Best Practices for the Children Who Witness Abuse Program

BC Yukon Society of Transition Houses

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for the
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For
BC Yukon Society of Transition Houses

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Introduction

It is estimated that between 11% and 23% of all Canadian children are exposed to violence against their mother in the home (Suderman & Jaffe, 1999). The exposure may be limited; it may be sporadic. Often, however, it is consistent and prolonged. The type of violence perpetrated against the mother varies widely, and the effect on her children similarly depends on a number of factors. Many of these children experience emotional and behavioural problems similar to those found in children who are themselves physically abused. They may display symptoms such as difficulty concentrating, challenging behaviours, or learning difficulties, and they are often misdiagnosed as having attention deficit disorder. Children who are exposed to the abuse of their parent are at increased risk for depression, truancy, delinquency, and running away. They are also at significantly higher risk of being physically and sexually abused themselves by their mother's abuser.

In British Columbia, there is a specialized program whose purpose is to assist children who have witnessed abuse, providing group or individualized counselling following psychoeducational methods. This manual is a compilation of best practices that have grown from the literature and the wisdom of the counsellors who work to support these children in healing from their trauma.

The Children Who Witness Abuse Program in British Columbia

The Children Who Witness Abuse (CWWA) program in British Columbia grew out of concern for the children of women who came to transition houses to escape abuse in their own homes. In 1992 the BC Yukon Society of Transition Houses (BCYSTH) obtained funding from the Vancouver Foundation and the United Way of Greater Vancouver to research the effects on children of exposure to the abuse of their mothers, and to develop a program to assist these children. In 1993 the Ministry of Social Services agreed to provide core funding for this service and 41 CWWA programs were established. Today there are 90 CWWA programs operating throughout the province.

The rationale for the program arises from evidence that children of abused women are affected in predictable ways that depend on factors including their developmental stage and the extent and type of violence to which they have been exposed. These children need support to deal with the traumatic events they have witnessed. The CWWA program uses psychoeducational methods, including individual and group interventions. The program aims to help children between the ages of 3 and 18 years understand and cope with the abuse of their mothers and the effects of this abuse on themselves. In addition to the services directed

towards children, CWWA counsellors provide support and information to mothers and also work with schools on prevention activities such as the Violence Is Preventable Project (VIP).

The goals of the CWWA program, as listed in *Children Who Witness Abuse Program Counsellor's Handbook: 20 Most Commonly Asked Questions,* are to:

- break the cycle of violence;
- assist children who have witnessed abuse with developing self-esteem, an awareness of safety issues, and an understanding of their own emotions and of the dynamics of violence against women in relationships;
- provide services to these children (such as support groups and individual counselling);
- provide support to mothers (resources, groups, and/or counselling); and,
- raise community awareness of issues related to violence against women in relationships. (White & McConnell, 1995, p. 7)

The CWWA program is not intended to respond to a child who is in crisis. Most children served in the programs have moved to stable, safe situations. Usually their mothers have by this time set up permanent homes away from the abusers.

The CWWA program is highly structured and uses specific educational activities to achieve its goals. The program is based on a feminist perspective that incorporates considerations of power imbalances, gender roles, and responsibility for abuse (BC Yukon Society of Transition Houses, 1996).

The objectives of the CWWA program include helping participants to:

- define violence and responsibility for violence;
- express feelings, including anger;
- improve communication, problem-solving, and cognitive coping skills;
- increase self-esteem;
- develop social support networks;
- develop safety plans; and,
- experience safety and trust during group sessions. (BC Yukon Society of Transition Houses, 1996, p. 2.3)

While the overall approach is psychoeducational, individual counsellors have a wide range of backgrounds and are encouraged to draw on their

own specific skills while recognizing the limits both of their training and of the program mandate. Some CWWA counsellors, for example, use techniques associated with art and play therapy to meet the needs of the children with whom they work.

Purpose of This Manual

A best practices manual is a collection of the wisdom developed within a field over its lifetime. Best practices are based on formal research as well as the practices developed over time by practitioners. Best practices also represent expectations for program design and implementation as well as agency infrastructure. They lay the foundation for how CWWA programs ensure that:

- participants are treated ethically and with respect for their rights;
- programs are planned and delivered according to province-wide best practice standards;
- physical environments are appropriately planned and maintained; and,
- programs are governed and administered ethically and responsibly.

This manual was prepared for BCYSTH to distribute to counsellors who work in CWWA programs across British Columbia. BCYSTH provides training once or twice a year for CWWA counsellors; so, depending on the time that they are hired, it may be several months between the beginning of their work and the time of their formal training. This manual will be helpful for new counsellors in that interim period.

The manual will also be useful for counsellors who have been doing the work for years. As the field evolves, so do our practices. It is helpful to occasionally review practices and learn from more recent research. The manual can also be a helpful reference when specific kinds of questions arise.

This manual summarizes some theoretical information that is important to the development of a CWWA counsellor's perspective, such as what it means to work from a feminist perspective and how knowledge of child development informs our practice. It touches on specific topics such as working with parents (both offending and non-offending), safety planning, and how to maintain one's own wellness while doing this difficult work. It also covers administrative and legal issues that help a CWWA counsellor manage the program.

How to Use This Manual

This document summarizes up-to-date research and offers direction regarding best practices.

Section 1 provides background information from a theoretical perspective on working with children, on child development, and on specific practice issues. Section 2 addresses specific administrative and legal issues faced by CWWA counsellors. These two sections are intended to help counsellors understand and reflect on the work they do. Throughout Sections 1 and 2, there are examples of the Standards of Practice that follow from the theory discussed. Where they are embedded in the text, these standards are identified with an icon and a change in the margins.

Section 3 provides a summary of those Standards of Practice. While implementation of the standards is not mandatory, they should be seen as a guide to providing the best possible programming to the children served in these programs. CWWA counsellors should work towards implementation of these standards, beginning with those that are easily achievable and working towards full implementation over time.

Section 4 provides a list of references and suggestions for further reading. A great many of the references listed are available at no cost over the Internet, and website addresses are provided wherever possible. Section 5 is a collection of appendices, including sample forms, sample policies, and other material that CWWA counsellors may find useful.

This is a best practices manual and the suggestions contained in it point to ideal work under optimal conditions. No one works in a situation that is perfect and each program must adapt to meet its unique constraints. CWWA counsellors should always strive to achieve best practice, while acknowledging that in the real world, we often have to manage with the resources available.

Throughout Sections 1 and 2 of this manual, you will find examples of specific Best Practice Standards identified by the icon shown to the left. The Standards are presented as a whole in Section 3.

A Word about Language

In this document, "violence against women" means physical, mental, emotional, and/or sexual abuse of a woman by her partner or ex-partner. It is acknowledged that violence occurs in some same-sex relationships and that women can be abusive towards their male partners. That said, statistically the overwhelming majority of violence in families is perpetrated by men against women. Furthermore, it is this type of abuse that is and has been condoned socially in order to control women. For these reasons, this document is grounded in a gendered understanding of violence in intimate relationships and the language used throughout reflects this feminist perspective. In most examples, the word "mother" is used to refer to the abused partner and the word "father" is used to refer to the abuser.

Likewise, the feminine pronoun is used when referring to CWWA counsellors. It is acknowledged that there are some male CWWA counsellors and that in most cases it is optimal for a children's group to be co-facilitated by a male-female team.

The CWWA program in British Columbia is mandated to serve children and youth from the ages of 3 to 18 years. In this document, the terms "child" and "children" refer to persons under the age of 19 unless it is explicit that a particular age group is being discussed.

Section 1
Theory and Its Impact on CWWA Practice

Section 1 of this document is the first of two that focus on background information helpful in the evolution of a CWWA counsellor's perspective. This section focuses on three main areas: Working with Children from a CWWA Perspective, Child Development and CWWA, and Practice Issues.

The first part of this section, Working with Children from a CWWA Perspective, discusses what it is to work from a feminist perspective, how to provide psychoeducational services, what is involved in working from the child's perspective, how to develop and maintain professionalism within this field, and the impact of diversity issues on this work.

In the second part, the focus is on understanding child development as it relates to children who witness abuse. There is a detailed examination of Attachment Theory and a review of the emerging literature on the effects of prolonged stress on the developing brain. This part ends with a discussion of the impact of witnessing abuse on children at different developmental stages.

The third part of this section addresses specific practice issues such as working with other professionals, working with parents and other caregivers, and safety planning with children. It goes on to discuss aspects of support for CWWA counsellors and ends with a discussion of the importance of program evaluation.

A. Working with Children from a CWWA Perspective

A.1 A Feminist Perspective

The CWWA programs grew out of the work done in transition houses across British Columbia in the late 1980s. CWWA programs are informed by the same feminist understanding of gender relations and of the use of power to control women in intimate relationships. From a feminist perspective, individual women's experiences are viewed in the context of a patriarchal system that devalues women's perspectives and privileges those of their abusers. This brief review of the principles of feminist counselling provides one piece of the CWWA perspective on working with children.

Women of colour and other marginalized women have consistently challenged feminists to see gender as one system of oppression among many. To work authentically for justice requires an analysis of the ways in which women's other identities overlap with and shape their experience of the world as women. Adopting a feminist perspective, therefore, requires an understanding of more than simply gender oppression. It

To work authentically for justice requires an analysis of the ways in which women's other identities overlap with and shape their experience of the world as women.

requires recognition of the many identities a woman lives with, and the ways in which privilege and oppression operate on each of these identities. Feminist counsellors have a responsibility to nurture a perspective that includes the realities of race, class, age, ability, sexuality, and other overlapping identities of the women with whom they work. More detail on diversity issues is provided in Section 1.A.5, "Diversity Issues," on page 20.

In the 2006 *Best Practices Manual for Stopping the Violence Counselling Programs in British Columbia,* McEvoy & Ziegler list the following attributes of a feminist counsellor. She:

- utilizes knowledge of the impact and dynamics of violence and abuse, and of the power imbalances in society that expose women to violence or abuse;
- places highest priority on the safety of women and children rather than keeping families together, where these two may be in conflict;
- confirms the abuser's responsibility for the abuse and does not place blame on the woman;
- validates the woman's experience of abuse, and acknowledges and respects the woman's expertise with respect to her own experience;
- provides services in a non-judgemental, non-labelling manner;
- provides services to address the woman's needs while respecting her right to self-determination; and,
- fosters self-empowerment by supporting the woman towards increased control over her life, maximizing her control over the counselling process itself and reducing the power differential between the counsellor and the woman. (pp. 16-17)

Feminist counselling, they continue, has the following characteristics:

- The survivors' symptoms, experiences, and behaviours are viewed not as pathological but rather as the outcomes of victimization. These symptoms and behaviours came into existence for the positive purpose of psychic and physical survival.
- Feminist counselling supports the empowerment of survivors in the following ways: by prioritizing emotional and physical safety, by normalizing symptoms and working with survivors to regain control over their lives and symptoms, and by appreciating the empowering nature of information and of psychosocial education interventions.
- Feminist counselling stresses the importance of building circles of support and connection and the healing aspects of joining groups with others who have similar experiences.
- Feminist counselling values finding, valuing, and expressing survivor voices that have been silenced, and taking a strong position that

the victim did not deserve the violence and that the victim is not responsible for the violence.

- A feminist perspective goes beyond the individual victim to view the ongoing suffering and humiliation of oppressed groups as traumatic. Feminists are sensitive to the ways in which the systemic roots of violence are invisible. (McEvoy & Ziegler, 2006)

Feminist counsellors acknowledge the power differential between the service provider and the woman seeking service. A feminist counsellor works to reduce that power differential through transparency, consistency, and predictability. This means honouring commitments. It means keeps excellent records and engaging the woman in the process of documenting her healing to the extent appropriate. For children, it means modelling equality in relationships and helping boys and girls become their most complete and authentic selves. CWWA counsellors work with girls to help them feel stronger and more secure in their sense of self. They work with boys to help them learn to acknowledge and articulate their feelings. All children are supported in developing self-esteem and the language to express their fears and their desires.

Standard A.3.2. CWWA programs maintain a written summary of client rights and responsibilities that is communicated to clients in a manner that is meaningful to them. A written summary of client rights and responsibilities is posted in the program area or reception area.[1]

Standard A.3.3. CWWA programs have a formal client complaint process that is communicated to children and their parents in a manner that is meaningful to them.

Feminist counsellors approach their work from a strength-based perspective. They focus on supporting women and their children in finding strengths, naming and celebrating them, and working to enhance strengths as opposed to repairing weaknesses.

McEvoy and Ziegler (2006) also note that survivors feel safest when they are actively participating and making decisions in the counselling process. Clients are most empowered when a counsellor:

- assesses their symptoms and vulnerabilities, as well as strengths and abilities;
- works with them to set mutual goals;

[1] Throughout Sections 1 and 2 of this manual, you will find examples of specific Best Practice Standards identified by the icon shown here. The Standards are presented as a whole in Section 3.

- provides information on reactions to trauma and the counselling process;
- invites them to offer feedback on their experience.

Standard A.1.1. CWWA programs are rooted in feminist principles.

A.2 Psychoeducational Methods

The CWWA program employs psychoeducational methods. This means that the program focuses on providing children with information to help them understand their responses to their mother's abuse. In addition, counsellors may suggest ways for children to deal with the symptoms they often experience after witnessing their mother's abuse. CWWA programs are not mandated to provide clinical counselling, and most CWWA counsellors are not trained therapists. It is important, in both group and individual sessions, for a counsellor to be aware of the often blurry line between psychoeducation and clinical counselling, and to ensure that the methods used fall within the mandate of the program.

In many cases the funding contract states the limits of the program mandate. The primary purpose of the CWWA program is to support children and help them learn concrete skills. An important secondary purpose is to screen children who need more intensive therapeutic services and ensure that such referrals are made as appropriate.

The children who attend CWWA programs have not consented to clinical therapy.

Gaining clarity regarding the limits of the CWWA counsellor's role does not imply a lack of confidence in the counsellor's abilities. While some CWWA counsellors are trained therapists, this is not a therapy program. The children who attend CWWA programs have not consented to clinical therapy.

Children come to CWWA programs for specific reasons. They and their mothers have consented to a program that will help them learn skills to cope with their trauma. The program's goals are to provide a safe, playful setting within which to discuss their trauma and learn to manage their response to it. A psychoeducational program is not "therapy lite"; it is something importantly different.

The purpose of a psychoeducational program is to promote attitudinal and behavioural change in ways that will help the child feel safe and better able to succeed socially and academically. In a psychoeducational program, the locus of change is within the child; the counsellor's job is to empower the child through information and strategies. This can be accomplished in both group and individual settings.

Group

In group settings, one guideline is to ensure that the content of the group is helpful and healing for all children. The group leaders may use exercises aimed at helping children learn particular skills or encouraging them to share their own stories. A personal story shared by a child that helps group members to normalize their experiences, to learn new ways to cope, or to break their own silences is probably within the focus of the group. Group leaders have to use careful judgement in allowing children to share while gently helping them to stay present and engaged with the group as a whole.

Individual

In individual sessions, counsellors will use activities and strategies such as games and storytelling to help the child develop tools and coping skills. If it becomes clear that a child wants and needs therapy that focuses on deeper healing, the CWWA counsellor should seek supervisory guidance.

In individual or group situations, CWWA counsellors should be aware of the signs that a conversation should be steered in new ways. If a child shows signs of anxiety or agitation, appears detached or dissociated, or seems to be having more feelings than she can handle, the CWWA counsellor should shift the direction of the child's thoughts.

Here are some examples of things a CWWA counsellor can say to help a child avoid opening up deep feelings that are outside the work of this program:

- "I think this is too much for us to talk about right now. It may not be good for you to talk about this."
- "I'm going to stop you now, because you are telling me a very big story and I think it's not going to feel good for you if you tell me this big story. We are going to talk instead about ways to help you feel better."
- "Let's stop talking about what that was like for you and instead let's talk about how you can make yourself feel better when that happens."
- "Let's talk about how you make yourself feel better in those moments. What helps you feel better when you have those feelings?"

"I'm going to stop you now, because you are telling me a very big story and I think it's not going to feel good for you if you tell me this big story. We are going to talk instead about ways to help you feel better."

At this point, the CWWA counsellor should stop asking questions about emotions and instead become more concrete. The counsellor's job is to honour the child's experiences, to remind her that she is doing the best she can, and to reassure her that her mother is also doing the best she can to take care of herself and to take care of her child.

Referrals

Some signs that a child requires referral to other services include:

- disclosures of sexual or other abuse;
- severe depression;
- concerns about self-harming or suicidal ideation;
- any psychiatric concerns;
- drug or alcohol issues that require intervention; and
- any indication that a child wants or needs therapy that is not related to witnessing abuse or that is aimed at deeper healing.

A CWWA counsellor who has any concerns about whether a particular child requires outside referrals should seek guidance from an experienced peer or supervisor.

A.3 Working from the Child's Perspective

In addition to adopting a feminist perspective, CWWA counsellors are committed to the perspectives of the children in their programs.

UN Convention on the Rights of the Child

CWWA counsellors acknowledge that children are entitled to the rights described in the United Nations Convention on the Rights of the Child, ratified in Canada in 1991. The 10 principles of the convention are reproduced in Appendix 4, "Declaration of the Rights of the Child."

Risk and Protective Factors

CWWA counsellors work to support the development of some of the protective factors, and to mitigate some of the risk factors, that influence how children respond to the trauma of exposure to their mother's abuse.

Although many children will experience similar kinds of trauma, each child's response is unique. A wide range of factors influences each child's response to adverse experiences. Researchers often describe specific kinds of risk and protective factors that appear to be linked to a child's ability to cope with experiences more successfully. Risk and protective factors may be linked to the individual child, the family, the child's school, the peer group, or the community.

Risk factors are negative influences in the life of an individual or a community. Risk factors within and around a child may make it more difficult for the child to accept or benefit from supportive services following a traumatic experience.

Some Internal Risk Factors	Some External Risk Factors
• Cognitive barriers • Emotional delays • Mental health concerns • Other barriers to receiving and benefiting from services	• Poverty • Unstable housing • Pressures from peers • Parental substance abuse • Lack of understanding by teachers or other professionals

Protective factors are those positive influences that support a child's healing. Children cope more successfully with adverse experiences when they have strong protective factors, particularly when these protective factors occur in combination rather than singly.

Secure attachment to a non-abusive parent or caregiver is an important protective factor for children.

Some Internal Protective Factors	Some External Protective Factors
• Positive self-esteem • Personality factors such as being easygoing or humorous	• Secure attachment to a non-abusive parent or caregiver • The existence of networks of personal support • Supportive community and social frameworks

CWWA programs work to identify and promote internal protective factors through helping a child develop self-esteem, for example, and teaching concrete skills for coping with the abuse they have witnessed. CWWA programs can also help to support external protective factors by supporting the child's mother in obtaining basic needs, such as secure housing. Risk factors can also be addressed, sometimes through support for the child's mother and sometimes by referring the child to other resources, such as treatment for mental health or addiction issues.

Strength-Based Practice

CWWA programs adopt a perspective that focuses on children's strengths rather than the problems they are dealing with. This contrasts with more traditional therapies that define individual or family functioning in terms of clinical diagnoses or deficits. Strength-based practice avoids the use of stigmatizing language and provides alternatives to victim identities. A strength-based approach encourages counsellors to discover and support the skills a child already has in addition to teaching new ones. It also encourages participants to reframe their own perceptions of events to find the good, even in very difficult situations.

From within a strength based approach, CWWA counsellors view symptoms not as pathological but rather as a natural response to traumatic events.

From within a strength based approach, CWWA counsellors view symptoms not as pathological but rather as a natural response to traumatic events. Counsellors foster hope by reminding children of their abilities and how they have used strategies in the past to successfully cope with adversity. The program offers reassurance that the child's reactions are normal under the circumstances, and provides strategies to help children cope with and minimize symptoms.

Standard A.1.3. CWWA programs are strength-based and individualized.

Developmental Approach

CWWA counsellors understand that children experience violence against women differently at different developmental stages. Groups are designed to match children who are at approximately the same developmental stage, and individual counselling is adapted to suit the child's developmental needs. Furniture and equipment are designed to be comfortable and attractive for children. More on the specifics of children's development is provided in Section 1.B, "Child Development and CWWA," on page 27.

Standard A.1.2. CWWA programs are child-focused.

Standard C.1.3. CWWA programs are provided in an environment that is comfortable for children.

A.4 Professionalism

The CWWA programs have grown out of the work of supporting and empowering abused women. Rooted in a commitment to fight against oppression, anti-violence workers strive against power imbalances in their work. The emphasis on balancing power can lead to confusion regarding boundaries between the counsellor and the referring parent. On the one hand, the counsellor wants to support an abused woman's growing power and encourage her to take her place as an equal in her relationships. On the other hand, this is a professional relationship and so can never be reciprocal. It is the counsellor's responsibility to maintain professional and ethical standards in all dealings with both the child and her mother.

Standard A.3.1. CWWA counsellors maintain appropriate professional boundaries in their relationships with both children and their parents.

Standard D.5.2. CWWA programs recruit and hire staff and volunteers according to established procedures.

Standard D.5.3. CWWA programs have written procedures that require background checks, including criminal records checks, for all staff and all volunteers who work with clients.

Standard D.5.5. CWWA programs hire staff who are knowledgeable about the community and the needs of the families who participate.

Standard D.5.6. CWWA programs hire staff who have an appropriate combination of post-secondary education in a relevant field and professional and life experiences.

