CHILDREN IN CRISIS:
Advocates for Children's Domestic Violence Education Advocacy Project

Advocates for Children of New York
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EXECUTIVE SUMMARY

During the 2001-2002 school year, Advocates for Children (AFC) piloted a project called the Domestic Violence Educational Advocacy Project (DVEAP) that provided individual school-related advocacy for children who had been exposed to domestic violence or abuse and who were having significant problems in school. Our experience indicates that many of these children were also suffering from undetected and untreated trauma-related illnesses. As a result, these children were unable to perform up to their academic potential, suffered from overwhelming anxiety, and developed behavior problems that, at best, exacerbated any learning difficulties or other emotional problems they may had already had, and, at worst, led to psychiatric hospitalizations or involvement with the juvenile justice system. AFC's cases suggest that the public school system, in particular the special education system, bears the brunt of this problem.

A common thread in all the cases AFC has worked on is the reluctance of mental health providers, educational evaluators, and school staff to coordinate their assessment and treatment efforts in order to develop appropriate educational and mental health plans for these children. Thus, even though children may see an array of professionals and service providers throughout the years, their trauma-related conditions are not being identified or addressed in a comprehensive or meaningful way. Children who have been exposed to family violence and who are suffering from chronic trauma-related disorders slip through the cracks of many different social service systems simply because of each system's unwillingness to see the full scope and consequences of the problem.

Without appropriate and targeted interventions, these children, and thousands of others in New York City, are at significant risk for academic failure, continued social difficulties and, ultimately, involvement with the juvenile justice system. The solution must include a multi-disciplinary approach, focused on building the capacity of schools and health professionals who continue to have contact with children even after a family recovers from crisis.

Findings

The DVEAP served a total of 111 families, 40 of which we served through direct representation and 71 of which we served by providing technical assistance to professionals and advice to parents. From working with these families and children exposed to domestic violence, we made the following findings.

Schools do not respond appropriately to the needs of children who have been exposed to violence or abuse.

- Of the children who had been evaluated for special education (over 90%), most had a disclosed history of exposure to violence and this history was documented in Board of Education files. Nonetheless, the Board of Education never offered any targeted interventions to these children.

Children who have been exposed to domestic violence are having severe behavioral problems in school.

- 50% of children had been diagnosed with attention-deficit hyperactivity disorder (ADHD).
- Over 50% of children had been classified as "emotionally disturbed."
- 45% of these children had been diagnosed with a mental illness or disorder1 or had a prior psychiatric hospitalization.
- Almost all demonstrated symptoms of trauma-related illness such as increased aggression, severe anxiety, enuresis, severe temper tantrums, and self-injurious behavior.

Children who have been exposed to violence and who may be suffering from trauma-related illnesses are being referred to special education.

- 90% of children had been referred for an evaluation for special education services.
- 50% of children had been given recommendations for segregated special education settings – classrooms reserved for only the most severely disabled.

These children are not getting the evaluations, treatment, or services they need because there is a lack of coordination among mental health providers, primary care professionals, educational evaluators, educators, and outside service providers.

- Almost all children had been involved with social service agencies and had received counseling. Almost all had been evaluated for special education services. Many had been involved with mental health professionals.
- There was no coordination among these professionals to develop appropriate educational programming or effective and targeted therapeutic services.

The effects of exposure to violence can last for years.

- At the time of representation, all children were having serious problems in school. In approximately 35% of the cases, the violence had ended 3 or more years prior to representation. For 33% of the children, the traumatic event(s) occurred more than 1 year prior to representation.

Recommendations

The consequences of leaving trauma-related illnesses in children untreated are enormous and long-lasting, as demonstrated by the DVEAP pilot project's cases. It is clearly time to provide a comprehensive solution for the tens of thousands of families that are affected by domestic violence each year in New York City.

- *Form a working group* of educators, special educators, educational advocates, hospital-based trauma specialists, researchers, and domestic violence children's

1 E.g. bipolar or mood disorder, oppositional defiant disorder, conduct disorder, depression.

services staff to form an agenda for addressing school-related problems and inter-agency service delivery in New York City.

- *Develop a collaborative center for children exposed to violence* where low-income children can be properly evaluated and treated, research can be conducted, and clinicians and educators can develop appropriate school-based interventions and educational and therapeutic programming.

- *Build the capacity of domestic violence service providers* to effectively identify and address children's educational issues, and expand the legal definition of children's services in the social services regulations, as it is currently limited to counseling and childcare.

- *Build the capacity of special education evaluators and service providers* to understand the impact of trauma on learning and to make appropriate service recommendations that are guaranteed by law.

- *Develop research projects* to study the school experiences of children exposed to domestic violence, child abuse, and other trauma, with a focus on examining the incidence of children exposed to childhood trauma who are referred for special education and placed in segregated special education settings, such as those run by District 75 programs and day treatment.

I. Introduction

During the 2001-2002 school year, Advocates for Children of New York (AFC) piloted a project that provided individual school-related legal services and advocacy for children exposed to domestic violence or abuse, and who were having significant behavioral, social, and learning difficulties in school. These services were designed to help battered mothers navigate the education system and, where appropriate, the special education system to obtain special education and related services, which are entitlements created by federal law. AFC initiated this project because over the past few years, staff had begun to identify significant and increasing numbers of challenging special education cases in which there was a history of family violence and children were experiencing behavioral and learning difficulties in school.

Staff of this project found that many of the children served were suffering from undetected and untreated Post Traumatic Stress Disorder (PTSD), co-occurring with a history of exposure to family violence, as well a range of other emotional, behavioral, cognitive, and attitudinal problems associated with domestic violence.[2] This population of children was unable to perform up to their academic potential, suffered from overwhelming anxiety, and had developed behavior problems that appeared to exacerbate any learning difficulties and other emotional problems they already had. In the most extreme cases, the children needed psychiatric hospitalizations and/or ended up involved with the juvenile or criminal justice systems. AFC's cases suggest that the special

[2] The project was concerned specifically with cases in which there was a co-occurrence of exposure to family violence and problems such as PTSD, and behavioral, social, and learning disabilities. Many, but not all, children who are exposed to domestic violence suffer such extreme effects. The available research reveals a great deal of variability in the impact on children of exposure to family violence, depending on the child's inherent coping skills as well as risk and protective factors in their environment. See "Responding to the Co-occurrence of Child Maltreatment and Adult Domestic Violence in Hennepin County," Jeffrey L. Edelson, Ph.D. (2000) http://www.mincava.umn.edu/link/documents/finrport/finrport.shtml.

education system, in particular, bears the brunt of the responsibility for addressing not only the educational needs of this population, but for addressing the complex behavioral and emotional needs which may be affecting their school performance. Our work demonstrated to us that the school system was unable to properly address these issues and there were no other programs set up to address the set of issues and problems that these children face.

