Children's Home Society of Florida Pilot Project: Enhanced Domestic Violence Services
Initial Assessment Summary and Recommendations

Overview

It is well known from past natural disasters and economic downturns that domestic abuse cases rise as perpetrators use violence to feel more in control — and take their fear and anger out on their partners. For the past year, advocates, police, and government officials have sounded the alarm about the violence that would erupt from vulnerable families during the COVID-19 pandemic as victims are quarantined at home with their abusers. Scrambling to make extra resources available, the U.S. government added millions in funding to shelters and hotlines. Uber donated 50,000 free rides to shelters for survivors needing to escape. PSAs were created to raise awareness of the enhanced danger. The following study reveals a significant finding that the state child welfare system is missing or not addressing domestic violence that is present and a clear threat to the child in 64% of cases.

A Change from the Traditional Approach is Long Overdue

Domestic violence is one of the most common co-occurring maltreatments and sources of danger in child abuse and neglect cases across the country. In Florida, domestic violence is a clear danger that is often present but not identified by child welfare staff. When identified, lack of training or understanding of the danger this abuse presents results in the issue being pushed aside or mishandled.

To date, two traditional primary models have been tried to address the issue of child abuse and DV in the child welfare system: training staff and co-locating domestic violence advocates with investigations. These approaches have not had a considerable effect despite millions of dollars spent on implementation. Staff who are trained rarely receive subsequent supervision to understand how cases should be handled differently because of domestic violence. Staff turnover also affects the long-term effectiveness of the training.

Research has shown that, while co-located domestic violence advocates are helpful, there is no measurable effect in reducing removals or re-entry into the foster care system. These advocates

are often placed with investigative staff and rarely interact directly with the teams charged with managing the cases after removal. The bottom line: methods used to improve the systemic response to domestic violence might have short-term or isolated impact, but they do not result in systemic change.

Traditional approaches fail to understand the one uncontrollable factor: the abuser

These traditional child welfare approaches to domestic violence prevention place a heavy emphasis on the victim's actions to protect themselves and their child(ren) from the abuser. Many case managers view the act of hiding victims in shelters and then separating them from abusers as a successful resolution to the violence. This approach does not work for many reasons. Relying solely on the victim to stop the violence, at best, results in the victim being labeled as having a "lack of protective capacity." Well-meaning case managers often increase the danger by forcing a separation without the appropriate safety plan and resources to keep the survivor safe. For decades, this view that separation is the only solution has forced thousands of women to choose between extreme danger, homelessness, or staying with their abuser for lack of other options. Sadly, the result is that they all too frequently lose their children.

The ultimate issue is that the child welfare system is not designed to address the behaviors of domestic violence perpetrators. Like other forms of violence, domestic violence's gravest acts tend to be committed by "chronic" offenders. Research also shows that those who don't fit this profile can be "deterred by relatively low-level sanctions." The key is to address the problem at the earliest possible stage before the violence escalates — this is where our current system most often fails. For abusers, counseling is generally not offered until after the assault is so severe it is court-ordered. Additionally, if the abuser refuses to cooperate with case management or clinical staff, the focus is often shifted to the victim rather than to hold the perpetrator accountable. This can lead to the abuse or level of abuse being minimized by the survivor to comply with case plan requirements and have their children returned.

Stopping the rapid escalation of violence will require a combination of new strategies alongside existing ones.

THE PILOT

Children's Home Society of Florida (CHS) is the largest child welfare organization in Florida. Upon identifying a higher rate of re-entry into the foster care system for children in the Miami-Dade region, CHS wanted to determine if unidentified domestic violence was an underlying cause. The goal was to keep more children safe and to reduce the number of re-entries into care. To assess and address the issues, CHS engaged Sharity, as a national leader in domestic violence services to work with the clinical and case management team to develop a model that would identify and address intimate partner violence in cases where a child had been removed from the home.

The pilot sought to address the following questions: 1) Could staff – if highly trained, supervised and equipped with evidenced-based tools – assess, identify, and respond to cases with domestic violence in a way that would increase safety and address issues that were currently being missed? 2) Were staff inadvertently missing or overlooking domestic violence because perpetrators were non-compliant? 3) Were untrained staff inadvertently endangering survivors by forcing them to leave the abuser, which research shows heightens the danger?

To ensure adherence to consistent methodology and data collection for analysis, CHS added its measurement and evaluation staff member to the pilot to oversee data collection and evaluation. While much of the data at this point is qualitative and quantitative, some are anecdotal in nature. This paper is a partnership of the CHS case management team in Miami-Dade, the CHS management and evaluation team, and Sharity.

INTERVENTIONS

The pilot consisted of three primary interventions: 1) intensive training of staff, 2) expert consultation, and 3) evidence-based assessment of domestic violence. To begin the pilot, the team, in partnership with the domestic violence expert, created a model for screening that would be used in the pilot. Of primary concern throughout this project was the safety of children, survivors, and staff. Significant emphasis was placed on engaging external resources such as certified domestic violence programs, law enforcement, and the courts to help ensure survivors and their children were protected. Since many of the traditional interventions in child welfare are designed to force the survivor to leave the abuser, having additional support, safety planning, and staffing to address safety is believed to significantly reduce rather than heighten danger.

