving six counties where the local Domestic Violence Center partners with the DCF regional offices and Community Based Care Lead Agencies. In addition, FCADV secured the leadership and participation of Attorney General Pam Bondi to partner with FCADV and DCF to expand and enhance these projects by increasing the leadership and participation with local law enforcement agencies and prosecutors. The additional projects include:

- Lee Conlee House, Inc. and the Putnam County DCF Office;
- The Shelter for Abused Women and Children and the Collier County DCF Office;
- The Salvation Army Domestic Violence and Rape Crisis Program and DCF Offices covering Bay, Gulf, and Calhoun Counties; and
- Victim Response Inc./The Lodge and the Miami Dade County DCF Office.

Each year, FCADV conducts intensive training and ongoing technical assistance with partners in each of the participating communities to enhance and reduce barriers to ensure successful implementation of the CPI Project. In addition, FCADV conducts regional Learning Exchanges and on-site Train the Trainers with co-located domestic violence advocates to prepare them to train their child welfare partners on strategies for increasing domestic violence perpetrator accountability and family safety in the child welfare system. Co-located advocates in the project sites are now conducting pre-service and/or in-service trainings on domestic violence for child welfare staff.

In 2010, FCADV expanded technical assistance and training to include any DV Center or child welfare office in the state that expressed a desire to replicate this project or enhance their current collaborations. In order to meet this growing need for training across the state, FCADV and David Mandel and Associates provided the highly touted *Safe and Together Model* training for domestic violence advocates and child welfare staff. This training helped to build their capacity to collaborate

locally on reducing the removal of children from the non-offending parent while employing strategies to hold the perpetrator accountable. FCADV continues to support DV Centers and their child welfare partners to build solid and sustainable partnerships and collaborations with the ultimate goal of increasing the safety of survivors and their children.

Integrating Services for Families Experiencing Domestic Violence

In efforts to effectively support the statewide integration of domestic violence services within Florida's child welfare, substance abuse, and mental health systems, FCADV developed a plan to assess the service integration of Certified Domestic Violence Centers, Community Based Care Agencies (CBCs), CPI units, and Managing Entities for Substance Abuse and Mental Health (SAMH) Services. The plan included the identification of barriers to addressing the unique situations when there is a co-occurrence of domestic violence and child abuse, highlighted strengths associated with same, and detailed steps that FCADV would take to conduct a comprehensive local community readiness assessment. Initially, the plan focused primarily on domestic violence and child welfare service integration. However, after the plan was developed, the DCF requested FCADV to send surveys to Managing Entities for Substance Abuse and Mental Health Services and gather baseline data regarding partnerships existing among those entities and DV centers. This report is a follow-up to the Service Integration Plan and identifies gaps and strengths of domestic violence, child welfare, mental health, and substance abuse agencies related to stakeholder and community readiness, training needs, and processes to coordinate services for survivors of domestic violence and their children when domestic violence co-occurs with child maltreatment. The report also includes, in a more limited scope, barriers to addressing the complexities of the co-occurrence of domestic violence and substance abuse and/or mental health.

Recommendations for Child Welfare and Domestic Violence Services

The report includes recommendations to increase and enhance the integration of domestic violence and child welfare services throughout Florida. These recommendations are based on the community readiness assessment findings described herein, on the best practices derived from FCADV's CPI Project sites, and on FCADV's collaborative work with DCF to implement the Transformation Project as it relates to child welfare agencies' work with Domestic Violence Centers in Florida. Recommendations include the following:

- **Leadership in Clarifying Roles and Responsibilities:** Leadership of Domestic Violence Centers and child welfare agencies should come together to find common ground and to clarify roles and responsibilities of their respective agencies and staff.
- **Developing Formal Agreements:** Child welfare agencies and Domestic Violence Centers should thoughtfully develop formal agreements such as Memoranda of Understanding and partnership protocols.
- **Training for Domestic Violence Advocates and Child Welfare Staff:** Domestic violence advocates and child welfare staff should be regularly and consistently cross-trained in order to increase the understanding of each others' roles and expertise. Training for child welfare staff

should be conducted by and/or in collaboration with local Certified Domestic Violence Centers in order to enhance local relationships and partnerships.

- **State Level Database with Partnership Information:** In an effort to conduct the most effective technical assistance possible, FCADV should work to develop and maintain a state level database that includes relevant partnership information for local child welfare agencies and Domestic Violence Centers.
- **Referrals to Certified Domestic Violence Centers:** Child welfare agencies should make referrals to Certified Domestic Violence Centers within 24 to 48 hours of the initial abuse investigation and throughout the case thereafter when domestic violence is identified. This is imperative to increasing the safety of survivors and their children.
- **Funding for Co-located Domestic Violence Advocates:** DCF should work collaboratively with FCADV to secure additional funding from the Legislature to staff co-located advocates at a rate of 40 CPIs to one co-located domestic violence advocate. These co-located advocates should be employed by Certified Domestic Violence Centers in Florida and will provide expert consultation on domestic violence cases in the child welfare system.
- **Perpetrator Accountability and Partnership with the Non-offending Parent:** It is critical that domestic violence and child welfare agencies come together to partner with non-offending parents and hold domestic violence perpetrators accountable in order to enhance family safety in domestic violence cases. In addition to training and partnership building, this will require a coordinated community response that involves partners including, but not limited to: law enforcement, probation offices, state attorney's offices, courts, child welfare agencies, and Domestic Violence Centers.

Laying the Foundation: Domestic Violence, Substance Abuse, and Mental Health

Five years ago, FCADV began conducting “survivor listening groups” to obtain feedback regarding critical needs and barriers identified by domestic violence survivors. As such, two priority areas identified by survivors have emerged year after year: 1) Survivors expressed a need and desire to receive mental health counseling/therapy in addition to the crisis intervention counseling and advocacy received from domestic violence advocates. 2) Survivors expressed the need for chemical dependency intervention and treatment by addictions counselors who understand the dynamics of domestic violence including the critical importance of safety when receiving substance abuse treatment. As such, FCADV receives numerous training and technical assistance requests from Domestic Violence Centers and allied partners regarding working with survivors living with substance abuse and mental health complexities. In 2011, FCADV utilized the STOP funds that were designated to the organization, to fund a pilot project that focuses on the intersection of domestic violence and mental health. Specifically, the project addresses the gaps in service delivery and lack of access to services for survivors of domestic violence who are also living with mental health concerns. Through this project, FCADV is laying the groundwork for similar partnerships across the state.

Although there have been great strides in integrating domestic violence and child welfare services, the integration of domestic violence services with mental health and substance abuse services is in the

infancy phase. There is much work to be done in this arena to effectively plan and implement statewide initiatives to meet the critical needs of survivors living with mental health and/or substance abuse issues. In order to advance this important work, FCADV recommends the following:

- **State Level Partnership Building:** Representatives from FCADV and the DCF SAMH Program should begin meeting on a regular basis to create a comprehensive plan for the integration of domestic violence services with mental health and substance abuse services in Florida.
- **Assessment of Current Work:** FCADV should conduct an assessment of its current pilot project related to domestic violence and mental health service integration in order to create a blueprint for other communities in Florida.
- **Domestic Violence, Substance Abuse, and Mental Health Pilot Projects:** FCADV should fund one or two additional pilot sites, pending available funding, to address the unique complexities of working with domestic violence survivors where substance abuse and/or mental health issues also exist.
- **Full Integration Pilot Projects:** FCADV should fund a minimum of one pilot site, pending available funding, in a community in which an FCADV CPI project currently exists in order to support and garner evidence for the full integration of domestic violence, substance abuse, mental health, and child welfare services related to domestic violence.

The recommendations in this report are offered as guidelines for local Domestic Violence Centers, SAMH providers, and child welfare agencies to build formal collaborative relationships to work with families experiencing domestic violence with one or more of these co-occurring issues. State and local agencies in Florida have a responsibility to come to the table together to enhance services for survivors and their children. This can be accomplished through thoughtful planning, a commitment to understanding each others' perspectives, and under the ideals that all parties involved want to keep children safe and lessen the impact that violence in the home has on families.

Introduction

The Florida Coalition Against Domestic Violence Child Welfare and Child Protection Initiative projects are a collaborative effort between FCADV, the Office of the Attorney General, the Department of Children and Families, local Certified Domestic Violence Centers, Community Based Care agencies, and other child welfare professionals, implemented to provide an optimal coordinated community response to families experiencing the co-occurrence of domestic violence and child abuse. After years of partnership, the DCF Domestic Violence Program Office and FCADV possess a clear understanding that early involvement of domestic violence advocates in cases where child abuse and domestic violence co-occur can reduce the risk to children by providing immediate resource and referral information and safety planning for the non-offending parent and their children.

FCADV's Child Protection Initiative Project establishes partnerships in which a domestic violence and child welfare advocate is co-located within a Child Protection Investigation Unit. The co-located advocate provides consultation to child protection staff, referral services to survivors, and attends monthly meetings between all partnering stakeholders to develop strategies to resolve any barriers or issues that may arise. The ultimate goal of these projects is to bridge the gap between child welfare and domestic violence service providers to enhance family safety, create permanency for children, and hold perpetrators accountable for their actions.

In efforts to effectively support the statewide integration of domestic violence services within Florida's child welfare and Substance Abuse and Mental Health (SAMH) systems, FCADV developed a plan to assess the service integration of Certified Domestic Violence Centers, CBCs, CPI units, and Managing Entities of SAMH providers. The plan addressed how gaps, strengths, and local community readiness would be assessed within each circuit. Specific focus areas of the plan included: determining the geographic location of all the aforementioned child welfare entities in relation to the Certified Domestic Violence Center(s) in their communities; determining local child welfare organizational profiles; assessing current field practices of CPI units and CBCs regarding domestic violence cases in the child welfare system; and, assessing community partnerships and responses to families experiencing, domestic violence, child abuse, and/or substance abuse and mental health issues.

From January through May 2013, FCADV conducted the community readiness assessment as outlined in the Service Integration Plan. FCADV contracted with a data analysis consultant, demographer, and transcriptionist to assist with the readiness assessment. This report is a follow-up to the Service Integration Plan and will identify the gaps and strengths of domestic violence and child welfare agencies related to stakeholder and community readiness, training needs, and processes to coordinate services for survivors of domestic violence and their children when domestic violence co-occurs with child maltreatment. The report addresses, in a more limited scope, current strengths, gaps, and needs regarding the integration of domestic violence and SAMH services. The recommendations section outlines the need for domestic violence perpetrator accountability in the child welfare system, for partnerships among domestic violence and child welfare agencies, for hiring co-located domestic violence and child welfare advocates in each of Florida's communities, and next steps in building partnerships among state and local domestic violence and SAMH agencies.

