Journal of Family Violence (2019) 34:47–54
https://doi.org/10.1007/s10896-018-9991-2

ORIGINAL ARTICLE

# "It's Tricky …": Intimate Partner Violence Service Providers' Perspectives of Assessments and Referrals by Child Welfare Workers

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Published online: 17 August 2018


## Abstract

The present study explored the perceptions of workers who provide intimate partner violence (IPV) services regarding child welfare workers' IPV assessment and referral processes. Data from four focus groups was interrogated to find common themes. A total of 27 individuals participated in the focus groups, working in the community, shelters, and prisons/jails. Participants primarily expressed concerns regarding child welfare workers' practices. IPV providers perceived child welfare workers as incompetent in performing IPV assessments and making referrals. IPV workers also perceived that some child welfare workers engaged in dismissive, manipulative, or coercive behaviors when working with IPV victims. While the present findings are not generalizable, they speak to the tension frequently noted between victim services and child welfare. Child welfare agencies should consider ongoing, trauma-informed training for IPV assessment to help increase worker self-efficacy in performing these tasks. Local, interdisciplinary trainings including both IPV and child welfare providers may be particularly useful to promote better understanding of each provider's role in cases with co-occurring IPV and child maltreatment concerns, which may help to reduce tensions between the intersecting service systems.

**Keywords** Intimate partner violence · Assessment · Referral · Screening · Child welfare

Intimate partner violence (IPV) is a common experience, as one in four women and one in ten men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime (Smith et al. 2015). IPV victims can experience myriad psychosocial problems, either related or unrelated to the IPV (e.g., health care, mental health, child welfare, or substance use). Given this, IPV victims are sometimes identified by adjacent system providers and referred to IPV-serving agencies. The present qualitative study explored IPV service providers' perceptions of the IPV assessment and referral processes. Participants primarily focused on their perceptions of child welfare professionals' role in assessment and referral and, as such, the present article is framed using this context.

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## Literature Review

Child welfare workers often interact with clients who have histories of IPV and need appropriate referrals. IPV is prevalent in child welfare cases, with up to 70% co-occurrence (Cross et al. 2012; Fusco 2013). In addition to consequences for the adult IPV victims (Centers for Disease Control and Prevention [CDC] 2017), researchers have established significant relationships between witnessing IPV in childhood and both behavioral and emotional problems (Evans et al. 2008). Though tensions frequently arise between the IPV and child welfare service sectors over who should be the primary client—the child or the adult (Fleck-Henderson 2000; Fusco 2013)—the prevalence of their co-occurrence necessitates coordinated efforts to address family violence holistically. For child welfare workers, this often includes assessing for IPV and making appropriate referrals to IPV resources.

However, research findings indicate that child welfare caseworkers frequently underidentify active IPV in their risk assessments (Casanueva et al. 2014).

Those working in IPV-specific services (hereinafter "IPV agencies" or "IPV providers") are trained in the complex process of assessment, which includes screening tools, open-ended questions, and the use of clinical expertise or judgment. Specifically, a combination of a structured interview and unstructured follow-up questions results in client "storytelling" and effectively captures more of the client's experience (Cattaneo and Chapman 2011). Often screening tools are used to assess violence, but they can only glean so much. Assessors must rely on other means to gather information. Due to the difficulty in empirically defining IPV, assessment involves a combination of experience and intuition (Waltermaurer 2005), placing much of the onus on the assessor and their skills in the field (Stover and Lent 2014). A significant skill necessary for assessment is the ability to build rapport, which can help workers earn a client's trust. For example, Fincher et al. (2015) found that women utilizing Women, Infants, and Children (WIC) services were more likely to disclose IPV in a face-to-face interview in which the interviewer established rapport, remained non-judgmental, and expressed interest in the situation. While this method of assessment is ideal for IPV workers, staff from non-IPV agencies often do not have the time or support to conduct such thorough assessments.