ASSESSMENTS

The topic of adequate domestic violence (DV) or intimate partner violence (IPV) screening remains controversial even to this day. Systems that frequently come into contact with IPV rarely consistently screen, so little data exists about efficacy. Further, the intervention necessary to see positive outcomes is even less regularly studied when accompanied by screening. For this pilot, due to the nature of staff skillsets and the primary focus of the survivors' safety, a brief screen was initially implemented that would, if the score indicated DV or IPV, result in a more extended screen and subsequent safety plan. The tools were chosen based on their widespread use in the domestic violence field and extensive efficacy through years of research. The expert consultant was also certified to use the appropriate tools or had an extensive history with the tool.

THE DANGER ASSESSMENT

One of the most widely respected utilized assessment tools used by domestic violence advocates is the Danger Assessment (DA). The Danger Assessment is an instrument that helps to determine the level of danger an abused woman has of being killed by her intimate partner. Jacquelyn Campbell originally developed the tool in 1986 with consultation and content validity support from survivors and other experts. While the staff was trained in both the tool, the calendar, and the questionnaire, only the 20-item scoring instrument was used.

The 20-item instrument uses a weighted system to score yes/no responses to risk factors associated with intimate partner homicide. The assessment was given in person or virtually by clinical staff trained by and in consultation with the pilot expert. All staff, including case managers, were instructed about the assessment, including the risk factors such as strangulation, partner's employment status, and partner's access to a gun.

Research has shown that, despite certain limitations, the DA can, with some reliability, identify women who may be at risk of being killed by their intimate partners. The CHS/Sharity study found that women who score eight or higher on the Danger Assessment are at very grave risk. It is important to note that the average score for women who were murdered by their partner was just under 8. Women who score four or higher are at significant risk, and the average score for abused women was just over 3. Critically important to this pilot is that the study also found that almost half the murdered women in the survey cited did not recognize the high level of their risk. It is clear from findings in this pilot that the system is not recognizing that danger either.

Due to the pilot's limited scope, the score needed to be placed into the high lethality team was set at 18. All other survivors who were identified to be at risk or where risk factors were seen were provided safety planning and referrals; on several occasions, however, they were admitted to the pilot due to escalating danger despite the score. For future implementation, it is recommended that the high-risk intervention begins at a score of 7 or higher.

A short four-item version of the Danger Assessment called the Lethality Assessment, or DA-5, was initially implemented for the initial screen. It was initially developed for use by law enforcement officials responding to domestic violence calls, and it was felt that the case management staff could implement the assessment. Case management staff struggled to administer the tool, and it was later replaced with the HITS.

Kevin Sherin developed the HITS in 1998 as a screening tool for family physicians, though the HITS is designed not to assess danger but rather the presence of domestic violence. The screening tool has been evaluated in diverse settings and shows internal reliability and concurrent validity. In a study of all screening tools for DV, the HITS was among the six instruments found to be highly accurate and recommended for use by the U.S. Preventative Service Task Force (USPSTF). The HITS tool asks five questions and is simple to score each question on a 5-point

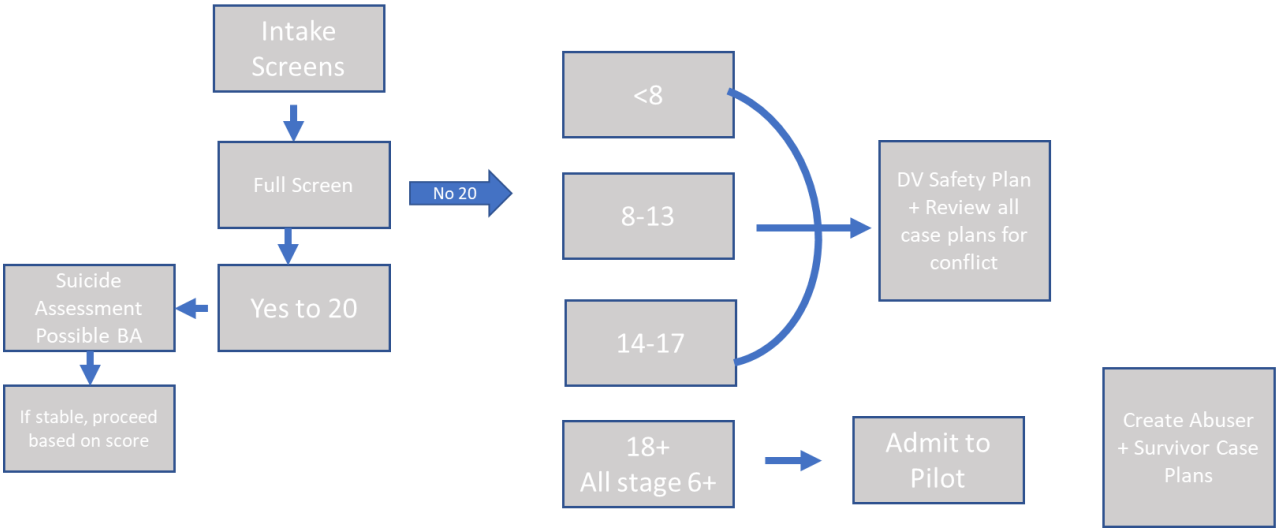
Likert scale. A 10 or higher score for this pilot resulted in further screening with the full 20 question DA.

While the pre-screen was intended to be used by intake or case management, most of the assessments either were not completed or done incorrectly. Of the 45 that initially was planned for completion, only four were completed. For this reason, the data of the pre-assessment scores are not used in this paper.

