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Services Bureau

Family Violence Prevention & Services Program

Developing Outcome Measures for Domestic Violence Programs' Work With Children And Youth



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 National Resource Center
on Domestic Violence



This paper is a companion to *Building Promising Futures: Guidelines for Enhancing Response of Domestic Violence Programs to Children and Youth* (2016), which can be found on the Promising Futures website at:

<http://www.futureswithoutviolence.org/developing-outcome-measures>

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Sincerely,

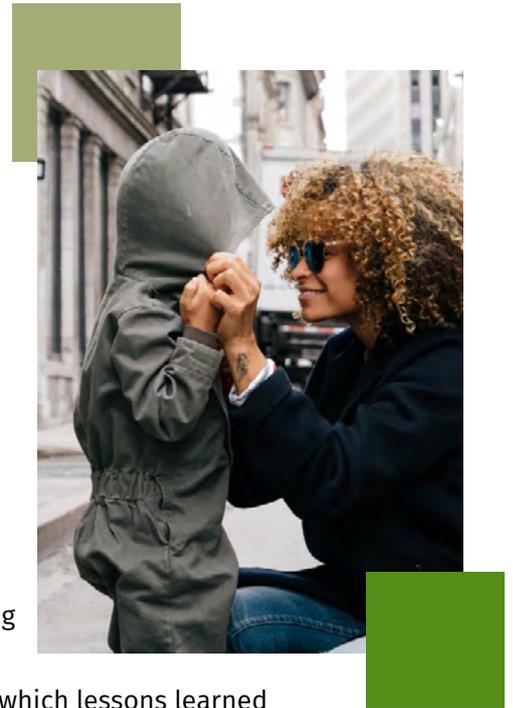
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Introduction

Domestic violence often involves more than physical and emotional abuse directed at an intimate partner; it commonly includes efforts to undermine relationships between non-abusive parents and their children. In order to provide effective intervention responses and enhance prevention efforts, domestic violence (DV) programs in the United States must include a more systematic focus on the children, and on the role of adult survivors as parents or caretakers¹. Recent research demonstrating that children’s well-being can be adversely affected is a central concern of survivors and influences the decisions they make (e.g., Meyer, 2010; Rhodes, Cerulli, Dichter, Kothari & Barg, 2010) has added impetus to advocates’ awareness and determination to improve programs’ responses. Federal efforts to identify factors that promote children’s well-being (e.g., Development Services Group [DSG], 2013) have also contributed in many ways. These include increased interagency collaboration and funding for demonstration projects aimed at developing child- and family-focused interventions and improving state and local community coordination.² Some of these projects have explored ways in which lessons learned from experimental research on structured clinical interventions with children and their mothers/ caretakers might be applied in DV programs, while others have focused on improved coordination of resources and agencies at the community level. All have incorporated an increased focus on children and their family relationships.



It is especially important to carefully consider realistic outcomes and outcome measures that DV programs can use in the context of these children- and family-focused programs. Some programs have been doing this work for several years, yet they are often working on these program enhancements while their funding resources have remained static, or have declined.³ They do not have the ability to administer the clinical measures that well-funded research projects have used. Nonetheless, the valuable information that even simple measures could provide is sorely needed to aid in program development, as described in more detail below. Simple measures for DV programs’ work with children have not yet been developed or adopted on a broad scale.

This paper is a companion to one that offers guidelines for enhancing children’s programming in DV programs (Lyon, Perilla & Menard, 2016). It explores some of the major complexities involved in developing and utilizing outcome measures for DV programs’ work with children. It begins with an overview of some of the major considerations involved. It then describes the process used to reach the measures proposed here, along with issues to be discussed and resolved in order to implement them. Although the importance and complexity

¹ We are aware that children who have witnessed/experienced violence in their home live in families in which their primary caregiver may be one or both parents, grandparents or other family members. In this document we will use the term “mother/caregiver” to refer to any person who has primary ongoing responsibility for childrearing in the home, while at the same time recognizing that the majority of caregivers who provide most of the care of these children are their mothers or grandmothers.