Given the prevalence of IPV across settings, many non-IPV agencies have documented challenges in conducting assessments. For example, non-IPV providers are often inadequately trained on the best practices and intricacies of IPV assessment (Bennett et al. 2016). Further, they may question the value or appropriateness of screening for IPV given their lack of training, workload priorities, and concerns about the outcome of screening (Minsky-Kelly et al. 2005). This is especially true for the child welfare system. For example, child welfare workers report a lack of preparedness and confidence in assessing for IPV, even though they are required to do so (Coulter and Mercado-Crespo 2015). In fact, results from two waves of the National Survey of Child and Adolescent Well-Being indicated that child welfare workers underidentified IPV in more than two-thirds of cases (Casanueva et al. 2014), likely due to lack of training in recognizing the spectrum of IPV-related behaviors (e.g., emotional abuse; Zannettino and McLaren 2014). Additionally, many child welfare workers reportedly dislike IPV cases (Fusco 2013); perceive a lack of personal safety when working with IPV perpetrators (Bourassa et al. 2008); and have contrasting viewpoints with IPV service providers (Coulter and Mercado-Crespo 2015).

Since many non-IPV providers note a lack of comfort and training to address IPV, referral to specialized services is key. IPV providers receive the training necessary to ensure their comfort and knowledge of assessment protocol. Unfortunately, many individuals who seek services from non-IPV providers face barriers related to the referral process. Many agencies do not have an in-house IPV specialist or do not have a clear protocol for referral (Bennett et al. 2016). In a study of mothers involved with child protective services, 25% reported an incident of domestic violence in the past 12 months and of those cases, only 32% reported receiving a referral to IPV-specific services (Casanueva et al. 2014). This is attributed to both a lack of identification of IPV by child welfare workers as well as the lack of availability of IPV-specific services (Casanueva et al. 2014).

## Aim

At the outset, this study aimed to explore the IPV assessment and referral process from the perspectives of both IPV and non-IPV providers, which is conveyed in the Methods section below. However, what achieved thematic saturation were the IPV providers' thick descriptions of assessments and referrals conducted by child welfare professionals. Therefore the aim of this paper was to explore IPV service providers' perceptions of the IPV assessment and referral processes.

## Methods

### Design

Researchers conducted five focus groups among service providers in [Southern state name blinded for review] and [Northeastern state blinded for review. Three groups were comprised of service providers who worked within different arms of a county social service organization, including one group for direct domestic violence-related services (victim support and batterer intervention), one group for homelessness and substance use services, and one group for services for workers who provided IPV services to child welfare-involved families. A fourth group was conducted with staff of the North Carolina correctional agency who provide batterer intervention services to incarcerated men. Lastly, a group was conducted among a domestic violence victim services organization in New York. The five focus groups varied in size: two groups had nine participants, and the others had six, seven, and three. Because the aim of this project focused on the perspective of IPV workers, responses from the homelessness/substance use focus group were not analyzed. This resulted in a total of four focus groups being analyzed, including 27 participants.

## Participants

Participants were recruited through coordination with administrative staff at the agencies. The staff distributed flyers about the focus group, coordinated space and times, and managed a list of interested participants. By coordinating with agency supervisors, groups were scheduled at convenient times for employees. Participation was incentivized by offering a $10 gift card to a local retail establishment to compensate for their time.

See Table 1 for a detailed description of the demographic characteristics of the sample. A total of 27 service providers participated. The majority of participants were female (89%, $n = 24$), and the modal age category was between 30 and 39 years old (37%, $n = 10$). Twelve service providers identified as Black, two identified as multiracial, nine as White, and four identified in other racial categories. Providers had a wide range of experience in the field, from 2.5 years to over 30 years. The majority of service providers classified their work as intervention ($n = 23$), while some selected both prevention ($n = 8$) and intervention. Some provided "other" services, such as case management or assessments. Service providers could indicate multiple settings in which they did their work, including in the community ($n = 17$), shelters ($n = 8$), and jails or prisons ($n = 3$). Other service settings included administrative offices and schools.