Additional training was provided on the relatively new Femicide Scale to improve staff understanding of the risks of homicide in domestic violence cases. Based on the research of 372 murders of women by their partners or ex-partners in the U.K., criminology expert Dr. Jane Monckton Smith found an eight-stage pattern that was consistently followed preceding a homicide.

These eight stages were presented to all CHS case management staff and enhanced in the training of the primary team. Additionally, the staff was required to use their judgment based on the assessment of what stage the relationship was currently in. At the time of the pilot, the Femicide Scale training was not yet available. Future pilots or expansion using this method should take advantage of the available new tools. By identifying the stage on the scale, the staff looked not only at a score on an assessment but also looked to understand the escalating danger to their client. This is important because research shows that clusters of risk markers are more predictive than the numbers of markers. For example, where there is control, violence, and a separation after living together, there can be as high as a 900% increase in the potential for a homicide (NCICP 2003).

Taking into account the lessons learned during the pilot, the final process for assessment is below. Staff are better able to identify markers and do not rely solely on the DA score, which is what was developed in the first part of this pilot. Cases screened at intake are immediately staffed, and expert consultation is called in as needed.



EXPERT CONSULTATION

Carol Wick was the domestic violence expert engaged to assist and consult on the study. Carol has extensive expertise in the areas of trauma, domestic violence, and child abuse. She started her career working with traumatized children and spent the next 30 years in nonprofit leadership, creating collaborative program models to address community issues.

Carol holds a bachelor's degree from Florida State University, a Master's degree from Auburn University, a Certificate in Board Governance from the Harvard University Kennedy School of Government, and a Certificate in Advanced Entrepreneurship at Rollins College Crummer School of Business. She is on the expert roster as a consultant for UNWomen, Ending Violence Against Women.

With a background in program evaluation, published research, and over 30 years as a trauma therapist, Carol brings a unique set of skills to the project. As the CEO of one of the largest domestic violence services organizations in the US, Carol oversaw 19 locations and over 115 advocates. She created a new model for community engagement and intervention that was researched and published in numerous journals, including the Journal of American Medicine (JAMA). In partnership with Dr. Kevin Sherin, Carol created the first domestic violence screening app utilizing the HITS tool, the R3App. This app also provided the only available-by-zip-code

listing of domestic violence services in the U.S. The app has been used worldwide and won global awards.

Carol has been a licensed therapist since 1994 and began her practice working with sexually abused children and adult survivors. Her work as a therapist and clinical supervisor span 30 years. She now trains child welfare workers, advocates, and therapists to work with survivors of domestic violence to reduce danger and promote long-term healing and safety. She holds both a license as a Marriage and Family Therapist and an Approved Supervisor in Florida.

Carol assisted with the development of the training, selection, and implementation of assessments and pilot design. She also provided ongoing domestic violence consultation and assistance in arranging resources such as emergency shelter as needed.

DOMESTIC VIOLENCE TRAINING

The first phase involved training staff. While all staff was invited to participate statewide, the primary focus was the Miami-Dade Region. All clinical and case management staff and managers in the region were required to attend. Due to pandemic restrictions, all training was conducted online. Training on the dynamics of domestic violence continues to be provided to all staff twice per month for a period of three months. These were recorded for distribution for the team statewide.

The training was provided by Carol Wick, a licensed therapist and internationally recognized expert on domestic violence. The staff who attended were provided with continuing education; it is possible, for licensed staff, that this training could be applied for state CEU requirements for domestic violence, not only provided internally but also offered at a cost externally as an additional revenue source.

- Understanding Domestic Violence – The Latest Research
- Understanding Complex Trauma and the Domestic Violence Perpetrator
- Domestic Violence for Mental Health Practitioners
- Coercive Control – Understanding Non-Physical Forms of Abuse
- Understanding Lethality – How to Assess Danger and Safety Plan
- Techniques for Working with DV Survivors

Post-training satisfaction surveys were conducted for each training. Nearly all participants (93.94% in Sessions One and Two and 96.43% in Session Three) found the training to be relevant, helpful, and easy to follow. While the training sessions were very well received, it became clear that those who participated in the training had limited knowledge on domestic violence and how to apply their knowledge of it in their roles. Participants in Phase One commented:

"The statistics were extremely helpful and eye-opening."

"The facts and figures regarding DV are not often discussed."

"I learned some new things, which is always a great outcome. And it was very interesting."

"I am learning more appropriate ways to safety plan and hands-on tools to aid in helping clients understand violence's impact."

"I truly enjoyed this training and the perspective on trauma, child welfare, and the struggle between DV providers and therapeutic providers. Left me wanting more."

The second phase involved training the high-lethality specialty team. This team received advanced training in working with complex trauma, high-risk abusers, and critical lethality screening. The group participated in an additional 10 hours of intensive training as well as group supervision. The goal was to increase the team's knowledge so that they could effectively provide services to assigned high-risk clients.

Though naturally, the intensive training sessions provided only to Miami Dade staff had fewer participants, 100% found the training sessions to be relevant, helpful, and easy to follow. Some of the most valuable feedback from the Intensive Training Sessions One through Three respectively was:

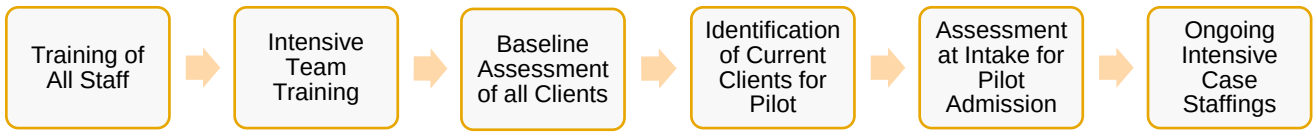
"Working through a case example was helpful. Interesting to learn how to best approach victims that is more in-depth than what was taught in school."