Community Readiness Assessment Overview

FCADV gathered demographic information from Certified Domestic Violence (DV) Centers, CPI Units, DCF Circuit Administrators, CBCs, and Managing Entities for SAMH providers. Much of this information was gathered from online sources such as the Florida DCF website. FCADV then submitted requests to DCF and received the outstanding information that could not be obtained from online sources. A comprehensive document was created that includes information collected for each of the respective entities such as: physical addresses, telephone numbers, mailing addresses, contact information, email addresses, and service areas. Upon completion of the information gathering phase, FCADV emailed each of the contact persons listed and requested that they complete the FCADV Service Integration Survey via www.surveymonkey.com. The surveys were utilized to gather specific information about SAMH, child welfare, and domestic violence entities' capacity and readiness to institute, enhance, and/or formalize partnerships to increase the safety of families experiencing domestic violence. FCADV tailored each version of the survey for the specific type of entity to ensure information was applicable and relevant by agency. The first email to initiate the electronic data collection was sent out on March 1, 2013 and the survey links remained active for three weeks. Weekly follow-up correspondence was sent out to remind agencies to complete the survey and also to request follow-up documentation such as Memoranda of Understanding, collaborative agreements, training curricula, screening tools, and any policies or protocols related to the integration of services.

FCADV contracted with Dr. Melissa Radey, to conduct the analysis of the service integration survey data. Upon the initial survey data review, FCADV selected eight agency representatives to participate with on-site and telephone service integration interviews during the month of April 2013. These interviews were used to assist FCADV in collecting additional information needed to identify gaps and strengths related to stakeholder and community readiness, agency partnerships, and training needs. Dr. Radey assisted FCADV in developing the interview guides that were utilized during the meetings. In addition to the written responses, FCADV obtained permission to digitally record and professionally transcribe each interview so that the data could be compiled for the final analysis.

The final component of the community readiness assessment was to develop an electronic map (See Appendix A). Because Domestic Violence Center and child welfare partnerships are most effective when they are based on appropriate geographical service areas, FCADV contracted with a demographer, Dr. Robert Pennock from the Florida State University Applied Center for Demography and Population Health, to develop an electronic map with corresponding contact information for DCF Circuit Administrators, CBCs, and Certified Domestic Violence Centers. Information for individual CPI Unit locations is included as a separate attachment due to the large number of such units throughout Florida (See Appendix B). Managing Entities for SAMH providers were omitted because contracts for some of these entities were still under negotiation during the development of the map. The map assists FCADV with the provision of statewide technical assistance by matching the partnering agencies with their respective service areas which will ensure appropriate referrals and partnerships.

Data Analysis: Domestic Violence Center Participants

Sample

FCADV conducted an Internet survey that was distributed to the 42 Certified Domestic Violence (DV) Center executive directors/administrators throughout Florida. The survey contained 43 items covering demographics, training, staff collaboration, DV Center protocol, involvement with local child welfare agencies, and DV Center employee resources. Thirty-four DV Centers responded to at least one content question in the survey. In addition to the Internet survey, FCADV conducted qualitative in person and telephone interviews with representatives of DV Centers including a program manager, an agency advocate, and a DV Center executive director.

The goal of the qualitative interviews was to provide insight behind DV Center strengths and barriers to establishing partnerships and providing comprehensive services to families experiencing domestic violence who also are involved in the child welfare system. Whereas the Internet survey included 43 questionnaire items (many with subcomponents), the qualitative interview guide included 10 in-depth items (e.g., explain your Center's procedure when working with survivors with an open DCF case). The criteria for participant selection included (1) willingness to participate and (2) desire to discuss the Center's intersection with the child welfare system. All of the tables in this report include the numeric data from Internet survey respondents only. The results from the telephone respondents are integrated into the text when respondents answered similar questions, produced comparable results, or provided elaboration to common themes.

FCADV conducted an analysis of similarities and differences between circuits. However, there were no significant trends identified to include in the report. There is much variability *within* circuits as there is *between* circuits. In order to assess the strengths and needs of each circuit, and to create a tool to determine the technical assistance needs of each local community, FCADV created a document that lists the domestic violence and child welfare agency responses related to current partnerships and efforts to enhance such partnerships by circuit. This document will be continuously updated as FCADV receives additional information from local community partners in the future. Per the agreement between DCF and FCADV to preserve the integrity of the data collected from participants, this report is presented in aggregate form as to not identify individuals' responses.

Demographic Characteristics of DV Center Participants

DV Center staff from throughout the state completed the survey with the greatest representation from the Central and North regions of the state (see Figure 1). Respondents held a variety of executive titles including, but not limited to: executive director, chief executive officer, director of programs, chief operating officer, and chief program officer. One-time mentions included, but were not limited to: CPI liaison, grants and compliance coordinator, victim advocate, outreach manager, and shelter manager. DV Center respondents also had a range of experience in their current positions from six months to 26 years. Experience in their current position averaged 8.5 years with a median of 8 years (see Figure 2).

Figure 1. Region of DV Center Respondents (N = 34)

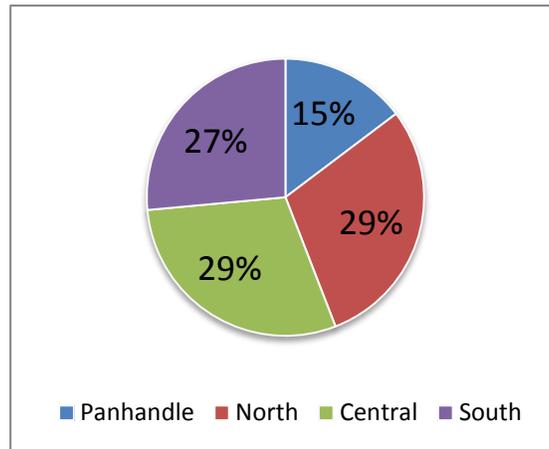
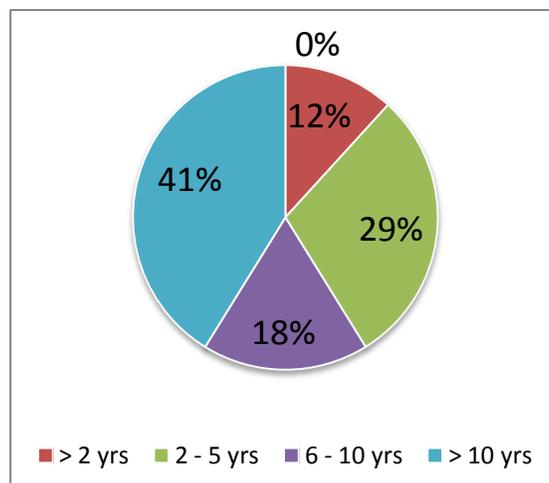


Figure 2. Number of Years in Current Position: DV Center Respondents (N = 34)



Child Welfare Training Among Domestic Violence Center Providers

Ninety-four percent of survey respondents working within DV Centers required child welfare training for DV Center direct service staff (see Figure 3). Most commonly covered topics in the trainings included: the dynamics of child abuse, mandatory reporting, confidentiality of survivors' information when working with external agencies, general information about the child welfare system, and the Florida Abuse Hotline process and number. Fewer than half of DV Centers' trainings covered the *Safe and Together Model* or domestic violence perpetrator accountability within the child welfare system (see Figure 4).

Figure 3. Child Welfare Training Requirement for DV Center Direct Service Staff (N = 34)

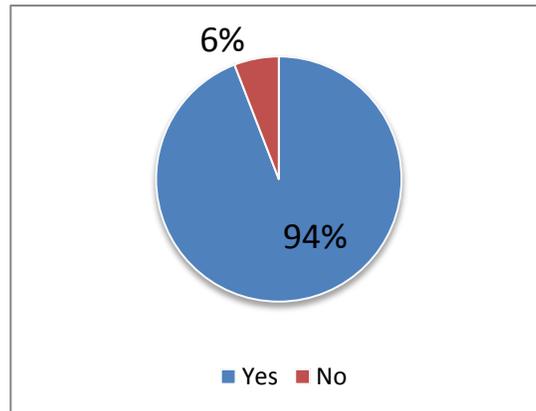
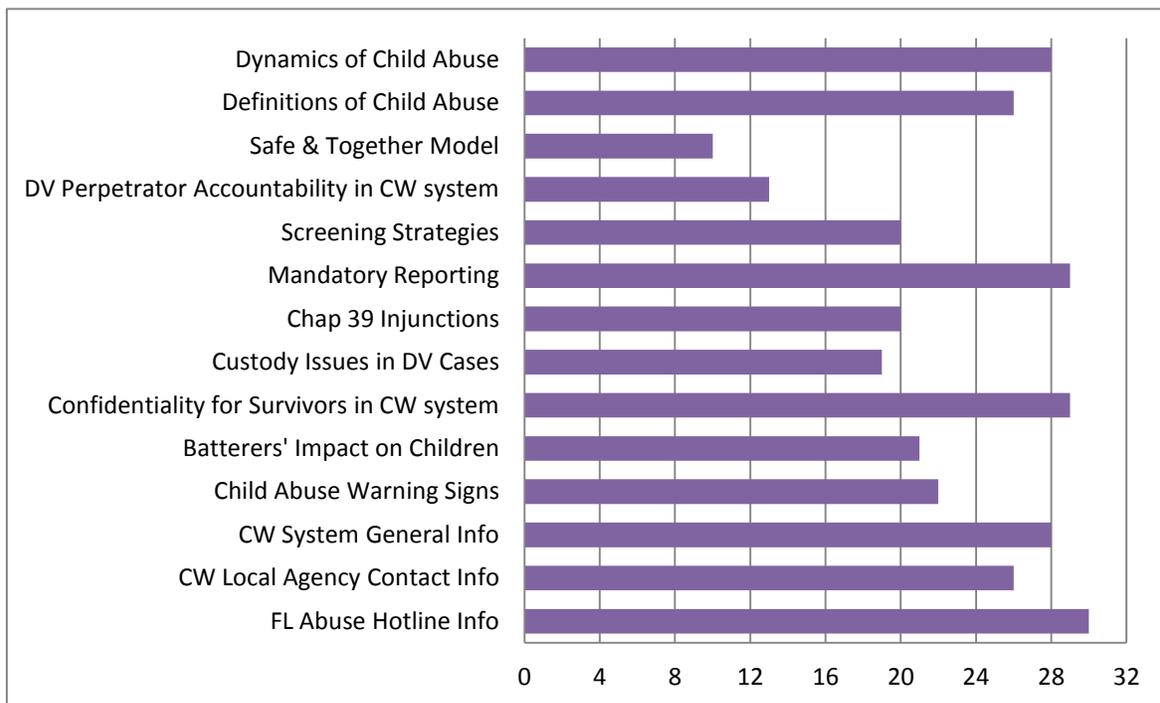


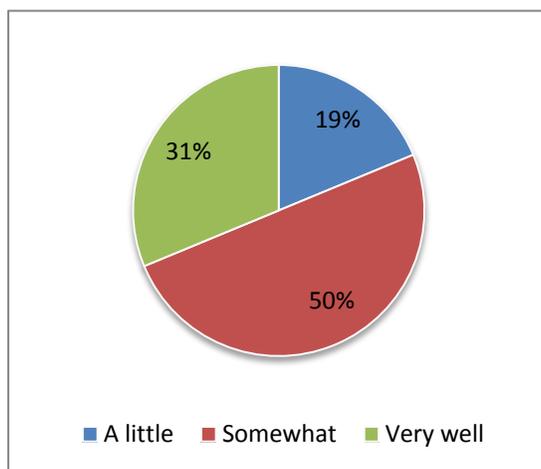
Figure 4. Areas of Training for DV Center Direct Service Staff (N = 32)



In addition to identifying components covered in DV Center child welfare related trainings, respondents (n = 4) provided additional details of *FCADV's Core Competency Training* materials on child abuse. Two respondents described their Center's core competency training related to child abuse (which is derived from FCADV's curricula). One respondent noted the provision of DCF materials for DV Center staff and another mentioned offering training topics such as: the *Safe and Together Model*, mandatory reporting, assessment of children, abuse risk, hotline procedures, and coordination with CPI. While the vast majority of Center respondents *provided* direct service staff with child welfare training, only one worked in a Center *requiring* a number of child welfare training hours. In this instance, the DV Center required two hours of related child welfare training.