During the project year, we served a total of 111 families, 40 of which we served through direct representation and 71 of which we served by providing technical assistance to professionals and advice to parents.

In our experience, the school system is not trained to identify trauma that is associated with exposure to family violence, evaluate the impact it has on children, or offer instructional and supportive services to address those needs. Moreover, service providers who come into contact with families dealing with domestic violence and its residual effects do not have the capacity to provide parents with information about their children's educational rights, in particular about the special education service system. Parents need this information to ensure that their children are properly serviced, so that their children can academically progress and succeed.

This report provides an overview of the pilot project and information learned through the experiences of trying to work with multiple systems to leverage existing service entitlements for the children. The report begins with a summary of the impact of domestic violence on children and the incidence of domestic violence in New York. Next is an overview of the special education system and a short description of the manner in which the federal law governing special education is supposed to be implemented for

children. AFC's pilot program is then described in detail, and case examples are highlighted to illustrate the systemic problems identified through our project. Finally, the report concludes with recommendations for the next steps to start improving service delivery to these children.

II. The Prevalence of Childhood Exposure to Domestic Violence

National research studies estimate that between 3.3 million and 10 million children a year are exposed to domestic violence.[3] The rates of domestic violence are significantly higher in cities than in rural or suburban areas. Furthermore, poor families are more likely to be affected than are middle class or affluent families.[4] Statistics gathered from New York City (NYC) agencies point to tens of thousands of families affected by domestic violence each year.

According to the Mayor's Management Report, in 2002 there were over 220,000 domestic violence incidents reported by the NYC Police Department and NYC's Domestic Violence Hotline received over 150,000 calls. According to the Mayor's Office to Combat Domestic Violence, the NYPD, on average, responds to over 600 domestic violence incidents per day. The NYC Health and Hospitals Corporation reports that public hospitals and treatment centers identified 2,518 cases of domestic violence in 2001. These statistics, however, may not accurately capture how many children are exposed to domestic violence each year in NYC, as there are concerns amongst advocates about the underreporting of domestic violence incidents.

[3] "Domestic Violence and Children: Analysis and Recommendations," The Future of Children Winter 1999, p. 5.
[4] "Special Report: Intimate Partner Violence," U.S. Department of Justice, Bureau of Justice Statistics (May 2000) p. 5.

Despite the desperate need to identify and serve children who have been exposed to family violence, there are currently few resources devoted to developing a system for identifying, evaluating, and treating children exposed to violence in NYC.

A. The Impact of Domestic Violence on Children

More than a decade of empirical studies demonstrates a significant correlation between exposure to domestic violence and negative effects on a child's behavioral, emotional, social, and cognitive development. Children exposed to domestic violence can develop problems such as anxiety, sleep disturbances, increased aggression, and depression.

Behavior problems can also include temper tantrums or fights, suicidal tendencies, tics, bed-wetting, phobias, and attention deficits. Studies find that children exposed to violence also demonstrate lower motor, verbal, and cognitive skills. On the academic level, there is a higher rate of academic difficulties.[5] Children who both witness and are victims of violence are more at-risk than children who only witness it. Exacerbating the problem is the multiple related forms of exposure to conflict and violence that many children experience, such as community violence, media violence, and violence in the school itself.[6]

Early identification and intervention in the lives of children suffering negative consequences from exposure to domestic violence are critical. School-based

[5] Expert testimony of David Pelcovitz, M.D., child and adolescent psychiatrist, as reported in Nicholson v. Williams, 203 F.Supp.153, 197 (E.D.N.Y. 2001).
[6] "Children's Witnessing of Domestic Violence," Jeffrey L. Edelson Ph.D., Journal of Interpersonal Violence, Vol. 14, No. 8 (August 1988).

intervention and a favorable educational climate have been shown to contribute significantly to children's resiliency. [7]

If left untreated, these symptoms may lead to serious problems in adolescence and adulthood, including aggression and violent behavior in the home, academic difficulties, and involvement in the juvenile justice system. Furthermore, without intervention, these children may possibly fall into the same types of abusive relationships as their parents.[8]

B. Picture of Services in New York City

Although NYC, as an extremely large urban area, has a huge number of children exposed to domestic violence, there is no center here designed to conduct research and assessments, or provide services and offer technical assistance to schools and mental health providers on how to address the needs of this vulnerable population. Other locations are leaps and bounds ahead of NYC on this issue, to the extreme detriment of NYC children.

For example, Boston Medical Center's Child Witness to Violence Project employs a multidisciplinary team of mental health practitioners, social workers, and early childhood specialists to provide counseling, advocacy, and outreach to serve children exposed to domestic and community violence. In Connecticut, the National Center for Children Exposed to Violence serves as a resource center and provider of technical assistance to programs that respond to children and families exposed to violence.

[7] "The Impact of Violence on Children," Joy D. Osofsky, Domestic Violence and Children, Vol. 9, No. 3 (Winter 1999).
[8] "Emerging Strategies in the Prevention of Domestic Violence," David A Wolfe and Peter G. Jaffe, The Future of Children: Domestic Violence and Children, Vol. 9, No. 3 (Winter 1999).

While New York City has Child Advocacy Centers, these centers, which focus on child sex abuse investigations, do not target the needs of children who exhibit effects of witnessing violence in terms of structured mental health assessments and school-based interventions.