One area of concern for many CWWA counsellors, particularly those in smaller cities or rural locations, is how to manage dual relationships. A dual relationship is a situation in which the counsellor and the client know each other in two different contexts. For example, the client may be a neighbour or relative or friend of the counsellor's. Or, in a small town it may be that the counsellor regularly shops in a store owned by the client's family. Sometimes the counsellor works with the client in two different professional roles, such as running the CWWA program and also volunteering at the town's recreation centre.

In their *Best Practices Manual for Stopping the Violence Counselling Programs in British Columbia,* McEvoy and Ziegler (2006) caution counsellors to take care with dual relationships. While the most cautious approach is to avoid such relationships completely, this is not always possible, nor is it always advisable. Rural counsellors, for example, might find themselves socially isolated if they limit contacts within the community and this can contribute to seclusion and burnout. Younggren (quoted in McEvoy & Ziegler, 2006) recommends that counsellors considering whether to enter a dual relationship seek consultation regarding their decision, and take care to document the decision in the event that it is questioned. Questions to ask include who the dual relationship will benefit and whether the client might be placed at risk. Feminist counsellors must be prepared to engage in complex discussions of ethical behaviours.

Standard A.3.6. CWWA programs develop and follow a Code of Conduct for staff and volunteers that:

a) addresses both confidentiality and conflict of interest;

b) includes procedures to deal with violations; and,

c) provides for educating staff and volunteers regarding the Code of Conduct.

A.5 Diversity Issues

Earlier, the section "A.1. A Feminist Perspective" discussed the importance of a feminist taking into account the variety of identities that every woman and child brings to a service provider, and the ways in which differing relationships of power operate on a family. For example, a child may belong to certain dominant groups (perhaps the child is male and able-bodied, or perhaps the child's parents have higher levels of education) or other oppressed groups (perhaps the child is of colour and perhaps his parents are both women). A key goal of CWWA programs is to be adaptable to the diverse needs presented by the families they serve. These diverse needs include: having differing abilities, being of Aboriginal heritage, being a new Canadian family, and being a family with parents of the same sex.

Standard A.4.1. CWWA programs have a written plan that enables staff and volunteers to promote an environment valuing diversity in all its forms.

Standard A.4.2. CWWA programs take account of diverse groups when planning programs, and develop specific strategies to reach out to and engage diverse groups.

Standard D.5.1. CWWA programs do not discriminate against any persons or categories of persons.

Differing Abilities and Accessibility

CWWA counsellors take steps as appropriate and possible to ensure that their programs are fully accessible to the children who need them. Accessibility in this context includes ensuring that the physical space is welcoming to children and their mothers from all cultures, as well as to individuals with physical disabilities. It is helpful to invite prospective clients to discuss any special needs they may have that are pertinent to the service. Counsellors should also document the fact that they have had this conversation and any adaptations that they have made to accommodate a client.

With respect to clients who may have physical or mental disabilities, Ruebsaat (2006), in *Records Management Guidelines: Protecting Privacy for Survivors of Violence,* recommends that counsellors identify and document safety issues relevant to the service and consider the possible need for additional support. While it is always important to consider the developmental level of a child client, this is even more complex when working with a child who has developmental delays or other cognitive disabilities.

Standard C.1.1. The interior of a CWWA program is accessible and inviting to clients and their families.

Standard C.1.2. The location of a CWWA program is planned in consideration of accessibility for participants.

Besides the issues associated with providing service to children with differing abilities, CWWA counsellors should also consider the concerns of the referring parent. The Ministry of Children and Family Development's *Best Practice Approaches: Child Protection and Violence against Women* (2004) notes that women with disabilities who experience abuse may face particular obstacles to services, such as:

- Violence may be committed by individuals on whom the woman is quite dependent, such as the husband or family member who is the woman's primary caregiver.
- In many situations, the woman is unable to give free and informed consent.
- Because of her dependency on others for her daily needs, the woman may fear the consequences of reporting abuse.
- Women with disabilities are aware that they may not be considered "adequate" mothers by some.

Any of these factors may make it particularly difficult for the abused parent to seek service for her child, and may contribute to an abrupt ending of the program.

Aboriginal Families

When working with children from Aboriginal families, CWWA counsellors must bear in mind the historical and social dynamics of colonialism and racism from which many Aboriginal communities are recovering, and the impact of this history on Aboriginal families. Work with Aboriginal families must also incorporate knowledge of Aboriginal conceptions of health and healing.

Context of Abuse in Aboriginal Communities

In 2003 a study was conducted by Phil Lane, Judie Bopp, and Michael Bopp into Aboriginal family violence and abuse in Canada. The authors argue that Aboriginal family violence is a complicated social syndrome; it is more than simply an undesirable behaviour. This syndrome resides within Aboriginal individuals, families, and community relationships. Violence typically takes the form of domination that is established and enforced through violence, fear, and a variety of abuse strategies. It is usually not an isolated incident but is most often rooted in intergenerational abuse. It is almost always linked to the need for healing from trauma.

Family violence in Aboriginal communities, the authors say, is allowed to continue and flourish because of the presence of enabling community dynamics. The syndrome has its roots in Aboriginal historical experience. The history must be adequately understood in order to restore wholeness, trust, and safety to the Aboriginal family and community life (Lane et al., 2003).

Aboriginal Healing

From an Aboriginal perspective, the solution does not lie in punishing the abuser but in resolving the conflict through traditional healing. This involves rehabilitation that is focused on achieving balance and harmony for both the survivor and the abuser.

Besides taking into account the context of violence, it is important to consider the Aboriginal paradigm for healing. The Aboriginal conception of health is holistic. From this perspective, physical, mental, emotional, and spiritual components are interconnected and must be in balance with each other for optimum health. Keeping the four elements healthy can be achieved only by living in harmony with nature. From an Aboriginal perspective, the solution does not lie in punishing the abuser but in resolving the conflict through traditional healing. This involves rehabilitation that is focused on achieving balance and harmony for both the survivor and the abuser. It also encourages the active participation of the person through the healing process.

While it is important to focus on healing rather than punishment, it is equally important to create circumstances within which the abuser can be invited to take responsibility. Some people within Aboriginal communities believe that taking the abuser to court is helpful and perhaps even necessary for him to fully acknowledge his responsibility and begin his healing. Others disagree, arguing that the Canadian justice system does more harm than good for most Aboriginal people, often stands in the way of true responsibility taking, and impedes the healing that is necessary for both the abuser and his family.

Barriers to Service for Aboriginal Families

Aboriginal women who have been abused face a number of unique barriers to service, described by McEvoy and Ziegler (2006). Often, they note, Aboriginal women experience:

- difficulty naming the behaviour as abuse;
- difficulty assessing oneself as “battered” or “abused” when violence has become normalized in a closed or isolated community;
- fear of retaliation or being banned from the community;
- fear of children being removed by child protection authorities, as has happened disproportionately to Aboriginal families both in the past and today;
- fear of racist stereotypes and judgements;
- family or community pressure to remain in the relationship, especially given the important role of the family and the family unit in the community;

- loss of self-esteem because of the cumulative impact of colonization and residential schools;
- geographic isolation, poverty, or lack of housing options; and,
- loss of indigenous language while at the same time having limited English vocabulary due to learning under traumatic conditions.

In the *Children Who Witness Abuse Program Counsellor's Handbook: 20 Most Commonly Asked Questions,* White and McConnell recommend that the CWWA program be adapted for use in Aboriginal communities, and they advice counsellors to be aware of Aboriginal perspectives in both urban and rural settings. They note that many Aboriginal communities need solutions to end violence that are holistic and that involve the entire community, rather than individual solutions that involve institutions such as the police. Some concrete suggestions include:

- Acknowledge the abuse of Aboriginal persons by the dominant culture for over 500 years. Canadian experiences include the physical, sexual, and spiritual abuse of many Aboriginal children and adolescents in residential schools throughout Canada.
- Offer to provide a group within the Aboriginal community, perhaps on the reserve.
- Co-facilitate with an Aboriginal counsellor.
- Incorporate culturally specific exercises, material, and examples into your program.
- Endeavour to assess the specific needs of First Nations children before you start the group.
- Before beginning any intervention, meet with the resource people and perhaps the elders within the community to seek their guidance. (White & McConnell, 1995)

New Canadians

CWWA counsellors work with families from a wide range of life experiences, including those who have recently come to Canada, either as immigrants or as refugees. In *Best Practices Manual for Stopping the Violence Counselling Programs in British Columbia*, McEvoy and Ziegler (2006) suggest that women from marginalized communities may have different attitudes and expectations of the criminal justice system and social services, based on their experiences of poverty, racism, and oppression. These varying attitudes and expectations will extend to the CWWA program. In addition, some families arrive in Canada fleeing countries where regimes have legitimized and used force for social control. These experiences will have influenced how both the women and the men view violence within the family.

McEvoy and Ziegler also recommend that a counsellor working with new Canadians have a working knowledge of immigration and refugee law and the resources available to women and their children. They note the importance of acknowledging the fears that mothers may have about deportation, lack of familiarity about their rights, and worries about child custody if they leave their abuser.

It is important for a CWWA counsellor to recognize that an immigrant or refugee may have strong values within her culture or religion regarding the importance of the family unit. Apart from her own struggle to leave her abuser, she may also be facing the loss of community support systems, including family and friends she has depended on. These family circumstances will play a role in the child's experience of violence against women as well as the decision to leave the abusive situation.

In *Children Who Witness Abuse Program Counsellor's Handbook,* White and McConnell (1995) remind us that members of visible minorities may be more vulnerable to violence in relationships due to the various forms of racism they have survived. Compounded experiences of violence can cause greater feelings of hopelessness and helplessness related to ending the abuse. It is also important to recognize the additional roadblocks faced by immigrant and refugee families in gaining access to support services that are culturally sensitive and available in their language.

Here are some suggestions for working with children from immigrant or refugee families:

- Discuss with the referring parent (and the child who is old enough) particular needs related to their culture (restrictions on meeting times? dietary needs?) as well as strengths and how these strengths can be accessed to provide support and protection in culturally appropriate ways (McEvoy & Ziegler, 2006).
- Where possible, have at least two children from the same race in each group (White & McConnell, 1995).
- Consider working with community leaders within immigrant or refugee groups to identify ways to design the service and especially the intake process. Work to balance the need for safety and health-related information with the need to respect the dignity and privacy of the client (McEvoy & Ziegler, 2006).

Consider working with community leaders within immigrant or refugee groups to identify ways to design the service and especially the intake process.

Standard A.4.3. To the extent possible, CWWA programs offer programs and services in languages that reflect those preferred by the clients.

Standard A.4.4. CWWA programs utilize resources and decor that reflect cultural diversity respectfully.

Parents in Same-Sex Relationships and Transgendered Parents

Violence in relationships is not only a heterosexual problem. Violence also occurs in same-sex relationships and abuse takes the same forms, including physical, emotional/psychological, sexual, and economic violence, as well as property destruction, stalking, and harassment. Custody disputes also occur in same-sex relationships, often with the same viciousness seen in straight relationships. But there are unique tactics available to abusers in a same-sex relationship, such as using heterosexist and/or transphobic abusive tactics to control their partners, threatening to "out" them to their family, friends, or community, and insults to their sexual and/or gender identity (MCFD, 2004). In order to best support the child, the CWWA counsellor has to understand the context within which this family lives.

Best Practice Approaches: Child Protection and Violence against Women (MCFD, 2004) notes that lesbians, gay men, bisexuals, and transgendered women (LGBT) have identified the following particular obstacles:

- fear of being "outed" to family, friends, or community, and of experiencing homophobia, transphobia, and other forms of oppression;
- fear of discrimination for herself and her abusive partner;
- fear of isolation from other LGBT/queer people;
- fear of experiencing abusive tactics and that her sexual or gender identity will be used against her in custody and access disputes; and;
- staying to protect the children and fearing that by leaving she will lose custody or access to the children.

Bias

Gay men, lesbians, bisexuals, and transgendered people face very real bias in the justice system. This bias works in a variety of ways. Someone in a same-sex relationship may resist reporting an assault because of fear, based on a long history of experience, that the abusive partner will be mistreated by police. A person who does report an assault may not be treated seriously by police or the court, based on false assumptions that violence between two men or between two women cannot be serious or must be mutual (Braun, 2001).

Custody

This bias may be particularly apparent in custody issues. The law in British Columbia does not overtly discriminate against gay men or lesbians, and custody decisions must be made based on the "best interests" of the child. However, the standard of "best interest" is subjectively interpreted (Braun, 2001). A mother who wishes to leave a heterosexual relationship may face bias if she admits to being lesbian, bisexual, or transgender. An abuse survivor leaving a same-sex relationship may or may not have a legal relationship with the children she has been raising.

Safety

McEvoy and Ziegler (2006) point out that the small and insular nature of LGBT communities means that it can be very hard for individuals to avoid abusive ex-partners. This is even truer for women who are of colour, immigrants, or Aboriginal, as well as those in rural areas and small cities. It may be much easier for abusive partners to gather information and stalk their partners or ex-partners in small, insular communities. In a heterosexist and homophobic culture, there are a limited number of places where LGBT people can go to socialize comfortably and openly.

Families in LGBT Communities

Families in LGBT communities may look different from those in straight society, and they may also use different language to describe themselves. For many LGBT people, families may be formed by choice rather than being related biologically, and in some cases family relations are not recognized legally. While Canadian queer people now have the right to marry, to adopt children together (except where the child's jurisdiction of birth does not allow it), and to adopt their partner's children, these legal rights are relatively recent and are not exercised by all LGBT people creating families.

Like straight women and men, queer parents may adopt children (as a single parent or as part of a couple), may bear children via donor insemination, or may have blended families from previous relationships. Many have had children within a previous straight relationship and are now parenting on their own or with their current partner. It is important to recognize and validate the family-defined roles and identities in LGBT families; for example, not to assume that the birth mother has a more significant role in the child's life than her partner who has also parented this child since birth.

MCFD's *Best Practice Approaches: Child Protection and Violence against Women* (2004) notes that children in families that are closeted may not have the language to talk about their parents' relationship; for example, they may refer to their parent's partner as a "roommate" even though the "roommate" may have been significantly involved in rearing that child for many years. Even in households where there is much openness, children may be reluctant to talk about their parents' relationship for fear of being ostracized or discriminated against.

CWWA counsellors should not make assumptions about a child's family but instead ask the child and the referring parent to explain who the child's family members are and what their relationship is to the child.

CWWA counsellors should not make assumptions about a child's family but instead ask the child and the referring parent to explain who the child's family members are and what their relationship is to the child. It is the CWWA counsellor's responsibility to accept and validate that family, and to reassure the child that this program is welcoming and does not discriminate against *anyone's* family.

B. Child Development and CWWA

B.1 Attachment

According to Attachment Theory, the attachment a child forms with her primary caregiver is the foundation for all the relationships she will develop throughout her life. All children attach to their caregivers; some develop "secure attachment" while others develop one of several types of "insecure attachment."

- Without secure attachment, an individual is at higher risk for relationship problems as a teen and as an adult.
- Research shows that many abusers have insecure attachments.
- When a woman is abused, she may be less able to develop a secure attachment with her child. CWWA counsellors may be able to support a mother in this area.

To work effectively with children, particularly children who have survived trauma, a counsellor should understand how attachment develops and the consequences of not being securely attached. This section outlines Attachment Theory and its impact on the work of CWWA counsellors.

What Is Attachment?

Human beings are social creatures and create many different kinds of bonds between themselves and other humans. A bond is simply a connection between one person and another. "Attachment" is the term used to describe a special bond that has particular characteristics and is most obvious in the relationship between an infant and his primary caregiver. The attachment bond has the following key elements:

- An attachment bond is an enduring emotional relationship with a specific person.
- The relationship brings safety, comfort, and pleasure.
- Loss or threat of loss of the person evokes intense distress. (Perry, 2008)

The concept of attachment was originally developed by John Bowlby and first published in the 1960s. Inspired by Bowlby's work, Mary Ainsworth studied the relationship between parents and infants in Uganda and discovered that virtually all infants develop special attachments to their caregivers. Ainsworth also discovered that some infants are more securely attached than others. According to Attachment Theory, new close relationships that arise later in life are influenced by these first attachments.

When two people are attached, they respond to each other in particular ways. Infants show their attachment through *proximity-seeking behaviours,* such as approaching and following their caregivers, and through *contact-maintaining behaviours,* such as touching, snuggling, and holding. A securely attached toddler is curious and eager to explore but maintains contact by looking back at the caregiver (Berger, 2008).

Attachment is classified into four types, labelled A to D:

Four Types of Attachment

A Insecure-avoidant	**B** Secure	**C** Insecure-resistant/ ambivalent	**D** Disorganized
Ignores caregiver	Explores and maintains contact	Extremely clingy	Behavioural changes

Secure attachment (B) refers to an infant who is comfortable and secure with her primary caregiver. The child draws comfort from being close to the caregiver and this provides her with the confidence to explore. A toddler, for example, may climb down from her mother's lap to examine and play with a new toy, but will periodically look back, vocalize, and perhaps bring the toy back to show it to her mother, or simply return for a hug.

Insecure attachment (A and C) is characterized by fear, anxiety, anger, or indifference. An insecurely attached child may play without maintaining contact with the caregiver. This is insecure-avoidant attachment (A). Alternatively, an insecurely attached child may cling to her mother, unwilling to leave her lap. This is insecure-resistant/ambivalent attachment (C).

The fourth category of attachment (D) includes behaviour that shifts from one type to another and is called disorganized attachment. A child who has disorganized attachment may hit his mother one minute and kiss her the next; may stare blankly, then begin crying hysterically; may harm himself and then simply freeze in place.

A child cannot be "overly attached." A securely attached child is confident enough to explore her world while maintaining contact with her mother.

Sometimes people mistake Type C attachment – the type that is characterized by clingy behaviour and an unwillingness to leave the mother's lap to explore – as "overattachment." This is not accurate. A child cannot be "overly attached." A securely attached child is confident enough to explore her world while maintaining contact with her mother.

Patterns of Infant Attachment

Type	Name of Pattern	In Play Room	Mother Leaves	Mother Returns	Toddlers in This Category
A	Insecure-avoidant	Child plays happily.	Child continues playing.	Child ignores her.	10-20%
B	Secure	Child plays happily.	Child pauses; is not as happy.	Child welcomes her; returns to play.	50-70%
C	Insecure-resistant/ ambivalent	Child clings; is preoccupied with mother.	Child is unhappy; may stop playing.	Child is angry; may cry, hit mother, or cling.	10-20%
D	Disorganized	Child is cautious.	Child may stare or yell; looks scared, confused.	Child acts oddly; may freeze, scream, hit self, throw things.	5-10%

Source: Adapted from Berger, 2008, p. 194.

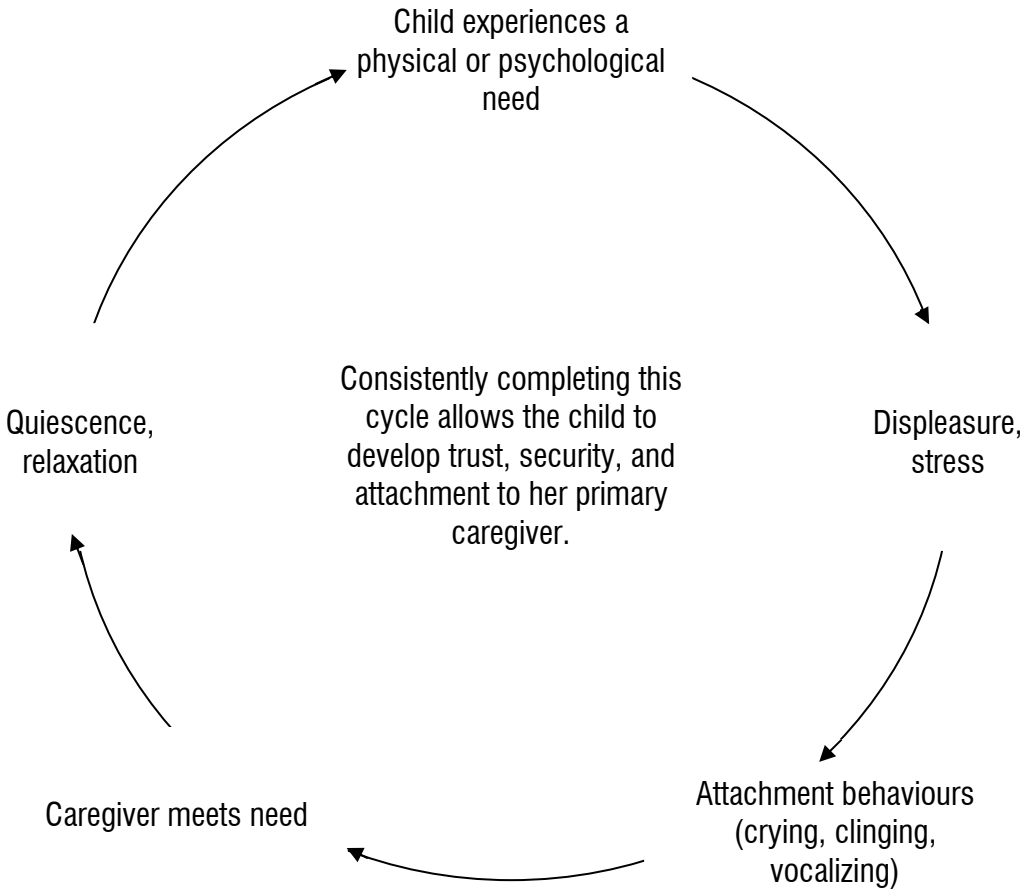
How Attachment Develops

When an infant is alarmed or distressed, whether by hunger, pain, fear, or any other stressor, she seeks out soothing physical contact with her primary caregiver through behaviours that change with age. These "attachment behaviours" include crying, grasping, clinging, approaching, following, smiling, reaching, and vocalizing. These behaviours are used by the infant/child to seek contact with her caregiver and to elicit a comforting response. In most families, these needs are met quickly and consistently by one of a few caregivers. Stability and continuity of care build trust, and over time the infant/child develops deeper and deeper levels of attachment to these caregivers. The caregivers provide an infant with feelings of safety and security, allowing the child to explore her world and know that if she is frightened or distressed, she will be safe, soothed, or comforted when returning to the secure base of the caregiver.