² One such effort is the project of which this paper is a part is “Expanding Services for Children and Youth Program.” It included four demonstration sites funded by the U.S. Department of Health and Human Services, Administration for Children, Youth, and Families, Family Violence Prevention and Services Program to develop or expand programming for children exposed to domestic violence.

³ Profiles of promising programs can be found at <http://promising.futureswithoutviolence.org/advancing-the-field/communities-in-action/>

of programs' supports for survivor families would ideally suggest nuanced measures, a practical, incremental approach best fits DV program realities. The paper concludes with recommendations for a process to be used regionally or nationally to expand the discussion and refine the measures, in order to achieve a small number of measures that can be used easily by DV programs, yet accommodate the significant variations in what they do with the diverse survivor families with whom they work.



Fundamental Considerations for Measures of Outcomes⁴ of Work with Children

Although developing appropriate outcome measures for any type of program involves extensive considerations, DV programs present additional complications, even for adults (see, for example, Lyon & Sullivan, 2007). For example, adult survivors have widely varying needs, participate in programs for varying lengths of time, and may access many or only one specific type of support. The present effort to identify outcome measures for DV programs' work with children faces the issues associated with work with adults, as well

as additional considerations. The primary recommendations are described in the list that follows. The outcome measures to be developed will be most useful if they:

- **Apply to a range of services.** If DV programs will be expected to administer measures related to children's services and supports without additional resources,⁵ the measures should be applicable to a range of types of contacts. The outcomes to be measured should be reasonably expected to result for children and youth in shelter, taking part in support groups, and receiving individual and/or family advocacy support. A DV program with all of these types of services could measure how and when DV information and education is provided to children and youth across all of these services.
- **Apply with limited amounts of contact.** Families come to DV programs for a wide variety of reasons. Some come for emergency shelter, where they may remain for a period ranging from a single day to three months or more. The majority of people who approach DV programs come for other support, including legal or other advocacy issues, psychoeducational support groups, or more therapeutically-oriented counseling; they may come only one time or return for many contacts. Program staff often do not know which families will return or for how long. Measures that reflect the basic work of DV programs should address the kinds of change that can occur with limited contact, so that the majority of families can be included. Regardless of how they come into contact with a family, a DV program can measure whether the family learned about strategies for increasing the safety of their children.
- **Are associated with evidence of improved well-being for children.** Most DV programs do not have the resources to administer lengthy, expensive, or complex established measures; placing additional burdens on families, especially with longer-term follow-up, should be avoided unless dedicated resources are available to support the process for both participating families and DV programs. Nonetheless, the outcome measures

⁴ It is important to remember that "outcomes" are understood here as changes that occur as a result of a program intervention. Such changes may include knowledge, skills, attitudes, behavior, emotional status, expectations or life circumstance.

⁵ For more information on programs funded by FYSB/FVPSA related to providing specialized services for abused parents and their children, see www.acf.hhs.gov/programs/fysb/family-violence-prevention-services, NRCDD's special collection on lessons learned from earlier FVPSA-funded children's programs at www.vawnet.org/special-collections/ChildrenExposed.php, and the programs profiled on FUTURES' Promising Futures site at <http://promising.futureswithoutviolence.org/advancing-the-field/communities-in-action/>

developed for this work will have more meaning and credibility if they are clearly associated with known aspects of improved well-being. There is growing consensus about such factors, which are discussed in more detail later, in the literature review section (see e.g. DSG, 2013; Schultz et al., 2013).

