CHILD ABUSE AND NEGLECT
USER MANUAL SERIES

Child Protection in Families Experiencing Domestic Violence (2nd ed.)

2018

Capacity Building
CENTER FOR STATES

Child Protection in Families Experiencing Domestic Violence (2nd ed.)

Kristen Selleck, Jeannie Newman, and Debra Gilmore

2018

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau
Office on Child Abuse and Neglect

Children's Bureau

Table of Contents

Preface

Each day, the safety and well-being of children across the United States are endangered by child abuse and neglect. Many of these children live in homes that are experiencing domestic violence. The child welfare field continues to work to find effective ways to serve families where this overlap occurs. Intervening effectively in the lives of these children and their families is not the sole responsibility of a single agency or professional group but a shared community concern.

The Child Abuse and Neglect User Manual Series has provided guidance on child protection to hundreds of thousands of multidisciplinary professionals and concerned community members since the late 1970s. The series provides a foundation for understanding child maltreatment and the roles and responsibilities of various practitioners in its prevention, identification, investigation, assessment, and treatment. Through the years, the manuals have served as valuable resources for building knowledge, promoting effective practices, and enhancing community collaboration. It is our hope that these manuals continue that tradition.

Since the last update of the *User Manual Series* in the early 2000s, the changing landscape reflects an increased recognition of the complex issues facing parents and their children, new legislation, practice innovations, and system reform efforts. Advances in research and evidence-based practice have helped shape new directions for interventions. The Office on Child Abuse and Neglect within the Children's Bureau of the Administration for Children and Families, U.S. Department of Health and Human Services, has developed the fourth edition of two of the manuals in the User Manual Series to reflect this increased knowledge base and the evolving state of practice. *Child Protective Services: A Guide for Caseworkers* (*Caseworker* manual) provides a comprehensive view of the child welfare process. This manual, *Child Protection in Families Experiencing Domestic Violence,* serves as a companion piece to the *Caseworker* manual. It helps support caseworkers by providing background and principles that can be applied in working with families experiencing domestic violence.

This manual, along with *Child Protective Services: A Guide for Caseworkers* and the prior versions of the entire User Manual Series, is available at https://www.childwelfare.gov/pubs/usermanuals/.

Acknowledgments

Kristen Selleck, M.S.W., is a supervisor with the Capacity Building Center for States and oversees capacity-building services to public child welfare agencies in five federal regions. With more than 15 years' experience in the intersection of domestic violence and child maltreatment, Ms. Selleck has presented numerous times, both nationally and internationally, on strategies for child welfare to intervene successfully in domestic violence cases. She was the first National Training Director for the Safe and Together Institute, providing training and coaching to multiple child welfare agencies throughout the United States and in England, Ireland, and Australia to improve practice and policy. Prior to her national work, Ms. Selleck was an advocate and domestic violence consultant to the Connecticut Department of Children and Families. She sits on the National Advisory Committee of the Quality Improvement Center for Domestic Violence in Child Welfare and has been an Adjunct Professor of Social Work specializing in social work policy.

Jeannie Newman, M.I.B.S., M.S.W., is a consultant with over 25 years of experience in the child welfare field. From working with child abuse prevention and child protective services, Ms. Newman went on to help formulate policies, manage programs, facilitate conferences, give presentations, and write and edit numerous reports and materials addressing child maltreatment and overlapping issues, including domestic violence. She remains active in the fields of child welfare and pediatric hospice. Ms. Newman also edited and coauthored many of the manuals in the last edition of the *Child Abuse and Neglect User Manual Series*.

Debra A. Gilmore, M.P.A., J.D., is a research strategist with the Capacity Building Center for States. Ms. Gilmore has more than 25 years of experience in the child welfare field as a youth counselor, attorney, policy analyst, trainer, program manager, district manager, and capacity-building team member. She has published and presented to national audiences on child and family safety and child welfare best practices, and she co-created a research-based practice model designed for families frequently referred to child welfare. Ms. Gilmore is a past recipient of a U.S Department of Health and Human Services Adoption Excellence Award. She is the humble and happy parent of two adopted children, ages 6 and 27.

Acknowledgment of Prior Editions

This manual is an update of the first version of this manual written by H. Lien Bragg in 2003.

Principal Reviewers

These individuals provided extensive review and feedback.

Kathy Simms, M.S.W.
Program Area Advisor,
Protective Services & In-Home Services
Capacity Building Center for States

Quincy Wilkins, M.S., L.M.F.T., L.P.C.C.
Program Area Manager, Child Protection Services
Capacity Building Center for States

Reviewers

The following individuals also reviewed drafts and provided valuable feedback.

Gloria Carroll, M.S.W., L.C.S.W.
Program Area Manager, In-Home/Family Preservation Services
Capacity Building Center for States

Suzan Cohen
Staff Paralegal
Child Welfare Information Gateway

Theresa Costello
Executive Director
Action for Child Protection

Lonna Davis, M.S.W.
Director of Children and Youth Program
Futures Without Violence

Debra Gilmore, M.P.A., J.D.
Research Strategist
Capacity Building Center for States

Rita L. Katzman, M.S.W.
Consultant
ICF International

Matthew Shuman, M.S.W.
Senior Writer/Editor
Child Welfare Information Gateway

Eileen West
Senior Program Specialist
Administration for Children and Families, Children's Bureau

Other Acknowledgments

This user manual was developed under the direction and guidance of Jean Blankenship, Child Welfare Program Specialist; Julie Fliss, Child Welfare Program Specialist; and Elaine Voces Stedt, Director, Office on Child Abuse and Neglect.

This product was created by the Capacity Building Center for States under Contract No. HHSP233201400033C, funded by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Suggested Citation: Capacity Building Center for States. (2018). *Child protection in families experiencing domestic violence* (2nd ed.). Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

For more information: Please visit the Child Welfare Capacity Building Collaborative website https://capacity.childwelfare.gov/states.

Chapter 1:
Purpose and Overview

With the recognized co-occurrence between child maltreatment and domestic violence, the second edition of *Child Protection in Families Experiencing Domestic Violence* seeks to inform child welfare agencies of updated demographics and practices to identify and respond to the presence of domestic violence and to reduce the risk posed to children and domestic violence survivors. This manual aims to guide casework practice by helping to ensure domestic violence survivor safety, perpetrator accountability, and agency response. Working more closely with those providing services related to domestic violence helps create a more comprehensive approach and improve child and family assistance. This chapter:

- Provides the context for this manual
- Defines basic terms, used in general and throughout the manual, for describing child abuse and neglect and domestic violence
- Discusses briefly the overlap of child maltreatment and domestic violence, described in greater detail in Chapter 5, "The Overlap Between Child Maltreatment and Domestic Violence"
- Lays out the sequencing of the chapters, each of which builds upon the previous ones, for ease of reference

1.1 Background

Child abuse and neglect is a community concern. Each community has a legal and moral obligation to promote the safety, permanency, and well-being of children, which includes responding effectively to child maltreatment. At the federal level, the Child and Family Services Reviews (CFSRs) monitor states to measure their effectiveness at achieving these goals. At the state and local levels, professionals assume the roles and responsibilities (ranging from prevention, identification, and reporting of child maltreatment to assessment, intervention, and treatment). Child protective services (CPS) agencies, along with law enforcement, play a central role in receiving and investigating reports of child maltreatment.

CFSRs and Domestic Violence

CFSRs enable the Children's Bureau, a part of the U.S. Department of Health and Human Services, Administration for Children and Families, to (1) ensure conformity with federal child welfare requirements, (2) determine what is actually happening to children and families engaged in child welfare services, and (3) assist states in enhancing their capacity to help children and families achieve positive outcomes. The Children's Bureau completed the first round of CFSRs in 2004 (after the publication of the first edition of this manual) and currently is conducting the third round. The reviews are structured to help public child welfare systems identify strengths and areas needing improvement within their agencies and programs by examining how well they achieve safety, permanency, and well-being in difficult situations of child maltreatment (U.S. Department of Health and Human Services, Children's Bureau, n.d.). CFSRs also help states develop effective Program Improvement Plans to improve child and family outcomes, including in domestic violence cases, and to enhance collaboration with service providers experienced in domestic violence (Taggart, 2009). For more information on CFSRs, visit https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews.

For federal fiscal year 2015, the Children's Bureau found that the United States had approximately 683,000 reported victims of child abuse and neglect, or 9.2 victims per 1,000 children in the population (U.S. Department of Health and Human Services, Children's Bureau, 2017). To protect children from harm, CPS agencies rely on community members to identify and report suspected cases of child maltreatment, including physical abuse, sexual abuse, neglect, and psychological maltreatment. Many community professionals (including health-care providers, mental health professionals, educators, and legal and court system personnel) are involved in responding to cases of child maltreatment and domestic violence and in providing needed services.

Various professionals are mandated to report suspected child maltreatment to CPS or law enforcement, such as health care workers and school personnel. In some states, those who provide services related to domestic violence also are mandated reporters. In addition, community-based agency staff, clergy, extended family members, and concerned citizens play important roles in supporting and keeping families safe. To find individual state statutes regulating mandatory reporting of child maltreatment, visit: https://www.childwelfare.gov/topics/systemwide/laws-policies/state/.

Domestic violence is a devastating social problem, which affects every segment of the population—all genders, ethnicities, and ages across the socioeconomic spectrum. While system responses are primarily targeted towards adult survivors of abuse, increasingly attention also focuses on the children who witness domestic violence. Estimates of the number of children who have been exposed to domestic violence each year vary. Research suggests that nearly 30 million children in the United States will be exposed to some type of family violence before the age of 17, and there is a 30 to 60 percent overlap of child maltreatment and domestic violence (Child Welfare Information Gateway, 2014; Hamby, Finkelhor, Turner, & Ormrod, 2011; Taggart, 2011).

1.2 Terms and Definitions

Terminology varies throughout the field and from system to system. **Appendix A** provides a glossary of terms used throughout this and other manuals. The term "domestic violence" is a pattern of coercively controlling behaviors perpetrated by one intimate partner against another (Schechter & Edleson, 1999; Child Welfare Information Gateway, n.d.-a). While systems may choose to use a term that best fits their needs, this manual will use "domestic violence." Chapter 2 details the dynamics, tactics, and examples of domestic violence. Other terms used in the field include:

- Adult domestic violence
- Intimate partner violence
- Partner violence
- Family violence
- Violence against women
- Domestic assault
- Domestic abuse
- Domestic terrorism

Similarly, this manual uses the term "perpetrator" to identify the person who commits a pattern of domestic violence and coercive control[1] (University of Michigan, 2009; Washington State Department of Social and Health Services, 2010). Other similarly acceptable terms, based on the need of the agency, include:

- Batterer
- Abuser
- Person using violence

This manual uses two terms to refer to the perpetrator's target of domestic violence: "survivor" and "nonoffending parent." "Survivor" is used for general discussion and is defined as the perpetrator's target (adult or child) of domestic violence, including emotional, physical, verbal, sexual, and coercive control, and children who also witness domestic violence (University of Michigan, 2009; Washington State Department of Social and Health Services, 2010). In almost all instances in the manual, when used alone, the term refers to the adult survivor. The manual uses "nonoffending parent" to describe a survivor who also is parenting. Many advocates have adopted "survivor" because the term encompasses the active role survivors take in being protective despite the abuse they experience. "Nonoffending parent" serves as a guide for caseworkers in differentiating the roles of the parents, i.e., offending parents are perpetrators who may harm their partners and children in the home. However, it is important to remember that a nonoffending parent experiencing domestic violence may also be an offending parent when child maltreatment is alleged. Other terms, such as "victim" or "battered partner," are commonly used. In this manual, however, "victim" will refer only to those who have died due to domestic violence homicide.

In the manual, "parent" refers to birth parents as well as other parental-role caregivers. Examples include guardians, emotional or psychological parents (e.g., fictive kin who often assume a parental role without any legal or biological relationship or responsibility to the children), foster and adoptive parents, and stepparents.

1 Evan Stark developed the term "coercive control" (described in more detail in the next chapter) to help the public understand that domestic violence involves more than physical abuse. It is a pattern of behavior that seeks to take away the survivor's liberty or freedom and to strip away the survivor's sense of self (Children Experiencing Domestic Abuse Recovery Network, 2017).

Additionally, this manual refers to domestic violence "advocates" and "specialists." While each jurisdiction may use these or other terms (e.g., liaison), for the purposes of this manual, an "advocate" is a person who works for a domestic violence service provider and advocates for the survivors. A "specialist" is a person who works within the child welfare (or agency other than the domestic violence service provider) and, as the name implies, specializes in addressing domestic violence issues for that particular agency. Certainly, an advocate can be placed as a specialist in these agencies, but, for simplification, specialist means employed by or placed at the child welfare agency.

The reader should note three additional items:

1. While this manual, to be useful, deals in generalizations about domestic violence and child maltreatment, it recognizes that every survivor and perpetrator has his or her own unique experience, which is influenced by cultural background; gender, sexual identity, and sexual orientation; socioeconomic status; and other factors.
2. The authors and reviewers made every effort to use the most current research and materials. However, in some cases, the material referenced is older because the field recognizes it as the gold standard of certain definitions, terminology, or concepts.
3. Callout boxes and figures are used throughout this manual to inform and to break up the text. In some cases, they provide examples, resources, or additional information. In others, they reiterate key points made earlier in the text that are pertinent again to the current section. While the formatting of each may vary depending on the content, the intent is to provide easily accessible information to the reader.

1.3 Topics Addressed in This Manual

In addition to helping the reader understand the background and key issues inherent in a discussion of the co-occurrence of child maltreatment and domestic violence, this manual also addresses the following practice issues:

- Basics of domestic violence
- Perpetrators of domestic violence
- Adult survivors and child witnesses
- Overlap between child abuse and neglect and domestic violence and its impact on children
- Practice guidelines for caseworkers assessing families experiencing domestic violence
- Decision-making, safety planning, and case planning when domestic violence is present
- Complexity of children's issues: A trauma-focused approach
- Safety and wellness for CPS workers in cases involving domestic violence
- Building collaborative responses for families experiencing domestic violence

Each chapter concludes with highlights of its key points for a quick summary.

Please note that the mention or discussion of any program, model, instrument, survey, or website in this manual does not connote an endorsement by the Children's Bureau.

Chapter 2:
The Basics of Domestic Violence

To establish a foundation for understanding child protection in families experiencing domestic violence, it is important to understand its core components. This chapter:

- Provides an overview of the dynamics of domestic violence
- Defines domestic violence and provides examples
- Explains the scope of the problem
- Details tactics used in perpetrating domestic violence
- Examines the root causes of domestic violence
- Explores and helps dispel common myths and misperceptions

This chapter concentrates on a basic understanding of domestic violence. Subsequent chapters will build upon this by looking at (1) the perpetrators, survivors, and children in more depth and (2) how caseworkers assess and intervene in cases involving domestic violence.

2.1 What Is Domestic Violence?

Historically, domestic violence has been framed and understood exclusively as a women's issue. Domestic violence, however, can happen to anyone regardless of race, age, sexual orientation, religion, or gender. It affects people of all socioeconomic backgrounds and education levels. According to the U.S. Department of Justice's (DOJ) Office on Violence Against Women (OVW) (2017), domestic violence occurs in both opposite- and same-sex relationships and can happen to intimate partners who are married, living together, or dating. (Chapter 4 describes the demographics of survivors of domestic violence in more detail. This section explores the dynamics of domestic violence and provides common definitions.)

2.1.1 Dynamics of Domestic Violence

Domestic violence not only affects survivors, it also has a substantial effect on family members, friends, coworkers, other witnesses, and the community at large. Children exposed to domestic violence are among those seriously affected by this crime. OVW (2017) found that frequent exposure to violence (also known as witnessing domestic violence) in the home not only predisposes children to numerous social and physical problems but also teaches and normalizes violence, increasing their risk of

becoming the next generation of survivors and perpetrators. Research typically recognizes the effects of domestic violence on survivors, but abusive behavior also affects perpetrators: they may lose their children, damage relationships, and face legal consequences. Formal systems, such as child protective services (CPS) agencies, face enormous challenges responding to domestic violence in their communities.

The most commonly considered type of domestic violence centers on a pattern of coercively controlling behaviors perpetrated by one intimate partner against another (Stark, 2002). These controlling behaviors do not always involve physical violence, but physical violence can escalate in coercively controlling situations. These behaviors also include situations in which the relationship between perpetrators and survivors has ended, thereby still affecting survivors and children, because domestic violence does not always end when survivors escape perpetrators, try to terminate the relationship, and/or seek help. Separation often may intensify the situation because perpetrators feel a loss of control over survivors. Survivors often are in the most danger directly after they leave the relationship or seek help. Vittes and Sorenson (2008) found that 20 percent of domestic violence homicide victims with restraining orders are murdered within 2 days of obtaining the order, and one-third are murdered within the first month (National Coalition Against Domestic Violence, n.d.-b).

Behavioral patterns are important to understand because perpetrators do not act in isolated tactics. They often use multiple tactics in their relationships to maintain control (as described below). The most common behaviors are not physical, which poses challenges as physical violence is typically what garners the attention of CPS after an arrest or incident. Perpetrators can be quite dangerous without physical violence and their coercive behaviors can harm children in various ways, including when children witness such behaviors.

2.2 Definitions of Domestic Violence

Context often determines the definition of domestic violence. This manual uses examples of clinical or behavioral definitions to describe "a pattern of assaultive and/or coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners" (Schechter & Edelson, 1999, p.122; Child Welfare Information Gateway, 2013). Actual legal definitions—which explain specific conduct or acts, including defining child witnesses to domestic violence—vary across states and depend on whether the definitions appear in the civil or criminal sections of the state's code (Child Welfare Information Gateway, 2013; Child Welfare Information Gateway, 2016a).

Resources

For more information on the civil and criminal definitions of domestic violence and children's exposure to it, as well as summaries of relevant laws for all states and U.S. territories, see *Definitions of Domestic Violence* at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/defdomvio/ and *Child Witnesses to Domestic Violence* at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/witnessdv/.

Domestic violence is not typically a singular event, nor is it limited to only physical aggression. Rather, it is the pervasive and methodical use of threats, intimidation, manipulation, and/or physical violence by someone who seeks power and control over his or her intimate partner. It can occur in same- and opposite-sex relationships and can include current or former spouses, boyfriends or girlfriends, dating partners, and sexual partners.

Perpetrators use a specific tactic or a combination of tactics to instill fear in and dominance over their partners. Their strategies are intended to establish a pattern of desired behaviors from their victims. While a later section of this manual provides an indepth discussion of these tactics and their use, **Exhibit 2.1** lists various common behaviors generally recognized as domestic violence.

Exhibit 2.1. Common Domestic Violence Tactics

Physical Tactics

- Pushing and shoving
- Restraining
- Pinching or pulling hair
- Slapping
- Punching
- Biting
- Kicking
- Suffocating
- Strangling
- Using a weapon
- Kidnapping
- Physically abusing or threatening to abuse children or pets

Sexual Tactics

- Raping or forcing the survivor into unwanted sexual practices
- Objectifying or treating the survivor like a sexual object
- Forcing the survivor to have an abortion or sabotaging birth control methods
- Engaging in a pattern of extramarital or other sexual relationships
- Sexually assaulting the children

Verbal, Emotional, and Psychological Tactics

- Using degrading language, insults, criticism, or name calling
- Screaming
- Harassing
- Refusing to talk, i.e., the "silent treatment"
- Engaging in manipulative behaviors to make the survivor believe he or she is "crazy" or imagining things or denying the abuse and physical attacks, i.e., "gaslighting"
- Humiliating the survivor privately or in the presence of other peop
- Blaming the survivor for the abusive behavior
- Controlling where the survivor goes, to whom he or she talks, and what he or she does

Exhibit 2.1. Common Domestic Violence Tactics

- Forcing the survivor to use or abuse drugs and alcohol and/or undermining substance use disorder treatment
- Accusing the survivor of infidelity to justify the perpetrator's controlling and abusive behaviors
- Threats and Intimidation
- Breaking and smashing objects or destroying the survivor's personal property
- Glaring or staring at the survivor to force compliance
- Intimidating the survivor with certain physical behaviors or gestures
- Instilling fear by threatening to kidnap or to seek sole custody of the children or pets
- Threatening acts of homicide, suicide, or injury
- Forcing the survivor to engage in illegal activity
- Harming pets or animals
- Stalking the survivor
- Displaying or making implied threats with weapons
- Making false allegations to law enforcement or CPS

Economic Coercion

- Preventing the survivor from obtaining employment or an education
- Withholding money, prohibiting access to family income, or lying about financial assets and debts
- Making the survivor ask or beg for money
- Forcing the survivor to hand over any income
- Stealing money
- Refusing to contribute to shared or household bills
- Neglecting to comply with child support orders
- Providing an allowance

Entitlement Behaviors

- Treating the survivor like a servant
- Making all decisions for the survivor and the children
- Defining gender roles in the home and relationship

Other types of domestic violence exist and may be present in families that caseworkers encounter. For example, Johnson (2008) describes situational violence in which other conflict rises to violence, typically due to other stressors, such as financial issues. This type of domestic violence does not have a perpetrator who regularly uses controlling behaviors or other forms of abuse. It is helpful for caseworkers to understand the differences between one-off, situational violence and the true prevalence of domestic violence, especially because domestic violence advocates and criminal justice statistics typically do not highlight situational violence. However, all forms of domestic violence have an impact on children.

It is important to note that a lack of criminal or arrest records are not necessarily an indicator of lack of domestic violence perpetration. Many perpetrators have no or limited criminal records, which is not a gauge of how dangerous they are or will be. On the other hand, survivors may have arrest or criminal records because of high rates of dual arrests in domestic violence situations or because of the differing legal requirements of law enforcement from CPS. So, while criminal or arrest records can be a tool used to assess domestic violence, they should not be viewed its only indicator.

Domestic Violence Versus Situational Violence and Mutual Violence

While all relationships should be free from abuse, situational violence differs from domestic violence. Although the type of abuse can vary (e.g., physical, sexual, emotional), the distinguishing feature of domestic violence is that it forms a pattern of abuse where the perpetrator exhibits consistent efforts to maintain power and control over the other person.

By contrast, situational violence does not necessarily form a pattern but occurs when one or both partners handles conflict with violence, i.e., the violence is specific to the situation, is generally minor and does not escalate over time, and there is not an ongoing effort to exert power or control over the other person between fights. The violence may be mutual and may occur less often and less regularly than domestic violence does. Often, those who engage in situational violence tend to be poor communicators who do not know how to argue without resorting to physical or verbal aggression. Both men and women engage in this type of violence. However, while this type of violence differs from domestic violence, that does not mean that it is acceptable or is not criminal behavior (Blackburn Center, 2015).

2.3 Scope of the Problem

What is the scope of the problem? The Centers for Disease Control and Prevention (CDC) developed the *National Intimate Partner and Sexual Violence Survey* (NISVS), which included a broad range of behaviorally specific questions to capture the full impact of physical, sexual, and psychological violence by an intimate partner, as well as stalking, in the United States. The survey asked respondents about their relationship at the time the perpetrator first committed any violence against them. The NISVS considered incidents perpetrated by a current or former intimate partner as violence by an intimate. According to this survey (Black et al., 2011):

- More than one-third of women (35.6 percent or approximately 42.4 million) have experienced rape, physical violence, and/ or stalking by an intimate partner at some point in their lifetime.
- More than 1 in 4 men (28.5 percent) has experienced rape, physical violence, and/ or stalking by an intimate partner at some point in their lifetime. (Most of the violence reported by men was physical violence, with only 2.1 percent reported experiencing stalking by an intimate partner.)
- Nearly half of all women (48.4 percent or approximately 57.6 million) have experienced at least one form of psychological aggression by an intimate partner during their lifetime.
- Approximately 4 in 10 (40.3 percent) reported some form of expressive aggression (e.g., their partner acted angry in a way that seemed dangerous, told them they were a loser or a failure, insulted or humiliated them) or some form of coercive control (41.1 percent) by an intimate partner.
- Nearly half of men (48.8 percent or approximately 55.2 million) have experienced psychological aggression by an intimate partner during their lifetime.
- Approximately 86.1 percent of women and 83.6 percent of men who experienced rape, physical violence, and/ or stalking by an intimate partner during their lifetime reported that the perpetrator was a current intimate partner at the time when the violence first occurred, while less than a quarter (21.9 percent and 23.1 percent, respectively) experienced one of these forms of intimate partner violence by a former intimate partner at the time the violence first occurred.

These statistics demonstrate the wide prevalence of domestic violence. The data, however, do not provide the contextual information that caseworkers must assess, (Chapter 6 discusses assessment in detail) nor do they track resistive violence or self-defense. In fact, experts consider the prevalence of domestic violence to be widespread and underreported (Klein, 2009).

Additionally, findings show that (Hamby et al., 2011; Taggart, 2011):

- More than 11 percent of children and youth (approximately 8 million) were exposed to some form of family violence within the past year.
- 26 percent (approximately 18 million) were exposed to at least one form of family violence during their lifetimes.
- Approximately 60 percent of child welfare cases involve some known domestic violence.

By looking at domestic violence through the lens of coercive control, it may be hard to determine exactly the percentage of cases presenting with domestic violence in the child welfare system. This may be due to the underreporting of or failure to identify incidents of coercive control without physical violence as domestic violence cases, while other family violence cases may increase the number of cases classified as domestic violence. Because caseworkers often will routinely work on domestic violence cases, it is imperative

to understand how perpetrators behave and how, in turn, those patterns of behavior affect children. Caseworkers can draw upon numerous multidisciplinary resources, partners, and services in working with these cases, which will be discussed in later chapters.

2.4 Understanding the Tactics of Abuse

As **Exhibit 2.1** illustrated, domestic violence takes many forms. In any domestic violence case, knowing the dynamics and perpetrators' pattern of behaviors is necessary to understanding risk and safety. The key is both understanding the pattern and learning the full array of a perpetrator's behaviors, as detailed below. What they all have in common is that fear is a powerful motivator and a tool used by many perpetrators to control their partners.

Every perpetrator behaves differently. Not all perpetrators will use every tactic. Some perpetrators choose to use physical violence, but many do not. While those who use physical violence may attract more attention, those who use other tactics to exert extreme control over their families also can be very dangerous. Not all perpetrators are equally dangerous, and the vast majority will never commit or attempt homicide (Auchter, 2010).

2.4.1 Possessive and Entitled Behaviors

Many perpetrators use possessive or entitled behaviors designed to control survivors or families. Perpetrators feel and act "entitled" and often demonstrate that through their language (e.g., by talking about their "rights") and through behaviors to demonstrate that they want survivors and families to act according to how they dictate. These behaviors can vary, and some can be extreme or dangerous. Escalated behavior often indicates increased risk. Perpetrators may use the following tactics to control survivors:

- Accusations
  - Telling service providers (including caseworkers) that the survivors are unfaithful in order to discredit them
  - Telling survivors' family or friends about these accusations and attempting to gain sympathy from the survivors' support system
  - Following or watching their partners and assaulting individuals with whom the perpetrators assert the survivors are cheating
- Jealousy
  - Trying to appear loving or protective, e.g., "for their own protection" but, instead, being restricting and isolating to survivors
  - Telling survivors not to go places, wear certain items, talk to other people, e.g., not allowing him or her to visit family, attend school, go to work, or leave the home alone
  - Checking survivors' call, text, and social media histories
- Possessive language
  - Using language of ownership or isolation, e.g., "You are mine," "No one else can ever have you," or "You're nothing without me!"
  - Speaking possessively about their children, and claiming that no one else is allowed to care for or spend time with them
  - Insisting on being physically present with the survivors and/or the children, e.g., during interviews with caseworkers or in the survivors' everyday life, such as acting as the only mode of transportation for survivors, thus limiting their access to resources, jobs, and, certainly, domestic violence services

Examples of Coercive Control

In coercive control, demands are more about controlling the family than about actually having any concern for the well-being of the survivors or children. By using coercive language, many perpetrators are trying to send a clear message to their families that they are not free to act or be as they choose but, rather, are property of the perpetrator.

- One perpetrator told his child's caseworker that no one was allowed to talk to "my wife" without his permission. The couple had been divorced for several years, but he maintained his ownership over her.
- Another perpetrator required his wife not to leave the home with their son. One day, when their son had a medical appointment, she took the child for care, and the perpetrator called the police alleging kidnapping.

2.4.2 Using Children as a Weapon

Perpetrators may use children as a tool or weapon to harm and control the adult survivor. By using custody as a tool, or simply by attempting to turn the children against the survivor, perpetrators may control survivors by using their children. This can affect the children's relationships with the nonoffending parent. Children struggle with loyalty when they are exposed to the perpetrators' behaviors. The conflict arises when this authority figure, whom they respect and love, tells them to do something that could be harmful to the survivor, whom the children also love and respect. Perpetrators' use of children can occur through many tactics:

- **Engaging children in the perpetrators' abuse against the survivors,** e.g., asking children to agree with them in their verbal abuse against their nonoffending parent. The children may not want to call their parent names or to agree that their parent is "bad", but may fear the perpetrator too much to not comply. Perpetrators may also ask their children to participate in physical abuse and even in sexual abuse against the survivor.
- **Incorporating subtle tactics to use their children against the survivor,** e.g., undermining survivors' attempts at developing stability or consistency for the children or asking children to question the authority of the nonoffending parent.
- **Asking children to spy on survivors,** e.g., to report back on survivors' whereabouts, dating relationships, or other activities.

- **Exploiting custody of children,** e.g., attempting to manipulate family court or child welfare systems or even attempts to kidnap. The threat that some perpetrators make to apply for joint or sole legal custody or to take the children is very serious Because many courts do not view domestic violence as a child safety issue, many perpetrators have higher rates than fathers who have not committed domestic violence of maintaining or gaining custody of their children (Meier, n.d.). There are various reasons this can occur:
  - Perpetrators' control of financial or legal access
  - Their manipulative and/or charming behaviors
  - The impact perpetrators have had on the adult survivors, which may make the latter seem less credible or less desirable as a parent
  - The belief that domestic violence is not an indicator of a perpetrator's parenting or potential harm to children
- **Manipulating their time with children,** e.g., refusing to show up on time or at all for visitation time, which can limit the survivors' ability make their own plans during these times. As stated earlier, after separation is a dangerous time for survivors and is also a time during which perpetrators may have unsupervised access to children. Perpetrators may:
  - Show up unexpectedly and demand visitation time or come into the home to be with the children
  - Refuse to return the children on time or limit the children's access to speaking with their nonoffending parent during visits
- **Threatening to harm their children or their pets physically,** e.g., attempting to gain significant control over their partners who fear that their children will be hurt, kidnapped, or even killed.

2.4.3 Verbal or Emotional Abuse

Perpetrators use verbal and emotional abuse to degrade, humiliate, and/or criticize their partners in order to control them. In their attempts to make their partners feel bad about themselves, perpetrators may be working to reduce survivors' self-esteem or to limit their options in leaving. By using verbal abuse, perpetrators can cause significant distress to their families. Perpetrators may:

- Criticize survivors (e.g., call them names or criticize their looks, intelligence, parenting, or other element of their lives)
- Make survivors feel diminished to gain control over them

Survivors may take these insults as valid reasons for why their partners treat them so poorly or may believe these abusive terms to be true. Not only does this have an effect on a survivor's self-esteem, but a survivor may also then put significant energy into correcting the "problem" the perpetrator has identified.

Example of Verbal or Emotional Abuse

One common example is when a perpetrator calls the survivor a "whore" or unfaithful. Perpetrators often use possessive language (described above) as well. Some survivors will work to prove their loyalty or remove people from their lives to whom the perpetrator has accused them of being attracted. Not knowing that perpetrators will not change this tactic simply because the accusation is disproven, survivors expend energy on trying to debunk the criticisms of their partners, further isolating themselves in the process.

2.4.4 Economic and Other Controlling Behaviors

By controlling a survivor's economic freedom, perpetrators gain a significant amount of control in their relationships. Perpetrators may actively restrict survivors' access to money, bank accounts, credit, or public assistance funds. When perpetrators control survivors' access to employment, education, transportation, or legal documents (such as birth certificates, passports, insurance cards, immigration, or other legal paperwork), they further gain economic control. Controlling behaviors, like the behaviors listed below, isolate adult and child survivors intentionally and harmfully:

- Use blaming language to attempt to justify their controlling behaviors. For example, a perpetrator may say the survivor is a bad driver and, therefore, not allow him or her to drive.
- Withhold documents. A perpetrator may say his or her partner is irresponsible and then withhold access to a bus pass, money, or EBT or bank cards. Survivors need not only their own legal documents, but also access to their children's legal documents.
- Withhold money to control their partners' access to financial freedom. Some perpetrators may withhold paperwork for social services funding, e.g., Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF), which then limits a survivors' access to income.
- Interfere with survivors' ability to maintain a job or get an education. Perpetrators may interfere with survivors' jobs or schooling to limit their options or ability to leave the relationship by:
    - Actively trying to get survivors fired by telling employers (true or not) that survivors have done things that would result in a termination
    - Being disruptive at survivors' workplaces to cause enough problems to lead survivors to quit or be fired
    - Assaulting their partners to keep them from going to work or school, resulting in unexcused absences

When a perpetrator withholds documents and access to funds from survivors, or limits their job or educational opportunities, they interfere with survivors being able to leave the relationship and actively limit survivors' abilities to provide food, clothing, shelter, medical, or other basic care for their children. Domestic violence is one of the leading causes of unemployment for survivors (Ridley et al., 2008). When nonoffending parents then are unable meet the needs of their children, they may be held accountable rather than their perpetrators (Stark, 2002).

2.4.5 Stalking

Stalking is a dangerous but common tactic of perpetrators that the National Violence Against Women Survey defines as "a course of conduct directed at a specific person that involves repeated (two or more occasions) visual or physical proximity, nonconsensual communication, or verbal, written, or implied threats, or a combination thereof, that would cause a reasonable person fear" (Tjaden & Thoennes, 1998, p. 2; DOJ, National Institute of Justice, 2007, para. 1). Stalking can take many forms. While some perpetrators physically watch the family, many use other resources to learn about survivors' habits, schedules, and routines. Perpetrators may use a variety of stalking strategies to monitor their partners. Stalking in any form is a high-risk domestic violence behavior.

Stalking can include perpetrators showing up to disrupt survivors' lives. Some perpetrators may show up at survivors' places of employment or wait at survivors' family's homes or other places expecting to see the survivor. In these

events, perpetrators may choose to make a scene, embarrass the survivor or others, or may make threats. Sometimes perpetrators may not make their presence known at all but are simply monitoring the actions of survivors and their support networks. Perpetrators also may monitor or stalk survivors through the use of technology and social media, i.e., cyberstalking.

Cyberstalking

Cyberstalking is the use of technology—e.g., phone, fax, Global Positioning System (GPS), cameras, computer spyware, or the Internet—to stalk. It shares some characteristics with in-person stalking, such as the pursuit, harassment, or contact of others in an unsolicited fashion, initially via the Internet and email. Cyberstalkers can install apps on survivors' phones that allow the stalker to read emails and text messages or can monitor the phone's GPS to locate the survivor. Cyberstalking can intensify in chat rooms, where stalkers systematically flood their target's inbox with obscene, hateful, or threatening messages and images. A cyberstalker also may assume the identity of the victim by posting information (fictitious or not) and soliciting responses from the cybercommunity. Cyberstalkers may use information acquired online to further intimidate, harass, and threaten the survivor via courier mail, phone calls, and physically appearing at a residence or workplace. The ease with which the Internet allows others access to personal information makes this form of stalking ever more accessible and easier for potential stalkers to stalk via a remote device rather than to confront the actual person (DomesticShelters.org, 2016b; Tjaden & Thoennes, 1998).

By following, monitoring, and stalking their survivors, perpetrators gain information that they can use in numerous ways. Perpetrators may use the information to make allegations about the survivor, whether or not they are true. Some use the information to make survivors believe that they know everything and to demonstrate their power over the survivor. Stalking is intended to scare survivors and to make them feel uneasy and controlled. While the number of perpetrators who commit homicide is not high, those who do often stalk their survivors beforehand (MacFarlane et al., 1999) and may use these behaviors to find survivors' schedules to gain access to them to cause harm.

Also, as discussed earlier, perpetrators may use children to aid them in their stalking behavior by asking their children to share information about where survivors go, what they do, and whom they see. When a survivor is in hiding from a perpetrator, but the perpetrator still has access to the children, this can be a very common strategy for finding survivors.

2.4.6 Physical Abuse

While physical abuse tactics cause varied degrees of physical harm to survivors, all physical violence is intended to instill fear and to control survivors. On a spectrum of behaviors, physical violence and aggression can be indicators of in how much danger a family is, as well as to assess the level of impact on children.

Not all perpetrators use physical violence, and even those who do not can still be dangerous. Some perpetrators who have used minimal physical violence have committed homicide, and some perpetrators who regularly use more severe or extreme violence may never commit homicide. Assessing physical violence is both easier at times—because the evidence of an assault is typically more obvious—but also very challenging, because incorrect assumptions can easily be made about the dangerousness of a person. Some perpetrators' use of physical violence escalates over time, while others maintain the same level of violence throughout the course of their relationships. Knowing a perpetrators' history and use of physical violence across the course of multiple relationships is important to making the best-informed predictions of their risk. The spectrum of physical violence includes:

- **Less severe tactics,** e.g., throwing items without hitting a person, punching holes in walls, or aggressively being in a survivor's personal space. While these behaviors are typically considered (without evidence of other behaviors) less dangerous, they still can be very frightening, and survivors and their children may fear for their safety.
- **Escalating behaviors,** e.g., poking, pushing or slapping. As behaviors worsen, perpetrators may hit, punch, bite, kick, pull their partners' hair, or knock their partners down.
- **More severe and/or extreme tactics,** e.g., hitting multiple times, strangling, breaking the survivors' bones, and using a weapon. Strangulation, use of weapons, and extreme assaults may also be attempts to kill the survivor but not always.
- **Homicide.** Not only are 20 people physically abused by a partner in the U.S. every minute (National Coalition Against Domestic Violence, n.d. para. 1, Black et al., 2011), statistics show that 9 women are murdered by a partner each day (National Network to End Domestic Violence, n.d., para. 3). The CDC found that homicide is one of the leading causes of death for women 44 years of age or under, and nearly half of female victims are killed by a current or former male intimate partner (Petrovsky et al., 2017, para.1; Catalano, Smith, Snyder, & Rand, 2009, p. 3). Homicide may be committed in various ways, including through the use of a weapon, through severe assaults, through strangulation, or by other tactics.

Physical child abuse may also be a tactic perpetrators use. (This overlap between child maltreatment and domestic violence is detailed in Chapter 5.) Children also may be physically injured when they intervene when a perpetrator is acting violently. They also are at risk of severe or grave physical harm, as well as deep emotional trauma, when a perpetrator is planning or willing to commit murder.

2.4.7 Sexual Violence

Perpetrators, in many instances, use sexual violence against their partners. Like other abuse, sexual violence takes many forms. Perpetrators may:

- **Rape their partners.** Because of the power perpetrators have in their relationships, survivors may feel afraid to refuse perpetrators sexually. Many survivors have described having sex or performing unwanted sexual acts out of fear of being hurt if they said no. Perpetrators may use their skills of manipulation to make survivors engage in unwanted sexual activities.

- **Control survivors' reproductive choices.** By withholding, interfering with, or damaging contraception, or by raping survivors, perpetrators may actively force an unwanted pregnancy. Survivors have described instances of perpetrators throwing away birth control pills or refusing to wear a condom. Perpetrators may take action to interfere with survivors getting a wanted abortion by withholding money, refusing transportation, or simply physically not allowing survivors to access care. Alternatively, perpetrators may interfere with the pregnancy by assaulting survivors in an attempt to harm the fetus, forcing survivors to get an unwanted abortion, or refusing to allow survivors to receive prenatal care.
- **Sexually abuse their children.** Perpetrators of domestic violence statistically have higher rates of sexually abusing their children (Bancroft, 2007; McCloskey, Figueredo, & Koss, 1995).

2.4.8 Threatening Behaviors

Threats can take many forms and often build upon the tactics listed above. On a spectrum, threats can appear minor or can be fatally severe. Not all threats are necessarily threats of violence. Additionally, perpetrators may use either vague or incredibly clear language. But the desired result is to instill fear in survivors and their children.

Threats are not always considered criminal acts, despite laws against threatening that exist in most states. Some threats are clearly criminal, such as explicit threats to kill, physically hurt, sexually assault, or cause other physical harm, and can lead to grave concerns for the survivor, the children, and service providers making assessments. (Chapter 6 discusses assessing safety risks for the family, and Chapter 8 addresses caseworker safety). Perpetrators might hold a knife or gun to the survivor and either make an explicit threat of harm without using any words or tell them specifics of their planned harm, e.g., how they will hurt them, where they will murder them, or what weapon they will use.

Perpetrators may also make generalized but very serious threats, e.g., "You know what will happen," "You'll see," or any other generic comment. If that statement has significant meaning to a survivor or the children, however, it may be just as threatening as any explicit plan. These statements are particularly powerful and intimidating, because they are rarely sufficient to trigger a criminal arrest. For example, if the last time the perpetrator strangled the survivor, the perpetrator said, "Now you know what will happen next time you do that," and then the perpetrator, at a later date, says to the survivor, "Don't you remember what happened last time?" the survivor will clearly know that this is a threat to strangle.

These threats are important in understanding both the context of how the survivor and children experience them and how child welfare acknowledges them. As discussed in Chapter 3, the perpetrator may threaten to notify the caseworker, e.g., "I will tell them XYZ about you." Sometimes caseworkers may interpret the survivors staying with the perpetrators as their bonding with their perpetrators or picking the perpetrator over the children. It is more likely, however, that the survivor is more afraid of losing her children than of what the perpetrator may do to him or her.

As discussed earlier, threats to take children away can cause significant fear and anxiety for both the children and the adult survivor. In many instances, children will hear or know about these threats and fear not being able to see their nonoffending parent or having to live with the perpetrator. Some survivors have reported staying with their partner because of this fear of losing their children; other survivors have reported feeling afraid that their perpetrator will harm the children if they leave. Conversely, some survivors fear that caseworkers and other professionals may see them as "unfit" or assume that the survivor is "choosing" to stay with the perpetrator.

2.5 Root Causes of Domestic Violence

So why do perpetrators abuse? The answer is challenging and not easily answered as there are myriad theories of the underlying causes. Some people believe domestic violence occurs because the survivor provokes the abuser to violent action, while others believe the perpetrator simply has a problem managing anger. While not all perpetrators will have the same background or privilege associated with many other perpetrators, there is value in understanding as many of the causes of domestic violence as is possible.

A variety of cultural, social, economic, and psychological factors contribute to the roots of domestic violence. According to the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women, 2012), these factors stem from a confluence of values and beliefs, including social norms, misogyny, learned behaviors, entitlement thinking, gender inequality, discrimination, and a desire for control. For example, some of these norms may include ideas about male heads of household in heterosexual relationships, female submissiveness, or ideas about parental differences and role expectations. These norms do not, by themselves, pose a problem, but perpetrators can misuse them to justify their abusive behavior.

2.5.1 Social Constructs

Domestic violence has been a prevalent social problem with documented evidence of its existence throughout history. In recent decades, violence against women has motivated a series of changes to federal laws. **Exhibit 2.2** lists relevant legislation. While the language is gendered, it is important to note that all survivors of domestic violence are included in the legal protections that exist. The language focuses on women because, historically, women have been the primary targets. Not only is domestic violence an individual choice of a perpetrator, as discussed below, but also a larger societal problem.

Domestic violence thrives on misogyny or any belief that the female sex is weaker or lesser. Perpetrators have been able to use and exploit misogynistic beliefs to excuse their behaviors. For example, a gender norm might be that women are in need of protection; a perpetrator might use that rationale to defend his or her behaviors of controlling the survivors. Or the perpetrator may not "allow" his or her partner to wear certain clothing and justify it by saying it is a protective act of not wanting others to see him or her as a sexual object. Misogyny, however, cannot be the only factor that perpetuates domestic violence, as it does not account for domestic violence in the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) communities (discussed in Chapter 4) or for female perpetrators who harm male survivors (significantly less common) (Breiding et al., 2014).

Entitlement and a desire for control are also factors contributing to domestic violence (Bancroft, 2003). These are only abusive if followed up with patterns of coercive and abusive behaviors in order to achieve them. Control is also culturally supported; those with power and control are often more respected or famous, and, therefore it can be an attractive attribute for someone to try to attain.

Exhibit 2.2. Relevant Legislation

Violence Against Women Act (VAWA)

In 1994, Congress passed Title IV of the Violent Crime Control and Law Enforcement Act, better known as VAWA, to stem the tide of ever-increasing violence against women and to encourage societal change. VAWA created new programs to help law enforcement officials fight violence against women, provided grant money for the same purpose, strengthened penalties, and prohibited criminal activities previously not legally recognized. VAWA has been reauthorized three times. The reauthorizations expanded VAWA to combat sex trafficking, gave some tribal courts jurisdiction over non-American Indian and Alaska Native perpetrators who committed violence against women on tribal lands, authorized money to address the rape-kit processing backlog, established a nondiscrimination requirement for programs receiving VAWA grant money, and created a "rape shield" law. As part of the Violence Against Women Reauthorization Act of 2005, Congress extended the federal interstate stalking statute to include cyberstalking.[1]

Family Violence Prevention and Services Act (FVPSA)

Congress created FVPSA, the primary source of federal funding for domestic violence direct-service providers, as part of the Child Abuse Amendments of 1984. FVPSA is reauthorized every 5 years. The Family and Youth Services Bureau oversees FVPSA and administers grants to states, territories, tribes, state domestic violence coalitions, and resource centers. The majority of the funding goes to states and territories, which then allocate the money to service providers, including shelters and nonresidential programs. FVPSA-funded programs provide direct services to more than 1.3 million victims annually, respond to 2.7 million crisis calls, and educate almost 5 million adults and youth.