Children who have developed healthy attachments are more likely to be able to build and sustain other relationships, to be independent, and to develop conscience and self-discipline (Van Den Brandt & Wilgocki, 2003). If early relationships are characterized by trust, reciprocity, consistency, and child-centred nurturing activities, the child's propensity to develop positive, desirable relations with peers and other adults is enhanced. On the other hand, an early parent/child relationship marked by fear, inconsistency, and unmet physical and psychological needs is associated with poor formation of peer relationships and a higher frequency of behavioural and emotional disorders (Jaffe, Wolfe, & Wilson 1990, p. 38). The image on the following page summarizes the cycle of arousal and relaxation that leads to the development of attachment.

The Arousal/Relaxation Cycle

(Adapted from MCFD Integrated Caregiver Education)



Attachment in Children Exposed to Violence

Gewirtz and Edleson (2004) note that relatively little research to date has investigated attachment among infants and young children exposed to violence against their mothers, or the impact of such violence on attachment relationships. However, the research that has been done suggests that exposure to violence against a mother can have a negative effect on the development of secure attachment. One study found that when fathers were physically violent with mothers, infants were more likely to be insecurely attached to their mothers.

Because of their dependence, young children are vulnerable to threats aimed at their mother, especially when the source of those threats is another caregiver, such as their father or their mother's boyfriend. Early studies found that children's responses to community violence were mediated by the responses of their caregivers, and that the level of stress of the primary caregiver has an effect on the level of stress of the young child. More recent reviews of research on battered women reveal a less clear relationship between the mother's stress and that of the child (Edleson, Mbilinyi, & Shetty, 2003, as cited in Gerwitz and Edleson, 2004). That said, longitudinal studies have also shown that attachment status can change over time with changes in environment. Some studies have shown that the mother/child relationship improves following the end of the violence and increased stability in living conditions.

While further research is needed to look at the effects of exposure to violence on mother/infant attachment, the behaviour of the abusive partner clearly disrupts the child's and the mother's sense of safety and creates fright in addition to any physical injury (Gewirtz & Edleson, 2004). It is also true, however, that disruptions to attachment relationships result from many other stressors in some children's environments, including poverty, homelessness, and separation from their caregiver.

B.2 Effects of Prolonged Stress on the Developing Brain

A student of child development is repeatedly brought back to questions about the relationship between the child's genetic inheritance and the environment in which that child is reared: the old "nature versus nurture" debate. How much of a child's developing self is "hard-wired" into his brain, and how much is the result of exposure to his environment?

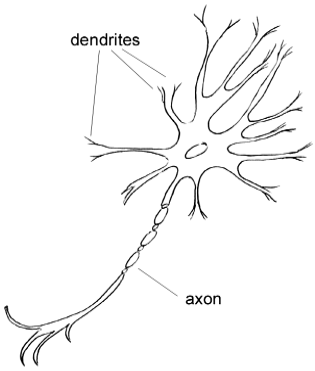
Recent research into brain development has brought a new twist to this discussion, as we have discovered the extent to which the physical brain develops in response to early environmental factors. As Bruce Perry, a physician and expert on children in crisis, puts it, human beings become a reflection of the world in which they develop. If that world is safe and predictable, the child is more likely to grow up to be a self-regulating, thoughtful, and productive member of family, community, and society. In contrast, if the developing child's world is chaotic and threatening,

the child may become impulsive, aggressive, and inattentive, and may have difficulties with relationships (Perry, 2004).

How the Brain Develops

Neurons communicate by sending electrochemical impulses, through their axons, to synapses where they are picked up by the dendrites of another neuron.

The brain's communication system begins with nerve cells called neurons, most of which develop before birth.[2] Neurons are connected to each other by a complicated network made up of nerve fibres called axons and dendrites. An axon is a fibre that extends from a neuron. *Axons transmit electrochemical impulses* from that neuron to the dendrites of other neurons. A dendrite is another type of fibre that extends from a neuron. *Dendrites receive electrochemical impulses* transmitted from other neurons via their axons. Synapses are the tiny gaps between the axon of one neuron and the dendrite of the next. Neurons communicate by sending electrochemical impulses, through their axons, to synapses where they are picked up by the dendrites of another neuron.



Neuron

At birth, the brain contains more than 100 billion neurons, far more than one person will ever use in a lifetime. On the other hand, the newborn brain has far fewer dendrites and synapses than the person will eventually possess. During the first months and years of life, a great many new axons, dendrites, and synapses develop, especially in the part of the brain most responsible for thinking, feeling, and sensing. Dendrite growth is the major reason that brain weight triples in the first two years of a child's life.

This early rapid growth is followed by a process called "pruning," in which unused neurons and misconnected dendrites atrophy and die to make way for the growth of those that are healthy and being used most. The process is called pruning because it is similar to the way a gardener might prune a bush or tree, removing dead or misshapen branches to allow room for the development of healthy ones. It seems ironic, but the brain's ability to think more complex thoughts as a child grows is related to a loss, rather than a gain, of synapses. Synapses, dendrites, and even neurons continue to form and die throughout a person's life, but never as rapidly as in infancy.

So early experiences, before age two, help to decide which dendrites will continue to develop and which will be "pruned." These experiences affect the brain's physical structure in ways that last throughout the person's lifetime.

[2] This section on brain development draws heavily on Berger, 2008, pp. 129-132.

Effect of Early Experiences

When a person experiences stress, cortisol and other hormones are released into the brain. Cortisol is often referred to as the "stress hormone" because it helps the body respond to stress by, for example, raising blood pressure and blood sugar. Cortisol also affects other systems within the body, for example, reducing the immune response and increasing stomach acids. It can also affect memory and other cognitive functions. Cortisol is a wonderful thing in a crisis, but is harmful if the body doesn't have the opportunity to relax and return to normal after a crisis episode. Research shows that the cortisol-flooded brain of a young child is changed in significant ways. When that individual is older, her brain may either overproduce stress hormones, making her hypervigilant, or underproduce them, making her emotionally flat (Berger, 2008).

The time of early brain growth and development, up to age four, provides an opportunity that Perry (2004) refers to as a "biological gift." In a nurturing environment, a child can grow to achieve the full potential preordained by underlying genetics. If the brain produces too much cortisol early in life however, as happens when an infant is frequently terrified, brain development is affected and the brain may become incapable of normal stress responses. The result is often the hypervigilance or emotional flatness described above.

Perry reports that for a hypervigilant child, a small stressor, such as an argument with a peer or a demanding school task, can cause the child to escalate to a state of fear very quickly. Compared with their peers, therefore, traumatized children may have less capacity to tolerate the normal demands and stresses of school, home, and social life (Perry 2004). Gewirtz and Edleson (2004) note that children who regularly produce higher levels of cortisol show more difficulties in sustaining attention, poorer memory, and a decreased ability to control their behaviour.

Healing the Brain

Perry also notes, however, that a child's brain that has been shaped in destructive ways by trauma and neglect can also be altered in reparative, healing ways. Exposing the child, over and over again, to developmentally appropriate experiences is the key, he writes. With adequate repetition, this therapeutic healing process can influence those parts of the brain altered by developmental trauma (Perry, 2004).

A child's brain that has been shaped in destructive ways by trauma and neglect can also be altered in reparative, healing ways.

B.3 Impact of Witnessing Abuse

Numerous sources list the lasting effects on children who have witnessed violence in their homes:

- Serious emotional and behavioural problems are seen at greatly elevated rates (between 10 and 17 times greater) in these children compared with children from non-violent homes (Jaffe, Wolfe, & Wilson, 1990).
- Many children experience symptoms of post-traumatic stress disorder (PTSD), including fear, anxiety, irritability, difficulty concentrating, intrusive memories of the abuse, anger outbursts, and hyperarousal (Lehman, 1997, cited in Agar, 2004; Graham-Berman & Levendosky, 1998).
- Aggression against peers, teachers, and mothers is increased in children who witness woman abuse, particularly among boys but also among girls (Jaffe, Wolfe, Wilson, & Slusczazck, 1986; Kerig, Fedorowicz, Brown, & Warren, 2000, both cited in Agar 2004).
- Emotional problems, such as depression, worry, school refusal, withdrawal from social interactions, and difficulty separating from the mother are frequently seen (Sternberg et al., 1993, cited in Agar 2004; Suderman & Jaffe, 1999).
- Many children suffer somatic complaints, such as body aches and pains, and illnesses with no known medical causes (Suderman & Jaffe, 1999).
- School achievement and social development are frequently compromised, as is the development of social competence (Moore & Pepler, 1989, cited in Agar 2004).
- Often there are more subtle symptoms, such as inappropriate attitudes about the use of violence in resolving conflicts, inappropriate attitudes about violence against women, and condoning violence in intimate and dating relationships; hypersensitivity about problems at home; and a sense that they are to blame for the violence (Suderman & Jaffe, 1999).

Symptoms are dependent on factors such as whether the abuse has stopped, feelings of safety on the part of the children and the mother, duration and intensity of abuse witnessed, and the child's coping style and other strengths or vulnerabilities. The ways that individual children remember and are affected by traumatic events depend largely on their age at the time, and coping styles vary with age (Cunningham & Baker, 2007). As well, children at various stages of development are differentially able to understand what is happening (Jaffe, Wolfe, & Wilson 1990). This section details the ways in which exposure to violence affects children at different developmental stages.

Prenatal

It is common for abuse to begin when a woman is pregnant. While consequences to the fetus require further study, there is certainly an elevated risk of physical injury to the fetus. What is less clear is the effect of elevated cortisol and other stress-related hormones on the developing fetus.

Infants and Toddlers

Even very young infants respond to witnessing parental conflict by stress that can be measured through changes in heart rate, crying, and other signs of distress (Suderman & Jaffe, 1999). The violence can directly interfere with the mother's ability to care for her infant, and it can also result in attachment problems (discussed above in Section B.1, "Attachment," beginning on page 27). Babies are also at risk of being physically harmed themselves, either intentionally by the abuser or unintentionally if they are in their mother's arms when she is being assaulted. Jaffe, Wolfe, and Wilson (1990) note that routines around sleeping and feeding are often upset, and a mother living in fear of her husband may be unable to handle the stressful demands of her infant. Infants who witness violence, they report, are often characterized by poor health, poor sleeping habits, and excessive screaming, all of which may contribute to further violence towards their mother.

Arroyo and Eth (1995) remark that while children who are traumatized at this young age are unable to put their trauma into words, they may display symptoms that include hypervigilance, exaggerated startle responses, developmental regressions, clinging behaviour, body dysregulation, and nightmares. Cunningham and Baker (2007) suggest that despite not understanding what is happening between adults, they nevertheless hear the noise and feel the tension, and may be distressed or scared, upset if not getting their needs met promptly, or too frightened to explore and play.

Features of woman abuse that might be most stressful for this age group include:

- loud noise, such as banging and yelling;
- sudden and unpredictable eruption of loud noise;
- a distracted, tense, unhappy, socially isolated mother;
- an angry, self-centred, inconsistent father or father figure;
- the chance of being injured physically by accident or physical maltreatment; and,
- compromised nutrition and health if financial abuse restricts money to buy formula, vitamins, diapers, home safety devices, and so on. (Cunningham & Baker, 2007, p. 16)

Preschoolers

Preschoolers are easily upset by changes to daily routines and are comforted by the re-establishment of routines such as those at mealtime and bedtime.

Preschoolers, from about age 3-6 years, are severely distressed by witnessing the abuse of their mother. They may be very clingy or difficult to manage and negative in their mood (Suderman & Jaffe, 1999). Jaffe, Wolfe, and Wilson (1990) report that researchers found signs of terror evidenced by the children's yelling, displaying irritability, hiding, shaking, and stuttering. They also note that children at this age appear more likely to experience physical complaints and to regress to earlier stages of functioning. Preschoolers are easily upset by changes to daily routines and are comforted by the re-establishment of routines such as those at mealtime and bedtime (Cunningham & Baker, 2007).

Cunningham and Baker (2007) further note that for this age group, what they experience is more real than anything you tell them. The child may worry about being hurt and may have nightmares about being hurt. He may believe that the violence is his fault, and he may try to stop the abuse, for example, by yelling. He may tune out the violence and focus instead on something like toys or television. He may hope that a television character or superhero will come and save him. He may be confused if Daddy is gone and worry that Mommy may leave too.

Features of woman abuse that might be most stressful for this age group include:

- seeing Mommy upset, crying, and maybe bleeding or with a bruise;
- seeing (and hearing) Daddy angry and yelling;
- sounds and sights of first responders when they secure the scene and assist on a call to the home;
- chaotic change and unpredictability;
- fear that they might be injured; and,
- disruption in their routines if they leave a familiar home (e.g., to go into shelter) or if a father is no longer in the home. (Cunningham & Baker, 2007, p. 19)

School-Aged Children

School-agers, from 6 to 11 years, show their distress through aggressive and/or withdrawn behaviours at school and difficulty in concentrating (Suderman and Jaffe, 1999). These children are often labelled with attention deficit disorders (without having been asked about violence at home) and may have difficulties in peer relationships and low self-esteem. Boys may begin to be particularly defiant with female teachers, mimicking the disrespect for women that they see at home (Suderman & Jaffe, 1999).

At this stage, children look to their parents as significant role models. Boys and girls quickly learn that violence is an appropriate way of resolving

conflict in human relationships (Jaffe, Wolfe, & Wilson, 1990). They may also suffer significant emotional consequences and experience embarrassment and shame related to the family secret. They may feel guilt at their own inability to prevent the violence and be confused by their divided sense of loyalty in wanting to protect their mother while also fearing their father's control over the family. Often these children will spend long hours at school, distracted and inattentive (Jaffe, Wolfe, & Wilson, 1990). Arroyo and Eth (1995) note that developmental regressions may lead to ostracism by classmates. Hypervigilance combined with impaired concentration may make it very difficult for these children to learn well at school.

Cunningham and Baker remark that as children grow through the elementary school years, their understanding of abuse directed towards their mothers becomes more sophisticated. They see that actions have effects, and they may believe that the cause of the "fighting" is stress, family finances, alcohol, or whatever else their parents argue over. Believing this explanation is easier (emotionally) than seeing a beloved parent as someone who is mean on purpose (Cunningham & Baker, 2007, p. 20).

Features of woman abuse that might be most stressful for this age group include:

- a realization that their mother can't control her partner to protect herself (or perhaps even to keep the children safe);
- understanding that their mother is sad and upset between incidents;
- concern that their mother may be hurt;
- scared that no one will take care of them if mother is seriously hurt or dies;
- if their father is loved, concern that he might experience negative consequences such as arrest, or that the parents will separate;
- fear that they might be injured (now or in the next "fight");
- when noise keeps them awake at night, adverse effect on school performance;
- anticipatory anxiety about the next incident; unpredictability of father's "moods";
- worry that neighbours and friends will hear the noise or find out;
- because of a need to preserve a sense of their father as a good person, being upset by negative comments that others make about him; and,
- being upset at changing schools and losing touch with friends if the family has to move (e.g., to go into shelter). (Cunningham & Baker, 2007, p. 21)

Adolescents

It is common for adolescents to have trouble focusing on the future, and involvement in juvenile delinquency is more common among adolescents who have been exposed to the abuse of their mothers.

Adolescents may demonstrate their distress at violence against their mother through school truancy, dropping out, and/or running away from home. It is common for adolescents to have trouble focusing on the future, and involvement in juvenile delinquency is more common among adolescents who have been exposed to the abuse of their mothers. Depression and suicide are also more common (Suderman & Jaffe, 1999). Jaffe, Wolfe, and Wilson (1990) note that adolescents normally develop closer relationships outside the family. These may include intimate relationships in which they practise the sex roles and communication styles learned from their parents. This may also be a time when teens begin to experience violence within their own relationships. For girls, this may be a turning point in which they make decisions about how to respond to threats or violence from boys. Some boys handle their frustration with the violent behaviour they see at home by assaulting their mother or siblings.

Cunningham and Baker (2007) note that as they grow physically larger and stronger, teens may choose to intervene in incidents and even risk injury. Adolescents may feel embarrassment and a strong desire to hide the abuse from those outside the family. They may feel concern for the well-being of their mother and responsibility for taking care of younger siblings and perhaps their mother as well. They may feel vengeful towards the abuser and may have anger aimed at either or both parents. Teens have access to a wider range of coping strategies than do younger children. Some of these techniques are effective at solving the immediate problem, such as running away or using drugs to numb the emotional pain, but this relief comes at a cost if it leads to problems at school or in other contexts.

Summary of Immediate Effects

Infants	Preschoolers	School-Aged Children	Early Adolescence 12-14 years	Later Adolescence 15-18 years
• Failure to thrive • Listlessness • Disruption in eating and sleeping routines • Developmental delays	• Aggressive acts • Clinging • Anxiety • Cruelty to animals • Destruction of property • PTSD symptoms	• Bullying • General aggression • Depression • Anxiety • Withdrawal • PTSD symptoms • Oppositional behaviour • Destruction of property • Poor school achievement • Disrespect for females; sex role stereotyped beliefs	• Dating violence • Bullying • Poor self-esteem • Suicide • PTSD symptoms • Truancy • Somatic concerns • Disrespect for females; sex role stereotyped beliefs	• Dating violence • Alcohol/drug use • Running away from home • Sudden decline in school achievement and attendance • Disrespect for females; sex role stereotyped beliefs

Source: Reproduced from Suderman & Jaffe, 1999, p. 13.

Long-Term Effects

Suderman and Jaffe (1999) report on a number of studies that find that childhood exposure to violence against women predicts less positive adult social adjustment and depression in adults. Agar (2004) also summarizes studies showing that teenagers who witness violence against women are more likely to have depression, anxiety, health-related concerns, and drug and alcohol use in adulthood. Witnessing violence against women has also been linked to trauma symptoms in adulthood, even after taking into account the impact of other forms of abuse. Besides having an impact on adult adjustment, Agar notes that witnessing violence as a child is a risk factor for engaging in violent and/or antisocial behaviour as an adult, and especially violence against women. Male batterers report high rates of both witnessing and being victims of violence as children. In addition, women who witnessed violence as children are more likely to be physically abused in their own adult relationships. Finally, there is evidence that witnessing violence can have an impact on long-term physical health, including heart disease, cancer, stroke, and chronic bronchitis or emphysema.

Impact on Children's Roles in the Family

Cunningham and Baker (2007) write at length about the roles all children play within their families. Some are conscious and others unconscious; some are willingly assumed while others are imposed on a child. For example, in many families one person is the mediator of disputes, another is the "baby" of the family, one might be the prized child who can do no wrong, another might be the "black sheep" who does not fit in and is expected to disappoint the others. In a family that lives with woman abuse, the roles reflect the unique ways by which each child copes with the situation in which they live.

The authors note the following key points about family roles:

- Children may play roles before, during, or in the aftermath of violence.
- During abusive incidents, a child might play the referee, rescuer, deflector/distractor, or caretaker of younger siblings.
- A child may use the role as a strategy to cope, so it might not be turned off overnight once the abuser is gone.
- Roles assigned by the abuser can lead to guilt, grief, and other hurtful emotions, especially after he leaves.

C. Practice Issues

C.1 Working with Other Professionals

Coordinating Services

The children served in CWWA programs often have multiple, complex needs that require the support of more than one service provider. Integrated service provision, whether through formal case management or otherwise, helps avoid gaps in service and allows the family and service providers to work together to ensure the best possible support for the child and the family. Communication, cross-training, consultation, and joint practice among community agencies all support positive outcomes for children in CWWA programs (Agar, 2004).

In addition to collaborating at the level of individual families, CWWA counsellors should collaborate with partners at the community level to:

- discuss community needs and service gaps;
- plan services;
- establish collaborations to provide services;
- discuss and resolve inter-agency protocols on meeting the needs of children; and,
- undertake special joint initiatives in areas such as public education and professional development. (Suderman & Jaffe, 1999)

A good example of this type of collaboration is the Violence Is Preventable Project (VIP) in operation across British Columbia. Violence Is Preventable is an initiative of BCYSTH aimed at increasing the coordination of services between CWWA programs and schools (BC Yukon Society of Transition Houses, 2007). The manual for the VIP program includes sample protocols for building partnerships with schools as well as a discussion of relevant legislation and policy. The manual also includes materials for delivering violence prevention education and group interventions for children who witness abuse.

Agar (2004) argues that communication and cooperation are also crucial needs for battered women's advocates and child protection workers. Both have family safety as a primary goal, although there can sometimes be disagreement regarding the best means to achieve it.