**Table 1** Participant demographics ($N = 27$)

| | % (*n*) |
|---|---|
| Gender | |
| Female | 88.8 (24) |
| Male | 11.1 (3) |
| Race | |
| Black | 44.4 (12) |
| White | 33.3 (9) |
| Multiracial | 7.4 (2) |
| Other | 14.8 (4) |
| Age | |
| 20–29 | 7.4 (2) |
| 30–39 | 37.0 (10) |
| 40–49 | 29.6 (8) |
| 50–59 | 11.1 (3) |
| 60–69 | 11.1 (3) |
| Years in field | |
| Less than 5 | 25.9 (7) |
| 5–10 | 25.9 (7) |
| 11–20 | 25.9 (7) |
| More than 20 | 22.2 (6) |
| Client Population Served* | |
| Homelessness | 37.0 (10) |
| Domestic Violence | 81.5 (22) |
| Substance use/Abuse | 18.5 (5) |
| Other | 11.1 (3) |
| Services Provided* | |
| Prevention | 29.6 (8) |
| Intervention | 85.2 (23) |
| Other | 25.9 (7) |
| Service Setting* | |
| Jail/Prison | 11.1 (3) |
| Shelter | 29.6 (8) |
| Community | 63.0 (17) |
| Other | 33.3 (9) |

*Percentages in category do not add up to 100 as participants could select multiple categories

## Procedures

Each focus group lasted approximately 90 min. The facilitator discussed the study procedures and gathered informed consent. Focus groups were audio recorded and transcribed verbatim. Any identifying information was anonymized during the transcription process to protect the identity of respondents and eliminate potential sources of bias from the coders. All procedures were approved by the Institutional Review Board at the [University blinded for review] as well as the [state blinded for review] Department of Public Safety.

The researcher followed a semi-structured interview guide with seven main questions. The facilitators prompted the discussion with probing questions as needed. Interview questions focused on defining relevant terms (e.g., "Can you tell me how you define the following ideas: intimate partner violence; domestic violence; abuse; family violence; violence against women; violence; control; coercion; conflict"); discussing problematic relationships that clients are experiencing (i.e., "What do they look like? What are both partners doing?"); identifying assessment procedures used for these relationships/clients ("Do you directly ask about violence? control? Do you use assessments? observations? written reports?"); and clustering types of IPV ("How confident do you feel about this solution?"). Focus groups were all facilitated by the first author, with support from graduate research assistants.

## Analysis

Transcripts, field notes, and memos were uploaded into the qualitative software NVivo. Transcripts were coded using the hierarchical coding process based on Strauss and Corbin's (1990) constant comparative method. First, each transcript was read and reread by coders to get a general sense of the data. Next, two coders assigned codes to transcripts until acceptable inter-coder reliability was reached (>90% congruence). Once codes were assigned, codebooks were used to identify manifest themes (those

explicitly stated by participants) and latent themes (discrete patterns of responding not explicitly stated by participants). All participants' focus group data were coded, including both IPV and non-IPV providers. However, interpretation focused on IPV providers' perceptions specific to child welfare professionals, as this is what rose to saturation. As such, themes with associated exemplars and a random participant number are presented below.

## Results

IPV service providers referred to assessment as "tricky" even for those who are trained and specialize in the field. For example, one IPV specialist stated, "I'm not trying to side-step the issue of assessment, although actually I am a little bit, because it's tricky" (Participant 1). One participant expounded on this idea, stating,

> I think these blurry ones we tend to with our assessment process, tends to be significantly longer, there's no stereotypical victim of domestic violence. We spend a lot more time really looking at what [is] going on with this person, like [another participant] was saying, where is this violence coming from? Figuring out whether it's a survival mechanism, or if this person is just mean, it's not really [a] power and control thing. So really just taking more time, umm to get to know where that client's coming from, and then like [another participant] said, stopping it. (Participant 10).

Despite this acknowledgement of the difficulty in conducting thorough IPV screenings, IPV workers did not trust assessments and referrals from child welfare workers. Reasons for this mistrust, which contribute to tensions between the fields, were rooted in two themes. First, IPV workers perceived that child welfare workers lacked competence when it came to assessing for IPV. Second, IPV workers described manipulative or otherwise coercive practices that child welfare workers engaged in when working with clients who experienced IPV in their relationships.

