TERM Domestic Violence Victim Group Psychotherapy Treatment Standards

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Optum gratefully acknowledges the collaboration of County of San Diego HHSA Child Welfare Services in the development and writing of these Standards.

Optum TERM: Important Updates to TERM Domestic Violence Victim Group Psychotherapy Treatment Standards

Dear TERM Provider:

The TERM Domestic Violence Victim Group Psychotherapy Treatment Standards have been revised to reflect updates to timelines for submission of Intake Assessments. When reviewing the standards, please pay close attention to the following:

- Intake Assessment (page 14)
  - Timelines for Child Welfare Services Initial Treatment Plan submission have been updated for consistency across the system and to allow for more timely medical necessity and case decision making. The due date for Initial Treatment Plans for all service types, including Domestic Violence Victim groups, is **fourteen (14) calendar days** from the initial authorization date.
  - **Adherence to the updated timeline for TERM DV Victim Group Intake Assessment submission is required for all Child Welfare Services-referred clients effective November 1, 2016**.

Optum TERM staff can be reached at (877) 824-8376, Option 4 for any questions about the updated timelines for Intake Assessment submission. Thank you for working with Optum in serving clients of the County of San Diego.

Respectfully,

LeAnn Skimming, Ph.D.

TERM Clinical Program Manager

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TERM Domestic Violence Group Treatment Standards

Introduction

Optum TERM is an acronym for Optum Treatment and Evaluation Resource Management, a mental health oversight unit developed under the direction of the County of San Diego Board of Supervisors and operated by Optum through a contract with the County of San Diego HHSA Behavioral Health Services. Optum TERM's mission is to improve the quality and appropriateness of mental health services provided to children and families involved with Child Welfare Services (CWS) and the Juvenile Probation Department.

The current standards were developed to assist TERM group psychotherapy providers in rendering the best possible services to families affected by intimate partner violence and child maltreatment, and should be used as a guide in the operation of Domestic Violence Victim groups delivered to clients referred by San Diego County Child Welfare Services.

Definitions

The Centers for Disease Control and Prevention (CDC) define **domestic violence ("DV"), or intimate partner violence ("IPV")**, as "the establishment of power and control through a pattern of coercive behaviors that include physical, sexual, verbal, and emotional assaults perpetrated by one intimate partner against another," (Saltzman, Fanslow, McMahon, & Shelley, 1999). The assaults or behaviors may also jeopardize the safety and well-being of children. Intimate partner violence can occur in heterosexual relationships, same-sex relationships, teen dating relationships, and may be perpetrated by males or females (Ganley, 1995; Saltzman et al., 1999). The CDC further define **child maltreatment** as any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child. Within the child welfare context, **safety** has been defined as the actions of protection taken by the caregiver that mitigate the danger demonstrated over time (Boffa & Podesta, 2004).

It should be noted that the literature pertaining to intimate partner violence is predominantly based on a female population. Throughout these Standards, group participants are referred to as "female,'' though the standards of practice for Domestic Violence group treatment described below apply to both female and male victims. Please also note that the terms "victim", "survivor", and "battered woman" are used interchangeably.

Key Principles

Key principles for increasing child safety and better outcomes for victims of intimate partner violence and their children identified by the California Leadership Group on Domestic Violence and Child Well-Being (Rosewater & Moore, 2010) include:

- Keeping the parent safe and ensuring that he/she is able to engage in a safe, secure and nurturing relationship with the child.
- Respecting a child's developmental needs and keeping safety paramount to ensure that a child maintains a continuous relationship with his/her non-offending parent and when

possible, a safe relationship with his/her offending parent.
- Ensuring a non-offending parent is not held responsible for the offending partner's behavior.
- Recognizing and strengthening the protective behaviors that parents engage in.

Prevalence

Studies have reported a prevalence of intimate partner physical violence ranging from 29-52% in coupled relationships in the U.S. population (Renner & Boel-Studt, 2012). A recent national study found that in a sample of 2629 women, 31.8% of women reported experiencing physical violence by a partner and 55.1% reported experiencing psychological victimization by an intimate partner (Krebs, Breiding, Browne, & Warner, 2011). While estimates of prevalence vary depending on the methodology employed and the population studied, intimate partner violence has been identified across studies as a significant health concern in the United States. In addition to affecting those most directly involved, partner abuse and violence impacts medical, public health, criminal justice, and economic systems and has public policy implications as well (Tjaden & Thoennes, 2000).

Over the past few decades, there has been a growing awareness of children's exposure to intimate partner violence (Appel & Holden, 1998). According to a national study by the U.S. Department of Health and Human Services (2003), it was estimated that 15.5 million children in two-parent households live in families in which intimate partner violence occurs at least once in a 12 month period (McDonald, Jouriles, Ramisetty-Mikler, Caetano & Green, 2006) with approximately 7 million living in households where the violence was considered severe. Recent research through the National Survey of Children's Exposure to Violence (Hamby, Finkelhor, Turner, & Ormrod, 2011) indicates that more than 1 in 9 (11%) of children in the survey were exposed to some form of family violence, and that 1 in 15 (6.6%) were exposed to intimate partner violence between their parents or between a parent and the parent's partner. This research further reflects that 1 in 4 children (26%) were exposed to at least one form of family violence in their lifetime. The majority of youth surveyed (90%) were direct eyewitnesses to the violence and almost one-half reported attempting to intervene to stop the violence. The most commonly cited perpetrators were father figures, although partner violence perpetrated by mothers and other caregivers was also reported. It is also noted that both partners may engage in mutual violence (McDonald et al., 2006).

Studies show that children exposed to intimate partner violence are at a greater risk for co-occurring physical abuse (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008). In homes where intimate partner violence occurs, studies have estimated that children are physically abused and neglected at a rate 15 times higher than the national average (Strauss, Gelles & Smith, 1990). Several studies have shown that in 60-75 percent of families in which a woman is battered, children are also battered (Osofsky, 1999; Taggart, 2009). Edelson (1999) reviewed multiple studies and found a slightly lower estimate of 30-60% of households with domestic violence and co-occurring child maltreatment.

Cultural Factors

Optum TERM requires approved providers to deliver services that are culturally responsive. Such services meet the needs of a community with diverse cultures and linguistic needs. For this reason, Optum TERM's operational definition of "diversity" includes a broad range of dimensions including race, ethnicity, language, national origins, sexual orientation, age, gender, disabilities, religion/spirituality, and groups from a multitude of other backgrounds, situations, and environments. Providers are required to complete a minimum of four hours of continuing education each year in the area of cultural competency. The four hours of cultural competency training required by Fee for Service Medi-Cal network will also satisfy the TERM network cultural competency requirement.