Standard D.3.1. CWWA programs collaborate with community members to identify gaps and redundancies in community service delivery to the shared population they serve and to advocate on issues of mutual concern.

Standard D.3.2. CWWA programs conduct ongoing community outreach and education to promote services provided and the needs of the service population.

Seeking Outside Help

A CWWA counsellor recognizes when a particular child cannot be properly served within the CWWA program and must be referred to another provider. This can happen when the child's needs are outside the mandate of the program or when the child's needs are beyond the training and experience of the counsellor.

McEvoy and Ziegler (2006) make the case for a counsellor working within her own competencies, quoting from the Feminist Therapy Institute Code of Ethics (1999): "A feminist therapist works only with those issues and clients within the realm of her competencies."

Given the current pressure to do more with less, service providers face dilemmas when making decisions about providing service that is beyond their competencies or the mandate of the program. Sometimes counsellors feel pressure to continue working with a child because they know either that there is no other service available or that alternate services will have long waiting lists and that the child will be without service until a space opens up.

These suggestions for feminist counselling are adapted from McEvoy and Ziegler (2006):

- The counsellor must conduct an honest inventory of her own knowledge, skills, and abilities. If a client presents with an issue that is outside the parameters of the counsellor's experience, she must explain the situation to the child or to the referring parent, as appropriate.
- If referral to another provider is not possible or appropriate, the counsellor may, with the consent of the parent, provide limited supportive counselling intended to avert a crisis or reduce the possibility of further harm.
- Questions about competencies to provide services should always be discussed with a supervisor or peer.

Apart from the limits of a counsellor's training, a child should be referred to a more appropriate service if his needs are beyond the mandate of the CWWA program. Even a registered clinical counsellor must not engage in therapy that is beyond what the program is designed to provide and what the child has consented to. For more on the limits of the CWWA program, see Section 1.A.2, "Psychoeducational Methods," on page 14.

Even a registered clinical counsellor must not engage in therapy that is beyond what the program is designed to provide and what the child has consented to.

C.2 Working with Parents and Other Caregivers

Supporting the Non-Abusive Parent

There are several reasons for working closely with the referring caregivers of children in CWWA programs:

- The program goals in the short term relate to changes within the child, but the long-term goal of keeping family members safe and reducing family violence requires that support of some kind be provided to the child's mother.
- The support provided by the program is short-term and professional. Mothers provide the long-term, consistent environment in which children will achieve their real healing from the trauma.
- CWWA programs usually work with children after their stay in a transition house; in many cases, the mother of a child in the CWWA program is not currently connected to any supportive services.
- Families often have multiple needs that range far beyond those that can be met within the CWWA program.
- Assistance with practical issues such as housing, legal advocacy, income support, and job retraining ensures better results for the whole family.
- Parenting education and support groups support a mother's improved abilities to cope with the demands of her children.

Standard B.1.3. CWWA programs provide supportive services to the non-abusive parent.

CWWA Program Components that Support Mothers

Some programs run support groups specifically for the mothers of children in their CWWA program. Haven Society, in Nanaimo, runs a 14-week group that covers topics such as how mothers can promote their child's healing, how to help mothers deal with their own feelings, and how to establish boundaries and positive discipline within the family. In groups and also in one-to-one counselling, CWWA counsellors can affirm the mother as a parent and help her discover and nurture her strengths and resiliency.

Maintaining a psychoeducational approach is important. Some ways to ensure this include:

- focusing on parenting concerns rather than on a mother's personal issues;
- staying grounded in the present rather than in past issues;

- avoiding the probing questions that might lead to deeper therapeutic work, which is inappropriate in this context and outside the mandate of the program;
- using instructional materials such as films, exercises, and handouts; and,
- ensuring that women who need and desire therapy are referred to an appropriate resource, such as a Stopping the Violence program.[3]

One of the primary goals of supporting the mother is helping her learn to see things from her child's perspective. In the midst of her own trauma, a mother may be tempted to minimize the effects of the abuse on her child. She may require help understanding her child's reactions, including anger that may be directed at her as the safe parent. She may not understand why several months later the child is still acting out or displaying anger.

Suderman and Jaffe (1999) point to some important components of a program to support mothers.

Advocacy

Women who have survived abuse can have multiple and often integrated needs (e.g., for housing, income assistance, referral). Women often experience stressors above and beyond the abuse, such as poverty.

CWWA counsellors can support women in accessing the services they need.

Healing the Bond between Mother and Child

Children's emotions may include anger at their mother, a sense of betrayal, fear of abandonment, grief, and confusion. Children need to know that their mother loves them, does not blame them for anything that happened, and will keep them safe.

CWWA counsellors can:

- provide children a psychologically safe space to begin to acknowledge and process grief, loss, and pain;
- create opportunities for children to safely reconnect with a parent around what has often been a shared experience of trauma; and,
- facilitate a positive shared experience between the child and the parent, opening the way for them to communicate about past issues.

[3] Stopping the Violence is a specialized counselling program in British Columbia aimed at female survivors of childhood abuse, sexual assault and abuse, and violence in intimate relationships (McEvoy and Ziegler, 2006).

Help with Concerning Behaviour

Helping a mother address a child's concerning behaviour removes a major stressor from the mother's life.

CWWA counsellors can share their knowledge about child development and how to respond to the child's behaviour.

Understanding How Their Children Are Affected

Mothers are highly motivated to help their children and want to know how they can support the development of healthy coping skills.

Mothers are highly motivated to help their children and want to know how they can support the development of healthy coping skills. Mothers can help children heal from the effects of violence at home, and they can be supported in seeing how each of their children has been affected in a unique way.

CWWA counsellors can provide supportive and educational groups and workshops that address topics such as:

- how an abusive partner can affect her as a mother;
- how abusive men parent;
- how a child may be thinking and feeling about what happened;
- normal feelings that a mother may have about her children;
- everyday essentials of parenting when children have lived with violence;
- basics of "good" discipline; and
- guidelines for setting family rules that are respectful of everyone.

Counsellors should be mindful of meeting the mother at her current cognitive and emotional level. Often information must be shared and modified several times to support a mother's full understanding, particularly when she too is recovering from the trauma of the abuse.

The goal is to support the mother from a strength-based perspective. By building on her abilities and reminding her of her strengths while offering concrete educational information, a CWWA counsellor can support the child's mother both in her healing as an abused woman and in her role as the mother of a traumatized child.

Including the Referring Caregiver

Besides supporting the abuse survivor, CWWA counsellors should include the referring caregiver in the child's service. Children who come to CWWA programs are not always in the care of their mothers. They may be living, temporarily or permanently, with foster parents, grandparents, or other members of their extended family.

Here are some concrete suggestions for involving the child's caregiver.[4]

Caregiver Interview

In individual or group sessions, meet with the referring caregiver and explain the goals and structure of the CWWA program. Encourage questions and expressions of concern. Clarify that caregivers are welcome to call you should any issues arise and that you will do the same. If you are running any support groups for mothers, you may use this opportunity to assess the mother's willingness to participate.

Caregiver Letters

Consider sending standard letters home each week to briefly explain what was done in the group and to suggest how the caregiver may reinforce what was learned.

Final Interview

Schedule an interview with the caregiver after the group ends to discuss the child's participation in the program. Encourage questions. Discuss the strengths you have observed in the child and discuss any concerns and suggestions you may have.

Working with the Offending Parent

When the CWWA programs were first initiated in British Columbia, in the early 1990s, it was acknowledged that they were not crisis programs but were designed to support children after they had stopped living in an abusive situation. Program developers feared that many of the strategies taught to children to support their developing sense of safety and strength could actually put them at increased risk if used in a home where violence was still present. Most CWWA programs adopted a principle of not working with a child who is living with or has extended visitation with the abuser.

Over the years, some CWWA counsellors have had to make difficult decisions regarding this principle. What should be done if a child begins in the program and then the abuser returns to the family home? Where should the line be drawn between "occasional" and "extended" visitation with the abusive parent? Can we serve a child whose father lives in the family home but who has taken responsibility for and ended his abuse? Can we serve children who are in the custody of their fathers?

A review of the literature shows that some models of CWWA programs encourage the participation of the father as long as he is no longer using violence against the mother or the child. If the safety of the mother and

[4] These suggestions are adapted from *Children Who Witness Abuse Program Counsellor's Handbook: 20 Most Commonly Asked Questions* (White & McConnell, 1995).

child are assured, and if the child will have ongoing contact with him, some argue that the father's participation is important. It may be helpful for the father to learn how to respond to his children's ambivalent feelings towards him and how to engage in the non-violent management of children's behaviour. Some studies also show that the participation of the father increases the likelihood that a child will successfully complete a CWWA group (Agar, 2004).

Each CWWA program must consider this issue and create policy that clarifies whether formerly abusive parents should ever be involved. If they are involved, the policy should provide direction on screening fathers for appropriateness and describe the ways in which they can participate in the program.

Counsellors who are not sure whether to work with a particular father should seek consultation from a peer or a supervisor.

Taking the time to create policy ahead of time that anticipates different possibilities will help guide the counsellor in making individual decisions about inclusion or exclusion. Counsellors who are not sure whether to work with a particular father should seek consultation from an experienced peer or a supervisor.

Things to Consider

In developing a policy to help CWWA counsellors decide whether and when to work with an abusive parent, it will be helpful to consider the following:

- Are the mother and child currently safe from violence?
- Has the father taken responsibility for the violence?
- Do both the mother and the child wish the father to be involved?
- Might the father be using his participation in the program as a means of increasing his control over the mother and child?
- Might the father be using his participation in the program to gain leverage in custody and access?
- Might the father use the program material to harass the mother?

Other Resources for Fathers

A variety of programs are currently available to support a formerly abusive parent in learning healthier ways to act within a family. The goals of these programs include helping men who have used violence understand the impact of family violence, helping them unlearn social messages that condone and support violence against women and children, and teaching them positive skills for managing their anger, interacting with their spouse, and parenting their children.

In BC, the Victoria Family Violence Prevention Society, in partnership with the Victoria Women's Transition House Society, created the Fantastic Fathers program. This program assists fathers who have used abuse

to adjust to a more child-centred approach to fathering and to be supportive of their partner's parenting in a respectful and nurturing way.

C.3 Safety Planning with Children

When working with children who have been exposed to family violence, it is important to establish the safety of the entire family. There is extensive literature that deals with safety for the battered woman but relatively little that addresses the safety needs of the children (Agar, 2004). Children require a sense of physical and emotional safety in order to fully recover from the trauma of their experience. A safety plan is one step towards this goal.

To work on safety planning with children, it is important to first understand how children have coped with witnessing violence in the past. Some of the ways in which they coped in the past will not have been optimal; for example, children may have been reluctant to call the police or supportive neighbours due pressure within the family to keep the abuse secret.

Safety Planning after a Disclosure

Suderman and Jaffe (1999) provide the following suggestions for CWWA counsellors:

- Include the children and the mother in safety planning.
- Inform the mother of community resources.
- Contact police if danger is imminent.
- Contact child protection authorities if the child has been physically or sexually abused or if the child shows signs of emotional trauma.

Safety Planning for Visits to the Abuser

When the child will be visiting the abusive parent in an unsupervised setting, it may be helpful to problem-solve with the child ahead of time regarding potentially dangerous situations. Counsellors may also wish to help the child prepare for unsafe events, such as a violent incident, the intoxication of the abusive parent, or the possibility of the child being kidnapped. Safety plans should be tailored to the individual situation (Agar, 2004).

Long-Term Safety

The CWWA counsellor can help the family plan ways to establish the structure, limits, and predictability necessary for the children's recovery (Agar, 2004). For the family to fully heal from the violence, they will need to create an environment that is safe and nurturing, in contrast to the chaos and unpredictability that characterizes most abusive situations.

Agar reports that reduction in family stressors is very important in children's recovery and facilitates their participation in supportive services such as the CWWA program.

Children and Youth Who Are Suicidal or Self-Harming

Suicide is the second most common cause of death for youth between the ages of 12 and 18 in British Columbia (BC Coroner's Service, 2008). A retrospective review of child and youth deaths by suicide, completed by the BC Coroner's Service in 2008, found that those who are at greatest risk for suicide are older youth, males, Aboriginal children and youth, and children and youth who are gay, lesbian, bisexual, or questioning their sexuality. The following factors increased the risk of suicide:

- a history of suicidal behaviour, including previous non-fatal attempts and suicidal ideation;
- a history of use of alcohol and/or illicit drugs; and,
- school challenges, including learning difficulties and absenteeism or dropping out.

The study found that:

- Almost half of the children and youth studied had diagnosed mental health problems, commonly depression.
- Almost half of the children and youth studied had experienced the death by suicide of a family member or peer.
- Almost half of the children and youth studied lived with family dysfunction, including abuse, neglect, mental health problems, *and exposure to family violence.*
- Poverty was a factor for one-fifth of the children and youth studied.
- Nearly one-quarter of those studied were known to have been violent towards others.

Fully two-thirds of the children who died by suicide had reached out for help to parents, friends, teachers, doctors, counsellors, or others in their lives.

If a child is very depressed or talks with the counsellor about suicide, it is important to seek consultation from an experienced peer or supervisor.

CWWA counsellors must be aware of the risk factors that children and youth bring to the program. If a child is very depressed or talks with the counsellor about suicide, it is important to seek consultation from an experienced peer or supervisor. Referral to mental health services may be appropriate. Remember the legal duty to report disclosure of a plan to self-harm. The BC Crisis Line has a webpage that provides a wide range of resources for teens as well as professionals: http://www.crisiscentre.bc.ca/distress/links.php

C.4 Support for CWWA Counsellors

The work done by CWWA counsellors and others who work in the anti-violence field carries with it a particular burden of responsibility to remain healthy and avoid becoming traumatized or "burned out." This is a field in which the worker is exposed to painful, frightening stories and events that are hidden from most of the world. Bearing witness to the stories told by abuse victims and their children makes anti-violence workers particularly vulnerable to vicarious trauma.

It is especially important for CWWA counsellors and their colleagues who work in transition houses and related counselling programs to remain psychically healthy, available for their clients, and able to advocate for themselves. This section provides suggestions for how to maintain personal wellness and balance in this work.

It is especially important for CWWA counsellors and their colleagues who work in transition houses and related counselling programs to remain psychically healthy, available for their clients, and able to advocate for themselves.

Counsellor Safety

All CWWA programs must have a plan for ensuring counsellor safety. The Workers' Compensation Board (WorkSafeBC) requires that employers have a policy that ensures the safety of anyone who is required to work alone or in isolation. This applies to counsellors who regularly work alone in the office, for example, seeing clients in the evening or on weekends. It also applies to counsellors who see clients outside the office, for example, meeting them in their homes or driving children to and from sessions.

In addition to working-alone policies, CWWA counsellors should consider ways to promote their safety both in the office and away from the office. Examples will be specific to each situation, but might include phone check-in as appropriate and direction regarding assessing the danger of a situation, such as driving a child home and finding that the abusive partner is there. Programs should also consider providing specific training to counsellors, perhaps collaboratively with transition house staff, regarding assessing and managing dangerous situations.

Standard C.1.4. When planning CWWA programs, consideration is given to safety issues.

Standard C.1.5. CWWA programs have written policies addressing safety for those working alone or in isolation.

Supervision

CWWA counsellors require frequent, high-quality supervision both to help them make difficult decisions and to provide support in managing the feelings that may arise from the work. Supervision can be provided through peer meetings and also one-to-one with a clinical supervisor.

Clinical supervision can be used to:

- help plan services for groups or individuals;
- problem-solve complicated situations;
- debrief particularly difficult or traumatic work;
- help resolve conflicts of interest or ethical issues;
- help resolve concerns over whether and when to refer clients to more intensive services;
- provide support during times of personal stress to avoid having that stress spill over into the counsellor's work;
- help manage workloads to avoid burnout;
- reduce a counsellor's isolation; and,
- provide ongoing support and reassurance.

"Clinical supervision provides me with perspective and a chance to brainstorm. It supports my self-care. I feel validated."

– a CWWA counsellor

CWWA counsellors report that clinical supervision provides them with perspective, helps them solve problems, and helps protect them from isolation and burnout. It also helps counsellors make decisions related to safety issues, especially those related to legal problems.

As part of their contract for service, all CWWA counsellors in British Columbia have a designated clinical supervisor and time built into their workload. While it is true that in more remote locations the CWWA counsellor may have only phone contact with her clinical supervisor, it is still important to keep that relationship alive through regular conversations. The importance of clinical supervision in supporting counsellor well-being and maintaining good clinical practice cannot be overstated.

Standard D.1.1. CWWA programs provide regular, appropriate supervision for the counsellor, and counsellors meet regularly with supervisors.

Standard D.1.2. CWWA caseloads are jointly established by the counsellors and the Program Coordinator.

Standard D.1.3. CWWA programs orient new staff and provide ongoing training and professional development opportunities for all staff.

Professional Development

Besides staying current with the literature, CWWA counsellors need opportunities to train and to attend conferences that enable them to network with peers. Agencies should acknowledge this and make time and funds available for these purposes.

Ongoing training and professional development are crucial to remaining vital in any job. There is a wide range of educational material available

for CWWA counsellors. Section 4 of this manual provides a detailed list of resources for CWWA counsellors, many of which are available at no cost via Internet download.

Dealing with Vicarious Trauma and Burnout

Cunningham and Baker (2007) discuss the ways in which this work can affect a counsellor. Counsellors may be affected by anxiety, diminished concentration, and the desire to withdraw from friends. Some resort to unhealthy coping strategies such as using alcohol to relax. A counsellor's health may be compromised, leading to physical symptoms and an impaired immune system. A counsellor's work may also be compromised, including performance of job tasks, lower morale, diminished relationships with colleagues, and absenteeism.

CWWA counsellors should develop constructive coping strategies. These may include:

- good nutritional habits;
- exercise;
- getting adequate sleep;
- making time to relax;
- developing and maintaining good support networks, both on and off the job; and,
- working within the agency to establish supportive activities, such as debriefing protocols.

McEvoy and Ziegler (2006, pp. 70-71) offer the "ABCs of sustaining yourself in this work." They are *awareness, balance,* and *connection.*

Awareness

- being attuned to one's needs, limits, emotions, and resources;
- heeding all levels of awareness and sources of information; and,
- practising mindfulness and acceptance.

Balance

- maintaining balance among all activities, especially work, play, and rest;
- balancing workload and variety; and,
- maintaining inner balance that allows attention to all aspects of oneself.

Connection

- staying connected to oneself, to others, and to something larger;
- breaking the silence of unacknowledged pain; and,
- staying connected to offset isolation and increase validation and hope.

C.5 Program Evaluation

Evaluation of a program can take a number of different forms and achieve a wide range of ends, all aimed at continually improving service delivery. Meaningful evaluation generates information that is understandable and clearly linked to outcomes that staff understand and commit to. Program evaluation is worth undertaking because it:

- helps counsellors see what is working or not working in their program;
- gives counsellors language and examples to show funders and community partners that the CWWA program makes a difference;
- can generate information that will help in fundraising; and,
- helps improve work with clients by showing strengths and weaknesses in a counsellor's practice.

Creating an evaluation plan takes time, energy, and expertise. This section outlines the basic steps in developing a system for evaluating a CWWA program.

Most programs are accustomed to gathering client satisfaction data, usually through written surveys. Satisfaction surveys ask questions related to whether the client enjoyed the program, whether it was conveniently scheduled, and whether the client felt respected, and other questions geared towards an evaluation of the client's *experience* with the program. Satisfaction data can yield rich information that counsellors use to better meet their clients' needs, and often to increase the reach of their program.

Program outcomes, on the other hand, answer the questions "How will I know if my program was effective? How will I know if I've done what I set out to do?" A program outcome is a measure of how the client has *changed* as a result of the program. The client may have learned new information, developed new skills, or come to a new understanding of past events. Some examples of client outcomes for a CWWA program may include:

- Children report that they feel less isolated in their experience.
- Children report that they have learned new ways of coping with their traumatic experiences.
- (For small children) Parents report a reduction in their child's symptoms, such as acting out behaviours.

- (For parents) Parents report an increase in their knowledge of child development and appropriate behaviours.

These are just a few examples of possible client outcomes. Each program should assess its own specific goals and create outcomes that reflect success relative to those goals.

Notice that it's possible for a client to change in a positive way (such as learning a new skill) even if she reported not being happy with some elements of the program (perhaps the time was inconvenient or she felt that the group ran too long). On the other hand, a client can have a lovely time attending a program, meet interesting new people, enjoy the snacks, and leave feeling terrific about the experience but still not have *changed* in the ways that the program planners hoped (no new knowledge or understanding, no new skills or abilities). This highlights the difference between satisfaction data and outcomes data. A comprehensive evaluation program will include both because each generates information that is important in its own way.

Methods for Gathering Data

Evaluation data can be gathered in a variety of ways. Written surveys are commonly used, as are interviews, either over the phone or in person. Focus groups are another way to solicit feedback. To ensure that respondents feel free to give fully honest answers, it is a good idea to allow for anonymity. The easiest way to do this is through a written survey, but this may not be appropriate for clients for whom English is not the preferred language or whose literacy is lower. Programs will also have to adapt the format to be accessible to children at different developmental stages. Interviews are a good way to gather feedback from children, but the lack of anonymity may lead to answers that are aimed at pleasing the interviewer. Interviews are also time-consuming. When choosing the method for gathering feedback, a program will have to balance all factors.