Moreover, while the NYC school system employs hundreds of psychologists, school counselors, social workers, and other staff who work with children who are experiencing behavioral, social, and learning difficulties, these staff are not generally trained to recognize symptoms of trauma, to understand how trauma affects children, or how to craft interventions that can be implemented during the day in school. This is particularly troubling for children who are classified as disabled through the special education system. These children are regularly provided social, emotional and psychological evaluations in the school system, but providers are unaware of how to assist children who demonstrate symptoms of trauma, or even how to recognize its symptoms. Often, the special education evaluators are aware of the child's history, but do not recognize the impact that it may be having on the child's school-related difficulties. A major tool for assisting these children is being squandered because of this lack of knowledge and training.

There also appears to be a lack of service providers who operate outside the NYC Department of Education (DOE) who have expertise in addressing the educational needs of children exposed to violence. Low-income families have little access to those who do exist. While many agencies offer counseling, most of these services do not appear to be focused on trauma and behavioral strategies needed to address the child's needs in school. Moreover, these counselors are also unfamiliar with the special education system

and may not realize the rights that their clients have to obtain services through the school system.

There is a lack of coordination between school-based special education staff, mental health professionals, and domestic violence service providers as well as a seeming absence of knowledge of each other's systems. As a result, it can be difficult to effectively coordinate about the needs of the children in school. We have found similar difficulties in trying to work on a policy level. The different service systems are insular and do not generally work with each other, resulting in difficulty with communication about specific issues. However, in other states, groups have convened on a policy level to work collaboratively on the issues of the educational needs of children exposed to violence. In Massachusetts, for example, there is a state-wide group that meets to discuss school-related services for children exposed to trauma and that has advocated collectively for funds to pilot school-based programs across the state.

Finally, there is no research focused on understanding the scope of the problem in NYC schools, particularly in the DOE's segregated special education classes and programs for students with behavioral, emotional, and social problems. From our anecdotal work, it is clear than many principals, school administrators and teachers are aware of the fact that the children have lived or live in homes in which there is domestic violence, but appear to feel that they don't have the resources to assist them. In addition, there is little to no research devoted to identifying effective school-based, behavioral, or mental health interventions for children who are exposed to trauma, or for implementing effective interventions for children. Instead, children are often suspended or excluded from school and school staff members are left overwhelmed and unprepared.

III. IDEA-The Framework of the Special Education Service Delivery System

In this section, a short description of the Individuals with Disabilities Education Act (IDEA), the federal law that governs the delivery of special education services to children with disabilities, is set out. The overview provides a context for the discussion of the scope of services that children with emotional, learning and other disabilities are entitled to receive from the school system.

Congress enacted the IDEA to ensure that children with disabilities have meaningful access to public education. States receive substantial federal funds in exchange for their agreement to provide a free appropriate public education (FAPE) to all disabled children in the state, and to comply with the IDEA's procedural and substantive mandates. The IDEA provides that every student (birth to 21) must be provided with FAPE. There are, generally speaking, three types of services that must be provided to children with disabilities: services for early intervention (children from 0-3 years), pre-school services (3-5 years), and school-age services (5-21 years).

In order to be eligible for school-age services, a child must have one of thirteen disabling conditions, defined under the IDEA, and the condition must impact the child's ability to learn. These conditions include, but are not limited to, classifications of "learning disabled," "emotionally disturbed," and "speech and language impaired."

Eligible students are entitled to special education, related services, and supplementary aids and supports provided in the least restrictive environment (LRE). LRE generally means educating a disabled child with his or her non-disabled peers, to the maximum extent appropriate. "Special education" is defined as instruction specifically

designed to meet the unique needs of a child with a disability.[9] "Related Services" are to be provided if children need them to benefit from special education. They include services such as transportation to and from school, psychological services, physical and occupational therapy, counseling services, medical services for diagnostic or evaluation purpose, school health services, social work services, speech-language pathology services, and parent training and counseling.[10]

The IDEA also requires that state and local districts provide an adequate supply of properly trained staff to meet children's unique needs.[11] Schools must employ research-tested methods for teaching, behavior management and, other service provision.

A. The Special Education Process

The first step in the process is for a child to be referred for an evaluation. The law requires that school districts have procedures to ensure that all disabled children who are in need of special education and related services are identified, located, and evaluated.[12]

Thus, school personnel, parents, and others are able to refer children for an evaluation. The law also provides that children with disabilities be evaluated pursuant to certain minimum standards, which include the requirements that children must be assessed in all areas related to the suspected disability and that the evaluation must be sufficiently comprehensive to identify all of the child's special education and related services needs.[13] Children with behavioral difficulties are supposed to receive specialized

[9] 34 C.F.R. § 300.26 (Special Education).
[10] 34 C.F.R. § 300.24 (Related Services).
[11] 34 C.F.R. §§ 300.380-382.
[12] 34 C.F.R. § 300.125 (Child Find).
[13] 34 C.F.R. § 300.532.

behavior-related evaluations that are to be used to develop a behavior plan. If a parent disagrees with the school district's evaluation, he or she is entitled to obtain a private evaluation that is paid for by the school district. The law further provides that all special education students must be re-evaluated at least triennially.[14]

Once a child is evaluated and found to have a disability, an Individualized Education Program (IEP) must be developed for that child, which is a blueprint for the delivery of services. The IEP must be created by a multidisciplinary team that includes the child's parent(s), a general education and a special education teacher of the child, a representative of the local school district, an individual who can interpret the instructional implications of evaluation results, and others, depending on the circumstances.[15] In developing an IEP, the team must consider a number of issues. These include the strengths and weaknesses of the child, the concerns of the parents for enhancing the education of their child, and the results of the child's most recent evaluations. This team must further consider strategies, including positive behavioral interventions, to address problem behavior.[16]

The IEP itself must meet certain legal requirements. The IEP must include a statement of the child's present levels of educational performance, a statement of measurable annual goals, including benchmarks or short-term objectives, and a plan for service provision in order to meet the child's needs and to enable the child to advance toward attaining these goals. It must further indicate how the child will be assessed, how the services the child needs will be delivered, how the child's progress toward his or her

[14] 34 C.F.R. § 300.536.
[15] 34 C.F.R. § 300.344.
[16] 34 C.F.R. § 300.346.

goals will be measured, and how the child's parents will be informed of their child's progress.[17] The IEP must be implemented in its entirety.