Victims of Crime Act (VOCA)

In 1984, Congress passed VOCA, which established the Crime Victims Fund to assist and compensate victims and survivors of crime. The fund comprises federal criminal fines, forfeited bonds, forfeiture of profits from criminal activity, additional special assessments, and private party donations. The Office for Victims of Crime oversees the fund and distributes the money in the form of formula grants to states and territories. The states use this money to fund victim services (including domestic violence shelters and other domestic violence direct-service providers) and to compensate victims for crime-related losses, including medical and counseling costs and lost wages (National Coalition Against Domestic Violence, n.d.-a; Office of Justice Programs, National Institute of Justice, 2007; Department of Health and Human Services (DHHS), Administration for Children and Families, 2013).

1 See 18 U.S.C. § 2261 A

Exhibit 2.2. Relevant Legislation

Child Abuse Prevention and Treatment Act (CAPTA)

The key federal legislation addressing child abuse and neglect, CAPTA was originally enacted in 1974 (P.L. 93–247) and was most recently amended by the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114–198). CAPTA includes significant provisions to address the co-occurrence of child maltreatment and domestic violence. Building on the knowledge gained from previous efforts to address this overlap, the provisions called for stronger federal and state responses to help children and parents in the child welfare system affected by domestic violence. These included requiring the U.S. Department of Health and Human Services to disseminate information and provide training and technical assistance on effective programs and practices related to domestic violence in a child welfare context, collect information on the incidence and characteristics of child maltreatment and domestic violence co-occurrence, and support research on effective collaboration between child protective and domestic violence services through CAPTA state grants (Child Welfare Information Gateway, 2016b; Miller & Robuck, 2014, p. 6).

2.5.2 Behavioral Constructs

One way to look at domestic violence is that it is caused by a perpetrator choosing to engage in controlling, aggressive, or impulsive behaviors up to and including physical abuse. Focusing on domestic violence as a choice helps guide casework and social services practice while understanding that the social constructs that have supported domestic violence historically are also important.

Domestic violence is a learned behavior. This does not mean that perpetrators all witnessed domestic violence as children, nor does it mean that witnessing domestic violence will ensure that someone grows up to become either a survivor or perpetrator. Many children who witness domestic violence do not perpetrate or experience abuse as adults. Children who did not witness domestic violence also perpetrate it or experience it in their relationships (Futures Without Violence, 2013; Baker & Stith, 2008; Vézina & Hébert, 2007).

As a learned behavior, domestic violence is modeled by individuals, institutions, and society, which may influence child and adult perspectives regarding its acceptability or normalization. People can learn abusive and violent behaviors through (UN Women, 2012; Child Welfare Information Gateway, 2003):

- Childhood witnessing of domestic violence
- Individual experience of victimization
- Exposure to community, school, or peer group violence
- Living in a culture of violence (e.g., violent movies or video games, community norms, and cultural beliefs)

Once learned, domestic violence tactics are tested out. Perpetrators learn and develop their tactics in all their relationships, not just the ones they are in when they come to the attention of CPS or law enforcement. A perpetrator may, at a young age, try subtly controlling or possessive behaviors and learn that he or she can get his or her way by acting in this manner with no negative consequences. Domestic violence is reinforced by cultural values and beliefs that are repeatedly communicated through the media and other societal institutions that tolerate it. Therefore, the perpetrator's violence is further supported when peers, family members, or others in the

community (e.g., coworkers, social service providers, police, or clergy) minimize or ignore the abuse and fail to provide consequences. As a result, the perpetrator learns that, not only is the behavior justified, but it is also acceptable.

While some abusive behavior, e.g., situational violence, may be triggered by stress or anger, coercive control and patterns of abuse have little to do with anger or conflict management issues of the perpetrator. They do not result from a loss of control, despite the fact that many perpetrators will describe themselves as losing control. Instead, it is a series of acts of control where perpetrators make purposeful decisions about what to say or do to maintain control over their partners. If perpetrators truly were losing control of their behaviors, they would also react violently towards their employers, strangers, and friends. Often, controlling perpetrators do not act aggressively outside of their relationships or families, unless it also has an impact on their partners. For example, this type of perpetrator may be violent towards his or her ex-partner's new partner but would not be violent to a new boss. They are not "snapping" or losing control, but are choosing to harm their families.

2.5.3 Co-Occurrence With Mental Health and Substance Use Issues

While mental illness may play a role, domestic violence itself is not a mental health issue. Many perpetrators do not have a diagnosable mental health issue, and most people who have mental health issues do not perpetrate domestic violence (Humphreys, 2007). Despite that, workers should consider how to evaluate and treat a perpetrator's mental health needs separately, if present.

Additionally, while it may have an impact, domestic violence is not a substance abuse issue. Many perpetrators of domestic violence have no substance abuse issues, while others do. There is evidence that a perpetrator who has a substance use disorder (SUD) may be a higher risk to partners; alcohol and drugs can lower a person's inhibitions, which may increase his or her dangerousness. (Bancroft, n.d.; Soper, 2014). While a SUD and domestic violence as individual issues may affect each other, a perpetrator gaining sobriety may not necessarily change their abusive behaviors (WomanSafe, Inc., 2002).

2.5.4 Myths About Domestic Violence

Domestic violence affects many people, encompasses many tactics, and has complex causes. This chapter helps dispel the most common myths about it, as illustrated in **Exhibit 2.3.** Understanding the context of domestic violence is vital to helping caseworkers better understand the experiences of both the survivors and the children exposed to perpetrator's behaviors, as explored in later chapters.

Exhibit 2.3. Common Myths About Domestic Violence[2]

- Myth: Domestic violence is not a problem in my community.
- Fact: Domestic violence exists in all communities even when hidden or more difficult to see in some communities.
- Myth: Domestic violence only happens to poor women and women of color.
- Fact: Domestic violence does not discriminate based on status, gender, or ethnicity.
- Myth: Some people deserve to be hit.
- Fact: No one deserves to be hit.
- Myth: Alcohol, drug abuse, stress, and mental illness cause domestic violence.
- Fact: Although these may exacerbate domestic violence, none of these issues causes domestic violence.
- Myth: Domestic violence is a personal problem between two partners.
- Fact: Domestic violence affects not only the partners but also other family members, especially children, and others involved with the partners, such as the adult survivor's employer (work absences).
- Myth: If it were that bad, she would just leave.
- Fact: There are innumerable reasons why an adult survivor may not be able to leave, and each situation is unique.

2 From DomesticViolence.org, 2015.

Highlights

1. While often framed and understood exclusively as a women's issue, domestic violence, can happen to anyone regardless of socioeconomic background, race, age, sexual orientation, religion, or gender.
2. The most common type of domestic violence is a pattern of coercively controlling behaviors perpetrated by one intimate partner against another. These behaviors do not always involve physical violence, but physical violence can escalate in coercively controlling situations.
3. In addition to physical violence, other domestic violence tactics include: sexual; verbal, emotional, and psychological; threats and intimidation; economic coercion; and entitlement behaviors.
4. Perpetrators may use children as a tool or weapon to harm and control the adult survivor (e.g., using custody as a tool, attempting to turn the children against the survivor), which can affect the children's relationships with the nonoffending parent.
5. Over 11 percent of children and youth in the U.S. (approximately 8 million) were exposed to some form of family violence within the past year, and 26 percent (approximately 18 million) were exposed to at least one form of family violence during their lifetimes. Approximately 60 percent of child welfare cases involve some known domestic violence (Hamby et al., 2011; Taggart, 2011).
6. A variety of cultural, social, economic, and psychological factors contribute to the roots of domestic violence, including a confluence of values and beliefs, such as social norms, misogyny, learned behaviors, entitlement thinking, gender inequality, discrimination, and a desire for control.
7. Domestic violence is a learned behavior, which is reinforced by cultural values and beliefs that are repeatedly communicated through the media and other societal institutions that tolerate it.

Chapter 3:
Perpetrators of Domestic Violence

The prior chapter laid out the basic components of domestic violence, including definitions and tactics which perpetrators use. Building upon that foundation, this chapter delves into the role of the perpetrators. The reader will:

- Learn common characteristics shared by perpetrators
- Recognize the levels of danger and how to identify them
- Understand the effects of domestic violence and the perpetrator on parenting
- Explore what happens when the perpetrator leaves the home

While their behaviors are concerning and can harm children, perpetrators are also parents and loved ones with whom children are likely to have life-long relationships. To obtain a better understanding of domestic violence, it helps to learn about those who perpetrate it. To do so does not mean sympathizing with perpetrators or rationalizing their behavior. Instead, understanding who perpetrators are helps caseworkers recognize perpetrators' unique risks to children, relationships with children, and potential willingness to make changes to keep children safer. As later chapters will discuss, caseworkers can work to make the relationship as healthy and safe as possible and appropriate for survivors, children, and perpetrators.

3.1 Who Are Perpetrators of Domestic Violence?

Individuals who choose to engage in patterns of abusive or controlling behaviors are perpetrators of domestic violence. As discussed in the previous chapter, certain issues such as mental illness or substance use disorder may affect or exacerbate perpetrators' behaviors, but they are not causal.

It is important, however, to see perpetrators as people and parents who act along a continuum of domestic violence tactics, rather than as monsters or overall "bad" people. This recognition also helps caseworkers, who have an obligation to engage perpetrators meaningfully. Survivors and children see perpetrators as multifaceted individuals. It becomes harder to work with survivors and children if caseworkers only view perpetrators one dimensionally. While this does not mean that caseworkers will like, agree with, or even want to engage the perpetrators, it does mean that they can understand perpetrators as diverse and complex people.

3.1.1 Demographics

Perpetrators come from every background, religion, socioeconomic status, race, gender, sexual orientation, and ethnicity (DomesticShelters.org, 2015b). Their levels of intellect can vary, and they may or may not have any number of impairments, disabilities, or illnesses. Perpetrators may or may not have witnessed domestic violence (Baker & Stith, 2008). Some perpetrators engage in various crimes that have nothing to do with domestic violence; many perpetrators have no criminal background. Most importantly, none of the factors above can determine perpetrators' level of risk to children; their dangerousness is only connected to their behavioral patterns.

3.1.2 Common Characteristics

Even with this diversity, some characteristics are common among many who engage in coercive control and other forms of domestic violence. Recognizing these characteristics supports perpetrator assessment and engagement. They do not, however, serve as indicators of how all perpetrators behave. These characteristics include being or feeling (Bancroft, 2003):

- Entitled
- Possessive
- Manipulative
- Skillfully dishonest
- Controlling
- "Good" in the beginning of relationships and as seen in public
- Deflective of blame

The word "good," while generic, functions as an overall descriptor of the normalcy or positive behaviors of perpetrators, either in public or in the beginning of relationships. Not all perpetrators engage in positive public behaviors, but many put on an appealing or a positive public face. Perpetrators also use dishonesty in convincing ways to control their families. It is not surprising that perpetrators lie about their abusive behaviors—admitting to them provides little benefit.

Many people question how perpetrators they know could act in such abusive ways, because perpetrators' public behavior often differs significantly from their private behavior. They also may wonder how survivors end up in abusive relationships and incorrectly think survivors choose people who are abusive. More accurately, survivors enter into relationships with people who behave normally or "good," with few signs of problematic behaviors. Survivors often are shocked or confused when the abuse starts, because it feels dramatically different from their initial experience of the relationship. Like survivors, caseworkers also may have difficulty reconciling perpetrators' personas with their behaviors.

Manipulation and the Caseworker

Perpetrators have strong manipulative skills, which can make working with them challenging. They use manipulation as a tactic not only against their partners or families, but also against systems such as courts and child welfare agencies. Anecdotally, caseworkers have reported experiences of perpetrators engaging in any number of manipulations, such as refusing to show up for scheduled appointments, then arriving at the office unexpectedly and demanding to see the caseworker, or telling the caseworker they are grateful for the opportunity to talk about keeping their children safe.

Perpetrators can attempt to use child welfare interventions to their benefit, which may explain why some make reports of child maltreatment so often. They may be attempting to:

- Find out if they can use the system to monitor survivors
- Remove the children from survivors' care
- Learn more about their families
- Document issues that are "wrong" with survivors

Perpetrators have a vested interest in making survivors appear less credible or as bad parents. They will use manipulation to attempt to make this happen.

Just as numerous myths exist about domestic violence, there are myths about perpetrators, which can make working with them more challenging. These include preconceptions that:

- **Perpetrators are stressed and releasing tension in destructive ways.** While they may have the same stressors as others, they typically do not have more stress than anyone else who chooses not to engage in abusive behaviors.
- **Perpetrators have poor skills to regulate their emotions, especially their anger.** Some perpetrators have described feeling calm and happy when engaging in abusive behaviors. If they truly had difficulty regulating their anger, they also would engage in abusive behaviors toward their bosses, neighbors, friends, coworkers, or strangers who aggravate them. Perpetrators typically can control and regulate their anger but choose to act aggressively only toward their families.
- **Perpetrators are thought of as "out of control."** In domestic violence homicides, perpetrators are often reported to have snapped or "lost it." Except in extreme cases of situational violence, perpetrators of domestic violence are not angry, stressed, or "snapping"; they are making clear choices in their behaviors to be abusive.

It is more accurate to understand perpetrators as being in complete control—over whom they harm, how, and to what extent.

Understanding how perpetrators behave and that they are in control of their behavior, whether being abusive or kind, can guide the caseworker's intervention: If perpetrators are in charge of their behaviors, then they can choose to not harm children or the survivors. Through their behaviors, perpetrators provide information about the levels of danger and potential risk, and also about their parenting.

3.2 Indicators of Dangerousness

Perpetrators of domestic violence vary in their dangerousness. There are certain behaviors or elements, however, which indicate a higher risk of danger. Some perpetrators may have numerous indicators of lethality but will not necessarily commit a homicide; others have killed their victim and had very few indicators of lethality. Therefore, it is vital to listen to survivors who say they are in lethal or grave danger; their instinct may serve as the most important indicator, in the absence of others. This section will explore common "red flags" of dangerousness.

As Websdale (2000, p. 1) writes, "Research into domestic homicides typically reveals these to be crimes of cumulation in which men's violence and women's entrapment seem to intensify over time. … [T]he distinction between lethal and non-lethal cases is a false dichotomy." Websdale goes on to explain that a range or continuum of violence and entrapment exists, so it is more appropriate and useful to employ the term "dangerousness" rather than "lethality" assessment. Instruments, therefore, are more useful as means of identifying future dangerousness rather than precisely predicting lethal outcomes (Sargent, 2009). Chapters 5 and 6 detail how caseworkers can use this information to guide in assessment of perpetrators, safety planning, and case planning.

3.2.1 Tools for Assessing the Level of Danger

Domestic violence advocates typically use the Danger Assessment, a common tool for risk assessment, when gathering information from survivors about potential perpetrators (Campbell, 2001). One of the lessons of this tool is that the level of danger differs for every survivor, because each perpetrator is unique. The tool gathers information and weighs different perpetrator tactics to score the survivor's risk of homicide by the perpetrator. Domestic violence specialists then use the tool to guide discussions about strategies survivors can use to try to enhance their safety.

Unfortunately, while it may be of considerable help to caseworkers, this tool may not necessarily be a good fit because survivors may feel less safe disclosing the abuse to child welfare caseworkers than to domestic violence advocates or specialists. Therefore, the results could be skewed. In these cases, not only would the tool not help, it could harm development of a safety plan for the children and family. As a later chapter will discuss, this is why it is often key to work with a domestic violence advocate or specialist or have indepth cross-training for these cases.

Lethality Assessment Program (LAP)

Based on Campbell's research, the LAP, which originated in Maryland, is a program designed to help first responders and law enforcement officials to screen for, assess, and respond to domestic violence (Sargent, 2009). For more information on the LAP, see https://lethalityassessmentprogram.org/.

3.2.2 Factors to Consider

It is important to assess perpetrators' patterns and history of behavior. For example, a recent incident or arrest may have been for a minor or lower-level assault, but a perpetrator's history may indicate prior use of severe or potentially lethal violence or threats. Both history of behaviors and recent changes to a perpetrator's life should be examined to assess for risk. A recent change includes when the survivor leaves or attempts to leave the relationship, which is the most dangerous time for a survivor and the children (Bachman & Saltzman, 1995; Domesticviolence.org, 2015). Survivors who break up with, file for divorce from, move away from, or file a restraining order against their partners are at the greatest risk for homicide. Factors in assessing dangerousness include when perpetrators (National Coalition Against Domestic Violence, 2015; Campbell et al., 2003):

- Have access to a gun, which poses a higher risk of homicide, as victims of domestic violence homicide were killed at a 500 percent higher rate when a gun was available to the perpetrator
- Experience major life changes or circumstances, including the recent loss of employment or other major loss, e.g., a death in the family
- Feel they have less or nothing left to lose

Some behavioral factors also demonstrate a higher level of danger. Perpetrators of domestic violence who have engaged in strangulation, sexual assault, or severe physical violence leading to lasting injuries are more likely to commit homicide. Perpetrators who have used weapons to assault their partners, threatened their partners with weapons, or have threatened to kill their partners or children also have a higher risk of committing homicide (Pennsylvania Coalition Against Domestic Violence, 2017).

It is important to note that not all perpetrators who engage in these behaviors will commit homicide, but it is necessary to assess for these behaviors to have an informed conversation with the survivor, and separately, with the perpetrator. Another area to assess is the belief the survivor may have about the potential life-threatening danger posed by the perpetrator. If the violence is considered minor, or the risk assessment did not uncover any high-risk behaviors or changes, but the survivor states that he or she believes the perpetrator will murder him or her and/or the children, caseworkers should intervene and plan in the same manner that any high-risk case would be handled. Additionally, if the survivor states that the worker will not be in danger, but that talking to the perpetrator will lead to increased violence or danger to the family, workers should speak with their supervisors and managers about whether or not it enhances child safety to engage the perpetrator; if it does, significant planning with the survivor should occur.

Example of Increased Level of Dangerousness

A perpetrator who had a high level of risk based on screening for danger was on probation and was determined not to return to jail. Probation initially acted as a deterrent to escalation of his behaviors. When circumstances changed, and the perpetrator violated probation by committing a nonviolent offense, the survivor and children had to make an alternate safety plan. The survivor believed they were all in grave danger as the perpetrator faced jail time—she feared the perpetrator would hurt her or the children worse if he was about to lose his freedom.

Exhibit 3.1 synthesizes the various levels of dangerousness.

Indicators of potential harm to children may include threats to harm or kidnap children. Threats or concerns about the dangerousness of an adult also should be considered a safety concern for children; in lethal events, perpetrators may accidentally or intentionally physically harm children. Perpetrators also have targeted children in numerous incidents in homicides or familicides. Even in the absence of physical harm to children, perpetrators who kill or severely injure nonoffending parents deeply and emotionally traumatize the children. Risk assessment in domestic violence cases must consider the children's safety and emotional experiences.

3.3 Impact of Assessing Danger on Child Welfare Intervention

Caseworkers must be able to respond creatively and effectively to cases with differing levels of danger. Because not all perpetrators carry the same level of dangerousness, the worker must be able to assess each case uniquely by understanding the perpetrator's behavioral pattern, the child's age and developmental stage, the parents and family's strengths and protective factors, and other risk factors that may be present. Caseworkers must then make plans to address those behaviors accordingly.

Managing high-risk domestic violence cases is challenging, as in many child maltreatment settings, and requires the capacity to act responsively rather than reactively. It is difficult not to react quickly to a potentially dangerous case. Unfortunately, due to the volatility of some high-risk perpetrators, interventions need to be planned and thoughtful to ensure the best possible outcomes based on the specific and unique danger presented by the perpetrator. Chapters 6 and 7 provide more detail and guidelines for ensuring safety in cases involving domestic violence.

Exhibit 3.1. Assessing Dangerousness

All domestic violence is dangerous, but some perpetrators are more likely to kill than others, and some are more likely to kill at specific times. The likelihood of homicide is greater when the following factors are present (Independent Living Resource Centre Thunder Bay, n.d.):

- **Threats of homicide or suicide.** The perpetrator may threaten to kill him- or herself, the survivor, the children, relatives, friends, or someone else.
- **Plans for homicide or suicide.** The more detailed the perpetrator's plan and the more available the method, the greater the risk he or she will use deadly force.
- **Weapons.** The perpetrator possesses weapons and has threatened to use them in the past against the survivor, the children, or him- or herself. If the perpetrator has a history of arson, fire should be considered a weapon.
- **"Ownership" of the survivor.** The perpetrator says things like, "If I can't have you, no one can," or, "I would rather see you dead than have you divorce me." The perpetrator believes he or she is absolutely entitled to the obedience and loyalty of the survivor.
- **Centrality of survivor to the perpetrator.** The perpetrator idolizes the survivor, depending heavily on him or her to organize and sustain the perpetrator's life, or the perpetrator isolates the survivor from outside supports.
- **Separation violence.** The perpetrator believes he or she is about to lose the survivor.
- **Repeated calls to law enforcement.** A history of violence is indicated by repeated police involvement.
- **Escalation of risk taking.** The perpetrator has begun to act without regard to legal or social consequences that previously constrained his or her violence.
- **Hostage taking.** He or she is desperate enough to risk the life of innocent persons by taking hostages. There is a very serious likelihood of the situation turning deadly.

3.4 Perpetrators and Parenting

Caseworkers should recognize that children can have varying and complicated relationships with their parents who are perpetrators; many perpetrators will be engaged with their children throughout their lives. Caseworkers can positively affect those relationships by recognizing the parental role of each individual perpetrator, assessing the safety of that relationship and the perpetrator's parenting skills, and intervening to enhance the safety of the children, which will have a significant impact on the lives of children. These are critical components to both the safety and family plans discussed in Chapters 6 and 7.

Perpetrators of domestic violence vary widely in their parenting styles, skills, and capacities. It is necessary to understand each perpetrator's parenting role and abilities in order to ensure that the children are safe and, when possible and appropriate, to maintain their routines. Some perpetrators may have primary parenting roles, while others may have limited or no contact with their children. Regardless of their involvement, perpetrators can have significant impact on their children, both positively and negatively.

In addition to abuse being a relationship choice by perpetrators, abuse can be a parental style for some perpetrators. Some perpetrators will also direct physical, sexual, or emotional abuse towards their children. Perpetrators of domestic violence are more likely than those who are not perpetrators to abuse their children (McGee, 2000). Therefore, caseworkers have a responsibility to screen for other forms of child abuse, besides being exposed to domestic violence, in these cases (Child Welfare Information Gateway, 2016a).

Perpetrators and Parenting

As discussed earlier, perpetrators make a choice when they commit domestic violence. This choice is not simply a series of acts committed toward a partner but also a series of acts that affect the relationship between offending parents and their children. For example, children hear when the perpetrator verbally abuses his partner, calling her "stupid" and saying she is a "bad mother." Because children often internalize what occurs around them or what they believe about their parents, children may then believe that they, too, are stupid, as the offspring of that mother. The children could also believe that their mother is being told she is a bad parent because of something the children themselves did wrong. They may then feel bad about themselves or guilty for the abuse. This harms both the relationship between the children and their father and between the children and their mother. By choosing to behave in this manner, the perpetrator has made a parenting decision to be abusive and, at best, lacks insight into how it is affecting the children. Perpetrators make numerous parenting choices when they are abusive, and holding them accountable as parents is necessary to enhancing child safety.

3.4.1 Father Engagement

Child welfare agencies historically have scrutinized the parenting of mothers more than that of fathers (Stark, 2002). Many agencies have prioritized father engagement because of this practice and because they recognize that fathers are deeply important to children and often are valuable supports to their children. The Child and Family Services Reviews actively measure father engagement when reviewing state performance (National Family Preservation Network, n.d.).

Despite this improved understanding and practice in recent years, agencies and other entities still do not consistently assess fathers separately from mothers regarding parenting style. For example, during a home visit, caseworkers need to ask many questions about the children concerning their schooling, medical care, needs, and behaviors. How often do fathers serve as the primary or joint source of information about their children when mothers are in the home?

Good practice relies on talking with fathers about their children for several reasons. Often, fathers have useful information about their children for a family assessment. They may also have solutions to address children's needs. By asking fathers about their children, caseworkers demonstrate the importance of fathers. This also is true when fathers are domestic violence perpetrators; they, too, have information about their children, and may even have solutions. Perhaps more importantly, asking perpetrators about their children and their parenting performs four important functions:

1. Demonstrating to the perpetrator that he is as equally responsible for his children as the nonoffending parent.
2. Allowing the worker to assess how well the perpetrator knows his children. This information is useful should the perpetrator ever be a placement resource or has unsupervised visits with the children.
3. Helping the worker identify the perpetrator's parenting style and, potentially, how to intervene to support the perpetrator's parenting needs.
4. Keeping the focus of the case on the children and their needs.

3.4.2 Assessing Perpetrators' Parenting Styles

Why does a caseworker need to know about perpetrators' parenting? Historically, the child protective services' intervention is to remove the perpetrators from the children's lives when domestic violence is present. However, this may not be either realistic or sustainable, because many perpetrators have legal rights to their children or will have access to their children in various ways. Assessing a perpetrator's parenting style can help determine the level of risk to the children. Additionally, caseworkers document a perpetrator's parenting of and relationship with the children as part of a comprehensive assessment of the family dynamics and in case that individual is being or will be considered a placement resource for the children. (Chapter 6 discusses the family assessment in more detail.)

While some people assume that perpetrators pose no risk to their children as long as they do not engage or communicate with the adult survivors, perpetrators can pose significant risk to children through their parenting. Many child and adult survivors have shared experiences of perpetrators engaging in reckless, dangerous, or harmful behaviors when parenting their children alone (Bancroft, 2002). In addition, many survivors have reported staying in relationships with perpetrators, despite wanting to leave, because they feared that perpetrators would have unsupervised access to the children and hurt them and/or not care for them.

Numerous child welfare partner systems, including family courts, law enforcement, criminal courts, or mental health systems, do not have the access or resources to assess a perpetrator's parenting. Because many of those systems are either focused on an incident, such as an arrest, or on the adults, such as in a divorce, the system perhaps best equipped to holistically assess a perpetrator's risk to children is child welfare. It is important for workers to assess perpetrators' behavioral patterns and their parenting and relationships with children to guide interventions and services to keep the children safe. When it does not conflict with confidentiality issues, it also demonstrates the responsibility caseworkers have in sharing information with its partner systems to help them also make the most informed decisions possible.

Example of Effect on Parental Relationship

Alex, age 13, has grown up listening to his stepfather, Ivan, belittle his mother, Sara. Ivan has called Sara a whore repeatedly over the years. In the beginning, Ivan did not control where Sara went. Over the last 2 years, he has forbidden Sara from seeing her family and friends when he is not present. Ivan does not let Sara work. When she tried to get a job behind his back, he punched her in the face, breaking her eye socket. Ivan tells Alex not to listen to Sara; he says Sara does not know anything and Alex would be better off with no mother than with Sara.

Ivan allows Alex to skip school regularly. Alex asked Sara to buy him a video game system; she said he could not have one until his grades improved. Ivan bought Alex an Xbox the next day. Ivan allows Alex to stay up late at night and to watch pornographic movies online. Alex recently was caught smoking marijuana, and Sara grounded him. Ivan told him smoking marijuana was acceptable because he also tried it as a kid.

How would you describe Ivan's parenting? How might Ivan's parenting affect Alex's relationship with Sara? (Sara may lose her authority; Alex may prefer Ivan to Sara.) How might Ivan's parenting affect Alex? (Alex may feel acting out is acceptable; Alex might get hurt or in trouble in the community; Alex may have educational difficulties.)

3.5 What Happens After the Perpetrator Leaves the Home?

Perpetrators can continue to perpetrate violence regardless of their relationship status or living situation. Historically, people have assumed that if perpetrators move out of the home, families are safer. Time after time that assumption has been proven to be incorrect (National Coalition Against Domestic Violence, n.d.-b). Not only is this the most dangerous time for survivors and children, but during this time perpetrators have changing levels of access to children, which will affect children and their relationship with perpetrators. Caseworkers have an opportunity to engage children about their relationships with their perpetrating parent.

Knowing that the relationships between children and perpetrators may change over time, it is important to ask the children about their experiences throughout the case. By building trust with the children and ensuring that they know they are safe to speak with the caseworkers, children have an opportunity to process these changes and to share information that may be useful for the ongoing family assessment. This also demonstrates to children that they can talk about the violence and their experiences. Children need an opportunity to be heard about what they have witnessed and about how they feel, especially as their feelings and level of safety may change (positively or negatively) with the perpetrator out of the home.

If a perpetrator has custody or visitation with the children, caseworkers need to do home visits to observe the home and the perpetrator's parenting. This accomplishes three goals:

1. Assesses for child safety concerns.
2. Demonstrates to perpetrators, children, and survivors the continued assessment of the perpetrators and that perpetrators are accountable for their parenting.
3. Helps caseworkers further assess perpetrators' strengths and needs to tailor the case plan accordingly, and provides perpetrators with both accountability and some control over ways to address those needs (for more detail on case planning, see Chapter 7).

Another way to assess a perpetrator's parenting after he or she leaves the home is to observe the way the perpetrator supports the relationship between the children and the nonoffending parent. Does the perpetrator allow the children to communicate with their nonoffending parent during visitation? How does the perpetrator talk about the nonoffending parent to or in front of the children? For example, does the perpetrator call the survivor names, belittle him or her, or instruct the children not to listen to or trust the survivor? Or does the perpetrator tell the children to respect both parents or stay consistent with rules that are in place in the survivor's home? Assessing how a perpetrator supports the relationship between the children and the survivor is important to understanding both the perpetrator's parenting and the experience of the children.

Children typically know about the domestic violence. In a developmentally appropriate manner, perpetrators have an opportunity to help the children heal by taking responsibility and being honest about their abusive actions. This does not mean that the perpetrator should inform the children of abuse about which they are unaware. It does mean that, when children are already aware of or have witnessed abuse, they need to be asked and spoken with honestly about their experience of the abuse.

Caseworkers have an opportunity to assess a perpetrator's parenting by how well he or she talks to the children about their experiences. Does the perpetrator take responsibility for his or her actions or blame the survivor or others? It is important to listen for subtle forms of blame. For example, a perpetrator may say, "I know what I did was wrong and that I have no one to blame but myself. I just don't understand why (the survivor) gets to keep bringing it up, like he or she never made a mistake before." This type of statement sounds at first like the perpetrator is accepting responsibility for his or her actions. However, the perpetrator then demonstrates behaviors of wanting to control when the survivor talks about having been abused and of subtly blaming the survivor's "mistakes" or questioning the survivor's innocence in their relationship.

These types of statements can be very harmful to children who are learning right from wrong and how to take responsibility for their behaviors. How a perpetrator models these behaviors is an important element of their parenting to assess. Some perpetrators are more forthcoming in accepting blame and may tell the children that. Some perpetrators may not acknowledge their behaviors at all. These are parenting choices about how to help a child heal from a trauma he or she has experienced. Assessing these choices helps determine whether or not the perpetrator is emotionally safe for the children, as well.

This chapter built upon the basic components of domestic violence outlined in the previous chapter by looking at the perpetrator, level of dangerousness, and parenting styles affected by domestic violence. The next chapter examines more about who the adult survivors of domestic violence are and the impact of the abuse on them.

Resources

For a videos on hearing from and working with perpetrators, go to:

Domestic Abusers and Victims Speak at https://www.youtube.com/watch?v=NyN_mXOQc3I

Working With Perpetrators of Domestic Violence at https://www.youtube.com/watch?v=NjijqDbcuDs

Who Are Perpetrators of Domestic Violence at https://www.youtube.com/watch?v=YvMqe5SfFlU

It Ends Where It Begins at https://www.youtube.com/watch?v=A-luJWp2_SI

Highlights

1. Perpetrators are also parents and loved ones with whom children are likely to have life-long relationships. To obtain a better understanding of domestic violence, it helps to learn about those who perpetrate it. It becomes harder to work with survivors and children if caseworkers only view perpetrators one dimensionally.
2. Perpetrators come from every background, religion, socioeconomic status, race, gender, sexual orientation, and ethnicity.
3. Even with this diversity, some characteristics are common among many who engage in coercive control and other forms of domestic violence, including being or feeling entitled, possessive, manipulative, dishonest, controlling, "good" in public, and deflective of blame.
4. Perpetrators vary in their levels of dangerousness. There are certain behaviors or elements, however, that indicate a higher risk of danger, and there are several tools to evaluate that risk.
5. Even if the violence is considered minor, or the risk assessment did not uncover any high-risk behaviors or changes, if the survivor states that he or she believes the perpetrator will murder him or her and/or the children, caseworkers should intervene and plan in the same manner that any high-risk case would be handled.
6. Perpetrators can continue to perpetrate violence regardless of their relationship status or living situation. While people assume that if perpetrators move out of the home families are safer, that assumption has been proven to be incorrect. Not only is this the most dangerous time for survivors and children, but, during this time perpetrators have changing levels of access to children, which will affect children and their relationship with perpetrators.
7. Caseworkers should recognize that children can have varying and complicated relationships with their parents who are perpetrators; perpetrators can vary widely in their parenting styles, skills, and capacities. It is necessary to understand each perpetrator's parenting role and abilities in order to ensure that the children are safe.
8. Additionally, knowing that the relationships between children and perpetrators may change over time, it is important to ask the children about their experiences throughout the case.
9. Understanding how perpetrators behave and that they are in control of their behavior, whether being abusive or kind, can guide the caseworker's intervention. If perpetrators are in charge of their behaviors, then they can choose to not harm children or the survivors. Through their behaviors, perpetrators provide information about the levels of dangerousness and potential risk and also about their parenting.

Chapter 4:
Working With Adult Survivors of Domestic Violence

It is vital that caseworkers be aware of and recognize the numerous effects that domestic violence can have on survivors. Caseworkers can then use that knowledge when developing the family (or case) plan to not only reduce the risks to children's safety but also to advocate for supportive services and resources for the survivor, such as trauma-focused therapy. (Chapter 7 discusses trauma and developing the family plan in more depth.)

This manual uses the terms "nonoffending parent" or "adult survivors" to refer to those who are also parents or are in a parental role for children and are also the perpetrator's target of domestic violence. Research has repeatedly demonstrated that a high percentage of nonoffending parents continue to parent effectively despite being abused (Stark, 2002), are typically consistent in their discipline and parenting, provide stability and affection, and meet their children's emotional and developmental needs more often than not (Sullivan et al., 2000). This means that when caseworkers are attempting to meet their goals of child safety and well-being, they have a potential partner in the adult survivor. Survivors often are parents who can work collaboratively with the child welfare agency towards efficient and effective strategies to meet the needs of children exposed to domestic violence (Mandel, 2008). Therefore, the purpose of this chapter is to help readers:

- Understand who adult survivors are and what they experience
- Recognize and gain an understanding of the barriers to leaving an abusive relationship
- Learn the impact of domestic violence on survivors' physical and mental health
- Recognize risk and protective factors affecting survivors' parenting authority and abilities

4.1 Who Are the Adult Survivors of Domestic Violence?

As the data from the National Intimate Partner and Sexual Violence Survey (NISVS) show, adult survivors of domestic violence are a diverse population. While the majority are women, men also are survivors (National Coalition Against Domestic Violence, n.d.-b). Survivors come from every background and environment—racial, ethnic, religious, socioeconomic, ability, health, sexual orientation, and gender identification (U.S. Department of Justice, Office on Violence Against Women, 2017).

4.1.1 Diverse Communities and Populations

Chapter 2 provided statistics about the general population, but clearly differences exist among survivors. Their diversity is not solely in demographics but also in experiences, communities, environments, and other daily realities of their lives. However diverse, all survivors share the common thread of being the target of another person's controlling and/or violent choices. The next sections examine some of the underserved populations and their different experiences and context.

Native American Community

The NISVS found that (Black et al., 2011; Rosay, 2016, pp. 2, 46):

- More than 4 in 5 American Indian and Alaska Native (AI/AN) women (84.3 percent) have experienced domestic violence in their lifetime
- 56.1 percent of the AI/AN women have experienced sexual violence, 55.5 percent physical violence, 48.8 percent stalking, and 66.4 percent psychological aggression by an intimate partner
- More than 4 in 5 AI/AN men (81.6 percent) have experienced domestic violence in their lifetime
- 27.5 percent of the AI/AN men have experienced sexual violence, 43.2 percent physical violence, 18.6 percent stalking, and 73.0 percent psychological aggression by an intimate partner
- AI/AN survivors are significantly more likely than non-Hispanic, White-only survivors to have experienced violence by an interracial intimate partner

Unfortunately, no federal or tribal agency or organization systematically collects comprehensive data on violence against women under tribal jurisdiction (Futures Without Violence, n.d.-c). Additionally, insufficient funding, inadequate training, and survivors' mistrust of outside authority exacerbate problems in law enforcement's response to domestic violence on many tribal lands. There are also many jurisdictional complexities and limitations regarding the division of authority among tribal, federal, and state governments (Futures Without Violence, n.d.-c; Valencia-Weber & Zuni, 1995).

Historical trauma, a form of trauma often associated with racial and ethnic population groups who have suffered major intergenerational losses and assaults on their culture and well-being, refers to the cumulative emotional and psychological wounding transmitted across generations within a community as a result of group traumatic experiences (DHHS, Substance Abuse and Mental Health Services Administration, 2016). The historical trauma that the AI/AN community experiences compounds the effects of domestic violence. Scholars suggest that violence against AI/AN women directly relates to historical victimization and that domination and oppression of Native peoples has increased both economic deprivation and dependency through denial of tribal rights and sovereignty. Consequently, they experience internalized oppression and the normalization of violence. Some AI/AN communities, however, are developing culturally sensitive interventions for domestic violence, both within and outside of the criminal justice system, which emphasize restorative and reparative approaches to justice (Futures Without Violence, n.d.-c; Burbar & Thurman, 2004; Bachman, Zaykowski, Kallmyer, Poteyeva, & Lanier, 2008).

Same-Sex Community

The NISVS results also showed that domestic violence affects both heterosexual people and people within the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) communities (Black et al., 2011):

- 44 percent of lesbians and 61 percent of bisexual women (compared to 35 percent of heterosexual women) experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.
- 26 percent of gay men and 37 percent of bisexual men (compared to 29 percent of heterosexual men) experienced rape, physical violence, and/or stalking by an intimate partner at some point in their lifetime.

There are many similarities in how abusers control their victims regardless of sexual orientation. However, as Exhibit 4.1 illustrates, the LGBTQ community faces concerns distinct from the heterosexual community.

Exhibit 4.1. Domestic Violence Issues in the LGBTQ Community[1]

- Perpetrators may threaten to "out" the survivors to work colleagues, family, and friends. This threat is amplified by the sense of extreme isolation for those still closeted from friends and family.
- Survivors have fewer civil rights protections and may lack access to the legal system. They may be more reluctant to report abuse to legal authorities because doing so would force them to reveal their sexual orientation or gender identity. Some states allow for LGBTQ persons to be fired from their jobs based on their sexuality or gender identity. The Williams Institute found that that 9.2 percent of openly gay, lesbian, bisexual or transgender people had lost a job due to their sexuality (Sears & Mallory, 2011, p.1).
- Survivors are also reluctant to seek help out of fear of showing a lack of solidarity in the LGBTQ community or that society will perceive same-sex relationships as inherently dysfunctional.
- LGBTQ survivors are more likely to fight back than are women in heterosexual relationships. This can lead law enforcement to conclude that the violence was mutual, overlooking the larger context of domestic violence and the history of power and control in the relationship.
- Perpetrators can threaten to take away the children from the survivor. In some states, adoption laws do not allow same-sex parents to adopt each other's children. This can leave the survivor with no legal rights should the couple separate. The perpetrator can easily use the children as leverage to prevent the survivor from leaving or seeking help. Even when the survivor is the legally recognized parent, the perpetrator may threaten to expose him or her to social workers hostile to LGBTQ people, which may result in a loss of custody.

1 Adapted from Sears and Mallory (2011) and Center for American Progress. (n.d.).

Immigrant Community

Immigrant women are at particularly high risk of domestic violence and face unique challenges in escaping violence. They often feel trapped due to immigration laws, language barriers, social isolation, lack of financial resources, and other barriers (Mose & Gillum, 2016; Erez et al., 2009; Futures Without Violence, n.d.-b; Orloff & Little, 1999; Sullivan et al., 2005; Thomas, 2000). Immigration law gives a perpetrator, who is here legally, control over the immigration status of the spouse and children, who are awarded "derivative" immigration status so that they can join him or her (e.g., spouses and children of diplomats, workers for religious or international organizations, students, and people who receive work-related visas). The survivors often fear continued abuse if they stay, and deportation if they attempt to leave their spouse (Orloff, 2002). Additionally, a survivor who is an undocumented immigrant or has past negative experiences with law enforcement may be reluctant to call the police as a plan for safety (American Civil Liberties Union, 2015).

However, the U.S. Department of Homeland Security, Citizenship and Immigration Services (2011) lays out in its fact sheet[2] on domestic violence and immigration, that, under all circumstances domestic violence and child abuse are illegal in the United States. Everyone, regardless of national origin or immigration status, is guaranteed protection from abuse under the law and can seek help. An immigrant survivor of domestic violence may also be eligible for immigration-related protections. Therefore, when working with immigrant families, it is important for the caseworker to have knowledge of legal aid organizations in the state or nearby area that specialize in immigration law.

2 For more information, go to https://www.uscis.gov/news/fact-sheets/information-legal-rights-available-immigrant-victims-domestic-violence-united-states-and-facts-about-immigrating-marriage-based-visa-fact-sheet.

Military Community

There have been numerous and conflicting studies about the prevalence of domestic violence in the military. The wide range of discrepancy in data indicates both the likelihood of underreporting and possible differences in the interpretation of what constitutes domestic violence (Kern, 2017; Domesticshelters.org, 2016a).

In 2010, the Department of Defense (DoD), Department of Justice, and Centers for Disease Control and Prevention (CDC) collaborated for the first time to include two random samples from the military in the NISVS. That survey found, with few exceptions, that past-year and lifetime occurrence of domestic violence, sexual violence, and stalking in the civilian and military populations had no statistically significant differences (Battered Women's Justice Project, 2017; Black et al., 2011). However, several studies conducted outside of the DoD found the rate of husband-to-wife partner violence much higher than that of the civilian population (Kern, 2017, p. 356; Foran, Smith Slep, & Heyman, 2011; Rosen et al., 2002; Klostermann, Mignone, Kelley, Musson, & Bohall, 2011).

Many issues may affect domestic violence and/or its reporting in the military. Survivors may fear repercussions should the perpetrator be demoted as a result of reporting the abuse. When a domestic violence report is made in the military, it may be subject to a military-led investigation, and consequences may be dictated by the military code of conduct as well as federal law (Domsticshelter.org, 2016). One study of the U.S. Navy found that both the number of deployments and the level of satisfaction in the relationship had an effect, i.e., higher number of deployments and/or lower level of satisfaction with the relationship correlated to increased incidents of domestic violence. (Kelley, Stambaugh, Milletich, Veprinsky, & Snell, 2015). Posttraumatic stress disorder (PTSD) also is considered a factor possibly contributing to domestic violence.

Veterans with PTSD were 2 to 3 times more likely to be violent toward a female partner than were veterans without PTSD (Frierson, 2013, p. 80; DomesticShelters.org, 2016a, para.4; Teten, Schumacher, Taft, Stanley, Kent, Bailey, et al., 2010).

Rural Community

Because the majority of studies on domestic violence have been conducted in urban populations, Peek-Asa, Wallis, Harland, Beyer, & Saftlas (2011) studied women in small, rural, and isolated areas. Rural women in the study reported the highest prevalence of domestic violence (22.5 percent and 17.9 percent, respectively) compared to 15.5 percent for urban women (p.1745). They not only experienced higher rates but also greater frequency and severity of physical abuse (Peek-Asa et al., 2011).

Rural women face greater barriers than their urban counterparts in accessing needed support and services (National Advisory Committee on Rural Health and Human Services, 2015). Isolation, high rates of poverty, and limited access to services all have an impact. Social factors, including gender roles, religious convictions, rural cultural norms, a high degree of social cohesion, and a perceived lack of confidentiality or privacy can also make it hard for women in rural communities to ask for and obtain assistance. Rural women who have experienced domestic violence report having less social support and greater feelings of loneliness than urban women and are less likely to seek help. In addition, high rates of poverty, transportation barriers, lack of affordable housing, and telecommunication barriers create additional challenges for rural survivors who want to leave an abusive situation and establish a new life (National Advisory Committee on Rural Health and Human Services, 2015; Logan, Walker, Cole, Ratliff, & Leukefeld, 2003; Shannon, Logan, Cole, & Medley, 2006; Wider Opportunities for Women, 2013; McCall-Hosenfeld, Weisman, Perry, Hillemeier, & Chuang, 2014; Grossman, Hinkley, Kawalski, & Margrave, 2005).

People Living With Disabilities Community

While research on abuse of people with disabilities is limited in number and methodology, the limited research that does exist suggests that people with disabilities are abused at alarming rates (Vera Institute of Justice, 2018, para.1). One study, using a nationally representative sample, found that 4.3 percent of people with physical health impairments and 6.5 percent of people with mental health impairments reported experiencing domestic violence in the past year (Niolon et al. 2017, p. 8; Hahn, McCormick, Silverman, Robinson, & Koenen, 2014, p. 3073). Additionally, studies show that people with a disability have nearly double the lifetime risk of domestic violence than do those without a disability (Niolon et al., 2017, p. 8; Smith, 2007, p. 15).