Standard A.2.1. CWWA programs identify stakeholder groups and make plans to include them in all areas of planning and providing service.

Standard A.2.2. CWWA programs gather stakeholder input on an ongoing basis using a variety of mechanisms.

Standard A.2.3. CWWA programs analyze stakeholder input on a regular schedule (such as annually) and use this information to plan.

Satisfaction Data

Satisfaction data should be gathered from a range of stakeholder groups, including child clients, referring parents, and community members who care about your work, such as referring professionals and others who work with the same children. A sample satisfaction survey is included in Appendix 2, "Sample Forms."

Outcome Measures

As discussed above, outcomes provide one way of measuring the effect that a program is having on clients. Creating and measuring basic client outcomes does not have to be complex or difficult. It does not have to involve expensive tools or a great deal of staff time if it is properly planned. Gathering and analyzing client outcomes can help a program discover how it is making a difference for clients. It can also give program staff language to explain program successes, and it can help point to areas within programming that might be improved. Outcomes measurement can enhance a program's credibility in the community by demonstrating its impact. A number of excellent resources are available both in print and online to help an organization begin to measure client outcomes. A few of them are listed in Section 4 of this manual.

Remember that outcomes measurement is not experimental research. It is a management tool that can be used to improve programs.

Some programs worry that they cannot use outcomes data unless it would be considered reliable from a research perspective. Remember that outcomes measurement is not experimental research. It is a management tool that can be used to improve programs. A program might gather outcomes information from only a very small number of clients; perhaps there are only five children in the program. Or a program may be large but have a very low rate of return of client surveys. It may be tempting to think in experimental terms and discount the value of the data gathered. But while a program hopes to gather data from as many sources as possible, it remains true that useful information can be learned from a relatively small number of clients. Changes to a program will be made based on the judgement of those who run the program, and that judgement will be informed by data gathered.

The following steps, adapted from the *BC Association of Family Resource Programs Provincial Standards of Practice* (Ellis & Barbeau, 2008), provide some guidance in developing outcome measures for a CWWA program. It is important to note that at the time of writing, CWWA programs are not required by funders to measure outcomes for their clients. Some have outcomes measurement in place to comply with accreditation standards, whereas others have chosen to implement them for the internal benefits.

Step 1 – Identify Client Outcomes

- Ask yourself what you are hoping to accomplish in this program. How will you know if you are successful?
- Outcomes must be realistic, specific, and measurable.
- Outcomes describe the ways in which a client will change for the better if your program is successful.
- Most outcome measures describe growth in knowledge, skills, understanding, development, and so on.
- Most CWWA programs will identify four to five outcomes.

Step 2 – Identify Success Indicators

- For each outcome, identify two to three indicators of success.
- Example
  - Outcome: Children experience increased safety in their lives.
  - Indicators:
    - Children can name at least one person outside their family whom they can talk with about the abuse.
    - Children have a plan for how to stay safe if there is violence in their home.
    - Children report feeling safer more often than they did before starting the program.
- Ensure that indicators are precise and measurable, and that they clarify the outcome.

Step 3 – Develop Evaluation Tools

- What type of evaluation tool(s) will gather information in the most appropriate way? Consider resources available within the program (time available, experience with developing evaluation tools), and participant needs (literacy, time, availability).
- Who and how many people should receive the evaluation tool or be involved in the data gathering? Consider the amount of time required for data analysis.
- What questions should be asked? Questions should relate directly to the success indicators.
- Some agencies prefer to use one tool (usually a survey) to gather both satisfaction and outcome data.
- Many surveys include one or two open-ended questions at the end to allow respondents to voice their own comments.

Step 4 – Gather the Data

- Prepare the evaluation tool and test/revise it as necessary prior to using it.
- Administer the evaluation tool: explain it; ensure confidentiality; hand it out or send it out or conduct the interviews.
- Manage the returned data: record the number of evaluations completed and store the data safely.

Step 5 – Analyze the Data

- Count the numerical responses.
- Sort and label the descriptive responses.
- Analyze the numerical and descriptive data. What are the overall patterns and trends of response?
- Interpret the data. What do the sorted and counted data reveal? What can be learned from this about the program and about results for participants?
- Check the data against the original outcomes and success indicators. Ask questions such as: Have we achieved our desired outcomes? If not, why not? Are some met and not others? Why might this be so?

Step 6 – Use the Results

- Some programs prepare a formal evaluation report. At the very least, the evaluation findings should be summarized in a concise, readable manner for general program use.
- Use the results to improve the program. What do the results suggest about what is working or not working? What needs to be changed or not?
- Share the evaluation results with others. This could include the public, other stakeholders, the board, clients, and so on.
- Use the results in public relations about your program, including brochures, website, and speeches.
- Use the results in making presentations to existing and potential funders, policy-makers at varying levels of government, and so on.

Standard D.2.1. CWWA programs have a plan for regular internal evaluation, and this plan includes the evaluation of client outcomes.

Standard D.2.2. CWWA programs collect data and use the data to improve the quality of programs, ensure accountability, and facilitate program decision making and strategic planning.

Standard D.2.3. CWWA programs share the results of quality improvement efforts with all stakeholders.

Section 2
Administrative and Legal Issues

Section 2 examines the administrative and legal issues that can arise in creating and managing a CWWA program. The first part of this section deals with administrative issues, including setting up a client record and managing the security of confidential information. There is a detailed discussion of how to deliver both group and individual services. In the second part of this section, there is a discussion of some legal concerns, such as what kind of information to gather from clients and how to manage it, issues around children's consent for service, how to respond to children's disclosures of abuse, and how to navigate custody issues.

A. Delivering the Program

The information provided in this section draws on a variety of best practice sources, including the *Best Practices Manual for Stopping the Violence Counselling Programs in British Columbia* (McEvoy & Ziegler, 2006), *Records Management Guidelines: Protecting Privacy for Survivors of Violence* (Ruebsaat, 2006), the *Children Who Witness Abuse Counselling Source Book* (BC Yukon Society of Transition Houses, 1996), and the most current versions of major accreditation standards in use in child- and family-serving agencies in British Columbia.

Delivering a high-quality program depends in large part on careful planning. Time should be taken on a regular basis to step back and consider the program, to review the past year, and to make plans to continue improving the program in the coming year. Every program should have a written plan that clearly describes the type of program that is being offered, including the philosophy that guides the program.

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Standard B.1.1. CWWA programs have a written service philosophy that details the type of services provided and the general methods used.

Standard B.1.4. CWWA programs have written program descriptions that include:

a) the program mandate;

b) the intended target group;

c) the hours of operations;

d) how to access the service; and,

e) the length of service.

A.1 Security of Information

CWWA counsellors have a responsibility to protect the physical security of client records, both print and electronic versions. Client records should be protected from unauthorized access, duplication, or theft.

- Electronic information should be password-protected.
- All computers should be protected through up-to-date antivirus software and appropriate firewalls.
- Electronic information should also be protected by a system of regular backups and backups stored away from the program site.
- Voice mail should be password-protected.
- CWWA programs should develop policy regarding faxing and emailing personal information.

Some consultants recommend that the server that holds sensitive information should not be connected to the Internet. Because the technology is advancing so rapidly in this field, counsellors should seek up-to-date advice from an expert and regularly revisit this question.

Many programs do not allow personal information to be transmitted by fax or email because of the danger of sending it to the wrong person. Others allow the use of fax and email when it is necessary. CWWA counsellors can increase the security of fax transmission by taking precautions, such as phoning first to ensure that the intended recipient is the right person and to confirm the fax number. Ask the recipient to phone back to confirm receipt. Consider using codes or abbreviations such as a client number or initials to help protect the identity of the client.

Counsellors should also consider the concerns of some clients if their personal information is linked to a transition house or other anti-violence program. Programs can consider removing their identifying information from the header that is printed on every fax sent.

Standard D.6.1. CWWA programs keep confidential information secure, including paper and electronic information.

Standard D.6.2. CWWA programs train their staff on appropriate procedures to ensure the security of all information.

Standard D.6.3. CWWA programs ensure that electronic information is backed up and secured offsite.

Standard D.6.4. CWWA programs ensure that paper information is locked when not in use.

Standard D.6.5. CWWA programs ensure that all staff and volunteers follow privacy legislation with respect to confidential information.

Standard D.6.6. CWWA programs develop policy regarding the retention and destruction of records

A.2 Screening and Waitlist Management

When a family first approaches the program for service, it is important to discuss with the referring parent how this program operates and whom it is designed to serve. Every CWWA program should have clear screening procedures and eligibility criteria. For example, the program should clearly state any geographical boundaries, age limits, and other restrictions, such as whether it will accept children who are living with the abuser. Because CWWA counsellors are concerned about reducing power imbalances, all policies should be transparent and consistently applied so that the family feels fairly treated. The process of screening a client, accepting her into the program, and beginning to gather information from her is part of the Intake process.

Because CWWA counsellors are concerned about reducing power imbalances, all policies should be transparent and consistently applied so that the family feels fairly treated.

Standard B.2.1. CWWA programs have an Intake process that obtains information needed to plan for service provision.

Standard B.2.2. The Intake process results in a decision regarding the provision of service, and that decision is documented.

Standard B.2.3. When services cannot be provided for any reason, the CWWA program provides the family with alternative resources and facilitates referrals as appropriate.

Screening

At the time of initial screening, the program should gather only enough information to:

- establish whether the family is safe;
- determine eligibility for service;
- determine the child's readiness for a particular type of service (for example, individual or group service); and,
- have a way to contact the family, including determining whether or not the client gives permission to be contacted at home.

Standard B.1.5. CWWA programs have written eligibility criteria that address the ages of participants it will serve and whether the program serves children in crisis.

Waitlist Management

It is an unfortunate truth that there are not enough resources to provide service to everyone who needs it at the time that they need it. Most programs find that they have more prospective clients than they can reasonably accommodate, and use a range of tactics to manage this situation. Families not able to begin the program immediately may be disappointed, confused, and sometimes frustrated by this. A mother may see this as yet another example of her relative lack of power in a relationship.

The most important thing a counsellor can do is design clear, fair procedures, communicate them transparently to the prospective client, and stick with them consistently.

- Most programs adopt a first-come, first-served policy, but other elements may be taken into account, such as priority of service (for example, based on risk) or acceptance of children in order to create an appropriate group (for example, a group for younger children is held in September, while the group for adolescents runs in November).
- The acceptance policy should also include provisions for returning clients. It should explain whether the program prioritizes returning clients or requires them to rejoin the waitlist.
- When explaining the waitlist procedure to a family, counsellors should let them know about other services that may be appropriate both at the same agency and elsewhere in the community, and help connect them to those services.
- If a child will be waiting several weeks or months for service, it is helpful to keep in touch with the child, for example, through periodic phone calls.

A.3 Opening a Client Record

Normally a client record should be opened when the client is ready to begin service, not when the client is on the waitlist for service. The exception to this is when the client is involved in legal proceedings or when the CWWA counsellor has reason to believe that there is a higher than usual risk of liability in relation to a particular client.

The client record should follow a standard format designed by the program that includes timelines for submission of required documents. This helps ensure that the information is completed on time and makes it easier to review the file periodically and to find information when needed.

Typical elements of a client record include:

- intake records and demographic data;
- consent for service and release of information forms;
- documentation that the client was informed of her rights, including the right to complain;
- assessments completed by the agency;
- service plans;
- progress notes documenting ongoing service provision;
- reviews of progress, which may include formal progress reports;
- third-party reports, such as assessments by physicians, psychologists, and so on;
- documentation of any correspondence with third parties;
- documentation of any mandated reporting;
- documentation of any referrals made to other programs or services;
- miscellaneous documents that are directly related to service delivery, such as safety plans, letters of advocacy written on behalf of the client, and so on; and,
- closing summary reports, including any recommendations for future services.

Some counsellors recommend keeping a copy of the guardianship or custody order in the file, if there is one, to help guide the counsellor in interactions with the non-custodial parent; for example, if the father phones the CWWA counsellor requesting details about his child's service. Normally a client record will not include personal materials created by the child, such as journals, letters, or artwork, unless they are required for the provision of service.

Client records should be kept in ink, with corrections made by crossing out the deleted material so that it can still be read.

Progress notes should be completed as soon as possible after the session and should be brief, observational, and relevant. Note the main activities and themes of the session and keep details minimal. CWWA counsellors should ensure that they are recording their observations only, and not their conclusions or speculations except in sections of reports that are appropriately indicated. Avoid including information about people other than the client except as necessary.

A.4 Beginning Service

All CWWA programs should have a comprehensive Intake procedure, beginning with initial screening, that details what information should be gathered, and when, and for what reason. To protect client privacy, programs should collect only information that is necessary to deliver the specific service being requested, and collect that information only at the time it is needed.

Intake information should include:

- basic demographic information that meets the program's needs (examples include age, sex, preferred language, and other elements based on agency policy);
- contact information, including emergency contact, and information regarding how the client prefers to be contacted (for example, does the client wish to receive phone calls or mail from the program?);
- information about other services the child is receiving; and,
- information about cultural or other needs the child has that may have an impact on service delivery.

In many programs the Intake information described here is collected using the same form as the Screening information. Each program should determine the method and the specific information that it requires to initiate service.

At the start of service, the program should be fully explained to the child and to the referring parent. This should include a full discussion of their rights, including the right to complain. When both the child and the referring parent are ready, they can provide their informed consent for the service.

A.5 Assessment

A more complete assessment should be conducted after the counsellor has had an opportunity to build rapport with the child. Each program will create its own policy regarding assessments, but detailed assessments are usually required for individual counselling and not for groups.

The assessment gathers information that focuses on the child's situation, the nature and severity of the abuse witnessed, and the child's response to the abuse.

The assessment helps establish priorities for service and also helps create an estimate of the frequency and format of the counselling. Suderman and Jaffe (1999) write about the difficulty some children have in discussing the abuse they have witnessed, both because they are reluctant to

break the code of secrecy and because it may be very painful for them to bring up these difficult memories. CWWA counsellors should reassure the child that it is all right to talk about the abuse and that the child will help the situation by telling. The authors recommend using multiple assessment perspectives, including extended family members, teachers, child advocates, and others who are involved in supporting the child. (Of course, the counsellor never contacts a third party without the written permission of the family.) The assessment should also include detail about the child's current and past symptoms together with an assessment of the child's environment, and the child's coping skills, strengths, and supports (Suderman & Jaffe, 1999).

Standard B.2.4. After Intake, an appropriate assessment is completed that guides service planning.

A.6 Service Plans: Group and Individual

A properly documented service plan is part of a complete client record. Service plans are normally developed with the participation of the child and the referring parent. Service plans outline the goals of service and the methods that will be used to achieve those goals.

The CWWA counsellor should develop a written service plan for each individual or group served. Service plans as well as significant changes to them should be signed by the referring parent and also by the child as appropriate. The service plan should include information about the services being provided and by whom, service goals, desired outcomes, proposed strategies to address any special needs, and approximate timeframes.

Suderman and Jaffe (1999, p. 27) write that children who have witnessed abuse have a number of needs in common that are usually addressed in the program. These are:

- breaking the silence about the abuse;
- learning about safety planning in case the abuse recurs;
- learning that they were not at fault;
- processing the traumatic memories in a safe, nurturing environment;
- assistance with coping strategies around trauma symptoms, such as irritability, avoidance of situations that remind them of the abuse, anger outbursts, withdrawal, fearfulness, tension, and intrusive memories;
- learning that there are alternatives to violence in relationships, and that violence is not acceptable (e.g., sibling violence, child physical

abuse, child sexual abuse, verbal abuse, dating violence, peer-to-peer violence); and,

- learning about equality in relationships and dispelling myths about woman abuse.

Most CWWA programs provide service in both group and individual formats. Groups are valuable for many children because they:

- allow children to learn that they are not alone in witnessing abuse;
- help children break the silence surrounding their experiences;
- enable children to learn from peers' stories and responses; and,
- are similar to activities and routines the children are used to at school and other venues.

Despite the benefits of the group format, sometimes a group is not the appropriate environment for a child. For example:

- for children who are very young or very vulnerable and cannot be comfortably separated from their mothers;
- for children who are very aggressive or active and cannot participate effectively in a group;
- for children who have been so severely traumatized multiple times that their experiences would seem extreme in the context of other children's experiences;
- for mothers who have had unpleasant experiences in groups in the past or report that their child has had such experiences, and who would prefer individual sessions; and,
- for mothers who worry that their child will be traumatized by the stories other children may share.

There may also be administrative reasons to see children individually. For example:

- It is preferable to run a CWWA group with two co-facilitators, but many counsellors work alone.
- There may not be enough children of a given age group or developmental level to run a group.
- Some children have been referred to another, more appropriate service but are waiting for that service to begin.
- In some programs, no appropriate venue is available for running a group.
- In a small town, privacy concerns may make a group inappropriate.

Finally, some children prefer individual sessions and report that this one-to-one time is an important way for them to feel acknowledged and validated.

Standard B.1.2. CWWA programs provide both group and/or individual counselling when the counsellor finds it appropriate or has the capacity to do so.

Standard B.3.1. A written service plan is established that relates to the assessment.

Standard B.3.2. The service plan guides the delivery of services.

Standard B.3.3. The service plan is developed in consultation with the child and the referring parent.

Standard B.3.4. The service plan is reviewed regularly and revised as required.

Groups

Most CWWA groups for younger children last for 10 sessions, while those for adolescents usually run for 8 sessions. The length of each session varies according to the developmental level of the children. Groups for preschoolers might last 45 minutes to an hour, for example, whereas those for young school-aged children might be between 1 and 1.5 hours, and adolescent groups may be up to 2 hours long. Groups should provide warm, safe environments where children can enjoy themselves and each other while dealing with their experiences.

CWWA counsellors assist children to:

- problem-solve safety issues;
- break the silence by telling others about their experiences and feelings;
- learn to identify and name different forms of abuse;
- learn about non-violent ways to resolve conflict; and,
- learn non-abusive ways to express anger and other feelings.

CWWA counsellors typically group children by age, often within a range of two to three years. Groups usually work best with between six and eight participants. Ideally, the group should be co-facilitated by a male and a female counsellor in order to model appropriate, respectful behaviour between men and women.

There are very few male CWWA counsellors in British Columbia, so male/female co-facilitation is not always possible. To work around this problem, female CWWA counsellors may choose to:

- partner with child care counsellors in the schools;
- partner with male counsellors in other agencies; or,
- utilize practicum students.

Individual Sessions

When individual sessions are chosen, the methods used will vary depending on the child's need and the counsellor's training and experience. Some counsellors provide a space for the child to express past and present experiences, worries, and concerns. Sometimes systematic desensitization and relaxation therapy are taught. Other counsellors prefer play therapy or art therapy.

Individual counselling should include an assessment phase to prepare the child and to help the counsellor plan for the child's needs. The length of the counselling varies, normally lasting between 8 and 15 sessions. Counselling may end when goals have been met, or when family circumstances change, or when the child simply feels ready to stop. The number of sessions for the child will depend on the needs of the child as well as the demands of the service. It is important to remember that the CWWA program is a psychoeducational program, not therapy. When the child's needs fall outside the program mandate or the counsellor's training and experience, that child must be referred to another resource.

Group programming should be the model of choice unless there is a reason to avoid it.

Individual counselling can be a positive venue for children to develop self-esteem and enjoy programming that is tailored specifically to their needs. However, most children do benefit from a group. Group programming should be the model of choice unless there is a reason to avoid it.

A.7 Closure and Follow-up

The conclusion of the CWWA program should be planned from the time of Intake. From the beginning of service, the counsellor, the child, and the referring parent should have a sense of how long the service will last and what goals will be accomplished. CWWA counsellors can remind children along the way as intermediate goals are reached so that the conclusion does not feel abrupt. Planning for the conclusion of counselling can also be incorporated into service reviews. Of course, the counsellor must also consider the possibility of an unanticipated ending.

The conclusion of counselling and the final report will include information about recommended future services and options for future CWWA assistance. Often when children leave the CWWA program they continue working with another professional, such as a school counsellor. The CWWA counsellor should discuss these options with the parent in addition to writing them into the closing report.

Standard B.4.1. Planning for closure begins at Intake.

Standard B.4.2. Both the child and the referring parent are involved in planning for closure.

Standard B.4.3. The CWWA counsellor prepares for unanticipated endings.

Standard B.4.4. The CWWA counsellor prepares a closing report that includes recommendations for further services.

A.8 Other Administrative Issues

This section describes issues that are under the control of the agency that operates the CWWA program but that may not be the responsibility of the CWWA counsellor. The BC Yukon Society of Transition Houses encourages agencies to implement the best practices described here.

Emergency Planning

All organizations should have comprehensive written policies and procedures that deal with emergency preparedness. The purpose of the emergency plan is to prepare agency employees to respond to an emergency effectively, efficiently, and without confusion. A good emergency plan minimizes the potential for trauma and injury to both clients and agency personnel. The plan should include information for responding to:

- fire;
- earthquake, flooding, and other natural disasters;
- medical emergencies;
- hazardous material spills;
- utility damage or outage; and,
- threats to the organization, such as a bomb threat.

All employees should be trained on the emergency plan and it should be reviewed annually and updated as necessary.

Standard C.2.1. CWWA programs have written emergency plans that include evacuation procedures.

Agencies should also have policy regarding first aid training for their staff, including how many trained staff are required at a given site and whether or not the agency pays for the training.