With regard to DV Center priority on child welfare training, 81% of Center providers reported that direct service staff have at least somewhat of an understanding of the child welfare systems in the area (see Figure 5). In fact, nearly one-third of DV Centers felt that direct staff understood child welfare systems “Very well.” While 19% of Center respondents felt that staff only had “A little” understanding of child welfare systems; no one reported that DV Center direct service staff had no understanding at all.

Figure 5. DV Center Direct Service Staff's Understanding of Child Welfare Systems (N = 32)



DV Center Strengths in Serving Families Involved in the Child Welfare System

Both online and telephone respondents identified DV Center strengths and capacity to serve families involved in the child welfare system. DV Center respondents most commonly reported having strong relationships with a wide variety of community partners and community agencies; domestic violence service quality and quantity; and caring, competent domestic violence advocates. One telephone respondent summed up what the DV Center was doing right by saying, “[We are] able to meet people where they are at and give them what they need.” Another director listed several services that are provided to meet families’ needs, including “Housing, case management planning for moving forward, safety planning, on-site children's programs, and on-site child care.” Other strengths included available legal services or support systems in the court, on-site space for case workers, and available training. In delineating strengths, respondents also emphasized that DV Centers prioritize survivor needs as one provider summarized, “The greatest strength is the support given to the survivor in terms of we are her/his advocate. Survivors who are involved in the [child welfare system] feel comfortable coming to us for assistance.”

DV Center Barriers and Concerns for Serving Families Involved in the Child Welfare System

In combination with strengths, survey respondents identified barriers in their capacity to serve families involved in the child welfare system. In terms of DV Center service provision, Center respondents identified barriers of limited services, limited staff capacity or funding, and limited outreach or

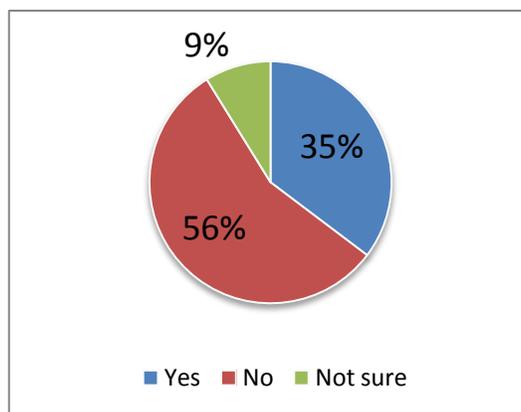
community capacity. Respondents also identified problems with child welfare field staff including turnover and inadequate domestic violence related training. DV Center providers identified survivor-focused Center goals and policies, including those prioritizing batterer accountability, as incongruent with child welfare partner agency goals.

Respondents mentioned a variety of concerns for DV Center direct service staff when working with families who are involved in the child welfare system. Top concerns included child welfare professionals' lack of knowledge and understanding about domestic violence and domestic violence advocates' lack of knowledge about the child welfare system. In the words of one telephone respondent, "It's a difficult process. [It] can be confusing [and] you have to ask the right questions in order to advocate effectively." DV Center providers also articulated concerns regarding misunderstandings about confidentiality statutes, safety, and perpetrator accountability. Other concerns included extensive case plans and expectations for survivors, high caseloads for child welfare professionals, the need for additional child welfare staff training, clearer worker role definitions, and survivors' fears of losing their children.

Child Welfare Staff and Partnerships among DV Center Providers

One mechanism for DV Centers to increase organizational capacity regarding child welfare issues, is to maintain child welfare experts on staff or as external consultants. Thirty-five percent of DV Center respondents surveyed, and all three telephone respondents, had access to some type of child welfare expert (see Figure 6). DV Center respondents described that the child welfare experts' were CBC or DCF front line employees, a licensed child care specialist, or DCF supervisors. Consultants' roles varied considerably from Center to Center. One respondent detailed the consultant's participation in several aspects of DV Center services including monthly integrated services meetings, [County] Transformation Project team member, weekly service team staffings with DCF and the CBC, health leadership committee participation, and the Health Families Advisory Board. DV Center respondents more frequently reported that consultants will participate and come to the DV Centers only when necessary or that the DV Center has "Co-located [office space] at DCF."

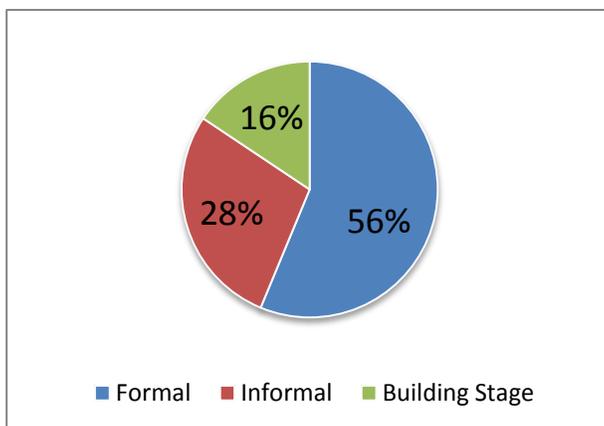
Figure 6. Presence of Child Welfare Experts on Center Staff (N = 34)



In addition to having access to child welfare experts, the development of DCF partnerships is another mechanism for DV Centers to prioritize child welfare concerns. Approximately 56% of survey respondents had formal partnerships with at least one local child welfare agency and an additional 16% were in the process of building relationships (see Figure 7). All three telephone respondents had formal partnerships. In sum, all respondents were either participating in or building some type of partnership. Both survey and telephone respondents articulated several ways in which their agency's partnerships were successful. Most commonly, respondents emphasized the importance of the relationships and access within partnerships. As one respondent summarized, "We have access to supervisors with child welfare agencies to discuss concerns with their employees; we are able to obtain services when needed; and, in general, [we] have a very good relationship with [community partners]." Partnerships have also led to greater understanding of each other's roles as stated by one telephone respondent, "We learned over time what each of our [respective] agencies does better. We're able to understand the position that DCF has and the CPIs. They are able to understand where we come from too, and how we want to advocate for and empower the participant. [DCF workers] definitely have learned about our [work], especially the confidentiality."

DV Center respondents also highlighted the importance of communication with DCF through conference calls or meetings. In the words of one respondent articulating meetings' success, "Meetings are regular, issues are addressed and 'one parent removals' were created as an outgrowth of the partnership." Other mentions of successful partnerships included child welfare staff training, on-site or shared office space with child welfare partners, DCF referrals, MOUs or formal interagency agreements, and the participation of the local Sheriff's Office.

Figure 7. DV Center Types of Partnerships with Local Child Welfare Agencies (N = 32)



When identifying components of successful partnerships, survey respondents and telephone respondents alike identified barriers to successful partnerships. Disparate goals among partners were common barriers. Participants described their concern about child welfare agency practices in which

survivors were mandated to attend parenting or other types of classes as a part of their case plan. Respondents also noted their Centers' prioritization of confidentiality as a disparate goal with child welfare agencies as well as a lack of batterer accountability within the system.

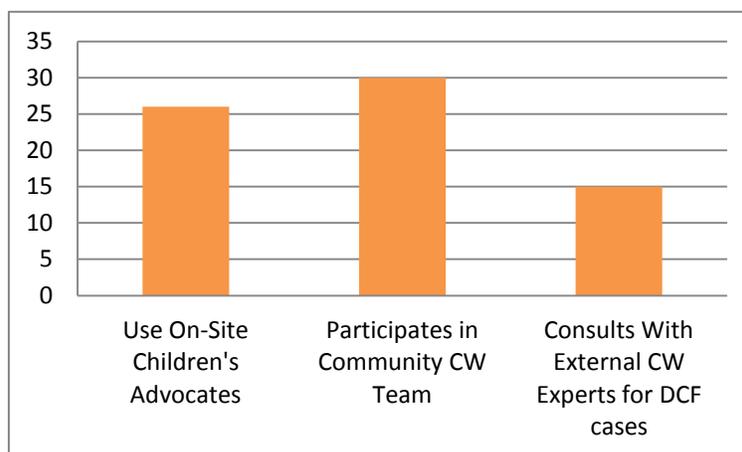
Just as respondents highlighted relationships and communication as successful, they also identified unproductive or territorial relationships and ineffective communication with DCF. Several respondents mentioned that frequent staff turnover stymies partnerships with individual DCF workers. Others mentioned barriers including DCF's lack of understanding about domestic violence, DCF caseworkers' failure to use the developed protocols, the need for training, and unannounced visits between agencies.

DV Center survey respondents also indicated several critical components for building partnerships with child welfare agencies in order to enhance survivor safety and batterer accountability. They highlighted the importance of relationships, partnerships or task forces, and education or training. Education was often defined as understanding the approach and rules of DV Centers. For example, one respondent articulated the importance of helping child welfare staff understand why domestic violence advocates need to maintain confidentiality of survivors' information. In addition, respondents noted the need to increase child welfare personnel's understanding of batterer accountability instead of relying on previous approaches in which survivors are held accountable for the batterer's non-compliance. Others prioritized the importance of leadership buy in and participation in the process of educating staff and building effective partnerships between DV Centers and child welfare agencies.

Child Welfare Collaboration and Staffing among DV Center Providers

DV Center respondents answered three types of questions regarding collaboration and staffing related to child welfare: the use of on-site children's advocates, participation in a local community team dedicated to child welfare issues (e.g., Community Action Team), and consultation with outside child welfare experts when working with domestic violence survivors with open DCF child abuse or neglect cases. DV Centers more often utilized on-site children's advocates (76%) and participated in community teams (88%) than utilizing external child welfare experts (44%) (see Figure 8).

Figure 8. DV Center Collaboration and Staffing (N = 34)



Center respondents also had the opportunity to describe the role of child advocates. They often highlighted the role of the advocate as being there for the child. In the words of one respondent, advocates “Ensure children's needs are being addressed and met.” Specific responsibilities included conducting assessments, individual or group counseling services, community resources, and special programs such as art programs or after-school programs. DV Center respondents also emphasized that advocates participate with parents too by extending services to “Mothers [or fathers] around issues they identify with [their] children.” Among DV Centers that used external child welfare experts, Centers most often worked with them in some or most child abuse cases. One DV Center worked with a child welfare expert in all child welfare cases that were known to them and two Centers worked with child welfare experts only in high risk cases.