According to the National Domestic Violence Hotline (n.d.), people living with disabilities may face unique challenges and barriers to accessing support. They often are isolated, may be reliant upon others as caregivers, and have limited transportation (VERA Institute of Justice, 2018). They may also experience "nontraditional" signs of abuse, such as a perpetrator who (National Domestic Violence Hotline, n.d.):

- Refuses to help the person use the bathroom or complete necessary life tasks
- Withholds medication or over medicates
- Uses the disability to shame or humiliate
- Threatens harm to a service animal
- Denies access to assistive devices and/or doctors
- Instigates sexual activity when they know their partner is not capable of consenting

Resources

Appendix B, *Resource Listings of Selected Organizations Concerned With Domestic Violence and Child Maltreatment,* not only provides a list of general domestic violence organizations but also includes resources that address many of the needs of these diverse communities.

4.1.2 Survivors and Mental Illness

One of the impacts of domestic violence on survivors is its effects on their mental health. One literature review and meta-analysis suggests that the abuse can have increasing, adverse effects on the mental health of survivors compared with those who have never experienced domestic violence or with those experiencing other traumatic events (Lagdon, Armour, & Stringer, 2014). Survivors of domestic violence have higher rates of posttraumatic stress PTSD, depression, anxiety, and other mental illnesses than the general population; survivors of more severe abuse have an increased likelihood of mental health diagnoses (Ferrari et al., 2016). Caseworkers should therefore work with mental health professionals to screen for possible mental health issues and to advocate for survivors experiencing mental health needs to receive treatment and to have opportunities to heal from their experiences.

It is also important to distinguish the choices a survivor makes about the relationship from his or her mental health diagnoses. Humphreys and Thiara (2003) identified that health practitioners more often saw a survivor's decision to remain in an abusive relationship as a symptom of a mental disorder rather than as a signal of a perpetrator's abuse and control in the relationship. While important to assist survivors in accessing mental health services when appropriate, caseworkers should recognize that the choice to stay may be a result of the abuse and its own survival mechanism, not a mental deficit of the survivor. Additionally, survivors may fear that being sent for treatment is evidence that the perpetrators were correct in calling them "crazy," or that the child welfare system will focus on their mental health rather than on the violence that caused or exacerbated it (Humphreys & Thiara, 2003).

Despite the increased likelihood that the mental health of survivors will be affected by domestic violence, some have no mental illness diagnosis at all (Cascardi, O'Leary, & Schlee, 1999). Survivors having to receive treatment or psychological evaluations based solely on having been victimized, without exhibiting any symptom of mental illness, can be unnecessary and may damage the relationship between them and the caseworkers. However, there may be underlying conditions, such as depression or anxiety, which the caseworkers may not easily see. It is important, therefore, to talk with the agency's mental health professionals for guidance on the effects of trauma. Chapter 7 discusses trauma in more detail.

4.1.3 Survivors and Substance Use Disorder

Survivors of domestic violence also have higher rates of substance use and abuse than the general population and may use substances as a coping mechanism for the trauma of the abuse (Campbell, 2002). A survivor who is using substances may need treatment for a substance use disorder (SUD) to support his or her recovery and services to address any coexisting mental health concerns. When referring the survivor for SUD treatment, it is important to note the survivor's experience of domestic violence to make sure the provider is aware. It is crucial in the caseworker's assessment of risk to children to look at both the SUD and domestic violence factors. A survivor who is abusing substances may be able to achieve recovery, but there may be continued risk to children based on the domestic violence perpetrators' abusive behaviors. Those behaviors or the trauma of past abuse may also be a trigger for a survivor's relapse. Perpetrators also may actively encourage survivors to use, drink, and/or relapse because the survivors' SUD may provide perpetrators with a different avenue for control.

Example About SUD

A survivor of domestic violence had a history of cocaine use, and the children were unattended while she was high. The children were removed from her care when she tested positive. After she was clean for 6 months, the children were returned to her care with a strong warning that, if she relapsed, the children would return to care.

The domestic violence perpetrator, who did not use drugs himself, would bring cocaine into the home. The survivor would get rid of it and inform her worker about what occurred. She routinely tested negative for any substances. After several months, the survivor relapsed and used the drugs brought to her by the perpetrator. He then drove her and the children to the child welfare office and demanded she be tested because she had used. Instead of removing the children, the worker consulted with her supervisor and then connected the survivor with additional services and developed a safety plan for the survivor's mother to watch the children in the interim. A plan was put into place restricting the perpetrator's unsupervised access to the children due to his active role in coercing the survivor's substance use as part of his pattern of coercive control.

4.2 Survivors' Experiences With Child Welfare

Because of the diversity of survivors and their experiences, they have unique and varied responses to working with child welfare. In one study, domestic violence shelter staff reported that survivors have had both positive and negative experiences with child welfare involvement (Steen, 2009). Some survivors may welcome the assistance, while others may feel fearful of the system, being blamed, or having their children removed; survivors may feel disempowered by child welfare interventions or discouraged to seek help (Steen, 2009). Other survivors may be more forthcoming, while some may never tell the caseworker about the domestic violence they are experiencing. Some survivors come from communities that feel distrustful of child welfare, law enforcement, or other systems, which may affect their ability or willingness to share information or to seek assistance from these systems. Other survivors have had positive experiences with systems' involvement and may reach out for support even after a case has been closed. There is no one way in which a survivor will or should act with child welfare. Caseworkers should not assess survivors' compliance or desire to work with child welfare as an indicator of their parenting or protective abilities (Mirick, 2013).

Many systems, particularly child welfare, have a strong desire for survivors to end their abusive relationships, but not all survivors may have that as their goal. Survivors may not want to leave for various reasons, several of which are explored later in this section and manual. There is evidence of adversarial relationships between child welfare and domestic violence workers, which may be exacerbated by seemingly different goals for survivors (Cozzolino, 2014). Partnering with survivors around a goal of safety and well-being for children may help child welfare workers engage with families experiencing domestic violence more efficiently regardless of the hopes and goals of survivors for their relationships (Mandel, 2008). Later chapters discuss in more detail how caseworkers can work with families experiencing domestic violence.

4.3 Barriers to Leaving an Abusive Relationship

There are many reasons why some survivors may feel unsafe to leave an abusive relationship, as this section lays out. There are those who feel unsafe or unable to leave for various reasons. Survivors may choose to remain in abusive relationships for any number of reasons, including economics, religious beliefs, hope, love, fear, shared children, or wanting children to have a two-parent home (National Coalition Against Domestic Violence., n.d.-c). Survivors who chose to stay are not making a decision that is inherently harmful to children (Stark, 2002). While children are potentially at risk of perpetrators harming them, the decision to stay does not necessarily increase the risk to children (Bancroft, Silverman, & Ritchie, 2011). Therefore, caseworkers should always be evaluating safety for the children, whether or not the perpetrator is in the home.

There are numerous and significant barriers survivors face in planning for their safety. Davies (2009) discusses how survivors may make plans for how to enhance their own and the children's safety while remaining in the relationship; other survivors may make plans for how to leave safely. The act of leaving can look very different in different circumstances. Some survivors escape because of an imminent threat or fear. Escaping in such a situation is a short-term plan; survivors may then face the challenge of leaving without fully developed plans or resources. Another type of leaving is a planned separation, which means the survivor (and the children, when developmentally appropriate) makes a long-term plan to leave, which should include (Davies, 2009):

- Timing the leaving
- Finding a place to go
- Attempting to gather important documents (e.g., birth certificates, drivers' licenses, legal documents) and resources
- Engaging in interim plans to stay safe in the relationship before leaving

4.3.1 Cultural Barriers to Leaving an Abusive Relationship

There are numerous cultural barriers to leaving an abusive relationship that confront survivors, including the lack of culturally responsive services or of access to supports. For example, survivors' experiences with domestic violence services or supports in the community may shape their decision-making about their relationship. In one study, African-American women showed a dissatisfaction with both the services themselves and the cultural competency of those services received when trying to leave their abusive relationships (Gillum, 2008), which could affect their ability or decision to leave. Additionally, there are limited AI/AN supports or services specific to their experiences as Native Americans (van den Bosse & McGinn, 2009). The federal government, however, responded to this issue by distributing 10 percent of its appropriated Family Violence Prevention and Services Act (FVPSA) funds to 238 different tribes in 27 states in fiscal year (FY) 2014. (U.S. Department of Health and Human Services [DHHS], Family and Youth Services Bureau, 2015, p. 1). Those numbers have increased to 260 tribes in 28 states in FY 2015 (DHHS, Family and Youth Services Bureau, 2016, p. 1).

Survivors also may face pressures from their faith-based or ethnic communities. Fear of embarrassing the family or disapproval from community elders may hinder a survivor leaving an abusive marriage. They may also have religious reasons for staying in their relationships; the counsel they receive from religious leaders, who may not have training working with survivors, to not leave because of religious duty may affect those decisions as well (Zust, Housley, & Klatke, 2017). Survivors may not be able to access their faith community upon leaving (Rhoades, 2015) or may believe that their religion or culture is perceived as a cause of the abuse (Oyewuwo-Gassikia, 2016).

While all cultures have examples of domestic violence occurring, survivors from marginalized communities may have limited or different access to resources (Warrier, 2008). It is important for caseworkers not to make assumptions based on perceived cultural supports or barriers for survivors. Instead, they should allow survivors to share their beliefs about how their culture guides them in their decision-making about their relationships.

4.3.2 Lack of Access to Financial and Transportation Resources

Some survivors remain in their relationships for numerous financial reasons (National Coalition Against Domestic Violence, n.d.-c). They may be economically dependent or may fear becoming or be destitute, homeless, or without the financial resources to meet the basic needs of their children. They may then decide that remaining with an abusive partner is ultimately safer than the alternative. Some survivors may have more wealth, and their children have particular privileges, including high-quality medical care or education and survivors may not want their children to lose those opportunities by their leaving the relationship. Other survivors may be facing medical crises or have children with significant medical needs and will not be able to afford insurance or treatment if they end their relationships.

Transportation access may be a barrier. In rural areas, survivors may not have any mode of transportation to get away from the home. In urban areas, survivors may not have access to a bus pass or a way to use transportation without being found easily by the perpetrator. Many perpetrators have withheld access to money, employment, education, and/or insurance information from survivors. Without access to these resources, leaving can seem not only difficult, but impossible (National Network to End Domestic Violence, 2017). The variations of survivors' financial experiences are important to understand so that workers can recognize the barriers and determine if there are ways to remove them safely.

4.3.3 Emotional and Legal Reasons for Not Leaving

As can be seen, there are numerous barriers to leaving a relationship. It is important for caseworkers to recognize that how the children and/or survivor feel about the perpetrator will also affect survivors' decision-making. For example, survivors may have love and desire for their partners and the relationship, even with the domestic violence. Additionally, the perpetrator may not always be abusive, and the survivor often hopes that the abuse will stop, and they will experience the "good times" again.

Survivors' children also may have deep love for the perpetrators, so survivors may be reluctant to affect the children emotionally by taking them away from the perpetrator. They may stay with their partners because of their past experiences. For example, a survivor may not have grown up with both parents in her or his life and may not want that same experience for their children. Staying to keep stability for the children is a common reason for survivors not leaving (National Coalition Against Domestic Violence, n.d.-c).

Survivors may have trauma histories that affect their desire to leave the relationship. Others may have had criminal records or involvement with systems that make them reluctant to seek those interventions or to believe they can make it on their own. In addition, there may be legal implications, such as custody or immigration matters, that may affect survivors' decision-making. Caseworkers should understand that every survivor has a unique background that influences his or her decision-making.

Key Point

It must be reiterated that leaving is the most dangerous time for a survivor and his or her children (Bachman & Saltzman, 1995; Domesticviolence.org, 2015). This is a common and valid reason survivors stay in their relationships. The relationship itself may be dangerous, harmful, and/or emotionally difficult, but leaving may be more dangerous. When this is the case, survivors may choose to stay with their partners for their own safety or the safety of the children, especially if the perpetrators have inflicted harm when they left before and/or has threatened harm if they leave. In these instances, survivors may be demonstrating protective capacity by staying. Leaving or staying by itself is not a protective act, nor should it be the only indicator to the caseworker of how protective survivors are or are not.

4.4 Impact of Domestic Violence on Adult Survivors

When a caseworker works with a family, it is important to look not only at the safety of the child but also at the safety of the family as a whole. Particularly in cases where there is or may be domestic violence, the caseworker needs to understand its impact on the survivor to provide a comprehensive assessment. This section looks at the numerous effects of domestic violence on the adult survivors, including on their physical and mental health and parental authority.

4.4.1 Physical Health

The impact of domestic violence on a survivor's physical health can take many forms. In addition to common physical signs of possible violence (e.g., bruises, black eyes, red or purple marks at the neck), there are other effects on a survivor's overall physical health. These can manifest immediately after an incident or later after the abuse has ended. Common physical effects of trauma, such as experiencing domestic violence, include (Joyful Heart Foundation, n.d.; Black et al., 2011; National Network to End Domestic Violence, 2016):

- Chronic fatigue
- Shortness of breath
- Muscle tension
- Involuntary shaking
- Changes in eating and sleeping patterns
- Gastrointestinal problems
- Chronic pain

There also can be a physical impact on survivors' sexual and reproductive systems, such as sexually transmitted infections, miscarriage from rape or physical abuse, and unwanted or forced pregnancies (Miller et al., 2014) or abortions.

Survivors often suffer injury to their head, neck, and face, so there is a growing concern for the high potential for survivors to have mild to severe traumatic brain injury (TBI). The effects can cause irreversible psychological and physical harm (Empire Justice Center, 2006). The survivor may be agitated, depressed, forgetful, or confused; have slurred speech; or experience headaches, pain, vertigo, and other physical symptoms associated with brain injury, which may not be appropriately diagnosed and treated. The effects of repeated brain injury are cumulative and not unlike those experienced by a boxer or football player who has had multiple concussions. The consequences of brain injury may be confused with mental health or substance abuse problems, discussed in the next section (Gaynor, 2015).

4.4.2 Mental Health and Substance Use Issues

As Gaynor (2015) stated, in addition to physical trauma survivors also experience the toll of psychological trauma from living in fear of each attack and of the next event, which could happen tomorrow or at any minute in a relationship characterized by explosive violence. These can be coupled with the effects of TBI. Psychological consequences can include depression, suicidal thoughts and attempts, lowered self-esteem, dissociation, PTSD, and/or alcohol and drug misuse, as illustrated below (Joyful Heart Foundation, n.d.; National Network to End Domestic Violence, 2017; Gaynor, 2015):

- Depression remains the most common symptom exhibited by survivors of domestic violence.
- Dissociation (i.e., feeling like one has "checked out" or is not present) can impair a survivor's ability to function, such as not being able to focus on work-related duties or on schoolwork.
- PTSD is triggered by a terrifying event. Some common symptoms include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event.

Conflicts with spirituality also are common, especially in situations where the perpetrator used the survivor's faith to control him or her. Because the perpetrator has taken away the survivor's control over the situation, the mental and physical effects can be devastating. The survivor may feel the need to self-medicate or to use drugs or alcohol to cope with the overwhelming feelings (Joyful Heart Foundation, n.d.).

According to the American Society of Addiction Medicine (Soper, 2014), 56 percent of female survivors have mental health problems, and all survivors are vulnerable to tobacco, alcohol, and marijuana use (para. 14). Because of the anxiety and depression that understandably arise from domestic violence, doctors typically prescribe tranquilizers, sedatives, and painkillers to address the symptoms, which can increase the risk of a SUD (Joyful Heart Foundation, n.d.; Soper, 2014). While treatment of mental health and SUD issues is beyond the scope of this manual, caseworkers can use this information to provide referrals and resources that are suited best to support the survivors' needs.

Costs of Domestic Violence

In addition to the obvious negative impact on individuals and families, the cost of domestic violence is enormous. Adjusted to the Consumer Price Index for 2016, $6.3 billion each year goes to pay direct health care services required because of domestic violence.[3] Another impact of physical violence by the perpetrators is that each year survivors miss nearly 8 million days of paid work, costing American employers an estimated $13 billion per year (National Network to End Domestic Violence, 2016, para.1; DHHS, CDC, 2003; DHHS, CDC, 2013).

3 According to figures from the CDC and adjusted to 2016 based on the Bureau of Labor Statistics Consumer Price Index.

4.4.3 Parental Authority and Relationship

Another effect of domestic violence can be the loss of parental authority for the survivor. This can take several forms, including the undermining of the survivor's authority and/or retaliating against the survivor's effort to protect the children. One study also found that women whose parenting was compromised struggled with depression and PTSD (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003).

As Bancroft (2002) writes, domestic violence is inherently destructive to parental authority because the perpetrator's verbal abuse and violence provide a model for children of contemptuous and aggressive behavior toward their parent; children of survivors have increased rates of violence and disobedience toward their mothers. Some survivors report perpetrators barring them from picking up a crying infant, assisting a frightened or injured child, or providing other basic physical, emotional, or even medical care. This can cause the children to feel that the survivor does not care about them or is unreliable. The perpetrator may reinforce such feelings by telling the children that the survivor does not love them or only cares about him- or herself.

The perpetrator, who may also maltreat the children, sometimes will also assault or intimidate survivors when they attempt to prevent the perpetrator from mistreating the children as a means of punishing the survivor for standing up for the children. Therefore, survivors may feel forced to stop intervening on the children's behalf. This dynamic can cause children to perceive the survivor as uncaring about the perpetrator's mistreatment of them. This can lead to reports to CPS of the survivor's "failure to protect" the children (Bancroft, 2002). ("Failure to protect" is discussed in greater detail in Chapter 7.)

However, domestic violence does not always impair survivors' relationships with their children. One study found that some mothers are able to compensate for the effects of domestic violence by being more effective and responsive to their children (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003). It suggests that women in domestic violence situations often cope very well with the violence and do not suffer from "learned helplessness"[4] (p. 285).

Stark (2002) found no evidence that survivors' capacity to parent was compromised, stating that the vast majority "exhibit unimpaired capacities to parent" (p. 111). A more recent study found that maternal satisfaction, including perception of social support, was the only parenting variable that predicted both maternal mental health and children's emotional and behavioral problems, suggesting that it is a protective factor for both mothers and children (Pinto, Correia Santos, Levendosky, & Jongenelen, 2016). Therefore, caseworkers should focus on additional supports and resources for adult survivors to cope with the violence and its effects on the survivor's mental health, and on how to safely and effectively leave their violent situations rather than solely on attempts to remove the children. (Appendix B looks at various resources available.)

The ability to assess each domestic violence survivor uniquely will assist caseworkers in their efforts to work with the survivor to make plans to enhance child safety. Caseworkers should assess each survivor's capabilities and circumstances holistically for their parenting capacity, protective capacity, and past and current efforts to support the needs of their children. For example, if an adult survivor has been abused in a previous relationship, workers can have indepth discussions about how he or she maintained his or her and the children's safety in past efforts to leave a relationship. If a survivor shares information about his or her parenting skills, workers can learn about those unique skills and assess their effectiveness in maintaining safety and well-being for the children. Assessing survivors' experiences will help workers engage in a strengths-based manner, use trauma-informed practice, and develop plans with survivors that are more likely to be useful to them and the children. Chapters 6 and 7 discuss strategies to protect the children and the survivor as a part of developing safety and family plans.

4 "A condition in which a person suffers from a sense of powerlessness, arising from a traumatic event or persistent failure to succeed. It is thought to be one of the underlying causes of depression." See https://en.oxforddictionaries.com/definition/learned_helplessness.

Resources

For videos of adult survivors' perspectives, go to:

Susan Still https://www.youtube.com/watch?v=nfuUq0dLf68

#SurvivorSpeaks https://www.youtube.com/playlist?list=PLMw1IIS4sY_wxEtaoW0912aHTSA03h4G7

Behind Closed Doors https://www.youtube.com/watch?v=YZS1JSwBNKM

Highlights

1. Survivors often are parents who can work collaboratively with the child welfare agency towards efficient and effective strategies to meet the needs of children exposed to domestic violence, which means that caseworkers attempting to meet their goals of child safety and well-being have a potential partner in the adult survivor.
2. Survivors are a diverse population—racially, ethnically, religiously, socioeconomically, culturally, as well as in abilities, health, sexuality, and gender identification. Their individual experiences of domestic violence are equally diverse.
3. Survivors have higher rates of PTSD, depression, anxiety, and other mental illnesses, as well as higher rates of substance use and abuse, than the general population.
4. There are numerous barriers to survivors leaving the abusive relationship, including loving the perpetrator, fear of being outed, concern about the impact on the children, cultural responses, and lack of resources (e.g., economic, transportation, medical). It is also important to understand that survivors are at greatest risk of danger after leaving.
5. Children may also have deep love for the perpetrators, so survivors may be reluctant to affect the children emotionally by taking them away from the perpetrator.
6. Where there is or may be domestic violence, the caseworker needs to understand its impact on the survivor to provide a comprehensive assessment, including assessment of survivors' physical and mental health and parental authority.

Chapter 5:
The Overlap Between Child Maltreatment and Domestic Violence

Chapters 1 and 2 discussed the rates of child abuse and neglect and of domestic violence. Chapter 4 examined the effects of domestic violence on the adult survivor. This chapter not only looks at how these forms of family violence overlap but also at how both the overlap and/or exposure to domestic violence affects children. This chapter examines:

- Statistics on the co-occurrence of child maltreatment and domestic violence
- The impact on children who witness domestic violence
- Co-occurring variables to the overlap
- Risk and protective factors affecting children exposed to domestic violence

5.1. Co-Occurrence of Child Maltreatment and Domestic Violence

Estimates of the number of children who have been exposed to domestic violence each year vary. Research suggests that nearly 30 million children in the United States will be exposed to some type of family violence before the age of 17, and there is a 30 to 60 percent overlap of child maltreatment and domestic violence (Child Welfare Information Gateway, 2014, p. 3; Hamby et al., 2011; Taggart, 2011).

Conducted in 2008, the National Survey of Children's Exposure to Violence (NatSCEV1)[1] was the first comprehensive national survey to look at the entire spectrum of children's exposure to violence, crime, and abuse across all ages, settings, and timeframes. NatSCEV1 examined past-year and lifetime exposure to physical and emotional violence through both direct victimization and indirect exposure to violence (either as an eyewitness or through other knowledge). It was the most comprehensive, nationwide survey of the incidence and prevalence of children's exposure to violence at the time, and also examined exposure to domestic violence, assaults by parents on siblings of children surveyed, and other assaults involving teen and adult household members. Updated in 2011, NatSCEV2 found (Finkelhor, Turner, Shattuck, Hamby, & Kracke, 2015, pp. 7–9):

- Over their lifetimes, more than 1 in 5 children surveyed (20.8 percent) witnessed a family assault, and more than 1 in 6 (17.3 percent) witnessed a parent assault another parent or parental partner
- In the past year, 8.2 percent had witnessed a family assault, and 6.1 percent had witnessed a parent assault another parent or parental partner

1 Sponsored by the Office of Juvenile Justice and Delinquency Prevention and the CDC.

- 25.6 percent experienced child maltreatment during their lifetimes
- 13.8 percent experienced maltreatment in the past year

The NatSCEV1 and 2 rates of exposure to domestic violence and other family violence were considerably higher than prior surveys that captured more limited data on these exposures (Finkelhor et al., 2015). Even with a slight decrease in exposure to family violence reported in NatSCEV2, the study confirmed how large the problem is, indicating that exposure to violence within the family remains a huge concern.

Resources

In its *State Statutes Series,* the Child Welfare Information Gateway discusses that most states do not address the issue of domestic violence within their child abuse and neglect reporting laws. In Montana, "commission of acts of violence against another person residing in the child's home" is included in its definition of psychological abuse or neglect. West Virginia defines an abused child, in part, as one whose health or welfare is harmed or threatened by domestic violence. As of this writing of the series, approximately 24 States and Puerto Rico address the issue of children exposed to domestic violence in their homes in civil or criminal codes other than child protection laws. For more information, visit https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/defdomvio/

5.2 Effects of Domestic Violence on Children

Children may be physically harmed (either accidentally or intentionally when witnessing violence), sexually harmed (either intentionally abused or indirectly from witnessing unhealthy relationship patterns) or traumatized from experiencing domestic violence. They do not have to be physically present to experience it; they can hear verbal or physical abuse, see the aftermath (bruises, broken items, depression, etc.), hear verbal threats or demeaning language, or know about it through other direct or indirect communications. They often have increased feelings of fear, self-blame, being threatened; decreased ability to regulate affect; and heightened risk of behavioral or mental health problems (Greeson et al., 2014).

The Child Welfare Information Gateway (2014) describes research findings on how children exposed to domestic violence are more likely than their peers to experience a wide range of difficulties, which can vary by age and developmental stage. These generally fall into three categories (Moffitt & the Klaus-Grawe 2012 Think Tank, 2013; National Child Traumatic Stress Network, n.d.-b; Felitti et al., 1998):

- **Behavioral, social, and emotional problems,** including depression and anxiety; higher levels of anger and/or disobedience; fear and withdrawal; poor peer, sibling, and social relationships; and low self-esteem.
- **Cognitive and attitudinal problems,** including difficulties in school and with concentration and task completion; lower scores on assessments of verbal, motor, and cognitive skills; lack of conflict resolution skills; limited problem-solving skills; and more pro-violence attitudes.

- **Long-term problems,** including higher rates of delinquency and substance use. The Adverse Childhood Experiences (ACE) Study found that exposure to domestic violence is one of several ACE shown to be risk factors for many of the most common causes of death of adults in the United States, including SUD, smoking, obesity, and more.

Children's developmental levels at the time of their exposure to domestic violence have an impact on their experience of it and the effects. As the Centre for Children and Families in the Justice System explains, "[c]hildren are good observers and poor interpreters" (Cunningham, Baker, & Centre for Children & Families in the Justice System, 2007, p. 8). While they listen and see, they do not understand situations the same way adults would. Children may feel fear, confusion, guilt, anger, frustration, stomach and headaches, and worry. While too young to understand what other people may be feeling, visible cues (e.g., blood and crying) signal to even small children that someone is hurt. Young children who see violence at home often have common misperceptions, such as (Cunningham, Baker, & Centre for Children & Families in the Justice System, 2007, p. 8):

- Mommy and Daddy are equal parties in what appears to be a "fight."
- "It's my fault they are fighting."
- If there is no blood or other signs of injury, Mommy (or Daddy) is not hurt.
- If Mommy is not crying, she is not upset or no longer upset.
- Once the "fight" stops, everything goes back to normal.
- "If I try really hard to be good, they won't fight again."

Older children and teenagers can imagine how the survivor feels, which can be very traumatic. Some may try hard to stay out of the way to avoid becoming the next target. Children who feel responsible for starting the "fight" may blame themselves for any negative consequences, such as visible injury, arrest, incarceration, or one parent leaving the family. Some hope for rescue, perhaps even by super heroes (Cunningham, Baker, & Centre for Children & Families in the Justice System, 2007). **Exhibit 5.1** shows examples of some of the feelings of older children and teenagers who witness domestic violence.

Exhibit 5.1. What Teenagers May Think or Feel When Witnessing Domestic Violence
(Cunningham, Baker, & Centre for Children & Families in the Justice System, 2007, p. 9)

- Sadness: Why is this happening again?
- Confusion: Why doesn't Mom or Dad just kick him or her out?
- Concern: Mom or Dad is going to get really hurt one day.
- Frustration: I have problems, too, but no one seems to care.
- Isolation: I can't talk to anyone about this.
- Guilt: I could have done something to prevent this.
- Fear: He or she might turn on me next or hurt me.
- Anxiety: Is this what my future relationships will be like?
- Embarrassment: Other families don't do this, or the neighbors will hear.
- Resignation: This is never going to stop.
- Vengeful: I wish he or she would die or get hit by a bus.
- Worthlessness: If they really cared about me, they would stop this.
- Helplessness: There is nothing I can do to help my mom or dad.
- Responsibility: I have to protect my younger siblings from this situation.
- Anger: Why does Mom let him treat her (and me) so badly?
- Worry: I don't want to move, so I hope Mom or Dad puts up with it.
- Panic: How will we afford to eat if Mom or Dad leaves?

Moylan et al. (2010) found that other factors can influence the effects of witnessing domestic violence on children. While children often have higher levels of anxiety and fear immediately after a violent event, observable effects decrease as time passes. Gender also plays a role. Generally, boys exhibit more externalized behaviors (e.g., delinquency, aggression, and acting out), while girls exhibit more internalized behaviors (e.g., withdrawal and depression, suicidal ideation) (Moylan et al., 2010; Child Welfare Information Gateway, 2014). Girls exposed to domestic violence as adolescents are significantly more likely to become victims of dating violence than daughters of nonviolent parents (Department of Justice, National Institute of Justice, 2014; Noland, Liller, McDermott, Coulter, & Seraphine, 2004; Futures Without Violence, n.d.1).

One study found that the psychological component of domestic violence (e.g., name calling, intimidation, manipulation) caused the most damaging impact on children. This suggests that children who see these psychological behaviors fare worse than those who experience physical domestic violence between their caregivers. They often feel less supported, perhaps because society tends to downplay psychological violence as marginal, which only adds to the negative effect (Naughton, O'Donnell, & Muldoon, 2017).

5.3 Other Risk Factors and Their Effects

Gewirtz and Edleson (2007) found that children's exposure to domestic violence may frequently co-occur with other risk factors, such as poverty. It also often co-occurs with other types of violence, such as child maltreatment (sexual, physical, or psychological abuse or neglect) and violence occurring in the neighborhood, school, or community (Moffitt & The Klaus-Grawe 2012 Think Tank, 2013; Edleson, 1999; Rudo, Powell, & Dunlap, 1998). Other examples of risk factors for children include premature birth, children's conduct problems, and parental mental illness or SUD.

Additionally, many researchers agree that risks of a chronic, rather than acute, nature are most likely to have damaging long-term effects (Garmezy & Masten, 1994). This makes it hard to separate the unique effects of exposure to domestic violence from those of other risks in a child's life (Gewirtz & Edleson, 2007).

Moylan et al. (2010) also found that children who are also physically or sexually abused are at higher risk for emotional and psychological maladjustment than children who witness violence and are not maltreated. Pelcovitz et al. (2000) found that adolescents who were physically abused and living in homes with domestic violence were at greater risk for depression, separation anxiety disorder, PTSD, and oppositional defiant disorder than those who were not exposed to any family violence.

While not all children exposed to domestic violence develop symptoms of PTSD, estimates of those affected vary widely depending on the study, ranging from 13 to 70 percent (Margolin, & Vickerman, 2007, para. 2; Illinois Department of Human Services, 2005; Tsavoussis, Stawicki, Stoicea, & Papadimos, 2014). Children suffering from PTSD often are misdiagnosed as having attention deficit disorder because of symptoms of difficulty concentrating and of diminished interest or participation in school work and activities (Illinois Department of Human Services, 2005). It may help for the caseworker to have a mental health professional conduct a formal evaluation.

There often are barriers to children reporting domestic violence. They may not tell for different reasons, including their developmental level and/or relationship with the perpetrator. Exhibit 5.2 lists other possible reasons.

Exhibit 5.2. Why Children Do Not Tell When They Witness Domestic Violence
(Baker & Cunningham, 2005; Cunningham, Baker, & Centre for Children & Families in the Justice System, 2007, p. 36)

- Not understanding that abusive behavior is wrong or not normal
- Embarrassment or desire for privacy
- Warnings to "keep your mouth shut"
- Being denied contact with people who could intervene (e.g., doctor) or having that contact monitored (e.g., caseworker)
- Belief that they caused the violence
- Lack of a trusted adult in their lives
- Fear of consequences for themselves (e.g., being taken from the family) and for the family (e.g., arrest of the perpetrator, divorce, survivor being hurt)
- Fear of being pitied, shunned, or teased by other kids
- Family's anger at them and/or being kicked out of the home

5.4 Protective Factors

Children's risk levels and reactions to domestic violence exist on a continuum. Some children demonstrate enormous resiliency, while others show signs of significant maladaptive adjustment. Minimizing the number of risk factors to which children are exposed, while simultaneously encouraging protective processes, can be highly effective in reducing negative outcomes (Gewirtz & Edleson, 2007).

As mentioned in the previous chapter, one study found that maternal satisfaction was the most predictive protective factor for both maternal mental health and children's emotional and behavioral problems (Pinto et al., 2016). According to Futures Without Violence (n.d.-a), "The single most important resource for children in fostering resilience and healing from the traumatic effects of domestic violence is a secure attachment relationship with a loving parent or caregiver over time" (Futures Without Violence, n.d.-a; Osofsky, 1999, p. 38). Additionally, the influence of certain protective processes (e.g., social support and the extent to which survivors are able to buffer young children from exposure to violence) are key protective factors (Gewirtz & Edleson, 2007). Other factors that promote children's resilience in mitigating exposure to domestic violence include (Martinez-Torteya, Bogat, von Eye, & Levendosky, 2009; Werner & Smith, 1992; Garmezy & Masten, 1994; Gewirtz & Edleson, 2007; Child Welfare Information Gateway, 2014):

- Competent parenting
- Social competence
- Intelligence
- High self-esteem

5.4.1 Parent Protective Factors

A supportive relationship with an adult (especially a nonabusive parent) can help protect children from the adverse effects of exposure to domestic violence (Martinez-Torteya et al., 2009; Gewirtz & Edleson, 2007, Child Welfare Information Gateway, 2014). In fact, there are two relationship-level factors with strong or moderate evidence of protection (Development Services Group, Inc. & Child Welfare Information Gateway, 2015):

1. **Parenting competencies,** e.g., parental acceptance or responsiveness, maternal warmth, strong parent-child bonds, and emotional support. Strong evidence links parenting competencies to positive outcomes for children exposed to domestic violence, including better self-esteem, lower risk of antisocial behavior, and a lower likelihood of running away and of teen pregnancy.
2. **Parent or caregiver well-being,** e.g., lower rates of parental depression and other mental health problems. Evidence links this to children having higher levels of resilient behavior and better mental health outcomes than other young people who are exposed to domestic violence.

5.4.2 Child Protective Factors

For children experiencing domestic violence, the strongest individual protective factors are self-regulation and problem-solving skills. Self-regulation skills include emotional awareness, anger management, stress management, and cognitive coping abilities. These skills are related to children's resiliency, having supportive friends, reductions in internalizing problems, better cognitive functioning, and decreases in PTSD, anxiety, depression, and overall behavior problems. Problem-solving skills include adaptive functioning and the ability to solve problems and are primarily related to improved child mental health (Development Services Group & Child Welfare Information Gateway, 2015).

In dealing with exposure to domestic violence and maltreatment, there are numerous risk and protective factors. Trauma-informed practice, specifically designed to address and respond to the impact of traumatic stress, can help children and families build resiliency and prevent further trauma (Child Welfare Information Gateway, 2014). Chapter 7 presents more on this approach in child welfare.

Informed caseworkers are aware of the complexity of their cases, including those involving domestic violence, and use this knowledge to make appropriate assessment, placement, and service delivery decisions. Traditionally, even with this co-occurrence, child welfare and domestic violence programs have responded separately to victims. This focus on the safety and protection of only the survivor or of the child can lead to unintended consequences. For example, removing children from their homes and placing them in out-of-home care can cause additional trauma (Child Welfare Information Gateway, 2014). The next chapters examine child protective practices to address and to prevent these consequences, including looking at how best to keep the child and survivor together while keeping the child safe.

Resources

For videos on the impact of domestic violence on children, go to:

What About Us: Perspectives of the Children of Domestic Violence at https://www.youtube.com/watch?v=eWK_xebLgbk

Through Their Eyes at https://www.youtube.com/watch?v=JAZx7i3_Ncg

Highlights

1. While rates vary, research suggests that nearly 30 million children in the United States will be exposed to some type of family violence before the age of 17, and there is a 30 to 60 percent overlap of child maltreatment and domestic violence (Child Welfare Information Gateway, 2014, p. 3; Hamby et al., 2011; Taggart, 2011).

2. Children may be harmed (either accidentally or intentionally when witnessing violence), or traumatized from experiencing domestic violence.

3. Children exposed to domestic violence are more likely than their peers to experience a wide range of difficulties, which can vary by age and developmental stage. These generally fall into three categories: (1) behavioral, social, and emotional problems; (2) cognitive and attitudinal problems; and (3) long-term problems.

4. Children's exposure to domestic violence frequently co-occurs with other risk factors, such as poverty and its impact and other types of violence, such as child maltreatment and violence occurring in the neighborhood, school, or community.

5. Children's risk levels and reactions to domestic violence exist on a continuum, from resiliency to significant maladaptive adjustment. Reducing the risk factors to which children are exposed and encouraging the protective factors (e.g., a strong relationship with a nonoffending parent or other caring adult) can be highly effective in reducing negative outcomes.

6. The strongest individual protective factors for children exposed to domestic violence are self-regulation and problem-solving skills.

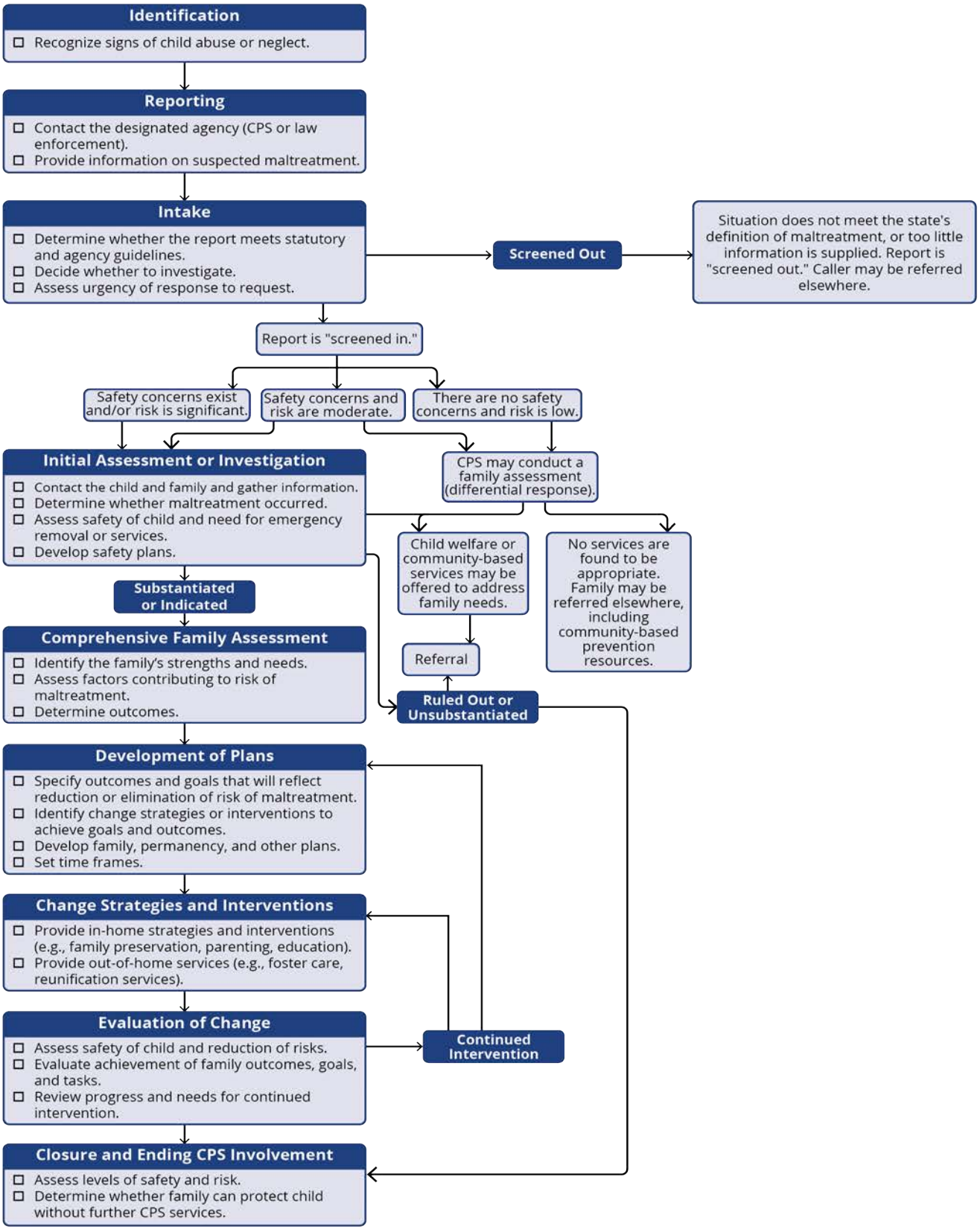
Chapter 6:
Child Protective Services Process: Intake, Initial Assessment/Investigation, and Safety Assessment and Planning

The primary mission of child protective services (CPS) is to preserve the safety, permanency, and well-being of the children who come to the agency's attention. Families experiencing child maltreatment and domestic violence can present complex challenges to CPS practice due to safety concerns for both the child and adult survivor, which adds to the family dynamics. To address these challenges CPS often works collaboratively with partners such as domestic violence advocates and law enforcement. As Chapter 9 discusses in more detail, while these partners share a commonality in serving children and families, sometimes their missions, mandates, and confidentiality requirements may not align with those of CPS.

While each parent is accountable for his or her actions that affect their children, too often a nonoffending parent is held solely responsible for a child's safety, while simultaneously struggling to survive threats to his or her own safety. Therefore, workers need a solid philosophical framework to guide each stage of the CPS process as laid out in Exhibit 6.1. The most recent edition of the user manual (currently in press), *Child Protective Services: A Guide for Caseworkers* (*Caseworker* manual), details each of the stages of the CPS process. This manual serves as its companion. Therefore, to avoid repetition, these next two chapters reference that manual's specific chapters and/or sections, provide the basics of those stages to give a framework, and examine those stages through the lens of families dealing with domestic violence. Topics addressed include:

- Guiding principles for families experiencing domestic violence who come to the attention of CPS
- Differences between child welfare agencies and domestic violence providers
- Guidelines for CPS practices for initial intake and screening for considering domestic violence
- Conducting the initial family assessment
- Assessing safety and developing a safety plan

Exhibit 6.1
Overview of Child Protection Process



6.1 Guiding Principles for Working With Families Experiencing Domestic Violence

As discussed in Chapter 1, at the federal level, the Child and Family Services Reviews (CFSR) monitor the states to measure their effectiveness at achieving the guiding goals of child safety, permanency, and well-being.[1] While Round 3 is in progress at the time of writing, results from Round 2 found that domestic violence was the sixth most frequently cited primary reason for opening a child welfare case (4.5 percent) of cases nationally (DHHS, Children's Bureau, 2011, p. 54).[2]

The following guiding principles serve as a foundation for child protection practice with families experiencing domestic violence (Turner et al., 2015; Callaghan, Alexander, Fellin, & Sixsmith, 2015; Greenbook Evaluation Team, 2008):

- **Every reasonable effort should be made to keep children in the care of a nonoffending parent,** as long as that parent has, through assessment, been determined to have sufficient protective capacities to maintain safety for the children. Child safety and adult survivor safety are linked. By helping nonoffending parents develop a workable safety plan in a supportive, noncoercive, and empowering way, caseworkers will enhance child safety and well-being.
- **Identifying and assessing domestic violence and its effects at all stages of the child protection process is critical in reducing risks to and potential trauma experienced by children.** Exposure to domestic violence, even when children are not physically or sexually harmed, causes damage to children.
- **When domestic violence has occurred, perpetrators must be held solely responsible for that violence, while receiving interventions that address their abusive behaviors.** This accountability must be consistent throughout the community's response system (e.g., CPS, domestic violence programs, law enforcement, batter intervention programs, etc.).
- **Collaboration with partners is essential and may take different forms at different stages of the CPS process.** This could include activities such as joint investigations with law enforcement; co-located domestic violence specialists (either a domestic violence advocate or a CPS caseworker specializing in domestic violence) who participate in safety and case planning; joint training; and multidisciplinary teams with protocols addressing information sharing and confidentiality.

While differences exist between the goals and mandates of domestic violence service providers and child welfare agencies, these guidelines can help support their essential commonality in serving children and families.

Key Point

It is important to note that assessing for domestic violence—or any other co-occurring issue, such as substance use disorder or mental illness—does not alter the fact that the caseworker must assess for the child's safety at all times. Both the survivor and perpetrator's parenting must be assessed for safety and risk, as either or both may be a maltreating parent.

1 For more on the CFSRs, visit https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews.
2 Following neglect (nonmedical), substance use disorder (parents), physical abuse, child's behavior, and sexual abuse

6.2. Differences Between CPS and Domestic Violence Services Agencies

CPS and domestic violence services programs have historically responded separately to safety concerns facing adult and child survivors within the same family. The divergent responses are due largely to the differences in each system's historical development, philosophy, mandates, policies, and practices. For example, CPS has the legal standing to make decisions about the family, while domestic violence programs do not. As a result, these differences have led to variations in desired outcomes and practice methods for caseworkers and domestic violence advocates who may lack a mutual understanding of one another's mission (and legal mandate in the case of CPS) and approach when addressing the co-occurrence of child maltreatment and domestic violence (Aron & Olson, 1997; Beeman, Hagemeister, & Edleson, 1999; Carter & Schechter, 1997; Findlater & Kelly, 1999; Spears, 2000; Witney & Davis, 1999; Child Welfare Information Gateway, 2003).