### Perceived Lack of Competence

IPV service providers perceived that child welfare workers lacked competence regarding IPV generally and with assessment in particular. IPV providers reported that child welfare workers often did not adhere to best practices because they did not have a comprehensive working knowledge of the dynamics of IPV. As it relates to assessing for IPV, one participant with professional experience in both IPV and child welfare stated:

> Because I used to do, I used to be a [child welfare] investigator and, it's not until I got here that I was like hmm I wasn't doing that right. And I didn't get the DV state training until I started this job. So I worked there for years and didn't have any DV training. So I do think that's very … it makes a difference. (Participant 8)

As a result of this, IPV workers reported that child welfare workers sometimes missed identifying IPV in a client. For example, Participant 8 stated,

> And there's the cases that don't necessarily come in as domestic violence, that aren't labeled as domestic violence, and you know, we call team staffing with [child welfare] and we'll be sitting in there and we'll hear the case and I'm like, this is a domestic violence case but … it wasn't [screened in].

This led to feelings of frustration toward child welfare workers. For example, Participant 8 continued, "What ends up happening is, and I find myself, I have to stop myself, I'm not their supervisor. So I shouldn't have to tell them, that's something that should be coming from their supervisor."

Even for trained IPV service providers, assessments are complex, which participants acknowledged could contribute to child welfare workers sometimes getting it wrong. For IPV workers, screening tools help, but, ultimately, they rely on open-ended questions and clinical expertise to make determinations about clients' needs. This comprehensive process requires time to sort through nuance, which child welfare workers do not have. For example, Participant 9 spoke to the challenge of receiving conflicting information on cases:

> While I have [child welfare] workers tell me all the time that domestic violence cases are their least favorite cases … I think it's because it's tricky, a lot of people will hear something, you'll go to the house and they'll tell you something different.

Despite acknowledging the inherent difficulties of working IPV cases, other IPV workers made statements implying this was more than a lack of training, instead perceiving child welfare workers as incompetent when it came to assessing for IPV. Participant 10 spoke to her own history as a child welfare professional:

> I think a lot of times when [child welfare workers] become involved, you make people feel like they're not human … I used to work at [a child welfare agency], I had a caseload, I mean you have a job to do and your thought is, "I have X [number of] cases to deal with. You're the 10th or 15th case. I'm just trying to get through the day.

Based on their own experiences conducting assessments, participants stressed that the process requires skill, which is developed over time and is heavily influenced by both building rapport and relying on one's own intuition.

In addition to the need for more training, IPV workers acknowledge that part of the tension between the two fields stemmed from constraints within the agencies and differing priorities. Participant 12 summed it up by stating, "It's a very different role obviously being a [child welfare] worker and being a victim advocate and, um, it's tough for [child welfare workers] too, their hands are tied a lot of the times …" Another described these differing priorities by way of describing how they built rapport with clients, stating:

> In the engagement and the rapport building part, is helping the client understand the different roles. [Child welfare's] goal is to protect that child, ok, but then as a part of protecting that child is making a referral to these supportive agencies to get that supportive education, to help the parent who's responsible for supervision, and then for us, our client is the parent, not the child. We're all kind of operating from a different perspective, with a singular goal for how we get there too. A lot of times for me in that engagement process is helping the client understand the role, ok. A lot of people are here, ok. And I know I've had a lot of conversations with social workers in the past too, based on my recommendations too, and again, they're advocating for the best interest of the child, I'm advocating for the best interest of the consumer hoping that that's going to help in their relationship with the child. We all come from it from different perspectives as well. (Participant 15)

## Manipulative Practices

Though participants perceived that child welfare workers lacked competence, they acknowledged that assessing for IPV is no easy task. Conversely, participants were less forgiving of those child welfare workers who they perceived to engage in manipulative or otherwise coercive practices on IPV cases. Participants felt like some child welfare workers were dismissive of IPV and tried to manipulate screening tools to avoid initiating a referral and making the case more complicated. For example, many participants noted that child welfare workers would flippantly state, "No power and control," when staffing a case, because they knew this was how the IPV specialists screened in for IPV. One participant stated, "Some of us have noticed that since we've been in these positions, they realize that we're asking about power and control, so they'll start off, 'I don't see power and control'" (Participant 9). That same participant added:

> Well that's part of our consult. We have to ask those questions, but they'll come to these staffings, and wanna shut down the case so they'll start it off with, "There's no power and control." Because, they're wanting to … close the case.