- **Can be reduced to a very small number of items.** Ultimately, the goal of this effort is to identify just two or three items that could be easily used by DV programs about their work with children & adolescents. Ideally, programs with more resources, or more fully-developed or longer-term services/supports for children, would want to include more comprehensive or complex measures of change. In addition, a wider array of measures and other feedback mechanisms would make sense as programs are developed and enhanced to help to guide the process (Chanmugam & Hall, 2012; Lyon, Perilla & Menard, 2016; Rizo, Macy, Ermantrout & Johns, 2011).
- **Apply across cultures.** Selecting a very small number of items is further complicated by the fact that children's and families' needs and goals may differ across cultures, and the approaches and foci offered by DV programs may vary by the extent to which they are culturally grounded. For example, the role and importance of family relationships are more central in some cultures; culturally-specific interventions may focus more on the family than on individuals. Safety and well-being may "look" different, and need to be measured differently, for these families and programs. Families that have had to grapple with racism and discrimination, in addition to DV, may experience added stress as well as limited access to services and support. Some families and programs are profoundly affected by immigration-related issues and policies, which then influences interventions. Similarly, the role of community support and influence (as sources of both strength and risk) may vary across cultures, and affect interventions, goals and outcomes. When approaches vary systematically, and "one size does not fit all," finding appropriate common outcome measures becomes more challenging and essential.
- **Apply to all children.** As is true of adults, children's and adolescents' reactions to violence and abuse in their family can vary dramatically, depending on such factors as the type (physical, sexual, neglect and emotional, among others), and extent (including frequency, severity and duration) of the abuse, as well as other risk and protective factors, the child's age, developmental stage, and gender (see, e.g. DSG, 2013; Gewirtz & Edleson, 2007; Holt, Buckley & Whelan, 2008; Howell, 2011; Martinez-Torteya, Bogat, vonEye & Levendosky, 2009). In addition, some children living in families where domestic violence occurs do not show evidence of adverse effects (Kitzmann, Gaylord, Holt & Kenny, 2003) as discussed in more detail in the brief summary of literature in the next section, so they may not provide evidence of some of the more clinical types of change after program involvement. Again, finding a small number of outcome measures that are appropriate for all of these different circumstances is challenging.
- **Can be implemented with sensitivity to ethical issues.** The primary ethical concern is that outcome measures be administered so that mothers/caretakers and/or children feel safe and comfortable about responding, understand that they have a choice, and feel that their responses are confidential (or anonymous). Respondents must have ways to provide responses that are private; their responses should be provided so that program staff with whom they have worked cannot identify the source (see Lyon & Sullivan, 2007, for suggested strategies). If children or adolescents are going to be asked to complete outcome measurement



tools or surveys, the items need to be age-appropriate, so they are fully understood, and the process for approaching the youth (as for adults) should provide information about the purpose of the information and that there will be no consequences if they refuse to participate.

The Process Used to Develop the Proposed Outcome Measures

Conversations with the demonstration sites. The process began with individual and group conversations held with the four demonstration sites involved in the “Expanding Services for Children and Youth Program”.⁶ These conversations addressed the different types of interventions involved in each site, and their rationales. Some were culturally-specific, others consisted of modifications of promising practices or curricula, while others focused on efforts to improve understanding and cooperation among community agencies. Perhaps more pertinent, the conversations emphasized the sites’ experience with the approaches and interventions that had been most helpful for mothers/caretakers and children/adolescents, as well as specific suggestions for outcome measures. Those that were too specific to apply across types of interventions were noted, but not included in the list of potential items provided later in this paper.

Conversations with child advocates. Next, ideas were solicited through individual conversations and/or written communications with child advocate key informants, who had a range of backgrounds and experience levels.⁷ They were asked what children and adolescents most need when they come to DV programs. They were also asked what outcomes could reasonably be anticipated from DV programs’ work, understanding that programs and needs vary considerably, and contact could be limited. The conversations were often rich and detailed. The following themes, described very simply and succinctly, emerged from these conversations:

- Children and adolescents’ needs and reactions vary considerably, especially by stage of development, family relationships and culture. DV programs need to be sensitive to and respond to these variations, without making assumptions.
- Establishing trust (with advocates, adults, and/or parents) is critical, because it contributes to increased comfort in communication (sharing concerns and feelings) and ultimately a sense of safety. If children/adolescents can trust that they will be understood and respected, and will get a helpful response, they will be safer, as well as feel better about themselves. They need access to supportive resources.
- Building relationships is an important part of increasing trust—relationships with advocates as well as parents or other supportive adults. Positive, trusting relationships and communication help children/adolescents sort out the confusing feelings they often have. Some may blame their mothers/caretakers for “causing” or “allowing” the abuse, and not providing the safety and protection the young person wants. Others may feel angry at the abusive adult/father for hurting their mother and also hurting or frightening them, while the child/adolescent loves and respects him for other reasons. Some may have all of these sources of confusion, and others, as well. Developmental stage influences all of these issues, and their likelihood.
- Children/adolescents need to understand domestic violence, and the many forms it can take. Understanding can help to sort out the confusion, and help the young person to realize that they are not responsible for