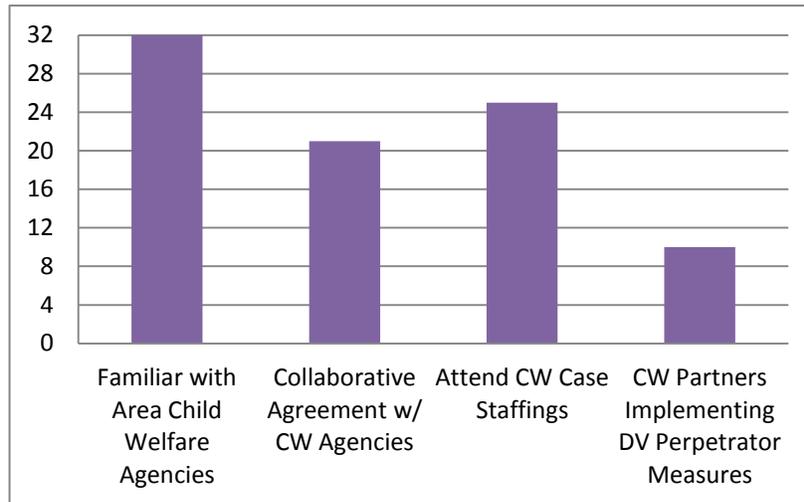
DV Centers’ Child Welfare Protocol and Collaboration

DV Center respondents indicated that there were relatively high levels of case overlap with domestic violence and child welfare services. Respondents’ estimates for the percentage of domestic violence survivors involved with the DV Center and in the child welfare system ranged from 2% to 75%, averaging 29%. In terms of protocol between domestic violence and child welfare agencies for working together to serve these families, most Center respondents stated that their Center had a written policy or protocol for working with DCF (n=23; 68%).

DV Center providers responded about engagement with child welfare agencies through four additional mechanisms: familiarity with the child welfare agencies in the service area; a written collaborative agreement such as a Memoranda of Understanding with a local child welfare agency; attendance at case staffings, family team conferencing meetings, or other meetings with child welfare agencies discussing specific child maltreatment cases; and partnering with child welfare agencies to implement domestic violence perpetrator accountability measures in child welfare cases (see Figure 9). All Center respondents were familiar with local child welfare agencies. From among the remaining measures, case staffing attendance (n =25; 78%) and MOUs (n = 21; 66%) were most common. Nine DV Center respondents (31%) reported that their child welfare partners were implementing domestic violence perpetrator accountability measures in child welfare cases; however, the largest group of respondents (n=15; 47%) did not know if their local child welfare agencies were implementing perpetrator accountability partnerships and seven (22%) reported that such measures were not in place.

FCADV requested that all survey and interview respondents email any related partnership documents such as protocol and/or MOUs. A coordinating spreadsheet was developed in order to analyze the components of each document (See Appendix C). FCADV received seven relevant MOU documents and six relevant protocol documents that are included and analyzed in the aforementioned spreadsheet. This document will be continuously updated as MOU and protocol documents are collected.

Figure 9. Collaborations with Child Welfare Agencies (N = 32)



Of Center respondents who specified their collaboration partners, CBCs were mentioned most frequently followed by DCF. Partnerships with both DCF and CBCs were common. Four respondents, all of which are partners in FCADV’s CPI Project, mentioned partnerships with the County Sheriffs’ Office. In these locations, the Legislature privatized the child protective investigative function to the Sheriff’s Offices. A minority of respondents provided an overview of their collaborative agreements, perhaps due to complexity as one director commented: “I can send you all a copy if you would like. It is quite lengthy.” Most frequently, the agreements specified the roles of each partnering agency and protocol for working with children and families. Community Based Care Agencies were responsible for clinical services to children or in the words of one director, “Contract[ed] for services in support groups, counseling, and children’s programs.” One respondent mentioned the agreement provided “Cross-training and [a mechanism] of understanding the limitations of each other’s statutes.” Another respondent mentioned that the MOU outlines the co-location of a domestic violence advocate within the child protective investigations office along with protocols regarding meetings, trainings, and support.

Of DV Center respondents who specified the types of child welfare meetings that Center staff attend, DCF case staffings were most common, followed by service team meetings. DV Center respondents also stated the frequency of such meetings. Most respondents met weekly or more. Others met monthly, quarterly, as needed, or infrequently. One respondent reported an abundance of meetings including “Daily, weekly, monthly and quarterly.” While not specifically asked of telephone respondents, all three DV Center respondents brought up the importance of meeting on a regular basis. While meeting frequency varied from weekly to monthly, each telephone respondent attributed part of their success in service provision to the communication available through regular meetings. As one respondent mentioned when identifying what works in her partnership and relationship with DCF, “[DCF workers] are very busy, but they take the time to meet with us.”

The minority of DV Center respondents reported that their local child welfare agencies were implementing any domestic violence perpetrator accountability measures in child welfare cases and one respondent voiced the lack of batterer accountability as a barrier to effective service delivery. Of those specifying the perpetrator accountability measures, respondents reported using the *Safe and Together Model*, a Batterers' Intervention Program (BIP), or a non violent action plan. Three respondents of DV Centers without established measures mentioned that child welfare providers do recognize the need for perpetrator accountability. In the words of one respondent, child welfare providers "Are attempting to create a culture within the department that focuses on holding perpetrators accountable."

Data Analysis: Child Welfare Agency Participants

Sample

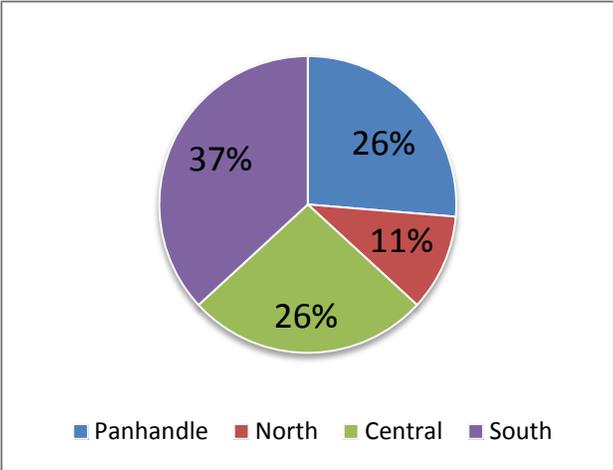
FCADV's Internet survey was distributed to Department of Children and Families Circuit Administrators, Community Based Care Agencies, Child Protection Team members, and Sheriff's Offices with Child Protection Investigation Units throughout Florida. The survey contained 51 items covering demographics, training, staff and collaboration, agency protocol, involvement with Domestic Violence Centers, and agency employee resources. Nineteen providers responded to at least one content question in the survey. As with most surveys, in addition to respondents dropping out before the first question (n = 10), respondents (n = 7) dropped out of the survey before completion and respondents opted to skip various survey items. As such, we include relevant available data resulting in various sample sizes with a maximum of 19 respondents.

In addition to the Internet survey, FCADV conducted qualitative telephone and in-person interviews with agency providers, including three CPI supervisors, and two program directors. The goal of the qualitative interviews was to provide insight into agency capacity, strengths, and barriers to establishing partnerships and providing comprehensive services to families in the child welfare system also experiencing domestic violence. Whereas the Internet survey included 51 questionnaire items (many with subcomponents, including both close-ended and open-ended questions), the qualitative interview guide included 10 open-ended items (e.g., explain your agency's procedure when working with child abuse and neglect cases in which domestic violence is also occurring). The criteria for participant selection included (1) willingness to participate and (2) desire to discuss agency services as they relate to domestic violence.

Demographic Characteristics of Agency Providers

Figures 10-12 illustrate respondents' agency locations throughout Florida, respondents' roles within agencies, and respondents' years of experience in their current positions. All regions of Florida are represented with the most agencies from the Southern region. The most represented circuits included Circuit 1 (n = 3) and Circuit 17 (n = 4).

Figure 10. Region of Agency Respondents (N = 19)



The majority of respondents were agency administrators while one-fourth were program managers/supervisors. In terms of length of time in current position, respondents ranged from six months to 31 years with an average of 7.5 years and a median of 5 years.

Figure 11. Respondent Position Type (N=19)

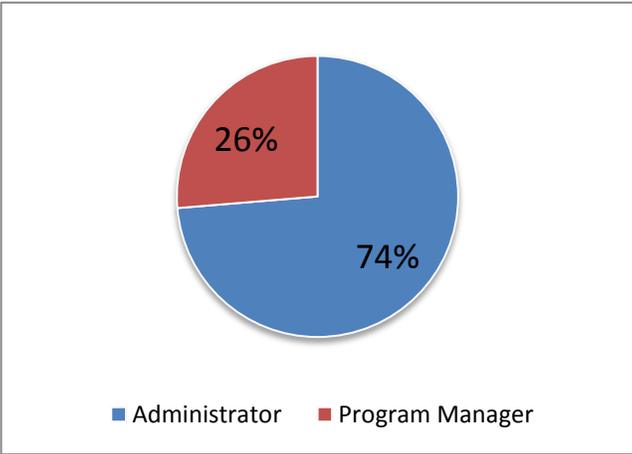
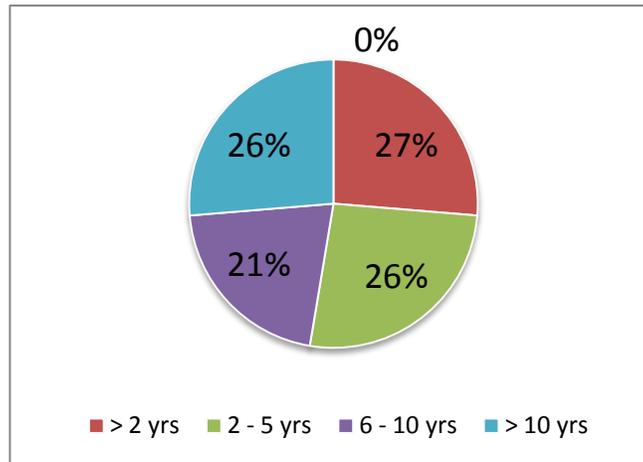


Figure 12. Number of Years in Current Position (N=19)



Domestic Violence Training among Child Welfare Agencies

Nearly 75% of respondents worked in agencies that offered training on domestic violence (see Figure 13). Most common topics included the dynamics of domestic violence, power and control, warning signs of domestic violence, and the effects of domestic violence on children (see Figure 14). Qualitative interviews with agency personnel provided insight into domestic violence training. Three telephone respondents explained that domestic violence was integrated into current child welfare training conducted by the agencies. Likewise, when explaining the frequency of training, one respondent explained that child welfare professionals must fulfill continuing education units (CEUs) and individuals select from an assortment of training, including at least one focusing on domestic violence annually. In fact, only two of the survey respondents had a required number of domestic violence training hours for direct service staff and both trainings consisted of four hours. None of the telephone respondents (n = 5) required domestic violence training for child welfare staff. As one telephone respondent concluded the discussion of training, “[Training] varies from county to county even though it’s within the same agency. It does vary.” Varying training requirements mean that knowledge about domestic violence depends on the individual worker, their background and experience, their selected trainings, and agency or location specific training opportunities and requirements.