In providing culturally responsive treatment of intimate partner violence, it is important to be aware that for many ethnic groups there is a stronger emphasis on preserving family unity than in Anglo cultures. For example, African American, Asian, and Latina women may be pressured by their family or community to stay in a relationship (Bragg, 2003). For Latina women, family and relationships have been found to be an important influence in their willingness to leave an abusive relationship (Torres, 1991). Studies have reported a "community code of silence" adhered to by African American women who have been victims of intimate partner violence, showing African American women may not want to seek help because they want to protect their partners from an oppressive legal system (Taylor, 2002; Moss, Pitula, Campbell, & Halstead, 1997). These findings indicate that an individual's response to an abusive partnership is a "cultural-bound" process (Moss et al., 1997). For additional cultural considerations, Murray and Graves (2013) provide an overview of subgroups impacted by domestic violence.

Until recently most studies of partner violence have been almost exclusively focused on heterosexual partners, with only limited information about prevalence/incidence of partner violence among gay, lesbian, bisexual and transgendered individuals. There is a growing body of evidence which suggests that same-gender partner violence is as common as heterosexual partner violence (Brown & Groscup, 2009; Farley, 1996; Renzetti, 1992). The literature indicates that the dynamics and types of violence in same-gender relationships are similar to heterosexual partner violence.

Risk Factors

Individual, interpersonal, community and social factors influence risk for intimate partner violence (Crandall, Nathens, Kernic, Holt & Rivara, 2004). High risk groups for victimization noted in the literature include females between the ages of 19-29, those with a history of substance abuse, participation in high risk sexual behavior, lower educational and socio-economic levels, and those who have prior trauma histories such as abuse by a partner or those who have witnessed or experienced abuse during childhood (Crandall et al., 2004; Ganley, 1995). Risk factors found to be associated with co-occurrence of child abuse and exposure to intimate partner violence include family variables (such as poverty, parental unemployment, substance abuse, mental illness, financial or parenting stress, poor health, and

lower educational levels), as well as environmental variables (such as living in a disadvantaged neighborhood and violence outside the home) (Herrenkohl et al., 2008). Other studies demonstrate that perpetrators of intimate partner violence who were abused as children are more likely to physically harm their children (Bragg, 2003).

Intimate partner violence and trauma history can severely impair a parent's ability to nurture the development of their children and may affect a parent's ability to engage with service providers and with child welfare services as a whole (ACS-NYU Children's Trauma Institute, 2012). A high prevalence of PTSD has been noted in women who have been battered (Kuijpers, van der Knaap, Winkel, Pemberton & Baldry, 2010). Mothers who are abused may be depressed or preoccupied with the violence, emotionally withdrawn or numb, irritable, have feelings of hopelessness, or other post-traumatic reactions. Mothers with untreated PTSD and trauma may be less likely to effectively parent and may have less ability to protect their children from the effects of abuse (ACS-NYU Children's Trauma Institute, 2012). The result can be a parent who is less emotionally available to their children, less likely to be able to read cues or less able to care for their children's basic needs. Exposure to partner violence may also impact the parent's ability to form a secure attachment with the child, and studies suggest that some battered women may use more punitive child-rearing strategies or exhibit aggression toward their children (Carter, Weithorn, & Behrman, 1999; Newton, 2001).

PTSD has also been found to be a predictor of future re-victimization, especially for battered women with numbing symptoms (Iverson, Litwack, Pineles, Suvak, Vaughn, & Resick, 2013). Survivors who reduced their symptoms of PTSD during a course of CBT treatment were significantly less likely to report re-victimization relative to women who did not experience similar reductions in PTSD. Iverson et al. (2013) also found that a protective factor against future IPV is coping style. Women who used an engagement form of coping (such as proactive steps to manage the abuse, problem-solving, eliciting social support) were less likely to be re-victimized than those using disengagement coping (such as problem avoidance, wishful thinking, social withdrawal).

In a 1999 study from Johns Hopkins, it was reported that abused women are at higher risk of miscarriages, stillbirths, and infant deaths, and are more likely to give birth to low birth weight children (a risk factor for neonatal and infant deaths). In addition, children of abused women were more likely to be malnourished and were less likely to have been immunized against childhood diseases (Heise, Ellsberg & Gottemoeller, 1999). Babies are highly vulnerable to maltreatment (Cunningham & Baker, 2007), and children 5 years old or younger appear to be disproportionately represented among families with partner violence histories (Fantuzzo, Boruch, Beriama, Atkins & Marcus, 1997).

Why do victims who experience intimate partner violence stay in violent relationships?

Many victims may stay or return to their abusers (Burman, 2003; Sonkin, 2012). The most commonly cited barriers to leaving are economics, fear, desire to keep the family together, lack of protection from courts and lack of support from friends and family. According to the American Psychological Association Task Force on Violence and the Family (1996), victims

may fear retaliation against themselves and their children by the abuser and fear the upheaval that may follow leaving the relationship. Many times, a victim's self-esteem is so low as a result of spousal abuse, that they are unable to see themselves as worthy of seeking help, believing they caused or deserve it. Research also indicates that emotional and financial dependency contributes to risk of domestic partner abuse and that high levels of dependency in an abused partner may reduce the likelihood that they will terminate the relationship (Burman, 2003; Sonkin, 2012). Cultural dynamics and norms also play an important role in a victim's decision to stay in an abusive relationship; for example, cultural differences in acceptance of intimate partner violence, cultural customs and beliefs about leaving relationships, concerns about citizenship status, and potential lack of culturally relevant resources that are available to help the victim.

Another contributing factor cited by Dutton (1992) is the development of a traumatic bond with the abuser, or emotional connection that is formed during the early phase of the relationship before the abuse begins and that is strengthened by intermittent expressions of concern and violence. As part of the traumatic bond, the victim may dissociate the abusive aspects of the relationship in order to allow her to survive within the relationship. As a result of dissociation of the abuse, the ability to accurately evaluate danger and to perceive alternatives to the situation may become impaired. Forced isolation on the victim may also cause increased dependency on the batterer. From an attachment theory perspective, a victim's own relational and trauma history may impact attachment style and style of coping with the abuse (Sonkin, 2012).

Victims of intimate partner violence are often reluctant to report abuse and victims who do report abuse or end the relationship may continue to experience abuse. Petitioners of domestic violence restraining orders are 2-3 times more likely to be killed after their order has been put into place. In general, domestic violence protection orders are violated about half of the time, and in many cases can aggravate a situation instead of making it safer (Fairweather, 2012). Studies show that the highest risk for serious injury or death from violence in an intimate relationship is at the point of separation or at the time when the decision to separate is made (Campbell & Dienemann, 2001).