"Working through a case example and the safety plan document [I liked the most]. There was a lot about safety planning that I did not know and enjoyed how thorough it was. The safety planning training I've received has been very fast, but the thoroughness of this safety plan will be beneficial in providing some security for clients in this hard position."

"The case examples and reviews [I liked the most]. It helps me understand more how to assess my clients."

PROCESS

The following plan outlines the process and results of the pilot project that occurred in Miami-Dade from June 2020 through December 2020. The pilot involved two phases of work: Intensive training in domestic violence and assessment, and expert consultation on cases admitted to the pilot. The design of work was adjusted as lessons were learned throughout the process. The original process, as designed, is identified below.



This plan involved creating a team of staff – clinical and case management – that would be highly trained and work together throughout the pilot. This team would receive cases that were too high risk as identified through the evidence-based screening. The Domestic Violence Specialty Team, as it was called, consisted of a team of therapists, managers, and case managers who were selected to participate.

This process was ultimately changed due to several systemic issues. First, while the initially identified team did stay together through phase 1, the logistics of case assignment prohibited the cases assigned to the pilot from being assigned to the trained case managers. It became apparent that the primary burden of initial screening and plan development would fall on the clinical staff, who could more easily be assigned the cases and supervised.

The second challenge came when attempting to gather baseline data on all current clients. The entire Miami-Dade team was asked to complete the DA-5 with all their existing clients. Many of

the team members were unable to meet the assessments by the deadline set. Despite numerous attempts, the assessments were not being completed. Of those completed, staff ultimately reported that they had completed them based on memory, and few had been done as trained.

When asked why they had not completed the assessments, staff reported that clients were resistant to answer questions that might cause their case plan to be changed, mostly if they were near closure. While there was concern that there might be domestic violence present in cases that were ready to be closed, the decision was made to shift the plan and only assess new cases at intake where parents might be more open with staff. Ultimately it became clear that case managers did not have adequate therapeutic interviewing training to conduct the assessments with clients.

The decision was made to have the master-level therapists who had been trained in the assessments complete the HITS and Danger Assessment as well as the DV safety plan. The case would then be staffed with the Sharity consultant, and a plan developed. The final process that was developed resulted in a more streamlined flow that became easier to integrate into the existing system.

BASELINE DATA

The pilot data was selected over 12 months from January 1, 2020, to December 31, 2020. It should be acknowledged that the pilot did take place during massive shutdowns due to the pandemic, and that it began in March of 2020. The data, however, remained relatively consistent from both the pre-pilot and during pilot time frames. Domestic violence, unless it is primary maltreatment, is not often identified in The Florida Safe Families Network (FSFN) application, which is utilized to meet the State of Florida's requirements for a child welfare system and meet Federal reporting requirements for child protection, foster care and adoption. This is a concern for several reasons. First, when it is not recognized as a primary or co-occurring issue, staff tend to not assess for it further. The purpose of this pilot is to determine if

abuse is happening between the adults in the family unit and, if so, if that abuse, unidentified and unaddressed, is causing returns to the system and future removals. Because the system does not show IPV or DV in the database, it further inhibits the system's ability to address the problem.

CASES WITH SYSTEM-IDENTIFIED DOMESTIC VIOLENCE

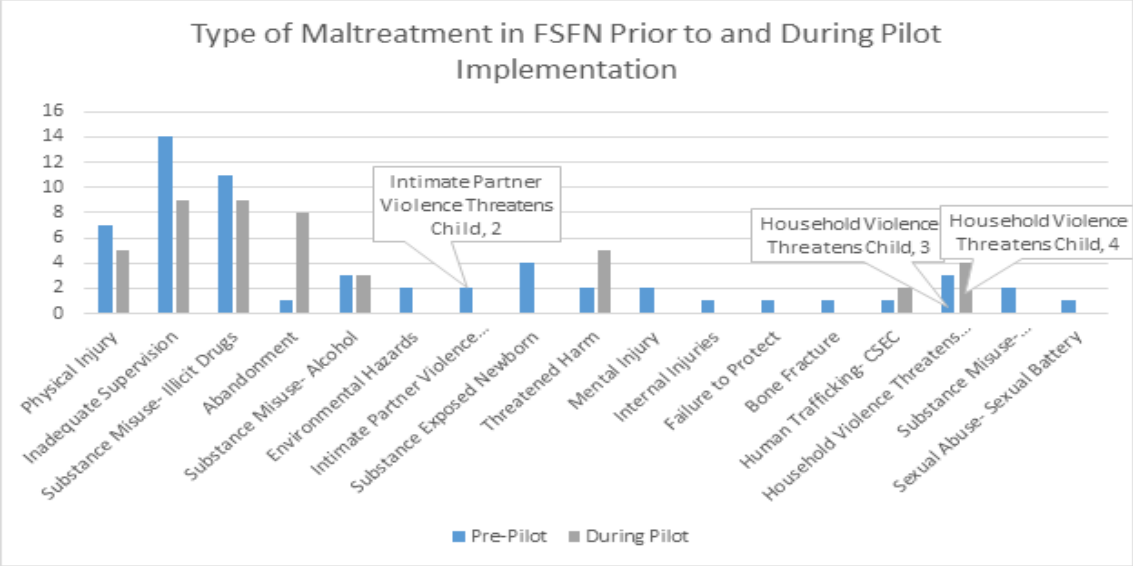
A total of 109 cases were evaluated for data—sixty-two for the baseline evaluation and 47 for the pilot period. Before pilot implementation, from January until June 2020, there were 62 removal cases in total referred to the Miami Clinical Team, and only five cases were identified for either "Household Violence Threatens Child" or "Intimate Partner Violence Threatens Child." During the pilot implementation period from July 23, 2020, through December, 47 removal cases were referred to the Miami Clinical team citing a variety of maltreatments, though only four for the maltreatment of "Household Violence Threatens Child," indicative of an active domestic violence component within the family unit.