⁶ The program was funded through Grant Number 90EV0401 from the Administration on Children, Youth and Families, Family and Youth Services Bureau, U.S. Department of Health and Human Services, www.acf.hhs.gov/fvpsa. The sites involved varying numbers of programs in four states: Alaska, Idaho, New Jersey and Wisconsin.

⁷ These included Susan Blumenfeld, Ann Brickson, Casey Keene, Ericka Kimball, Carolina Martinez, Leo Martinez, Johnny Rice II, and Amy Torchia, among others.

the violence. In some families where adults appear unstable or unpredictable, children (especially older children) may assume responsibility for the safety of younger siblings or try to protect the abused parent. If their efforts fail, they can feel that the violence or family trouble is their fault.

- Children/adolescents need to be able to talk about what they can do and where they can turn to increase their sense of safety.
- It is important for children/adolescents to understand their own reactions to their experiences—their feelings and their strengths. Depending on their developmental stage, young people may not understand or be able to control their feelings of anger, sadness, blame, fear and others. They may also not recognize the various ways they have coped with their situation and contributed to the safety, support or well-being of themselves and/or others in their family.
- When children/adolescents have experienced violence and volatility at home (and potentially elsewhere, as well), opportunities to experience consistency and predictability—in situations as well as relationships—become especially important. DV programs and advocates can be a significant source of these experiences (as long as they don't impose inflexible rules), as can improved relationships with their mothers/caretakers and other family members.

Review of research literature. Recent literature about children's reactions to domestic violence was also reviewed, looking for results that would contribute to understanding of common patterns, and aid in identifying potentially helpful outcome measures. Although the review could not be exhaustive (there is voluminous information available), multiple reviews and meta-analyses prepared by leaders and task forces in the field were included.

Much of the existing research literature has come from funded tests (experimental and otherwise) of clinical interventions conducted in therapeutic settings of DV programs (see Leenarts, Diehle, Doreleijers, Jansma & Lindauer, 2013; Chamberlain, 2014, has reviewed evaluations of promising programs). Most of the clinical measures involve multiple items (ranging from as "few" as 10 or 15 to over 100) for each of the types of outcomes addressed (e.g., changes in depression, changes in PTSD symptoms, changes in problem behaviors, changes in adjustment, changes in relationships). While some of these outcome measures could be helpful in programs that are able to offer therapeutic interventions over a long period of time, they are unlikely to be realistic for DV programs that are just beginning to focus on their work with children, that provide the most basic services and supports, or that rely on family/community to engage in and sustain positive outcomes.

The review also revealed that most of the structured clinical interventions focus on reducing children's/adolescents' problem behaviors and/or emotions (Holt et al., 2008; Jouriles et al., 2009; Leenarts et al., 2013; McDonald, Jouriles & Skoop, 2006). This focus may be understandable in the context of evidence of adverse impacts on some children, leading to later difficulties such as delinquency and risks of further difficulties in adulthood (Dube, Anda, Felitti, Edwards & Williamson, 2003). In contrast to an approach that emphasizes reduction of weaknesses, however, many DV programs recognize the value of identifying and building on individuals' and families' strengths, and strive to work that way (see Lyon, Perilla & Menard, 2016). Since outcome measures should reflect the efforts and foci of the interventions, we believe that measures used for basic services for children should specifically measure improvements, rather than reductions of problems.