Standard C.2.7. CWWA programs have written procedures regarding first aid training for their staff.

Agencies should also have written procedures regarding critical incident reporting, including who is notified of a critical incident (the Executive Director? the Board of Directors? the child's parents?). Procedures regarding critical incident reporting should provide for regular review of critical incidents, such as quarterly review by an agency committee.

Standard C.2.8. CWWA programs have written procedures regarding critical incident reporting.

Safety and Hygiene

Every agency should have written policy that describes how it maintains safe and hygienic program and work environments. This policy should include regular inspections of all equipment, furniture, and toys for safety as well as cleanliness. There should be procedures for servicing equipment as required and routines for cleaning and sanitizing as necessary.

Standard C.2.2. CWWA programs have written policy that addresses universal precautions and infection control.

Standard C.2.3. CWWA programs regularly inspect the service and administrative environments, including all equipment.

Standard C.2.4. CWWA programs have written procedures regarding the safety and cleanliness of toys and play equipment.

Standard C.2.5. CWWA programs have written procedures that govern the handling and storage of hazardous materials.

Standard C.2.9. CWWA programs have written procedures regarding food preparation and food safety, and these procedures include any training required of staff.

Transportation

Any agency that allows or requires employees to transport clients, either in agency vehicles or in their own personal vehicles, should have policy governing:

- licensing and safety inspections for vehicles;
- licensing of the driver, including adequate insurance coverage; and,
- use of appropriate child restraint systems when transporting children.

New infant and child seat regulations went into effect in British Columbia in July 2008. They are available on the website of the Insurance Corporation of British Columbia (ICBC) at http://www.icbc.com.

Standard C.2.6. CWWA programs have written procedures that govern transportation of clients in agency vehicles and in staff vehicles. These procedures include requirements for appropriate licensing and insurance.

Program Planning

All CWWA programs should make time to plan for their service delivery. Most programs choose to do this once a year. This time is spent reviewing activities and their outcomes from the past year and making plans to continue to improve service delivery in the year to come. Budget considerations and program evaluation are usually part of this planning.

Standard D.4.1. CWWA programs devote sufficient resources to planning and administration to ensure that their programs are appropriately supported.

Standard D.4.2. CWWA programs develop a planning cycle (typically annually) that includes:

a) appropriate program goals and objectives;

b) a method of monitoring the plan; and,

c) evaluation of program goals and objectives.

Standard D.4.3. CWWA programs have a written budget that is developed according to the policies of the parent agency.

Standard A.3.8. CWWA programs that raise funds by individual solicitation from the general public do so following written procedures that ensure ethical, fiscally responsible practice.

Human Resources

Agencies should have comprehensive human resources policies that ensure consistent and equitable treatment for all employees, volunteers, and students who work in the agency. These policies should include hiring practices, maintaining a complete and up-to-date personnel record, and conducting regular and useful performance evaluations.

Standard D.5.4. CWWA programs have human resources policies and procedures that include job descriptions for all staff and volunteers.

Standard D.5.7. CWWA programs maintain a personnel record for every staff person and volunteer.

Standard D.5.8. CWWA programs have human resources policies that provide for annual performance reviews for all staff.

Standard D.5.9. Performance reviews assess job performance based on measurable criteria and emphasize self-development and professional growth.

Standard D.5.10. Staff have an opportunity to review their performance evaluation with the person evaluating them and provide written comments, to sign their performance evaluation, and to receive a copy.

Standard D.5.11. CWWA programs establish and follow a plan for volunteer recruitment, orientation, initial training, retention, supervision, and ongoing professional development.

Standard D.5.12. When CWWA programs accept practicum students into their programs, there is a signed agreement with the educational institution.

B. Legal Issues in Service Delivery

B.1 Records Management

All service-providing programs maintain records of some kind. In the anti-violence field, there has been much discussion regarding the information that should be included in records and the best ways to maintain their security. Because of the risk of client records being subpoenaed by advocates for the abuser, many workers in this field are reluctant to gather and store sensitive personal information. On the other hand, there are compelling reasons to keep accurate and up-to-date client records, ranging from best possible planning and provision of service, to accountability for services, to helping mitigate the risk of false accusations against a worker.

Recordkeeping and Planning and Providing Services

Consistent recordkeeping that follows a standard procedure helps a CWWA counsellor develop habits related to, for example, Intake procedures, what to keep in session notes, how and when to write reports, and the best ways to maintain all documentation of the service. A complete client record should provide information that will help with safety planning, with locating and accessing related services, and with any kind of client advocacy that is required. Regular reviews of the client record will help a counsellor evaluate the effectiveness of the service for a particular child, and will assist in the supervision process. Finally, a complete record helps ensure consistent service provision in the event that the client is transferred to another staff member.

Recordkeeping and Accountability

Client records should contain enough information to satisfy the administrative requirements of the agency, such as providing measures of service delivery outputs, demographic data, and other administrative information.

Clear policy regarding recordkeeping is important to ensure that only required information is recorded and that all personal information is maintained in compliance with privacy legislation. Agency policy should detail procedures for clients to review their record; this is particularly important in the case of child clients who may want to review their record years later, when they are adults.

Clear policy regarding recordkeeping is important to ensure that only required information is recorded and that all personal information is maintained in compliance with privacy legislation.

Complete, up-to-date records also permit accountability reviews by internal and external surveyors as required by agency policy or accreditation standards.

Recordkeeping and Liability

It is important to keep a complete record to show that:

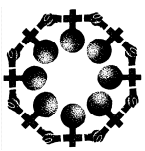
- the client provided informed consent;
- the client consented in writing to the release of any information to third parties (except as required by law); and,
- the client took part in planning for services.

Proper documentation of these events protects the CWWA counsellor and the agency against allegations that these steps were not followed. Documentation of the counsellor's activities with the client can also help in cases where the counsellor is alleged to have acted negligently or improperly. This is particularly important in situations that involve mandated reporting of child abuse or neglect under the *Child, Family and Community Service Act.* Finally, a complete record can assist agency management and board members in the event that they are faced with potential legal liability for the actions of their staff.

Privacy of Information

Along with their commitment to complete and up-to-date recordkeeping, CWWA counsellors must bear in mind the responsibility they have to record only the information they need and to safeguard that information to protect both the privacy and the safety of their client.

Counsellors should remember that they may be required to release a client record to a child protection authority or to the lawyer representing either the abusive or non-abusive parent. This includes both a paper record and any electronic record maintained on a computer.



CWWA counsellors should be prepared to answer questions regarding information that is recorded in a client record as well as information that they have decided not to include.

CWWA counsellors have a responsibility to protect the identity of their clients. This means not disclosing the identity of a client to anyone unless that person has the client's permission (and the permission of the child's parent, as appropriate) or is a member of your staff who is providing service to the client. This includes non-disclosure to supervisory staff, administrative support, board members, and volunteers except as required to provide service.

Standard A.3.4. CWWA programs have a confidentiality policy that is communicated to clients, including the limits thereof.

Standard A.3.5. CWWA programs follow written procedures regarding the release of confidential information. Except where required by law, confidential information is not released without the written consent of the client or parent. CWWA programs have a standard form that is used to secure client permission for release of information.

Standard A.3.7. CWWA programs that participate in or permit research involving clients have written procedures that:

a) govern the review and acceptance of research proposals; and,

b) safeguard the privacy and the voluntariness of clients in the research.

B.2 Consent

CWWA programs are voluntary, meaning that all clients must consent to take part in the service. To consent to service, a client must (a) be fully informed regarding what he or she is consenting to, and (b) have the legal capacity to consent. CWWA counsellors are required to ensure that both of these elements are present.

Informed Consent

CWWA counsellors have a duty to ensure that both the child and the referring parent understand enough about the program to provide fully informed consent.

McEvoy and Ziegler (2006) suggest that a feminist counsellor should:

- describe herself, her training, and her experience;
- explain the mandate, services, and constraints of the program;
- explain the hours, expectations, cancellation policy, out-of-session guidelines, and so on;
- explain what might happen if the child misses several sessions;

- explain how long the program is expected to last;
- explain the confidentiality policy, including the limits of confidentiality, specifically the duty to report child protection concerns or concerns that a client may harm herself or someone else, and the requirement to respond to a subpoena;
- describe the kind of information she might share with her supervisor or others in the agency;
- explain what records will be kept and for what purpose;
- explain the complaint policy and specifically tell the client whom they can speak with if they wish to make a complaint; and,
- if the family is also involved with the Ministry of Children and Family Development, explain her relationship with the Ministry social worker and what kind of information or reports might be shared.

Legal Requirements

In order to consent to services, clients must have legal capacity. In *Records Management Guidelines: Protecting Privacy for Survivors of Violence,* Ruebsaat (2006) notes that according to the *Age of Majority Act,* an individual who is 19 years or older can make decisions affecting his or her welfare. When working with children, a CWWA counsellor normally obtains the (legal) consent of the non-abusive parent.[1]

According to the *Infants Act* and case law, an individual under the age of 19 (described in the law as an "infant") is also capable of consenting to health care if the service provider:

- is satisfied that the infant understands the nature and consequences and the benefits and risks of a particular plan of care; and,
- has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests. (Ruebsaat, 2006, p. 71)

The counsellor should also ensure that the consent is voluntary and not the result of undue pressure.

Technically, Ruebsaat says, anyone under 19, even someone as young as 10 years of age, can consent to treatment or health care (including support services or counselling), provided they understand the nature and consequences of treatment and the associated benefits and risks, and provided the care is in their best interests. In practice, however, 12 years of age is often used by public agencies and service providers as a benchmark to help determine whether a child has the legal capacity to consent

[1] Note that while the parent provides legal consent for service, it is still ethically important for the child to provide informed consent as described above.

(Ruebsaat, 2006, pp. 71-72). The question of consent by a minor is raised again later in this manual, in Section 2.B.4, "Custody Issues," on page 78.

For more detail on the legal issues surrounding consent to service and consent to release information in British Columbia, see *Records Management Guidelines: Protecting Privacy for Survivors of Violence* (Ruebsaat, 2006), pages 71-90.

B.3 Disclosures and Reports

Reporting Suspected Child Abuse or Neglect

In British Columbia, under the *Child, Family and Community Service Act,* anyone who "has reason to believe a child needs protection" must "promptly" make a report to a child protection authority. Each program will have its own procedures for making this report, and most require consultation, before or afterwards, with a supervisor. In the past, some CWWA counsellors worried that child protection authorities would blame the mother or treat her harshly if a report was made. A recent publication by the Ministry of Children and Family Development outlines best practices for coordination of child protection and agencies that work with abused women and their children. This document is available for download from http://www.mcf.gov.bc.ca/child_protection/pdf/cp_vaw_best_practice_2004-07-22.pdf.

It is important to remember that the CWWA counsellor is not legally mandated to determine whether a child was abused or neglected. Reports must be made based on a counsellor's concerns, and a Ministry worker will make the decision regarding whether to investigate.

Child Disclosures

Children may disclose to their counsellor that they are the victims of abuse or neglect, or they may disclose a plan to harm themselves or someone else. In these cases the counsellor will make the report described above, as appropriate. Children may also tell the counsellor that their mother is being hurt. According to the MCFD best practices document referenced above, exposure to parental violence or abuse is not in and of itself considered a child protection concern (for more details, see Ministry of Children and Family Development, 2004, Appendix 4).

Cunningham and Baker (2007) remind counsellors to take a moment when receiving a disclosure of any kind from a child to recognize the importance of this from the child's perspective. They ask counsellors to:

- appreciate how difficult it was to reveal a family secret;
- assume that the child has decided that help is needed; and,
- understand the risk to the child if the counsellor does not respond appropriately.

Counsellors should not pressure the child to talk. The counsellor's role is to support the child, not to gather evidence or conduct an investigation. Note that:

- The counsellor should allow the child to tell the story in her own words, using active listening. It is helpful to acknowledge the child's feelings and reassure the child that she has done the right thing in making the disclosure.
- The counsellor must not promise to keep this a secret, but instead explain to the child that it may be necessary to tell this to someone whose job it is to help children be safe.
- Counsellors should remember not to criticize or speak negatively about the abusive parent.
- Counsellors should remember that a child who does not receive the hoped-for reaction may not disclose again. (Cunningham & Baker, 2007)

Sometimes a child discloses abuse perpetrated by the mother. Counsellors recognize their moral and legal responsibility to report the disclosure and at the same time their responsibility to support the mother through this process. The specific protocols for making such a report will be determined within each agency. Things a counsellor should consider when creating this protocol include:

- the importance of fully and transparently informing both children and their parents about the legal mandate to report abuse or neglect of children at the beginning of the program;
- the importance of maintaining the safety of the child as our first priority;
- the importance of working supportively and compassionately with the mother throughout the process; and,
- the potential liability of the agency if a disclosure is not handled appropriately.

In most cases, best practices dictate that when a child discloses abuse, the CWWA counsellor makes the report without informing the abuser ahead of time. The reasons for this include the risk of the abuser retaliating against the child and the risk of the abuser encouraging the child to change her story. We have a responsibility as feminists to acknowledge the potential strain to the relationship between the mother and the counsellor in this situation. Counsellors should consult with a supervisor or experienced peer whenever concerns arise regarding how to handle a disclosure.

B.4 Custody Issues

If the abused parent decides to leave the relationship, the children may become involved in a dispute over custody or visitation. Often the abuser sues for custody of the children as a way of punishing the victim and retaining control through the children (Agar, 2004). This can lead to arguments concerning the veracity of the abuse allegations, the mother's and the father's ability to parent, and the best interests of the children (Suderman & Jaffe, 1999). Often there is pressure on the parents to reduce hostilities and "set aside" past conflicts (Agar, 2004). CWWA counsellors in British Columbia have indicated that children may be forced to visit with abusers against their will, exposing the children to ongoing psychological abuse. Too often, the non-offending parent is made responsible for enacting all of the necessary changes to stabilize the child's life.

Agar (2004) reports on a 2002 study suggesting that in some cases, in the context of strong protection of their physical and emotional safety, contact with the non-custodial battering parent may enhance children's recovery. Ongoing safe contact may enable children to maintain the positive aspects of the father/child relationship. However, she notes that care must be taken to ensure that contact with the father does not undermine the children's relationship with their mother or have a negative impact on their behaviour.

Joint Custody/Guardianship

Over the years that the CWWA program has been operating in British Columbia, counsellors have seen a shift in the population of children they serve away from sole custody of the non-offending parent towards shared custody by both, even in families where abuse has been reported. This raises questions about consent for service and how to work with children who are spending increasing amounts of time with their fathers who may or may not be continuing to engage in abuse within their families.

The CWWA program was originally designed for children who are no longer in crisis and who are not living with their abusive parent. Some of the activities and goals of the program include teaching children to express their feelings and assert themselves when they are not feeling safe. The program designers felt that it might not be safe to encourage children to use these strategies while they were living with an abusive parent. Over the years, some CWWA counsellors have refused to accept children into their programs when they felt that the program might undermine the child's safety. In more recent years, CWWA counsellors have begun to question whether refusing service is the most appropriate response to the situation. Other options might include running a separate group for these children if the numbers allow, holding individual sessions, or adapting the group to ensure everyone's safety.

CWWA counsellors should consult with peers and supervisors for help in making decisions about how to best serve children who have close contact with the abusive parent.

Children as Witnesses in Court

Sometimes children are called to testify in court regarding the violence they have witnessed. Suderman and Jaffe (1999) report on this and note that the experience can be difficult and anxiety-provoking because:

- courtrooms are formal and adult-oriented and may be daunting for a child;
- the language and procedures of a courtroom may be difficult for children to understand;
- a child who testifies in court is being asked to reveal family secrets that may be harmful to the abusive parent; and,
- the testimony may have long-term effects for the child/parent relationship.

Agar (2004) reports that there has been increasing sensitivity to the difficulties that children face in the courtroom, and this has led to the development of support services designed to prepare children for the experience of testifying. Among them is the Child Witness Project, a program of the London Family Court Clinic. The project created a "Bill of Rights for Child Witnesses," reproduced below. For a complete description of their program, see *Child Witnesses in Canada: Where We've Been, Where We're Going,* which can be downloaded from http://www.lfcc.on.ca/Cwp_2002.pdf.

The "Bill of Rights" for Child Witnesses

1. Every child has the right to court preparation tailored to his or her individual needs.
2. Every child should have easy access to testimonial aids.
3. Every child has the right to be treated with respect during his or her involvement in the criminal justice system.
4. Every child has the right to feel safe and protected in a courtroom.
5. A child should be questioned by adults who adapt their communication to his or her developmental age and linguistic ability.
6. A child should have the opportunity to meet with the Crown well in advance of the court date.
7. A child and his or her family should be advised of all court dates, adjournments, and guilty pleas as soon as that information becomes available.
8. A child's special needs and vulnerabilities should be addressed.

9. A child-friendly courtroom, or routine accommodations, should be made available for every child who is called upon to testify.
10. Expedited case should be the norm when children are witnesses.

Section 3
Best Practice Standards

Section 3 is a summary of the Best Practice Standards that flow from the discussion in the two previous sections. CWWA counsellors should consider employing these guidelines when developing or revising their programs. The BC Yukon Society of Transition Houses endorses these as Best Practice Standards for the field and hopes that they will guide and assist CWWA counsellors in delivering their programs.

At this time, the standards are not mandatory but BCYSTH considers them optimal and encourages all programs to implement them as fully as possible. Throughout this section, there are also examples attached to many of the standards. The examples are intended to help counsellors understand the intent of the standard and to offer one way of meeting the standard. It is understood that each program is unique and will develop its own ways to implement the standards.

The standards are divided into four parts that address:

- Client Rights and Ethical Practice;
- Program Planning and Delivery;
- Design and Function of the Environment; and,
- Administration of the Program.

The standards related to governance and administration of the program may be the responsibility of the agency within which the CWWA program is housed. These standards might not be ones that the CWWA counsellor is able to implement without the agreement of the larger agency. They are included here because they are fundamental to supporting a CWWA program. BCYSTH encourages programs and agencies to adopt all of the standards described here.

BCYSTH encourages programs and agencies to adopt all of the standards described here.

A. Client Rights and Ethical Practice

A.1 Participant-Focused

A.1.1 CWWA programs are rooted in feminist principles.

For a description of the history of CWWA programs and their feminist roots, see Section 1.A.1, "A Feminist Perspective," on page 11.

A.1.2 CWWA programs are child-focused.

While CWWA programs work alongside the referring parent, the focus of the program is the child's experience of violence in the home, and activities are geared towards helping the child resolve those experiences.

A.1.3 CWWA programs are strength-based and individualized.

CWWA counsellors focus on discovering and supporting a child's strengths rather than "fixing" concerns. All activities are planned with the individual children in mind and groups are tailored to the needs of the particular children attending.

A.2 Stakeholder Input

CWWA programs gather feedback from all stakeholder groups and use it to improve service delivery and the service environment.

A.2.1 CWWA programs identify stakeholder groups and make plans to include them in all areas of planning and providing service.

Typical internal stakeholder groups include clients (children and their parents), staff, and volunteers, including board members. External stakeholder groups may include funders, referring agencies, and other community partners. Each program should create its own list of stakeholder groups and work towards including as diverse a cross-section as possible.

A.2.2 CWWA programs gather stakeholder input on an ongoing basis using a variety of mechanisms.

For example, many programs use surveys that are distributed to stakeholder groups once or twice per year. These surveys ask questions that are tailored to the needs of the specific program and community.

A.2.3 CWWA programs analyze stakeholder input on a regular schedule (such as annually) and use this information to plan.

Many organizations have a mechanism, such as a specific committee or task group that focuses on gathering and summarizing input from stakeholder groups. It is important for CWWA programs to create a process that meets its unique needs. Consider how the information may be used, such as in strategic planning, program planning, performance improvement, and so on.

A.3 Ethical Conduct

A.3.1 CWWA counsellors maintain appropriate professional boundaries in their relationships with both children and their parents.

For more details on professional expectations, see Section 1.A.4, "Professionalism," on page 18.

A.3.2 CWWA programs maintain a written summary of client rights and responsibilities that is communicated to clients in a manner that is meaningful to them. A written summary of client rights and responsibilities is posted in the program area or reception area.

A.3.3 CWWA programs have a formal client complaint process that is communicated to children and their parents in a manner that is meaningful to them.

A.3.4 CWWA programs have a confidentiality policy that is communicated to clients, including the limits thereof.

For more information on confidentiality in the context of this program, see Section 2.B.2, "Consent," on page 74 and Section 2.B.3, "Disclosures and Reports," on page 76.

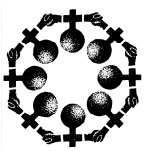
A.3.5 CWWA programs follow written procedures regarding the release of confidential information. Except where required by law, confidential information is not released without the written consent of the client or parent. CWWA programs have a standard form that is used to secure client permission for release of information.

A.3.6 CWWA programs develop and follow a Code of Conduct for staff and volunteers that:

a) addresses both confidentiality and conflict of interest;

b) includes procedures to deal with violations; and,

c) provides for educating staff and volunteers regarding the Code of Conduct.



A.3.7 CWWA programs that participate in or permit research involving clients have written procedures that:

a) govern the review and acceptance of research proposals; and,

b) safeguard the privacy and the voluntariness of clients in the research.

A.3.8 CWWA programs that raise funds by individual solicitation from the general public do so following written procedures that ensure ethical, fiscally responsible practice.