In order to ensure that children are receiving their legally mandated educational services and the parents have meaningful opportunities to participate in the special education process, the IDEA guarantees children and their parents numerous procedural safeguards. These include but are not limited to: (1) the right to receive notice every time the district proposes to evaluate a child or change a child's placement; (2) the right to consent to any evaluation conducted; (3) the right to raise complaints concerning the referral, evaluation, IEP, placement, or receipt of free appropriate public education through mediation or an administrative hearing and appeal; (4) the right not to be denied services for more than ten days in any given year; (5) the right to a private evaluation paid for by the district if the parent disagrees with the district's evaluation; and (6) the right to receive notice of all rights and safeguards. In addition, the IDEA contains a complaint procedure whereby parents can file letter complaints with the state educational agency concerning violations of their children's rights or illegal district policies.[18]

Unfortunately, the federal framework for service delivery, while mandated, is not being properly implemented in New York City. The law, however, demonstrates that services are mandated and that improvements in evaluation, training, and service delivery could generate improved services for the City's disabled children who are exposed to or are victims of family violence.

[17] 34 C.F.R. § 300.347 (Content of IEP).
[18] 29 U.S.C. § 700 et seq.

IV. The New York City School System and Special Education Service Delivery

There are over 1.1 million children in the NYC school system and approximately 160,000 of those students receive special education services.[19] Minority students make up 85% of school enrollment, and NYC schools serve over 63% of New York State students who live in poverty.[20] Students who are English Language Learners (ELLs) comprise almost 17% of NYC's students, compared to 8% statewide.[21] The official drop-out rate for NYC students hovers around 20%, but schools also engage in a practice of pushing out low performing students, which may bring the rate to as high as 30%[22]

While the federal law contemplates that most disabled students will be able to meet the standards for regular education students, the outcomes for disabled students are dismal – out of approximately 15,000 students between the ages of 14-21 who left NYC schools during the 2001-2002 school year, less than 60 children earned Regent's diplomas and only 1,500 earned local diplomas. This represents a total graduation rate of approximately 10%, leaving 90% of special education students without a high school degree. The dropout rate for children classified as emotionally disturbed is almost 75%.

The NYC DOE offers a range of services called the "Continuum" and provides educational services for children with disabilities in regular schools and classes, special classes within regular schools, and special segregated schools. The DOE will also fund a child's placement in a specialized private school, a residential program, or day treatment

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[19] OSERS Twenty-Third Annual Report to Congress, at http://www.ed.gov/about/reports/annual/osep/2001/index.html, PD -4 form for 2000-2001, and VESID report to the Board of Regents on Special Ed. Data (April 2002).
[20] University of the State of New York/NYSED, "A Report to the Governor" (February 1999). In NYC, 23% of children receive public assistance and 40% are living with only one parent. Touchstone.
[21] Facts & Figures (2000-2001): Answers to Frequently Asked Questions About English Language Learners (ELLs) and bilingual/ESL programs, NYC BOE, Office of English Language Learners, p.3.
[22] July 31, 2003. New York Times, Section A-1. *To Cut Failure Rate, Schools Shed Students*.

program if there is no public program available to properly serve the child's needs. Children can receive special education teacher support services in conjunction with a regular or special class (a special education teacher in a small group or on an individualized basis), team teaching (a special education and general education teacher who teach a class comprised of regular and special education students), and instruction in small classes with ratios of 15:1 or less. Children are supposed to be placed in groups according to their similarity of cognitive, social, behavioral, academic, and management needs. The DOE must offer at least all of the services available under the federal statute and any other services, if necessary, to meet a child's individual's disability-related needs.[23]

A. Advocates for Children of New York, An Overview

Advocates for Children of New York provides a full range of advocacy and legal services directly to parents and students in the NYC school system. For more than 32 years, AFC has worked in partnership with the City's most impoverished and vulnerable families to secure quality and equal public education for all children (from birth to age 21). AFC targets children who are at greatest risk for school-based discrimination and/or academic failure due to factors such as disability, poverty, ethnicity, immigration status/limited English proficiency, involvement in the child welfare or juvenile justice systems, homelessness, and domestic violence. AFC is the only organization of its kind in NYC providing a full range of services, from parent education and technical assistance

[23] New York City Board of Education, "Getting Started"-- Special Education as Part of a Unified Service Delivery System, the implementation plan for the new Continuum, is available at (and was viewed on August 24, 2001) http://www.nycenet.edu/spss/sei/gs.pdf.

to legal services, public policy, and impact litigation geared toward improving access to educational services.

AFC has over 30 years of experience in working to improve the quality of public education programs on the state and local level. AFC has participated in the drafting of almost every major policy in NYC effecting the education of children with disabilities or children involved in disciplinary actions, as well as directives on other high-risk students, such as homeless children. AFC has facilitated improvements of many aspects of the educational service delivery system, worked toward adoption of policies that comply with federal mandates, and highlighted systemic failure through policy reports and media campaigns. AFC, because of its direct service and training work, is in the unique position to provide information to and gather information from parents and professionals that is not and would not be available to other service providers. By combining its unique knowledge of parents' concerns and children's needs with its considerable experience delivering services, AFC influences the formulation of policies that facilitate accessibility of services and information to parents and children.

Over the past three years, AFC has provided direct assistance to nearly 9,000 high-need families, provided information and training through workshops and fairs to more than 27,000 people, spearheaded major educational policy initiatives affecting state educational policies, distributed more than 210,000 publications, and logged almost 500,000 user sessions on our three websites. For more than fifteen years, AFC has received funding from the U.S. Department of Education as a Training and Information Center for parents of children with disabilities to provide assistance in navigating the

special education system and has received funding from New York State Education Department for the past seven years to do similar work.

B. Advocates For Children's Domestic Violence Educational Advocacy Project

Because the staff at AFC noticed that many parents of the children who had complex special education cases had disclosed to the school system histories of exposure to family violence, AFC created a pilot project called the Domestic Violence Educational Advocacy Project (DVEAP) during the 2001-2002 school year. The DVEAP sought to identify cases where children were experiencing school-related problems and had also been exposed to violence. Project staff then assisted these families in securing appropriate educational placements and services for their children. Staff also assisted families in coordinating access to other needed services, including mental health assessments and services to address the trauma underlying their educational difficulties.