These findings highlight the complexity of the process of ending intimate partner violence. The reason victims may stay in violent relationships is determined by a complex interaction of biological, psychological, cultural, relational and social dynamics. For optimal outcomes, assessment and intervention need to be geared to address all of these variables (Sonkin, 2012). A victim needs to feel safe and out of "survival mode" before she will be able to make significant changes.

Common Responses

Individuals who experience intimate partner or relationship violence often experience the following associated symptoms (Mancoske, Standifer, & Cauley 1994; Rycroft, 2000; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002):

- Lowered self-esteem

- Increased anxiety
- Depression
- Increased hostility
- Lack of assertiveness
- Lack of social support
- Lack of self-efficacy
- Lack of trust
- Suicidality
- Fear of intimacy
- Other PTSD symptoms (including detachment, sleep problems, nightmares and flashbacks)
- Substance abuse
- Acute and long-term effects on physical health

Effects on Children

When describing the effects of intimate partner violence on children, it is important to note that intimate partner violence and child abuse are often present in the same families. Children exposed to intimate partner violence may experience many events including hearing the batterer verbally degrade and threaten the adult victim, observing injuries sustained by the adult victim, being forced to participate in the adult victim's abuse, degradation by the batterer, attempting to intervene, and being physically injured themselves (Carlson, 1984; Strauss et al., 1990).

Studies have found that among children who were present during an incident of intimate partner violence, the majority had direct sensory exposure (Fusco & Fantuzzo, 2009; Hamby et al., 2011). The research shows that children may still be negatively impacted by intimate partner violence even when they have not directly witnessed the violence.

According to Holden (2003), the impact of children's exposure to intimate partner violence extends beyond witnessing the violence firsthand to include exposure to the aftermath of the incident (e.g., seeing injuries to his/her parent, hearing about the abuse, or experiencing changes in living arrangements).

Studies have found that children exposed to intimate partner violence experience a range of negative outcomes, with many of the same developmental consequences as child abuse. Children may blame themselves for the abuse (Cunningham & Baker, 2007), and may experience feelings of shame, guilt, and divided loyalties to parents making it unlikely that they will disclose the violence to others (Groves, 1999). Higher levels of internalizing and externalizing behaviors have been found in comparison to children who have not been exposed, such as low self-esteem, post-traumatic stress disorder, depression, anxiety, physical aggression, substance use, and school failure (Herrenkohl et al., 2008; Howell, 2011; Newton, 2001; Renner & Boel-Studt, 2012). There is some evidence of even longer term consequences; for example, the Adverse Childhood Experiences (ACEs) study showed evidence of a strong association between childhood stress (including from intimate partner

violence) and shortened lifespan (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss & Marks, 1998).

From an attachment perspective, Sonkin (2012) notes when exposed to intimate partner violence, infants are more likely to be insecurely attached to their mothers. Witnessing intimate partner violence also may cause children to have uncertainty about their parent's ability to respond to the their distress, as well as increased attachment anxiety due to fear that something bad may happen to either parent. Sonkin further reports that attachment challenges may lead to deleterious effects on the developing brain.

In terms of the impact of trauma on children's development, Perry, Pollard, Blakley, Baker & Vigilante (1995) report that "childhood trauma has profound impact on the emotional, behavioral, cognitive, social, and physical functioning of children…there are various adaptive mental and physical responses to trauma, including physiological hyperarousal and dissociation. Because the developing brain organizes and internalizes new information in a use-dependent fashion, the more a child is in a state of hyperarousal or dissociation, the more likely they are to have neuropsychiatric symptoms following trauma." Perry (2009) elaborates that trauma can increase risk of dysfunction in any brain-mediated function, such as speech, motor, social, emotional, or behavioral functioning.

The effects of witnessing or experiencing violence at home vary from one child to another. Because a child's level of coping skills and perception of intimate partner violence may vary according to age, effects of exposure to intimate partner violence may manifest differently in children of different developmental stages. The attributes that have been cited as giving a child the greatest chance of surviving or coping the most effectively with the abuse are average to above-average cognitive development, good interpersonal skills, high self-esteem and self-efficacy, religious affiliations, socioeconomic advantage, opportunities for good schooling, and contact with people and environments that are positive for development (Osofsky, 1999). A strong relationship with a parent or caregiver is also cited as a key factor in helping children heal from the effects of family violence. Maternal warmth, maternal limit setting abilities, and better maternal mental health are factors that have distinguished resilient children from those with depression or behavioral problems (Graham-Bermann, Gruber, Howell & Girz, 2009).

Standards of Practice for TERM Domestic Violence Group Treatment

Provider Credentialing

For information on ***Credentialing Standards, the Optum Credentialing Committee, Re-credentialing, Provisional Providers, and Interns*** please refer to the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) pages 3-7, along with Optum TERM standards for interns and provisional providers.

Provider Training and Experience Requirements

Because of the high risk nature of intimate partner abuse and relationship violence, combined with the severity of its impact on children at many levels, it is imperative that mental health providers be trained in appropriate assessment and intervention techniques. To be approved as a TERM domestic violence group treatment provider, providers are required to demonstrate a minimum of six (6) months supervised training experience in working with intimate partner violence victims and topics relevant to the Child Welfare population (including child abuse, parenting, denial, violence, neglect, substance abuse, child development, and diagnosis and treatment of emotional and mental disorders) and completion of an approved **forty (40) hour** training program in intimate partner violence that fulfills California State's requirement for domestic violence victim counselors. Ongoing advanced training in the area of intimate partner violence and related topics are also required to maintain approval for this specialty and include the following: 1) **Fifteen (15) hours** of CEUs in intimate partner violence training in the last thirty-six (36) months; AND 2) evidence of recent practice experience in group treatment of intimate partner violence victims.

Recommended training topics may include:

1) Information about same gender couple violence and treatment needs of this population.
2) Trainings in cultural competency: Understanding issues of culture, ethnicity, inter-racial relationships, acculturation, immigrant status, citizenship, SES, geographic origin such as rural or urban and the intersection of these factors.
3) Ethical issues, maintaining appropriate boundaries, and vicarious trauma.
4) Legal issues as they relate to intimate partner violence treatment, including mandated reporting requirements, confidentiality, and privilege.
5) A historical context of intimate partner violence, the role of society in perpetuating violence.
6) How to work effectively with victims who remain in contact with their abusers.
7) Co-occurring disorders and intimate partner violence.
8) Substance abuse and intimate partner violence.
9) Personality disorders and intimate partner violence.
10) Effects of intimate partner violence on parenting and children.
11) Trauma informed services.
12) Neurobiology of trauma and PTSD and the effects of intimate partner violence.
13) Attachment theory and child development.
14) Motivational Interviewing.