During the investigation period, all new, incoming referrals to the Miami clinical team from dependency were screened for having an active domestic violence component within the family unit. The data in the chart below is a cross-reference of Florida's Safe Family Network (FSFN) data with the SpecOps (Referral App) database to examine open dependency cases with those that resulted in a referral of the client to receive CHS clinical services. Of the 109 cases retrieved, from January 2020 to December 2020, only nine cases (8.3%) had either "Household Violence Threatens Child" (6.4%) or "Intimate Partner Violence Threatens Child" (1.8%) listed as the most recent type of maltreatment. No cases were categorized as "Family Violence Threatens Child," another common term used to indicate that domestic violence was the reason for child removal.

DCM Cases with a Removal Due to Maltreatment, Referred to Clinical Filtered by the Most Recent Incident Date (January 2020 - December 2020):		
Type of Maltreatment	Frequency	%
Household Violence Threatens Child	7	6.4%
Intimate Partner Violence Threatens Child	2	1.8%
Physical Injury	12	11%
Inadequate Supervision	23	21.1%

Substance Misuse- Illicit Drugs	20	18.3%
Abandonment	9	8.3%
Substance Misuse- Alcohol	7	6.4%
Environmental Hazards	2	1.8%
Substance Misuse- Prescription Drugs	4	3.7%
Substance Exposed Newborn	4	3.7%
Threatened Harm	7	6.4%
Medical Neglect	2	1.8%
Mental Injury	2	1.8%
Human Trafficking- CSEC	3	2.6%
Sexual Abuse- Sexual Battery	3	2.6%
Internal Injuries	1	0.9%
Failure to Protect	1	0.9%
Bone Fracture	1	0.9%
Total	109	100%

In examining the data prior to the implementation of the pilot, five cases in total were removals referred to clinical because of domestic violence (3 Maltreatments of Household Violence Threatens Child; 2 Maltreatments of Intimate Partner Violence Threatens Child). In examining the data within the pilot time frame results, in even fewer instances of removals due to domestic violence. "Household Violence Threatens Child" increased to four cases referred to clinical from July to December, although "Intimate Partner Violence Threatens Child" was removed from the dataset completely, and "Family Violence Threatens Child" remained excluded from the data. This is inconsistent with the number of referrals the pilot team received over the same time period, citing the need for various types of therapeutic intervention resulting from our clients experiencing domestic violence.



The Case ID associated with the cases of removals with referrals to clinical services was cross-referenced against available shelter petitions associated with these cases. In nearly all available shelter petitions, active domestic violence or a history of domestic violence was identified as a primary factor for the status of the case.

AVERAGE NUMBER OF MALTREATMENTS

On average, each case coming into the system had eight allegations of maltreatment. It can be inferred that allegations of domestic violence via "Family Violence Threatens Child," "Household Violence Threatens Child," and/or "Intimate Partner Violence Threatens Child" may not be prioritized by those initially investigating the case at the state level or instances of an active domestic violence component within the life of our clients is being missed altogether.

Total Number of Allegations in Pilot Phase All Cases 7/20-12/20	
Minimum	1
Maximum	50
Range	49
Mean	8

TIME IN CARE

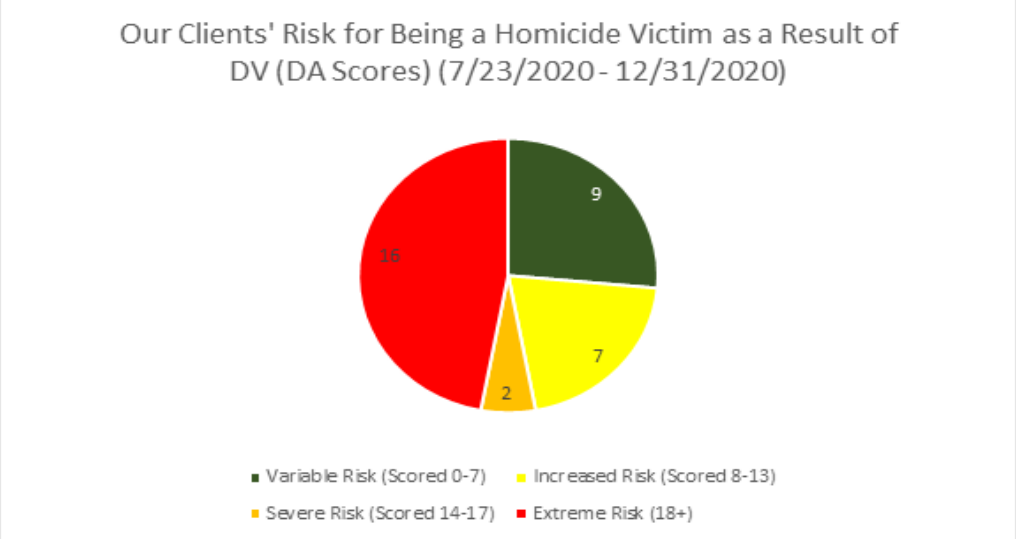
The premise of the pilot is that cases where domestic violence is present but not identified will result in poorer outcomes. A review of the cases open during the pilot period found that many cases were not being closed in a timely manner or, when permanency was achieved timely, clients were re-entering care. On average, dependency cases that were referred to clinical within the investigation period stayed open for 495 days. The statewide goal is 365 days.