In addition, the literature review indicated clear evidence about several issues that are compatible with the experience of the four sites, the patterns reported by child advocates, and evidence about what DV programs do, including the following:

- **Resilience.** Although there is also ample evidence of the negative impacts on children and adolescents of living in families where domestic violence recurs, the evidence of human resilience is clear and notable. A

wide range of studies has documented sometimes amazing coping and recovery even among young people who have lived in horrific conditions (see Gewirtz & Edleson, 2007; Graham-Berman, Gruber, Howell & Girz, 2009; Howell, 2011; Kitzmann et al., 2003; and Martinez-Torteya et al., 2009 for just a few examples and reviews). Social factors such as connection with supportive adults, positive experience of power and control and social justice, and access to information, as well as individual attributes, are among the things that foster resilience (Ungar et al., 2007).

- **Reactions vary, especially at different stages of development.** Even infants can have adverse reactions; children and youth respond differently at different stages (Holt et al., 2008; Margolin & Gordis, 2000), based on their cognitive capacities and diversity of experience (for example, the presence and quality of family and peer support, accomplishments at school and other settings outside the family, having a sense of competence, developing autonomy, developing abilities for abstract reasoning; see Cohen, 2013). These factors can influence children’s behavioral and emotional reactions, both during abusive incidents and during their other life experiences. Again, it is important to remember that some children show virtually no negative effects at all (Kitzmann et al., 2003).⁸
- **Parental functioning and relationships are centrally important.** Reviews of research consistently find that parenting skills and positive parent-child interactions show strong evidence of helping to protect the well-being of children who are exposed to domestic violence. A wide array of controlled studies and reviews has supported the importance of parent-child relationships (e.g. Jouriles et al., 2009; Letourneau et al., 2013; Levendosky & Graham-Bermann, 2001; Lieberman, Ipp & Van Horn, 2006). A significant aspect of the relationship has been identified as “attachment,” especially in younger children (Graham-Bermann, DeVoe, Mattis, Lynch & Thomas, 2006; Holt et al., 2003).
- **The ability to regulate emotions is associated with improved outcomes.** When children and adolescents are able to identify and control their feelings, such as anger and otherwise overwhelming sadness, they are better able to sustain relationships, focus on tasks, and succeed socially and educationally. Such skills, including self-soothing or calming, are increasingly recognized as important to overall well-being (e.g. Harding, Morelen, Thomassin, Bradbury, & Shaffer, 2013; Katz, Hessler & Anest, 2007).
- **Protective factors promote resilience and enhanced well-being.** A comprehensive review of protective factors (DSG, 2013) found evidence ranging from “emerging” to “strong” for children/youth exposed to domestic violence for specific categories at three levels:
 - *Relationships:* parenting competencies (described above), parental or caregiver well-being, and positive peers;
 - *Individual:* children’s and adolescents’ skills (self-regulation, problem-solving and relationship skills) and characteristics (sense of purpose and sense of optimism); and
 - *Community:* positive school environment (this review noted that community influences have received relatively little research attention, so evidence here is limited).

This review, while more comprehensive than most, is consistent with others reported recently and already noted.

⁸ A new resource for organizations committed to using trauma informed practices with adults and children using their services are a set of Trauma-Informed Practice (TIP) Scales, developed by Drs. Cris M. Sullivan and Lisa Goodman, found at www.nationalcenterdvtraumamh.org/201503/new-resource-for-dv-programs-a-guide-for-using-the-trauma-informed-practice-tip-scales-by-drs-cris-m-sullivan-and-lisa-goodman/.

To summarize, the research literature suggests that measures that are sensitive to age-appropriate *increases in knowledge and skills* (including understanding/recognition of feelings related to domestic violence and ability to modulate them) and *increases in knowledge about and trust in supportive resources* (including mothers/caretakers and other adults) are meaningful. Even simple measures of changes in these areas can connect the initial, basic work of DV programs to the evidence of improved well-being found in more comprehensive and controlled studies.

In the next section, practical outcome measures found as significant in the literature are linked with the primary goals and efforts of DV programs. The primary goals of early stages of DV program development focusing on children/adolescents and their relationships with mothers/caretakers are to provide information and resources to support understanding and safety. As DV programs continue to develop and enhance their work with children and adolescents, and tailor their approaches to specific communities, more numerous and complex measures, focusing on changes in the parent/child relationship and other issues, may offer a better reflection of outcomes.