15) Parenting skills, including how to address reunification and co-parenting issues.
16) Impact of intimate partner violence on children and youth.
17) Dynamics of power and control.
18) Conflict resolution, respectful communication, assertiveness, and boundaries.
19) Assessment of intimate partner violence.
20) Safety planning and relapse prevention planning.
21) Seeking Safety to work with victims with co-occurring PTSD and substance abuse.
22) Crisis Intervention, including suicidality.
23) Cognitive restructuring IPV-related attitudes and beliefs, such as self-defeating thoughts.
24) Resiliency, empowerment, strengths-based treatment, and the recovery model.
25) Dialectical Behavioral Therapy.
26) Safety-Organized Practice/Signs of Safety.
27) Transtheoretical Model of Behavior Change.
28) Solution Focused Therapy.
29) Group facilitation and group dynamics.
30) Community resources.

The following trainings are available as a resource for providers:

1) Local domestic violence agencies provide a 40-hour training curriculum which meets CA State requirements for domestic violence victim counselors. The San Diego Domestic Violence Hotline, (888) DV-LINKS, have current information on approved 40-hour trainings in the community.
2) DV Essentials: An 8 hour bi-annual training given by the Domestic Violence Council.
3) Institute of Violence, Abuse and Trauma (IVAT).

Ethical and Legal Standards

Treatment providers and agencies working with victims of intimate partner violence must meet the ethical standards outlined by professional groups with which they are affiliated, e.g., the American Psychological Association, National Association of Social Workers, and the California Association of Marriage and Family Therapists.

Confidentiality and Consent for Treatment

Optum TERM providers do not have a “typical” therapist-client relationship with Child Welfare Services (CWS) clients. The limits of confidentiality are substantially different when performing Court-ordered therapy. In Voluntary Services cases, and when clients participate in services voluntarily in cases that are pre-jurisdiction, the therapist also closely collaborates with the Protective Service Worker (PSW). It is required that all TERM therapists discuss the limitations of confidentiality with all clients (e.g., that information gathered during the therapy process may appear in a treatment plan or progress report reviewed by the PSW and ultimately by the Court; delineating exceptions such as reasonable suspicion of child abuse, suicidal or homicidal threats; and TERM On-Site Monitoring Visits). As part of the informed consent process, providers should also obtain the client’s agreement to maintain confidentiality of the other members of the group. The general guideline for ensuring informed consent is that the

client must be advised in a language reasonably understandable to him/her and that the client be provided specific information regarding the nature of services, the role of the therapist, and confidentiality limitations. Providers are required to appropriately document the consent process in the client's record. For additional guidelines, please refer to Confidentiality and Consent for Treatment section in the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) pages 26-28.

Role of the Therapist

For general information on the role of a TERM provider, please see the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) pages 25-27. Additional key obligations for group providers include:

- For concerns regarding the appropriateness of a referral, providers should consult with the client's PSW.
- If a referral is generated from the PSW that may pose a potential conflict of interest, it is the responsibility of the provider to evaluate the appropriateness of the referral and decline if necessary.
- Providers acting as the treating therapist for other treatment modalities (e.g., individual therapy) should decline the role of group therapist if their client is referred for these services unless there are overriding clinical circumstances (e.g., lack of additional service providers in client's geographic area or with the required clinical expertise).
- Providers should not include perpetrators in the same group as victims.
- In the case in which a client has been both the perpetrator and victim of domestic violence, the provider should consult with the PSW if there is any question about which group type is appropriate.
- Services should be provided in the most appropriate language as determined by the client, and providers should be mindful of the client's level of literacy.
- Providers will report any new episodes of violence reported during treatment to Child Welfare Services as soon as possible.
- Statements made during the course of treatment may trigger mandated child abuse reporting. Providers will immediately report child abuse or neglect pursuant to PC Article 2.5 Child Abuse and Neglect Reporting Act, Section 11166.
- It is expected that providers will coordinate care with the referring agency, as well as with all professionals involved in a client's case. To facilitate effective coordination and communication, the client's written consent to exchange information with other appropriate professionals involved in the case should be obtained during the initial intake assessment.

Scope of Group Treatment

The focus of intimate partner violence treatment for parent victims is on increasing the safety of the parent and child(ren) and decreasing risk of violence in the family. The scope of therapy is determined by the Court's order (in Court ordered cases) and specified by protective issues and treatment goals supplied by the PSW on the Therapy Referral Form. For additional guidelines, please refer to Scope of Treatment section in the Optum TERM Provider Handbook

(Optum website under the TERM Manuals tab) pages 27-28.

Treatment Structure

Groups may be open (accepting new members on an ongoing basis) or closed in structure. The groups may range from a minimum of three (3) to a maximum of twelve (12) clients in any particular treatment group and should be separated by gender.

Group sessions will be a minimum of one and one half (1.5) hours per session. The length of treatment is based on a 26-week curriculum following a schedule of one (1) session weekly. Request for additional sessions must be communicated proactively to the PSW prior to exhausting the authorization on file and will be considered on the basis of clinical necessity.

Intake & Assessment

Each client will be evaluated individually at intake. The intake process shall be conducted or supervised by a licensed TERM provider. Clients whom treatment providers determine to be inappropriate for group treatment (e.g., due to immaturity, actively psychotic behavior, or borderline intellectual functioning) may be referred to individual treatment or other services for intimate partner violence as appropriate. Additional client care must be coordinated through the PSW. Providers are required to read the Therapy Referral Form and case background materials, and to use the information contained in these documents and gathered from the initial clinical interview to create case specific treatment goals and safety plans.

Intake

The intake process should include a clinical interview, review of collateral records, and formal assessment that covers the following:

- Basic identifying and demographic information, including educational, military and occupational history.
- Trauma history, including a detailing of the client's intimate partner violence history, including assessment of each type of abuse, physical, emotional, sexual and whether or not the child(ren) were present. Independent descriptions should be included from the referring agency and from criminal justice agencies, victims, and other treatment providers as applicable. A history of any other types of trauma and the client's role in the violence should be assessed as well.
- A mental status examination and clinical observations, including potential for harm to self or others.
- Risk assessment to identify and manage/reduce risk to clients and their children.
- A psychosocial assessment including mental health history, medical history, substance abuse history, cultural history, family of origin, developmental history, and relationship history.
- Strengths and protective factors.
- Barriers to participating in and adhering to treatment.
- History of child welfare involvement.
- Assessment of parenting, including names and ages of client's children, client's perceived

impact of IPV on children, and parenting skills/discipline strategies used by client.