Figure 13. Domestic Violence Training Requirement for Service Staff (N=19)

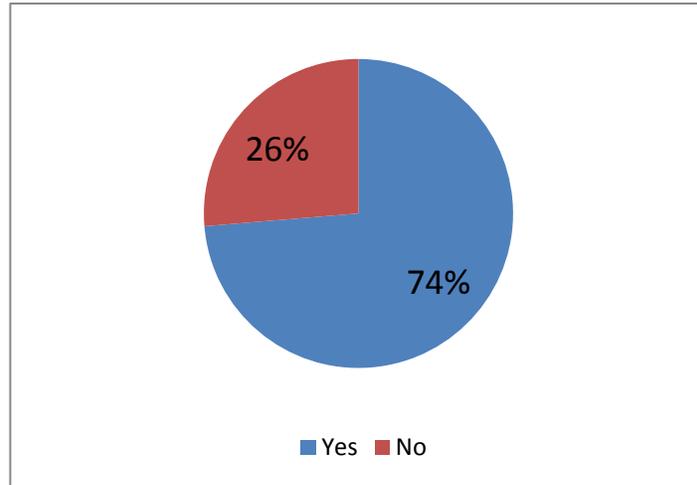
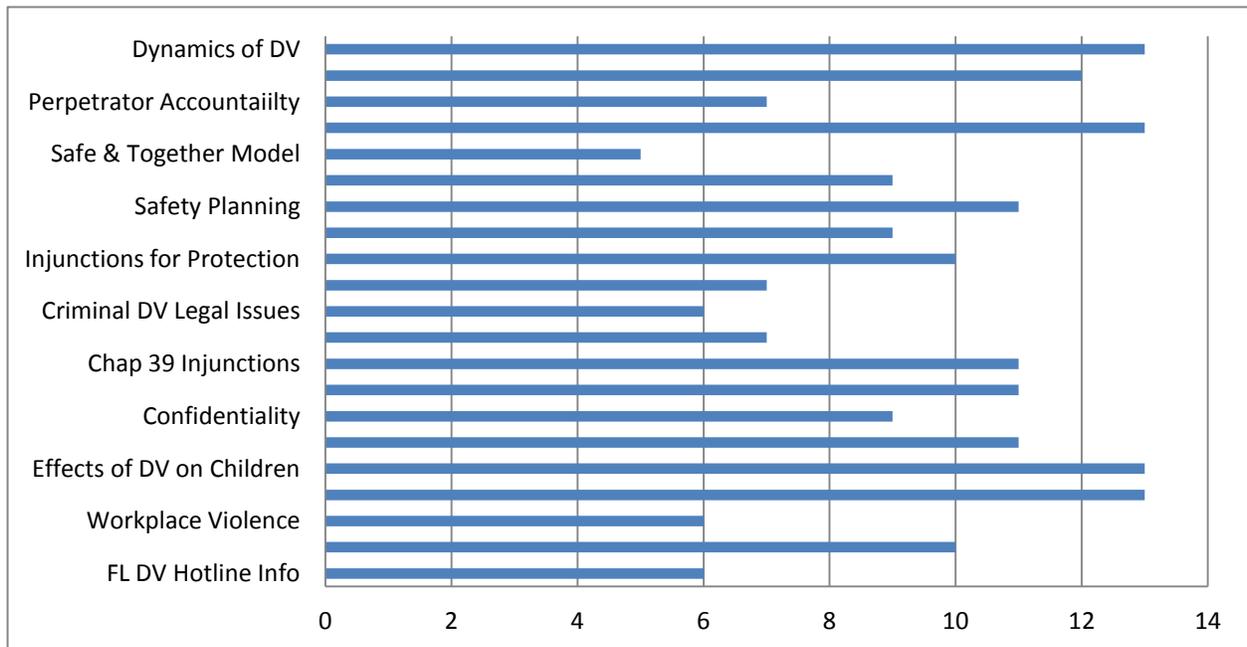


Figure 14. Topic Areas of Training (N = 14)

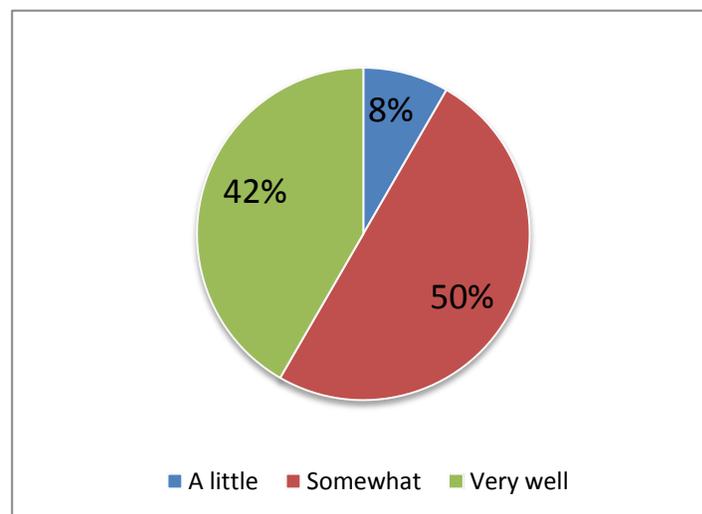


Although only two agencies required a specific number of domestic violence training hours, 42% of survey respondents (n = 8) had a formal training plan or curricula on the topic of domestic violence. Agencies used the *Safe and Together Model* (n = 2), pre-service curriculum (n = 3), DCF standard

curriculum (n = 1), trauma-informed care training (n = 1), family-centered practice training (n = 2), community trainings (n = 2), training by DV Center employees (n = 2) and annual resource fairs (n = 1).

When child welfare agency providers were asked how well they feel that direct service staff at their agencies understand the dynamics of domestic violence, 42% (n = 5) reported that staff members understand the dynamic “Very well” while 50% (n = 6) report staff understand it “Somewhat well.” Only one respondent felt that direct service staff members understand the dynamic only “A little” and no respondents reported that direct staff did not understand the dynamics of domestic violence at all (Figure 15).

Figure 15. Child Welfare Staff's Understanding of Domestic Violence Dynamics (N=12)



Child Welfare Agency Strengths in Serving Families Experiencing Domestic Violence

To ascertain agency capacity to serve families experiencing domestic violence, both survey and telephone respondents were asked to identify agency strengths and barriers in serving families experiencing domestic violence. From the 17 agency providers who identified their agencies' strengths, the message was clear: agencies' strengths were based on education and available training (n = 8); partnerships and collaborations with Domestic Violence Centers (n = 8); and the courts (n = 2). One respondent highlighted the strength of eager, trained personnel: “We are always willing to participate in trainings and other community projects to increase our understanding and knowledge of how domestic violence affects children as well as better ways to work with and strengthen the family.” Two telephone respondents credited partnerships entirely for their success. In the words of one: “Having the advocate here was the best decision; the partnership is a blessing for us and the families we serve.”

Child Welfare Agency Barriers and Concerns in Serving Families Experiencing Domestic Violence

Although less common, agency providers also identified barriers in agency capacity to serve families experiencing domestic violence (n = 10). Two providers identified the incongruent approaches of DV Centers and child welfare workers regarding family reunification. Confidentiality may be related to differing goals as one respondent stated, “[The] differences in interpretations of confidentiality between domestic violence, child welfare, and court expectations regarding information to be provided [is problematic].” Child welfare agency personnel also mentioned a lack of services or lack of variety of service providers (n = 5) and a need for domestic violence education or expertise (n = 2).

Related to barriers in serving families experiencing domestic violence, telephone and survey respondents also identified concerns for direct service staff when working with families experiencing domestic violence. Of child welfare agency personnel mentioning concerns (n = 15), they most commonly noted safety both for survivors and direct service staff. One respondent voiced concern with “The level of danger in working with the perpetrator [and potential] intimidation by the perpetrator.” Child welfare respondents also mentioned the importance of knowledge and assessment skills of the direct care staff and resources for victims such as transportation in rural areas. One agency respondent succinctly indicated the importance of assessments: “Domestic violence should be assessed at all times when families receive services; we assist DCF in investigating abuse allegations so sometimes other issues, like domestic violence and substance abuse, are overshadowed by physical or sexual abuse issues [of the child].” Another respondent voiced the complexity of domestic violence assessment and the need to make sure that child welfare staff were asking the right questions and looking for all forms of domestic violence, not only physical abuse. Concerns mentioned once included: confidentiality issues, violations of domestic violence injunctions, batterer accountability, children’s placement with the non-offending parent, and appropriate referrals.

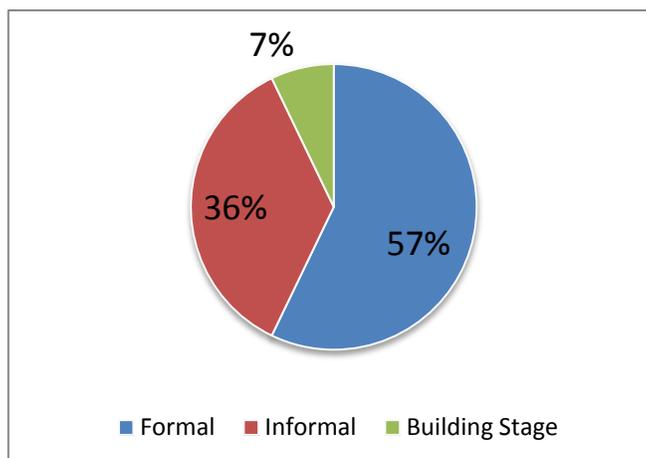
Domestic Violence Staff and Partnerships among Agency Providers

While the majority of survey respondents reported that they had domestic violence experts on staff (n = 8; 62%), none of the telephone respondents had experts on staff. This discrepancy could be due to the fact that domestic violence and DCF providers often shared office space if there are partnerships such as through the FCADV funded CPI Project. Three telephone respondents worked with domestic violence advocates who had office space in their agencies. A supervisor at a Sheriff’s Office stated, “[Our domestic violence advocate] isn’t paid by the Sheriff’s Office, but she’s on staff and is always here to answer questions. We consult and staff with her.” Similarly, partnerships operate in a variety of ways. As one telephone respondent explained, “We partner with a [Domestic Violence Center] and they’re co-located in our office to provide crisis counseling when needed for families. The collaborative agreement is actually with our lead agency [and] we benefit from those services.”

The majority of child welfare survey respondents (n = 8) (see Figure 16) and all of the telephone respondents reported that they had a formal relationship with the local Certified Domestic Violence Center. Five survey respondents indicated an informal relationship and one indicated that they were working to build a partnership. No respondents lacked a relationship altogether. Of those who specified

success within their partnerships, respondents most often identified the importance of relationships, access within partnerships, and mutual trainings for domestic violence and DCF workers. Other contributors to successful partnerships included on-site or shared office space, communication with DV Center personnel, domestic violence referrals, and competent, individual DV Center advocates. It is important to note that most respondents indicated more than one component leading to their success (n = 11). For example, one respondent indicated the intersections of relationships, training, and individual workers: “Representatives from both domestic violence shelters trained with our staff in the *Safe and Together Model* and they are active participants in our circuit’s quarterly meeting. They also participate in our case transfer staffings as well as our clinical response teams - time permitting. We do know that we can call them for assistance and they are very involved in working with our staff around domestic violence issues.” In the words of one telephone respondent, “We have a great working relationship with [the shelter]. We have someone housed at our office. She supports us when we work on domestic violence cases. The relationship with other DV Center staff is good.”

Figure 16. Relationship with Local Domestic Violence Center (N=14)



While respondents identified many strengths of partnerships, eight survey respondents and all telephone respondents (n = 5) identified challenges to partnerships with the local DV Center. Similar to DV Center directors, agency personnel mentioned disparate goals or DV Centers’ prioritization of confidentiality. Confidentiality was an overarching theme as child welfare agencies reported challenges when working with DV Centers because they may not be able to obtain enough information from them about the services provided to survivors.