Differing Points of View[3]

Several key debates stemming from these differences have limited collaboration between the two fields. For caseworkers, whose legal mandate is the protection of the maltreated child, responding to domestic violence has sometimes been viewed as a peripheral issue. Alternatively, domestic violence advocates have primarily focused on pursuing safety and empowerment for the adult survivors. The differing opinions about whose safety is paramount have led to misconceptions and critical accusations by both systems. Some child welfare advocates have charged domestic violence advocates with discounting the safety needs of children by focusing primarily on the adult survivors, who also may be neglectful or abusive towards the children. Conversely, some advocates accuse child welfare caseworkers of "revictimizing" the survivors by placing responsibility and blame on them for the violent behaviors of perpetrators or by charging the survivor with "failing to protect" the child (Aron & Olson, 1997; Beeman, Hagemeister, & Edleson, 1999; Carter & Schechter, 1997; Findlater & Kelly, 1999; Spears, 2000; Witney & Davis, 1999; Child Welfare Information Gateway, 2003).

Furthermore, interactions with the perpetrator are markedly distinct for each system. Child welfare has a growing emphasis on a family-centered approach aimed at creating healthy and stable families. Caseworkers also are required by law to interview and engage both parents/caregivers—survivors and perpetrators—in most states, tribes, and jurisdictions. In contrast, domestic violence service providers often view separation from perpetrators as a desirable intervention until the safety of all family members is assured. Despite their differences, domestic violence and child welfare systems share areas of common ground that can bridge the gap between them, including that both systems (Child Welfare Information Gateway, 2014; Aron & Olson, 1997; Beeman, Hagemeister, & Edleson, 1999; Carter & Schechter, 1997; Findlater & Kelly, 1999; Spears, 2000; Witney & Davis, 1999; Child Welfare Information Gateway, 2003):

- Want:
  - To end domestic violence and child maltreatment
  - Children to be safe
  - Adult survivors to be protected—for their own safety and so their children are not harmed by the violence
- Believe in supporting a parent's strengths and protective capacities
- Prefer that children not be involved in CPS, if involvement is avoidable

3 Adapted from Davies, J. (n.d.). *Confidentiality and information sharing issues.* Retrieved from https://www.futureswithoutviolence.org/userfiles/file/Children_and_Families/InfoSharing.pdf

Confidentiality Issues

Confidentiality is another issue that has created strife between the systems due to the different protocols (and laws, in the case of child welfare) for each. These challenges can be remedied through the development and negotiation of interagency protocols that reflect each agency's role in protecting children and in meeting the survivors' privacy and safety needs (i.e., any protocol should be analyzed for its effects on both the adult and children survivors). **Exhibit 6.1** lists some of the questions to consider when developing confidentiality protocols.

Exhibit 6.1. Confidentiality Considerations

- Under what circumstances will domestic violence service providers, CPS, or courts request permission from survivors to disclose confidential information?
- How will a system receiving information handle that information and ensure that survivors' privacy is maintained?
- What process will be used to address inappropriate disclosures of information and prevent repeat occurrences? In particular, protocols should consider when a perpetrator might gain access to the information and include protections for the survivor and children. For example, once a case is filed in court, a perpetrator might have a right to access certain CPS information. If a perpetrator learned the details of the survivor's safety plan, it could place the children and survivor in danger.
- How will information be handled if domestic violence service providers are providing analysis and information as part of multidisciplinary teams or case conferences? Will the discussions include identifying information? How will that information be used and protected? Who will ensure that the team has permission from the family members involved in the case to discuss confidential information?
- How will CPS and the domestic violence agency respond to situations when a survivor and his or her children are in a shelter, and CPS needs to contact them? For example, a CPS worker may know they are in a particular shelter and have a legal responsibility to see the children and assess their situation. What procedures are necessary to assure both the safety and privacy of all shelter residents and the responsiveness to CPS requests for contact?

Once an interagency protocol is developed, does it help ensure that CPS, courts, and domestic violence advocates will comply with confidentiality, privacy, and reporting laws? Determining what laws govern information sharing can be complex. The laws regarding mandated reporting and how CPS is to act not only vary from state to state, as discussed earlier, but there are multiple rules from different sources that often are complicated and may even conflict with one another. Information and privacy may be governed by federal and state statutes and court interpretations of those statutes. Particular agencies, such as CPS, may also have agency rules and regulations providing additional details and procedures.

The rules and laws requiring that CPS information be kept confidential usually also define:

- When the information can be disclosed
- What information can be disclosed
- Who will have access to CPS files

For example, an attorney representing a perpetrator in a child protection case will typically have access to the file. If this is the case, then domestic violence service providers need to work with CPS to develop rules to keep information from being disclosed to a perpetrator that would undermine safety plans for the survivor and children. Later sections of this chapter and Chapter 7 discuss the effect of confidentiality issues on developing the safety and family plans.

Reporting Child Maltreatment

It helps for caseworkers to understand that it may feel overwhelming for domestic violence advocates when they have to make information-sharing decisions about children and the survivors involved with CPS or the court. Advocates know that, for children, the decision to share certain information either might lead to a safer place to grow up, or it might mean they will still be in danger or even that they lose contact with both parents. They also know that for the survivors, the decision might mean the state intervenes in ways that either enhance safety and autonomy from a perpetrator or that limit options and increase danger, and in some cases, will lead to the loss of the children. **Exhibit 6.2** examines the questions that domestic violence advocates have to address in these situations.

Exhibit 6.2. Domestic Violence Advocates and Reporting Child Maltreatment (Davies, n.d.)

As mandated reporters, a domestic violence advocate does not need to determine if a particular domestic violence situation meets the legal definition of alleged child maltreatment in the state in order to make a report to CPS. The child welfare agency (or hotline staff) should provide consultation when the advocate has questions, advising the advocate that both the questioning and reporting can be done anonymously. Because there may be a difference of opinion between CPS staff and domestic violence advocates about when domestic violence meets the legal standard for child maltreatment, it is important for advocates to understand that they need only suspect child maltreatment to make a report and that confirming the maltreatment is the role of CPS. The following examples are illustrative:

- The children have witnessed/been exposed to domestic violence, but there are no other risk factors (e.g., there is no physical abuse of the children, and their basic nutritional, health, and educational needs are met). In what circumstances will the domestic violence service provider consider this exposure significant enough to report it as maltreatment to CPS? The advocate can consult CPS caseworkers to gain clarity and guidance.
- As part of a safety plan, agreement with CPS, or court order, the survivor and children are to have no contact with the perpetrator. The domestic violence service providers learn that there is contact. Questions they will have to answer include:
  - As a violation of the safety plan or as rising to the level of suspected abuse or neglect, what are the next steps in reporting it to CPS?
  - Who in the agency must be involved in the decision to make a mandated report to CPS? Who will complete the report and meet the legal requirements for reporting? How will the agency decide how much information to include in the report? For example, there may be circumstances when providing more information than required may help a survivor and the children remain together.
  - How will the survivor and children be involved, if at all, in the reporting process? Will advocacy be provided during the reporting process, investigation, or court proceedings? Will advocacy be available if the survivor loses the children?

6.3 CPS Practice Guidelines for Initial Screening

After a referral of alleged maltreatment is received, the purpose of the intake stage is to determine if the reported information meets the statutory definition of child maltreatment and, therefore, results in assignment for a face-to-face investigation or assessment. If the report is accepted or "screened in," the worker then determines the urgency of the response. Chapter 5 in the *Caseworker* manual describes the intake process in depth.

Every child maltreatment referral should be screened for potential domestic violence (Colorado Department of Human Services, 2013; Ganley & Hobart, 2010; Greenbook National Evaluation Team, 2008). Early identification of domestic violence is the first step in achieving positive and safe outcomes for children experiencing domestic violence (Taggart, 2009; U.S. Preventive Services Task Force, 2004). Identifying it at the initial screening can help caseworkers conduct thorough assessments and create effective family plans. In cases where domestic violence exists but has not been identified, caseworkers may find they are focusing their efforts on other presenting issues, such as substance use disorder, that are often exacerbated by undisclosed domestic violence. Most importantly, failure to screen for and address domestic violence in child protection cases may compromise child safety and contribute to poor family outcomes (Taggart, 2009).

6.3.1 Screening for Domestic Violence at Intake

When intake receives a report of alleged child maltreatment, screening practices need to be applied consistently to reduce the potential for worker or supervisor bias in decision-making. To actively screen each referral for domestic violence, the screener should let the reporter know there are several routine questions (Colorado Dept. of Human Services, 2013; Ganley & Hobart, 2010):

- Has any adult hurt or threatened to injure another adult in the home? (If yes, the caseworker asks, "Who did what, to whom?")
- Has the child ever said that one of his or her caregivers has been hurt or threatened by another adult?

If the reporter indicates the presence of domestic violence, the initial screener should continue with additional questions to assess the nature and severity of the domestic violence as a co-occurring issue and to determine if the violence described meets the statutory criteria for an allegation of child maltreatment. Examples of supplementary questions include (Ganley & Hobart, 2010; Colorado Dept. of Human Services, 2013):

- Has a child in the home witnessed any incident(s)? Has the child intervened or been physically harmed during an incident?
- Has law enforcement ever been to the home to respond to assaults against adults or children?
- Are there firearms or weapons in the home? Have any weapons been used to threaten or hurt a family member? If yes, does the alleged perpetrator still have access to firearms or weapons?
- What has the child said about the domestic violence? How has the child reacted?
- Has any adult in the homemade threats of homicide or suicide?
- Where is the alleged perpetrator right now?

- To what extent is the alleged survivor involved in the child's daily care? To what extent is the alleged perpetrator involved?
- How has the alleged survivor attempted to protect the child?
- Is anyone using alcohol and/or drugs?
- Has there been a recent change in employment?
- Has anyone threatened to run off with the children?

Resources

There are some online screening tools for domestic violence. The HITS (Hurt, Insult, Threaten, Scream) screening tool may be used to screen for domestic violence with collateral contacts, such as family members, professionals, service providers, anonymous callers, and mandated reporters (http://www.getdomesticviolencehelp.com/hits-screening-tool.html). Another screening tool, which can be used with survivors, is the Women's Experience with Battering (WEB) tool (http://www.dbhds.virginia.gov/library/mental%20health%20services/scrn-pw-web.pdf).

Before the intake screener makes a decision about whether to accept a referral for investigation or assessment and how to characterize any evidence of domestic violence (i.e., as a concern or a separate allegation), the screener should gather and review certain file and record information (referred to as passive screening), including (Ganley & Hobart, 2010; Ganley & Schechter, 1996; Massachusetts Department of Social Services, 1995; Bragg, 1998):

- Conduct a criminal and court records check on the alleged perpetrator and nonoffending parent for domestic violence-related charges or convictions, civil protection or restraining orders, or probation violations
- Review the agency's case file, making particular note of past allegations and evidence of domestic violence, even if the prior case was inconclusive or unsubstantiated
- Contact law enforcement to inquire about domestic violence-related service calls (e.g., 911) made at or from the home

Systematically collecting initial information about domestic violence will allow the screener to make a competent and informed decision as to whether domestic violence is occurring, whether it is contributing to or causing child maltreatment, and what type of response the situation may require.

6.3.2 Assessing the Report

Not every report involving domestic violence needs to be accepted for formal investigation or assessment, but each should trigger some action (such as passive screening) before making the screening decision, a referral to community resources after a determination to screen out a report, or a cross-report to law enforcement for any case involving possible criminal activity. Arrangements that maximize opportunities for law enforcement and caseworkers to share agency information appear to offer the best option for achieving informed decisions about the appropriate level of service response to children and families experiencing domestic violence (Stanley, Miller, Richardson, Foster, & Thomson, 2010). Families with allegations that do not indicate a child safety threat or serious risk of harm may be referred to external community agencies for specialized domestic violence services.

CPS agencies should have policies that specify the criteria for when domestic violence should be screened in as a separate allegation, how to document domestic violence as a concern to assess when it is not a separate allegation, and what response type to assign for accepted reports (Colorado Department of Human Services, 2013). The variations in state and local child welfare statutes, policies, and practices will result in different standards for when children's experiences of domestic violence independently warrant CPS involvement. In general, caseworkers would use agency policy or protocol, which may use the following criteria, when considering accepting a report due to domestic violence (Colorado Department of Human Services, 2013):

- The child:
  - Has physically intervened in a violent incident
  - Has been physically injured because of being present during an incident or because of an attempt to intervene
  - Exhibits behavioral, emotional, or physical effects due to a known incident or alleged incidences or patterns of domestic violence
  - Is fearful for his or her or the adult survivor's safety
- The alleged perpetrator has made threats of homicide or suicide and has access to weapons or firearms
- There appears to be serious, recurring domestic violence or domestic violence in combination with other significant risk factors (e.g., substance use disorder)
- There has been repeated law enforcement involvement, and/or protective orders have been obtained
- There is a history of domestic violence, or the violence is increasing in frequency or intensity and occurs in the proximity of the child

6.3.3 Differential Response to Domestic Violence

Some in the field feel that families and their children who show minimal evidence of harm resulting from exposure to domestic violence and have other protective factors present in their lives may benefit more from voluntary services in the community. One such approach—differential response, also known as alternative response, multiple response, or dual track—emphasizes a broad assessment of a family's situation and a determination of whether the family can be helped while maintaining the children in the home using services and supports either with or instead of the child welfare system and courts (Child Welfare Information Gateway, 2014). Chapter 6 in the *Caseworker* manual discusses differential response in more depth.

Initially, child welfare systems included only two tracks or responses: investigation or no investigation. Differential response systems can conduct traditional investigations for high-risk or severe cases, but they also allow for cases to receive an alternative response without a formal maltreatment determination. Depending on legislation or agency policies, eligibility criteria for differential response vary by state or even by jurisdiction within a state. Once CPS receives a report of child maltreatment, determining whether a family is eligible for a noninvestigative response typically is based on immediate safety concerns and risk for the children, the type of maltreatment, previous reports, age of the child or children, and caregiver factors. CPS then decides whether to initiate a standard investigation or to move forward with a noninvestigative assessment response. Some agencies include a specialized, noninvestigative pathway for families dealing with domestic violence (Child Welfare Information Gateway, 2014).

Differential response allows child welfare agencies to approach the issue of domestic violence in a family-centered, nonthreatening way when there is low to moderate risk, helping to ensure the safety and well-being of the children together with the survivor. The difference between the differential response model and the traditional, investigative response is that the former allows (Colorado Department of Human Services, 2013):

- Child welfare to address concerns and family needs with the provision of services and supports
- Elimination of the fault-finding inherent in the traditional child welfare response
- A legal finding of maltreatment not to be made
- The ability to address the perpetrator's behavior and enhance the survivor's protective capacities
- The development of safety plans with survivors to reduce risk and/or the recurrence of physical or emotional harm to the children, without the "failure to protect" label

Resources

In addition to Chapter 6 in the *Caseworker* manual, for more information on differential response in child welfare, see Child Welfare Information Gateway's issue brief, *Differential Response to Reports of Child Abuse and Neglect,* at https://www.childwelfare.gov/pubs/issue-briefs/differential-response/ or its web section, *Differential Response in Child Protective Services,* at https://www.childwelfare.gov/topics/responding/alternative/.

6.4 Assessing the Family

After receiving the report of alleged child maltreatment, once the decision is made (almost always in consultation with the supervisor) to "screen" it in, there are several stages of assessing the family. These include preparing for the initial assessment; interviewing the family members, including the child, survivor, perpetrator, siblings, etc.; and assessing safety and risk. Chapters 6 and 7 of the *Caseworker* manual discuss these various stages in detail. Therefore, the sections below outline only the basics of each stage and focus on the effect the presence of domestic violence has on how the caseworker should proceed.

6.4.1 Preparing for Initial Assessment/ Investigation

This stage involves preparing for and implementing interview protocols, gathering information from relevant sources, collaborating with law enforcement or child advocacy centers in some situations, and consulting with other professionals to assist with specific assessments (e.g., alcohol or other drugs, domestic violence, medical and mental health). To make accurate decisions during the initial assessment/ investigation, the basic steps for the caseworker typically include (DePanfilis, in press):

- Using a trauma-informed approach (discussed in more detail in Chapter 7) to minimize the potentially adverse impact of the initial assessment process and to improve the accuracy of the information collected, while enhancing engagement of all parties; actions that make both the child and adult caregiver(s) feel as psychologically safe as possible can improve fact finding and enhance engagement, while limiting the addition of new, system-oriented traumas
- Employing a protocol for interviewing the identified child, siblings, all of the adults in the home, nonresident parents (if applicable), alleged maltreating parent/caregiver, and perpetrator

- Observing the child's, siblings', parents'/caregivers' interaction between family members, home, neighborhood, and general climate of the environment
- Gathering information from other sources who may have information about the alleged maltreatment or the risk and safety of the children
- Analyzing the information gathered to make necessary decisions

Whenever domestic violence is a concern or has been alleged in a child maltreatment report, the caseworker should use available information to assess the worker's own safety, consult with the supervisor to discuss any safety concerns, develop appropriate interview protocols, and choose a safe location with security nearby for interviewing the alleged perpetrator. Chapter 7 also discusses worker safety in more detail.

6.4.2 Interviewing the Family

Like most families who come into contact with CPS, families exposed to domestic violence may feel that agency intervention violates family privacy. However, workers will also need to exercise an extra layer of caution when establishing their interview protocol for the family. A perpetrator who is using coercive control may not only perceive a privacy violation but also a threat to the perpetrator's control over the nonoffending parent and family. Perpetrators often enforce secrecy about the abuse by monitoring what the survivors, children, and other family or friends say or by using them for surveillance of each other when the perpetrator cannot be present to enforce secrecy (Washington State Department of Social and Health Services, 2010). Therefore, separate interviews for each adult and child (when developmentally appropriate) are critical. When possible, it is also important to conduct the interviews in locations where the child and adult survivors are out of eye sight of the perpetrator; even if the perpetrator cannot hear the survivors, just having them within eye sight can be a way to control or intimidate. Ideally, interviews should be conducted with either the children first or the children and nonoffending parent together, depending on agency protocols (e.g., differential response versus traditional investigative methods), and then the alleged perpetrator of domestic violence separately.

The caseworker should make direct contact with the alleged adult survivor both to avoid any attempts by the alleged perpetrator to sabotage the survivor's information and to keep him or her and the children safe. If caseworkers are not able to make initial contact with the adult survivor alone, they should find alternative, creative means of follow-up contact (e.g., through the children's school or daycare, at the alleged survivor's place of work).

There will be times when caseworkers arrive at the home and find both partners present. In these instances, caseworkers should collect general family information and refrain from direct inquiry about any domestic violence concerns. CPS caseworkers can use their agency policies and protocols to request separate, follow-up interviews and to inform family members that separate interviews are a routine agency procedure.

To safeguard domestic violence information from the alleged perpetrator, caseworkers should not leave domestic violence resource information, letters, or text or voicemail messages that ask to speak with the adult survivor about domestic violence. Such information can jeopardize not only the alleged survivor's safety but also the nature of the caseworker's interview with family members who may be threatened or forced to deny the allegations.

Example of Interviewing

A worker was assigned a case with allegations that the mother drank excessively and used methamphetamines in the home with a 6-month old child. There was no mention of domestic violence in the intake report. The worker went to the home where she met with the mother and infant's father, and she observed their 6-month-old. The father insisted that the worker did not need to talk with the mother alone because they talk about their problems as a family. He stated that the mother puts the alcohol and drugs ahead of him and their daughter. The worker observed that the mother looked down at her lap throughout the interview and did not speak. The worker chose not to do a full domestic violence screen. Before ending the joint interview, she thanked the family and let them know she may have follow-up questions. At that time, the caseworker determined the child to be safe.

When given the opportunity at the mother's substance abuse screen the next morning, the worker was able to meet the mother alone and asked questions to inquire about domestic violence. The mother admitted that her screen would be positive. She disclosed that the infant's father made it hard for her to go to treatment by leaving her with no car seat or by taking her bus pass, thus leaving her with no way to go to her appointments. She also disclosed that the father does not like for her to leave the home because "the neighborhood is unsafe," and she showed the worker a scar from a time the father got mad at her for leaving the home without permission. The mother reported that the father had made no attempts at harming the child, although the child was present during the scar incident. By interviewing her alone, the worker was able to gather additional information that affected the initial assessment, safety planning, and potential barriers for service planning.

6.4.3 Interviewing the Adult Survivor/ Nonoffending Parent[4]

The caseworker interviews the adult survivor as part of the assessment of safety and risk for the child. Assessing for domestic violence and the survivor's safety is important, but only one part of that assessment—the adult survivor may also be the maltreating parent. When dealing with a family who may be experiencing domestic violence, there may be difficulty in arranging a meeting with the adult survivor, which may be an indicator of the perpetrator's level of control or of the survivor's level of fear. Caseworkers, with supervisor guidance, can offer creative and flexible solutions to the survivor, such as meeting at a public place that is less likely to raise the alleged perpetrator's suspicion and at a time when the alleged perpetrator is working or away from the home. It is also important to have a plan in case the perpetrator shows up. The adult survivor may be able to provide other suggestions of how and where to meet.

Domestic violence survivors do not always present as cooperative or meek people. Caseworkers may be surprised or confused to meet an angry, uncooperative alleged survivor when they were expecting a scared, passive individual desperate for help. Adult survivors may, understandably, fear losing their children or being subjected to more violence. They may feel conflicted, wanting the violence to end, but not the relationship (National Resource Center for Healthy Marriage and Families, 2013). Survivors may have additional problems, such as mental illness or substance use disorder, which can contribute to their unwillingness to reveal family information or to be open to external help. As discussed earlier, caseworkers should not assume that "resistant" survivors want or choose to be in violent relationships. Often, this resistance is a strategy that the adult survivor has adopted to further protect him- or herself by demonstrating loyalty to the

4 Chapter 6 of the *Caseworker* manual provides interviewing techniques for adult family members.

perpetrator. Caseworkers who recognize these issues, as well as identified fears, will increase their ability to engage an adult survivor in planning for and achieving child (and survivor) safety.

Regardless of a survivor's behavior, she or he and the children desire safety and deserve to have access to services that will address the violence in their lives. The caseworker should explain that CPS is required to protect children from harm, and any disclosures made will be used to plan for the children's safety. If the adult survivor is receiving services from a domestic violence service provider, the provider may be present for the interview if requested by the survivor. Additionally, it is helpful to explain the CPS process to provide assurance that the children's safety, as well as survivor's, is the goal of the assessment. The following are practice recommendations for interviewing the adult survivor during the initial assessment.

Interview the adult survivor alone. Interviewing the alleged survivor alone (and out of sight of the perpetrator, if possible) decreases risk of the perpetrator trying to control the discussion or put the survivor in harm's way and increases the ability to build trust and rapport. It allows caseworkers to communicate that they are acutely aware of potential safety threats and that the agency independently assesses each parent's ability to protect the child. This can be especially important with nonoffending parents who may be afraid of any type of intervention from a responding agency.

Build trust and rapport. Caseworkers can also build trust and rapport by acknowledging the survivor's feelings (including anger at agency intervention or love for the perpetrator), explaining that the violence is not the survivor's fault, and expressing concern for the survivor and children's safety. It is important to indicate a commitment to safeguard the nonoffending parent's safety by not sharing with the alleged perpetrator any accounts of threats or abuse that the nonoffending parent discloses. It is imperative, however, that caseworkers also explain the limits of their confidentiality and discuss safety planning around unavoidable disclosures (Taggart, 2009). It is critical that survivors know that if the family becomes involved in court proceedings, case file information may be obtained by the perpetrator's attorney, and information may need to be shared with all parties in court.

Consider safe alternatives. Caseworkers should empower the nonoffending parent to consider safe alternatives and to access domestic violence resources. They can give survivors contact numbers for advocacy services, but should never demand that a survivor leave the abusive relationship. Not only does this reinforce the message that the survivor does not have control over her or his situation, but leaving also puts the survivor at higher risk of injury. (Chapter 4 discusses barriers to leaving.)

Be nonjudgmental. The interview and initial assessment should be conducted with sensitivity and in a nonjudgmental, nonthreatening manner. Information about the nature of one's intimate relationships are private and not shared by most people, particularly with strangers. Asking for information about a partner's coercive or degrading treatment can make survivors feel ashamed.

Caseworkers can initiate the interview with nonthreatening questions about the children (e.g., ages, favorite school topic or activity), then move to a neutral inquiry regarding the survivor's relationship with his or her partner. While it is important to obtain relevant information, caseworkers typically do not need to elicit small or salacious details regarding the abuse, which may trigger a reliving of the experience. Suggested questions to begin a neutral inquiry into domestic violence concerns (including when domestic violence was not identified in the initial report) may include the following:

- Tell me what you like most about your partner.
- Tell me about something you'd like to see change in your partner.
- All couples have disagreements. How do you and your partner handle them?
- When does your partner's behavior worry you the most? Tell me (more) about that.
- Who does most of the talking when you are with your partner? How does that make you feel? How do you think it makes your partner feel?
- Who makes the decisions in your family? How do you feel about that? How do you think it makes your partner feel?
- What makes your partner act jealous? Can you tell me more about that?

It is important that caseworkers avoid "survivor-blaming" questions or statements, which can deepen an alleged survivor's feelings of shame, guilt, or responsibility for the perpetrator's behaviors. Exhibit 6.3 lists examples of what not to say.

Exhibit 6.3. What Not to Say to an Adult Survivor

Inappropriate comments that suggest the survivor provoked or deserved the violence likely will discourage thorough disclosure of the abuse or negatively affect cooperation in the CPS process. Examples of survivor-blaming questions include the following (Child Welfare Information Gateway, 2003):

- What did you do to make your partner so mad?
- What could you have done to stop him or her from hitting you?
- Why don't you just leave?
- Why do you put up with the violence?
- Why do you hit each other?
- What do you get out of the violent situation?
- If you care about your children, why would you stay?

Before ending the interview, caseworkers will also ask the usual assessment/investigation questions that will identify child safety issues and the capacity to support child safety and protection by the adult survivor. They should also explain that they will need to interview the alleged perpetrator alone and discuss what, if anything, will be shared about the worker's meeting with the survivor and children. The purpose of this discussion is to continue building trust and to limit the alleged perpetrator's power to later manipulate other family members to share what was disclosed in their interviews. However, caseworkers will need to explain (1) that information about domestic violence disclosed by the survivor or children will not be shared with the perpetrator unless a court requires disclosure, and (2) what information is routinely disclosed to the other parent through the process. Caseworkers should also ask the survivor if he or she will feel endangered by worker interviews with the perpetrator and should work together to alleviate safety issues. It is important to

reiterate that the goal of this process is to protect children from harm and that survivor disclosures will be used to plan for that (Washington State Department of Social and Health Services, 2010). It is also important to explain the confidentiality issues discussed earlier. **Appendix D** provides a sample assessment for domestic violence survivors.

6.4.4 Interviewing the Child Survivor[5]

Parents may underestimate or choose not to think about the effects of their children experiencing domestic violence (Osofsky, 2003). Whether or not children are experiencing physical violence, their own lived experiences are affected by the relationships and violence in their homes (Callaghan et al., 2015). Approximately 90 percent of children who live with domestic violence can provide detailed descriptions of the incidents (Callaghan et al.,

2015; Doyne et al., 1999; Jaffe, Wolfe, & Wilson, 1990). Exploring children's experiences and behaviors (e.g., generally keeping quiet and/or out of the way, learning to hide at certain times, degrading or blaming the survivor, lashing out at peers) will help workers fully assess the family and the extent of the negative effects of domestic violence experiences on the children.

Caseworkers must proceed cautiously during their interviews with children. Children receive messages, either directly or indirectly, that domestic violence is a "family secret." The worker may consider asking the survivor about how to approach the children about domestic violence in order to have an initial understanding of the children's likely attitude or behavior. The following are practice guidelines for caseworkers when performing any assessments with children (DePanfilis, in press):

- Carefully choose the setting so that it is age appropriate, private (preferably alone with the child, if developmentally appropriate), and child friendly, with minimal distractions.
- Give children permission to say, "I don't know," or "I don't understand."
- Use a phased approach for developing rapport, followed by inviting the child to tell his or her story without interruptions and using his or her own words.
- Do not make promises but describe next steps in the closing part of the interview.
- Consider the age and development of the child when deciding the length of the interview, as well as issues related to their potential reluctance and suggestibility (i.e., being careful not to lead the child to say things that may not be true).
- Pay attention to nonverbal cues, and use reflections of content and feeling to support the child.
- Avoid concepts that are difficult for the child to understand (e.g., it may be impossible for young children to accurately report how many times something has happened or for how long).
- Use elaboration prompts, in the child's own words, to explore something that has previously been stated further (e.g., asking "And then what happened?").

Similar to the worker's interview with an adult survivor, the worker should ask about and listen to children's feelings about agency involvement and about any violence or dysfunction in the home, as well as emphasize that the violence is not their fault. As discussed in the last chapter, the worker should remember that the children may have conflicted feelings about the perpetrator or be fearful of splitting the family.

5 Chapter 6 of the *Caseworker* manual provides general tips on interviewing children, including using private, child-friendly settings and multidisciplinary teams.

Caseworkers can begin the conversation about domestic violence with a general, developmentally tailored statement. They can help make the child feel more at ease by starting with broad-based statements before asking specific questions about the family (Child Welfare Information Gateway, 2003, 2003; Graham-Bermann & Brescoll, 2000; Jaffe et al., 1990; Marcus, Lindahl, & Malik, 2001; Massachusetts Department of Social Services, 1995). For example, for an elementary school-aged child: "Sometimes when moms and dads (or boyfriends) are angry . . . sometimes even too angry, they may start to yell at each other or even hit each other. I know fights can be scary. I want to ask you a few questions about how your parents fight and what you think about it. Would that be ok?" (Child Welfare Information Gateway, 2003; Graham-Bermann & Brescoll, 2000; Jaffe et al., 1990; Marcus et al., 2001; Massachusetts Department of Social Services, 1995).

If the child is not willing to discuss the situation, the caseworker can reassure him or her that it is understandable to feel reluctant talking about such matters. It is never appropriate to attempt to instill any type of guilt or fear in the child in an effort to gain compliance or to obtain information. **Appendix E** provides a sample domestic violence assessment appropriate for children.

6.4.5 Interviewing the Alleged Perpetrator

It is normal for caseworkers (or anyone) to feel uneasy and nervous about interviewing an alleged perpetrator about abusive behaviors, which may make it more difficult to remain open minded. As discussed earlier, perpetrators vary in their patterns and levels of violent behavior. Collecting information before the interview can inform caseworkers about safety precautions they may want to consider. Workers can develop a precautionary plan for their own safety with their supervisor prior to meeting with an alleged perpetrator. This may include interviewing the alleged perpetrator in the agency office or another public setting, and it should include sharing the worker's destination and an estimated time of return with the supervisor or a peer. It may include a request for law enforcement to accompany the caseworker, even if there is no evidence of current criminal activity. Chapter 7 discusses worker safety in dealing with domestic violence in more depth.

Some perpetrators will act concerned and cooperative, or even charming, in an effort to avoid exposure and to decrease the caseworker's involvement with the family. Nevertheless, it is critical to assess the alleged perpetrator's level of dangerousness (to the survivor and the children) and the risks his or her behavior presents to family members. The following are practice recommendations for caseworkers when interviewing alleged perpetrators.

Mederos (n.d.) wrote that building rapport with an alleged perpetrator, as with any family member, is an important first step. Caseworkers should plan ahead to conduct a focused, structured interview. During the interview, they should (Mederos, n.d.; Washington State Department of Social and Health Services, 2010):

- Begin the interview in a neutral, nonconfrontational manner. For example, it may begin by asking the alleged perpetrator general questions about parenting duties or the child. If the worker successfully establishes rapport, this can later lead to a conversation about the impact on the children of witnessing domestic violence.
- Be respectful and nonconfrontational, while maintaining a firm grasp of structure. It is useful to be clear about the purpose of the interview, such as, "I need to speak with you about your family. Everybody gets a chance to talk about what's going on."

- Clearly communicate the goals and format of the interview. This will help caseworkers focus the interview, as well as convey their control over the process and the authority to set limits. Use third-party reports (e.g., law enforcement and criminal records, civil protection orders, hospital records, or prior CPS information) to inquire about domestic violence. They should never confront the perpetrator with information provided by the survivor as this can compromise the survivor's safety. If supplemental information is not available, caseworkers should inform the alleged perpetrator that it is routine procedure for child protection to inquire about domestic violence.
- Focus on obtaining information about the perpetrator's behaviors and the degree to which he or she accepts responsibility.
    - Caseworkers should not try to obtain a "confession" or hold a "debate" regarding domestic violence allegations. This can result in the interview ending abruptly, and the caseworker will not be able to gather critical information regarding the alleged abusive behavior or may result in retaliation against the children or adult survivors. Caseworkers can be more effective by presenting factual information and listening to the alleged perpetrator's responses. However, caseworkers should document (as quotations) what the perpetrator says in denying the abuse (including child maltreatment, if applicable), as these statements are sometimes examples of the minimizing, denying, or lying that perpetrators use to control survivors' access to information.
    - Some perpetrators admit to domestic violence behaviors while justifying it; others do not. Caseworkers should see partial disclosures by perpetrators as positive but not the whole story, and they should not think that a family is free from abuse and violence or that the perpetrator is ready to change.
- Gain the alleged perpetrator's perspective by actively listening to his or her responses, which helps inform the worker's assessment and demonstrates that the worker is open to hearing from all parties. Some perpetrators will admit to being abusive, which usually increases the likelihood that they will be open to case and service planning efforts.

Appendix F provides a sample domestic violence assessment for alleged perpetrators.

6.5 Safety Assessment and Safety Planning[6]

As with any family who comes to the agency's attention, there are two key decision points during the initial assessment in which the child's safety must be evaluated: at first contact with the child and family, and at the assessment's conclusion. As discussed earlier in Chapter 3, assessing the level of dangerousness of the perpetrator and determining the effect of that danger on the children are key. Building on that, **Exhibit 6.4** lists the factors to consider when evaluating safety in cases where domestic violence and child abuse and neglect coexist.

6 Chapters 6 and 7 in the *Caseworker* manual discuss these decision points and how to address safety in detail.

Exhibit 6.4. Evaluating Safety When Domestic Violence and Child Maltreatment Co-Occur

- Circumstances of the alleged child maltreatment
  - Child was assaulted, injured, or threatened during a domestic violence incident
  - Child was in danger of physical harm during the domestic violence incident
- Perpetrator's access to the child or adult survivor(s)
- Diminished protective capacity of the adult survivor because the parent was harmed or incapacitated by the perpetrator to such an extent that he or she is unable to meet the needs of the children
- Pattern of the abuse
  - Frequency/severity of the abuse in the current and past relationships
  - Use and presence of weapons
  - Threats to kill the survivor or other family members
  - Hostage taking, stalking
  - Past criminal record
  - Abuse of pets
  - Child's exposure to violence
- Perpetrator's state of mind
  - Obsession with the adult survivor
  - Jealousy
  - Ignoring the negative consequences of the violence
  - Depression or desperation
  - Threats or attempts to kill adults or children
  - Display, threat, or use of firearms or other deadly weapons
- Individual factors that reduce the behavioral controls of either the survivor or perpetrator
  - Abuse of alcohol or other substances
  - Untreated psychosis or other major mental health disorder
  - Brain damage
- Survivor, child, or perpetrator thinking about or planning suicide
- Adult survivor's use of physical force or emotional abuse against the child or perpetrator
- Child's use of violence
- Situational factors
  - Presence of other major stresses, such as poverty, loss of a job, or chronic illness
  - Increased threat of violence when the survivor leaves or attempts to leave the perpetrator
  - Increased risk when the perpetrator has ongoing or easy access to survivors
  - Physical inability of nonoffending parent to protect child due to assault
  - Nonoffending parent's fear of leaving or inability to leave due to economic status or lack of a safe, alternative place (Ganley & Schecter, 1996; Child Welfare Information Gateway, 2003; DePanfilis, in press)

Best casework practices in safety and case planning with the family suggest involving the survivor as a partner in the planning process, along with the children to the extent feasible. The children's involvement will depend on their developmental stages and circumstances. Some children find that developing a safety plan helps them feel safer and can provide life-saving strategies, while others need to know that their parents can protect them. **Exhibit 6.5** outlines the safety planning phases with the adult survivor and children.

Unlike other cases, the caseworker will work separately with the perpetrator to identify actions he or she will take to participate in protecting the child, which may be documented in a separate child safety plan. Additionally, the workers will develop a separate service plan with the alleged perpetrator.

Exhibit 6.5. Safety Planning With the Adult Survivor and Children

If a caseworker does not have experience working with domestic violence, then he or she should work with the supervisor to devise alternatives, such as consulting with a colleague with experience working with domestic violence (i.e., specialist) or a domestic violence advocate to develop the safety plan. The initial phase includes:

- Engaging the adult survivor in exploration of available options to keep him or her and the children safe, including what has been tried before
- Exploring the benefits and disadvantages of specific options
- Collecting and gathering important documents and various personal items that will be necessary for the survivor and children to bring if they relocate
- Providing resources, including a list of phone numbers of neighbors, friends, family, and community services providers that the adult survivor can contact for safety and services; it is important to identify a safe way to keep this information available without raising suspicion about its purpose

After that, the adult survivor and caseworker work together to develop the main child safety plan, which may include:

- Action steps (whom to call or text, where to go, what to do) for the survivor to take when the survivor notices triggers for a violent situation or a violent situation begins; for example, the adult survivor can have a code word that, when said, the children know to leave and call 911
- Action steps for the children to find a safe adult and to ask for help when they witness or experience violence, which may involve calling supportive family members, friends, clergy, sports coach, teacher, mentor, or community agencies for help
- An exit plan for the children to immediately leave the house if an assault is imminent or in progress or to find a secure place in the house if they cannot safely leave
- Individualized solutions for the family as any initial solutions may be very short term

Ongoing safety and case planning activities with the adult survivor and children may include all of the above, as well as:

- Developing a home security plan, which might involve changing or adding door and window locks, installing a security system, or having additional outside lighting
- Informing friends, coworkers, school personnel, and neighbors of the situation and of any restraining orders that are in effect
- Creating longer-term solutions for the family that align with desired outcomes to reduce risk and to increase the protective capacities of the nonoffending parent.

An initial safety plan may include the survivor and children visiting overnight with a relative or friend, going to a domestic violence shelter, or sending the children to a safe, temporary living arrangement. Or, it may detail identified safety steps that the nonoffending parent will take with the children when the perpetrator next becomes threatening or violent.

As part of safety planning, the worker should share information about local services for domestic violence survivors and jointly develop a safe place for the survivor to access resource information and family legal documents. While exploring options, the caseworker can assess the survivor's readiness to meet with a domestic violence advocate or specialist (if available) or to seek an order of protection from the court system.[7] Due to the risks it presents to the survivor's safety, a worker should let a survivor decide whether to seek a protective order. Rather, the emphasis should be on working together to plan for child safety while minimizing risk to the survivor. This may include action steps to address concrete emergency needs, such as temporary housing or shelter, medical care, and child care. Caseworkers should also know how to reach the local domestic violence advocate or specialist for tips and guidance on community services and approaches. The worker can compile this information even when a survivor is not ready to connect with the domestic violence advocate or specialist.

Safety plans are not intended to hold survivors responsible for possible future domestic violence. Instead, these plans can help them feel empowered and provide concrete steps to help avoid or to respond to abusive actions. Incorporating domestic violence safety plans into service plans provides realistic and relevant actions for family members living with abuse. The safety plans of survivors and children **should not** be shared with the perpetrator. This is especially true if the plan involves the survivor leaving the abusive relationship. In fact, some survivors will need to hide their safety plans to avoid potential harm by the perpetrator. There are some cases, however, where safety planning can be conducted with the perpetrator as a way to hold him or her responsible. In this case, the safety plan should include steps to take to stop the violence (e.g., honoring protection orders, leaving the house, time-outs, going to perpetrator intervention groups). However, these should be: (1) developed only by experienced caseworkers or in consultation with a supervisor or a domestic violence specialist advocate; and (2) implemented only in ways that minimize any possibly harmful impact on the children.

As discussed throughout this manual, it is vital that the level of dangerousness of the perpetrators be evaluated. This is crucial when developing safety plans, because perpetrators' dangerousness varies widely, and this difference should be taken into account in case practice. As Mederos states: "Many men have low frequency and low levels of violent behavior, and many can stop violent behavior and develop healthy parenting skills. A better understanding of an abuser's level of dangerousness allows for a more strategic approach to assessing risk, safety planning, and creating service plans. Dangerousness assessment is also essential for safety planning for CPS personnel" (Mederos, n.d., p. 34). **Appendix G** provides sample domestic violence safety plans for a survivor and a child.

7 Survivors of domestic violence have several civil and criminal protection or restraining order options to protect themselves from further abuse. While they do not stop a perpetrator from stalking or hurting a survivor, they do permit him or her to call the police and have the perpetrator arrested if they break the order (FindLaw, 2017a).

6.6 Ongoing Assessments

Child safety assessment and child risk assessment are routine practices for CPS (described more fully in Chapters 6 and 7 of the *Caseworker* manual). The National Association of Public Child Welfare Administrators (2001) recommended that domestic violence assessments occur during all phases of a case, from intake to service plan development, placement decision, services review, to case closure. If a child maltreatment report that is accepted for investigation or assessment does not contain allegations of domestic violence, CPS caseworkers should continue to screen for its presence, as well as for levels of dangerousness, using the screening questions discussed earlier throughout the life of the case. Different collateral contacts and service providers will have varying knowledge of the family dynamics and circumstances. Additionally, family members may reveal sensitive information only after a caseworker has developed a family member's trust over time.

Because the safety of adult and child survivors can vary depending on the shifting dynamics of abuse, assessing for domestic violence throughout the case is key. Thus, caseworkers may need to revise service recommendations as the safety threats to and needs of the nonoffending parent and children change. For example, if a nonoffending parent's family plan initially includes seeking a protective order, but the nonoffending parent determines that seeking the order will escalate the abusive behaviors, the caseworker and nonoffending parent will need to modify the case plan to develop a safer alternative.

6.6.1 Risk and Protective Factors

There are numerous factors that can increase either risk or protective capacities depending on whether they are present or lacking, e.g., social support. In cases where domestic violence is a concern or allegation, there are some specialized considerations that will help a worker fully assess safety and risk for the child and the survivor, which build upon factors outlined earlier in this chapter, including the (Ganley & Hobart, 2010; Ganley & Schechter, 1996; Massachusetts Department of Social Services, 1995; Child Welfare Information Gateway, 2003, 1998):

- Nature, extent, and patterns of the domestic violence
- Effects of the domestic violence on adult and child survivors
- Help-seeking and safety strategies used by the survivor
- Help-seeking and safety strategies used by the child
- Survivor's employment or access to financial resources
- Perpetrator's employment status
- Degree to which the perpetrator accepts responsibility for abusive behavior
- Availability of social supports (e.g., family and community)

It is critical that ongoing safety and risk assessment occur in collaboration with the nonoffending parent and, as developmentally appropriate, the children, with input from involved domestic violence advocates and other involved community service providers.

Resources

Family Violence Risk Assessment and Safety Planning by Child Intervention Staff: An Environmental Scan lists numerous scales and instruments which may be helpful at http://cwrp.ca/sites/default/files/publications/en/FV_Risk_Assessment.pdf

6.6.2 Additional Factors to Consider During Initial and Ongoing Assessments

The diverse and multiple needs of families affected by domestic violence require thoughtful consideration of other variables that can add to the complexity of these cases. The following are some additional issues for CPS caseworkers to consider as part of their initial and ongoing assessment efforts.

Violent Resistance, Situational Couple Violence, and "Mutual" Domestic Violence

As noted in Chapter 2, coercively controlling violence is the most commonly considered form of domestic violence, but it is not the only form of violence and unhealthy relationship patterns between partners. In addition to the situational (or "mutual") violence, where couples mutually react to conflict by using serious verbal abuse, physical abuse, or both, there are also survivors who use physical force against the perpetrators in self-defense (a.k.a. "violent resistance") (U.S. Department of Justice, 1997; Kelly & Johnson, 2008). There are also perpetrators who accuse their partners of being equally abusive and claim to be the "real victim," which is part of the perpetrator's power and control dynamic. Some probing questions to identify the power dynamics and primary aggressor in a relationship include:

- Who controls or makes decisions (e.g., about parenting, spending money, spending time with friends, etc.) in the relationship?
- Who has more access to financial and economic resources?

Workers should document in the case notes their observations during partner interactions, such as whether one or both partner openly puts down the other or one partner dominates conversation, and the degree to which partners' behaviors match their self-reports of how they act. Chapter 7 discusses documenting domestic violence issues in case files in more detail.

Cultural Issues

As discussed in Chapter 4, with any family, caseworkers need to be aware of cultural factors that can influence the family dynamics and the survivors' response to the domestic violence. Cultural issues also can affect caseworkers' own lens. They should be aware of their personal values and biases (i.e., cognitive bias or "a systematic error in thinking that affects the decisions and judgments that people make" [Cherry, 2017, para. 1; Kahneman & Tversky, 1996]). Effective practice requires setting aside one's own beliefs to actively listen to and hear from all family members. Workers also must be careful not to perpetuate cultural stereotypes.

As stated earlier, there has been minimal research into the relationship between sociocultural factors and exposure to domestic violence (Ogbonnaya, Finno-Velasquez, & Kohl, 2015). While some religions or cultures may place a particularly strong emphasis on traditional family roles or on preserving family unity and privacy, this is not an excuse for a perpetrator's choice to perpetuate violence. It may, however, influence the roles that a couple take in their relationship. It may also influence a survivor's feelings about disclosure. For example, a survivor may refuse a provider's help in order to preserve connection to or family honor in a tightly knit cultural community. There might be added pressure from clergy or extended family members

who are vested in maintaining the sanctity of marital vows or the family construct (Casa de Esperanza, 2015). Workers should explore family members' cultural and religious self-identification and values, including how these might be strengths or protective factors and how they may influence relationship and family decisions. Also, where immigration matters are concerned, the worker and survivor will want to seek help from an attorney who specializes in that area.