- Use of required formal assessment measures including Drug Abuse Screening Test (DAST), Michigan Alcohol Screening Test (MAST), and Danger Assessment (Campbell, 2003) at a minimum and others as clinically indicated. For a list of assessment measures, please review online appendix Assessment Tools (Optum website under the TERM Group Standards Tab).
- Safety Plan

Assessment Measures

Minimum requirements include a substance abuse screening and domestic violence risk assessment as a part of the intake and initial assessment process. The literature indicates that formal risk assessments can help victims of abuse come to a more realistic evaluation of danger in their situation. Gathering as much information as possible both from clinical and actuarial sources is recommended to give providers information about whether or not the client will be able to participate in and benefit from treatment and to guide case-specific treatment planning efforts (Roehl, O'Sullivan, Webster & Campbell, 2005). For example, if assessment indicates that substance abuse or mental health symptoms require treatment before admission into the group or concurrently with the group; this should be documented in the Initial Client Plan and coordinated with the PSW. Providers are encouraged to use other assessment measures in order to capture an adequate picture of the client's needs and functioning. Please see online appendix Assessment Tools (Optum website under the TERM Group Standards Tab) for a list of relevant measures, which are divided into the following assessment categories:

Substance Abuse (required)

The literature indicates a strong bi-directional relationship between trauma and substance abuse, and an intimate partner violence victim cannot be successfully treated without also treating co-occurring substance abuse issues. During the intake and initial assessment process, clients participating in group therapy should be screened for alcohol and drug abuse, utilizing the DAST and MAST from the online appendix Assessment Tools (Optum website under the TERM Group Standards Tab). Therefore, if the initial intake evaluation indicates drug and/or alcohol abuse or dependence, this should be addressed at the onset and within the context of the overall treatment. Providers are required to document in the Initial Client Plan and to coordinate with the PSW if the client's substance abuse is so severe that it would impact the client's ability to benefit from group treatment. Providers will report to Child Welfare Services any client's failure to comply with the substance abuse treatment recommendations utilizing the Intake Assessment or Group Quarterly Progress Report form (found on the Optum website under the TERM Group Standards Tab).

Domestic Violence Risk (required)

Domestic Violence Risk assessments were designed to help professionals understand the victim's current risk of being re-assaulted and to provide useful data to consider during the safety planning process. A domestic violence risk measure needs to be used during the

intake and initial assessment process. The Campbell Danger Assessment (DA) is required.

Domestic Violence Assessments – Treatment Needs

Several different tools have been developed to provide insight into the impact of intimate partner violence on the client and his/her readiness for change. Providers can develop interventions specific to the stage of change the client is in and gauge what areas will need to be addressed in treatment. Several of these measures can also be used as outcome measures to track the effectiveness of therapy.

Trauma

Trauma measures can help clarify the nature and severity of trauma symptoms and can be used to inform treatment planning. Clients whose trauma symptoms are severe enough to impact their ability to benefit from group treatment should have their symptoms of trauma addressed before beginning a Domestic Violence group.

Mental Health

Providers should complete a mental health screening tool if mental health concerns are suspected, if risk for suicidal or homicidal intent is present, and/or if the client's PSW indicates concern. The results from the mental health screening can help determine whether the client is a candidate for group treatment and to target specific treatment needs. The mental health screening tools can also be used as outcome measures to track treatment effectiveness.

Outcome Measures

Repeated assessment to measure treatment progress and outcomes is recommended. Many of the assessment tools in Assessment Tools (Optum website under the TERM Group Standards Tab) can be given pre-treatment and post-treatment to track client's progress in group. Self-report measures, such as the Beck Depression Inventory-II, Beck Anxiety Inventory, or Beck Hopelessness Scale can track changes in a client's symptoms over time. The Domestic Violence Survivor Assessment (DVSA) measures the stage of change that the client is in related to her abusive relationship and can be used to demonstrate change over time as clients progress through treatment (Murray & Graves, 2013). One of the most important outcomes for domestic violence treatment is the client's ability to demonstrate the use of safety skills for herself and her children.

Treatment Approach

Therapists are required to provide services in a manner that is consistent with professional, ethical, and legal standards of practice. Domestic Violence group treatment approaches should be trauma and evidence-informed, and should be selected to maximize the client's ability to address the protective issue(s) and mitigate risk to the child(ren). The over-arching goal for intervention with victims of intimate partner violence is the promotion of safety for the family and ending the abuse. Treatment based upon formal risk and needs assessment is the

preferred approach, provided within a context of comprehensive support for the victim and child(ren).

Interventions should be formed from a recovery and resiliency based approach with an understanding of complex factors such as trauma history, gender, culture, sexual orientation, and socioeconomic class (Sanchez-Hucles & Dutton, 1999). In addition, a broader socio-cultural context in which intimate partner violence is both permitted and perpetuated should be considered (Brooks & Hesse-Biber, 2007).

It is important in the group setting to guard against potential re-traumatization of victims by using unbiased and non-judgmental wording and refraining from assigning blame. Any approach or practice that blames or intimidates the victim or places the victim in a position of danger is not appropriate. Techniques that increase the risk to the victim, such as ventilation techniques which encourage or include aggression, are not appropriate. It is imperative to assess and treat victims specifically for symptoms of PTSD and related mental or physical health issues (Kuijpers et al., 2011). Before beginning group work, providers should assess the individual's readiness to address trauma. They should also ensure the individual's mental health and substance use are stable enough to endure group work and that the individual has adequate coping skills and social support in place to avoid re-traumatization (Wiland, 2009). It is not appropriate to begin domestic violence treatment utilizing couples or family therapy, and these modalities should only be recommended with extreme caution at such a time that the perpetrator has demonstrated successful completion of treatment including completion of a relapse prevention plan. Per San Diego County Probation Domestic Violence Offender Standards "Couple's or family counseling are currently prohibited by California State Law within the 52 week program pursuant to PC1203.097(c)(1)(G). Any referral to couples counseling shall meet the criteria set by San Diego Domestic Violence Treatment and Intervention Committee of the Treatment, Evaluation and Monitoring Committee.