The DVEAP worked on 111 cases involving domestic or family violence. Although these cases do not constitute a random sample of families in the NYC public schools who have a history of family violence, they do suggest certain patterns and trends in how children exposed to violence may be affected.

The project was staffed by an attorney and a caseworker, and cases came through referrals from domestic violence service providers as well as AFC's general intake system. In addition to individual advocacy, the project provided technical assistance, training and educational materials to parents and staff members of domestic violence shelters and organizations. The DVEAP also sought to facilitate a dialogue between service providers in the fields of mental health and domestic violence, policymakers, the

school system and other stakeholders to develop strategies for creating a more comprehensive response to the needs of children survivors.

1. Client Profile

In order to qualify for representation through the DVEAP, the child must have been exposed to family violence at any time during his or her lifetime. For over 30% of the children in the project, the exposure to family violence was either ongoing or had just ended.[24] For another 30% of the clients, the traumatic events occurred between 1 and 3 years prior to the start of representation. Thirty-five percent of the children had been exposed to violence over 3 years prior to representation, and were still experiencing significant problems in school. In at least 42% of the cases, the exposure to violence had already been disclosed to the DOE, and the information was present in the child's special education or other school file.

Ninety-five percent of the clients in the DVEAP involved children with disabilities or suspected disabilities[25] which often severely impaired their ability to function in school. In at least half of the cases, the severity of these disabilities led to recommendations for segregated special education settings (i.e. special classes).[26] Of the children who had already been labeled as having a disability before their involvement with the DVEAP, over 50% had been classified as "emotionally disturbed."

Of the children with a disability or suspected disability, at least 40% had been diagnosed as having a severe mental illness such as bipolar or mood disorder, oppositional defiant disorder (ODD) or conduct disorder, or they had had a prior

[24] This includes all children residing in a domestic violence shelter at the time of representation.
[25] The term "suspected disability" indicates that the child has been referred for evaluation for special education services.
[26] Segregated settings include all classrooms or settings where there are no non-disabled peers.

psychiatric hospitalization. All of these children had multiple diagnoses. For example, a seven-year-old had two inpatient hospitalizations and had been diagnosed with mood disorder and oppositional-defiant disorder. His school reports indicate that he has demonstrated suicidal, homicidal and self-injurious behavior. Another case involved an eight-year-old boy who had witnessed the attempted murder of his mother by his father, and was later diagnosed with ODD and Attention-Deficit Hyperactivity Disorder (ADHD). He also had a history of self-injurious behavior and enuresis. Another client was a 14 year-old girl who was sexually abused, later admitted to a psychiatric hospital, and diagnosed with conduct disorder and depression. She had also experienced enuresis. Lastly, a nine year-old girl who had witnessed violence, possibly been sexually abused, and endured prolonged and multiple foster care placements was given multiple diagnoses. She had been admitted to psychiatric hospitals three times and diagnosed with ODD, PTSD and ADHD. She also had chronic nightmares and enuresis.

Despite the high disclosure rate of past trauma to the DOE and evidence that these children had significant problems in school, only three children had been diagnosed with PTSD. Even though PTSD was rarely diagnosed in the cases our office worked on, many of the children exhibited symptoms of PTSD. Four children had enuresis, six children had a history of self-injurious behavior and four children under the age of ten (the youngest was four years old) had severe and prolonged temper tantrums. The child who exhibited all three of these symptoms had been diagnosed with PTSD, but her symptoms showed no improvement after years of care under mental health professionals. For the rest of the children in the project, the most common diagnosis was Attention-Deficit Disorder (ADD) or ADHD. Almost 50% percent had been diagnosed with ADD or

ADHD and others had been noted as having attention problems, but they had not been diagnosed with either disorder. Many were simply being treated outside the DOE with a course of stimulants (such as Ritalin) for behavioral difficulties, and it appeared, in most cases, that the individuals prescribing the medication were not aware of the history of violence.

This remarkably low rate of diagnosed PTSD[27] and high rate of identified ADD/ADHD is interesting. Some research suggests a high comorbidity between PTSD and ADHD.[28]

Some studies also point out that differentiating between the two disorders may be extremely difficult due to high comorbidity and overlapping symptoms.[29] One study suggests that PTSD symptoms are more severe if a child with ADHD or ADD has been exposed to a traumatic event.[30] Cases from the DVEAP suggest that, although children are being diagnosed with ADHD, many children are not being evaluated and appropriately treated for disorders relating to trauma.[31]

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[27] One study found that 57% of children residing in a domestic violence shelter were suffering from PTSD. As quoted in "Domestic Violence and Children Policy Paper," Children's Health Fund, January 2001, www.childrenshealthfund.org/dv.html. "Estimates of children exposed to domestic violence who develop PTSD range from 13% to 51%." See "The Impact of Different Traumatic Experiences in Childhood and Adolescence," Nicole Caporino, et al., Report on Emotional and Behavioral Disorders in Youth (Summer 2003); Famularo, Richard et al. "Psychiatric comorbidity in childhood post traumatic stress disorder." Child Abuse and Neglect, Vol. 20, No. 10, pp. 953-961 (October 1996); Weinstein, Dan et al. "Attention-deficit hyperactivity disorder and posttraumatic stress disorder: differential diagnosis in childhood sexual abuse," Clinical Psychology Review, Vol. 20, No. 3, pp. 359-378 (April 2000).

[28] Famularo (1996); Weinstein (2000).

[29] Weinstein (2000); Bennett, Edith Allison, "Stress, trauma, and PTSD in ADHD-diagnosed children: a biopsychosocial perspective [dissertation]," doctoral dissertation, California School of Professional Psychology (2000); Thomas, Jean M., "Traumatic stress disorder presents as hyperactivity and disruptive behavior: case presentation, diagnoses, and treatment," Infant Mental Health Journal, Vol. 16, No. 4, pp. 306-317 (Winter 1995).