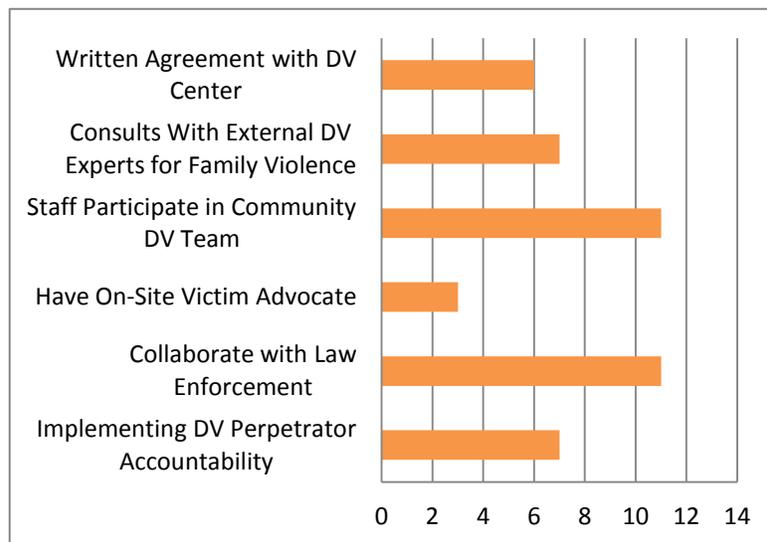
In addition to identifying strengths and barriers to partnerships, agency providers identified key components to building partnerships with a DV Center (n = 13). The most commonly reported features were effective relationships and open communication. When commenting on effective relationships, one respondent highlighted the importance of “A mutual understanding of roles, resources, limitations, and differing guidelines under which respective agencies work.” In the words of another child welfare agency provider, “[We need] a greater ability to communicate so that we can determine what services

are available at any given time; we need to be able to get the right people on the phone to answer our questions.” Other mentions included the importance of available services, education or training, and additional resources. One agency provider prioritized client service needs by stating the need “To provide our clients with access to support and appropriate services within the community [and to] link them with services that can continue to provide support to the family once we end our services.”

Domestic Violence Staffing and Collaboration with Child Welfare Agencies

Child welfare agency survey respondents answered six questions regarding collaboration and staffing related to domestic violence. These six items included: a written, collaborative agreement with the local Certified Domestic Violence Center; consultation with a domestic violence expert for cases involving family violence; staff participation on a community team dedicated to domestic violence issues; on-site victim advocates; collaboration with law enforcement when investigating domestic violence cases; and implementation of domestic violence perpetrator accountability measures. As displayed in Figure 17, participation in a community domestic violence team and collaboration with law enforcement were the most common collaborative activities. FCADV also created a count of collaborative activities to examine whether certain agencies had a high level of domestic violence participation whereas other agencies had a very low level. Rather than a split between very involved and less-involved agencies, the count revealed a wide dispersion of participation levels. Of the six potential domestic violence engagement opportunities, two agencies participated in one action, three agencies participated in two actions, four agencies participated in three actions, three agencies participated in four actions, and two agencies participated in five actions. This dispersion is important such that no respondents were completely disengaged from utilizing domestic violence resources.

Figure 17. Agency Involvement with Domestic Violence (N=14)



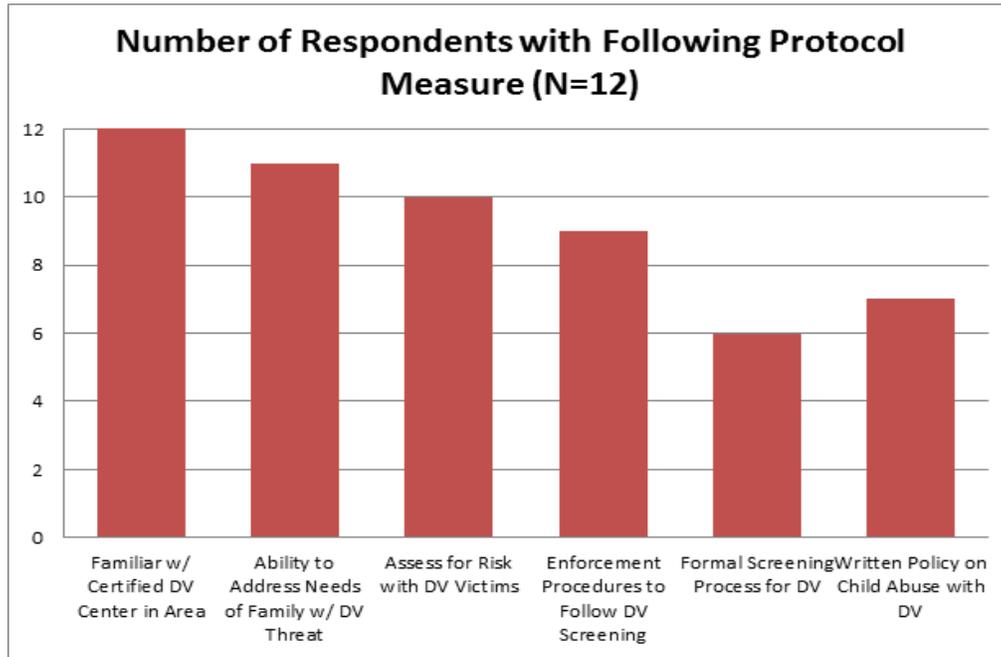
Through open-ended questions, respondents who participated in domestic violence collaborative activities elaborated on their participation. Of agency providers who reported their domestic violence expert's qualifications (n=7), the most common response was consultants being Domestic Violence Center employees. Other mentions included consultants who have worked with families experiencing domestic violence and consultants who are "Certified" by the DV Center. Of the three agency respondents who indicated that their agencies had on-site victim advocates and mentioned their roles in the agency, one mentioned the role to "Staff cases and provide consultation direction and intakes of clients daily," and another mentioned the role to "Provide referrals, information, and support to parents and children."

Nine agency personnel described a variety of collaborations with law enforcement on domestic violence cases and seven agencies reported implementing domestic violence perpetrator accountability measures. Two personnel mentioned the involvement of law enforcement during new reports of domestic violence. Of those who reported that their agency was implementing domestic violence perpetrator accountability measures, four were referring to BIPs and one agency mentioned utilizing the *Safe and Together Model*.

Domestic Violence Protocol among Child Welfare Agency Providers

Child welfare survey respondents answered six questions about protocol involving cases in which families are experiencing domestic violence. These items included familiarity with the Certified Domestic Violence Center(s) in the service area, ability to adequately address the needs of families with an immediate threat of domestic violence, assessment procedures regarding risk or lethality related to domestic violence, a formal screening process for domestic violence, enforcement procedures to ensure that domestic violence screening process is followed, and a written policy regarding child abuse and neglect cases in which domestic violence is occurring. Figure 18 illustrates protocol usage across agencies. All respondents were familiar with the Certified Domestic Violence Center in the area and eleven of the twelve felt their agencies had the capacity to address the needs of a family in immediate threat. When examining the number of protocols that each agency has in place, most have five (n = 5) or all six (n = 4) protocols. Two respondents only had three of the protocols and one respondent mentioned only one protocol (familiarity with the local Domestic Violence Center). The numeric distribution of the counts for each agency demonstrates that some agencies lack established policies and procedures for families experiencing child abuse and domestic violence. Selection bias is also important to consider. While 19 agency respondents answered the first questions about training, the sample reduced to 12 for these items. Likely, respondents without such protocols were more likely to drop out of the survey than those with extensive policies and procedures for handling domestic violence cases. Therefore, respondents in this sample may implement more domestic violence protocols than other agency providers in the state.

Figure 18. Number of Respondents with Protocol Measures (N = 12)

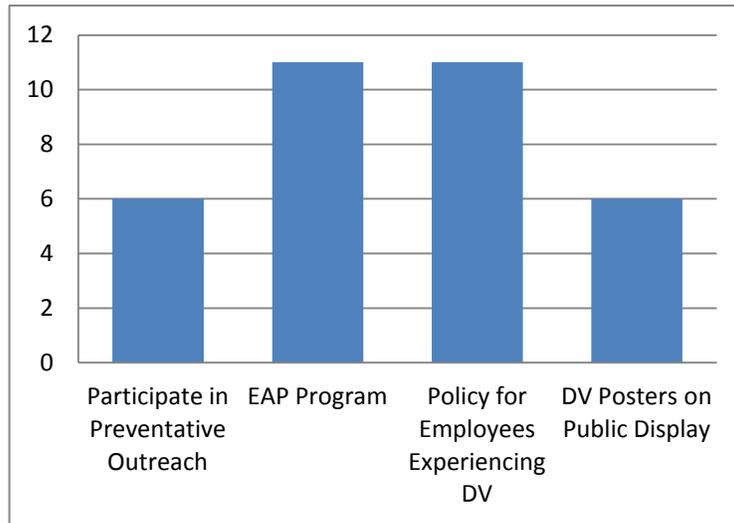


In addition to identifying established protocols and procedures, respondents answered open-ended questions regarding details of these identified protocols. Of the six child welfare respondents who specified a screening process for domestic violence, four reported that they used risk assessments or child assessments related to domestic violence. One respondent described a more in-depth process including, “Specialized interviews with family members; and specialized and forensic interviews with children.” Only three respondents elaborated on their enforcement procedures to ensure domestic violence assessment; all three respondents stated that domestic violence was simply part of the overall assessment process.

Domestic Violence Resources among Child Welfare Agency Providers

The final section of the survey questionnaire asked agency personnel about resources including preventative outreach regarding domestic violence, Employee Assistance Programs (EAP), policies for employees experiencing domestic violence, and domestic violence posters or brochures on display in their workplaces. EAP programs and policies for employees experiencing domestic violence were almost universal. Eleven of the twelve survey respondents (and all telephone respondents) reported EAP programs and a policy for employees experiencing domestic violence. Among survey respondents, only six participated in preventative outreach or public education activities on the topic of domestic violence (see Figure 19).

Figure 19. Agency Resources (N=12)



In describing preventative outreach or public education activities on the topic of domestic violence, respondents revealed a range of activities and involvement. One child welfare respondent detailed how outreach is a part of their family strengthening plan: “[Outreach] is integrated into our family strengthening, public education, and prevention outreach activities. We do a variety of community events related to family strengthening. We also host a production in our local high schools and middle schools to raise awareness with teens about the issues associated with dating/domestic violence.” Other personnel participated in a domestic violence task force, partnership, or community events including candlelight vigils, community workgroups, or locally-sponsored events and fairs.

Summary of Survey Results: Managing Entities for SAMH Services

There were a total of five survey respondents from Managing Entities, all of which were in executive level positions. The organizations have wide catchment areas ranging from region-wide to state-wide service provision. Domestic violence training was limited among respondent organizations. Of the organizations answering the training items (n=3), no organization had a written policy or protocol regarding working with families experiencing domestic violence. No organization required SAMH providers to mandate domestic violence training for direct service staff or had a formal training plan on the topic of domestic violence.

Staff in the surveyed organizations had limited experience in domestic violence. Of the responding organizations (n=3), only one respondent worked with SAMH providers that were members of a local community team dedicated to domestic violence and the same respondent represented the only organization who utilized on-site victim advocates. All three organizations stated that SAMH providers collaborate with law enforcement in all or most domestic violence cases.