A.4 Value in Diversity

A.4.1 CWWA programs have a written plan that enables staff and volunteers to promote an environment valuing diversity in all its forms.

This plan describes practices that encourage tolerance, honesty, respect, and openness. Responding to diversity will mean something different in each program. This standard requires each program to take time to consider which populations are currently being served, which populations in the community may be underserved, and the best methods for reaching these populations.

For more information on diversity in this context, see Section 1.A.5, "Diversity Issues," on page 20.

A.4.2 CWWA programs take account of diverse groups when planning programs, and develop specific strategies to reach out to and engage diverse groups.

A.4.3 To the extent possible, CWWA programs offer programs and services in languages that reflect those preferred by the clients.

A.4.4 CWWA programs utilize resources and decor that reflect cultural diversity respectfully.

B. Program Planning and Delivery

B.1 Program Planning

B.1.1 CWWA programs have a written service philosophy that details the type of services provided and the general methods used.

The service philosophy will typically describe services as being feminist in orientation, using psychoeducational methods, and being community-based. For more information, see Section 1.A, "Working with Children from a CWWA Perspective," on page 11.

B.1.2 CWWA programs provide both group and/or individual counselling when the counsellor finds it appropriate or has the capacity to do so.

For more detail on these program modes, see Section 2.A.6, "Service Plans: Group and Individual," on page 65.

B.1.3 CWWA programs provide supportive services to the non-abusive parent.

Each program will decide the type of support that it is able to provide. Some programs will also choose to work with parents who have engaged in abuse in the past. For more detail on working with parents, see Section 1.C.2, "Working with Parents and Other Caregivers," on page 42.

B.1.4 CWWA programs have written program descriptions that include:

a) the program mandate;

b) the intended target group;

c) the hours of operation;

d) how to access the service; and,

e) the length of service.

B.1.5 CWWA programs have written eligibility criteria that address the ages of participants it will serve and whether the program serves children in crisis.

B.2 Intake and Assessment

B.2.1 CWWA programs have an Intake process that obtains information needed to plan for service provision.

B.2.2 The Intake process results in a decision regarding the provision of service, and that decision is documented.

B.2.3 When services cannot be provided for any reason, the CWWA program provides the family with alternative resources and facilitates referrals as appropriate.

B.2.4 After Intake, an appropriate assessment is completed that guides service planning.

For more information on assessments, see Section 2.A.5, "Assessment," on page 64.

B.3 Service Planning and Provision

B.3.1 A written service plan is established that relates to the assessment.

The service planning process will look different in each CWWA program. A service plan for individual services will be more detailed and will include more specific goals than a service plan for group services. For more information on service planning, see Section 2.A.6, "Service Plans: Group and Individual," on page 65.

B.3.2 The service plan guides the delivery of services.

B.3.3 The service plan is developed in consultation with the child and the referring parent.

B.3.4 The service plan is reviewed regularly and revised as required.

B.4 Closure and Follow-up Planning

B.4.1 Planning for closure begins at Intake.

This means that throughout the service, the counsellor, the child, and the referring parent have a sense of how long it is going to last, what the intended goals are, and how they will know when they have achieved those goals. There may also be a sense of what the next steps will be for the child in terms of healing; for example, what other resources or services might be helpful.

B.4.2 Both the child and the referring parent are involved in planning for closure.

B.4.3 The CWWA counsellor prepares for unanticipated endings.

B.4.4 The CWWA counsellor prepares a closing report that includes recommendations for further services.

C. Design and Function of the Environment

C.1 Accessibility and Safety

C.1.1 The interior of a CWWA program is accessible and inviting to clients and their families.

The intention of this standard is to encourage CWWA programs to plan for accessibility whenever possible. It is understood that limited resources often restrict the environment in which a program is provided. CWWA programs should creatively address accessibility issues whenever possible, and take these concerns into account whenever planning to move or renovate.

C.1.2 The location of a CWWA program is planned in consideration of accessibility for participants.

Accessibility includes the interior (free from physical barriers, accessible washroom facilities, and so on) as well as the location (accessible to public transit, available parking, and so on).

C.1.3 CWWA programs are provided in an environment that is comfortable for children.

For example, furniture and materials are appropriate for children, the décor is suitable, and so on.

C.1.4 When planning CWWA programs, consideration is given to safety issues.

Examples include windows into the counselling room, panic buttons, and so on.

C.1.5 CWWA programs have written policies addressing safety for those working alone or in isolation.

C.2 Safe, Hygienic Environment

C.2.1 CWWA programs have written emergency plans that include evacuation procedures.

C.2.2 CWWA programs have written policy that addresses universal precautions and infection control.

C.2.3 CWWA programs regularly inspect the service and administrative environments, including all equipment.

C.2.4 CWWA programs have written procedures regarding the safety and cleanliness of toys and play equipment.

C.2.5 CWWA programs have written procedures that govern the handling and storage of hazardous materials.

C.2.6 CWWA programs have written procedures that govern transportation of clients in agency vehicles and in staff vehicles. These procedures include requirements for appropriate licensing and insurance.

C.2.7 CWWA programs have written procedures regarding first aid training for their staff.

C.2.8 CWWA programs have written procedures regarding critical incident reporting.

C.2.9 CWWA programs have written procedures regarding food preparation and food safety, and these procedures include any training required of staff.

D. Administration of the Program

D.1 Training, Supervision, and Support

D.1.1 CWWA programs provide regular, appropriate supervision for the counsellor, and counsellors meet regularly with supervisors.

Supervision may include group consultation and one-to-one supervision as appropriate. Clinical supervision is not always provided face to face, but counsellors nevertheless should ensure that they take advantage of it. For more information on the nature and importance of supervision, see Section 1.C.4, "Support for CWWA Counsellors > Supervision," on page 49.

D.1.2 CWWA caseloads are jointly established by the counsellors and the Program Coordinator.

D.1.3 CWWA programs orient new staff and provide ongoing training and professional development opportunities for all staff.

For more information on training for counsellors, see Section 1.C.4, "Support for CWWA Counsellors > Professional Development," on page 50.

D.1.4 CWWA programs encourage new staff to attend all three modules of CWWA training provided by BCYSTH.

D.2 Program Evaluation

D.2.1 CWWA programs have a plan for regular internal evaluation, and this plan includes the evaluation of client outcomes.

For more information on program evaluation, see Section 1.C.5, "Program Evaluation," on page 52.

D.2.2 CWWA programs collect data and use the data to improve the quality of programs, ensure accountability, and facilitate program decision making and strategic planning.

D.2.3 CWWA programs share the results of quality improvement efforts with all stakeholders.

D.3 Networking and Community Involvement

D.3.1 CWWA programs collaborate with community members to identify gaps and redundancies in community service delivery to the shared population they serve and to advocate on issues of mutual concern.

For more information on networking and collaboration, see Section 1.C.1, "Working with Other Professionals," on page 40.

D.3.2 CWWA programs conduct ongoing community outreach and education to promote services provided and the needs of the service population.

D.4 Administration of the Program

D.4.1 CWWA programs devote sufficient resources to planning and administration to ensure that their programs are appropriately supported.

D.4.2 CWWA programs develop a planning cycle (typically annually) that includes:

a) appropriate program goals and objectives;

b) a method of monitoring the plan; and,

c) evaluation of program goals and objectives.

D.4.3 CWWA programs have a written budget that is developed according to the policies of the parent agency.

The procedures for creating and administering a budget will differ from program to program. This standard requires that a consistent procedure be in place to guide the program.

D.5 Human Resources

D.5.1 CWWA programs do not discriminate against any persons or categories of persons.

D.5.2 CWWA programs recruit and hire staff and volunteers according to established procedures.

D.5.3 CWWA programs have written procedures that require background checks, including criminal records checks, for all staff and all volunteers who work with clients.

D.5.4 CWWA programs have human resources policies and procedures that include job descriptions for all staff and volunteers.

D.5.5 CWWA programs hire staff who are knowledgeable about the community and the needs of the families who participate.

D.5.6 CWWA programs hire staff who have an appropriate combination of post-secondary education in a relevant field and professional and life experiences.

Each program will decide what that appropriate combination is, based on the service population, the location of the program, and the range of applicants available.

D.5.7 CWWA programs maintain a personnel record for every staff person and volunteer.

D.5.8 CWWA programs have human resources policies that provide for annual performance reviews for all staff.

D.5.9 Performance reviews assess job performance based on measurable criteria and emphasize self-development and professional growth.

D.5.10 Staff have an opportunity to review their performance evaluation with the person evaluating them and provide written comments, to sign their performance evaluation, and to receive a copy.

D.5.11 CWWA programs establish and follow a plan for volunteer recruitment, orientation, initial training, retention, supervision, and ongoing professional development.

D.5.12 When CWWA programs accept practicum students into their programs, there is a signed agreement with the educational institution.

D.6 Information Management

For more information regarding information management and security, see Section 2.B.1, "Records Management," on page 72.

D.6.1 CWWA programs keep confidential information secure, including paper and electronic information.

D.6.2 CWWA programs train their staff on appropriate procedures to ensure the security of all information.

D.6.3 CWWA programs ensure that electronic information is backed up and secured offsite.

D.6.4 CWWA programs ensure that paper information is locked when not in use.

D.6.5 CWWA programs ensure that all staff and volunteers follow privacy legislation with respect to confidential information.

D.6.6 CWWA programs develop policy regarding the retention and destruction of records.

Section 4
References and Further Reading

A. References

Agar, S. (2004). *Interventions for children who witness intimate partner violence: A literature review*. Vancouver: BC Institute against Family Violence. Retrieved January 2, 2009, from http://www.bcifv.org/pubs/Agar_Lit_Review_2004.pdf.

Baker, L. (2005). *Principles of working with children exposed to domestic violence*. Retrieved November 13, 2008, from http://www.lfcc.on.ca/Baker_Principles_Children.pdf.

Baker, L., & Cunningham, A. (2005a). *Learning to listen, learning to help: Understanding woman abuse and its effects on children.* Retrieved November 13, 2008, from http://www.lfcc.on.ca/learning_to_listen.pdf.

Baker, L., & Cunningham, A. (2005b). *Through a new lens: Seeing woman abuse in the life of a young child: A learning module for early childhood education programs*. Retrieved November 13, 2008, from http://www.lfcc.on.ca/New_lens_module.pdf.

Baker, L., & Jaffe, P. G. (n.d.). *Woman abuse affects our children: An educator's guide*. Retrieved November 13, 2008, from http://www.lfcc.on.ca/Educators_Guide_to_Woman_Abuse.pdf.

Baker, L., Jaffe, P. G., & Ashbourne, L. (2002). *Children exposed to domestic violence: An early childhood educator's handbook to increase understanding and improve community responses.* Retrieved November 13, 2008, from http://www.lfcc.on.ca/ece-us.PDF.

BC Coroner's Service. (2008). *Child and youth suicide in BC: Summary of a five year retrospective review*. Retrieved January 24, 2009, from http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/cdru-suicidereportsummary.pdf.

BC Yukon Society of Transition Houses. (1996). *Children who witness abuse counselling source book*. Vancouver: BCYSTH.

BC Yukon Society of Transition Houses. (2007). *Violence is preventable: Building partnerships between Children Who Witness Abuse programs and BC schools* (2nd ed.). Vancouver: BCYSTH.

Berger, K. S. (2008). *The developing person through the lifespan.* New York: Worth.

Berry, R. (2005). Review of rebuilding attachments with traumatized children: Healing from losses, violence, abuse and neglect. *Emotional & Behavioural Difficulties, 10(2)*, 163-164.

Braun, J. (2001). *Child custody and access in the context of family violence: An overview of issues*. Vancouver: BC Institute against Family Violence. Retrieved January 2, 2009, from http://www.bcifv.org/pubs/Child%20Custody%20and%20Access%202001.pdf.

Child Witness Project. (2002). *Child witnesses in Canada: Where we've been, where we're going*. Retrieved December 29, 2008, from http://www.lfcc.on.ca/Cwp_2002.pdf.

Crooks, C., Chiodo, D., & Thomas, D. (2009). *Engaging and empowering Aboriginal youth: A toolkit for service providers.* Victoria, BC: Trafford.

Cunningham, A. (2005a). *Good practice models of working with mothers.* Retrieved November 13, 2008, from http://www.lfcc.on.ca/Cunningham_Good_Practice_Mothers.pdf.

Cunningham, A. (2005b). *Principles of working with mothers.* Retrieved November 13, 2008, from http://www.lfcc.on.ca/Cunningham_Principles_Mothers.pdf.

Cunningham A., & Baker L. (2004). *What about me? Seeking to understand a child's view of violence in the family.* Retrieved November 26, 2008, from http://www.lfcc.on.ca/what_about_me.pdf.

Cunningham, A., & Baker, L. (2007). *Little eyes, little ears: How violence against a mother shapes children as they grow.* Retrieved November 13, 2008, from http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/fem-2007-LELE_e.pdf.

Dauvergne, M., & Johnson, H. (2001). *Children witnessing family violence.* Ottawa: Canadian Centre for Justice Statistics, Statistics Canada.

Dumont-Smith, C. (1995). Aboriginal Canadian children who witness and live with violence. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 275-283). London: Sage.

Ellis, D., & Barbeau, E. (2008). *BC Association of Family Resource Programs provincial standards of practice.* Vancouver: BC Association of Family Resource Programs.

Gewirtz, A., & Edleson, J. L. (2004). *Young children's exposure to adult domestic violence: Toward a developmental risk and resilience framework for research and intervention.* Retrieved November 26, 2008, from http://www.nccev.org/pdfs/series_paper6.pdf.

Goldberg, S. (2000). *Attachment and development.* London: Arnold.

Graham-Bermann, S. A., & Levendosky, A. A. (1998). Traumatic stress symptoms in children of battered women. *Journal of Interpersonal Violence, 13(1),* 111-128.

Jaffe, P. G., Wolfe, A., & Wilson, S. K. (1990). *Children of battered women.* London: Sage.

Kelly, T. (2005). *Caring dads: Helping fathers value their children.* Retrieved November 13, 2008, from http://www.lfcc.on.ca/Kelly_Principles_Fathers.pdf.

Kilpatrick, K. L., & Williams, L. M. (1997). Post-traumatic stress disorder in child witnesses to domestic violence. *American Journal of Orthopsychiatry, 67(4),* 639-644.

Lane, P., Bopp, J., & Bopp, M. (2003). *Aboriginal domestic violence in Canada.* Ottawa: Aboriginal Healing Foundation.

McEvoy, M., & Ziegler, M. (2006). *Best practices manual for Stopping the Violence counselling programs in British Columbia.* Vancouver: BC Association of Specialized Victim Assistance and Counselling Programs.

Ministry of Children and Family Development. (n.d.). *Integrated caregiver education for foster, adoptive and concurrent planning families participant manual.* Victoria, BC: Ministry of Children and Family Development.

Ministry of Children and Family Development. (2004). *Best practice approaches: Child protection and violence against women.* Retrieved January 3, 2009, from http://www.mcf.gov.bc.ca/child_protection/pdf/cp_vaw_best_practice_2004-07-22.

Mullender, A., Hague, G., Imam, U., Kelly, L., Malos, E., & Regan, L. (2002). *Children's perspectives on domestic violence.* London: Sage.

Perry, B. (n.d.). *Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood.* Retrieved November 13, 2008, from http://teacher.scholastic.com/professional/bruceperry/bonding.htm.

Perry, B. (2004). *Maltreatment and the developing child: How early childhood experience shapes child and culture.* Retrieved November 13, 2008, from http://www.lfcc.on.ca/mccain/perry.pdf.

Ruebsaat, G. (2006). *Records management guidelines: Protecting privacy for survivors of violence* (3rd ed.). Vancouver: BC Association of Specialized Victim Assistance and Counselling Programs and BC Yukon Society of Transition Houses.

Smith, E. (2004). *Nowhere to turn? Responding to partner violence against immigrant and visible minority women.* Ottawa: Canadian Council on Social Development.

Sonkin, D. J. (2005). *Domestic violence and attachment theory: Clinical applications to treatment with perpetrators.* Retrieved December 29, 2008, from http://www.danielsonkin.com/sonkin82405.htm.

Suderman, M., & Jaffe, P. (1999). *A handbook for health and social service providers and educators on children exposed to woman abuse/family violence.* Ottawa: The National Clearinghouse on Family Violence. Retrieved January 10, 2009, from http://dsp-psd.pwgsc.gc.ca/Collection/H72-21-163-1998E.pdf.

Suderman, M., Jaffe, P. G., & Hastings, E. (1995). Prevention programs in secondary schools. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 232-254). Thousand Oaks, CA: Sage.

Van Den Brandt, J., & Wilgocki, J. (2003). *Fostering healthy attachment in young children.* Retrieved January 10, 2009, from http://www.mhcdc.org/Resources/newslettervol3.html.

White, S., & McConnell, J. (1995). *Children who witness abuse program counsellor's handbook: 20 most commonly asked questions.* Vancouver: BC Yukon Society of Transition Houses.

Wolfe, D. A., Wekerle, C., Reitzel, D., & Gough, R. (1995). Strategies to address violence in the lives of high-risk youths. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 255-274). Thousand Oaks, CA: Sage.

B. Recommended Further Reading

A large percentage of the resources in the following list are easily accessible without cost by download from the Internet. Where this is true, the web address is provided.

Many of the resources listed here are easily accessible without cost by download from the Internet.

B.1 General

Agar, S. (2004). *Interventions for children who witness intimate partner violence: A literature review*. Vancouver: BC Institute against Family Violence. Available at: http://www.bcifv.org/pubs/Agar_Lit_Review_2004.pdf.

Braun, J. (2001). *Child custody and access in the context of family violence: An overview of issues*. Vancouver: BC Institute against Family Violence. Available at: http://www.bcifv.org/pubs/Child%20Custody%20and%20Access%202001.pdf.

Baker, L., & Cunningham, A. (2005a). *Learning to listen, learning to help: Understanding woman abuse and its effects on children.* Available at: http://www.lfcc.on.ca/learning_to_listen.pdf.

Cunningham A., & Baker L. (2004). *What about me? Seeking to understand a child's view of violence in the family.* Available at: http://www.lfcc.on.ca/what_about_me.pdf.

Cunningham, A., & Baker, L. (2007). *Little eyes, little ears: How violence against a mother shapes children as they grow.* Available at: http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/fem-2007-LELE_e.pdf.

Dauvergne, M., & Johnson, H. (2001). *Children witnessing family violence.* Ottawa: Canadian Centre for Justice Statistics, Statistics Canada.

Edleson, J. L. (1999). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14(8),* 839-870.

Holden, G. W., Geffner, R., & Jouriles, E. N. (Eds.). (1998). *Children exposed to marital violence: Theory, research, and applied issues.* Washington, DC: American Psychological Association.

Jaffe, P. G., Wolfe, A., & Wilson, S. K. (1990). *Children of battered women.* London: Sage.

McEvoy, M., & Ziegler, M. (2006). *Best practices manual for Stopping the Violence counselling programs in British Columbia.* Vancouver: BC Association of Specialized Victim Assistance and Counselling Programs.

Trickett, P. K., & Schellenbach, C. J. (Eds.). (1998). *Violence against children in the family and the community*. Washington, DC: American Psychological Association.

B.2 Effects on Children

Baker, L., & Jaffe, P. G. (n.d.). *Woman abuse affects our children: An educator's guide*. Available at: http://www.lfcc.on.ca/Educators_Guide_to_Woman_Abuse.pdf.

Graham-Bermann, S. A., & Levendosky, A. A. (1998). Traumatic stress symptoms in children of battered women. *Journal of Interpersonal Violence, 13(1),* 111-128.

Kilpatrick, K. L., & Williams, L. M. (1997). Post-traumatic stress disorder in child witnesses to domestic violence. *American Journal of Orthopsychiatry, 67(4),* 639-644.

Margolin, G. (1998). Effects of domestic violence on children. In P. K. Trickett & C. J. Schellenbach (Eds.), *Violence against children in the family and the community*. Washington, DC: American Psychological Association.

Margolin, G., & Gordis, E. B. (2000). The effects of family and community violence on children. *Annual Review of Psychology (51),* 445-479.

Perry, B. (n.d.). *Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood.* Available at: http://teacher.scholastic.com/professional/bruceperry/bonding.htm.

Perry, B. (2004). *Maltreatment and the developing child: How early childhood experience shapes child and culture.* Available at: http://www.lfcc.on.ca/mccain/perry.pdf.

B.3 Intervention

Agar, S. (2004). *Interventions for children who witness intimate partner violence: A literature review*. Vancouver: BC Institute against Family Violence. Available at: http://www.bcifv.org/pubs/Agar_Lit_Review_2004.pdf.

Arroyo, W., & Eth, S. (1995). Assessment following violence-witnessing trauma. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 27-42). London: Sage.

BC Yukon Society of Transition Houses. (1996). *Children who witness abuse counselling source book*. Vancouver: BCYSTH.

BC Yukon Society of Transition Houses. (2000). *Children who witness abuse counsellor training.* Vancouver: BCYSTH.

BC Yukon Society of Transition Houses. (2007). *Violence is preventable: Building partnerships between Children Who Witness Abuse programs and BC schools* (2nd ed.). Vancouver: BCYSTH.

Child Witness Project. (2002). *Child witnesses in Canada: Where we've been, where we're going*. Available at: http://www.lfcc.on.ca/Cwp_2002.pdf.