[30] Ford, Julian D et al., "Child maltreatment, other trauma exposure, and posttraumatic sympomatology among children with oppositional defiant and attention deficit hyperactivity disorders," Child Maltreatment, Vol. 5, No. 3, pp. 205-217 (August 2000).

[31] See also "Domestic Violence and Children Policy Paper," Children's Health Fund, January 2001, http://www.childrenshealthfund.org/dv.html.

Informal surveys and discussions with domestic violence service providers anecdotally confirm that children in their programs have intensive educational and mental health needs. AFC conducted an informal survey of 20 domestic violence service providers during the 1999-2000 school year. All of the providers surveyed indicated that a significant percentage of the children they work with have emotional and behavioral difficulties in school. Five providers indicated that up to 25% of the children they see are diagnosed with ADD/ADHD, and all indicated that they had "some" children diagnosed with ADD who were receiving Ritalin or other drugs for hyperactivity. All survey participants had "some" children who received special education services, were failing classes, or were truant. All of the providers surveyed indicated a need for more services related to children's educational programming needs and targeted mental health programs for children who witnessed domestic violence.

2. Educational Needs

Because there are virtually no policies geared toward addressing the unique needs of these children,[32] children who have been exposed to family violence often find themselves substantively denied their right to a public education. This happens because oftentimes these students are, often times, excluded due to excessive delays in identifying placements for children with special needs, inappropriate disciplinary measures, and illegal discharges.

[31] The exception is a provision in a Chancellor's Regulation that requires districts to keep the addresses of domestic violence shelters confidential in a child's records.

i. Enrollment in appropriate school programs

Upon moving to a new district, children with special needs often sit at home for days, weeks, or sometimes months awaiting an appropriate placement. For children whose families are fleeing violent homes, going into emergency domestic violence or homeless shelters and then transitioning from the shelter system back into the community, these delays may happen repeatedly and can severely affect academic progress. Cases from the DVEAP, as well as reports from domestic violence shelters and service providers reflect this.

> Case example: Ms. S and her son, L, went to the district office on the first day of school to request a placement for L in their new district. Ms. S and her family had just left the domestic violence shelter system and had settled into their own apartment in a new borough and a new district. The DOE told Ms. S that there were no placements available in her new district and that L should stay home. L was out of school for 22 days until AFC advocated on behalf of Ms. S and L and the district offered L an appropriate placement in his zoned school along with compensatory tutoring to make up for the days of school L missed.

> Case example: Ms. C and her autistic son, R, recently moved to an emergency shelter. Prior to the move, R had been receiving intensive services and had obtained a recommendation from the DOE that he attend a special education private school designed to educate autistic children. After R and his mother entered the shelter, the DOE failed to transfer R's paperwork to the district in which he and his mother were residing, and thus R was placed in a public school setting without many of the services he needed. Furthermore, as a result of the move, the DOE office that was supposed to be searching for an appropriate private program simply closed R's case. Upon learning of R's situation, AFC located and secured a seat in an appropriate private program for R. AFC then forced the DOE to locate and reopen R's case and expedited transportation to R's new school. R is now doing very well in his new setting.

In addition to the delays in being placed in a classroom, the scarcity of appropriate placements for children with special needs may also become a barrier to finding shelter for some families.

> Case example: J has two autistic children. She needs shelter, but shelters are reluctant to take her because the children need specialized school placements and services. They are so severely disabled that even a few days without services could cause them to regress substantially. There is no one with the expertise to assist J in facilitating appropriate school placement near any shelter, which means J and her children cannot find themselves a safe place to escape the violence. AFC assisted J by providing the social worker at the shelter where she and her children were temporarily residing with the contact information of an advocacy organization for parents of children with disabilities in the state where she was seeking shelter.

ii. Access to appropriate educational and support services in school

Cases from the Domestic Violence Educational Advocacy Project show that even after placement, children with trauma-related illnesses face immense barriers in obtaining an appropriate education. Because symptoms of trauma often include mood swings, sudden outbursts, tantrums, increased aggression, anxiety and attention problems, children who are exposed to family violence are often illegally discharged and excluded from the public schools due to behavior problems. In some of the DVEAP's cases, children with disabilities had been suspended five or six times in one school year, with some of these suspensions lasting months, or even a year. In addition, many children who may be suffering from trauma-related illnesses are pushed into the special education system because they have "behavior problems," are labeled "emotionally disturbed," and are placed in segregated classrooms with other children with "behavior problems." Placing these children all together in these segregated settings that have few or no

therapeutic services does nothing to address the cause of the behavior problems. Moreover, since their behavior becomes the focus of their educational programs, any other disabilities or learning difficulties are often not addressed. Thus, instead of aiding these children, this pattern of segregation only serves to further isolate them.

> Case example: H is 10 years old and witnessed violent fights between his mother and father when he was younger. His father also beat H on occasion. In addition, H witnessed the sudden death of a close family member. While his father has since moved away, he sometimes shows up and threatens H and his mother. H has had behavior problems at school, and was recently labeled "emotionally disturbed" and given special educational services, but he had never been diagnosed with or evaluated for trauma-related illness. Prior to receiving these services, however, H was suspended multiple times, but H and his mother never received a due process hearing to dispute the veracity of the charges. Furthermore, the district never held a meeting to determine if the behavior was related to H's disability. As a result of a five-day suspension, H was told to go to an alternative education site. The site refused to accept H because no paperwork documenting his suspension could be found. Each day, H's mother tried to bring him to the site, but each day she was turned away. H sat at home for five days. At the end of five days, when H's mother took him back to school, H's principal told her to bring him back to the alternative site. Given no other choice, H's mother took him to the alternative site where he received schoolwork only sporadically. H has been there for over two months. With AFC's advocacy, H is now receiving the special education services to which he is entitled. AFC also referred H and his mother to a domestic violence organization near their home, and they are now participating in regular counseling sessions

> Case example: When Ms. P fled her abusive husband and went to a safe home, her son R was out of school awaiting placement for three weeks. Due to his behavior problems, R was then placed in a segregated classroom where the teacher required the mother to stay in the classroom with her son several days each week. The next year, when R was placed in a less restrictive setting, the principal of the school began calling the mother every day to say that her son was acting out and to tell her to pick her son up in the middle of the school day. The mother did so for a few days, but when she refused, the principal threatened to call the police or an ambulance. When AFC intervened on the mother's behalf and informed the principal that these removals were illegal without a formal suspension, the phone calls stopped.