Days Open All Cases 7/20-12/20	
Minimum	33
Maximum	3361
Range	3328
Mean	495

ASSESSMENT RESULTS

For the assessment evaluation, the pilot evaluated two areas: systemic identification versus assessment identification and danger level. In total, 34 assessments were administered between July 2020 and December 2020. Of the 34 assessments administered with clients, 74% scored at what Campbell refers to as "grave risk" with an increased level of risk for being a homicide victim due to domestic violence (n=25), and nearly half of the assessed clients' scores indicate that they are at extreme risk for becoming a homicide victim because of domestic violence (n=16).

The nine clients scoring in the "Variable Risk" category were also in danger when assessed on the number of markers present. Of the clients in the Variable Risk category, their responses ranged from their partners being unemployed and having a child not fathered by the perpetrator to a client who left her perpetrator after living with him over the last year, being violently and frequently jealous of her, controls most of her daily activities, and has admitted to the physical violence increasing in severity over the past year.

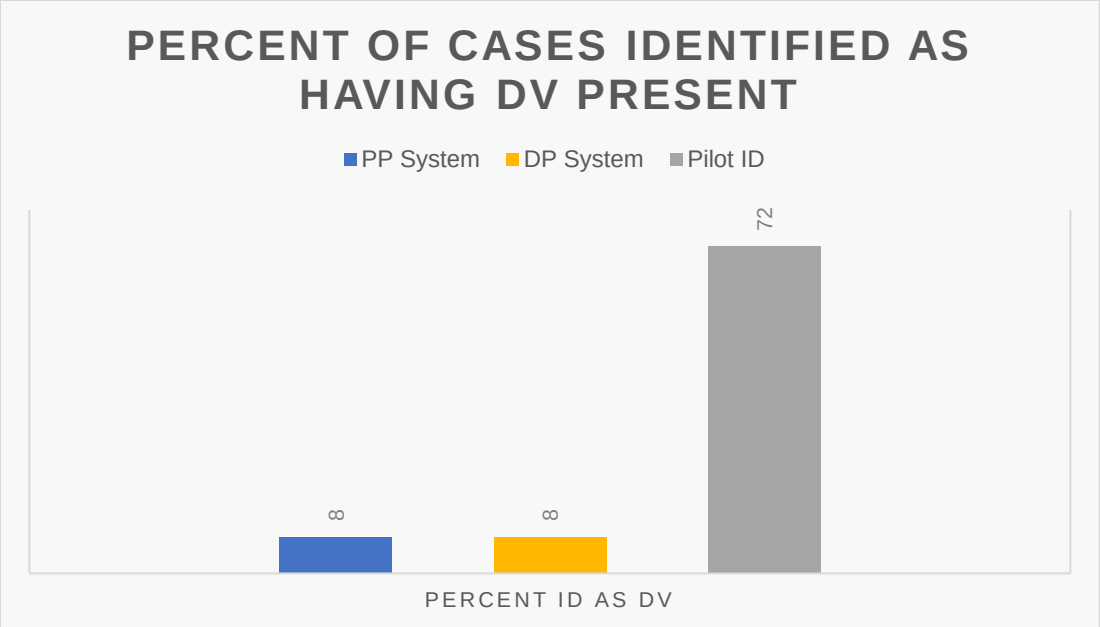


ADMISSION TO PILOT

Of the 34 assessments administered with clients, all 34 were admitted into the pilot in the best interest of their personal safety. Despite the range of scores clients received on the danger assessment, the therapists felt that there was enough danger present to continue working with them closely, using specialized safety planning as a core component of the pilot. This finding highlights one of the largest issues discovered through this research: though the types of maltreatments identified outside of CHS (via DCF) is widely varied, the conventional child welfare system in Florida is largely not identifying the presence and extent of domestic violence within the family unit. With assessment and advanced training, the maltreatment is not only identified, but interventions were able to be put into place to promote the achievement of timely permanency and to reduce or eliminate re-entry into the child welfare system.

Overall, the child welfare system, in both the pre-pilot phase and pilot phase, identified just eight (8) percent of cases as having domestic or intimate partner violence as maltreatment that should be addressed. The CHS pilot was much more successful in identifying abuse and found it in the present, often in extremely lethal levels, in 72 percent of all cases.

This is a significant finding that the state child welfare system is missing or not addressing domestic violence that is present and a clear threat to the child in 64% of cases.