Potential Outcome Measures

Keeping in mind that programs will vary greatly in their approach to supporting children (depending in part on their resources, their history with focusing on children, the cultural background of the survivors who come to their program, and other factors), that the types and duration of program contacts will have a significant impact on the extent and types of changes that can be expected to occur, that all types of intervention focus at least in part on safety and information, and that children's developmental stage will also affect changes, the following outcomes are proposed. The first two in each section, in green italics, are related to interventions and supports that DV programs early in the process of program development can use with families, even when there has been limited contact (see "Guidelines" paper: Lyon, Perilla & Menard, 2016).

For parents/caretakers:

- *I have a better understanding of the impact that domestic abuse/violence can have on my children*
- *I have more tools and information to plan for my children's safety*
- I have a better understanding of my child's developmental needs
- I feel more hopeful about my relationship with my children
- I feel more confident as a parent
- I feel better prepared to handle my concerns about my children
- I feel more supported as a parent
- I have a better understanding of the impact that domestic abuse/violence has had on my relationship with my children
- My children can express their feelings better
- I am more comfortable talking with my children about things that matter

For children/adolescents (over age 8):

- *I know more ways to get help when I am scared or upset*
- *I have a better understanding of the troubles in my family*
- I better understand that troubles in my family are not my fault
- I believe that adults care about me
- I believe that people at this program can help me and my mother
- My parent/caretaker(s) and I are more comfortable talking about things that matter
- I am better able to talk about my feelings
- I know more ways to calm down when I am upset

- I know more ways to resolve conflicts I may have with other people
- I have a better understanding of healthy relationships

Implementation of Outcome Measures

We reviewed some key considerations earlier in this paper. One key is *when* program participants are asked to respond to the items selected; a second is *who* is asked to respond; a third is the *type* of intervention.

Timing. In general, the more contact a person has with the program, the more evidence of change is reasonable to expect (Lyon, Lane & Menard, 2008; Lyon, Bradshaw & Menard, 2011). Unfortunately, DV programs often do not know when a parent/caretaker/child/adolescent will stop coming. Life circumstances can easily change, so that people stop attending even interventions that are time-specific, such as educational or supportive curricula with a pre-determined number of sessions. At the first contact, program staff are likely to obtain at least some information about why the child is there and her/his needs related to safety, as well as attempt to establish a relationship. In order to measure outcomes at a point when there is a reasonable chance of some change to have occurred, we propose that the items be administered *after at least two contacts*; for parent/caretakers, child-related issues should have been addressed. This may vary with the type of intervention and advocates' judgment about the likely duration of a family's program involvement.

Who is asked to respond. It is important that parents/caretakers are not the only ones asked. They may not be fully aware of their children's reactions and/or could have positive response biases, despite assurances of confidentiality. In addition, asking only parents/caretakers sends a message to youth that their experience is less valued. However, infants and very young children either cannot respond, or may not fully understand what they are being asked and why. Since part of supporting children involves providing support and information to adults in their role as parents, their experiences are also important to obtain. For these reasons, we propose that *the parent/caretaker measures be administered in all cases, and that children also be included when they are age 8 or older.*⁹ When asking these questions, both adults and children/youth should be assured of anonymity, and explained the reasons the questions are being asked; mothers/caretakers should not have reason to fear their children's participation.

Which interventions to include. As we have already discussed, programs will often not know how long families will be involved, but this is likely to vary with the type of intervention and the setting in which it occurs. Children and adults receiving residential supports, such as emergency shelter or transitional housing, generally experience more comprehensive interventions and extensive contacts. They will often take part in scheduled group meetings and/or individual counseling and advocacy meetings. Children/adolescents and adults, who participate in structured, scheduled interventions, such as regular support groups or counseling, even outside of a residential setting, are also more likely to have more predictable participation. However, these measures are not intended for other community settings where program advocates might be involved, such as educational groups offered in schools.