These disruptions often cost children dearly and put significant strain on mothers and families in crisis. For students who are already struggling academically, extended exclusions exacerbate these problems and increase the chances that these children will be held back. For children whose families relocate multiple times in a short period of time, the cost of these disruptions is multiplied. Children held over several times can suffer from lowered self-esteem or depression, especially when the age difference between themselves and their classmates becomes marked. Eventually, years of being held back can cause adolescents to become chronically truant or drop out of school entirely.

iii. Lack of adequate evaluations, services, and coordination among service providers

AFC's experiences working with clients who have been witnesses or victims of family violence indicate that children exposed to family violence are almost never appropriately identified or evaluated, even when parents disclose the history of exposure to violence to evaluators or school staff. Furthermore, even if these children were appropriately evaluated, NYC lacks appropriate therapeutic services and placements for these children.

Moreover, despite being evaluated and treated by a variety of mental health practitioners in different settings, a common thread in all of these cases is a lack of coordination between mental health providers, educational evaluators, and school staff to coordinate their assessment and treatment efforts in order to develop appropriate school-based programs for these children. Domestic violence service providers may work intensively with a family and accurately identify the probable cause of a child's behavior problems, but they may never make a referral to a trauma-specialist or work with school

staff to create a supportive environment for a child suffering from a trauma-related illness.

Educational evaluators in schools may be aware of a history of domestic violence or abuse and may identify some learning difficulties, but their recommendations do not include referrals or recommendations for mental health evaluations or treatment or programs appropriate for children exposed to violence. Schools see the symptoms of trauma, but they do not feel that it is their responsibility and are not equipped to provide services to treat the cause of these symptoms.

The DVEAP's caseload was filled with examples of these types of issues.

> Case example: C is 7 years old and was only 4 years old when he saw his father try to kill his mother. He and his mother fled to a shelter in another borough, and two years later, his family settled in a third borough. This turbulence disrupted C's education, as he has changed schools many times in the past 3 years. Since he requires special education services for behavior problems and speech and language delays, each time his family has moved, he has often been out of school for days or weeks while a special education class is located in the new district. In the last two years, C has developed serious behavior problems in school including disruptive and defiant behavior, and, occasionally, self-injurious behavior. C also exhibits signs of separation anxiety, enuresis, aggression, and mood swings. Despite his behavior problems, C is very bright. Although the DOE knows about C's exposure to violence, and although he has been to several mental health practitioners who knew about C's family history and were asked to treat C for his trauma-related symptoms, he has never been evaluated for or diagnosed with trauma-related illness. Instead, C has been diagnosed with ADHD. AFC worked with C's mother to get him evaluated and treated by a trauma specialist. AFC also located a special education private school setting that addresses C's emotional needs while allowing him to perform at his high intellectual capacity. After AFC advocated on behalf of C and his mother, the DOE agreed to allow C to attend this school, and C is now doing very well. Now that C is finally in a stable and appropriate educational placement, his mother has been able to turn her attention to rebuilding her life with C, her new baby, and her new husband.

Case example: D is a 6-year-old boy, and a few years ago, his father became abusive towards their mother after he began drinking heavily. He was also verbally and physically abusive toward all of his children. D's mother and father separated last year, but D still has contact with his father. D has had behavior problems in school including tantrums, running out of the room, and trouble separating from his mother. Recently, these problems have become very severe. His school has called an ambulance to take D to the psychiatric emergency room several times. The school psychologist, social worker and several teachers know the family's history and suggested that D could be suffering from PTSD, but there are no services within the DOE to address this. As a result, D's mother agreed to put D on temporary home instruction. D had been seeing a psychologist, but was never been diagnosed with a trauma-related illness. He has been tentatively diagnosed with ADHD. D requires other special education services for specific learning difficulties. AFC worked with D's new psychiatrist to have him properly evaluated for trauma-related illnesses and learning disabilities. The psychiatrist diagnosed D with a variety of disorders, including severe Generalized Anxiety Disorder, and recommended that D be placed in a therapeutic day treatment or hospital setting. After reviewing the psychiatrist's report, the DOE agreed to fund D's placement at a small therapeutic school. D has begun attending school and is making some progress.

Case example: E is 14 years old and in 8th grade. When she was young, E was sexually abused by her stepfather, and began developing behavior problems in school around this time. School staff reported that she began to be disruptive and disrespectful, and that this behavior went on for years and worsened as E entered middle school. E was referred to special education for academic difficulties. During the evaluation process, her abuse was disclosed to the school. E was labeled learning disabled and given extra services to address her learning problems. Her behavior continued to worsen and she began getting into fights, running in the hallways, destroying property and pulling attention-seeking stunts. At the same time, her relationship with her mother also deteriorated. When her behavior was at its worst, E was taken to a psychiatric hospital to be admitted for observation. The psychiatrists noted her history of family turbulence and abuse, but tentatively diagnosed her with conduct disorder and gave her psychotropic medication instead of evaluating her for signs of PTSD. E then moved in with her older sister where behavior stabilized, but the DOE referred her to a special class for students with behavior problems regardless. AFC got E into a less restrictive educational setting while AFC worked with E's guardian to get current and thorough evaluations for PTSD and learning disabilities.

Case example: F is a 6-year-old boy who was exposed to domestic violence between his mother and father when he was an infant. Since he was 1 year old, F has had significant problems including hyperactivity, trouble eating, aggression toward siblings and nightmares. A few years later, his symptoms worsened at home and school, and he began exhibiting self-mutilating behavior. He has been hospitalized a few times for aggressive outbursts. He has received mental health treatment from a variety of practitioners since he was 1 year old, and even though his exposure to violence was disclosed to the practitioners and is included in all of his social histories, he has not been diagnosed with a trauma-related illness. F has been tentatively diagnosed with mood disorder and ADHD. F's education has been substantially disrupted by his multiple hospitalizations. After his most recent hospitalization, F was out of school for several months. AFC assisted in obtaining an appropriate public setting for F. Due to the efforts of his experienced special education teacher, F is now making a good deal of behavioral and academic progress.