Language barriers also hinder a non-English-speaking survivor's ability to communicate strengths and needs and a worker's ability to build trust, accurately assess family dynamics, and explain services available. The survivor may confront additional challenges when communities do not have culturally sensitive services or resources. Bilingual staff are a helpful resource, but they may not fully understand a particular ethnicity, culture, or sect. Using a professional translator is better than using a family member for several reasons. Caseworkers should not use children as translators because the information exchanges may be inaccurate, distressing for the child, or both. Adult family members or friends may break confidentiality, translate inaccurately, or pose other risks for the adult survivor and children if used as translators.

Poverty

Domestic violence can affect a survivor's ability to be financially self-sufficient. Domestic violence and poverty are connected, and statistics show that survivors of domestic violence are over represented in the welfare system (Imbery, 2014). Unquestionably, a lack of viable job skills, education, and income presents huge challenges for survivors. Low-income survivors who want to leave their violent relationship are left with few and, often, less desirable choices. Homelessness and unsafe housing are common realities for them and their children. Thus, it is critical that caseworkers address those financial barriers and link survivors to economic services, such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), vocational skills training, job retention, and educational support.

6.7 Next Steps

The caseworker completes a domestic violence assessment to determine the immediate danger to the children and survivor, as well as any necessary interventions and community supports to meet their needs. This assessment helps inform the caseworker's decisions regarding the following questions:

- Is the child in danger from the domestic violence?
- What is the nature of the risks to the child?
- Who is responsible for causing the child to be in danger? To be at risk?
- Is emergency intervention necessary?
- When is further assessment needed?
- How can the caseworker best work with the family to address, reduce, or remove child safety threats or dangers?
- How can the risks to the child best be monitored over time?
- What community supports do the children and survivor have and need?

Once the caseworker has assessed the family, the next step is to make a determination about whether the report of maltreatment is substantiated. The next chapter explains the decision-making process and the steps that follow from there.

Resources

For videos on safety planning regarding domestic violence, go to:

Introduction to Safety Planning at https://www.youtube.com/watch?v=qbExoz_Ryyk

Overview of Safety Planning at https://www.youtube.com/watch?v=H1GXVjbwvzk

Family Safety Planning at https://www.youtube.com/watch?v=lMvjKtYo-FI Safety

Planning for Children at https://www.youtube.com/watch?v=h39YCl7MXrs

Highlights

1. While CPS's primary mission is to preserve the safety, permanency, and well-being of the children who come to the agency's attention, families experiencing child maltreatment and domestic violence can present complex challenges. CPS caseworkers will need to consider abuse and safety issues for both the child and adult survivor in addition to the family dynamics.
2. Although adult and child survivors often are found in the same families, CPS and domestic violence services programs historically have responded separately, primarily due to differences in historical development, philosophy, mandates, policies, and practices. However, these programs also build upon their commonalities in serving families experiencing domestic violence.
3. It is important to note that assessing for domestic violence—or any other co-occurring issue, such as substance use disorder or mental illness—does not alter the fact that the caseworker must assess for the child's safety at all times. Both the survivor and perpetrator's parenting must be assessed for safety and risk, as either or both may be a maltreating parent.
4. While confidentiality is an issue because of the different protocols and laws affecting domestic violence and child welfare agencies, collaboration and other strategies can work to carry out protocols to address confidentiality successfully.
5. It is best practice for every child maltreatment referral to screen for potential domestic violence upon intake. Systematically collecting this information allows the screener to make a competent and informed decision as to whether domestic violence is occurring, whether it is contributing to or causing child maltreatment, and what type of response the situation may require.
6. Variations in state and local child welfare statutes, policies, and practices will result in different standards for when children's experiences of domestic violence independently warrant CPS involvement.
7. Differential response, an alternative to the traditional, investigative response, allows child welfare agencies to approach the issue of domestic violence in a family-centered, nonthreatening way when there is low to moderate risk, helping to ensure the safety and well-being of the children together with the survivor.
8. There are several stages of assessing the family, including the initial assessment; interviewing the family members, including the child, survivor, perpetrator, siblings, etc.; and assessing safety and risk. Caseworkers should also consider other factors when conducting the assessments, including the existence of violent resistance, situational violence, or "mutual" domestic violence, cultural issues, and poverty.

9. With families experiencing domestic violence, the caseworker will work separately with the perpetrator to identify actions he or she will take to participate in protecting the child, which may be documented in a separate child safety plan.
10. Domestic violence assessments should occur during all phases of a case, from intake to service plan development, placement decision, services review, to case closure.
11. Assessing for domestic violence—or any other co-occurring issue, such as substance use disorder or mental illness—does not alter the fact that the caseworker must assess for the child's safety at all times. Both the survivor and perpetrator's parenting must be assessed for safety and risk, as either or both may be a maltreating parent.

Chapter 7: Decision-Making, Development of the Family Plan, and Case Closure

The previous chapter described the intake, initial assessment/investigation, and safety planning steps of the CPS process with families experiencing domestic violence. Once these are completed, a decision is made whether to open a case. The decision to substantiate a report of child maltreatment or not is made at the conclusion of the investigation, once all the information is collected from all sources. If substantiated, the caseworker continues the assessment to guide the development of the family plan. This chapter, like Chapter 6, focuses on the next steps through the lens of domestic violence and covers:

- Decision-making after the initial assessment/investigation
- Developing the family plan
- Using a trauma-focused approach
- Documenting domestic violence in the case record
- Closing the case

7.1. Making a Decision About Substantiation and Next Steps

As with any family involved in a CPS investigation or assessment, caseworkers need to carefully consider case information and whether children's safety and well-being will best be served through ongoing agency involvement or community-based services with or without agency involvement, e.g., differential response. Children's experiences of domestic violence alone do not necessarily meet the criteria to constitute child maltreatment, but they can be a significant risk factor for healthy child and family outcomes.

Failure to Protect

Whether to substantiate child maltreatment in cases involving exposure to domestic violence varies across states and jurisdictions, according to established statutes, which vary widely by state and jurisdiction. (For more information, see Child Welfare Information Gateway's *State Statutes: Definitions of Child Abuse and Neglect* at https://www.childwelfare.gov/pubPDFs/define.pdf.) Some jurisdictions grapple with the benefits and consequences with substantiating neglect by a survivor for "failure to protect." On one hand, substantiation would mean the family could benefit from the many services and support an agency has to offer. On the other hand, a failure-to-protect substantiation places the blame for the violence on the survivor rather than holding the perpetrator accountable. It also discounts the survivor's protective strategies and efforts to minimize their children's exposure. This practice prevents many survivors of domestic violence from accepting help because they fear losing their children and being labeled a neglectful parent.

While use of this practice should generally be avoided because it suggests the perpetrator is not accountable for his or her actions, there may be limited circumstances where it is the safest option. This may be the case when the perpetrator poses a substantial threat to the children and adult survivor, and the survivor does not (or is unable to) protect the child from the maltreatment. Failure to protect should not be used routinely to obtain court intervention, and it may be an indicator that either the safety assessment is incomplete or that judicial officers or other stakeholders would benefit from training or education on children's experiences with domestic violence (Child Welfare Information Gateway, 2003).

In determining whether domestic violence is an independent basis for a substantiation (or finding of child maltreatment), e.g., "failure to protect," the worker may consider the same criteria outlined in Chapter 6. To determine whether a family experiencing domestic violence should receive ongoing agency intervention, the caseworker should use available safety and risk assessment tools, agency policies, and supervisory consultation to make a final decision.

The worker, in consultation with his or her supervisor, should base the decision to substantiate a case for child maltreatment on both the actions of the perpetrator and the capacity and willingness of the survivor to take appropriate actions to protect the child. When the child welfare agency gives the survivor the necessary offer of help and system support to protect the survivor and the child, and the survivor then acts contrary to that help and support, the case may be substantiated for failing to protect the child. Every effort should be made to hold the perpetrator accountable for the violence and to hold the survivor accountable for steps (not) taken to protect the child. The caseworker should consider the following when making a decision to hold the survivor responsible for neglect/failure to protect:

- Has the survivor taken advantage of available domestic violence shelters, programs, or other legal alternatives?
- Is there a history of the survivor calling law enforcement or using court services to obtain protective orders?
- Does the survivor have a history of making or attempting to make other arrangements to protect the child, such as taking the child to a relative or friend's home?
- Does the survivor have a history and level of cooperation with child welfare services to protect the child?
- What other actions have been taken by the survivor to protect the child?

In-Home Services vs. Removal

Once a decision has been made to substantiate a case, the next step is to determine, based on the initial assessment (including the safety assessment), whether the child can safely remain in the home or needs to be placed temporarily in a different living situation, with services being provided either way. (As discussed in Chapter 6, services and/or referrals for services also may be provided when the agency uses a differential response system, e.g., the case is not substantiated but is referred for needed services.) According to the National Center on Domestic Violence, Trauma & Mental Health (2017), "[t]he single most important resource for children in fostering resilience and healing from the traumatic effects of domestic violence is a secure attachment relationship with a loving parent or caregiver over time" (para. 2). In child welfare, workers must make reasonable efforts to preserve family unity, but child safety is the federally mandated, paramount concern. The domestic violence and child welfare fields come together setting goals when they work together to keep children safely with a nonoffending parent. Unlike domestic violence advocates or specialists, child welfare workers are mandated to attempt to work with a perpetrator-parent to offer services, support, and solutions; they may also be responsible for arranging court-ordered, supervised visitation between the child and perpetrator. In all cases, it is ultimately up to a maltreating parent to make the behavioral changes necessary to mitigate risks to child safety.

While children's safety is the primary responsibility of CPS caseworkers, to prevent additional trauma every attempt should be made to maintain the child with the nonoffending parent if it is appropriate and possible. Examples of when this may not be possible include situations where:

- All other means of safety planning have been considered and offered but are not available for various reasons (i.e., the worker has attempted to explore safe alternatives with the survivor, and they are unable to come up with a temporary living arrangement that meets agency safety requirements)
- The situation presents a present or impending threat of harm to the children
- The perpetrator is unable or unwilling to make immediate changes for the children's safety, or the worker is unable to safely engage the perpetrator in child safety planning
- The survivor is unable to protect the children or accept services

Unfortunately, obstacles in deterring the perpetrator's violent behavior have led some child welfare agencies to believe that protective custody is the only viable method to ensure children's safety. As a result, children are removed from survivors who, in addition to their own abuse, suffer the agonizing loss of their children. This also can have a traumatic impact on children, as discussed in a later section. If removing the children from the home is considered a possibility, and the survivor is not safely able or willing to leave the abusive relationship, caseworkers should discuss their concerns and ask the survivor to provide options for the children's safety if he or she has the capacity to do so (Child Welfare Information Gateway, 2003; Ganley & Schechter, 1996). Caseworkers should also seek guidance from their supervisors and domestic violence advocates or specialists to ensure that they have explored every possible opportunity to keep children safely with the nonoffending

parent. Additionally, caseworkers should consult with the perpetrator's intervention services provider and his or her probation or parole officer, where applicable, in order to hold the perpetrator responsible and to maintain some legal leverage. As in every CPS case, out-of-home placement should be the last option, and caseworkers should work with the adult survivor to develop safe alternatives.

The courts have also addressed this issue. A 2001 federal lawsuit challenged the New York City Administration for Children's Services' routine practice of removing children from their homes when the children witnessed domestic violence. The New York State Court of Appeals was asked to resolve constitutional questions in the case. It found that a child's exposure to domestic violence against a caretaker, without evidence of serious or potential harm to the child and of a caretaker's failure to exercise a minimum degree of care, is insufficient for a finding of "neglect" under New York law and does not presumptively require removal[1] (Copps, 2009; Child Welfare Information Gateway, 2003; FindLaw, 2017b).

As the American Bar Association Commission on Domestic Violence wrote, this ruling set a precedent for the rest of the country by "analyzing and dispelling many of the myths that inform child protective services intervention in child welfare cases (Lansner, 2008, last para.), for not assuming that removal was a "safer" course of action and for beginning to shift agency practice to hold perpetrators more accountable (Copps, 2009).

If children are removed from the home, it is important to ensure that the foster family (or other out-of-home caregiver) is trained in and understands how to help a child who was exposed to domestic violence. As discussed later in this chapter, a trauma-based approach is key, because the foster child will likely have experienced complex trauma (i.e., experiencing/exposed to two forms of trauma, including physical abuse, sexual abuse, emotional abuse, neglect, or domestic violence). As one study found, compared to youth with other types of trauma, those with complex trauma histories had significantly higher rates of internalizing problems, posttraumatic stress, and clinical diagnoses (Greeson et al., 2011).

7.2 Family Group Decision-Making

Whether the child remains in the home or is removed, caseworkers may use a model called Family Group Decision-Making (also referred to as family team conferencing, family team meetings, family group conferencing, family team decision-making, or family unity meetings) to develop the family plan. The term refers to family intervention approaches in which family members come together to make decisions about caring for their children and to develop a plan for services (Child Welfare Information Gateway, n.d.-b).[2]

Child welfare has adapted this model for use with families, including those in which domestic violence is present. In these cases, the goal includes supporting efforts to enhance the protection and safety of survivors and children through a network of systems that provide services and perpetrator accountability (Child Welfare Information Gateway, 2003; National Association of Public Child Welfare Administrators, 2001; Carrillo & Carter, 2001). In domestic violence cases, the model incorporates the safety needs identified by

1 Nicholson v. Scoppetta, 820 N.E. 2d 840 (2004).

2 For more on this model, go to https://www.childwelfare.gov/topics/systemwide/assessment/approaches/family/.

survivors and builds on their strengths. It helps survivors expand on their existing protective strategies and resources by linking them with informal and formal resources that they have not accessed. Focusing on a family's strengths does not imply that problems, such as the perpetrator's abusive and controlling behavior, are to be ignored or minimized. Rather, strength-based practice promotes use of a family's coping and adaptive patterns, their natural support networks, and other available resources (National Association of Public Child Welfare Administrators, 2001).

There are ways to facilitate the meetings that address the concerns that arise from domestic violence in terms of preparing for, holding, and ending the meeting. If it is appropriate for the perpetrator to attend, caseworkers should:

- Choose a safe location and arrange for the perpetrator and the survivor to arrive and leave separately because a team meeting may increase the risk of violence
- Ensure that there are supportive individuals present for the survivor
- Arrange for security and be prepared to stop the meeting if things begin to escalate

If safety remains an issue, caseworkers should suggest meeting separately with the perpetrator and the survivor or have one party participate by phone or other electronic means, e.g., Skype or FaceTime.

Researchers have conducted studies on the use of family group decision-making with families experiencing domestic violence. One study found that most family members reported increased family unity without compromising safety, and measures independently demonstrated increased child and adult survivor safety (Pennell & Burford, 2000). In a minority of cases, survivors reported feeling worse because of separation from their children or disappointment in a relative caregiver's lack of follow-through following the conference. For more on this model, see *Caseworker* manual Chapter 8.

Peacemaking Programs

Peacemaking is a traditional Native American approach to justice, which focuses on healing and restoration rather than punishment that is being used in some tribal communities. While its implementation varies among tribal communities, it generally brings together the disputants, along with family members, friends, and other members of the community to speak about how the event, crime, or crisis affected each person. The goal of peacemaking is not only to resolve the immediate issue but also to heal the relationships among those involved and to restore balance to the community. In court-referred cases, the agreement reached is put on the record (Center for Court Innovation, n.d.). For more information, go to http://www.courtinnovation.org/topic/tribal-justice.

7.3 Developing the Family (or Case) Plan Basics[3]

Chapters 7 and 8 of the *Caseworker* manual detail the steps needed to assess the family more comprehensively once they enter the child welfare system and to develop the family plan. This section adapts those chapters and reviews the basics to supply context. The next section then examines how to develop a family plan in cases involving domestic violence.

3 Adapted from Chapters 7 and 8 of DePanfilis, D. (in press), *Caseworker* manual.

During the comprehensive family assessment stage, the caseworker engages the family to gain a greater understanding about its strengths, needs, and resources to tailor strategies to achieve relevant outcomes. What is learned at this stage will support the caseworker in providing or arranging change strategies to be developed in the family plan. The assessment also focuses on understanding any effects of child maltreatment, including trauma symptoms that may need change-oriented treatment or intervention. (Trauma-informed services are discussed later in this chapter and in detail in Chapter 9 in the *Caseworker* manual.) The specific objectives of the comprehensive assessment include:

- Developing and implementing a plan for meeting with all family members, extended family, and others who may have information about the risk and protective factors that led to the need for this family to receive continuing child welfare or community-based intervention
- Approaching each family with cultural sensitivity to communicate respect and interest in understanding the worldview of the child and family's situation and how accepting help may be perceived
- Attending to basic and concrete needs, as necessary
- Supporting families to move forward in considering the need to change behaviors and conditions that create risk of maltreatment and/or threaten safety
- Evaluating or reevaluating the safety plan to assess the need for adjustment, while the comprehensive family assessment continues
- Engaging other professionals and parent/child advocates (as determined by family members) who may wish to contribute to understanding and to provide support to family members through the assessment process; they may also become key components of the family plan and ongoing formal or informal intervention
- Considering the use of observational or self-report assessment tools to further explore risk and protective factors related to risk or risk reduction
- Assessing for trauma symptoms or other apparent effects of child maltreatment in the child and survivor, and engaging with other professionals as needed

The goal is to produce a comprehensive family assessment summary that synthesizes key information about the children, parents, family, culture, and environment. Its purpose is to understand strengths and needs of individuals and the family to target outcomes that will increase safety, decrease risk, and address the consequences of past trauma and maltreatment. There are certain situations that indicate the need for interdisciplinary professionals to contribute to this comprehensive understanding, and the caseworker should consult other providers when there is a specific client condition or behavior that requires additional professional assessment, such as domestic violence, substance use disorder (SUD), or mental illness.

The caseworker then schedules various meetings, e.g., with individual family members, parents and other caregivers, the children (where appropriate), etc. to review the assessment. At the conclusion of the family assessment meeting, the worker and family arrive at agreement on the changes necessary to keep children safe and to reduce the risk of maltreatment. These changes inform the family plan, which is used as a mechanism to finalize targeted outcomes at the child, parent, and family level; SMART (**S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime limited) goals; and action steps. These will then spell out the interventions that will support family members to achieve these outcomes and goals. They should:

- Be unique to each family
- Be measurable
- Match the most important risk and protective factors identified during the assessment process (e.g., enhance protective capacity, increase social support, improve family communication, reduce parenting stress)

7.4 Developing the Family Plan for Survivors, Children, and Perpetrators Experiencing Domestic Violence

The primary goal of developing the family plan with survivors and their children is to promote enhanced protection and safety and to hold perpetrators accountable for their abusive behaviors. Intervention with families experiencing domestic violence requires ongoing risk assessment and safety planning to ensure that service recommendations and outcomes are practical, viable, and achievable. Caseworkers can help accomplish this by consulting domestic violence specialists and incorporating their expertise in case plan recommendations. It is key to remember that safety planning occurs throughout the life of a case, not just at the first contact a worker has with the family. Safety options and safety plans are likely to change over time, adapting to the circumstances and available resources as they change.

Just as in the family assessment, caseworkers should involve the survivor in case planning efforts by validating experiences, identifying strengths, and building on those strengths to help him or her regain control over his or her life and achieve safety (Ganley & Schechter, 1996). In doing so, caseworkers can help prevent survivors from feeling that they are forced into receiving services. Often, when caseworkers prescribe a set of family plan activities without the survivor's input this may mirror the perpetrator's behavior, as it dictates control over choices. Caseworkers can empower survivors by allowing them to make informed decisions regarding safe alternatives and services that will enhance their children's safety.

Separate family plans are recommended in cases involving domestic violence. Writing separate case plans for the survivor, child, and perpetrator achieves two goals: (1) enhancing the survivor and children's safety, and (2) holding perpetrators accountable for their actions and abusive behaviors. For safety measures, caseworkers should develop separate plans when the survivor plans to:

- Leave the home and is coordinating with service providers or other support systems (e.g., church, family members, and friends)
- Obtain a restraining order against the perpetrator
- Call the police as a safety option
- Contact the probation or parole officer regarding violations of the perpetrator's probation or parole terms

The survivor and children's plans do not need to be shared with the perpetrator. Caseworkers can seek the survivor's guidance on service recommendations to include in the perpetrator's family plan, when appropriate, while also following agency guidelines in developing the plan.

Family plan activities are strengthened through collaboration with domestic violence advocates or specialists. The advocates can provide consultation on the feasibility of recommended services, educate survivors on available or appropriate services, and assist caseworkers with creative ways to engage and help survivors and their children. Collaborating with other community service providers (e.g., those who treat or help with SUD, mental health, economic, and housing services issues), law enforcement, and the courts also can enhance CPS efforts. Any co-occurring issues in addition to domestic violence will necessitate working with other service providers to help alleviate family conditions that affect children's safety. Caseworkers also should assist survivors, either directly or by collaborating with others, in the court proceedings process.[4] **Exhibit 7.1** lays out what the family plan's services should include for the survivors, children, and perpetrators.

Exhibit 7.1. Family Plan Activities for Families Experiencing Domestic Violence (Mederos, n.d.; National Center on Domestic Violence, Trauma & Mental Health, 2012; Child Welfare Information Gateway, 2003)

For survivors

- Safety planning with CPS and domestic violence specialists
- Individual and/or group counseling with a domestic violence program
- Specialized assessment services or crisis counseling with a survivor's domestic violence advocate
- Legal advocacy, housing, medical, economic, and daycare services
- Shelter or transitional living services
- Visitation or supervised exchange services, if necessary
- Review of domestic violence information regarding the dynamics of domestic violence, survivors' resources, and its effects on the children
- Mental health and/or substance abuse treatment referrals, if applicable.

For children

- Safety skills development
- Specialized individual and/or group counseling for children exposed to domestic violence
- Mentoring and afterschool program referrals
- Daycare or Head Start referrals
- Safe visitation and exchange services
- Community-based enrichment programs

For perpetrators

- Safe visitation and supervised exchange services
- Compliance with probation or parole, restraining orders, and custody orders
- Parenting programs that include a focus on domestic violence issues
- SUD treatment and/or mental health referrals, if applicable
- Perpetrator intervention programs
- Fatherhood programs, when appropriate

4 Additional information on working with the courts is available in the user manual, *Working With the Courts,* at https://www.childwelfare.gov/pubs/usermanuals/courts/.

In the initial stages of developing the family plan, activities that are not recommended until further risk assessment include (Child Welfare Information Gateway, 2003; National Association of Public Child Welfare Administrator, 2001; Bancroft & Silverman, 2002; Demaris, 1989; Gondolf, 1988; Hastings & Hamberger, 1988; Tolman & Saunders, 1988):

- Couples or family counseling
- Court or divorce mediation
- Visitation arrangements that endanger the survivor and children or are in conflict with a restraining or custody order
- Anger management classes

Participation in these types of services can increase risks to survivors and their children. Couples counseling and divorce mediation is based on the assumption that partners who possess equal amounts of power can negotiate a resolution. In abusive relationships, however, there is an unequal balance of power between survivors and perpetrators, as well as a fear of physical violence or coercive attacks when the perpetrator feels challenged. Couples counseling or divorce mediation is acceptable only when the survivor feels equally empowered and is not afraid that his or her participation will result in retaliation by the perpetrator. Anger management classes often are not appropriate because they do not focus on the overarching patterns of behavior common in abusive relationships. In addition, anger management classes are not effective in holding perpetrators accountable because it implies that they only have a problem with "managing" their anger, as discussed in Chapter 3. It is also important to note that batterer's intervention programs have mixed evidence of effectiveness (Eckhardt et al., 2013). 13).

Finally, as discussed throughout this manual, perpetrators are known to escalate their coercive and violent behaviors during times of separation and divorce. Visitations with the children provide perpetrators with access to their partners where they may try to intimidate and threaten them. Thus, caseworkers need to be especially cautious when scheduling agency visits with the perpetrator and the children. Caseworkers also should be certain that visitation schedules do not violate any existing restraining or child custody orders; it may be useful for the caseworkers to obtain a copy of the court orders to prevent conflicts. Caseworkers should adapt the family plan to include these services only when the survivor and service providers believe they are reasonably safe options.

7.5 Using a Trauma-Focused Approach

To provide trauma-informed care to families involved with child welfare, the caseworker and providers must understand the impact of trauma on child development and learn how to minimize its effects without causing additional trauma (Child Welfare Information Gateway, n.d.-b). This is especially true with children and families experiencing the trauma of domestic violence and maltreatment. Chapters 6 and 9 in the *Caseworker* manual explore using a trauma-focused approach in child welfare services. This section explains how to incorporate that approach when working with domestic violence.

In a meta-analysis looking at the effects of children's exposure to domestic violence, Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe (2003) caution that domestic violence is one of many adverse experiences a child may experience, making it hard to draw causal connections when there are multiple risk factors present, as there would be in child maltreatment cases. However, as the myriad effects on survivors and children exposed to domestic violence in Chapters 4 and 5 illustrate, whatever the cause, trauma is often the result. While activities in the family plan for the survivor may include trauma-based services, this section concentrates on that approach for children.

When developing the family plan, caseworkers should recognize that children's experiences of domestic violence are individual and varied. As the National Center on Domestic Violence, Trauma & Mental Health (2017) writes, some may do well and may not need additional supports as they grow into adulthood. Children living in homes where they have either experienced domestic violence from an early age or have been exposed to severe and prolonged violence are at greater risk for developing trauma-related responses, which may affect their growth and development. This traumatic impact may affect children and their nonoffending parents, their relationships with each other, and the primary relationships within their families that children rely upon for safety, nurturance, and protection from harm. Based on the research about resilience, the National Center (2017) maintains that the single most important resource for children in fostering resilience and healing from the traumatic effects of experiencing domestic violence is a secure attachment relationship with a loving parent or caregiver over time.

Also, when developing the family plan, it is key to assess both the exposure to and impact of complex trauma. The National Child Traumatic Stress Network (n.d.-a) explains that children can develop problems across many areas of functioning. In addition, their self-image is profoundly affected. Children with complex trauma often end up in multiple child-serving systems (e.g., mental health, child welfare, education, juvenile justice, and others) with complex needs. The behaviors resulting from the trauma of DV may cause children to be diagnosed with psychiatric disorders that may/may not be accurate (e.g., bipolar disorder, attention deficit hyperactivity disorder, etc.) or be prescribed numerous medications to address their symptoms, especially when the professional making the diagnoses is unaware of their trauma histories. Additionally, the providers may each use different frameworks to understand the children and have varying degrees of understanding of complex trauma. This can leave children with complex trauma at risk of being misunderstood, misdiagnosed, and thus "mistreated." Although being misdiagnosed and/or mistreated can occur with complex trauma, the rate and frequency are unknown. Therefore, it is important that, when developing the family plan and advocating for services and change strategies, the caseworkers coordinate with all the providers to develop a common framework for assessment of complex trauma that can work within the context of each particular system (National Child Traumatic Stress Network, n.d.-b).

When assessing for trauma, the caseworker should use a clinically trained provider who understands child development and complex trauma. Ideally, the assessment should involve a multidisciplinary team. The assessment's recommendations then serve as one of the bases for developing the family plan to be individualized and effective.

Resources

The PTSD: National Center for PTSD provides a list of child measures of trauma and PTSD at https://www.ptsd.va.gov/PTSD/professional/assessment/child/index.asp

Once the caseworker and team have received the recommendations and are starting to develop or to update the plan, how they work with the children and survivor will be crucial. Futures Without Violence produced a resource, entitled *16 Trauma-Informed, Evidence-Based Recommendations for Advocates Working with Children Exposed to Intimate Partner Violence,* as listed in **Exhibit 7.2.**[5] The stated goal of the recommended approaches is to build resilience and competence in children and parents, which usually begins with focusing on the parents. Strategies such as increasing parenting effectiveness, assisting parents in addressing mental health issues, and supporting parents to live in safe and supportive environments are closely connected to children's well-being (DeBoard-Lucas, Wasserman, McAlister Groves, & Bair-Merritt, 2013; Graham-Bermann, Gruber, Howell, & Girz, 2009).

5 For more detail on these recommendations, go to http://promising.futureswithoutviolence.org/files/2013/08/16-Trauma-Informed-Evidence-Based-Recommendations-For-Advocates.pdf.

Exhibit 7.2. 16 Trauma-Informed, Evidence-Based Recommendations for Advocates Working with Children Exposed to Domestic Violence (DeBoard-Lucas et al., 2013)

1. Understand that children of all ages, from infancy through adolescence, are vulnerable to the adverse impact of domestic violence exposure.
2. Establish a respectful and trusting relationship with the child's nonoffending parent.
3. Let survivors and children know that it is OK to talk about what has happened, if the child would like to engage in this type of discussion.
4. Tell children that violence is not their fault. If they say that it is or that they should have stopped it, tell them directly (or coach the survivor to do so) that they are not responsible for violence and that it is not their job to intervene.
5. Foster children's self-esteem by showing and telling them that they are lovable, competent, and important.
6. Help children know what to expect (e.g., what will happen next or if there will be a change in staff). Help the survivor set routines for the children.
7. Model and encourage good friendship skills. By demonstrating appropriate and positive social interactions and providing direct instructions on how to treat their peers with respect and kindness, adults can teach children how to be better friends.
8. Help survivors teach their children how to label their emotions. Discuss the use of emotion words with them to describe their child's sadness, anger, happiness, and worry.
9. Use emotion words to help children understand how others might feel during disagreements. Children exposed to domestic violence often need assistance in describing and identifying both positive and negative emotional states.
10. Recognize that when children are disruptive, they are generally feeling out of control and may not have the ability to use other strategies to express themselves.
11. Incorporate the family's culture into interventions, and support survivors and children to explore the values, norms, and cultural meanings that affect their choices and give them strength.
12. Actively teach and model alternatives to violence. Help children learn conflict resolution skills and nonviolent ways of playing.
13. Involve survivors in conversations with their children about the children's views of the abuse.
14. Discuss child development with survivors. They often report significant rates of parenting stress and frequently have developmentally inappropriate expectations for their young children's behavior.
15. Address survivors' parenting stress.
16. Work with survivors to help them extend both their own and their child's social support network.

For more on helping children and families exposed to domestic violence and to develop effective and relevant family plans, Promising Futures provides best practices at http://promising.futureswithoutviolence.org/. Child Welfare Information Gateway also provides numerous resources on building trauma-informed systems, assessing and treating trauma, addressing secondary trauma in caseworkers, and trauma training at https://www.childwelfare.gov/topics/responding/trauma/. It also offers trauma resources for caseworkers, caregivers, and families.

7.6 Documenting Domestic Violence in Child Protection Case Records[6]

It is important to document domestic violence in child protection case records from the initial assessment/investigation through case closure. Disclosing domestic violence can be a difficult process for survivors and their children and can elicit feelings of shame, guilt, and fear because of reluctance to reveal the violence in their lives. Caseworkers can demonstrate their sensitivity to domestic violence issues by safeguarding information that can compromise survivors and their children's safety and by engaging in documentation practices that reflect competent case practice with families affected by domestic violence.

The goals of documenting domestic violence in cases are to:

- Minimize perpetrator-generated risks to survivors and their children
- Avoid language that blames survivors for the violence
- Hold perpetrators accountable for their abusive behavior
- Identify the survivor and the perpetrator of domestic violence
- Document the effects of domestic violence on the abused partner and children
- Delineate the specific domestic violence tactics and behaviors that are posing a safety threat to family members.

Skillful documentation of domestic violence issues also can be helpful and serve as a learning tool for those who have access to the case record. For example, case notes and court reports can educate family court judges and parent attorneys about the complexities of domestic violence dynamics, the challenges faced by survivors, and the reasons survivors may struggle with meeting certain conditions of a family plan.

As discussed earlier regarding the confidentiality issues that often arise, documentation and disclosure also can increase the threat of harm to survivors and children. Therefore, the following guidelines and examples can help caseworkers reduce these risks when information must be shared (Child Welfare Information Gateway, 2003; Massachusetts Department of Social Services, 1995):

- Any information in the case record or public documents (e.g., court records) pertaining to a confidential address of the survivors (e.g., shelter location or relocation to new housing) should be flagged and never shared with the perpetrator.
- Disclosures made by the survivor and children regarding their safety plan or their accounts of the violence should not be shared with the perpetrator.
- When information must be shared in court proceedings, survivors should be notified in advance of the court date, so they may plan for their safety. In some states, the caseworker or agency attorney can ask for the information to be kept sealed, or the survivor can appoint an agent on his or her behalf.
- In cases where disclosure of the domestic violence is made during court proceedings, the caseworker, agency's attorney, or survivor's attorney may want to share with the judge the possible consequences of such disclosure and ask that it be kept sealed.
- The safety of the survivor and the children must be considered in the planning of case transfer. To protect the survivor and children's confidentiality (e.g., new address for the survivor), the case record should not only be flagged but discussed with the new caseworker so that he or she will receive this information and know to safeguard it from the perpetrator.
- All documentation of domestic violence (e.g., case dictation, affidavits, court petitions, court reports) should be written in a manner that holds the perpetrator responsible and avoids blaming the survivor.

6 Chapter 12 of the *Caseworker* manual provides extensive detail on how to provide documentation in the case file.

Examples of Case Documentation Practices

Inappropriate case documentation:

- "There is domestic violence between the parents."
- "There is a history of domestic violence, but the children were not exposed."

The language is vague and neither identifies a perpetrator nor what his or her behaviors have been. It does not identify how the caseworker determined the children were either unexposed or may have been harmed.

- "The children reported that Mom and Dad fight in front of them. The mother was asked to ensure that the children did not witness any fighting."

Fighting is not necessarily domestic violence, and, without clarity on naming abusive behaviors, it is unclear if this is a domestic violence case or parents who argue. In addition, if there is domestic violence it has not been made clear who the perpetrator is. Asking the survivor to ensure the children do not witness fighting may not be in her control if she is being abused and also puts the responsibility on the survivor rather than the perpetrator.

Appropriate case documentation:

- "The father has a history of abusive behaviors. These include (1) limiting the mother's access to the children by bringing the children to his mother's (paternal grandmother) home when he cannot be present with the children and survivor together and (2) preventing the survivor's access to counseling by taking the bus pass and/or showing up at the counselor's office to tell the mother to leave."

The perpetrator's coercive and controlling behaviors are important to document as they may affect the survivor's well-being, ability to parent, access to services, relationship with the children, and other areas of her or his life.

- "The father has chosen to be abusive in front of the children. All of the children have seen him slap the survivor on at least five occasions. The oldest child (age 10) witnessed him push the survivor down the stairs 4 years ago. Last month, he allegedly strangled the mother while she was holding their 1-year-old child. The older children report being afraid of their father and of seeing him hurt her; they said that they cannot sleep unless they are with their mother."

This clearly shows examples of the perpetrator's use of physical violence that can inform an assessment of level of dangerousness. It also uses a timeline to determine that, in this instance, the violence appears to be escalating. Finally, good documentation about domestic violence perpetrators' behaviors should be able to connect to the children's exposure to harm to or impact on the children.

- "The mother has made efforts to protect the children. She has a plan in place with the 8-year-old child to go to the downstairs neighbor's house if she gives her son a code word to do so. The mother has called 9-1-1 when the father has been violent, but has also called the paternal grandfather, who has intervened to protect the mother and his grandchildren. The mother has access to keys to the car and keeps them hidden in a place that can be accessed if she and children need to escape. On one occasion, she used this plan and drove the children to stay at an aunt's house until it was safe to return."

Being able to describe the survivor's specific actions that have been protective or attempts to protect the children is important in assessing her or his protective capacity. It also demonstrates the active role survivors have taken that can provide caseworkers with examples of previously successful efforts to build upon when developing a case plan.

7.6 Closing a Case[7]

Case closure is a critical decision that involves a final and careful analysis of the mitigation of harm posed by the domestic violence and its effect on securing safety for the child. Some caseworkers focus on family status changes or perpetrators' activities rather than on behavioral changes. They may think that if a survivor leaves an abusive relationship or if the perpetrator is removed from the home, completes a perpetrator's intervention program, or stops physically assaultive behaviors it is sufficient evidence to terminate a case. However, these are not indicators that a perpetrator has taken accountability or made behavioral changes that will keep the child and survivor safe.

Because some perpetrators are very skilled at manipulative behavior to avoid detection and accountability, caseworkers should be judicious in believing that survivors and children are at lower risk for harm when perpetrators express remorse for their violent behaviors, are vehement in their claims that they will not engage in violent behavior or have completed a perpetrator intervention program. The threat of harm may still be present for survivors and children as some perpetrators are likely to revictimize them despite completion of a perpetrator intervention program. (Demaris & Jackson, 1987; Edleson & Gruszynski, 1988; Gondolf, 1987; Petrick, Gildersleeve-High, McEllistrem, & Sobotnik, 1994; Tolman & Edleson, 1995; American Bar Association Commission on Domestic Violence, n.d.; Florida's Governor's Task Force on Domestic and Sexual Assault, 1997). Therefore, it is vital that the caseworker listens to any concerns or fears that the survivor or children have about closing the case and find ways to address them together.

In addition to conducting the final risk assessment for case closure, other criteria that caseworkers should consider in determining whether the survivor's and children's safety has been reasonably, if not absolutely, assured include the following:

- The survivor and children, when interviewed separately, report feeling safer.
- The survivor has knowledge of and access to relevant support services, information, and safety options.
- The survivor and the perpetrator understand the effects of domestic violence on their children.

The next chapter looks at ways that the caseworker can remain safe and provide self-care when dealing with cases involving domestic violence.

7 Chapter 11 in the *Caseworker* manual details case closure.

Highlights

1. The decision of whether to substantiate a report of child maltreatment (or refer for services, even if unsubstantiated or deferred to a differential response track) is made at the conclusion of the investigation, once all the information is collected from all sources. The worker should base the decision on both the actions of the perpetrator and the capacity and willingness of the survivor to take appropriate actions to protect the child.
2. If a report is substantiated, the caseworker continues the assessment to guide the development of the family plan.
3. Once a decision has been made to substantiate a case, the next step is to determine whether the child can safely remain in the home. Unfortunately, obstacles in deterring the perpetrator's violent behavior have led some child welfare agencies to believe that protective custody is the only viable method to ensure children's safety, an act that can further traumatize the adult and children survivors. However, legal rulings have challenged that premise, resulting in changes to practice.
4. Child welfare has adapted the family group decision-making model to work with families involving domestic violence. Its goal includes supporting efforts to enhance the protection and safety of survivors and children through a network of systems that provide services and perpetrator accountability.
5. When developing the family plan, the caseworker engages the family to gain a greater understanding about its strengths, needs, and resources in order to tailor strategies to achieve relevant outcomes, which will increase safety, decrease risk, and address the consequences of past trauma and maltreatment. Separate family plans for the nonoffending parent and the perpetrator are recommended in cases involving domestic violence.
6. Children who have either experienced domestic violence from an early age or have been exposed to severe and prolonged violence are at greater risk for developing trauma-related responses. Therefore, the caseworker should incorporate a trauma-focused approach in working with the family.
7. Case records and forms should accurately identify the survivor and the perpetrator of domestic violence, document the effects of domestic violence on the abused partner and children, and delineate the specific domestic violence tactics that are posing a safety threat to family members. However, it is important to remember that documentation and disclosure can also increase the threat of harm to survivors and children, and caseworkers should take steps to address those concerns.
8. Case closure is a critical decision that involves a final and careful analysis of the mitigation of harm posed by the domestic violence and its effect on securing safety for the child.

Chapter 8: Enhancing Caseworker Safety and Wellness in Child Protection Cases Involving Domestic Violence

Given the involuntary nature of child protective services (CPS) intervention (except in the case of voluntary differential response, as discussed in Chapter 6), every case has the potential for unexpected confrontation. Cases involving domestic violence may pose additional risks of threats and violence for caseworkers. Therefore, they need to understand the situations that might prompt violent confrontations and learn ways to protect their own safety. It is also important that caseworkers working with these families have support from their supervisors and agencies.

While there is research or material written about enhancing caseworker safety and wellness (referred to in earlier literature as self-care) in general, there is less about their safety when dealing with domestic violence in the families they serve. Chapters 13 and 14 of the *Caseworker* manual discuss worker safety, wellness, and effective supervision in more detail. This chapter examines:

- The impact of domestic violence on safety for caseworkers
- Steps to take to enhance caseworker safety
- Case examples
- The roles of supervisors in supporting caseworker safety and wellness

8.1 Safety Considerations for Caseworkers When Domestic Violence Is Involved

In general, people experience apprehension when confronted by a violent or emotionally charged situation or person. Domestic violence situations can potentially result in serious harm, injury, or death for anyone involved, not only the families. A recent report noted that domestic violence calls are the most dangerous for responding law enforcement officers (Breul & Keith, 2016, p. 67). Therefore, it is common for caseworkers to have feelings of fear or discomfort when they receive a case involving domestic violence. Some caseworkers lack the necessary knowledge and experience to address the dynamics involved in domestic violence, while others may find that their own personal history or beliefs about domestic violence and maltreatment provoke feelings of distress or anger. Fusco (2013) wrote about caseworkers' fears for their own safety and how their practice is affected when they personally know a survivor or perpetrator. In addition, some child welfare activities can incite a violent confrontation because they threaten the perpetrator's control and authority over the home and family members.

Several studies found that caseworkers' common responses to domestic violence were avoidance or minimization (e.g., focusing on alcohol abuse rather than domestic violence, not wanting to "offend" perpetrators by talking

about their use of violence) and examined the reasons for this avoidance and minimization (Hunt, Goddard, Cooper, Littlechild, & Wild, 2016; Virkki, 2008; Macdonald & Sirotich, 2005; Newhill & Wexler, 1997; Shin, 2011; Stanley & Goddard, 2002, Humphreys, 1999). They found that this tendency to disregard signs of possible risk for aggressive behavior (especially among child welfare workers, who often face more potentially violent situations than other social workers) is not only because trust is built into the helping professions and plays an important role for the caseworkers' sense of purpose but also because it serves as a coping strategy to deal with threatening behavior; therefore, it is difficult for them to accept the idea that a client would hurt them.

These studies highlight the need for extensive training and supervision for caseworkers when working with families dealing with domestic violence. Because violence is already a dynamic in many of these families, other family members, including the children and/or survivor, also may resort to violence when interacting with others, including caseworkers. Specific situations and child protection procedures that can increase risks to caseworkers, survivors, and children include:

- Preparation by the survivor to leave the relationship, seek shelter, initiate divorce proceedings, or obtain a restraining order
- Receipt by the perpetrator of agency documentation with allegations of neglect or abuse, or information about how child welfare services will continue to be involved with the family
- Allegations made directly to the perpetrator regarding domestic violence or child maltreatment
- Requests by the perpetrator for information regarding the survivor and children's location
- Activities involving the children's removal from the home
- Pursuit of permanency planning goals of adoption and termination of parental rights
- Release of the perpetrator from jail or confrontation with serious criminal charges and possible incarceration
- Court decisions that negatively affect the perpetrator regarding custody or visitation

Key Point

It is essential to understand the importance of assessing for levels of dangerousness (discussed in Chapter 3) not only for the survivor and family, but for the caseworker as well, in planning for safety.

Knowing as much as possible about an alleged perpetrator's history prior to any meeting will help child welfare staff engage him or her more safely. (As discussed in Chapter 7, information gathered in the screening and assessment phase should be included in the case notes.) Workers should pay particular attention to reports or arrests for assaulting a caseworker or a law enforcement officer, or to other potential threats or violence towards those providing services in the community. It is key that workers develop the habit of asking survivors how they think their partners will react to child welfare involvement as a step in assessing for the safety of workers. If a survivor answers that the worker might be in danger, the caseworker should take that very seriously and take significant precautions. In addition, if the survivor states that the worker will not be in danger but that talking to the perpetrator will lead to increased violence or danger to the family, workers should speak with their supervisors about whether or not it enhances child safety to engage the perpetrator; if it does, significant safety planning with the survivor should occur.

Caseworkers also should develop the habit of "checking in" with survivors after interviews with perpetrators. This practice helps the worker and survivor work as partners, which enhances the safety of survivors, children,

and workers alike. This "check in" does not mean sharing confidential information from the interview with the perpetrator. It can simply mean letting the survivor know that the perpetrator has left and whether there were any indicators of concern. When checking in, it is important to determine if the perpetrator is in the home or same location with the survivor, so the caseworker should ask first if the survivor is alone and/or can talk freely. If the survivor is not, then the caseworker can proceed with the check in using yes or no questions to enable the survivor to answer the caseworker without fear of upsetting the perpetrator or to inform the worker that he or she does not feel safe without alerting the perpetrator.

Examples of Caseworker Safety

A caseworker "checked in" with a survivor after meeting with a perpetrator. The survivor asked if the perpetrator seemed mad or agitated. The worker said that no, the perpetrator actually seemed quite calm. The survivor stated that this made her uncomfortable because the perpetrator was so rarely calm. She stated that she planned to stay at her mother's house until she got a better sense of her safety. This example shows that even seemingly unimportant details can help survivors plan for their safety and the safety of the children.

In another scenario, the worker called a survivor to say the perpetrator had left and that he was on his way home. An hour later, the survivor called the worker back and said the perpetrator had not come home and that the worker should make sure he was not lurking around the office. The worker alerted the building security, who did find the perpetrator in the parking lot waiting, with his intentions unknown. Checking in with survivors supports everyone's safety.