Linking back to perceived incompetence, Participant 10 expounded on this, saying, "But a lot of them don't know with power and control … they don't know what it is. When they say that, you should say, 'What is power and control?'"

Other participants highlighted how child welfare workers will try to coerce their clients to get a restraining order. For example, one participant stated:

> A lot of these ones that are being combative with, they came out and said, "This is your third case we got for you on [domestic violence]," and they're implying that you keep doing it, so just from the get go, they set it up where the person is very defensive and they bring up staffing with legal all the time to try to get them to do something. (Participant 9)

This idea about staffing with legal came up several times. After some clarification, participants explained how child welfare workers would use the threat of initiating a forced protective order to manipulate clients to voluntarily get one. Participant 12 described this as an informal practice, stating, "Yes, they say, 'We can't make you [get a restraining order], but we're putting it on your [case] plan.'" Participant 10 elaborated about this coercive practice by stating:

> [Child welfare workers] threaten to do a petition or staff the case with the legal team to see if they have enough to do a petition, and most of the time, to just hear we're going to staff with an attorney or staff with your legal team, [IPV victims/child welfare clients will] go get the protective order. They may just get the seven day [temporary protective order] and then not go for the one-year hearing, but they at least will say, "Well, I did what you asked me to do. I didn't go back for the one year." In their minds, they're thinking, "You told me to get a protective order. I got it. You didn't say go and get the standard one year." So, it's like a form of punishment because a lot of times people don't want the protective order. If they don't want it, they won't enforce it properly.

One participant did offer context to this practice, linking it back to a lack of comprehensive training, by stating:

> But [child welfare worker's] hands are tied a lot of the time. Because they have to get something done on these safety assessments, they have to put—so, let's get a

> restraining order, let's [do] this. It's trying to figure out what kinds of [things to put on the safety plan]. How can you safety plan without maybe a restraining order … without, you know, kicking the perpetrator out of the home? What can you do instead to safety plan? Without that education, it does make it difficult for them. (Participant 15)

## Discussion

The aim of this paper was to explore IPV service providers' perceptions of the IPV assessment and referral processes. Corroborating literature that interagency work on IPV cases can be challenging (e.g., Sudderth 2006), IPV providers in the current study spoke to issues of incompetence and coercive practices among child welfare workers. Participants frequently reported perceptions that child welfare workers lacked the training and knowledge to effectively conduct comprehensive assessments and referrals, contributing to counterproductive or otherwise inadvisable practices (i.e., screening manipulation, victim blaming, coercing restraining orders). These perceptions may, in fact, be shared by both child welfare workers and victims themselves. Previous research indicates that many child welfare workers (Postmus and Merritt 2010) and their supervisors (Postmus and Ortega 2005) lack necessary IPV training, leaving workers feeling unprepared for the complexity of these cases (Fusco 2013). From the victim perspective, Hughes et al. (2011) found that few child welfare-involved women who had experienced IPV thought their child welfare caseworker listened or offered support to them.

However, the substance of the case is not the only challenge child welfare workers face when conducting their work. The volume of their caseloads is often high (American Public Human Services Association 2005; Government Accountability Office [GAO] 2003), a consideration that some participants in the present sample were willing to take into consideration as a factor that might detract from competency in any one substantive area (e.g., IPV). It is also important to consider that, when child welfare workers have a case with IPV, they are often required to interact with all involved parties (e.g., child, victim, perpetrator) to fulfill their role, which can add to the challenging nature of these cases. For example, Fusco's (2013) study found that child welfare workers were often fearful of the perpetrator and frustrated when victims returned to their abusers. Though working primarily with IPV victims is not without its own challenges, it is likely easier to consistently engage in victim-centered practice than it is for service providers in other contexts. Child welfare workers who encounter IPV may have competing interests even within their own role, let alone when collaborating with others. Thus, while IPV-specific providers, with their wealth of victim-based advocacy knowledge, may experience frustration with child welfare workers' incompetence, it is plausible this "incompetence" is not due to lack of knowledge, but instead due to competing priorities on the case, perhaps dictated by agency policy, which are not aligned with IPV victim-centered practice.