The respondents were unaware of how many SAMH provider cases included domestic violence. Of the responding organizations (n=2), neither required that SAMH providers have a formal process to screen for domestic violence, assess risk/lethality with domestic violence victims, or provide counseling when domestic violence is occurring within families. However, both respondents felt that SAMH providers are able to identify and address immediate needs of a family who is in danger as a result of domestic violence. Both respondents felt that SAMH providers were somewhat familiar with Domestic Violence Center(s) in their areas and made referrals “Sometimes.”

Of the two respondents answering the items, both reported informal partnerships between the SAMH providers and the local Certified Domestic Violence Centers. The respondents were uncertain of successes with partnerships and articulated barriers such as a lack of familiarity, lack of a common vision, and limited resources.

SAMH providers’ provision of domestic violence information and engagement with domestic violence information provision is voluntary rather than mandated. Neither responding organization (n=2) required that SAMH providers have posters or brochures related to domestic violence on public display in their agencies. Only one respondent identified the top three concerns for SAMH providers when working with families experiencing domestic violence: confidentiality, safety issues, and boundaries. Both respondents felt that SAMH providers understand the dynamics of domestic violence “Somewhat well” yet neither were familiar with whether their SAMH providers participated in preventative outreach or public education activities on the topic of domestic violence.

Recommendations

Domestic Violence and Child Welfare Service Integration

'Family violence threatens child' has competed with 'substance misuse' for the most reported maltreatment type in Florida over the past ten years. As domestic violence and child welfare service providers know, it is not uncommon for these two maltreatment types to co-exist. This dynamic poses added challenges to our work with families experiencing domestic violence. It is more important than ever that domestic violence advocates participate with child protective service professionals to help families involved in the child welfare system. Domestic violence and child welfare agencies must work together to effectively serve these families. The following are recommendations to increase and enhance the integration of domestic violence and child welfare services throughout Florida. These recommendations are based on the community readiness assessment findings described in this report, on the best practices derived from FCADV's CPI Project sites, and on FCADV's collaborative work with DCF to implement the Transformation Project as it relates to child welfare agencies' work with Domestic Violence Centers in Florida.

Leadership in Clarifying Roles and Responsibilities

A common point of contention that has been identified between child welfare organizations and Domestic Violence Centers revolves around information sharing. This barrier is by no means simple to resolve. However, this challenge can be overcome if both child welfare professionals and domestic violence advocates understand each other's roles and responsibilities in working with families. Domestic Violence Centers' have legal limitations to information sharing based on survivors' rights to confidential and privileged services.¹ Child welfare staff must abide by strict timelines and documentation requirements when working with families involved in the child welfare system. Protocols and practices can be put into place that meet the needs of survivors and address the requirements that exist for DV Centers as well as child welfare agencies. Creating protocol that allows for appropriate releases of information is a positive practice for survivors and a necessary step in partnership.

Executive level leaders of domestic violence and child welfare agencies should convene meetings to work through these challenges and to discuss roles and responsibilities that are appropriate for staff in their respective agencies. Leaders must find common ground in order to build a solid foundation for establishing a formal partnership. All parties involved want to keep children safe and lessen the impact that violence in the home has on families. Leaders of these organizations must come together with this goal in mind so they can begin working together to provide a strong safety net for survivors and their children.

Formal Agreements: MOUs and Protocol

After DV Centers and child welfare organizations engage in initial meetings and conversations about roles and responsibilities and have had the opportunity to clarify misconceptions, they should work

¹ F.S. 39.908 and F.S. 90.5036

together to create a Memorandum of Understanding. The MOU should address all the issues that have been identified in the preliminary meetings. An MOU is an effective way to document how each party will contribute to overcoming the barriers and challenges of this collaborative and life saving work. The MOU should also include a grievance procedure for project staff to report issues that may emerge later in the partnership. Other important things to consider when writing an MOU that clarifies working agreements include, but are not limited to:

- Each organization's roles, responsibilities, and expectations;
- Participation in case staffings, court hearings, or other meetings about families or systemic issues;
- How staff from each organization will confirm their identity when coming to shelter or participating in staffings or meetings;
- How child welfare case managers may arrange to visit families living in shelter;
- What the DV Center will do to assist in providing an appropriate and confidential space for families to meet with child welfare case managers;
- How and what information will be shared between agencies;
- How releases of information will be secured; and,
- How home studies will be conducted.

Protocol developed between domestic violence and child welfare agencies should specify how often executive leaders and management/supervisory staff will reconvene to discuss barriers to continued partnership. Leaders should identify a liaison from each organization. The liaison should be a programmatic person with the decision making ability to help evolve the partnership as needed. Partners should decide how often they will communicate, how to resolve emerging issues, and how to continue to develop the partnerships as needed. Meetings should occur more often in the beginning and then move to monthly to continue building on and enhancing the partnerships.

Protocol should also outline when DV Centers will be consulted in child welfare cases involving domestic violence. FCADV recommends that domestic violence partners are consulted as early as possible and throughout the process until case closure as necessary. Domestic violence advocates' early involvement in cases can reduce risk to children by providing immediate resource and referral information and safety planning with the survivor and children. Domestic violence advocates work from an empowerment-based philosophy, therefore they are skilled at identifying strengths. This can increase and strengthen protective factors already existing in the home. Domestic violence advocates can also assist CPIs and case managers in clearly identifying batterers' patterns of coercive control by assisting them in gathering needed information to address behaviors with the batterer and the impacts that behavior has had on the children. *Appendix D: Sample MOU for DV and Child Welfare Agencies* and *Appendix E: Sample Protocol for DV and Child Welfare Agencies* should be utilized as templates in order to develop MOUs and protocol that are tailored for each community partnership. FCADV provides technical assistance and training to Certified DV Centers and child welfare organizations on building formal collaborations that benefit survivors of domestic violence and their children. DV Centers and child welfare agencies should contact FCADV to request assistance in developing formal partnerships as described herein.

Training for Domestic Violence Advocates and Child Welfare Staff

Domestic violence liaisons and other DV Center staff should be invited to attend pre-service training to ensure they have a complete understanding of the child welfare process from the hotline call to case closure. Many domestic violence advocates are unfamiliar with the requirements and timelines that exist for child welfare agencies in Chapter 39 Florida Statutes. These cross trainings can help to build a common understanding so that domestic violence advocates can effectively advocate for survivors and help them navigate the child welfare system.

Domestic violence advocates should be invited to conduct sections of pre-service training for child welfare staff that pertain to domestic violence. Domestic violence advocates' expertise can provide child welfare staff with a clearer understanding of models, philosophies, and services provided by DV Centers. Domestic violence advocates can also assist child welfare professionals with skills that will enhance their ability to engage families experiencing domestic violence in appropriate services. In addition to increasing individuals' knowledge and skills, these types of trainings help to sustain partnerships between domestic violence and child welfare agencies as child welfare staff begin to rely on DV Center staff as the experts in domestic violence cases.

Domestic Violence Center staff, child protective investigators, and case managers should all be trained on *Safe and Together Model* philosophies. The *Safe and Together Model*, which has been adopted in many communities in Florida, offers a protocol for child welfare staff working with families experiencing domestic violence that focuses on four parts:

1. Questions for the primary caretaker;
2. Questions for the children;
3. Questions for the partner or ex-partner; and,
4. Questions to help with assessment and case planning.

The first three parts of this protocol provide a structure for interviewing the family and the last part assists the child protective investigator in the evaluation of the information they have received from the family. The evaluation will lead to development and implementation of safety strategies for the non-offending parent and children as well as compliance based behavioral oriented tasks for the perpetrator. This change in practice, in which systems penalized the non-offending parent for the batterer's actions, supports a much needed shift in historic thinking regarding case management issues where domestic violence is identified.

State Level Database with Partnership Information

FCADV and DCF should become keenly aware of the existing and proposed working agreements and how they impact one another with an effort to reduce duplication. As working agreements go into effect with child welfare agencies and DV Centers, each agreement should be reviewed and explored to reduce conflicting agreements and duplication of services. FCADV should create and maintain a statewide database that includes, but is not limited to: MOU and protocol documents that are developed by domestic violence and child welfare agencies in each community, relevant data for each community

such as the number of child removals due to the ‘family violence threatens child’ maltreatment type, and the number of CPIs and case managers employed by child welfare agencies in order to determine funding needs for co-located domestic violence advocates to provide consultation on domestic violence cases.

Referrals to DV Centers

Florida’s Certified Domestic Violence Centers offer many services for domestic violence survivors and their children. The following are the “Core Services” that each Center maintains and operates in their respective communities:

- Emergency Shelter;
- Counseling/Advocacy;
- 24 Hour Local Hotline;
- Assessment of Children;
- Information and Referral;
- Case Management;
- Community Education;
- Professional Training; and,
- Safety Planning.

FCADV Standards mandate the provision of these nine core services per the Administrative Rule 65H-1.014. As such, DV Centers are available to assist survivors and their children during and after domestic violence crisis situations. Child welfare agencies that are not utilizing DV Centers as a resource in their work with survivors and their children should begin doing so. Child welfare staff should make referrals to a Certified Domestic Violence Center within 24 to 48 hours of the initial abuse investigation and throughout the case thereafter when domestic violence is identified. This type of referral should occur regardless of if a formal partnership currently exists between the Domestic Violence Center and child welfare agency as referrals to Certified DV Centers can help to increase the safety of the survivor and their child(ren).

Co-located Domestic Violence Advocates

Survey respondents from DV Centers identified a lack of funding to staff domestic violence advocates that work primarily with local child welfare partners on domestic violence cases. Advocates employed by DV Centers are most often assigned to working in shelter or outreach offices in which a majority of their time is spent meeting with survivors, working with children in on-site children’s programs, and ensuring that survivors’ and their children’s needs are met in shelter. In light of these staffing limitations, FCADV worked with DCF, the OAG, local Certified DV Centers, and child welfare agencies to implement the CPI Project in 10 Florida communities. These projects staff full-time domestic violence advocates who are employed by the DV Center and co-located within a CPI Unit site.

The greatest success of this project is reflected in the children that were able to remain with their protective parent and not placed in the foster care system. First and foremost, maintaining permanency,

safety, and well-being of children in the home decreases their risk of suffering from mental health issues and homelessness and decreases the likelihood of being drug or alcohol dependent as adults. Additionally, foster care costs the state an estimate of \$400 per month. From October 1, 2011 through September 30, 2012, FCADV's CPI programs helped 3,917 children to remain safely in the care of the non-offending parent. The State of Florida potentially saved over \$9,400,800 for six months of foster care services while these 3,917 children remained safely in their homes. The partnership between FCADV, the OAG, and DCF represents a model approach of reducing the number of children removed from their homes while achieving a significant cost savings to the state.

FCADV surveyed and interviewed many of the co-located advocates working in the CPI Project as a part of the community readiness assessment. Co-located advocates that worked with more than 40 CPIs reported needing more staff to help meet the critical consultation needs of front line child welfare professionals in domestic violence cases. Co-located domestic violence advocates working with 40 or less CPIs reported that they were better able to conduct consultation with CPIs as requested. Each of these co-located advocates is also working, in various degrees, with CBC case managers when cases are transferred. Based on the feedback from local community partners, FCADV recommends that DCF work collaboratively with FCADV to secure additional funding from the Legislature to staff co-located advocates at a rate of 40 CPIs to one co-located domestic violence advocate. These co-located advocates would also be responsible for working with case managers upon case transfer.