Safety Planning and Risk Assessment

Safety planning is the first priority when working with survivors of intimate partner violence (Murray & Graves, 2013). Safety planning should include an assessment of general safety risks that survivors encounter as well as specific risks that are present in various areas of their lives. The plan should encompass methods which are aimed at resolving immediate threats and other issues impairing welfare and safety of survivors, including identifying community, medical and social resources, facilitating access to resources, minimizing or eliminating risk and the development of a written safety and protection plan (Roberts & Burman, 1998). Battered women seeking help may already have a safety plan in place, but therapists should still review these plans with their clients to get a clearer understanding of their unique needs and to make any updates as clinically indicated. Providers are required to review collateral records and coordinate safety planning with safety goals identified in the client's case plan.

Interventions for victims should emphasize both immediate and short-term objectives as well as long-term adjustment goals. Immediate objectives include assisting victims in identifying the impact of violence and abuse, promoting their personal sense of safety and empowerment, and

planning to ensure the safety of the child(ren) (Rycroft, 2000). Long-term objectives emphasize the resolution of emotional and psychological trauma. Group counseling for victims of intimate partner violence offers a fairly uniform approach, including addressing steps to ensure client's safety, identifying effects of intimate partner violence, promoting resolution associated with emotional and psychological impact, promoting insight and self-empowerment, increasing problem solving skills and access to social support (Roberts & Burman, 1998; Rycroft, 2000; Mancoske et al., 1994).

Evidenced-Informed and/or Promising Practices

Interventions for victims of intimate partner violence are relatively under-developed in the literature (Brosi & Rolling, 2010; Lee, 2007). However, several approaches have gained empirical support or are cited in the literature as promising practices (Murray & Graves, 2013).

Cognitive-Behavioral Therapy (CBT)

CBT is specifically used in treatment of intimate partner violence and helps survivors understand the thoughts and feelings that influence behaviors. CBT helps survivors develop more helpful and healthy thoughts, feelings, and behaviors while highlighting client strengths and resources (Cohen, 2008). CBT is also commonly used to treat a wide range of co-occurring disorders, including phobias, addiction, depression and anxiety. A cognitive-behavioral approach seems to be the favored theoretical intervention with survivors of intimate partner violence and has had the most empirical support for treating trauma survivors in general (Roberts & Burman, 1998).

Dialectical Behavioral Therapy (DBT)

There is growing evidence identifying DBT as a useful component in treatment of intimate partner violence. Although the research is limited to date, several studies show that it is a promising intervention. The Mindfulness, Distress Tolerance, Emotional Regulation, and Interpersonal Effectiveness Skills components of DBT can help survivors of intimate partner violence learn more effective ways to manage their symptoms (Iverson, Fruzzetti & Shenk, 2009).

Solution-Focused Therapy

Solution-Focused Therapy has been used with domestic violence offenders and has also been shown to be a promising practice with women who have experienced intimate partner abuse (Lee, 2007). The overall goals of Solution-Focused Therapy are to stop violence, establish safety, empowerment, and healing. This form of therapy utilizes the client's strengths and competencies.

Group Psychoeducation

Survivors often benefit from psychoeducational material given in group settings that help them develop knowledge and skills to manage the effects of their abuse (Murray & Graves, 2013). Psychoeducational activities can include skills training and brainstorming discussions on topics such as self-esteem, trust building, boundaries and conflict

management. Research indicates the approach provides a useful forum for clients to develop increased insight while building support and connection with other group participants (Murray & Graves, 2013).

Transtheoretical Model of Behavior Change (TTM)

Leaving an abusive partner is a complex process that involves multiple stages. The Transtheoretical or Stages of Change Model conceptualizes this process as including five stages based on a woman's readiness to leave or address the intimate partner abuse (Burman, 2003). The Stages of Change include: pre-contemplation (i.e., minimizing the abuse), contemplation (i.e., ambivalent but questioning), preparation (i.e., exploring options for change), action (i.e., breaking away or curbing abuse), and maintenance (i.e., establishing a healthier new life). The process of behavior change in intimate partner relationships is often cyclical, with progress and relapse between stages (Burke, Mahoney, Gielen, McDonell & O'Campo, 2009). By assessing what stage of change a woman may be in at any given time, the provider's interventions can target specific needs at each stage. A potential limitation of this approach is it may not account for relational components unique to the process of leaving, in particular parenting and partner factors. For example, gender roles of women as wives/partners and as mothers may be barriers to them leaving (Brooks & Hesse-Biber, 2007; Burman, 2003).

Motivational Interviewing (MI)

MI is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. MI has been applied to a wide range of maladaptive behaviors, including intimate partner violence, related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. Providers can use MI to help victims progress through the Transtheoretical or Stages of Change Model above (Burkitt & Larkin, 2009).

Adjunctive Approaches

Seeking Safety

Seeking Safety is the first empirically studied, evidence-based integrative treatment approach developed specifically for PTSD and substance abuse (Najavits, 2011). It is based on CBT and is designed to explore the link between trauma and substance abuse using a present-focused coping skills model. It then teaches clients skills to help build resilience, detach from emotional pain, engage in "recovery thinking" and increase safety (Najavits, 2011). While not aimed specifically at treatment of domestic violence, numerous research studies document its effectiveness in a variety of populations and settings as an approach for co-occurring substance abuse and trauma.

Beyond Trauma: A Healing Journey for Women

This is an integrated curriculum based on theoretical, research, and clinical experience. While the materials are designed for trauma treatment, the connection between trauma and substance abuse in women who have been victims of abuse is a theme throughout

(Covington, 2003). The program has been developed for use in residential and outpatient treatment settings, domestic violence programs, mental health clinics, and criminal justice settings. *Beyond Trauma* uses a strengths based approach, with a psychoeducational component that teaches women what trauma is, its process, and its impact on both the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). The major emphasis is on coping skills with specific exercises for developing emotional wellness (Covington, 2003).

Curriculum

Treatment goals should be case specific, based on structured clinical assessment and review of collateral materials supplied by the PSW. Outcomes should be measured by increased safety and capacity for protection of the child(ren), and changes in three (3) core components: attitudes, beliefs, and behaviors that have perpetuated violence and maltreatment. The suggested core topics below should be incorporated into the Domestic Violence Victim group curriculum, with additional topics to be added as clinically appropriate at the provider's discretion. The curricula topics were derived from a variety of approaches described in the literature, for example, A Journey Beyond Abuse: A Step by Step Guide to Facilitating Women's Domestic Violence Abuse Groups (Fischer & McGrance, 2001), Motivational Interviewing and Stages of Change in Intimate Partner Violence (Murphy & Maiuro, Eds., 2009), Treating PTSD in Battered Women (Kubany & Ralston, 2008) and Responding to Family Violence: A Comprehensive, Research-Based Guide for Therapists (Murray & Graves, 2013).