The aforementioned issues speak to the importance of promoting institutional empathy between IPV providers and child welfare professionals. *Institutional empathy* is "the understanding of the context and environment that shape how another system operates and works with families who are experiencing child maltreatment and domestic violence" (Banks et al. 2008, p. 894). Understanding that child welfare workers must carry out their role in the context of a large bureaucracy with high turnover rates can help IPV providers better understand child welfare workers' case priorities and decision-making around child safety (Banks et al. 2008). Similarly, child welfare workers who have knowledge of the women's right's movement and other influential factors in IPV service provision might have a greater appreciation for the victim-centered practice of advocates (Banks et al. 2008). In the context of IPV-related collaborations, having a better understanding of one another's roles can help set more realistic expectations and reduce blaming among professionals (Laing et al. 2012). In the present sample, several participants alluded to their own institutional empathy. For example, by acknowledging how "tricky" assessments can be, even for IPV providers, the participants demonstrate an understanding that child welfare workers do not, as part of their role, receive the intensive assessment training that IPV providers receive.

### Limitations

The present study is not without limitations, namely, a lack of generalizability. Though our use of purposive sampling was appropriate for qualitative inquiry, the perceptions of this sample cannot be assumed to hold true across all IPV providers or all communities. Moreover, self-selection and social desirability bias are potential limitations. Demographically, though our sample is primarily women, it is relatively diverse in other ways (e.g., race, age). Moreover, the overrepresentation of women is similar to the common makeup seen in community and social services professions, such as social workers, counselors, and probation officers (Bureau of Labor Statistics 2018).

### Implications

Despite these limitations, we offer several suggestions for practice, research, and policy. Given the prevalence of child welfare competency concerns among the present sample,

coupled with extant literature indicating IPV competency issues from both the perspectives of child welfare workers (Fusco 2013) and victims (Hughes et al. 2011), child welfare agency leaders could consider increasing IPV training for their workforce. IPV education should extend beyond preservice training and include opportunities for ongoing learning that builds on previously acquired IPV knowledge and skills. Continuing education on the intricacies of IPV dynamics might help to dismantle implicit or explicit victim-blaming attitudes among child welfare workers as training content increases in complexity over time. Building proficiency in trauma-informed IPV assessment might increase worker self-efficacy and result in both more accurate assessments and more timely and appropriate referrals. Given research findings indicating child welfare-involved IPV victims often rely on their caseworkers for support (Jenney et al. 2014), it is imperative that we understand how to boost child welfare workers' self-efficacy in assessing for IPV and making appropriate referrals for services. Researchers should continue to explore the perspectives of both child welfare and IPV providers to determine what specific training content would be beneficial both for themselves as well as collaborating providers.

The onus for increased competency cannot rest solely on child welfare workers. IPV providers should be held to similar standards regarding both knowledge of IPV as well as of their sister agencies. In this vein, local, interdisciplinary trainings might be beneficial, as this would address both IPV competency and, ideally, help streamline the referral process by offering an opportunity for local providers to interact with one another. Further, local trainings might also offer an avenue for increasing institutional empathy between professionals through open dialogue and rapport building. Notably, several of the present participants had previous child welfare experience and their example quotes were ones that demonstrated an understanding of the challenging nature of conducting IPV assessments in child welfare. It is possible that their experience in both service sectors has resulted in greater institutional empathy than providers who have only worked in one sector. These individuals could have particularly insightful suggestions for improving both training and institutional empathy and their practice wisdom should be solicited in future research on these topics.

Since social service providers, and child welfare workers in particular, often endure a heavy workload (GAO 2003), agency leaders could help alleviate the stress of additional training by securing policies for protected time for their workers to participate in continuing education efforts. While we recognize that child welfare workers must be at least superficially familiar with numerous social problems to effectively do their jobs, because IPV is so prevalent on their caseloads (e.g., Fusco 2013), we believe this protected IPV training time to be justifiable within the confines of an already time-intensive work schedule.

**Funding** This work was supported, in part, by funds provided by the University of North Carolina at Charlotte.

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