It is incredibly important that domestic violence advocates providing this type of consultation are employed by Certified DV Centers. FCADV has learned the importance of this through its implementation of the CPI Project. Co-located domestic violence advocates need leadership and oversight from the DV Center in order to retain the necessary skills and training required to effectively work with survivors and their children. In addition, survivors need to feel confident that the information they disclose to domestic violence advocates will remain confidential unless the survivor deems it appropriate, via a signed release of information, to share such information. Confidentiality of survivors' information is critical to maintaining safety from the batterer. Finally, domestic violence advocates who are employed by Certified Domestic Violence Centers have a unique ability to quickly connect a survivor with the appropriate DV Center services. In doing so, the family's safety increases and child welfare and domestic violence agencies begin to form long lasting and sustainable partnerships.

Perpetrator Accountability and Partnering with the Non-Offending Parent

Many child welfare professionals, who have not had the opportunity to work closely with Domestic Violence Centers, believe that DV Centers are therapeutic organizations that seek to counsel women about their relationship choices so that they will not find themselves in another abusive relationship. On the contrary, DV Centers provide empowerment-based advocacy which is rooted in the philosophy that survivors do not need to be fixed and that the abuse is not their fault. Similarly, domestic violence advocates sometimes misunderstand the goals of child welfare agencies such as providing services that create permanency and support the safety and well being of children. In order to meet these goals, child welfare agencies are often forced into a path of least resistance that includes engaging the accessible parent, which is more often than not, the mother. Because of this, survivors of domestic violence are

often held ultimately and solely responsible for the safety and well-being of the children. Domestic violence advocates have the responsibility of helping such mothers maneuver a system that albeit unintentionally, can set her up for failure by making her responsible for the batterer's behavior.

Creating a productive partnership with child welfare agencies allows advocates the opportunity to share their expertise about the coercive control patterns of batterers and redirect the conversations away from focusing on the non-offending parents (often the mother). Domestic violence advocates can provide child welfare professionals with suggestions that seek to engage the batterer in services while holding him accountable for the violence, thereby creating increased levels of safety for the children. It is important that Domestic Violence Centers do not set themselves up to be spokespersons for survivors in child welfare cases but instead work to facilitate a relationship between the survivor and the child welfare professionals in an effort to create trust and give her a voice in what happens with her family.

The community readiness assessment identified a lack of perpetrator accountability measures among child welfare agencies. Holding domestic violence perpetrators accountable must be accomplished through a systemic uniform directive where domestic violence perpetrators will be referred to reputable batterer intervention programs (BIP) and every one will be followed for compliance. Child welfare partnerships with DV Centers, law enforcement, state attorney's offices, courts, and local probation offices should ensure seamless tracking of domestic violence perpetrators, engagement and completion of the BIP, and ensure that any violations of court orders or additional acts of violence are reported to the court. Follow through on criminal cases and enforcement of criminal court orders is imperative to child safety.

In addition to these imperative coordinated community efforts to increase domestic violence perpetrator accountability, child welfare agencies should begin to or continue filing Chapter 39 Injunctions for Protection. The Florida State Statute 39.504 allows for an outside entity to seek a protective injunction against the perpetrator to remove the offender from the household even if the perpetrator is not the parent to any of the children in the case. This type of injunction for protection should be implemented instead of requiring, via case plans, that survivors obtain Chapter 741 Injunction for Protection. Although Chapter 741 injunctions help to increase safety for some people, often times the perpetrator will become enraged with the survivor if she files for an Injunction. In fact, many of the domestic violence murders that have occurred in Florida (and elsewhere) occurred soon after a survivor filed for or was granted an Injunction for Protection.

It is critical that domestic violence and child welfare agencies come together to partner with non-offending parents in domestic violence cases. Survivors of domestic violence will often comply with rigorous case plans in an effort to keep their children safe at home with them. However, survivors are not creating or perpetuating the violence. Mandatory case plans for survivors of domestic violence can serve to reinforce what the batterer is telling her; that she is to blame for his violence. Domestic violence advocates can assist child welfare staff to develop compliance-based and behaviorally-oriented case plans with the perpetrator that seek to hold the perpetrator responsible for the safety of the non-offending parent and children. In addition, child welfare professionals can seek shelter and dependency petitions regarding only the perpetrator, while offering voluntary family centered services to survivors

and their children. This practice helps to strengthen the partnership with the non-offending parent, and has successfully been implemented by child welfare agencies participating in FCADV's CPI project.

Building the Foundation: Recommendations for the Integration of Domestic Violence Services with Substance Abuse and Mental Health Services

Although there have been great strides in integrating domestic violence and child welfare services, the integration of domestic violence services with mental health and substance abuse services is in the infancy phase. Based on input obtained from the responding Managing Entities for SAMH providers and DV Centers, little emphasis has been placed on understanding the complexities of the co-occurring issues, cross training relevant staff, building collaborative relationships, establishing written protocols or agreements, or understanding the historical perspectives of each others' fields of work. Therefore, the State of Florida has much work to accomplish in order to effectively plan and implement statewide initiatives to meet the critical needs of survivors living with mental health and/or substance abuse issues. To lay a foundation for this important work, FCADV recommends the following:

State Level Partnership Building

Five years ago, FCADV began conducting "survivor listening groups" to obtain feedback regarding critical needs and barriers identified by domestic violence survivors. As such, two priority areas identified by survivors have emerged year after year: 1) Survivors expressed a need and desire to receive mental health counseling/therapy in addition to the crisis intervention counseling and advocacy received from domestic violence advocates. 2) Survivors expressed the need for chemical dependency intervention and treatment by addictions counselors who understand the dynamics of domestic violence including the critical importance of safety when receiving substance abuse treatment.

Addressing the complexities of the co-occurrence of domestic violence with substance abuse and/or mental health issues continue to be the top two requests for training and technical assistance from FCADV. During the past two fiscal years, FCADV provided 80 units of technical assistance and training for 502 individuals on these topics. Best practices implemented by Florida's Certified Domestic Violence Centers focus on non-clinical approaches to working with survivors and as per Florida's Domestic Violence Center Certification Minimum Standards Administrative Rule, 65H-1: "Individuals who need mental health counseling services may be served through referral to an outside provider." It is critical that Domestic Violence Center advocates refer survivors to mental health providers or substance abuse programs that understand the dynamics of domestic violence and that possess the ability to address the complex needs of survivors with a trauma-informed approach.

In order to lay the foundation for these critical partnerships, representatives from FCADV and the DCF SAMH Program should begin meeting on a regular basis to create a comprehensive plan for the integration of domestic violence services with SAMH services in Florida. FCADV will initiate such meetings in order to enhance state level collaborations and to discuss a framework for the plan.

Assessment of Current Work

In 2011, FCADV utilized the STOP funds that were designated to the organization, to fund a pilot project that focuses on the intersection of domestic violence and mental health. Specifically, the project addresses the gaps in service delivery and lack of access to services for survivors of domestic violence who are also living with mental health complexities. Harbor House, a Certified Domestic Violence Center serving Orange County, and Lakeside Behavioral Healthcare, have partnered to increase access to mental health services. Through this project, a co-located licensed Lakeside employed therapist provides intensive one on one intervention to address the mental health needs of survivors who request such add on services. Harbor House and Lakeside are working together to effectively serve survivors of domestic violence within the framework of the battered women's movement and its empowerment-based, trauma-informed approach to working with survivors.

FCADV should produce a written assessment of its current pilot project related to domestic violence mental health service integration. The assessment will include details regarding the successes, barriers, and outcomes of the project and will provide a blueprint for other local communities to implement similar partnerships.

Domestic Violence and Substance Abuse and Mental Health Pilot Projects

Pending available funding, FCADV should fund one or two additional pilot sites with unique domestic violence and SAMH partnerships in order to lay the groundwork for future partnerships. FCADV will work with state and local partners to determine appropriate areas of the state to fund these pilot sites. In addition to funding new projects, FCADV will continue conducting training and technical assistance for Domestic Violence Centers and allied partners on the intersection of domestic violence with substance abuse and mental health. Trainings will be conducted on-site and regionally to meet the growing need of service providers throughout the state.

Full Integration Pilot Projects

FCADV should fund a minimum of one pilot site, pending available funding, in a community in which an FCADV CPI project currently exists in order to support and garner evidence for the full integration of domestic violence, substance abuse, mental health, and child welfare services for survivors and their children. It is important that these system partners come together to understand each others' roles, capacities, and limitations when working with survivors of domestic violence. Fully integrated pilot projects will build on the blueprint of the domestic violence and child welfare integration work, including adapting and replicating referral forms, MOUs, and protocol documents associated with integrating SAMH providers into existing CPI projects. Recently, FCADV discussed such project with a managing entity that is willing to participate and be included in a full service integration project where domestic violence, child abuse, mental health, and substance abuse issues are addressed in a holistic seamless approach.

Conclusion and Next Steps

The community readiness assessment reflects themes of common barriers and successes to partnership among domestic violence and child welfare agencies; as well as next steps to build partnerships with SAMH providers in Florida. FCADV will utilize the information gathered through this assessment to provide support to local communities in developing and/or enhancing these necessary, life saving partnerships. The data collected was also analyzed by Circuit in order to determine some of the existing partnerships, barriers, and successes. These data are available in disaggregate form; and will be utilized by FCADV to provide community specific technical assistance in coordination with the themes identified in this report.

The child welfare recommendations in this report are offered as guidelines for local Domestic Violence Centers and child welfare agencies to build formal collaborative relationships to work with families experiencing domestic violence. In order to accurately assess the co-located domestic violence staffing needs throughout the state, more data should be collected regarding the staffing levels of each child welfare agency in Florida. In addition, Domestic Violence Centers have various levels of resources to hire and train domestic violence staff that focus primarily on partnerships with local child welfare agencies. Some may have local funding sources that can be utilized to create or sustain such positions while others lack the necessary funds to do so at this time.

Recommendations included in this report regarding SAMH are focused on state level organizations modeling a strong collaborative partnership that local SAMH providers and DV Centers can replicate in their communities. These organizations must further assess strengths and barriers to lay the groundwork for future partnerships between DV Centers and SAMH providers. FCADV will continue gathering information about these needs and resources for both types of partnerships in order to seek and appropriate funds necessary to implement additional projects focused on the integration of domestic violence, substance abuse, and mental health services. Further, FCADV will meet with the DCF SAMH Program Office to discuss partnering on technical assistance requests from the individual managing entities and their local domestic violence center.

Each community can take steps to build and/or enhance their partnership regardless of funding levels. Meetings between leadership and managerial staff can help tremendously to clarify roles, responsibilities, resources, and limitations of staff at each respective agency. Appropriate referral processes can be formalized so that survivors and their children are being connected with the safety services offered by Certified Domestic Violence Centers. Child welfare agencies can continue shifting their focus toward holding perpetrators accountable and partnering with the non-offending parent. As state and local agencies continue making these important efforts, survivors of domestic violence will have more resources to seek and access safety for themselves and their children.