8.2 Steps to Enhance Caseworker Safety

As discussed in the earlier chapters, perpetrators of domestic violence frequently engage in manipulative behavior to escape detection of and the consequences for their violent and abusive behaviors. When perpetrators sense that calculating tactics, such as attempting to charm or collude with the caseworker, are not effective, they may resort to threatening behaviors to intimidate caseworkers into decreasing their involvement with the family. For example, the perpetrator may stare intently at the caseworker or act agitated by pacing the floor during an interview. Perpetrators may make subtle threats to "make trouble" for caseworkers by calling their supervisor or by warning them to "watch their back." Such actions should be documented in the case file.

If caseworkers have been confronted by an aggressive abuser or are uncomfortable with a potentially volatile situation, they should consult with their supervisor to discuss ways in which they can protect themselves. The National Association for Social Workers (NASW) (2013) established safety guidelines and emphasized the need for routinely practicing universal safety precautions with all clients and in all settings. It explained that a thorough understanding of the risk factors (individual/ clinical, environmental, and historical) associated with elevated risk for violence should inform safety assessments and development of safety plans as a matter of routine planning for all interactions with families. Agencies should also establish safety precautions when workers are asked to perform potentially dangerous tasks and use specific policies to reduce the risk of harm to social workers (NASW, 2013). While these guidelines do not deal specifically with domestic violence situations, several are pertinent when dealing with potentially violent situations. **Exhibit 8.1** lists other relevant safety guidelines.

Exhibit 8.1. Safety Guidelines When Dealing With Domestic Violence (NASW, 2015; Bragg, 2003; Massachusetts Department of Social Services' Domestic Violence Protocol, 1995)

- Adopt a proactive, preventative approach to violence management and risk.
- Receive training on working with perpetrators and conducting nonconfrontational interviews.
- Analyze and understand past incidents, and determine actions that can circumvent or avoid their reoccurrence (e.g., prior acts of violence).
- Conduct meetings or interviews with the perpetrator in the agency office or in a public place. If this is not possible, ask a supervisor (or get his or her approval to have a coworker or law enforcement official) to be present during any interaction with the perpetrator.
- Be aware of the surroundings when leaving the office or home, and park in a safe place.
- Notify coworkers or a supervisor that a potentially dangerous client is visiting the office, and provide the time and place of the interview. If possible, try to have a building security officer nearby.
- Ensure accessible exits when meeting with the perpetrator, and sit close to the door.
- Use technology appropriately and effectively to minimize risk:
  - Mobile safety devices that may incorporate GPS, audio/video recording, and/or silent panic buttons and have emergency contacts on speed dial
  - Agency phones, rather than personal phones, to reduce exposure of personal information
  - "Code" words or phrases to help workers convey the nature of threats to their managers or colleagues
  - Awareness of the destination having reduced reception for mobile devices (e.g., tunnels, rural areas)
- Keep the interior of the vehicle free from potential weapons (e.g., pens, pencils, magazines, books, handheld devices, hot beverages) when transporting family members.
- Provide addresses of visit and appointment times in the order scheduled, including:
  - Information about the clients being visited
  - Length of each visit (estimated arrival and departure times)
  - Information about the vehicle the caseworker will use (license number, make, model, color)
  - Change of plans to supervisor or designated agency representative (carry agency identification cards at all times)
- Attempt to avoid verbal confrontations or debates with the perpetrator as this may escalate the situation.
- Refrain from giving the perpetrator the sense that one is afraid. Caseworkers who feel threatened should try to de-escalate the situation by explaining that the perpetrator's anger is misplaced, and the caseworker simply wants to help the family. Caseworkers should then immediately end the interview or visit.
- Inform the survivor if the perpetrator's anger has escalated, posing a risk to the survivor or the children.
- Engage in safety planning to address possible harm to the survivor, children, or caseworker.

Child welfare agencies can provide additional resources that help caseworkers feel more comfortable and safe when they intervene in domestic violence cases. Supervisors can advocate that caseworkers have access to cellphones, debriefings, and caseworker safety planning efforts. Enhanced building security, secure meeting space, and protocols requesting law enforcement assistance should also be provided to staff. Finally, CPS agencies can develop human resource policies that take a "zero tolerance" approach to violence by ensuring caseworkers receive agency assistance that is supportive and confidential.

8.3 Role of Supervisors, Managers, and Administrators in Supporting Caseworkers' Safety and Wellness

Supervisors, managers, and administrators usually do not have frequent or direct contact with families experiencing domestic violence, but they have an instrumental role in ensuring that families have safe outcomes. They play a critical part in establishing an agency culture that recognizes the additional safety factors (for caseworkers and families) in cases involving domestic violence. Supervisors, managers, and administrators can set a positive example by attending agency- and community-based domestic violence trainings; participating on interagency committees and advisory boards; and advocating for domestic violence protocols, resources, and assistance for staff. By staying current on relevant issues involving overlapping domestic violence and child maltreatment, supervisors can assist caseworkers by remaining sensitive to the needs of these families and by guiding competent case practice.

Supervisors should provide support for caseworkers who are intimidated or afraid of working with families experiencing domestic violence, as well as validate these feelings as normal. It is important to demonstrate that they are available to discuss staff concerns and will help caseworkers alleviate or manage their apprehension. Developing a caseworker safety plan, accompanying caseworkers on home visits, or allowing caseworkers to travel in pairs are some of the ways supervisors can enhance the safety for their staff. As discussed earlier, supervisors can advocate that their staff have access to numerous resources, e.g., cell phones with GPS applications activated, panic buttons, or security assistance, which can increase the comfort levels of caseworkers responding to potentially volatile situations (NASW, 2013; Aron & Olson, 1997). Managers and administrators can budget for and provide safety devices for the field and in buildings.

David Mandel (2009), who has trained numerous child welfare professionals and developed the Safe and Together™ model (detailed in Chapter 9) maintains that supervision plays a critical role in determining both the quality and consistency of case practice in those involving domestic violence. The expectations of supervisors determine caseworkers' priorities, and supervisors make the critical decisions regarding case substantiation, transfer, and removal. With families experiencing domestic violence, it is the supervisor who reviews the caseworker's discussion with the survivor about both safety planning and the children's well-being (Mandel, 2009).

Therefore, when working with these families supervisors need to set expectations for workers on engaging perpetrators and partnering with survivors. They play a pivotal role in (Blythe, Hefferman, & Walters, 2010):

- Assessing to what degree workers are appropriately addressing special issues in their daily work
- Determining what obstacles are interfering with workers following a specialized domestic violence safety protocol and in brainstorming ways to overcome those obstacles
- Establishing when training is needed

Worker safety is paramount. Supervisors should both encourage workers to look at perpetrator history to better understand the potential risk and check in with the worker to make a plan for safety for any engagement. They should also give workers tacit permission to trust their instincts when engaging with perpetrators. Specific supervisory and administrative activities that can provide additional support to caseworkers confronted with these complex and challenging cases follow.

Providing oversight and review of appropriate child welfare practices. Every stage of the CPS process, from intake through case closure, presents a critical, decision-making juncture. Supervisors may need to provide additional guidance to caseworkers who are trying to make difficult decisions and recommendations that will not compromise the safety of survivors and children (or caseworkers) (Aron & Olson, 1997).

Developing specialized policies or protocols. This includes providing additional training and practice opportunities for cases involving domestic violence that can increase knowledge and skills for supervisors and caseworkers. It is key that supervisors and managers are knowledgeable about and enforce compliance with specific agency procedures for these cases to help caseworkers integrate specialized, case-practice guidelines in their assessments and interventions. Supervisors should continue to monitor and enforce compliance with agency protocols as a means to determine caseworker capability with cases involving domestic violence (Aron & Olson, 1997).

Supporting and encouraging collaborative relationships. Managers and administrators should maintain relationships with other service providers' management to seek opportunities to improve community capacity in this area. Supervisors should encourage staff to partner with service providers and other community agencies that can offer additional consultation on domestic violence assessment and intervention. They also can encourage caseworkers to access domestic violence expertise and resources, which might be located internally in the form of specialized domestic violence staff or co-located domestic violence service providers that are available for guidance and assistance. Cross-training is another approach to foster collaboration between child welfare and domestic violence programs. Supervisors and administrators who support caseworker participation in cross-training opportunities demonstrate their commitment to promoting competence in achieving safe outcomes for families experiencing domestic violence (Fusco, 2013; Aron & Olson, 1997). The next chapter discusses some of these collaborations in more detail.

Practicing skills. Supervisors and workers should also practice their de-escalation skills through group consultations, internal training, role playing, and supervisor consults. Workers may practice recognizing potential triggers and using de-escalation skills with their supervisors in advance of a meeting about which the worker is concerned. They can practice using language and tone so that, if faced with an escalating situation, they are prepared to use these skills. The supervisor and worker can also work on how workers should end the de-escalated meeting calmly and then quickly and safely get away, understanding that there is no information so important that a worker needs to be in danger to obtain it (Aron & Olson, 1997).

Example of Caseworker Safety

A caseworker and his colleague, a domestic violence specialist, met with a perpetrator. The court had barred the perpetrator from seeing his children for a period of time, and the caseworker was just beginning to complete an intake with the family. The father had been described as "volatile" in a police report, so the worker chose to meet with him in the child welfare office. During the meeting, the father kept saying, "You need to let me see my kids." The caseworker explained that was not his decision but the judge's. The father said it repeatedly, and his body language tightened up. He then said, "I'm really going to hurt someone if I can't see my kids."

The worker tried to finish the assessment tool questions. The domestic violence specialist, however, interjected and apologized, saying that she had to end the meeting as an emergency came up. She told the father they would call him to finish the conversation as soon as possible and reassured him that his concerns were noted. As the father walked out, the specialist alerted the office security guard to be aware if the father came back into the office.

After the meeting, the specialist, caseworker, and caseworker's supervisor met to debrief. The supervisor assured the caseworker that he would rather have him not finish the assessment tools and instead follow the cues of the father, which indicated that the meeting needed to end.

By paying attention to his behavior and language and following the specialist's lead, the caseworker and specialist were able to de-escalate the situation and safely end the engagement.

8.4 Role of Supervisor and Agency Support in Addressing the Effects of Trauma

Supervisor and administrative support is crucial not only at the individual caseworker level, but at the agency level as well. Chapters 13 and 14 in the *Caseworker* manual address this as well. Ferguson (2011) found that workers' state of mind and the quality of attention they can give to children was directly related to the quality of care and attention they themselves received from supervisors, managers, and co-workers. Other studies have found that when aggressive client behavior did occur, it had an impact at both the individual and organizational levels (Virkki, 2008; Macdonald & Sirotich, 2005). The studies found that at the individual level, the workers reported both emotional (e.g., feelings of stress and humiliation, mood changes, emotional exhaustion) and behavioral (e.g., burnout, lack of motivation, role rotation, absenteeism) impacts. At the organizational level, there was overall low morale and high absenteeism, leading to low efficiency and effectiveness, due to the effects of aggressive client behavior on other workers, their reactions, and on the workplace climate.

Researchers have found that practitioners dealing with family violence survivors can experience emotions beyond the usual work-related stress; they also can be indirectly traumatized as they empathically engage with trauma survivors (Ga-Young, 2011; Figley, 2002; Pearlman & Saakvitne, 1995). This indirect trauma is also known as secondary traumatic stress (STS), compassion fatigue, and vicarious traumatization, which all refer to helping professionals' psychological, cognitive, and physiological reactions similar to clients' trauma symptoms (Ga-Young, 2011; Baird & Jenkins, 2003; Sabin-Farrell & Turpin, 2003). Workers who received more support from their coworkers, supervisors, and work teams demonstrated lower levels of STS (Ga-Young, 2011; O'Brien, 2006).

Williams (2015) looked at these impacts differently and wrote about how the emotional and psychological aspects of social work are not typically considered part of workplace health and safety despite the possible effects. She noted that caseworkers are not given the same support and backup as other professionals dealing with workplace trauma and safety issues. Despite being subject to burnout, compassion fatigue, and STS, responsibility for self-care and wellness is placed almost entirely on individual caseworkers (NASW, 2008; Williams, 2015).

Williams used the analogy of firefighters and hypothesized how organizational policies, protocols, and practices would change if caseworkers were treated like them. A regulatory entity looks out for the firefighters, and they are provided with professional help in dealing with trauma, unlike caseworkers. She goes on to suggest "that eating right, sleeping well, and making time for fun" are not sufficient remedies for the emotional injuries incurred while treating trauma (p. 91). Instead, agencies should (Williams, 2015, pp. 90–91):

- Promote mental health policies and practices
- Offer all workers access to mental health care
- Provide weekly supervisorial support, regular screenings for vicarious trauma, and personalized emotional risk assessments
- Use a team-based, peer-support model
- Institutionalize emotional risk management

As stated throughout this manual, collaborating with domestic violence advocates or specialists, other services providers, and key community partners can help caseworkers serve families more effectively and provide guidance on safety and wellness issues. The next chapter looks at ways to collaborate and examines several models of collaboration.

Highlights

1. Every child welfare case has the potential for unexpected confrontation, and those where families are experiencing domestic violence may pose additional risks.
2. While caseworkers are aware of their safety concerns, some may respond by minimizing or avoiding the issue of domestic violence.
3. Development of safety protocols, training and supervision on how to work with these families, e.g., how to keep the child, survivor, and caseworker safe, and how to prepare for and/or de-escalate a potentially hostile situation are paramount in each agency.
4. Agency and supervisor support is important at both the individual caseworker and the agency levels. While the individual may experience burnout, stress, secondary trauma, etc., the resulting low morale and absenteeism of individuals can have an effect on the agency's efficiency and effectiveness in working with families.

Chapter 9:
Building Collaborative Responses for Families Experiencing Domestic Violence

Child welfare caseworkers alone cannot comprehensively address all of the multiple needs of the families they serve. Effectively responding to the needs of families experiencing domestic violence and ensuring the safety and well-being of all family members require close collaboration with other service providers, especially domestic violence advocates or specialists.

This chapter:

- Explains common ground and barriers between child welfare agencies and service providers
- Describes strategies that build collaborative responses
- Presents principles of collaboration with community partners
- Provides examples of promising initiatives, models, and programs

9.1. The Importance of and How to Partner With Other Service Providers

Communities serve many of the same families among child welfare, domestic violence advocacy, law enforcement, courts, perpetrator intervention, and other related service providers. Communities realize that no one agency or individual can do the work alone. The importance of collaboration is key for working with families that experience domestic violence and is supported by federal guidance through the Child and Family Services Reviews (CFSRs), as illustrated in Exhibit 9.1. There is value in being able to collaborate to connect families with the resources that best support their unique and individual needs.

In 1999, as part of its Greenbook Initiative,[1] the National Council of Juvenile and Family Court Judges issued a document, *Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice*,[2] bound with a green cover, which became known as the Greenbook. The Greenbook outlined policies and practices to promote the overall safety of children and families through enhanced collaboration between systems by providing seamless service delivery. As the Greenbook states:

> *No one program has the resources or expertise to develop a comprehensive response to families experiencing domestic violence and child maltreatment. These families often experience other problems, too, such as poverty, poor housing, lack of transportation, substance abuse, and mental illness. The administrators and staff of child welfare services, domestic violence agencies, and juvenile courts all have definitive roles to play in a coordinated response to these families. The degree to which agencies and courts can be effective depends in large part on their abilities to connect families with the expertise and resources of each other's programs and those of the local community (Schechter & Edleson, 1999, p. 9).*

Exhibit 9.1. The CFSRs and Collaboration

From their inception, the CFSRs were intended to promote change through collaborative principles, as listed below (JBS International, Inc., 2017):

The safety, permanency, and well-being of children is a shared responsibility, and child welfare agencies should make every effort to reach out to other partners in the state who can help to achieve positive results with respect to the CFSR child welfare outcome measures and systemic factors.

Child welfare agencies do not serve children and families in isolation; they should work in partnership with policymakers, community leaders, courts, service providers, and other public and private agencies to improve outcomes for children and families in their states. This includes partnering with organizations that directly serve children, youth, and families and those whose actions impact family and community life.

Family-centered and community-based practices are integral to improving outcomes for children and families. As such, collaboration with families, including young people, is important in identifying and assessing strengths and barriers to improved outcomes for children, youth, and families.

Real collaboration has a purpose and a goal; it takes time and effort to promote meaningful collaboration. There also are varying degrees of collaboration, each of which can serve the CFSR process and, more importantly, children, youth, and families.

1 Information about this initiative came from DiBella, Postmus, Simmel, Buttner, & Eckert, n.d.

2 The Greenbook can be found at https://www.futureswithoutviolence.org/greenbook-effective-interventions-in-domestic-violence-and-child-maltreatment-guidelines-for-policy-and-practice/.

True collaboration goes beyond communication, cooperation, and coordination to working jointly with others towards a common purpose or to achieve a common goal. As noted in prior chapters, however, historically the practice responses of the domestic violence and child welfare agencies developed independently and often operate with relatively little integration (Tomison, 2000; Waugh & Bonner, 2002). Their different service histories, philosophical underpinnings, and mandates created tensions and distrust, which has hindered collaboration (Zannettino, 2006). The above differences can become a hindrance because separate service provision for adult survivors (domestic violence) and children (child protection) implies that the needs and safety of survivors and their children can be addressed independently. Potito, Day, Carson, and O'Leary (2009) maintain that this separation framework potentially minimizes the maternal relationship, not only with respect to the decisions made about safety (e.g., whether or not to leave an abusive relationship, how to keep the child safe) but also to the general well-being of both survivors and children.

To mitigate these differences and to build upon the commonality of serving families, Cross, Mathews, Tonmyr, Scott, and Ouimet (2012), in their examination of current research and practice experience suggest that child welfare agencies seeking to improve the response to families exposed to domestic violence should:

- Collaborate with other disciplines involved with preventing and responding to domestic violence
- Seek resources to support training and programming
- Consider methods that avoid stigmatizing parents

Safety for children and adults affected by domestic violence can be enhanced greatly through collaborative partnerships and integrative practice approaches between caseworkers and various service providers. It is essential that these groups understand the unique challenges inherent within each system that can compromise case-sensitive practice and seamless service delivery. Similarly, child welfare can partner with different providers, advocates, and specialists to engage in activities that teach one another about relevant field issues and can incorporate their areas of expertise into case practice. Caseworkers can take active roles in building relationships with domestic violence advocates, focusing on their commonalities, and developing a shared understanding of their respective roles and responsibilities through the following activities:

Job shadowing. While visiting another practitioner's office or following a domestic violence advocate or specialist around for a day may appear to be a simplistic suggestion, it can be a powerful tool in building relationships. With supervisor approval, caseworkers can visit domestic violence shelters, observe a domestic violence intake, listen to hotline calls, and participate in domestic violence trainings. These visits will help caseworkers integrate practical domestic violence knowledge and competency into their child protection efforts. Similarly, CPS supervisors can invite domestic violence specialists to listen in on child abuse hotline calls or to accompany workers on interviews for a child abuse investigation/assessment. (If allowed, the advocates or specialists could observe court proceedings to learn when protective custody is necessary and the implications of child maltreatment.)

By doing so, domestic violence advocates or specialists can learn the criteria for when CPS accepts a referral for assessment, what they assess in determining child safety, and how they make the determination that a case meets the legal definitions for abuse or neglect. Domestic violence advocates or specialists will see that many of the families entering the child welfare system have multiple and complex needs and that CPS caseworkers are not only required to assess family dynamics through a child safety lens, but also to offer and prioritize appropriate services based on the multiple needs of each family member.

Cross-training. Regardless of who hosts the training, cross-training allows child welfare and domestic violence professionals (and others) to receive and provide relevant information simultaneously about their respective processes and subject areas. There are numerous ways to promote cross-training. One is for supervisors, with management approval, to invite domestic violence advocates to inservice trainings led by child welfare, which provide critical information about the definitions of child maltreatment, criteria for reporting to CPS, and the CPS process. Another is for supervisors from both the child welfare and domestic violence agency to provide training on their respective fields in the other's agency. These trainings also offer an opportunity to clarify misconceptions about each other's roles, responsibilities, and authority, as well as to emphasize commonalties. Caseworkers likely will see that some domestic violence advocates and specialists struggle with mandatory reporting requirements because they fear that:

- Survivors will be "revictimized" by punitive child welfare practices.
- It will cause survivors to lose their children.
- They are breaking survivors' confidentiality.

Caseworkers may ease such apprehensions by explaining the criteria for case substantiation or alternative response (where applicable), protective custody decisions, and required steps in the child protection process. They also can offer to help the advocates or specialists develop protocols and staff trainings on mandatory reporting to CPS. Similarly, domestic violence specialists and organizations can invite CPS caseworkers to trainings on topics such as appropriate safety measures for victims, perpetrator intervention programs, and the dynamics of domestic violence.

Integrating case practice knowledge and expertise. Caseworkers and domestic violence specialists can exchange information with the survivor's consent, make joint service or case planning decisions, and hold interagency staffings at critical, decision-making points. It also may be helpful to have the domestic violence advocates or specialists facilitate or co-facilitate with the caseworker the family team meetings or participate in team decision meetings for CPS cases involving domestic violence. Integrating cultural knowledge and expertise also is important (for example, the Peacemaking model discussed in Chapter 7[3]). Advocates or specialists can help caseworkers (1) think creatively (and culturally) about safety plans for adult survivors and children, and (2) better understand how the identified domestic violence may affect case plans and services. Additionally, specialists also can be involved in court proceedings as either witnesses or by providing expert testimony that educates attorneys, judges, and other parties about the impact of domestic violence on families. This integration of specialized, domestic violence knowledge contributes to better informed decisions, which benefits the safety and well-being of all family members. It also:

3 Peacemaking is a traditional Native American approach to justice, which focuses on healing and restoration rather than punishment. While its implementation varies among tribes, its goal is not only to resolve the immediate issue but also to heal the relationships among those involved and to restore balance to the community.

- Engages domestic violence specialists in the CPS process
- Helps them understand the mandatory timelines (such as those required by the Adoption and Safe Families Act[4])
- Increases their awareness of service-planning efforts

Improving Information Sharing. As discussed earlier, information sharing and confidentiality issues frequently present barriers to collaboration and can perpetuate negative stereotypes about caseworkers. Domestic violence advocates or specialists are sometimes perceived as being uncooperative with CPS and overly protective of their clients. In turn, they may perceive CPS caseworkers as unwilling to share information, especially when these same caseworkers ask them for information about shared clients.

Caseworkers can help counteract these misconceptions by explaining that full case record information is protected through agency policy or by statutes limiting their ability to share certain information. They can collaborate to the extent allowed by law by informing domestic violence specialists of case decisions, explaining the CPS process, consulting with the specialists on practice approaches, jointly discussing service needs and priorities for a survivor, and including them in developing the family plan. Domestic violence advocates or specialists also can explain their confidentiality policies to caseworkers, along with the survivors' expectation that the sensitive information they share with the specialist will not be used against them (though that cannot always be guaranteed if it affects the child's safety). Specialists can explain this delicate balance and ask supervisors or managers for guidance in developing practice guidelines on reporting to CPS and for sharing client information. For example, survivors may be asked to sign a confidentiality release form that allows some or all case information to be shared with other service providers. Domestic violence advocates or specialists and caseworkers, despite their differences, share one primary goal—safety and freedom from violence. They can work to accomplish this for all survivors of violence by joining in partnership to develop new ways to work on behalf of the families they jointly serve. **Exhibit 9.2** lists strategies for domestic violence and child welfare agencies to collaborate.

4 For a summary of Adoption and Safe Families Act, go to https://training.cfsrportal.org/section-2-understanding-child-welfare-system/2999.

Key Point

To create some of these cross-agency opportunities, it will often be necessary for the administrators or managers to establish a memorandum of understanding (MOU), which can also aid in communication and understanding of roles. See Appendix I for an example of how to develop an MOU.

Exhibit 9.2. Strategies for Working Together

Strategies for Child Welfare Agencies to Work Collaboratively With Domestic Violence Advocates and Specialists

- Ask about survivors' strengths, parenting and protective efforts, and concerns about perpetrators' harm to children (with appropriate releases).
- Learn about what the domestic violence advocate or specialist can do for adult and child survivors in general.
- Discuss barriers to success (e.g., lack of transportation to court or services) and strategies for how the child welfare agency and domestic violence providers can support families overcome barriers.
- Learn about domestic violence agency protocols, confidentiality, and access to clients who may be in a shelter. Some will neither confirm survivors are in a shelter nor allow caseworkers to come to the shelter to assess the living environment.
- Review any MOUs, and work to have a general understanding of domestic violence agency policy before case-specific issues arise.

Strategies for Domestic Violence Advocates and Specialists to Work Collaboratively With Child Welfare Agencies

- Value understanding the child welfare agency's mission, limitations, and resources.
- Focus on strengths and protective efforts of survivors.
- Understand the direct role perpetrators have had in harming children (in mandated reports or in discussions with caseworkers).
- Learn what child welfare can do to support survivors in overcoming barriers.
- Find out what caseworkers' expectations are for the family.
- Discuss how the domestic violence agency can be helpful and/or if there are concerns about the expectations being reasonable.
- Understand own MOUs and policies for communicating with the child welfare agency.
- Identify ways to support survivors meet the requirements of their child welfare involvement.

9.2 Principles of Collaboration With Community Partners

Domestic violence and child maltreatment are not the only issues for families involved in child welfare and domestic violence programs. Many of the families often face additional challenges or co-occurring issues, such as a substance use disorder (SUD), poverty, or mental health concerns. As a result, a number of communities find that they need a comprehensive, coordinated approach to meet the diverse and multiple needs of these families. Other key professionals and organizations that should be involved in responding to these families include:

- Health care providers (e.g., physicians, nurses, and public health agencies)
- Criminal justice personnel (e.g., legal aids, law enforcement officers, attorneys, and judges)
- Mental health care providers (e.g., therapists, psychologists, and psychiatrists)
- Educators (e.g., teachers, guidance counselors, and Head Start personnel)
- SUD treatment programs
- Housing programs
- Economic support and job training programs
- Daycare and family support providers
- Faith-based programs and clergy
- Neighborhood groups and community residents
- Survivors of domestic abuse and child maltreatment

A lack of interagency cooperation frequently stems from the different and, at times, conflicting philosophies, mission, and goals of each system, as discussed above between domestic violence service providers and child welfare agencies. These discrepancies can lead to systemic barriers that can make collaboration difficult and frustrating. Community partnerships can be created if they are based upon a set of general principles, listed below (Child Welfare Information Gateway, 2003; Aron & Olson, 1997; Beeman et al., 1999; Carter & Schechter, 1997; Findlater & Kelly, 1999; Spears, 2000).

Finding common ground. As a starting point, partnership members need to talk to one another. Asking questions will clarify misconceptions and confusion about each system and will help find similarities and areas of agreement related to the safety and well-being of families and individuals in their communities. Perhaps one of the most important benefits from establishing common ground is that it often helps to develop trust among partners, which can be instrumental in a partnership's success and sustainability.

Creating a shared mission. Open and respectful discussion can move participants toward identifying common values, beliefs, and goals. Through informal or formal meetings, partners can work toward developing a collective vision and mission for ending domestic violence in their communities. Once a unified mission is established, it will provide the foundation and focus to mobilize the efforts of all those involved.

Developing leadership. As in any successful initiative, leadership is essential for capacity building and sustainability. Participants need to identify people, among themselves or within the community, who are influential, impassioned, and committed to leading the charge of the collective group.

Taking action. With a unified mission as the focus and leadership in place, community members can move towards identifying gaps in services, available and needed resources, and strategies for creating or improving a comprehensive response for families in need. Action plans might include legislative or policy changes, demonstration projects, or multidisciplinary boards that meet regularly to address co-occurring domestic violence and child maltreatment issues.

9.3 Promising Initiatives, Models, and Programs

The above principles of collaboration merely serve as a starting point for groups seeking to improve outcomes for adult and child survivors of violence. Institutional and societal changes can only begin when child welfare, domestic violence programs, and an extensive network of providers integrate their expertise, resources, and services to reduce domestic violence in their communities. A number of innovative approaches for addressing overlapping child maltreatment and domestic violence problems continue to emerge at the national, state, tribal, and local levels. For example, child welfare agencies have been developing agency protocols and specialized units that integrate domestic violence knowledge into existing child welfare practice. In turn, domestic violence organizations are incorporating children's programs into shelter-based services. Other professional groups, such as hospital personnel and law enforcement officers, are including procedures to identify and respond to survivors and their children. Child welfare agencies, child advocates, domestic violence specialists, and an array of social service providers are forming interagency collaborations to develop comprehensive solutions that provide safety and stability for families.

However, there is still much work to be done to build strong collaborative partnerships, and evaluation data often are either lacking or inconclusive. Banks, Hazen, Coben, Wang, and Griffith (2009) examined collaborative activities between child welfare agencies and domestic violence service providers. While formal, collaborative activities existed in most of the communities examined, the data did not demonstrate a relationship between these activities and child welfare policy and practice related to domestic violence. However, there were improvements found in child welfare agency screening and assessment, advocacy for adult domestic violence victims, and multidisciplinary approaches to developing the family plans. Nevertheless, changes varied across the sites and appeared to be related to the specific planning approach undertaken. The evaluators recommended additional research to identify optimal collaborative strategies to enhance domestic violence policy and practice and to improve outcomes for families (Banks et al., 2009). Below are a several initiatives and models that are active at the time of writing.

The Greenbook Initiative.[5] As discussed earlier, the Greenbook outlined policies and practices to promote the overall safety of children and families through enhanced collaboration between systems by providing seamless service delivery. Several sites, funded by the U.S. Departments of Justice and Health and Human Services (DHHS) for 2000 through 2007, implemented the recommendations for collaborative work primarily among courts, child welfare agencies, and domestic violence organizations. The evaluation of this project found that:

- Creating specialized domestic violence positions within child welfare offices was key to successful collaboration
- Using the model significantly increased communication between domestic violence services providers and child welfare staff
- Domestic violence providers offered more "child-friendly" services and environments for families and developed full-time advocate positions for children exposed to domestic violence

However, the evaluation also noted several challenges, including:

- Lack of trust among organizations
- Multiple roles and responsibilities required of the co-located domestic violence specialist
- Issues over how:
  - Work would be evaluated and sustained
  - To define boundaries of information sharing and confidentiality between domestic violence and child welfare staff

5 Information about this initiative came from DiBella, Postmus, Simmel, Buttner, & Eckert, n.d.

One of the key lessons learned by the Greenbook sites was that collaboration is not an outcome in and of itself but a potential strategy for improving results for families. Sites struggled to define their collaborative efforts and to maintain focus on the end goal of improving outcomes for families (Rose, 2016). For more on the top ten lessons learned from the evaluation on the Greenbook Initiative, go to https://rcdvcpc.org/the-greenbook-initiative/lessons-learned.html.

While evaluation results were inconclusive, several of the programs are still continuing, and more information on them can be found at http://endingviolence.com/wp-content/uploads/2017/06/RUTGERS-DV-BRIEFING_061517.pdf (p. 4).

Co-located model.[6] A number of states use a co-located domestic violence specialist model, which also came out of the Greenbook Initiative, to address the co-occurrence of domestic violence and child abuse. Co-located staff are trained in domestic violence services, typically are employed through the local domestic violence services provider, and spend time in the local child welfare office working with caseworkers on cases with domestic violence concerns. While the role of the co-located specialist varies, one common goal across co-located programs is to use the specialist as a means to improve collaboration between systems and to enhance the quality of services provided to survivors. Some of the typical responsibilities of a co-located specialist include:

- Providing case management and advocacy to families referred, e.g., crisis intervention, education, safety planning, and advocacy
- Accompanying child welfare workers on home assessments
- Goal setting and development of family plans
- Assisting with temporary restraining orders
- Providing appropriate referrals to families
- Facilitating domestic violence training to child welfare workers

The Safe and Together™ model is a widely used model for collaboration between domestic violence service providers and the child welfare system (DiBella, Postmus, Simmel, Buttner, & Eckert, n.d., p. 5). A perpetrator pattern-based, child-centered, survivor-strengths approach, it aims to keep children both "safe and together" with the nonoffending parent by partnering with the nonoffending parent and by intervening with the domestic violence perpetrator using skilled engagement, accountability strategies, and the court system. The model teaches both domestic violence specialists and child welfare workers that keeping the perpetrator's pattern of coercive control visible enhances the caseworkers' ability to make appropriate decisions and service referrals to increase child safety.

For a list of states using the co-location and/or Safe and Together™ model, go to http://endingviolence.com/wp-content/uploads/2017/06/RUTGERS-DV-BRIEFING_061517.pdf (pp. 6–8) and http://endingviolence.com/our-programs/safe-together/safe-together-overview/.

6 Information about this model came from DiBella et al., n.d.

Ohio and the Safe and Together™ Model

As part of its efforts to support judicial decision-making in domestic violence cases involving children and to support Ohio's child welfare system is becoming more domestic violence-informed, the Supreme Court of Ohio published a bench card that relies heavily on the Safe and Together™ model. Part of the Ohio Interpersonal Violence Initiative, this guidance, combined with continuing training of child welfare staff and others in the Safe and Together™ model, aims to improve outcomes for children and families affected by domestic violence perpetrators behaviors (Mandel, 2017). To see a copy of the bench card, visit http://endingviolence.com/wp-content/uploads/2017/05/LEG_OH_FYLAW_BENCH-CARD_051817.pdf. roles. See Appendix I for an example of how to develop an MOU.

Domestic violence consultant model. Some states have used more of a domestic violence consultant role where the "client" is the child welfare agency rather than the domestic violence survivor. This model focuses on training and coaching child welfare staff, improving case practice, and identifying the needs of the families. Building upon the Safe and Together™ model, the specialists can help the caseworkers identify the impact of the domestic violence on the children and develop plans that (Mandel, 2008):

- Intervene with the domestic violence perpetrator
- Create the most effective partnership possible with the protective parent/survivor
- Meet the needs of the children in the home
- Are sensitive to the role of mental health issues, substance abuse, and culture
- Work to support keeping the children safe and together with the domestic violence survivor, when possible and appropriate

For more on how one state (Connecticut) used this model, go to http://endingviolence.com/category/ct-dcf-domestic-violence-consultation-initiative/.

CPS liaison model. Under DHHS, Family and Youth Services Bureau, the Family Violence Prevention and Services Program administers the Family Violence Prevention and Services Act (FVPSA), the primary federal funding stream dedicated to the support of emergency shelter and related assistance for survivors of domestic violence and their children.[7] In the fall of 2016, FVPSA awarded grants under the Specialized Services for Abused Parents and Children (SSAPC) program to 12 capacity-building projects to serve as leaders for improving responses to children, youth and parents experiencing domestic violence (Futures Without Children, 2016a). The program's goals include:

- Improving systems and responses to abused parents and their children exposed to domestic violence
- Coordinating or providing new or enhanced residential and nonresidential services for children exposed to violence
- Enhancing evidence- and practice-informed services, strategies, advocacy, and interventions for children and youth exposed to domestic violence

7 For more information, go to https://www.acf.hhs.gov/fysb/programs/family-violence-prevention-services.

One grantee, the Texas Council on Family Violence (TCFV), a statewide, domestic violence coalition, started an initiative that implemented two key strategies aimed at achieving enhanced services for survivors and their children: (1) to demonstrate that collaboration between domestic violence programs and CPS, through the use of an enhanced CPS liaison position, promotes better outcomes for families involved with CPS; and (2) to support nonoffending parents in promoting resiliency in their children by implementing a parenting curriculum designed specifically for survivor parents involved with the CPS system. TCPV's goal was to elevate the CPS liaison function, which is now required for all state-funded domestic violence organizations, so as to increase the capacity of this specialized domestic violence advocacy function to assist communities in addressing the co-occurrence of domestic violence and child abuse and neglect (Futures Without Violence, 2016b).

For more on the TCPV initiative, go to http://promising.futureswithoutviolence.org/advancing-the-field/communities-in-action/specialized-services-for-abused-parents-and-children-grantees/texas-council-on-family-violence/. For a list of all 12 SSAPC grantees, go to http://promising.futureswithoutviolence.org/advancing-the-field/communities-in-action/specialized-services-for-abused-parents-and-children-grantees/.

9.4 Conclusion

This manual explores the varied and complex facets of families experiencing domestic violence in order to support child welfare caseworkers in serving them better. It helps caseworkers achieve this goal by defining domestic violence, examining its causes and the ways that perpetrators perpetuate it, and looking at its impact on both the adult and child survivors. The manual then builds upon the basic elements of the stages of the CPS process detailed in *Child Protective Services: A Guide for Caseworkers,* and discusses practice implications for working with child welfare families experiencing domestic violence and considerations on how work with these families can affect caseworker safety and wellness and how to best support the staff engaging in this work.

The manual closes with an emphasis on collaboration. Domestic violence and child maltreatment cannot be viewed separately when responding to family violence. Although the mission of CPS is to ensure the safety, permanency, and well-being of children, child welfare agencies must consider family strengths and needs holistically, an approach that is consistent with the domestic violence field's goal of providing protection and strength to adult survivors of abuse. Child welfare and domestic violence agencies, together with other critical community partners, will best achieve their missions and goals through communication and collaboration at both an individual and a systemic level.

Highlights

1. Effectively responding to the needs of families experiencing domestic violence and ensuring the safety and well-being of all family members requires close collaboration with other service providers, especially domestic violence advocates or specialists. Communities realize that no one agency or individual has the resources to do the work alone.
2. While child welfare and domestic violence agencies have different service histories, philosophical underpinnings, and mandates that have hindered collaboration, they are working together in myriad ways to build upon their commonalities and desire to serve children and families better.
3. Activities to overcome these hindrances include job shadowing, cross-training, integrating case practice knowledge and expertise, and improving information sharing (a memorandum of understanding may be required in some instances).
4. Principles to guide collaboration include finding common ground, creating a shared mission, developing leadership, and taking action together. Examples of promising initiatives, models, and programs are provided.

References

American Civil Liberties Union. (2015). *Responses from the field: domestic violence, sexual assault and policing.* Retrieved from https://www.aclu.org/issues/womens-rights/violence-against-women/responses-field?redirect=responsesfromthefield

Aron, L. Y., & Olson, K. K. (1997). Efforts by child welfare agencies to address domestic violence. *Public Welfare, 55*(3), 4-13.

Auchter, B. (2010). Men who murder their families: What the research tells us. *National Institute of Justice Journal, 266,* 10–12. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/230412.pdf

Bachman, R., & Saltzman, L. (1995). *National Crime Victimization Survey, Violence against women: Estimates from the redesigned survey.* Retrieved from https://www.bjs.gov/content/pub/pdf/FEMVIED.PDF

Bachman, R., Zaykowski, H., Kallmyer, R., Poteyeva, M., & Lanier, C. (2008). *Violence against American Indian and Alaska Native women and the criminal justice response: What is known.* Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/223691.pdf

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims, 18*(1), 71–86.

Baker, C. R., & Stith, S. M. (2008). Factors predicting dating violence perpetration among male and female college students. *Journal of Aggression, Maltreatment & Trauma, 17*(2), 227–244.

Baker, L., & Cunningham, A. (2005). *Learning to listen, learning to help: Understanding woman abuse and its effects on children.* London, ON: Centre for Children & Families in the Justice System.

Bancroft, L. (2002). The batterer as a parent. *Synergy, 6*(1), 6–8. Retrieved from http://lundybancroft.com/articles/the-batterer-as-parent/

Bancroft, L. (2003). *Why does he do that?* New York, NY: Berkley Publishing.

Bancroft, L. (2007). *The connection between batterers and child sexual abuse perpetrators.* Retrieved from http://lundybancroft.com/articles/the-connection-between-batterers-and-child-sexual-abuse-perpetrators/

Bancroft, L. (n.d.). *Assessing dangerousness in men who abuse women.* Retrieved from http://lundybancroft.com/articles/assessing-dangerousness-in-men-who-abuse-women/

Bancroft, L., & Silverman, J. G. (2002). Impeding recovery: The batterer in custody and visitation disputes. In L. Bancroft & J. G. Silverman (Eds.), *The batterer as parent: Addressing the impact of domestic violence on family dynamics* (pp. 98–129). Thousand Oaks, CA: Sage.

Bancroft, R. L., Silverman, J. G., & Ritchie, D. (2011). *The batterer as parent* (2nd ed.). Thousand Oaks, CA: Sage.

Banks, D., Hazen, A. L., Coben, J. H., Wang, K., & Griffith, J. D. (2009). Collaboration between child welfare agencies and domestic violence service providers: Relationship with child welfare policies and practices. *Children and Youth Services Review, 31*(5), 497–505. doi:10.1016/j.childyouth.2008.10.005

Battered Women's Justice Project. (2017). *Military and veteran IPV.* Retrieved from http://www.bwjp.org/our-work/topics/military-ipv.html

Beeman, S. K., Hagemeister, A. K., & Edleson, J. L. (1999). Child protection and battered women services: From conflict to collaboration. *Child Maltreatment, 4*(2), 116–126.

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., . . . Stevens, M. R. (2011). *The National Intimate Partner and Sexual Violence Survey: 2010 summary report.* Retrieved from https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

Blackburn Center. (2015). *Situational violence versus domestic violence.* Retrieved from http://www.blackburncenter.org/single-post/2015/11/04/Situational-Violence-Versus-Domestic-Violence

Blythe, B., Hefferman, K., & Walters, B. (2010). Best practices for developing child protection workers' skills: Domestic violence, substance abuse and mental health training. *Revista De Asistenta Sociale (Social Work Review),* 9(2). 51–64.

Bragg, L. (1998). *Domestic violence protocol for child protective services intervention.* Charlotte, NC: Mecklenburg County Department of Social Services.

Breiding, M. J., Smith, S. G., Basile, K. C., Walters, M. L., Chen, J., & Merrick, M. T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization. *Morbidity and Mortality Weekly Report, 63*(8), 1–18.

Breul, N., & Keith, M. (2016). *Deadly calls and fatal encounters: An analysis of U. S. law enforcement line-of-duty fatalities as officers responded to calls for service and engaged in self-initiated enforcement activity (2010–2014).* Retrieved from http://www.nleomf.org/assets/pdfs/officer-safety/Primary_Research_Final_11-0_updated_8_31_16.pdf

Burbar, R., & Thurman, P.J. (2004) Violence against Native women. *Social Justice, 31*(4), 70–86.

Callaghan, J., Alexander, J., Fellin, L., & Sixsmith, J. (2015). Beyond 'witnessing': children's experiences of coercive control in domestic violence and abuse. *Journal of Interpersonal Violence.* doi:10.1177/0886260515618946

Campbell, J. C. (2001). *Danger assessment.* Retrieved from http://www.ncdsv.org/images/DANGERASSESSMENT.pdf

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331–1336.

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., . . . Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health, 93*(7), 1089–1097.

Capacity Building Center for States. 2018. *Child protective services: A guide for caseworkers.* Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Carrillo, R., & Carter, J. (2001). *Guidelines for conducting family team conferences when there is a history of domestic violence.* San Francisco, CA: Family Violence Prevention Fund.

Carter, J., & Schechter, S. (1997). *Child abuse and domestic violence: Creating community partnerships for safe families—Suggested components of an effective child welfare response to domestic violence.* San Francisco, CA: Family Violence Prevention Fund.

Casa de Esperanza. (2015). *Contextual factors: Facts on intimate partner violence among latinas.* Retrieved from http://casadeesperanza.org/wp-content/uploads/2015/01/IPVfactENG-contextualfactors1.pdf

Cascardi, M., O'Leary, K. D., & Schlee, K. (1999). Co-occurrence and correlates of posttraumatic stress disorder and major depression in physically abused women. *Journal of Family Violence,* 14, 227–249.

Catalano S., Smith, E., Snyder, H., & Rand, M. (2009). *Selected findings: Female victims of violence.* Retrieved from https://www.bjs.gov/content/pub/pdf/fvv.pdf

Center for American Progress. (n.d.). *LGBT domestic violence fact sheet.* Retrieved from https://cdn.americanprogress.org/wp-content/uploads/2012/12/domestic_violence.pdf

Center for Court Innovation. (n.d.) *Peacemaking program.* Retrieved from http://www.courtinnovation.org/project/peacemaking-program

Cherry, K. (2017). *How cognitive biases influence how we think and act.* Retrieved from https://www.verywell.com/what-is-a-cognitive-bias-2794963

Child Welfare Information Gateway. (2003). *Child protection in families experiencing domestic violence.* Retrieved from https://www.childwelfare.gov/pubs/usermanuals/domesticviolence/

Child Welfare Information Gateway. (2013). *Definitions of domestic violence.* Retrieved from https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/defdomvio/

Child Welfare Information Gateway. (2014). *Domestic violence and the child welfare system.* Retrieved from https://www.childwelfare.gov/pubPDFs/domestic-violence.pdf

Child Welfare Information Gateway. (2016a). *Child witnesses to domestic violence.* Retrieved from https://www.childwelfare.gov/pubPDFs/witnessdv.pdf

Child Welfare Information Gateway. (2016b). *Major federal legislation concerned with child protection, child welfare, and adoption.* Retrieved from https://www.childwelfare.gov/pubPDFs/majorfedlegis.pdf#page=2&view=Timeline of major federal legislation concerned with child protection, child welfare, and adoption

Child Welfare Information Gateway. (n.d.-a). *Glossary.* Retrieved from https://www.childwelfare.gov/glossary/glossaryd/

Child Welfare Information Gateway. (n.d.-b). *Family group decision-making.* Retrieved from https://www.childwelfare.gov/topics/systemwide/assessment/approaches/family/

Child Welfare Information Gateway. (n.d.-c). *Trauma-informed practice.* Retrieved from https://www.childwelfare.gov/topics/responding/trauma/

Children Experiencing Domestic Abuse Recovery Network. (2017). *What is coercive control?* Retrieved from https://www.cedarnetwork.org.uk/about/supporting-recovery/what-is-domestic-abuse/what-is-coercive-control/

Colorado Department of Human Services. (2013). *Domestic violence practice guide for child protective services.* Version 1.0. Retrieved from http://ccadv.org/wp-content/uploads/2013/11/DV_CPS_Practice_Guide_5.13.13.pdf

Copps, K. A. (2009). The good, the bad and the future of Nicholson v. Scoppetta: An analysis of the effects and suggestions for future improvements. *Albany Law Review,* 72, 497–526. Retrieved from http://www.albanylawreview.org/Articles/Vol72_2/72.2.0015%20Copps.pdf

Cozzolino, B. (2014). *Other "second assaults": How institutions fail separated mothers with domestic violence histories.* Conference Papers-American Sociological Association, 1–18.