During the completion of each danger assessment with clients, clients were presented with a list of different stages on the Femicide Scale and asked to identify which stage they perceived themselves to be. This scale is used to capture the escalation of relationships with domestic violence to the point of the male perpetrator committing homicide against his female partner. Stage 7 involves planning the homicide of the female in the relationship, and Stage 8 indicates that a homicide has occurred. Thankfully, none of the clients in the pilot indicated they were at stages 7 and 8, although several clients (n=6) indicated they were in Stage 6. Examining the scores of the Danger Assessments with the stages of our clients on the Femicide Scale, the numbers are quite comparable. The danger assessment scores 16 clients at extreme risk for being a victim of homicide, whereas 13 clients self-identified as at least in Stage 3 on the Femicide Scale. Stage 3 indicates warning signs and common behaviors of an abusive relationship, such as coercive control, stalking, violence at any level, sexual aggression, possessiveness, jealousy, violent threats, and social isolation.

Stage on the Femicide Scale		
Stage 1	Pre-Relationship Warning Signs: History of abuse (allegations or criminal), the abuser has a controlling personality, the abuser is thin-skinned and confrontational.	12
Stage 2	Early Relationship Behaviors: Early commitment, early cohabitation, early pregnancy, early declarations of love, using possessive language, jealous at early stage, resists attempts to slow down or end the relationship.	4
Stage 3	Warning Signs: Coercive control, stalking, violence (even low-level pushing and shoving), sexual aggression, possessiveness, jealousy, threats (to kill, commit suicide, harm pets/children), isolation from friends and family.	4
Stage 4	Homicide Trigger: Separation, threats of separation, imagines of separation (ex. accusations of an affair), order of an injunction, victim seeking child support, bankruptcy or financial ruins, physical and mental deterioration of either the abuser or victim.	1
Stage 5	Escalation: Concerning behaviors become more frequent, serious, and severe; stalking (even low level), threats to kill or suicide, may use language like "I won't let you leave," "I can't live without you," or "If I can't have you, no one can."	2
Stage 6	Change in Thinking: Victim blocks abuser's phone number, the victim does not or cannot respond to threats, there is a new relationship for the victim, last attempts at reconciliation between abuser and victim, stalking, mental/physical health deterioration is irreversible, financial troubles are unsolvable.	6
Stage 7	Planning Homicide	0
Stage 8	Homicide	0
Total		29

CASE STAFFING

This project sought to create an expert team within the organization that had the knowledge and expertise to address the more difficult cases and understand the dynamics that are not always clearly observable to those outside the system. Using the Danger Assessment and the Femicide Scale, two evidenced-based tools used to determine risk in domestic violence relationships, the team created a safety scoring system that classified cases. This grid then determined the type of planning for the family as well as the care plan used.

Staffings were held every other week for all clients admitted to the pilot. After the initial assessment process was refined, the number of cases identified overwhelmed this process, and on-demand staffings were scheduled and held. The entire team assigned to the case would be invited to be part of the staffing. This included the clinical supervisor who oversaw all cases in the pilot, intake clinician, or assigned clinician depending on where the case was in the process of admission, case manager, and the case manager supervisor.

Staffings were typically one hour per case and initially followed the following format: background of the case including past history with the system, current situation that caused the removal, assessment score, femicide scale, and current concerns. Throughout the staffing process, it was clear that case managers and clinical staff held different types of information. Often, one was unaware of significant issues that the other was not. The clinical staff did not have access to the computer data system that allowed them to see pertinent history. Often, case managers, many of whom had positive relationships with clients, had more clinical and abuse history knowledge than the clinicians. Staff often reported being shocked that they were unaware of significant trauma, past events, or even the status of current incarcerations or injunctions for protection.

The goal of these staffings was to get a comprehensive view of the case and to work to best ensure that the survivor was being protected and not blamed. The amount of intensive case management and child welfare system connection needed on many of the cases often overwhelmed the team, whose members were either unaware of how to access resources or unable to devote the level of time needed to address the danger. In some cases where the clients were referred for emergency shelter, challenges within the domestic violence system such as getting the shelter to admit the client, having to call numerous shelters to find open beds, or providing transportation for the parent caused considerable frustration. The consultant had to

personally reach out to DV program executive directors to get a placement in one case. The survivor had to find her transportation to the nearest shelter, which was over two hours away.

In addition to shelter, other frequently needed resources were access to legal services, immigration assistance, and housing. Managing the case often fell to the clinical supervisor, who worked with her team to reach out and find resources. Ultimately, it was found that relationships had to be built and MOUs developed with local providers to speed up access to resources, especially in crises.

In several instances, the cases developed heightened danger. On-demand consultation with the DV expert would be set up. In these situations, the staff was coached on encouraging the survivor to reach out to the certified DV program and complete safety plans. The team would often work closely together, each with a different assignment to deescalate the situation and help ensure everyone's safety.

In all 34 cases in the pilot, the case outcomes dramatically improved. In one case, scheduled for termination of parental rights, participation in the pilot resulted in the survivor relocating and ultimately reunifying with her child. In another, the survivor received custody of her child back from her abuser, relocated from a potential trafficking situation and found stable housing. After four months of coaching and consultation, the team relied less on expert intervention and made positive interventions with the cases.