Genrich, A., Steinkamp, S., & Horton, C.B. (2000). Treating children exposed to domestic violence: Lessons learned from five years of experience. In P. G. Jaffe, M. Russell, & M. J. Smith (Eds.), *Creating a legacy of hope: Proceedings of an international conference on children exposed to domestic violence* (pp. 50-53). Vancouver: BC Yukon Society of Transition Houses.

Peled, E., & Edleson, J. L. (1995). Process and outcome in small groups for children of battered women. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 77-96). London: Sage.

Suderman, M., & Jaffe, P. (1999). *A handbook for health and social service providers and educators on children exposed to woman abuse/family violence.* Ottawa: The National Clearinghouse on Family Violence. Available at: http://dsp-psd.pwgsc.gc.ca/Collection/H72-21-163-1998E.pdf.

Wachtel, A. (1997). *Children and other vulnerable witnesses: A guidebook on court design.* Victoria, BC: Ministry of Attorney General.

White, S., & McConnell, J. (1995). *Children who witness abuse program counsellor's handbook: 20 most commonly asked questions.* Vancouver: BC Yukon Society of Transition Houses.

Wolfe, D. A., Wekerle, C., Reitzel, D., & Gough, R. (1995). Strategies to address violence in the lives of high-risk youths. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 255-274). Thousand Oaks, CA: Sage.

B.4 Legal Issues

Braun, J. (2001). *Child custody and access in the context of family violence: An overview of issues*. Vancouver: BC Institute against Family Violence. Available at: http://www.bcifv.org/pubs/Child%20Custody%20and%20Access%202001.pdf.

Jaffe, P. G. (1995). Children of domestic violence: Special challenges in custody and visitation dispute resolution. In J. Carter, B. Hart, & C. Heisler (Eds.), *Domestic violence & children: Resolving custody and visitation disputes* (pp. 19-30). San Francisco: Family Violence Prevention Fund.

Jaffe, P. G., & Geffner, R. (1998). Child custody disputes and domestic violence: Critical issues for mental health, social service, and legal professionals. In G. W. Holden, R. Geffner, & E. N. Jouriles (Eds.), *Children exposed to marital violence: Theory, research and applied issues* (pp. 371-408). Washington, DC: American Psychological Association.

Kerr, S. G., & Jaffe, P. G. (1999). Legal and clinical issues in child custody disputes involving domestic violence. *Canadian Family Law Quarterly, 17,* 1-37.

Ministry of Children and Family Development. (2004). *Best practice approaches: Child protection and violence against women.* Available at: http://www.mcf.gov.bc.ca/child_protection/pdf/cp_vaw_best_practice_2004-07-22.

Ruebsaat, G. (2006). *Records management guidelines: Protecting privacy for survivors of violence* (3rd ed.). Vancouver: BC Association of Specialized Victim Assistance and Counselling Programs and BC Yukon Society of Transition Houses.

B.5 Working with Diverse Families

Crooks, C., Chiodo, D., & Thomas, D. (n.d.). *Transforming Aboriginal youth through engagement and empowerment: A toolkit for service providers.* Unpublished manuscript.

Dumont-Smith, C. (1995). Aboriginal Canadian children who witness and live with violence. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 275-283). London: Sage.

Kaschak, E. (Ed.). (2001). *Intimate betrayal: Domestic violence in lesbian relationships.* New York: Haworth Press.

Lane, P., Bopp, J., & Bopp, M. (2003). *Aboriginal domestic violence in Canada.* Ottawa: Aboriginal Healing Foundation.
Ministry of Children and Family Development. (2004). *Best practice approaches: Child protection and violence against women.* Available at: http://www.mcf.gov.bc.ca/child_protection/pdf/cp_vaw_best_practice_2004-07-22.

Report on the Canadian Forces' response to woman abuse in military families (2000). Prepared by the Family Violence and the Military Community research teams of the Muriel McQueen Fergusson Centre for Family Violence Research at the University of New Brunswick and the RESOLVE Violence and Abuse Research Centre at the University of Manitoba. Available at: http://www.unbf.ca/arts/CFVR/documents/REPORTONTHECANADIANFORCES.pdf.

Smith, E. (2004). *Nowhere to turn? Responding to partner violence against immigrant and visible minority women.* Ottawa: Canadian Council on Social Development.

B.6 Working with Fathers

Kelly, T. (2005). *Caring dads: Helping fathers value their children.* Presentation available at: http://www.lfcc.on.ca/Kelly_Principles_Fathers.pdf.

Mathews, D. (1995). *Parenting groups for men who batter.* In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 106-120). London: Sage.

B.7 Collaborating with Other Professionals

Baker, L., & Cunningham, A. (2005b). *Through a new lens: Seeing woman abuse in the life of a young child: A learning module for early childhood education programs*. Retrieved November 13, 2008, from http://www.lfcc.on.ca/New_lens_module.pdf.

Baker, L., & Jaffe, P. G. (n.d.). *Woman abuse affects our children: An educator's guide*. Retrieved November 13, 2008, from http://www.lfcc.on.ca/Educators_Guide_to_Woman_Abuse.pdf.

Baker, L., Jaffe, P. G., & Ashbourne, L. (2002). *Children exposed to domestic violence: An early childhood educator's handbook to increase understanding and improve community responses.* Retrieved November 13, 2008, from http://www.lfcc.on.ca/ece-us.PDF.

Suderman, M., & Jaffe, P. (1999). *A handbook for health and social service providers and educators on children exposed to woman abuse/family violence.* Ottawa: The National Clearinghouse on Family Violence. Retrieved January 10, 2009, from http://dsp-psd.pwgsc.gc.ca/Collection/H72-21-163-1998E.pdf.

Suderman, M., Jaffe, P. G., & Hastings, E. (1995). Prevention programs in secondary schools. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 232-254). Thousand Oaks, CA: Sage.

B.8 Program Evaluation

McNamara, C. *Basic guide to outcomes-based evaluation for nonprofit organizations with very limited resources.* Available at: http://www.managementhelp.org/evaluatn/outcomes.htm.

United Way. *Online resource network.* Available at: http://www.liveunited.org/outcomes/?

US Department of Health and Human Services. *The Program Manager's Guide to Evaluation.* Available at: http://www.acf.hhs.gov/programs/opre/other_resrch/pm_guide_eval/reports/pmguide/pmguide_toc.html.

B.9 Supporting CWWA Counsellors

McEvoy, M., & Ziegler, M. (2006). *Best practices manual for Stopping the Violence counselling programs in British Columbia.* Vancouver: BC Association of Specialized Victim Assistance and Counselling Programs.

Richardson, J. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers.* Ottawa: National Clearinghouse on Family Violence. Available at: http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/trauma_e.pdf.

B.10 Resources for Parents, Caregivers, and Children

Bernstein, S.C. (1991). *A family that fights.* Morton Grove, IL.: Albert Whitman.

Davis, D. (1984). *Something is wrong at my house.* Seattle: Parenting Press.

Eriksen, J., Henderson, A., Davidson, M., & Ogden, S. (1997). *Breaking the cycle: A parenting guide for single mothers of children who have witnessed domestic violence.* Vancouver: FREDA.

Hochban, T., & Vladyana, K. (1994). *Hear my roar: A story of family violence.* Toronto: Annick.

Otto, O. (1988). *Never, no matter what.* Toronto: Women Press.

Patterson, S., & D. Softing-Freed. (1987). *I wish the hitting would stop: A workbook for children living in violent homes.* Fargo, ND: Red Flag Green Flag Resources, Crisis Center of Fargo-Moorhead.

Section 5
Appendices

Appendix 1. Developing Policy to Meet Standards

Introduction

The standards provided in Section 3 of this document summarize the principles common to all Children Who Witness Abuse programs in British Columbia, and provide a benchmark against which to measure practices. Whereas the standards are common to all CWWA programs, the policies that bring them to life will be as unique as the programs themselves. This appendix is adapted from the *BC Association of Family Resource Programs Provincial Standards of Practice* (Ellis and Barbeau, 2008).

Writing Policy and Procedure

Policy writing isn't difficult but it requires planning and the support of the staff who will be implementing the policies. The line between policy and procedure is a fine one, but in general:

- policy can be thought of as a principle that guides action; and,
- procedures are the steps one must take to carry out the policy.

In most non-profit agencies, policy changes must be approved by the Board of Directors while procedural changes may be made at the level of the program. It is common for policies to be written following a template that includes:

- a Purpose statement at the beginning (if this will help people understand the policy);
- one or more Policy statements that set out the principles or the guidelines that this policy addresses and that are normally subject to approval by the board; and,
- one or more Procedures, which are detailed and fully spell out the steps required to accomplish the policy.

Not all policies have procedures attached. As an illustration, in the examples that follow there are two sample policies related to research that involves clients. The first, which states that research is not permitted, requires no accompanying procedure. The second, on the other hand, provides detailed procedure regarding how to conduct research in an ethical manner.

Steps for Reviewing the Standards and Your Policies

1. First of all, take time to read through all of the standards. Get a sense of the ones that you know you already have solid policy for and the areas where you feel you will need to create or amend your existing policy to meet the standard.

2. Choose a place to begin (it doesn't have to be at the beginning) and look carefully at one standard. Ask yourself what the purpose of the standard is, and think about what would be required to meet it.

3. Compare this one standard with your current practice (your program's own way of doing things). Is your current practice consistent with the standard? Are you satisfied with your current practice or would you like to improve it in some way? For example, you may find that your current practice meets the standard but you still feel it could be improved.

4. Now compare the standard and your current practice with any existing policy you have that relates to this standard. Some agencies find when they do this for the first time that they have policies they have not reviewed in years. Ask yourself whether your policy is consistent with your current practice. If not, will you change your practice or revise the policy? Some agencies find that they have a practice (a way of doing something) but they have never written a policy statement to accompany their practice. Now is the opportunity to review your practice and write the policy statement.

5. Create or amend policy as required to comply with the standard and to match your practice. Remember to get appropriate approval for any new or amended policies, based on the requirements of your agency.

6. Build your new Policy and Procedures Manual. Each policy you write becomes one piece of the whole. As you are writing your policies, you will probably discover practices that you want to retain but that are not directly addressed in the standards. That's great! Go ahead and write them and include them in your Policy and Procedures Manual.

7. Train staff on newly created or amended policy. Remember that a Policy Manual is meaningless until it is brought to life in your agency. Staff need to know what is expected of them and how the agency will support them in following policy.

Keep your policies as simple as possible while ensuring that they are complete. A policy that is simple and written in plain language is more likely to be understood and properly implemented. At the same time, make your policies as complete as they have to be to cover the practice

you are describing. A policy doesn't have to anticipate everything that might happen, but it should offer structure and guidance to support the organization in its normal activities.

Guidelines for Policy Writing

1. Use language that is precise and understandable. Avoid vague terms and unclear timelines.

2. Use language that most people will understand. Avoid jargon and when you must use technical language, define your terms.

3. State your policies in positive terms to make them clearer. For example, say, "Staff will protect the private information of clients," rather than "Staff will not disclose private information gathered from clients."

4. Use negative statements only for warnings. For example: "Do not return to the evacuated building until the person in charge advises that it is safe."

5. It is usually best to write your policy statements in the active voice to clarify who will be doing what. For example, say, "A designated staff member will inspect toys and equipment every evening to ensure safety and cleanliness," rather than, "Toys and equipment will be inspected every evening to ensure safety and cleanliness."

6. Be consistent in the terms you use from one policy to another.

7. Create a system for identifying and keeping track of revisions to the policies. Many organizations do this by putting the revision date or the revision number in a header or footer.

Sample Policies

On the pages that follow, there are a few samples of policies and the standards that they comply with. They are provided to show you what a typical policy looks like and how it operationalizes a standard. You are welcome to take these policies and adapt them to your own situation if you choose.

Sample Policy: Information about Client Rights

This policy complies with Standard A.3.2. You are welcome to adapt this policy to your own situation if you choose.

Policy

The agency provides clients with information about their rights in both written and verbal formats. Agency staff communicate this information in a language and manner that is appropriate to the client.

Procedure

1. The program will post the agency's "Client Bill of Rights" in the reception area.

2. CWWA counsellors will provide the "Client Bill of Rights" to every client in writing and will discuss it during the intake process.

3. Counsellors will discuss their rights with children in a manner that is meaningful to them.

4. Program supervisors will monitor the languages spoken by clients and will have written rights materials translated into languages other than English as appropriate.

Sample Policy: Research Involving Participants/Clients (1)

This policy complies with Standard A.3.7. You are welcome to adapt this policy to your own situation if you choose.

Policy

The agency does not participate in or support research involving participants/clients, except for the following:

a) internal program evaluation and outcomes research; and,

b) educational projects performed by students and interns as part of their professional training.

Sample Policy: Research Involving Participants/Clients (2)

This policy complies with Standard A.3.7. You are welcome to adapt this policy to your own situation if you choose.

Purpose

The agency will participate in or support only research projects that are in keeping with its mission and values. The agency has a responsibility to ensure that if and when it agrees to take part in research involving its clients, it does so in a manner that is ethical and that protects the rights of its clients.

Policy

1. The agency will not participate in or support research projects that:
   a) conflict with its values, particularly those involving the dignity or the rights of clients;
   b) conflict with its policies, particularly those relating to confidentiality; or,
   c) lack ethical or methodological clarity.

2. No client will participate in research conducted by or with the cooperation of the agency unless they have provided informed written consent. Where the research involves child clients, both the child and the referring parent will provide consent.

3. The agency will safeguard the identity and the privacy of all clients who participate in research by or with the cooperation of the agency.

Procedure

1. The Management Team will review all requests for involvement in research.

2. The agency will take reasonable steps to ensure that clients who participate in research conducted by or with the cooperation of the agency understand:
   a) the nature and the purpose of the research;
   b) any possible risks or discomfort associated with the research;
   c) that their participation is voluntary;
   d) that if they decline to participate in the research, there will be no reprisals and service will not be withheld from them; and,
   e) that they may withdraw from the research at any time.

3. While the agency will not provide personal information without the explicit consent of the client, it may, at its discretion, provide aggregate data to researchers provided that:

   a) the data do not include any identifying information; and,

   b) the research meets the criteria listed in Policy 1 above.

4. All approved research programs will be reviewed annually by the Management Team.

Sample Policy: Employee Recruitment and Selection

This policy complies with Standard D.5.2 as it relates to paid staff. You are welcome to adapt this policy to your own situation if you choose.

Policy

The agency follows the process detailed below for recruiting and hiring paid staff.

Procedure

1. The agency notifies existing staff of available positions before it advertises externally.

2. Agency staff interview all applicants before hiring, using standard interview protocols.

3. Agency staff provide all applicants with a written job description.

4. The agency provides an opportunity for all final applicants to speak with currently employed personnel regarding the position.

5. Before hiring, agency staff contact three unrelated references for the preferred applicant and document the reference interview.

6. The agency maintains records for all stages of the recruitment and selection process.

7. When the agency recruits and hires for a unionized position, these activities are governed by the relevant Collective Agreement.

Appendix 2. Sample Forms

Sample Intake Form

Adolescent Intake Form

Note: Inform the youth that information provided is confidential unless they disclose harm to self or others.

Date	Counsellor

Name	School
Age	Grade
Date of Birth	Sex

Getting to know you

What do you enjoy doing at school?

_____

_____

Do you have any siblings? (names, age, a few words that describe them)

_____

_____

What do you like to do for fun?

_____

_____

Friends and community

Do you have a friend(s) whom you are close to?

_____

_____

Do you belong to any groups/clubs/teams?

_____

_____

What's going on

Why do you think you are here?

_____

_____

How would you describe your feelings about being here?

_____

_____

How have you been eating/sleeping?

_____

_____

What does the word "abuse" mean to you?

_____

_____

Parents/guardians

How many parents do you have? What are their names?

_____

_____

For each of your parents, tell us briefly how you would describe the person to someone who doesn't know them. Then tell us a little about your relationship with each one.

_____

_____

_____

_____

_____

_____

_____

_____

Sample Form for Group Attendance and Progress Notes

Children Who Witness Abuse
School-based Group Goals and Progress Notes

Age group: _____ Topic: _____

Date: _____

NAMES	GOAL 1	GOAL 2	GOAL 3	GOAL 4
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Activities

_____

_____

_____

Significant verbalizations/behaviours/limit setting

_____

_____

_____

_____

Sample Closing Summary Form

Closing Summary

Program	Date of summary
Date client entered program	Date client exited program
Summary	
30-day follow-up ❒ Yes ❒ No	Date of follow-up and outcome

CWWA Counsellor (print name) Signature

Program Manager (print name) Signature

Sample Release of Information Form

Client Consent to Release Information

I, _____ *[name]* consent to _____ *[agency]* sharing information that concerns my family and myself as described below.

Name of originating program: _____

Address of program:_____

Name of individual with whom information may be shared: _____

_____

Organization:_____

Address of organization: _____

Purpose of information sharing: _____

_____

_____

Specific information that may be shared (list any specific documents):

_____

_____

_____

Specific exceptions (information that may not be shared):

_____

_____

_____

This consent is effective from _____ to _____.
I understand that I may withdraw my consent at any time, after which no further information will be shared.

_____ _____
Signature of client/guardian Date

_____ _____
Signature of CWWA counsellor Date

Sample Child Survey

This survey asks a combination of satisfaction and outcome questions.

Child Questionnaire

Please help us improve our program by answering some questions. Please choose the answer that is closest to how you feel.

1. Do you like attending the group?


yes


ok/not sure


no

2. Do you like the things we do in the group?


yes


ok/not sure


no

3. Do you feel that the counsellors are willing to listen when you have a problem?


yes


ok/not sure


no

4. Do you feel that you have learned any new skills since coming to the group?


yes


ok/not sure


no

5. Is there anything else you would like to tell us?

_____

_____

_____

_____

_____

_____

Today's date: _____ Your age: _____

Thank You!

Appendix 3. BC Infants Act

The full text of the BC Infants Act *is available at: http://www.bclaws.ca/Recon/document/freeside/--%20i%20-infants%20act%20%20rsbc%201996%20%20c.%20223/00_96223_01.xml.*

The portion that is relevant to consent for CWWA programs is reproduced below.

Part 2 – Medical Treatment

Consent of infant to medical treatment

17 (1) In this section:

> "**health care**" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of health care;
>
> "**health care provider**" includes a person licensed, certified or registered in British Columbia to provide health care.

(2) Subject to subsection (3), an infant may consent to health care whether or not that health care would, in the absence of consent, constitute a trespass to the infant's person, and if an infant provides that consent, the consent is effective and it is not necessary to obtain a consent to the health care from the infant's parent or guardian.

(3) A request for or consent, agreement or acquiescence to health care by an infant does not constitute consent to the health care for the purposes of subsection (2) unless the health care provider providing the health care

> (a) has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and
>
> (b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests.

Appendix 4. Declaration of the Rights of the Child

Proclaimed by General Assembly resolution 1386(XIV) of 20 November 1959

Whereas the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Whereas the United Nations has, in the Universal Declaration of Human Rights, proclaimed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Whereas the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth,

Whereas the need for such special safeguards has been stated in the Geneva Declaration of the Rights of the Child of 1924, and recognized in the Universal Declaration of Human Rights and in the statutes of specialized agencies and international organizations concerned with the welfare of children,

Whereas mankind owes to the child the best it has to give,

Now therefore,

The General Assembly

Proclaims this Declaration of the Rights of the Child to the end that he may have a happy childhood and enjoy for his own good and for the good of society the rights and freedoms herein set forth, and calls upon parents, upon men and women as individuals, and upon voluntary organizations, local authorities and national Governments to recognize these rights and strive for their observance by legislative and other measures progressively taken in accordance with the following principles:

Principle 1

The child shall enjoy all the rights set forth in this Declaration. Every child, without any exception whatsoever, shall be entitled to these rights, without distinction or discrimination on account of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of himself or of his family.

Principle 2

The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration.

Principle 3

The child shall be entitled from his birth to a name and a nationality.

Principle 4

The child shall enjoy the benefits of social security. He shall be entitled to grow and develop in health; to this end, special care and protection shall be provided both to him and to his mother, including adequate pre-natal and post-natal care. The child shall have the right to adequate nutrition, housing, recreation and medical services.

Principle 5

The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.

Principle 6

The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and, in any case, in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. Society and the public authorities shall have the duty to extend particular care to children without a family and to those without adequate means of support. Payment of State and other assistance towards the maintenance of children of large families is desirable.

Principle 7

The child is entitled to receive education, which shall be free and compulsory, at least in the elementary stages. He shall be given an education which will promote his general culture and enable him, on a basis of equal opportunity, to develop his abilities, his individual judgement, and his sense of moral and social responsibility, and to become a useful member of society.

The best interests of the child shall be the guiding principle of those responsible for his education and guidance; that responsibility lies in the first place with his parents.

The child shall have full opportunity for play and recreation, which should be directed to the same purposes as education; society and the public authorities shall endeavour to promote the enjoyment of this right.

Principle 8

The child shall in all circumstances be among the first to receive protection and relief.

Principle 9

The child shall be protected against all forms of neglect, cruelty and exploitation. He shall not be the subject of traffic, in any form.

The child shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education, or interfere with his physical, mental or moral development.

Principle 10

The child shall be protected from practices which may foster racial, religious and any other form of discrimination. He shall be brought up in a spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood, and in full consciousness that his energy and talents should be devoted to the service of his fellow men.

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