Cross, T. P., Mathews, B., Tonmyr, L., Scott, D., & Ouimet, C. (2012). Child welfare policy and practice on children's exposure to domestic violence. *Child Abuse & Neglect, 36*(3), 210–216. doi:10.1016/j.chiabu.2011.11.004

Cunningham, A. J., & Baker, L. L. (2007). *Little eyes, little ears: How violence against a mother shapes children as they grow.* Retrieved from https://www.illinois.gov/dcfs/safekids/protecting/Documents/little_eyes_little_ears.pdf

Davies, J. (2009). *Safety planning.* Retrieved from http://vawnet.org/sites/default/files/assets/files/2016-09/DaviesSafetyPlanning.pdf

Davies, J. (n.d.). *Confidentiality and information sharing issues.* Retrieved from https://www.futureswithoutviolence.org/userfiles/file/Children_and_Families/InfoSharing.pdf

DeBoard-Lucas, R., Wasserman, K., McAlister Groves, B., & Bair-Merritt, M. (2013). *16 trauma-informed, evidence-based recommendations for advocates working with children exposed to intimate partner violence.* Retrieved from http://promising.futureswithoutviolence.org/files/2013/01/16-Trauma-Informed-Evidence-Based-Recommendations-For-Advocates2.pdf

Demaris, A. (1989). Attrition in batterer's counseling: The role of social and demographic factors. *Social Service Review,* 63(1), 142–154.

Demaris, A., & Jackson, J. K. (1987). Batterers' reports of child protection in families experiencing domestic violence recidivism after counseling. *Social Casework, 68*(8), 458–465.

Development Services Group, Inc., & Child Welfare Information Gateway. (2015). *Promoting protective factors for children exposed to domestic violence: A guide for practitioners.* Retrieved from https://www.childwelfare.gov/pubPDFs/guide_domesticviolence.pdf#page=1&view=Introduction

DiBella, B., Postmus, J. L., Simmel, C., Buttner, C., & Eckert, C. (n.d.). *From research to practice: An overview of systems collaboration efforts to address the co-occurrence of domestic violence and child maltreatment.* Retrieved from http://endingviolence.com/wp-content/uploads/2017/06/RUTGERS-DV-BRIEFING_061517.pdf

DomesticViolence.org. (2015a). *Common myths and why they are wrong.* Retrieved from http://domesticviolence.org/common-myths/

DomesticShelters.org. (2015b). *Demographics and domestic violence.* Retrieved from https://www.domesticshelters.org/domestic-violence-articles-information/demographics-and-domestic-violence

DomesticShelters.org. (2016a). *The facts about abuse in military families.* Retrieved from https://www.domesticshelters.org/domestic-violence-articles-information/the-facts-about-abuse-in-military-families

DomesticShelters.org. (2016b). *The new cyberstalking.* Retrieved from https://www.domesticshelters.org/domestic-violence-articles-information/the-new-cyberstalking

Doyne, S. E., Bowermaster, J. M., Meloy, J. R., Dutton, D., Jaffe, P., Temko, S., & Mones, P. (1999). Custody disputes involving domestic violence: Making children's needs a priority. *Juvenile and Family Court Journal, 50*(2), 1–12.

Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse, 4*(2), 196–231(36). doi:10.1891/1946-6560.4.2.196

Edleson, J. L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women, 5*(2), 134–154.

Edleson, J. L., & Grusznski, R. J. (1988). Treating men who batter: Four years of outcome data from the Domestic Abuse Project. *Journal of Social Service Research, 12*(1/2), 3–22.

Empire Justice Center. (2006). *Traumatic brain injury and domestic violence.* Retrieved from http://www.doj.state.or.us/wp-content/uploads/2017/08/traumatic_brain_injury_and_domestic_violence.pdf

Enosh, G., Tzafrir, S., & Gur, A. (2012). Client aggression toward social workers and social services in Israel–A qualitative analysis. *Journal of Interpersonal Violence, 28*(6), 1123–1142. doi:10.1177/0886260512468230

Erez, E., Adelman, M., & Gregory, C. (2009). Intersections of immigration and domestic violence: Voices of battered immigrant women. *Feminist Criminology, 4*(1), 32–56. doi:10.1177/1557085108325413

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. American *Journal of Preventive Medicine,* 14(4), 245–258. doi:10.1016/S0749-3797(98)00017-8

Ferguson, H. (2011). *Child protection practice.* Basingstoke, U.K: Palgrave Macmillan.

Ferrari, G., Agnew-Davies, R., Bailey, J. Howard, L., Howarth, E., Peters, T. J., . . . Feder, G. S. (2016). Domestic violence and mental health: A cross-sectional survey of women seeking help from domestic violence support services. *Global Health Action, 9*(1). doi:10.3402/gha.v9.29890

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Psychotherapy in Practice, 58*(11), 1433–1441.

Findlater, J., & Kelly, S. (1999). Michigan's domestic violence and child welfare collaboration. In J. L. Edleson & S. Schechter (Eds.), *In the best interests of women and children: Child welfare and domestic violence services working together* (pp. 167–174). Thousand Oaks, CA: Sage.

FindLaw. (2017a). *Domestic violence: Orders of protection and restraining orders.* Retrieved from http://family.findlaw.com/domestic-violence/domestic-violence-orders-of-protection-and-restraining-orders.html

FindLaw. (2017b). *Nicholson v. Scopetta.* Retrieved from http://caselaw.findlaw.com/ny-court-of-appeals/1145205.html

Finkelhor, D., Turner, H., Shattuck, A., Hamby, S., & Kracke, K. (2015, September). Children's exposure to violence, crime, and abuse: An update. *Juvenile Justice Bulletin.* Retrieved from https://www.ojjdp.gov/pubs/248547.pdf

Florida's Governor's Task Force on Domestic and Sexual Assault. (1997). *Florida mortality review project* (p.45, Table 11). Tallahassee, FL: Office of the Governor.

Foran, H. M., Smith Slep, A. M., & Heyman, R. E. (2011). Prevalences of intimate partner violence in a representative U.S. Air Force sample. *Journal of Consulting and Clinical Psychology, 79,* 391–397. doi:10.1037/a0022962

Frierson, R. L. (2013). Combat-related posttraumatic stress disorder and criminal responsibility determinations in the post-Iraq era: A review and case report. *Journal of the American Academy of Psychiatry and the Law Online, 41*(1), 79–84. Retrieved from http://jaapl.org/content/jaapl/41/1/79.full.pdf

Fusco, R. A. (2013). "It's hard enough to deal with all the abuse issues": Child welfare workers' experiences with intimate partner violence on their caseloads. *Children & Youth Services Review; 35*(12), 1946–1953. doi:10.1016/j.childyouth.2013.09.020

Futures Without Violence. (2013). *Perpetrator risk factors for violence against women.* Retrieved from http://www.futureswithoutviolence.org/userfiles/file/Perpetrator%20Risk%20Factors%20Fact%20Sheet%202013.pdf

Futures Without Violence. (n.d.-a). The facts on children and domestic violence. Retrieved from https://www.futureswithoutviolence.org/userfiles/file/Children_and_Families/Children.pdf

Futures Without Violence. (n.d.-b). The facts on immigrant women and domestic violence. Retrieved from https://www.futureswithoutviolence.org/userfiles/file/Children_and_Families/Immigrant.pdf

Futures Without Violence (n.d.-c). The facts on violence against American Indian/Alaskan Native women. Retrieved from https://www.futureswithoutviolence.org/userfiles/file/Violence%20Against%20AI%20AN%20Women%20Fact%20Sheet.pdf

Futures Without Violence. (2016a). *Specialized services for abused parents and children grantees.* Retrieved from http://promising.futureswithoutviolence.org/advancing-the-field/communities-in-action/specialized-services-for-abused-parents-and-children-grantees

Futures Without Violence. (2016b). *Texas Council on Family Violence.* Retrieved from http://promising.futureswithoutviolence.org/advancing-the-field/communities-in-action/specialized-services-for-abused-parents-and-children-grantees/texas-council-on-family-violence/

Ganley, A., & Hobart, M. (2010). *Social worker's practice guide to domestic violence.* Retrieved from https://wscadv.org/wp-content/uploads/2015/05/social_workers_practice_guide_to_dv_feb_2010.pdf

Ganley, A., & Schechter, S. (1996). *Domestic violence: a national curriculum for child protective services.* Family Violence Prevention Fund.

Garmezy, N., & Masten, A. (1994). Chronic adversities. In M. Rutter, E. Taylor, & L. Hersov (Eds.), *Child and adolescent psychiatry: modern approaches.* Oxford, England: Blackwell Scientific Publications.

Gaynor, R. (2015). *Domestic violence, brain injury and psychological trauma.* Retrieved from http://www.traumaticbraininjury.net/domestic-violence-brain-injury-and-psychological-trauma/

Ga-Young, C. (2011). Organizational impacts on the secondary traumatic stress of social workers assisting family violence or sexual assault survivors. *Administration in Social Work, 35*(3), 225–242. doi:10.1080/03643107.2011.575333

Gewirtz, A. H., & Edelson, J. L. (2007). Young children's exposure to intimate partner violence: Towards a developmental risk and resilience framework for research and intervention. *Journal of Family Violence, 22,*151–163. Retrieved from http://reseauconceptuel.umontreal.ca/rid=1227194566394_245534838_3305/Young%20children's%20exposure%20to%20intimate%20partner%20violence.pdf

Gillum, T. L. (2008). Community response and needs of African American female survivors of domestic violence. *Journal of Interpersonal Violence, 23*(1), 39–57.

Gondolf, E. W. (1988). Who are those guys? Toward a behavioral typology of batterers. *Violence and Victims, 3*(3), 187–203.

Graham-Bermann, S. A., & Brescoll, V. (2000). Gender, power and violence: Assessing the family stereotypes of the children of batterers. *Journal of Family Psychology, 14*(4), 600–612.

Graham-Bermann, S. A., Gruber, G., Howell, K., & Girz, L. (2009). Factors discriminating against resilience and psychopathology in children exposed to intimate partner violence. *Child Abuse and Neglect, 33*(9), 648–660.

Greenbook National Evaluation Team (2008). *The Greenbook Initiative national evaluation report, Final.* Retrieved from https://aspe.hhs.gov/basic-report/greenbook-initiative-final-evaluation-report

Greeson, J. K. P., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake, G. S., Ko, S. J., . . . Fairbank, J. A. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the national child traumatic stress network. *Child Welfare, 90*(6), 91–108.

Greeson, M., Kennedy, A., Bybee, D., Beeble, M., Adams, A., & Sullivan, C. (2014). Beyond deficits: Intimate partner violence, maternal parenting, and child behavior over time. *American Journal of Community Psychology, 54*(1/2), 46–58. doi:10.1007/s10464-014-9658-y

Grossman, S. F., Hinkley, S., Kawalski, A., & Margrave, C. (2005). Rural versus urban victims of violence: The interplay of race and region. *Journal of Family Violence, 20*(2), 71–81. Retrieved from https://www.researchgate.net/profile/Susan_Grossman/publication/226613124_Rural_Versus_Urban_Victims_of_Violence_The_Interplay_of_Race_and_Region/links/53f2009d0cf2f2c3e7fca57f/Rural-Versus-Urban-Victims-of-Violence-The-Interplay-of-Race-and-Region.pdf

Hamby, S., Finkelhor, D., Turner, H.A., & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse and Neglect, 4*(10), 734–41. doi:10.1016/j.chiabu.2010.03.001

Hamby, S., Finkelhor, D., Turner, H.A., & Ormrod, R. (2011). Children's exposure to intimate partner violence and other family violence. *Juvenile Justice Bulletin: National Survey of Children's Exposure to Violence.* Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/232272.pdf

Hastings, J. E., & Hamberger, L. K. (1988). Personality characteristics of spouse abusers: A controlled comparison. *Violence and Victims, 3*(1), 31–48.

Hahn, J. W., McCormick, M. C., Silverman, J. G., Robinson, E. B., & Koenen, K. C. (2014). Examining the impact of disability status on intimate partner violence victimization in a population sample. *Journal of Interpersonal Violence, 29*(17), 3063–3085. Retrieved from https://frdat.niagara.edu/assets/ListPage/examining-the-impact-of-disability-status-on-IPV-victimization.pdf

Humphreys, C. (1999). Avoidance and confrontation: social work practice in relation to domestic violence and child abuse. *Child & Family Social Work, 4*(1). 77–87.

Humphreys, C. (2007). Domestic violence and child protection: Exploring the role of perpetrator risk assessments. *Child & Family Social Work, 12*(4), 360–369.

Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: I call it symptoms of abuse. *British Journal of Social Work, 33*(2), 209–226.

Hunt, S., Goddard, C., Cooper, J., Littlechild, B., & Wild. J. (2016). "If I feel like this, how does the child feel?" Child protection workers, supervision, management, and organizational responses to parental violence. *Journal of Social Work Practice, 30*(1), 5–24. doi:10.1080/02650533.2015.1073145

Illinois Department of Human Services. (2005). *Special populations: Children dually exposed to batterers and parental substance abuse.* Retrieved from http://www.dhs.state.il.us/page.aspx?item=38483

Imbery, L. (2014). *The intersection of poverty and domestic violence.* Retrieved from https://www.chn.org/2014/10/16/intersection-poverty-domestic-violence/#.WcqtYrKGP3g

Independent Living Resource Centre Thunder Bay. (n.d.). *Characteristics of abusers.* Retrieved from http://www.ilrctbay.com/upload/custom/abuse/content/abusers.htm

Jaffe, P. G., Wolfe, D. A., & Wilson, S. K. (1990). *Children of battered women.* Newbury Park, CA: Sage. JBS International, Inc. (2017). CFSR collaboration. Retrieved from https://training.cfsrportal.org/book/export/html/755

Johnson, M. P. (2008). *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence.* Lebanon, NH: University Press of New England.

Joyful Heart Foundation. (n.d.). *Effects of domestic violence.* Retrieved from http://www.joyfulheartfoundation.org/learn/domestic-violence/effects-domestic-violence

Kahneman, D., & Tversky, A. (1996). On the reality of cognitive illusions: A reply to Gigerenzer's critique. *Psychological Review, 103*, 582–591.

Kelley, M. L., Stambaugh, L., Milletich, R. J., Veprinsky, A., & Snell, A. K. (2015). Number of deployments, relationship satisfaction and perpetration of partner violence among U.S. Navy members. *Journal of Family Psychology, 29*(4), 635–641. doi:10.1037/fam0000101

Kelly, J.B., & Johnson, M.P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family Court Review, 46*(3), 476–499. Retrieved from https://www.masslegalservices.org/system/files/library/typologies_review_-_johnson.pdf

Kern, E. (2017). Systemic barriers faced by women attempting to leave abusive military marriages. *Journal of Counseling & Development, 95*(3), 354–364. doi:10.1002/jcad.12149

King County. (2015). *Domestic violence & child maltreatment: Coordinated response guideline.* Seattle, WA: Author. Retrieved from http://www.kingcounty.gov/~/media/courts/superior-court/docs/family/services/domestic-violence-and-child-maltreatment-coordinated-response-guideline.ashx?la=en

Klein, A. R. (2009). *Practical implications of current domestic violence research: For law enforcement, prosecutors and judges.* Retrieved from https://www.ncjrs.gov/pdffiles1/nij/225722.pdf

Klostermann, K., Mignone, T., Kelley, M. L., Musson, S., & Bohall, G. (2011). Intimate partner violence in the military: Treatment considerations. *Aggression and Violent Behavior, 7*, 53–58. doi:10.1016/j.avb.2011.09.004

Lagdon, S., Armour, C., & Stringer, M. (2014). Adult experience of mental health outcomes as a result of intimate partner violence victimisation: A systematic review. *European Journal of Psychotraumatology, 5*(1), 53–58. doi:10.3402/ejpt.v5.24794

Lansner, D. A. (2008, Fall). The Nicholson decisions: New York's response to 'failure to protect' allegations. *American Bar Association Committee on Domestic Violence e-Newsletter, 12.* Retrieved from https://www.americanbar.org/newsletter/publications/cdv_enewsletter_home/vol12_expert1.html

Levendosky, A. A., Huth-Bocks, A. C., Shapiro, D. L., & Semel, M. A. (2003). The impact of domestic violence on the maternal-child relationship and preschool-age children's functioning. *Journal of Family Psychology, 17*(3), 275–287. doi:10.1037/0893-3200.17.3.275

Littlechild, B. (2008). Child protection social work: Risks of fears and fears of risks—Impossible tasks from impossible goals? *Social Policy & Administration, 42*(6). 662–675. doi:10.1111/j.1467-9515.2008.00630.x

Logan, T. K., Walker, R., Cole, J., Ratliff, S., & Leukefeld, C. (2003). Qualitative differences among rural and urban intimate violence victimization experiences and consequences: A pilot study. *Journal of Family Violence, 18*(2), 83–92. https://doi.org/10.1023/A:1022837114205

MacDonald, G., & Sirotich, F. (2005). Violence in the social work workplace. *International Social Work, 48*, 772–781.

Mandel, D. (2008). *Connecticut Department of Children and Families domestic violence consultant initiative: A state child welfare agency response to domestic violence.* Retrieved from http://vawnet.org/sites/default/files/assets/files/2016-09/SafeTogetherReport2008.pdf

Mandel, D. (2009). *Domestic violence training for supervisors produces some positive results.* Retrieved from http://endingviolence.com/2009/09/domestic-violence-training-for-supervisors-produces-some-positive-results/

Mandel, D. (2017). *The Supreme Court of Ohio uses safe and together model in new bench card.* Retrieved from http://endingviolence.com/2017/05/the-supreme-court-of-ohio-uses-safe-and-together-model-in-new-bench-card/

Marcus, N. E., Lindahl, K. M., Malik, N. M. (2001). Interparental conflict, children's social cognitions, and child aggression: A test of a meditational model. *Journal of Family Psychology, 15*(2), 315–333.

Margolin, G., & Vickerman, K. A. (2007). Post-traumatic stress in children and adolescents exposed to family violence: I. Overview and issues. *Professional Psychology: Research & Practice, 38*(6): 613–619. doi:10.1037/0735-7028.38.6.613

Martinez-Torteya, G., Bogat, A., von Eye, A., & Levendosky, A. (2009). Resilience among children exposed to domestic violence: The role of risk and protective factors. *Child Development, 80*(2), 562–577.

Massachusetts Department of Social Services. (1995). Unpublished domestic violence practice protocol. Boston, MA: Massachusetts Department of Social Services.

McCall-Hosenfeld, J. S., Weisman, C. S., Perry, A. N., Hillemeier, M. M., & Chuang, C. H. (2014). "I just keep my antennae out." How rural primary care physicians respond to intimate partner violence. *Journal of interpersonal violence, 29*(14), 2670–2694. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4121375/

McCloskey, L. A., Figueredo, A. J., & Koss, M. P. (1995). The effects of systemic family violence on children's mental health. *Child Development, 66*(5), 1239–1261. doi:10.1111/j.1467-8624.1995.tb00933.x

McFarlane, J. M., Campbell, J. C., Wilt, S., Sachs, C. J., Ulrich, Y., & Xu, X. (1999). Stalking and intimate partner femicide. *Homicide Studies, 3*(4), 300–316.

McGee, C. (2000). *Childhood experiences of domestic violence.* Philadelphia, PA: Jessica Kingsley Publishers.

Mederos, F. (n.d.). *Accountability and connection with abusive men: A new child protection response to increasing family safety.* Retrieved from https://www.futureswithoutviolence.org/userfiles/file/Children_and_Families/Accountability_Connection.pdf

Meier, J. (n.d.). *Research summary: Rates at which accused and adjudicated batterers receive sole or joint custody.* Available from http://www.protectiveparents.com/rates-batterers-receive-custody.pdf

Miller, E., McCauley, H.L., Tancredi, D.J., Decker, M.R., Anderson, H., & Silverman, J.G. (2014). Recent reproductive coercion and unintended pregnancy among female family planning clients. *Contraception, 89*(2), 122–8. doi:10.1016/j.contraception.2013.10.011

Mirick, R. (2013). An unsuccessful partnership: Behavioral compliance and strengths-based child welfare practice. *Families In Society: The Journal of Contemporary Social Services, 94*(4), 227–234.

Miller, J., & Robuck, R. (2014). Child abuse and domestic violence: Putting CAPTA to work. Retrieved from https://s3.amazonaws.com/fwvcorp/wp-content/uploads/20160121115305/CAPTA-7-16-14.pdf

Moffitt, T. E., & the Klaus-Grawe 2012 Think Tank. (2013). Childhood exposure to violence and lifelong health: Clinical intervention science and stress biology research join forces. *Development and Psychopathology, 25*(4pt2), 1619–1634. doi:10.1017/S0954579413000801

Mose, G. B., & Gillum, T. L. (2016). Intimate partner violence in African immigrant communities in the United States: Reflections from the IDVAAC African women's round table on domestic violence. *Journal of Aggression, Maltreatment & Trauma, 25*(1), 50–62. doi:10.1080/10926771.2016.1090517

Moylan, C. A., Herrenkohl, T. I., Sousa, C., Tajima, E. A., Herrenkohl, R. C., & Russo, M. J. (2010). The effects of child abuse and exposure to domestic violence on adolescent internalizing and externalizing behavior problems. *Journal of Family Violence, 25*(1), 53–63. doi:10.1007/s10896-009-9269-9

National Advisory Committee on Rural Health and Human Services. (2015). *Intimate partner violence in rural America.* Retrieved from https://www.hrsa.gov/advisorycommittees/rural/publications/partnerviolencemarch2015.pdf

National Association of Public Child Welfare Administrators. (2001). *Guidelines for public child welfare agencies serving children and families experiencing domestic violence.* Washington, DC: American Public Human Services Association.

National Association of Social Workers. (2013). *Guidelines for social worker safety in the workplace.* Retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=6OEdoMjcNC0%3D&portalid=0

National Center on Domestic Violence, Trauma & Mental Health. (2012). *Tips for supporting children and youth exposed to domestic violence: What you might see and what you can do.* Retrieved from http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/05/Tipsheet_Children-Exposed_NCDVTMH_May2012.pdf

National Center on Domestic Violence, Trauma & Mental Health. (2017). *Supporting children, parents & caregivers impacted by DV.* Retrieved from http://www.nationalcenterdvtraumamh.org/trainingta/supporting-children-parents-caregivers-impacted-by-dv/

National Child Traumatic Stress Network. (n.d.-a). *Assessment of complex trauma.* Retrieved from http://www.nctsn.org/trauma-types/complex-trauma/assessment

National Child Traumatic Stress Network. (n.d.-b). *Children and domestic violence.* Retrieved from http://www.nctsn.org/content/children-and-domestic-violence

National Coalition Against Domestic Violence. (n.d.-a). *Legislation.* Retrieved from http://www.ncadv.org/get-involved/legislation

National Coalition Against Domestic Violence. (n.d.-b). *National statistics.* Retrieved from http://www.ncadv.org/learn-more/statistics

National Coalition Against Domestic Violence. (n.d.-c). *Understanding why victims stay.* Retrieved from http://www.ncadv.org/learn-more/what-is-domestic-violence/why-victims-stay

National Coalition Against Domestic Violence. (2015). *Domestic violence.* Retrieved from https://www.speakcdn.com/assets/2497/domestic_violence.pdf

National Domestic Violence Hotline. (n.d.) *Domestic violence & people with disabilities.* Retrieved from http://www.thehotline.org/is-this-abuse/domestic-violence-disabilities/

National Family Preservation Network. (n.d.). *Father involvement—Meeting CFSR standards.* Retrieved from http://www.nfpn.org/Portals/0/Documents/cfsr_father_involvement.pdf

National Network to End Domestic Violence. (2016). *Domestic violence: A public problem and a public health concern.* Retrieved from https://nnedv.org/latest_update/domestic-violence-public-health-concern/

National Network to End Domestic Violence. (2017). *About financial abuse.* Retrieved from https://nnedv.org/content/about-financial-abuse/

National Network to End Domestic Violence. (n.d.). *Domestic violence and women's homicides.* Retrieved from https://cpedv.memberclicks.net/assets/docs/advocacyday15homicides.pdf

National Resource Center for Healthy Marriage & Families. (2013). *Family violence prevention: A toolkit for stakeholders.* Available from https://www.healthymarriageandfamilies.org/family-safety

Naughton, C. M., O'Donnell, A. T., & Muldoon, O. T. (2017). Exposure to domestic violence and abuse: Evidence of distinct physical and psychological dimensions. *Journal of Interpersonal Violence.* doi:10.1177/0886260517706763

Newhill, C. E., & Wexler, S. (1997). Client violence toward children and youth services social workers. *Children and Youth Services Review, 19*(3), 195–212. doi:10.1016/S0190-7409(97)00014-5

Niolon, P. H., Kearns, M. C., Dills, J., Rambo, K., Irving, S. M., Armstead, T. L., & Gilbert, L. K. (2017). *Preventing intimate partner violence across the lifespan: a technical package of programs, policies, and practices.* Retrieved from https://stacks.cdc.gov/view/cdc/45820

Noland, V. J., Liller, K. D., McDermott, R. J., Coulter, M. L., & Seraphine, A. E. (2004). *Is adolescent sibling violence a precursor to college dating violence? American Journal of Health and Behavior, 28*, 813–823.

O'Brien, P. J. (2006). Creating compassion and connection in the work place. *Journal of Systemic Therapies, 25*(1), 16–36.

Ogbonnaya, I. N., Finno-Velasquez, M., & Kohl, P. L. (2015). Domestic violence and immigration status among Latina mothers in the child welfare system: Findings from the National Survey of Child and Adolescent Well-being II (NSCAWII). *Child Abuse & Neglect, 39,* 197–206. doi:10.1016/j.chiabu.2014.10.009

Orloff, L. E. (2002). *Women immigrants and domestic violence.* Retrieved from http://library.niwap.org/wp-content/uploads/2015/pdf/FAM-Jrnl-WomenImmDV2002.pdf

Orloff, L.E., & Little, R. (1999). Somewhere to turn: Making domestic violence services accessible to battered immigrant women. In *A "how to" manual for battered women's advocates and service providers* (pp. 2–21). Washington, DC: Ayuda.

Osofsky, J.D. (2003). Prevalence of children's exposure to domestic violence and child maltreatment: Implications for prevention and intervention. *Clinical Child & Family Psychology Review, 6*(3), 161–170.

Oyewuwo-Gassikia, O. B. (2016). American Muslim women and domestic violence service seeking. *Affilia: Journal of Women & Social Work, 31*(4), 450–462. doi:10.1177/0886109916654731

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York, NY: W. W. Norton & Co.

Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural disparity in domestic violence prevalence and access to resources. *Journal of Women's Health, 20*(11), 1743–1749. doi:10.1089/jwh.2011.2891

Pelcovitz, D., Kaplan, S. J., DeRosa, R. R., Mandel, F. S., & Salzinger, S. (2000). Psychiatric disorders in adolescents exposed to domestic violence and physical abuse. American *Journal of Orthopsychiatry, 70,* 360–369. doi:10.1037/h0087668

Pennell, J., & Burford, G. (2000). Family group decision making: Protecting children and women. *Child Welfare, 79,* 131–158.

Pennsylvania Coalition Against Domestic Violence. (2017). *DV fatality risk factors.* Retrieved from http://www.pcadv.org/Learn-More/Domestic-Violence-Topics/Fatalities/DV-Fatality-Risk-Factors/

Petrick, N. D., Gildersleeve-High, L., McEllistrem, J. E., & Sobotnik, L. S. (1994). The reduction of male abusiveness as a result of treatment: Reality or myth? *Journal of Interpersonal Violence, 9*(4), 307–316.

Petrosky E., Blair J. M., Betz, C. J., Fowler, K. A., Jack, S. P., & Lyons, B. H. (2017). Racial and ethnic differences in homicides of adult women and the role of intimate partner violence —United States, 2003–2014. *Morbidity and Mortality Weekly Report, 66,* 741–746. doi:10.15585/mmwr.mm6628a1

Pinto, R., Correia Santos, P., Levendosky, A., & Jongenelen, I. (2016, August). Psychological distress and posttraumatic stress symptoms: The role of maternal satisfaction, parenting stress, and social support among mothers and children exposed to intimate partner violence. *Journal of Interpersonal Violence,* 1–23. doi:10.1177/0886260516674199

Potito, C., Day, A., Carson, E., & O'Leary, P. (2009). Domestic violence and child protection: Partnerships and collaboration. *Australian Social Work, 62*(3), 369–387. doi:10.1080/03124070902964657

Rhoades, V. J. (2015). Religious identity: A micro-level sociological study of faith, religion, and spirituality in the lives of women in a domestic violence shelter. *Dissertation Abstracts International, Section A, 75.*

Ridley, E., Rioux, J., Lim, K. C., Mason, D., Houghton, K. F., Luppi, F., & Melody, T. (2005). *Domestic violence survivors at work: How perpetrators impact employment.* Retrieved from https://www1.maine.gov/labor/labor_stats/publications/dvreports/survivorstudy.pdf

Rosay, A. B. (2016). *Violence against American Indian and Alaska Native women and men. 2010 Findings from the National Intimate Partner and Sexual Violence Survey.* Retrieved from https://www.ncjrs.gov/pdffiles1/nij/249736.pdf

Rose, J. (2016). *Lessons learned from the Greenbook Initiative.* Retrieved from https://rcdvcpc.org/the-greenbook-initiative/lessons-learned.html

Rosen, L. N., Knudson, K. H., Brannen, S. J., Fancher, P., Killgore, T. E., & Barasich, G. G. (2002). Intimate partner violence among U.S. Army soldiers in Alaska: A comparison of reported rates and survey results. *Military Medicine, 167,* 688–691.

Rudo, Z. H., Powell, D. S., & Dunlap, G. (1998). The effects of violence in the home on children's emotional, behavioral, and social functioning: A review of the literature. *Journal of Emotional and Behavioral Disorders, 6*, 94–113.

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review, 23*(3), 449–480.

Sargent, D. (2009). *Maryland's lethality assessment program: From research into practice.* S. Avalon (Ed.). Retrieved from http://www.bwjp.org/resource-center/resource-results/maryland-s-lethality-assessment-programs.html

Schechter, S., & Edelson, J. L. (1999). *Effective intervention in domestic violence and child maltreatment cases: Guidelines for policy and practice.* Retrieved from http://www.bvsde.paho.org/bvsacd/cd32/viole.pdf

Sears, B., & Mallory, C. (2011). *Documented evidence of employment discrimination & its effects on LGBT people.* Retrieved from http://williamsinstitute.law.ucla.edu/wp-content/uploads/Sears-Mallory-Discrimination-July-20111.pdf

Shannon, L., Logan, T. K., Cole, J., & Medley, K. (2006). Help-seeking and coping strategies for intimate partner violence in rural and urban women. *Violence and victims, 21*(2), 167. http://dx.doi.org/10.1891/vivi.21.2.167

Shin, J. (2011). Client violence and its negative impacts on work attitudes of child protection workers compared to community service workers. *Journal of Interpersonal Violence, 26*(16), 3338–3360. doi:10.1177/0886260510393002

Smith, D. L. (2008). Disability, gender and intimate partner violence: Relationships from the behavioral risk factor surveillance system. *Sexuality and Disability, 26*(1), 15-28. Retrieved from https://www.researchgate.net/profile/Diane_Smith9/publication/227067883_Disability_Gender_and_Intimate_Partner_Violence_Relationships_from_the_Behavioral_Risk_Factor_Surveillance_System/links/55e84b6408aeb65162630264.pdf

Soper, R. G. (2014). *Intimate partner violence and co-occurring substance abuse/addiction.* Retrieved from https://www.asam.org/magazine/read/article/2014/10/06/intimate-partner-violence-and-co-occurring-substance-abuse-addiction

Spears, L. (2000). *Building bridges between domestic violence organizations and child protective services* [On-line]. Retrieved from https://vawnet.org/material/building-bridges-between-domestic-violence-organizations-and-child-protective-services

Stanley, J., & Goddard, C. (2002). *In the firing line: Violence and power in child protection work.* New York, NY: Wiley.

Stanley, N., Miller, P., Richardson Foster, H., Thomson, G. (2010). Children's experiences of domestic violence: Developing an integrated response from police and child protection services. *Journal of Interpersonal Violence, 26*, 2372–2391. Available from http://journals.sagepub.com/doi/abs/10.1177/0886260510383030

Stark, E. (2002). The battered mother in the child protective service caseload: Developing an appropriate response. *Women's Rights Law Reporter, 23*(2), 107–131. Retrieved from http://www.cpe.rutgers.edu/NJDCF2012/docs/Stark-Battered-Mother-CPS-Caseload.pdf

U.S. Department of Health and Human Services, Administration for Children and Families. (2013). *FVPSA (Family Violence Prevention and Services Act) program overview.* Retrieved from https://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_summary_20131105.pdf

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2013). Intimate partner violence: Consequences. Retrieved from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (2003). *Costs of Intimate Partner Violence Against Women in the United States.* Retrieved from https://www.cdc.gov/violenceprevention/pdf/ipvbook-a.pdf

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2014). *The National Intimate Partner and Sexual Violence Survey: National data on intimate partner violence, sexual violence, and stalking.* Retrieved from https://www.cdc.gov/violenceprevention/pdf/NISVS-Fact-Sheet-2014.pdf

U.S. Department of Health and Human Services, Children's Bureau. (2011). Federal Child and Family Services Reviews: Aggregate Report, Round 2, Fiscal Years 2007-2010. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/fcfsr_report.pdf

U.S. Department of Health and Human Services, Children's Bureau. (2017). *Child maltreatment 2015.* Available from https://www.acf.hhs.gov/cb/resource/child-maltreatment-2015

U.S. Department of Health and Human Services, Children's Bureau. (n.d.). *Fact sheet: History of the CFSRS.* Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/cfsr_general_factsheet.pdf

U.S. Department of Health and Human Services, Family and Youth Services Bureau. (2015). *History and purpose of the Family Violence Prevention and Services Act.* Retrieved from https://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_tribal_20150731.pdf

U.S. Department of Health and Human Services, Family and Youth Services Bureau. (2016). *Tribal domestic violence services: History and purpose of the Family Violence Prevention and Services Act.* Retrieved from https://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_tribal_20170216_0.pdf

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2016). *Types of trauma.* Retrieved from https://www.samhsa.gov/trauma-violence/types

U.S. Department of Homeland Security, U.S. Citizenship and Immigration Services. (2011). *Information on the legal rights available to immigrant victims of domestic violence in the United States and facts about immigrating on a marriage-based visa fact sheet.* Retrieved from https://www.uscis.gov/news/fact-sheets/information-legal-rights-available-immigrant-victims-domestic-violence-united-states-and-facts-about-immigrating-marriage-based-visa-fact-sheet

Stark, E. (2007). *Coercive control: How men entrap women in personal life*. New York, NY: Oxford University Press.

Stark, E., & Filcraft, A. H. (1988). Women and children at risk: A feminist perspective on child abuse. International *Journal of Health Services, 18*(1), 97–118.

Steen, J. A. (2009). The perceived impact of a child maltreatment report from the perspective of the domestic violence shelter worker. *Journal of Interpersonal Violence, 24*(11), 1906–1918. doi:10.1177/0886260508325495

Sullivan, M., Senturia, K., Negash, T., Shiu-Thornton, S., & Giday, B. (2005). "For us it is like living in the dark": Ethiopian women's experiences with domestic violence. *Journal of Interpersonal Violence, 20,* 922–940. doi:10.1177/0886260505277678

Taggart, S. (2009). *Child and Family Service Review outcomes: Strategies to improve domestic violence responses in CFSR Program Improvement Plans.* Retrieved from http://www.futureswithoutviolence.org/userfiles/file/Children_and_Families/CFSR%202009.pdf

Taggart, S. (2011). *Child and Family Service Review outcomes: Strategies to improve domestic violence responses in CFSR Program Improvement Plans* (Revised). Retrieved from http://www.ncjfcj.org/sites/default/files/cfsr%20dv_web.pdf

Teten, A. L., Schumacher, J. A., Taft, C. T., Stanley, M. A., Kent, T. A., Bailey, S. D., . . . & White, D. L. (2010). Intimate partner aggression perpetrated and sustained by male Afghanistan, Iraq, and Vietnam veterans with and without posttraumatic stress disorder. *Journal of Interpersonal Violence, 25*(9), 1612–1630. doi:10.1177/0886260509354583

Thomas, E. K. (2000). Domestic violence in the African-American and African-Asian communities: A comparative analysis of two racial/ethnic minority cultures and implications for mental health service provision for women of color. *Psychology: A Journal of Human Behavior, 37*(3–4), 31–43.

Tjaden, P., & Thoennes, N. (1998). *Stalking in America: Findings from the National Violence Against Women Survey.* Retrieved from https://www.ncjrs.gov/pdffiles/169592.pdf

Tolman, R. M., & Edleson, J. L. (1995). Intervention for men who batter: A review of research. In S. R. Stith & M. A. Straus (Eds.), *Understanding partner violence: Prevalences, causes, consequences and solutions* (pp. 262–273). Minneapolis, MN: National Council on Family Relations.

Tolman, R. M., & Saunders, D. G. (1988). The case for the cautious use of anger control with men who batter. *Response, 11*, 15–20.

Tomison, A.M. (2000). *Exploring family violence: Links between child maltreatment and domestic violence* (Issues Paper 13). Retrieved from https://aifs.gov.au/cfca/publications/exploring-family-violence-links-between-child-maltreatment

Tsavoussis, A., Stawicki, S. P. A., Stoicea, N., & Papadimos, T. J. (2014). Child-witnessed domestic violence and its adverse effects on brain development: A call for societal self-examination and awareness. *Frontiers in Public Health, 2*, 178. doi:10.3389/fpubh.2014.00178

Turner, W., Hester, M., Broad, J., Szilassy, E., Feder, G., Drinkwater, J., . . . Stanley, N. Interventions to improve the response of professionals to children exposed to domestic violence and abuse: A systematic review. *Child Abuse Review, 26*(1), 19–39. doi:10.1002/car.2385

U.S. Department of Justice. (1997). *Promising practices initiative report on the expert panels on domestic violence, sexual assault and state assistance project.* Washington, DC: U.S. Government Printing Office.

U.S. Department of Justice, National Institute of Justice. (2007). *Stalking.* Retrieved from https://www.nij.gov/topics/crime/stalking/Pages/welcome.aspx

U.S. Department of Justice, National Institute of Justice. (2014). *Prevention and intervention of teens dating violence.* Retrieved from https://www.nij.gov/topics/crime/intimate-partner-violence/teen-dating-violence/Pages/prevention-intervention.aspx

U.S. Department of Justice, Office on Violence Against Women. (2017). *Domestic violence.* Retrieved from https://www.justice.gov/ovw/domestic-violence

U.S. Department of Veterans Affairs, PTSD: National Center on PTSD. (2017). *Child measures of trauma and PTSD.* Retrieved from https://www.ptsd.va.gov/PTSD/professional/assessment/child/index.asp

U.S. Preventive Services Task Force. (2004). Screening for family and intimate partner violence: Recommendation statement. *Annals of Family Medicine, 2*(2), 156–160. Retrieved from http://www.annfammed.org/content/2/2/156.full

UN Women, Virtual Knowledge Centre to End Violence Against Women and Girls. (2012). *Causes, protective and risk factors.* Retrieved from http://www.endvawnow.org/en/articles/300-causes-protective-and-risk-factors-.html

University of Michigan. (2009). *Abuse hurts: Definitions.* Retrieved from http://stopabuse.umich.edu/resources/definitions.html

Valencia-Weber, G., & Zuni, C. P. (1995). Domestic violence and tribal protection of indigenous women in the United States. *St. John's Law Review, 69,* 16.

Van den Bosse, S., & McGinn, M. l. (2009). Child welfare professionals' experiences of childhood exposure to domestic violence. *Child Welfare, 88*(6), 49–65.

Vera Institute of Justice. (2018). *Violence against people with disabilities occurs at alarming rates.* Retrieved from https://www.endabusepwd.org/problem/alarming-rates/

Vézina, J., & Hébert, M. (2007). Risk factors for victimization in romantic relationships of young women: A review of empirical studies and implications for prevention. *Trauma, Violence, and Abuse, 8*(1), 33 66.

Virkki, T. (2008). Habitual trust in encountering violence at work: Attitudes towards client violence among Finnish social workers and nurses. *Journal of Social Work, 8,* 247–267.

Vittes, K. A., & Sorenson, S. B. (2008). Restraining orders among victims of intimate partner homicide. *Injury Prevention, 14*(3), 191–195. doi:10.1136/ip.2007.017947

Warrier, S. (2008). "It's in their culture:" Fairness and cultural consideration in domestic violence. *Family Court Review, 46*(3), 537–542. doi:10.1111/j.1744-1617.2008.00219.x

Washington State Department of Social and Health Services, Children's Administration. (2010). *Social workers practice guide to domestic violence.* Retrieved from https://wscadv.org/wp-content/uploads/2015/05/social_workers_practice_guide_to_dv_feb_2010.pdf

Waugh, F., & Bonner, M. (2002). Domestic violence and child protection: Issues in safety planning. *Child Abuse Review, 11*, 282–295.

Websdale, N. (2000). *Lethality assessment tools: A critical analysis.* Retrieved from http://www.fcadv.org/sites/default/files/Websdale%2020 20004.pdf

Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood.* Ithaca, NY: Cornell University Press.

Whitney, P., & Davis, L. (1999). Child abuse and domestic violence: Can practice be integrated in a public setting? *Child Maltreatment, 4*(2), 158–166.

Wider Opportunities for Women. (2013). *Rural survivors and economic security.* Washington, DC: Author.

Williams, N. (2015). Fighting fire: Emotional risk management at social service agencies. *Social Work, 60*(1), 89–91.

Wolfe, D. A., Crooks, C. V., Lee, V., McIntyre-Smith, A., & Jaffe, P. G. (2003). The effects of children's exposure to domestic violence: A meta-analysis and critique. *Clinical Child and Family Psychology Review, 6,* 171–87. doi:10.1023/A:1024910416164

WomenSafe. (2002). *Myths and facts about domestic violence and substance abuse.* Retrieved from http://www.womensafe.net/dv/dvmyths.html

Zannettino, L. (2006). *Better outcomes for children affected by domestic violence: Developing interagency collaboration between child protection and domestic violence services (Research report).* Adelaide, Australia: Research and Education Unit on Gendered Violence, University of South Australia, & the Department of Families and Communities, South Australian Government.

Zust, B. L., Housley, J., & Klatke, A. (2017). Evangelical Christian pastors' lived experience of counseling victims/survivors of domestic violence. *Pastoral Psychology, 66*(5), 675–687. doi:10.1007/s11089-017-0781-1

Appendix A: Glossary

Adjudicatory Hearings – held by the juvenile and family court to determine whether a child has been maltreated or whether another legal basis exists for the state to intervene to protect the child.

Adoption and Safe Families Act (ASFA) – passed in 1997, this act (P.L. 105–89) emphasized the safety of children as the paramount concern in child welfare and promoted timely adoption and other permanent placements for children in foster care.

Assessment – ongoing practice of informing decision-making by identifying, considering, and weighing factors that affect children, youth, and their families; occurs from the time children and families come to the attention of the child welfare system and continues until case closure. See also Family Assessment, Initial Assessment, Risk Assessment, and Safety Assessment.

Court Appointed Special Advocates (CASA) – people appointed by the court (usually volunteers) who serve to ensure that the needs and best interests of a child are fully presented to the court in child protection judicial proceedings. See also Guardian ad Litem.

Case Closure – the process of ending the involvement between the caseworker and the family, which often involves a mutual assessment of progress and outcome achievement. Optimally, cases are closed when families have achieved their goals, and the risk of maltreatment has been sufficiently reduced or mitigated.

Case Plan – See Family Plan.

Case Planning (also known as developing the family plan) – the process where the caseworker works with the family and other professionals comprising the family team to develop the family plan.

Caseworker Competency – professional behaviors based on the knowledge, skills, personal qualities, and values a person demonstrates and/or are required.

Central Registry – a centralized database containing information on all substantiated/founded reports of child maltreatment in a selected area (typically a state or tribe).

Child Abuse Prevention and Treatment Act (CAPTA) – Federal law (P.L. 93–247, enacted in 1974; last amended in 2016 as P.L. 114–198) establishing a federal definition of maltreatment as "at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."

Child and Family Services Review (CFSR) – periodic reviews of state child welfare systems conducted by the Children's Bureau to ensure conformity with federal child welfare requirements, determine what is actually happening to children and families as they are engaged in child welfare services, and assist states and territories in helping children and families achieve positive outcomes of safety, permanency, and well-being.

Child Protective Services (CPS) – the designated social services agency (in most states, tribes, and territories) that usually receives, investigates, or assesses reports of alleged maltreatment and provides intervention and treatment services to children and families in which child maltreatment has occurred; frequently located within larger public social service agencies, such as departments of social services.

Coercive Control – a domestic violence perpetrator's pattern of behavior that seeks to take away the survivor's liberty or freedom and to strip away the survivor's sense of self.