CONCLUSION

The pilot provided numerous lessons that should be taken into consideration in the replication or expansion of this project. Overall, the pilot was extremely successful in accomplishing what it set out to do: The process of training staff and providing reinforcement through consultation led to staff changing the way they addressed domestic violence and an improvement in case outcomes during the pilot timeframe. Additionally, the process was 6x more likely to identify domestic violence in the home as well as extreme danger resulting from that violence.

RECOMMENDATIONS

1. **All cases should be screened for domestic violence, danger, and potential for homicide.**

   Screening for domestic violence with an evidenced-based tool for both the abuser and survivor is critical as the system does not accurately assess the level of danger, nor does it translate danger to one parent as a danger to the children. The addition of the Femicide Scale is critical to ensure staff is not only evaluating based on a score but also where the relationship has escalated toward a potential homicide.

2. **Screening must be done early in the system process.**

   Ideally, this would be done by DCF during the investigation. When the screening was attempted mid or late in the case process, the families were reluctant to answer for fear it would delay reunification. This also indicated that abuse was still active despite months-long intervention and potential reunification. Based on the evidence-based assessment for danger, it was clear that cases screened revealed higher levels of danger than when staff assessed without the tool.

   Compliance with completing assessments associated with identifying domestic violence needs to be mandatory. Throughout the early stages of this research, lack of compliance by case management in completing necessary assessments may have resulted in us missing the ability to identify clients in significant danger further. Only 34 cases were fully assessed, whereas the FSFN data reflects that 47 cases were referred to the Miami Clinical Team. Case management and behavioral health teams working in silos exacerbates this issue. Though the current process identified is working well, success relies on all assessments conducted via the clients' clinicians. It is inappropriate to leave clients in danger due to non-compliance of completing required assessments.

3. **Increase the quantity and quality of staff training in domestic violence.**

   The staff does not have adequate training in or understanding of the basics of domestic violence. The minimal training that some staff receive is not sufficient for staff to understand the dynamics that exist in 75% of their cases. Even the clinicians often missed the warning signs.

It appeared that many cases are closed with DV still active in the home because the staff was unaware or unsure how to address it. Training managers to recognize red flags empowered staff to reach out and request staffings and adjust their approaches to these cases. It is possible that one of the primary reasons for returns to the system in DV cases is simply being missed.

Additionally, the current collective culture sets up staff to believe that certain interventions or actions on the part of the victim will fix the problem of domestic violence. Overwhelmingly, staff believed that getting the victim to go into a shelter would show protective capacity and solve the problem. After they attempted to assist with that process, staff found how incredibly difficult, if not impossible, it was and started to understand that it was a temporary solution to a critically dangerous situation, and that refusal to go to a shelter was understandable.

4. **Address system processes that hinder successful outcomes in DV cases.**

The system processes reinforce victim blame by creating a safety methodology that assesses "protective capacity" as the survivor's ability to control the perpetrator. This process further reinforces the systemic lack of response to domestic violence that often results in additional removals or time in care.

To further complicate the problem of victim-blaming, current electronic case plans are written in language that focuses on this collective culture ideology that the victim must prove they can control the perpetrator, or they may be viewed as a “terrible” parent. The system also creates identical plans for the victim and the perpetrator. When the perpetrator refuses to cooperate, the majority of the time, no consequence results, and case planning and reunification continue to assume that the survivor will stop the abuse (rather than "allow it") and the home will be safe. Again, the basic understanding of the danger is not considered as a risk factor.

Silos between case management and clinical services is a severe hindrance in addressing the most dangerous cases. The barriers in communication that exist between the two departments are not only physical but also electronic. Clinicians, who are expected to be more experienced in addressing DV, do not have access to case management notes. Unless staffings are held addressing the domestic violence and the identified danger, numerous clear

warning signs were missed and not shared. In several cases, one staff member had information that was critical for the other to have, but lack of access to notes and history, as well as routine communication, created situations where that information was not shared. This lack of information-sharing resulted in decisions being made that were contrary to what was needed to address the problem of conflicting case planning.

5. **Broader system engagement is critical to success.**

   A primary challenge was the additional work on staff that took on the supervision and clinical work. Though these cases were not different from previous ones, the knowledge of the danger created an urgency that had to be addressed with already full caseloads and time demands. It is recommended that additional staff manage the "extra" crisis work and be brought in to help ensure domestic violence does not get minimized due to staff's ability to address these cases' diverse needs.

   It also became evident very quickly that CHS does not work in a vacuum. To be successful with these complex cases, relationships with other systems not typically accessed by frontline staff would have to be developed. DCF, the community-based care lead agency, immigration support, housing coalitions, domestic violence agencies, the state attorney, and probation offices must be involved in the solution. Coordinated training and system integration are critical for success, yet most staff did not have connections to these essential groups to reach out to for support. Having case managers in each region whose sole responsibility is making and maintaining these connections to assist case managers is critical in the next steps of expansion.

6. **Improve data collection for ease of analysis**

   To ensure these assessments and ultimately clients' success, it would behoove CHS to invest in technology to streamline data collection. These assessments were written in Qualtrics software because of Qualtrics's sophistication and robustness in survey writing/tool creation, though Qualtrics is not a partner of CHS. It is recommended that these tools remain electronic and utilize some form of survey software (e.g., Qualtrics or SurveyMonkey). Technology statewide would avoid unnecessary hassle, potential confusion, and the possibility of lost documents resulting from collecting the data on paper and entering it manually into the

analysis software. It would also allow for tracking to ensure all assessments are completed and that appropriate interventions are being put in place.

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