What is Domestic Violence?

- Definitions
- Patterns and cycle of abusive behavior
- Myths and beliefs regarding intimate partner violence
- Tactics of power and control that include isolation, emotional abuse, economic abuse, sexual abuse, using children, using male privilege, intimidation, and threats

Obstacles to Leaving

- Readiness for change
- Identifying internal (emotions, beliefs, attitudes, cultural and family values) and external (money, transportation, family and social pressures) barriers that may keep victims stuck
- Co-dependency
- The process of leaving

Safety Planning (Refer to online appendix Safety Plan Guidelines, on the Optum website under the TERM Group Standards Tab, for elements)

- Development of a safety plan for parent victims and their children, including:
  - Identification of immediate and long term safety needs for both clients and children. Each identified safety threat should be included, along with detailed safety interventions
  - Building a safety network, identifying community resources, and building skills for

independence
- o After-care safety planning

Recognizing Warning Signs

- Recognizing risk of lethality and red flags
- Recognizing and responding to triggers for both victim and batterer
- Recognizing signs of exposure to violence and abuse in children

Legal Aspects

- TRO, Criminal Protective Orders, etc.
- Effects on immigration status
- Custody and family court

Alcohol, Drugs and Codependency

- Definitions of alcoholism and other forms of substance abuse, their impact on the individual and the family system
- Development of a relapse prevention plan (if indicated)
- Relationship between domestic violence and substance abuse, and substance abuse and trauma

Effects of Intimate Partner Violence

- Understanding its impact on individual and family
- Motivations for continuing abusive relationships versus leaving
- Identify what roles were played

Understanding the Effects of Intimate Partner Violence on Children

- Neurobiology of trauma (please refer to the Little Eyes, Little Ears link in the resources section below for a summary of the effects of abuse on the development of children or Bruce Perry's (1995 and 2009) articles in the references section below for more detailed information about the neurobiology of trauma)
- Relationship between intimate partner violence and risk for child abuse
- Risk intimate partner violence poses to the emotional and physical well-being of child(ren)
- Short and long term signs and symptoms of trauma on child(ren)
- Impact of trauma at different developmental stages

Setting Boundaries

- Assertiveness, conflict resolution, communication
- Anger management and behavioral control
- Sexuality and intimacy

Parenting and Developing the Protective Role

- Identify barriers and strengthen skillset for parenting
- Focus on safety, strategies for regulating affect and behavior in children, improving the child-caregiver relationship, normalization of child's trauma related response and helping children heal from trauma
- Reunification (anticipating and overcoming common challenges with reunifying)
- Co-parenting effectively
- Changing maladaptive patterns of interactions
- Establishing appropriate parent-child roles
- Appropriate limit setting

Understanding Trauma Responses

- Guilt, shame, and denial
- Grief and loss
- PTSD, depression, other mental health symptoms
- Mind-body connection

Trauma Recovery and Empowerment

- Coping skills to include self-soothing, grounding, distress tolerance, emotional and regulation skills
- Recovery plan to include identification of trauma triggers and strategies to proactively use coping skills during stressful times
- Building self-esteem, self-efficacy and resiliency
- Understanding linkages between past experiences and current thoughts, feelings and behaviors and the impact on parenting practices
- Learning how to develop more empowering and balanced thoughts
- Ability to identify and address trauma triggers

Understanding Healthy Relationships

- Family of origin patterns and behavior as it relates to partner violence
- Power sharing and decision making issues in a relationship
- Skills for gaining intimacy in relationships
- Cultural and societal basis for violence to include values, beliefs, and behaviors
- Non-violence and equality model for relationships that includes non-threatening behavior, respect, trust and support, honesty and accountability, shared responsibility, economic partnership, negotiation and fairness, and responsible parenting

Documentation Requirements

All providers are expected to keep a clinical record to document service provision, including a progress note of each service provided, Intake Assessment, documentation of informed consent and coordination of care, quarterly Group Progress Updates, and Discharge Summary. For additional documentation requirements refer to online appendix Documentation

Requirements (Optum website under the TERM Group Standards Tab).

Treatment Progress Reporting

Intake Assessments, Group Progress Updates, and Discharge Summaries are required to be submitted to Optum TERM at 877-624-8376 on the most current version of the required reporting forms (please note that the most up to date versions of the forms can be located on the Optum website under the TERM Group Standards tab). Once the Intake Assessments, Group Progress Updates, and Discharge Summaries have passed clinical review, they will be forwarded by Optum TERM to the client's assigned PSW.

Consistent with emergent values in mental health, transparency and collaboration in the treatment planning process is encouraged, including sharing perceptions of progress with the client. Documentation included in the progress section should be specific to the identified over-arching treatment goals.

Intake Assessment

A written individualized Intake Assessment (located on the Optum website under the TERM Group Standards Tab) listing the goals and objectives of the treatment program shall be developed during the intake process and submitted to Optum TERM **within fourteen (14) days from the date the initial authorization** for treatment is issued. A copy should be maintained in the client's case file.

The Intake Assessment must include a complete diagnosis from the most current DSM (*Note: As of the publication date of these standards, DSM-5 has not yet been adopted by the State of California Department of Health Care Services*). The Intake Assessment should include results of formal assessment measures and case specific treatment goals that address the identified client risk factors and curricula elements specified above.

Quarterly Group Progress Updates

A progress report indicating client's individual progress in group treatment should be submitted to Optum TERM **every twelve (12) weeks after the Intake Assessment is submitted**. Group Progress Update forms are located on the Optum website under the TERM Group Standards Tab. A copy should be maintained in the client's case file.

Discharge Summary

A Discharge Summary should be submitted to Optum TERM **on completion or termination of services** using the Group Progress Update form located on the Optum website under the TERM Group Standards Tab. A copy should be maintained in the client's case file. Progress toward treatment goals will be used to determine whether a client will be given a certificate of completion.

A certificate of completion will be given under the following conditions:

- Successful completion of the program with fulfillment of established treatment goals.
- Re-admission following a termination may be permitted based on re-evaluation by the

referring agency and the treatment provider. If the program is then successfully completed, a certificate should be given.

A certificate of completion will be withheld if:

- An administrative discharge is given (e.g., Child Welfare Services case is closed).
- An inability to continue in the program (e.g., a move out of state or a referral to another treatment program).
- Violation of the conditions of the client agreement for services (any additional treatment needs must be communicated proactively to the PSW for continuity of care).