Concurrent Planning – simultaneously identifies alternative permanency goals while making efforts to achieve reunification of the child with his or her parents. The process allows the child to realize other legal permanency more quickly if reunification efforts fail.

Cultural Competence (also known as Cultural Responsiveness) – a set of attitudes, behaviors, and policies that integrates knowledge about diverse groups of people into practices and standards to enhance the quality of services to all cultural groups being served.

Differential Response – also referred to as "dual track," "alternative," or "multi-track" response, it permits CPS agencies greater flexibility to respond with either a traditional investigation or a family assessment approach to children's needs for safety based on the degree of risk present and the family's needs for services and support. See Dual Track.

Dispositional Hearings – held by the court to determine the disposition of children, such as whether placement of the child in out-of-home care is necessary and/or should continue and what services and support the children and family will need to reduce the risk of maltreatment and to address the effects of maltreatment.

Domestic Violence – a pattern of coercively controlling behaviors perpetrated by one intimate partner against another.

Domestic Violence Perpetrator Intervention Program – typically court-ordered programs for domestic violence perpetrators, which both hold them accountable for their actions and identify alternate appropriate and nonviolent behaviors; usually held in a group format where participants learn about the dynamics of domestic violence, its effects on both the adult and child survivors, and issues of power and control. Also known as Batterer Intervention Programs.

Domestic Violence Advocates and/or Specialists – individuals, both professional and volunteer, who work to empower child and adult survivors of domestic violence by advocating for the rights of survivors within multiple systems, identifying resources and supports, and aiding them in developing plans for their safety. An advocate usually works for a domestic violence service provider and advocates for the survivors, while a specialist generally works within the child welfare (or agency other than the domestic violence service provider) and, as the name implies, specializes in addressing domestic violence issues for that particular agency.

Dual Track (also known as alternative response) – a term reflecting CPS response systems that typically combine a nonadversarial, service-based assessment track for cases where children are not at immediate risk with a traditional CPS investigative track for cases where children are unsafe or at greater risk for maltreatment. See Differential Response.

Emotional Abuse – See Psychological Maltreatment.

Evaluation of Family Progress – the ongoing process where the CPS caseworker measures changes in family behaviors and conditions, monitors risk elimination or reduction, assesses strengths, and determines case closure.

Exposure to Violence – environments in which children live where they are exposed to domestic violence perpetrators' abusive behaviors; applies to children who witness physical violence, as well as to those who do not (i.e., hearing violence, being exposed to threats or verbal abuse, intervening, having awareness of its aftermath).

Family Assessment – the stage of the child protection process when the CPS caseworker, community treatment provider, and the family develop a mutual understanding regarding the behaviors and conditions that must change to reduce or eliminate the risk of maltreatment, the most critical treatment needs that must be addressed, and the strengths on which to build.

Family Group Decision-Making – a generic term that includes a number of approaches in which family members are brought together and empowered to work with CPS and other service providers to make decisions about how to care for their children and to develop a plan for services. Different terms used for this type of intervention include family group conferencing, family team conferencing, family team decision making, family team meetings, and family unity meetings.

Family Preservation Services – short-term, family-focused, and community-based services designed to help families cope with significant stresses or problems that interfere with their ability to nurture their children; goal is to maintain children with their families or to reunify the family, when it can be done safely.

Family Plan (also known as Case Plan) – the casework document that outlines the outcomes, goals, timelines, tasks, and services and supports necessary to reduce the risk of maltreatment, assist in achieving those outcomes and goals, or facilitate adoption or other permanent placement when a child cannot safely return home.

Full Disclosure – CPS information to the family regarding the steps in the intervention process, the requirements of CPS, the expectations of the family, the consequences if the family does not fulfill the expectations, and the rights of the parents to ensure that the family completely understands the process.

Guardian ad Litem (GAL) – a lawyer or lay person who represents a child in court proceedings in CPS cases. Usually this person considers the "best interests" of the child and may perform a variety of roles, including those of independent investigator, advocate, advisor, and guardian for the child. See also CASA.

Historical Trauma – a form of trauma often associated with racial and ethnic population groups who have suffered major intergenerational losses and assaults on their culture and well-being; refers to the cumulative emotional and psychological wounding transmitted across generations within a community as a result of group traumatic experiences.

Home Visitation Programs – prevention programs (often voluntary) that offer a variety of family-focused services to pregnant mothers and families with new babies. Activities frequently encompass structured visits to the family's home and may address positive parenting practices, nonviolent discipline techniques, child development, maternal and child health, available services, and advocacy.

Indian Child Welfare Act (ICWA) – enacted in 1978 (P.L. 95–608), established standards for the placement of American Indian/Alaska Native children in foster and adoptive homes and enabled tribes and families to be involved in child welfare cases.

In-Home Services – services provided to families involved with the child welfare agency whose children remain at home or have returned home from out-of-home care.

Initial Assessment or Investigation – the stage of the CPS case process where the CPS caseworker determines whether a child is unsafe and assesses current safety threats and risk of future maltreatment; the worker also develops a safety plan, if needed to assure the child's protection, and determines if services are warranted.

Intake – the stage of the CPS case process (or on a child abuse hotline) where a worker (also known as the screener or intake specialist) screens alleged child maltreatment calls, reports, and referrals and makes collateral calls, as needed, to determine if the information meets the jurisdiction's criteria to assign for initial assessment or investigation.

Interview Protocol – a structured format to protect and preserve child safety while ensuring that all family members have an opportunity to participate in a planned strategy, service providers collaborate, and information gathering is consistent and thorough.

Juvenile and Family Courts – established in most states and Tribes to resolve conflict and to otherwise intervene in the lives of families in a manner that promotes the best interest of children; these courts specialize in areas such as child maltreatment, domestic violence, juvenile delinquency, divorce, child custody, and child support.

Kinship Care – child placement by the child welfare agency in the home of a child's relative or fictive kin.

Level of Dangerousness – assessment of both the number and types of indicators (e.g., use of weapons, stalking, threats of homicide, sexual abuse, mental illness) that helps determine the risk of a perpetrator severely harming or killing the adult survivor or children.

Mandated Reporter – people required by state statutes to report suspected child abuse and neglect to the proper authorities (usually CPS or law enforcement agencies). ; they vary by state and jurisdiction but typically include professionals such as educators and other school personnel, health care and mental health professionals, social workers, childcare providers, and law enforcement officers.

Memorandum of Understanding (MOU) – a written agreement that serves to clarify relationships and responsibilities between two or more organizations that share services, clients, or resources.

Multidisciplinary Team – established between agencies and professionals to confidentially share information related to families involved with CPS and to aid in decisions at various stages of the CPS case process; also known as child protection teams, interdisciplinary teams, or case consultation teams.

Multiethnic Placement Act of 1994 (MEPA) – as amended in 1996 by the Interethnic Placement provisions (MEPA-IEP), prohibits state agencies and other entities receiving federal funding and are involved in foster care or adoption placements from delaying, denying, or otherwise discriminating when making a foster care or adoption placement decision on the basis of the parent or child's race, color, or national origin.

Neglect – the failure to provide for the child's basic needs. Physical neglect can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection. Educational neglect includes failure to provide appropriate schooling, special educational needs, or allowing excessive truancies. Psychological neglect includes the lack of any emotional support and love, chronic inattention to the child, exposure to spouse abuse, or drug and alcohol abuse. Medical neglect includes the failure to (1) provide or to allow needed care as recommended by a competent health care professional and/or (2) seek timely and appropriate medical care for a serious health problem that any reasonable person would have recognized as needing professional medical attention.

Out-of-Home Care – placement of a child by the CPS agency in the care of a licensed foster parent, relative or fictive kin, or in a group home or residential facility.

Parens Patriae – originating in feudal England, a doctrine that vests in the state a right of guardianship of minors. This concept has gradually evolved into the principle that the community, in addition to the parent, has a strong interest in the care and nurturing of children. Schools, juvenile courts, and social service agencies all derive their authority from the state's power to ensure the protection and rights of children as a unique class.

Permanency – as defined in the Child and Family Services Reviews, a child in foster care is determined to have achieved permanency when any of the following occurs when the child is discharged from foster care to: (1) reunification with his or her family or either a parent or other relative, (2) a legally finalized adoption, or (3) the care of a legal guardian.

Perpetrator – the person who commits a pattern of domestic violence and coercive control; also referred to as offender, batterer, abuser, etc.

Physical Abuse – the inflicting of a nonaccidental physical injury upon a child. This may include burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. It may, however, have been the result of overdiscipline or physical punishment that is inappropriate to the child's age.

Protective Capacities – caregiver characteristics that help ensure the safety of his or her child; building protective capacities contributes to a reduction in risk.

Protective Factors – conditions or attributes of individuals, families, communities, or the larger society that reduce risk and promote healthy development and well-being of children and families, and appear to mitigate vulnerability to or negative effects from maltreatment.

Protective Order – an order issued by a criminal court that prohibits persons arrested for domestic violence from abusing their alleged victim(s); may include requirements that the perpetrator leave the home and/or refrain from contacting the victim(s). Typically expires when the case is adjudicated.

Psychological Maltreatment – a pattern of caregiver behavior or extreme incidents that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value to meeting another's needs; can include parents or caregivers using extreme or bizarre forms of punishment or threatening or terrorizing a child; also known as emotional abuse or neglect, verbal abuse, or mental abuse.

Response Time – a determination made by CPS and/or law enforcement regarding the immediacy of the response needed to a report of child abuse or neglect.

Restraining Order – a legal intervention where a survivor petitions a civil or family court for temporary protection. If granted by a judge, it typically orders that a perpetrator not commit acts of violence or threaten the adult or child survivors; some orders will not allow the perpetrator to enter the home of the survivor or may order no contact by the perpetrator with the survivor or children for a period of time guided by state law.

Review Hearings – held by the court to review dispositions (usually every 6 months) and the progress being made in meeting family plan goals and outcomes and to determine the need to maintain placement in out-of-home care or court jurisdiction over a child.

Risk – the likelihood that a child will be maltreated in the future.

Risk Assessment – to assess and measure the likelihood that a child will be maltreated in the future, frequently through the use of checklists, matrices, scales, and other methods of measurement.

Risk Factors – behaviors and conditions present in the child, parent, or family that will likely contribute to child maltreatment occurring in the future.

Safety – the absence of an imminent or immediate threat of moderate-to-serious harm to the child.

Safety Assessment – an ongoing CPS process in which available information is analyzed to identify whether a child is in immediate or imminent danger of moderate-to-serious harm.

Safety Plan – a casework document developed when it is determined that a child is in imminent or potential risk of serious harm; it targets the factors that are causing or contributing to the risk of imminent serious harm to the child and identifies, along with the family, the interventions that will control the safety factors and assure the child's protection.

Safety Plan (when domestic violence is involved) – a casework document developed when it is determined that the adult or child survivor is in imminent or potential risk of serious harm. In the safety plan, the caseworker targets the factors that are causing or contributing to the risk of serious harm and identifies, in concert with the adult survivor, the interventions that will control the safety factors and enhance the child and adult survivors' safety.

Secondary Traumatic Stress (STS) – work-related stress arising from secondary exposure to extremely or traumatically stressful events.

Service Provision – the ongoing process when CPS and other providers deliver specific services geared toward the reduction of risk of maltreatment and/or meeting outcomes.

Sexual Abuse – inappropriate adolescent or adult sexual behavior with a child. It includes fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, sexual exploitation, or exposure to pornography. To be considered child abuse, these acts have to be committed by a person responsible for the care of a child (for example a baby-sitter, parent, or daycare provider) or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

Shelter – a temporary, short-term home, which typically has an undisclosed location, where survivors of domestic violence and their children can reside safely. Shelter staff provide advocacy and access to resources and counseling for residents.

Substantiated/Founded – an investigation disposition concluding that the allegation of child maltreatment or risk of maltreatment was supported by state law or policy, i.e., that credible evidence exists that child abuse or neglect has occurred; terminology differs by state and jurisdiction.

Survivor – the perpetrator's target (adult or child) of domestic violence, including emotional, physical, verbal, sexual, and coercive control; included children who witness domestic violence.

Trauma-Informed – a trauma-informed system or practice is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers.

Treatment – the provision of specific, formal services by CPS and other providers to reduce the risk of maltreatment, support families in meeting case goals, and address the effects of maltreatment.

Unsubstantiated/Unfounded (not substantiated) – an investigation disposition that determines that there is not sufficient or credible evidence under state law or policy to conclude that the child has been maltreated or is at serious risk of maltreatment.; terminology differs by state and jurisdiction.

Well-Being – when the educational, emotional, physical, and mental health needs of children and their families are being met.

Appendix B: Resource Listings of Selected Organizations Concerned With Domestic Violence and Child Maltreatment

The Child Welfare Information Gateway provides a comprehensive list of resources for families dealing with domestic violence at https://www.childwelfare.gov/topics/systemwide/domviolence/resources/

It also offers an extensive database of national and state organizations dealing with child maltreatment at https://www.childwelfare.gov/organizations/

Within that database are organizations that address domestic violence at https://www.childwelfare.gov/organizations/?CWIGFunctionsaction=rols:main.dspList&rolType=Custom&RS_ID=115

Listed below are several additional organizations that deal with various aspects of child maltreatment and/or domestic violence.

Note: Inclusion on this list is for information purposes and does not constitute an endorsement by the Office on Child Abuse and Neglect or the Children's Bureau.

National Domestic Violence Hotline
Address:
PO Box 161810
Austin, TX 78716
Phone: 800.799.7233 (24-hour hotline)
800.787.3224 (TTY line)
E-mail: hotline.requests@ndvh.org for hearing impaired: deafhelp@ndvh.org
Website: http://www.thehotline.org/
Provides crisis intervention, information about domestic violence, and referrals to local service providers for all survivors of domestic violence (LGBTQ inclusive) and those calling on their behalf. Assistance is provided in both English and Spanish, and volunteers have access to translators in more than 200 languages.

Quality Improvement Center on Domestic Violence in Child Welfare (QIC-DVCW)
Address:
Futures Without Violence
100 Montgomery Street, The Presidio
San Francisco, CA 94129
Phone: 415.678.5500
866.678-8901 (TTY line)
Fax: 415.529.2930
Website: https://www.futureswithoutviolence.org/children-youth-teens/quality-improvement-center-domestic-violence-child-welfare-advancing-adult-child-survivor-centered-practice

E-mail: info@futureswithoutviolence.org
Tests interventions to improve how child welfare agencies and their partners work with families experiencing domestic violence. Resources include a webinar series on how domestic violence programs can enhance their work with survivors of domestic violence and their children by using evidence-based and promising practices. A service of the Children's Bureau.

Safe and Together™ Institute
Address:
David Mandel & Associates, LLC
P.O. Box 745
Canton, CT 06019
Phone: 860.319.0966
Website: www.endingviolence.com
Provides materials and access to information about training and technical assistance in the Safe and Together™ model. Resources include information about efforts to protect domestic violence survivors, creating a domestic violence-informed child welfare agency, and strategies for engaging perpetrators of domestic violence.

Family Violence Prevention Resource Centre (Canada)
Website: https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/prevention-resource-centre.html
Houses resources for families and professionals on domestic violence and the impact of domestic violence on children. Additionally, it includes the document *Little Eyes, Little Ears,* which is referenced throughout this manual, at https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/prevention-resource-centre/women/little-eyes-little-ears-violence-against-a-mother-shapes-children-they-grow.html

Abused Deaf Women's Advocacy Services
Address:
8623 Roosevelt Way NE
Seattle WA 98115
Phone: 206.922.7088 VP
855.8121001
Fax: 206.726-0017
Website: http://www.adwas.org
Email: adwas@adwas.org
Provides comprehensive services to Deaf and DeafBlind survivors of domestic violence, sexual assault, and harassment and their families, and provides community education and advocacy on systems and policy issues.

Military OneSource: Family Advocacy Program
Phone: 800.342.9647
Dial 711 and give the toll-free number 800-342-9647 (TTY/TDD line)
Website: http://www.militaryonesource.mil/-/the-family-advocacy-program
Department of Defense program to help prevent and support victims of child maltreatment and domestic violence.

VAWnet/Domestic Violence in Latin@ Communities
Address:
National Resource Center on Domestic Violence
6041 Linglestown Road
Harrisburg, PA 17112
Phone: 800.537.2238
Fax: 717.545.9456
Website: https://vawnet.org/sc/domestic-violence-latin-communities
Compilation by Casa de Esperanza and the National Latin@ Network for Healthy Families and Communities of tools and resources developed specifically by Latin@s and for Latin@s, as well as culturally adapted materials (not simply translations) to address domestic violence in Latin@ communities.

Child Welfare Capacity Building Collaborative
Website: https://capacity.childwelfare.gov/about/
Partnership designed to help public child welfare agencies, tribes, and courts enhance and mobilize the human and organizational assets necessary to meet federal standards and requirements, improve child welfare practice and administration, and achieve safety, permanency, and well-being outcomes for children, youth, and families. A service of the Children's Bureau, it comprises:

Capacity Building Center for States:
Phone: 844.222.0272
Email: capacityinfo@icfi.com
Website: https://capacity.childwelfare.gov/states/

Capacity Building Center for Tribes:
Phone: 800.871.8702
Email: info@cbc4tribes.org
Website: https://capacity.childwelfare.gov/tribes/

Capacity Building Center for Courts
Phone: 202.662.1731
Email: Jennifer.Renne@americanbar.org
Website: https://capacity.childwelfare.gov/courts/

Appendix C: State Directory of Where to Report Suspected Child Maltreatment

For updated contact information, please visit https://www.childwelfare.gov/organizations/?CWIG-Functionsaction=rols:main.dspList&rolType=custom&rs_id=5.

If you are unable to contact someone in your state, contact the National Child Abuse Hotline at 1-800-4-A-Child (1-800-422-4453). For more information, go to https://www.childhelp.org/.

State	Phone	Website
Alabama	Childhelp® (800) 422-4453	http://dhr.alabama.gov/services/Child_Protective_Services/Abuse_Neglect_Reporting.aspx
Alaska	Toll-free: (800) 478-4444	http://dhss.alaska.gov/ocs/Pages/default.aspx
Arizona	Toll-free: (888) SOS-CHILD (888-767-2445)	https://dcs.az.gov/report-child-abuse
Arkansas	Toll-free: (800) 482-5964 TDD: (800) 843-6349	http://humanservices.arkansas.gov/hotlines
California	Childhelp (800) 422-4453	http://www.cdss.ca.gov/Reporting/Report-Abuse/Child-Protective-Services/Report-Child-Abuse
Colorado	(844) 264-5437	http://co4kids.org/
Connecticut	Toll-free: (800) 842-2288 TDD: (800) 624-5518	http://www.ct.gov/dcf/cwp/view.asp?a=2556&Q=314388
Delaware	Toll-free: (800) 292-9582	http://kids.delaware.gov/services/crisis.shtml
District of Columbia	Local (toll): (202) 671-SAFE (202-671-7233)	http://cfsa.dc.gov/service/report-child-abuse-and-neglect
Florida	Toll-free: (800) 96-ABUSE (800-962-2873)	http://www.dcf.state.fl.us/abuse/

State	Phone	Website
Georgia	Childhelp (800) 422-4453	http://dfcs.dhs.georgia.gov/child-abuse-neglect
Hawaii	Local (toll): (808) 832-5300	http://humanservices.hawaii.gov/ssd/home/child-welfare-services/
Idaho	Toll-free: (800) 926-2588 TDD: (208) 332-7205	http://healthandwelfare.idaho.gov/Children/AbuseNeglect/ChildProtectionContactPhoneNumbers/tabid/475/Default.aspx
Illinois	Toll-free: (800) 252-2873 Local (toll): (217) 524-2606	http://www.state.il.us/dcfs/child/index.shtml
Indiana	Toll-free: (800) 800-5556	http://www.in.gov/dcs/2398.htm
Iowa	Toll-free: (800) 362-2178	http://dhs.iowa.gov/report-abuse-and-fraud
Kansas	Toll-free: (800) 922-5330	http://www.dcf.ks.gov/Pages/Report-Abuse-or-Neglect.aspx
Kentucky	Toll-free: (877) 597-2331	http://chfs.ky.gov/dcbs/dpp/childsafety.htm
Louisiana	Toll-free: (855) 452-5437	http://dss.louisiana.gov/index.cfm?md=pagebuilder&tmp=home&pid=109
Maine	Toll-free: (800) 452-1999 TTY: (800) 963-9490	http://www.maine.gov/dhhs/ocfs/hotlines.htm
Maryland	Childhelp (800) 422-4453	http://dhr.maryland.gov/child-protective-services/reporting-suspected-child-abuse-or-neglect/local-offices/
Massachusetts	Toll-free: (800) 792-5200	http://www.mass.gov/eohhs/gov/departments/dcf/child-abuse-neglect/
Michigan	Toll-free: (855) 444-3911 Fax: (616) 977-1154	http://www.michigan.gov/dhs/0,1607,7-124-5452_7119---,00.html
Minnesota	Childhelp (800) 422-4453	http://mn.gov/dhs/people-we-serve/children-and-families/services/child-protection/contact-us/index.jsp
Mississippi	Toll-free: (800) 222-8000 Local (toll): (601) 359-4991	https://www.mdcps.ms.gov/
Missouri	Toll-free: (800) 392-3738	http://dss.mo.gov/cd/can.htm
Montana	Toll-free: (866) 820-5437	http://www.dphhs.mt.gov/cfsd/index.shtml
Nebraska	Toll-free: (800) 652-1999	http://dhhs.ne.gov/children_family_services/Pages/children_family_services.aspx
Nevada	Childhelp (800) 422-4453	http://dcfs.nv.gov/Programs/CWS/CPS/CPS/

State	Phone	Website
New Hampshire	Toll-free: (800) 894-5533 Local (toll): (603) 271-6556	http://www.dhhs.state.nh.us/dcyf/cps/contact.htm
New Mexico	Toll-free: (855) 333-7233	http://cyfd.org/child-abuse-neglect
New York	Toll-free: (800) 342-3720 TDD: (800) 369-2437 Local (toll): (518) 474-8740	http://www.ocfs.state.ny.us/main/cps/
North Carolina	Childhelp (800) 422-4453	http://www2.ncdhhs.gov/dss/local/index.htm
North Dakota	Childhelp (800) 422-4453	https://www.nd.gov/dhs/services/childfamily/cps/#reporting
Ohio	Toll-free: (855) 642-4453	http://jfs.ohio.gov/ocf/reportchildabuseandneglect.stm
Oklahoma	Toll-free: (800) 522-3511	http://www.okdhs.org/contactus/pages/default.aspx
Oregon	Toll-free: (855) 503-SAFE (7233)	http://www.oregon.gov/dhs/children/child-abuse/Pages/Reporting-Numbers.aspx
Pennsylvania	Toll-free: (800) 932-0313 TDD: (866) 872-1677	http://www.dhs.pa.gov/citizens/reportabuse/
Puerto Rico	Toll-free: (800) 981-8333 Local (toll): (787) 749-1333	https://www.adfanpr.com/ (in Spanish)
Rhode Island	Toll-free: (800) RI-CHILD (800-742-4453)	http://www.dcyf.ri.gov/child_welfare/index.php
South Carolina	Local (toll): (803) 898-7318	https://dss.sc.gov/abuseneglect/report-child-abuse-and-neglect/
South Dakota	Childhelp (800) 422-4453	https://dss.sd.gov/childprotection/reporting.aspx
Tennessee	Toll-free: (877) 237-0004	https://www.tn.gov/content/tn/dcs/program-areas/child-safety/reporting/child-abuse.html
Texas	Toll-free: (800) 252-5400	https://www.dfps.state.tx.us/Contact_Us/report_abuse.asp
U.S. Virgin Islands	(340) 774-0930 St. Thomas (340) 773-2323 St. Croix (340) 776-6334 St. John	http://www.dhs.gov.vi/contact/index.html
Utah	(855) -323-3237	https://dcfs.utah.gov/
Vermont	After hours: (800) 649-5285	http://dcf.vermont.gov/protection/reporting

State	Phone	Website
Virginia	Toll-free: (800) 552-7096 Local (toll): (804) 786-8536	http://www.dss.virginia.gov/family/cps/index.cgi
Washington	Toll-free: (866) END-HARM (866-363-4276) Toll-free: (800) 562-5624 TTY: (800) 624-6186	http://www1.dshs.wa.gov/ca/safety/abuseReport.asp?2
West Virginia	Toll-free: (800) 352-6513	http://www.dhhr.wv.gov/bcf/
Wisconsin	Childhelp (800) 422-4453	https://dcf.wisconsin.gov/reportabuse
Wyoming	Childhelp (800) 422-4453	https://sites.google.com/a/wyo.gov/dfsweb/social-services/child-protective-services

Appendix D:
Domestic Violence Assessment: Survivor

The assessment of an adult survivor should be a conversation. By building a relationship and engaging with survivors, caseworkers can learn a great deal of information that can inform safety and risk assessments. Below are questions to help assess the level of violence comprehensively and to gather information about each of the categories.

While the caseworker should learn about the survivor's perspective of the family and of the domestic violence, it is important not to initiate any assessment with a series of rapid-fire, personal questions, which can be intimidating and off-putting.

1. Types and patterns of abusive tactics

Controlling, coercive, and threatening tactics

Does your partner prevent you from visiting people you care about?

Does your partner prevent you from going anywhere, like school or work?

Does your partner tell you what to wear, what to do, where you can go, or who you can talk to?

Do you have access to money, bus passes, car keys, insurance cards, or other items that you find important in your daily life? If not, why not? Has your partner tried to keep things from you? How?

Does your partner follow you to "check up" on you, check the mileage on your car, or time your trips, e.g., to the grocery store?

Does your partner call or text you in a way that feels overwhelming or intimidating while you're not together?

Does your partner give you threatening looks or stares when he or she does not agree with something you said or did?

Do you have access to control your own contraception? Has your partner ever interfered with your contraception?

What concerns you most about your partner's behavior?

If you have ever left your partner, has he or she ever made a threat or said that something bad would happen? If so, what did he or she say?

Verbal, emotional, sexual, or physical abuse

Does your partner call you degrading names, put you down, or humiliate you in public or in front of friends or family?

Does your partner blame you or tell you that you are at "fault" for the abuse or any problems you are having?

Does your partner deny or minimize his or her abusive behaviors towards you?

Has your partner ever destroyed your personal possessions? Broken or destroyed household items?

Has your partner ever pushed, kicked, slapped, or punched you?

Has your partner ever put his or her hands on your neck? Did you feel like you couldn't breathe?

Has your partner ever threatened to kill or harm him- or herself, you, the children, or a pet?

Has your partner ever threatened you with a weapon or gun? Does your partner have access to a dangerous weapon or gun?

Has your partner ever been arrested for a violent crime or behaved violently in public?

Has your partner ever forced you to commit illegal activities, use illegal drugs, or abuse alcohol?

Has your partner ever pressured you to do things sexually that made you uncomfortable?

2. Risks and impact on the adult survivor

How has your partner's abusive behavior affected you?

Do you suffer from anxiety or depression?

Do you have difficulty sleeping, eating, concentrating, etc.?

Do you suffer from headaches, stomachaches, breathing difficulties, or other health problems?

Have you had to seek medical assistance for injuries or health problems resulting from your partner's violence?

Have you been physically assaulted during pregnancy? Have you suffered prenatal problems or a miscarriage as a result of the abuse? Have you been forced to have an abortion?

Do you use alcohol or other substances? To what extent? If in recovery, how has your partner supported your sobriety? How has he or she made it harder?

Have you ever been hospitalized for a mental illness? Do you have a mental health diagnosis? Are you taking psychotropic medication? Does your partner ever interfere with your treatment or take away your medication?

Have you ever thought about or tried to hurt yourself or someone else?

3. Risks and impact on the children

Has your partner called your children degrading names or verbally threatened them?

Has your partner ever threatened to make a report to child protective services (CPS), take custody of the children, or kidnap them?

Does your partner physically discipline or touch the children in a manner that you don't agree with or that makes you uncomfortable?

Has your partner ever asked the children to report your daily activities or to "spy" on you?

Has your partner ever forced your children to watch or participate in his or her abuse of you?

Has your partner physically hurt you in front of the children?

How do you think the violence at home affects your children?

Do your children exhibit problems at school or at home (e.g., sleeping and eating difficulties, difficulty concentrating in school, aggressive behaviors)? Are there any instances you can think of where these issues have worsened?

Have your children ever intervened in a physical or verbal assault to protect you or to stop the violence?

Do your children behave in ways that remind you of your partner?

Has a school or child care center ever contacted you regarding behavioral problems of your children?

4. Help-seeking and protective strategies

Have you told anyone about the abuse? What happened?

Have you ever left home because of the abuse? Where did you go and what happened?

Have you ever called the police or 911? What was their response? Did you find this helpful? Why or why not?

Have you ever filed a restraining order or criminal charges? What was your partner's response? Did you find this helpful? Why or why not?

Have you ever used a domestic violence shelter or services? Was it helpful? Why or why not?

Have you fought back? What happened?

Can you describe how you talk to the children about how they feel and what they have witnessed?

What have you tried in the past to keep yourself and the children safe that felt helpful? What have you tried that did not feel helpful?

Can you describe what you do on a daily basis to parent the children and how you meet their needs despite what has happened?

How will your partner react if he or she finds out you talked with me?

Appendix E:
Domestic Violence Assessment: Child

To obtain accurate and reliable information from a child about a domestic violence situation, it is crucial that the language and questions are appropriate for the child's age and developmental stage. Training and experience in working with young children, in particular, may be necessary.

1. Types and frequency of exposure to domestic violence

What kinds of things do your mom and dad (or girlfriend or boyfriend) fight about?

What happens when they argue?

Do they yell at each other or call each other bad names?

Does anyone break or smash things when they get angry? Who?

Have they ever hit each other? Who does the hitting?

How does the hitting usually start?

How often do your mom and dad argue or hit?

Have the police ever come to your home? Why?

Have you ever seen your mom or dad get hurt? What happened?

2. Risks posed by the domestic violence

Have you ever been hit or hurt when your mom and dad (or girlfriend or boyfriend) are fighting?

Has your brother or sister ever been hit or hurt during a fight?

What do you do when they start arguing or when someone starts hitting?

Has either your mom or dad hurt your pet?

3. Impact of exposure to domestic violence

Do you think about your mom and dad (or girlfriend or boyfriend) fighting a lot?

Do you think about it when you are at school? While you're playing? When you're by yourself?

How does the fighting make you feel?

Do you ever have trouble sleeping at night? Why? Do you have nightmares? If so, what are they about?

Why do you think they fight so much?

What would you like them to do to make it better?

Are you afraid to be at home? To leave home?

What or who makes you afraid?

Do you think it's okay to hit when you're angry? When is it okay to hit someone?

How would you describe your mom? How would you describe your dad?

4. Protective factors

What do you do when your mom and dad (or girlfriend or boyfriend) are fighting?

If the child has difficulty responding to an open-ended question, the worker can ask if the child has:

- Stayed in the room
- Left or hidden
- Gotten help
- Gone to an older sibling
- Asked parents to stop
- Tried to stop the fighting

Have you ever called the police when your parents are fighting?

Have you ever talked to anyone about your parents' fighting?

Is there an adult you can talk to about what's happening at home?

Have you talked with your (primary caregiver/ adult survivor) about how you feel? Does it help you feel better?

Can you tell me about things that make you happy about your family?

What makes you feel better when you think about your parents' fighting?

Appendix F: Domestic Violence Assessment: Alleged Perpetrator

Increasingly, child protective services (CPS) develops family plans and change strategies with perpetrators, as required and when appropriate to do so. These plans not only work toward holding the perpetrator accountable for the abuse, but also guide decisions about involvement and interaction with the children. It is as important to engage the perpetrator as it is the survivor and children in order to obtain accurate and useful information, recognizing that the perpetrator may not be honest about the extent of his or her behaviors.

1. Expectations of the survivor and the relationship

Describe your relationship with your partner.

How would you describe your partner?

What type of things do you expect from your partner?

How do you support your partner's parenting and relationship with the children?

What do you do when you and your partner disagree?

What do you do when you become angry?

2. Types of abusive behavior and tactics

Have people told you that your temper is a problem? Who? And why did they tell you that?

How do you feel about your partner visiting his or her friends and family?

How do you and your partner manage your household duties and income?

Do you ever yell at your partner? Call your partner degrading names? Put your partner down?

Have you ever physically harmed or used force on anyone in your family? In what way? When?

Have you ever put your hands on your partner? For example, have you pushed, kicked, or slapped him or her? Held him or her down? Grabbed him or her by the neck?

Have you ever threatened to harm or kill yourself, your partner, your children, or your pet?

Have you ever threatened or used a weapon or gun against your partner? Do you have access to a weapon or gun?

Have the police ever come to your home? How many times? Why? What happened?

Have you ever been arrested, charged, or convicted of a domestic violence assault? If so, what happened?

3. Risks to the children

How would you describe your children?

What kinds of things do you expect from your children?

How do you discipline your children?

How do you think the children are affected when they see or hear you and your partner fighting?

Have your children ever tried to intervene during an argument with your partner? Why and what happened?

What are your goals for yourself as a parent?

Do your behaviors towards your partner ever affect that?

How would the children describe how they feel when they've seen you act aggressively?

4. Protective factors

What are you willing to do to change your behaviors in order to be safer for your children?

Do you have friends or family you can stay with if you need to leave the home to avoid exposing the children to your behaviors?

Whom have you told about your behaviors? How was it helpful to you?

What else do you need to support you in order to end your abusive behaviors?

What other supports do you need to help you achieve your goals as a safe parent?

What others supports do the children need to be safe and well?

5. Risk factors that may increase levels of dangerousness

Did you ever see either of your parents harmed by a spouse or significant other? If so, what did you do, and how did it make you feel?

Were you ever harmed as a child?

When was the last time you drank or used an illegal substance? How much?

Have you ever attended a substance abuse program or been arrested for DUI?

Have you ever been treated for depression?

Have you previously been violent with your partner? With others?

Have you experienced pervasive thoughts of homicide or suicide? Attempts?

References for Appendices D-F

Bragg. L. (1998). *Domestic violence protocol for child protective services intervention.* Charlotte, NC: Mecklenburg County Department of Social Services.

Connecticut Department of Children and Families. (2007). *Unpublished protocol.* Hartford, CT: Author.

Ganley, A. L., & Schechter, S. (1996). *Domestic violence: A national curriculum for child protective services.* San Francisco, CA: Family Violence Prevention Fund.

Mandel, D. (n.d.). *Safe and Together™ Model.* Retrieved from http://endingviolence.com/our-programs/safe-together/safe-together-overview/

Massachusetts Department of Social Services. (1995). *Unpublished domestic violence practice protocol.* Boston, MA: Author.

Mederos, F. (2000). *Child protection services, the judicial system and men who batter: Toward effective and safe intervention.* Unpublished practice paper. Jamaica Plains, MA: Massachusetts Department of Social Services.

Appendix G: Safety Plans

Safety plans in domestic violence cases should be separate for the survivor and the perpetrator. When developing a plan for a survivor, the caseworker should (1) build upon the survivor's previous efforts to protect him- or herself and the children and (2) not include activities that he or she identifies as being unsafe. Perpetrators should not have access to survivor's plans. If perpetrators are legally required to have access to survivors' plans in a particular state, the caseworker should ensure the plan does not disclose any information that should remain confidential or that the perpetrator can use to sabotage the plan. Perpetrators' plans should focus on addressing their behaviors in order to keep children safer.

Safety Plan—Adult Survivor

I, Jane Smith, can do the following to pursue safety prior to and during a violent incident:

In the past, I have found it helpful to ask the children to go next door when I identify that their father is escalating. The neighbors are aware of this plan and agreed to help.

I can have my purse and car keys ready and place them in a closet near an exit door so that I can leave quickly.

I can tell my neighbors about the violence and ask that they call the police if they hear yelling, screaming, or loud noises coming from my house.

I can teach my children how to use the telephone to call 911 and provide our address and phone number.

I will use "TIME" as the code word with my children, relatives, and friends so they can call for help.

If I have to leave my home, I can stay safely with a coworker. My partner does not have her address. I am aware that I can call the domestic violence hotline and learn about possibly going into a shelter if I need it.

When I expect my partner may become violent, I will try to move to a space that is lowest risk, such as the foyer or back hall where the doors are located.

I will tell my children NOT to intervene when we are arguing or if a violent incident occurs.

Safety Plan—Child

When my mom and I are not safe, I will not try to stop the fighting. I will go to my room or to my next-door neighbor's home.

If I call the police for help, I will dial 911 and tell them:

My name is Jack Smith.

I need help.

Send the police.

Someone is hurting my mom.

My address is 5011 Crooked Oak Lane. I will remember not to hang up until the police get there.

A code word for "help" or "I'm scared" is "BUNNY." I will practice this with my mom every night.

Safety Plan—Perpetrator

I will refrain from being physically violent or aggressive in any manner towards my partner, children, or pets.

If I believe that my behaviors are escalating towards violence, I will leave the home and stay with my brother. My brother has agreed to this plan and will call my partner when I leave his house.

I will not engage in any physical discipline of the children.

I will ensure my partner and children have access to all necessary items, such as insurance cards, car keys, bus passes, EBT cards, or others.

I will not interfere in any manner with my partner's parenting.

I will not withhold access for the children to attend medical appointments, mental health appointments, school, or other activities.

I will not use belittling or demeaning language in front of my children. If I believe that I will do so, I will leave the house and call my coworker or my brother. If I do not think I can refrain from using this language, I will stay at my brother's home.

I will follow all court orders, including protective and restraining orders.

References

Connecticut Department of Children and Families (2007). Unpublished protocol. Hartford, CT: Author.

Mandel, D. (n.d.). Safe and Together™ Model. Retrieved from http://endingviolence.com/our-programs/safe-together/safe-together-overview/

Appendix H:
Developing a Memorandum of Understanding

Although domestic violence and child welfare professionals frequently serve the same families, they have historically operated in isolation from one another. Consequently, this "disconnect" between these two professions has produced negative outcomes for the actual survivors that they attempt to serve. Communities and organizations have developed strategies to address this disconnect and joined together to integrate domestic violence and child welfare services to meet the needs of survivors and children better.

One of these strategies is to develop a memorandum of understanding (MOU). The MOU developed by the El Paso County (Colorado) Greenbook Project follows (verbatim).

What is an MOU?

It is a written agreement that serves to clarify relationships and responsibilities between two or more organizations that share services, clients, and resources.

Why is it important to have an MOU?

The purpose of an MOU is to strengthen partnerships between two or more organizations that seek solutions to mutual problems. The overall goal is to develop partnerships between all of the parties as they work more closely together and benefit from the interchange of ideas and practices. Communities with MOUs report that the strengthened partnerships result in enhanced services for adult survivors and children affected by family violence.

What is actually included in an MOU?

Generally, MOUs can include a variety of different issues and topics. Input from each partnering agency enhances the overall process of creating a jointly crafted MOU. Each MOU can range from one to several pages in length, with an allowance for signatures, which represents the commitment from all leaders involved. MOU content areas may include:

- Agency role clarification
- Cross-agency referrals
- Assessment protocols
- Confidentiality parameters
- Case management intervention
- Interagency training of staff
- Agency liaison/coordination
- Interagency conflict resolution management
- Periodic review of the MOU

How do we know our community them understand each other's language and historyis ready to develop an MOU?

Communities that are concerned about reducing the growing incidence of domestic violence and child abuse and neglect are excellent candidates for creating an MOU. Communities with a history of collaboration will have a foundation upon which to build. It is important to note, however, that in those communities experiencing strained relationships, the MOU-writing process provides an opportunity to address misperceptions and differences and to work together to resolve service-delivery gaps.

What strategies should we undertake as we begin the MOU process?

Depending on pre-existing relationships within communities, one strategy may include inviting key supporters to meetings to explore the feasibility of MOU development. Communities report that once they have the commitment and investment from the leaders of the domestic violence and child welfare agencies, the MOU process quickly crystallizes and results in a written MOU. An additional strategy may include inviting an outside consultant to facilitate a mutual partnership that leads to the development of an MOU.

What are the potential problems that arise during the MOU process?

Problems may arise concerning misperceptions about each other's goals, missions, legal mandates, and philosophy. Domestic violence and child welfare agency professionals report that the MOU meetings help them understand each other's language and history and provide a context in which to view each other's philosophy and mission. Another area of tension involves confidentiality and the various implications for each agency. Additional problematic issues may include assessment decisions, levels of intervention, and out-of-home placement for children when the survivor is the nonoffending parent. The MOU process provides an opportunity to address these critical issues to meet the needs of the mothers and children best.

How does the MOU actually help families and children?

Families affected by domestic violence and child maltreatment report that they are reluctant to request assistance, are required to participate in services that do not address the underlying issues, and frequently feel misunderstood by professionals. Communities with existing MOUs have found that children who were exposed to domestic violence were less likely to be placed in out-of-home settings and that families were more motivated to work with professionals to reduce their risk of future family violence. Families served in communities where MOUs have been established report a higher level of satisfaction in working with professionals. One mother commented, "Before, when I called, no one seemed to understand, and, now, I finally feel as though someone is really listening to what I have to say."

Greenbook Project Institutional Safety and Accountability Audit
Memorandum of Understanding
September 2005[1]

I. Background:
a. This MOU was developed as a result of discussions by the El Paso County Greenbook Judicial Integration Committee over the past year regarding the need to assess how victim safety and offender accountability is central to the processing of misdemeanor domestic violence cases.

b. The Greenbook Project has secured grant funding to enable the Judicial Integration Committee to conduct a Family Violence Safety and Accountability Audit in El Paso County, Colorado.

c. The Family Violence Safety and Accountability Audit (hereafter referred to as Audit) identified in this MOU agreement refers to the process developed in Duluth, Minnesota, by Ellen Pence and outlined in the manual The Duluth Safety and Accountability Audit, A Guide to Assessing Institutional responses to Domestic Violence.

d. The Audit is a multidisciplinary, community-based process and has several steps:
(1) Forming and preparing an inter-agency Audit team
(2) Determining which aspects of case processing the team will investigate
(3) Determining the scope of the investigation
(4) Collecting data from each point of institutional action on a case, including the link or relationship between the data produced at different points of intervention

(5) Analyzing the data
(6) Preparing findings that lead to specific recommendations

e. Data collection methods include text analysis (forms, documents, reports), interviews, observations, and focus groups. Analyzed texts relating to each step in the system response will be used to determine interview questions and the focus of observations and will generally help guide and develop the Audit process.

f. A multidisciplinary Audit Team will examine how each institution charged with intervening in cases of domestic violence organizes its practitioners to perform their duties. Rather than attending to the idiosyncrasies of individual practitioners, the Audit looks instead at how, where, and if their formal and informal practices ensure the safety of victims and the accountability of offenders.

g. Audit Team members will meet in small and large groups throughout the Audit process to discuss findings and propose changes to system practices that will enhance both victim safety and offender accountability.

h. The Audit Team in El Paso County will be trained and assisted by consultants from Praxis International (Praxis). Praxis has been contracted by the federal Violence Against Women Office to provide technical assistance to the recipients of the Rural Domestic Violence and Child Victimization Grants since 1998. In addition, the Greenbook Project will provide funding for technical assistance from Praxis.

1 This MOU is duplicated from El Paso County Greenbook Project. (2007). *El Paso County, Colorado, Institutional Safety & Accountability Audit Report.* Retrieved from http://www.bwjp.org/assets/documents/pdfs/el_paso_county_community_safety_assessment.pdf, pp. 71–72.

II. Roles and Responsibilities

1. Audit Team Participation

The following agencies have agreed to participate as consistent members of the Audit Team:

– Office of the District Attorney, Fourth Judicial District
– TESSA
– Colorado Springs Police Department (Including Dispatch)
– Fourth Judicial District/County Court
– Fourth Judicial District Probation
– El Paso County Sheriff's Office
– Survivor of Domestic Violence/Spanish-Speaking
– Domestic Violence Case Monitor
– Greenbook Project Staff
– Audit Coordinator

AGENCY agrees to designate and provide time for a staff member who is interested and committed to the goals of this project to actively participate as a member of the Audit team. The designated staff member will attend 2-day Audit training, participate in interviews and observations, and participate in Audit Team meetings to analyze the data that is collected and to make recommendations for system changes, if needed. The Audit Team member is expected to dedicate 8 hours per month to the audit process, which may be split into 2 meetings per month, over the course of 1 year.

AGENCY leadership agrees to work closely with the designated Audit Team representative to provide honest, up-to-date information that will enhance the outcomes of the Audit.

2. Text analysis

AGENCY will provide written information and documents to the Audit Coordinator that the agency/agency's designee determines is (a) reasonable and (b) will not compromise the safety of any victims.

AGENCY agrees that any documents it provides that have identifying features of individuals, including advocates/therapists/staff, will be redacted (made anonymous) by the Audit Coordinator and/or the agency designee. Redacted reports or documents provided by AGENCY will be kept by the Audit Coordinator in a locked cabinet. The analysis will use excerpts from the reports, but will not identify any person or agency involved with the cases.

3. Observations and Interviews

AGENCY will allow Audit Team members and Praxis consultants to interview, observe, and shadow/ride-a-long with practitioners in order to gather information on how domestic violence and similar cases are handled. Audit Team members will arrange for all observations/shadowing through a person designated by the AGENCY/Audit designee.

The Audit Coordinator will be responsible for arranging and scheduling all interviews and observations. The Audit Coordinator will arrange for all observations through person designated by the AGENCY/Audit Designee.

4. Implementation of Audit Team Recommendations

AGENCY agrees to review the Audit Team's findings and recommendations and work with the Audit Team to implement recommended changes to the fullest degree possible.

Signatures:

By _____
Date _____

By _____
Date _____