We propose administering the outcome measures to parents/caretakers and to children/adolescents over the age of 8 who receive individual or group interventions—in both residential and non-residential settings. Examples of individual interventions include ongoing support or counseling; examples of group interventions include recurring family meetings, scheduled psychoeducational support or sharing groups, and others.

⁹ Programs might also want to consider obtaining feedback from children ages 5 – 8, using drawing or other means to indicate changes. However, these kinds of indicators cannot be standardized or summarized, so they are not recommended for inclusion in any required reporting at the state or federal level.

Recommendations for Further Development of Outcome Measures for DV Programs' Work with Children

Since there are so many issues involved with creating consistent outcome measures for DV programs' work with children, further development, testing and refinement through a pilot process is recommended. This process would begin with the solicitation of additional input from adult parent/caretakers, children/adolescents and child advocates through focus groups, feedback to this document, and other means. Program participants' involvement in this process is particularly important. Some participants who have experienced violence become very interested in providing feedback to program staff regarding the services they are providing and the content of surveys/instruments that will be used to gauge the impact of the services. Many program participants have assisted in designing simple instruments (e.g., a "thermometer" to gauge safety climate on a weekly basis) that can be understood easily by other participants and also by their children. This may be the only manner in which culturally valid instruments to gauge the impact of work in communities as diverse as they are can be created. Using and/or simply adapting existing instruments without engaging the community for which they are designed or adapted is neither sufficient nor ethical.

Through the focus group process, 15-20 items would be identified that best reflect the expanded input and range of interventions provided by programs. These items would provide the basis for pilot testing with programs in a small number of states or regions, selected for their diversity (in types of interventions, cultural focus, resources, and willingness/ability to participate). Data would be collected from these sites, analyzed, and could then lead to final recommendations for national reporting of a very small number of common options, in addition to suggestions for supplemental items for programs with more resources and more highly developed interventions. Programs' experience with the pilot would also contribute to clearer definitions of terms, as needed, and detailed implementation guidelines. This would be an important step in creating tools that would aid the field in responding in a more systematic and realistic way to the plight of families affected by domestic violence.

Breaking the Cycle: Prioritizing Children and Youth for Over 10 Years



In October 2003, the United States Post Office issued a “Stop the Violence Stamp” as directed by the Stamp Out Family Violence Act of 2001, to provide the public with a direct and tangible way to contribute funding for domestic violence programs. The proceeds from the stamp sales over a two-year period were transferred to the U.S. Department of Health and Human Services (HHS) to carry out the purposes of the Act with a focus on enhancing services to children and youth impacted by domestic violence.

In 2005, the Family Violence Prevention and Services Programs/Family and Youth Services Bureau of the U.S. Department of Health and Human Services released funds for the development of demonstration projects to enhance services to children and youth who have been exposed to domestic violence. Three-year grants were awarded, after a competitive process, to projects in California, Colorado, Washington, D.C., Michigan, New York, Oklahoma, Oregon, Pennsylvania and Virginia to explore innovative approaches to intervention and prevention for families in both shelter and non-shelter settings. Across all programs, project staff and partners worked to:

- Develop and enhance assessment and intervention strategies for children and youth exposed to domestic violence and their parents;
- Train domestic violence program staff and community partners on the effects of being exposed to violence on children and youth and intervention strategies; and
- Develop or enhance community-based interventions specific to issues of domestic violence in order to meet the needs of children and youth impacted by such violence.

In 2010, three year grants were awarded to four statewide capacity-building projects – in Alaska, Idaho, New Jersey, and Wisconsin – and one national technical assistance provider to expand services for children and youth exposed to domestic violence. These five grantees have provided leadership in creating a broader network of support and for developing evidence-based interventions for children, youth and parents exposed to domestic violence.

Each of these funded projects has contributed new knowledge and experience to helping children and youth exposed to domestic violence. This knowledge and experience has strengthened the relationship between domestic violence victim advocates and other partners in the community serving children and youth exposed to domestic violence. Further, each collaboration has reinforced the shared mission of protecting abused women and their children from violence by providing them with the interventions, tools and resources to move their lives and their futures forward in positive, productive and violence-free directions.

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