Quality Review Process

All Intake Assessments, Group Progress Updates, and Discharge Summaries are subject to review by an Optum TERM clinician. The goal of the review process is the provision of reports to the Court that meet professional standards of practice and assist Child Welfare Services and the Court with case planning.

During the quality review process, Intake Assessments and Progress Updates are reviewed against quality standards outlined in the Standards. The reviewer ensures the guidelines for treatment and client plan requirements are followed. In addition, the following elements are also reviewed:

- Has appropriate assessment and safety planning been completed?
- Are client's current functioning and strengths included, with supportive behavioral examples?
- Are the obstacles to treatment and progress addressed?
- Are the therapeutic interventions cited appropriate to clinical circumstances and consistent with professional standards of care?
- Is progress related to the treatment goals, and is the reader provided with sufficient insight into how the case is progressing?
- Are protective and risk issues listed on the Therapy Referral Form being addressed? Are treatment goals case-specific?
- Is the report objective?

When an Intake Assessment or Progress Update does not meet quality review standards, or the reader of the report (e.g., judge, PSW, or attorney) expresses concerns or files a complaint, the Optum TERM reviewer may contact the provider by telephone or written correspondence (sent via mail or fax). The reviewer then discusses the specific concerns that were identified. If the provider concurs with these concerns, the provider revises the client plan and/or report and forwards it to Optum TERM. The provider has the right to disagree with the Optum TERM reviewer and to decline to submit revisions. This may result in notification to the PSW, and subsequently the Court, that the report did not pass quality review. In addition, at any time, Optum TERM may choose to implement the complaint process if there are significant concerns regarding the work product or if there are ongoing issues that cannot be resolved. Per contractual agreement, Optum TERM panel providers are required to comply with quality

improvement initiatives, including the quality review and complaint resolution processes.

Actions related to complaints could include, but are not limited to, the following: responding to inquiries by Optum TERM reviewers, meeting with Optum TERM staff, completing requested revisions to the treatment plan and/or progress report, fulfilling requirements for additional education, training, or consultation, adhering to a quality improvement plan, or being made temporarily unavailable to new referrals. Formal review by an Optum quality committee or referral to the Credentialing Committee may also occur in relation to any significant quality of care issues.

Please respond to staff requests for quality review consultation in a timely fashion so as to avoid missed deadlines or delays to Court proceedings. Intake Assessment and/or Progress Update revisions must be submitted within seven (7) business days of being requested by TERM staff. If there are extenuating circumstances that preclude meeting this expectation, this should be discussed with Optum TERM staff at the time of the consultation.

Site Monitoring

Providers must agree to monitoring, which will include but is not limited to annual site visits, inspection of required documentation, and visitation of treatment groups during actual group meetings performed by a TERM team clinician. A copy of the On-Site Group Monitoring Audit Tool is located on the Optum website under the TERM Group Standards Tab. Sites that do not meet established clinical standards or expectations may receive increased monitoring and disciplinary action.

Complaint Process

Providers understand that TERM, CWS, and the Probation Department will communicate regularly and specifically when issues arise regarding monitoring and/or certification, quality of care issues, ethical and/or professional concerns and any other issues relevant to TERM, CWS, or the Probation Department. For general information on the Optum TERM complaint process, please refer to the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) page 58.

Recommended Resources

California Partnership to End Domestic Violence: The California Partnership to End Domestic Violence is on the forefront in advocating for social change through innovative solutions to ensure safety and justice for victims and victims of domestic violence and their children.

Child Witness to Violence Project: Offers general information about the effects of domestic violence on children, statistics, and the *Report on Violence and Children.*

Domestic Violence 101: http://www.familyjusticecenter.org/jdownloads/finish/56-domestic-violence-101/357-dv-101-domestic-violence.html

Family Justice Center San Diego: A public safety initiative launched by the City of San Diego to assist victims of family violence. Known as the "One-Stop-Shop" for family violence needs.

The Greenbook Federal Initiative: Provides resources and information regarding the six federally funded communities implementing the National Council of Juvenile and Family Court Judges guidelines, Effective Intervention in Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice.

Little Eyes, Little Ears: How violence against a mother shapes children as they grow. Cunningham, A. & Baker, L. (2007). Provides a brief overview of how abuse affects children at various developmental stages.

National Center for Victims of Crime: NCVC strives to forge a national commitment to help victims of crime rebuild their lives. They provide important links as well as current issues relevant to individuals, families, and communities harmed by violence and crime.

National Child Traumatic Stress Network: A national organization whose mission is to raise the standard of care and improve access to services for traumatized children and their families and communities.

National Coalition Against Domestic Violence: The National Coalition Against Domestic Violence (NCADV) is dedicated to ending violence in the lives of women and children.

National Network to End Domestic Violence: The NNEDV is an advocacy organization for domestic violence coalitions and is a leading voice among domestic violence advocates in public policy, as well as providing support to local programs and coalitions through information, research, funding, and training.

National Partnership to End Interpersonal Violence: The NPEIV is a policy advocacy program whose mission is to make the prevention of interpersonal violence a national priority. The program works to address gaps and barriers through education, nationwide campaigns, and research.

Resource Center on Domestic Violence: Child Protection and Custody: Comprehensive publications and technical assistance to the fields of domestic violence, child protection, and custody regarding policy and practice issues inherent in work with children exposed to domestic violence.

Safe Start Initiative: A federal initiative with the mission to broaden the knowledge of and promote community investment in evidence-based strategies for preventing and reducing the impact of children's exposure to violence.

San Diego Domestic Violence Council: An organization that works with community partners to collaboratively promote initiatives to reduce intimate partner violence. The website has a complete list of nationwide resources.

San Diego Domestic Violence Hotline: (888) DV-LINKS (888-385-4657).

San Diego Regional Guide Domestic Violence Resources: Resources for Domestic Violence needs, such as counseling, legal, and shelter information.

Substance Abuse and Mental Health Services Administration (SAMHSA): Substance Abuse Treatment and Domestic Violence Treatment Improvement Protocol (TIP).

The 12 Core Concepts: Concepts for understanding traumatic stress responses in children and families.

Treating PTSD in Battered Women: A step-by-step manual for therapists and counselors emphasizing a cognitive behavioral approach to domestic violence therapy.

Understanding Domestic Violence: An overview of domestic violence dynamics for Victims, Batterers, Children, and Communities.

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Appendices

All appendices mentioned are listed below and available on the Optum website www.optumhealthsandiego.com under the TERM Group Standards tab.

- Assessment Tools
- Safety Plan Guidelines
- Intake Assessment Form
- Group Progress Report Form
- On-Site Group Monitoring Tool
- Documentation Requirements