Case example: K has been exposed to many traumatic events over the course of his life, and he is now 14 years old. K was sexually abused as a young child, and he witnessed many violent arguments between his parents. Many of K's family members have recently died, and there is ongoing turbulence in his home and in the homes of his close relatives. K has been receiving special education services and mental health services since he was an infant, and he has had enduring behavior problems despite these interventions. He has run out of his school, destroyed property, gotten into many fights and has been beaten up many times. He has been in and out of hospital settings. Because his education has been so sporadic and disrupted, he has been held over several times even though his cognitive abilities are above average. He has been diagnosed with bipolar disorder, ADHD, and mood disorder, and is on an array of medications, but K has never been diagnosed with PTSD. The school district is well aware of K's mental health and medical history, but it has not been able to locate an appropriate public placement for him. AFC worked with the district to recommend a private therapeutic setting for K, and K is now attending a specialized private school for children with severe emotional and behavioral problems. K is now making excellent progress.

Since the conclusion of this project, AFC's cases continue to reflect the patterns found in the project's cases. Clients who have been exposed to or are victims of

domestic violence continue to fail academically, be placed in inappropriate special education settings and oftentimes end up court-involved.

V. Conclusions and Recommendations

The consequences of leaving trauma-related illnesses untreated are enormous. The costs to families and schools are obvious: caregivers who are already overburdened with trying to find safety, financial independence, and stability are further burdened by their children's needs, classrooms are disrupted by children's behavior; and children are deprived of the opportunity to build solid educational foundations for their futures. The costs to society are less obvious, but just as large. There is evidence that, without intervention, children who witness domestic violence are at a higher risk for repeating the cycle of violence as adults.[33] In addition, the same behavioral difficulties that lead to the exclusion of children from the public education system may result in an increased risk for involvement in the juvenile justice or criminal court systems or mean a life dependent on public benefits.[34]

The DVEAP's cases demonstrate that the effects of exposure to violence may continue for years after the trauma. Thus, a solution to the particular issues identified in this report must reach well beyond the current domestic violence service organizations, which are often focused on addressing families in immediate crisis. The solution must include a multi-disciplinary approach, focused on building the capacity of schools and

[33] "Domestic Violence and Children: Analysis and Recommendations," The Future of Children, Winter 1999, p.6; Children's Health Fund, January 2001, http://www.childrenshealthfund.org/dv.html.
[34] Steiner, Hans, et al., "Posttraumatic stress disorder in incarcerated juvenile delinquents," Journal of American Academy of Child & Adolescent Psychiatry, Vol. 36, No. 3, pp. 357-365 (finding high rates of PTSD among incarcerated boys).

health professionals who continue to have contact with children even after a family recovers from crisis. As one researcher notes, "Most children spend as much waking time at schools as at home; therefore, schools and teachers have an enormous potential for providing emotional support and nurturing for children exposed to violence."[35]

Based on the work we have done in our pilot, we make the following recommendations:

A. Develop Statewide and Citywide Task Forces

A task force comprised of educators, school psychologists, special educators, trauma specialists, behavioral specialists, parents, advocates and domestic violence service providers should be convened to discuss how to begin to address the educational and mental health needs of children who have witnessed violence and been victims of abuse.

B. Develop a Child Victim Witness Center

In light of the need in NYC, a working group of stakeholders and experts should be convened to work on the development of a center modeled after one of the existing programs, such as the centers in Massachusetts or Connecticut. Among other things, the Center should have the capacity to:

- Deliver effective mental health services – including evaluation and treatment – to children exposed to family violence who are identified in

[35] Osofsky (1999).

the school setting as suffering from trauma-related symptoms**,** provided by trauma-specialists and educators working together;

- Provide technical assistance for school staff;
- Offer technical assistance for social service providers serving children exposed to violence, including shelters, advocacy groups, and educators;
- Service children without resources;
- Conduct research on the effects of exposure to violence on children and the efficacy of existing modes of treatment; and
- Develop liaison sites throughout the five boroughs.

C. Build Partnerships Between Domestic Violence Providers, Trauma Specialists, Special Education Personnel, and Schools

- Train school staff to recognize symptoms of trauma-related illness and give them techniques for dealing with these symptoms without removing children from school;
- Ensure proper evaluation protocols are developed and utilized for children exposed to violence or other traumatic events;
- Coordinate with outside mental health practitioners to provide proper screening, evaluation, and treatment; and
- Work with the DOE to develop the school system's capacity to educate children with behavior problems in therapeutic yet academically challenging settings.

D. Build Capacity of Domestic Violence Providers to Identify and Address Educational Needs of Children and to Navigate the DOE

Develop collaborative partnerships between domestic violence services providers and educational advocacy and parent groups who work with children with disabilities.

E. Expand Research on the Incidence of Violence and Victimization in the Special Education Population

Given the number of cases AFC has received and the anecdotal information we have received from organizations serving families who have been subjected to domestic violence, it is imperative to conduct more in-depth research in this area.

F. Fund Research of Development of School-based Interventions for Children Suffering from Trauma due to Family Violence

There are clear models in other states. However, further research would provide a strong guide for creating effective school-based interventions.

G. Provide Professional Development on Domestic Violence Issues for School Psychologists and Counselors

School psychologists and counselors must be trained to recognize behaviors that may be linked to violence within the home, and, in particular, should be educated about Post Traumatic Stress Disorder.

H. Create School-Based Programs Serving Children Experiencing Academic Problems as a Result of Witnessing or Being a Victim of Violence

The clients who we saw were unable to perform up to their academic potential, suffered from overwhelming anxiety and developed behavior problems that appeared to exacerbate any learning difficulties and other emotional problems they already had. AFC's cases suggest that the special education system in particular bears the brunt of the responsibility for addressing not only the educational needs of this population, but for addressing the complex behavioral and emotional needs which may be affecting their school performance. Programs should be developed within schools and in tandem with mental health agencies to serve these students.