Child Abuse & Neglect 34 (2010) 172–182

Contents lists available at ScienceDirect

Child Abuse & Neglect

# Domestic violence assessments in the child advocacy center☆

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ARTICLE INFO

*Article history:*
Received 5 September 2007
Received in revised form 21 October 2009
Accepted 23 October 2009
Available online 5 March 2010

*Keywords:*
Domestic violence
Intimate partner violence
Child advocacy center
Screening
Child abuse
Family violence

ABSTRACT

**Objective:** This study was designed to identify the frequency, methods, and practices of universal assessments for domestic violence (DV) within child advocacy centers (CACs) and determine which factors are associated with CACs that conduct universal DV assessments.
**Methods:** The study design was a cross-sectional, web-based survey distributed to executive directors of National Children's Alliance accredited or accreditation-eligible CACs.
**Results:** Responses were received from 323 of 376 eligible CACs (86%). Twenty-nine percent of CAC directors report familiarity with current DV recommendations and 29% require annual education for staff regarding DV. Twenty-nine percent of CACs conduct "universal assessments" (defined as a CAC that assesses female caregivers for DV more than 75% of the time). The majority of CACs use face-to-face interviews to conduct assessments, often with children, family or friends present. The presence of on-site DV resources (OR = 2.85, CI 1.25–6.50) and an annual DV educational requirement (OR = 2.88, CI 1.31–6.32) are associated with assessment of female caregivers. The presence of on-site DV resources (OR = 3.97, CI 2.21–7.14) is associated with universal assessments.
**Conclusions:** Many CAC directors are not aware of current DV recommendations and do not require annual DV training for staff. Less than one-third of CACs practice universal assessments and those that do often conduct DV assessments with methods and environments shown to be less comforting for the patient and less effective in victim identification. CACs are more likely to assess female caregivers if they have co-located DV resources and they require DV training of their staff. CACs are more likely to universally screen for DV if they have co-located DV resources.
**Practice implications:** The presence of DV in the home has significant potential to negatively impact a child's physical and mental health as well as the ability of the caregiver to adequately protect the child. Current practice in CACs suggests a knowledge gap in this area and this study identifies an opportunity to improve the services offered to these high-risk families.



## Introduction

It is estimated that 3.3–15.5 million children are exposed to DV each year in the United States (Child Welfare Information Gateway, 2007; McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). Children raised in homes with DV are at risk for poor behavioral, medical and emotional outcomes—both as a victim of abuse and as a witness to abuse. Past or

☆ The authors acknowledge the National Children's Alliance for funding this research.
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doi:10.1016/j.chiabu.2009.10.002

ongoing abuse of a caregiver is a significant risk factor for child abuse and may limit a parent's ability to adequately protect his/her child. Appel and Holden (1998) report in 40% of homes where either intimate partner violence or physical abuse is present, the other form of violence is present as well. In a similar manner, community samples looking at all forms of child maltreatment show co-occurrence rates of 5.6–55% (Appel & Holden, 1998; Dong et al., 2004; Slep & O'Leary, 2005; Zolotor, Theodore, Coyne-Beasley, & Runyan, 2007) and many studies describe childhood exposure to DV as a risk factor for future neglect, psychological, and physical abuse (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; McCloskey, Figueredo, & Koss, 1995; Tajima, 2000). McGuigan and Pratt (2001) demonstrated an increased risk for child maltreatment that persisted for up to 5 years after exposure to DV at an early age. Simply bearing witness to domestic violence may have detrimental effects on a child's emotional and social development. Children of abused caregivers are significantly more likely to demonstrate both internalizing behaviors, such as anxiety and depression, as well as externalizing behaviors, such as aggression and attentional issues (McFarlane, Groff, O'Brien, & Watson, 2003). In addition, children exposed to violence are more likely to have difficulty relating to peers (Jaffe, Wolfe, Wilson, & Zak, 1986) and performing well academically. Past or ongoing abuse of a caregiver and exposure to domestic violence in the home, therefore, are important risk factors to thoughtfully evaluate in the context of assessments of suspected child abuse.

Child advocacy centers (CACs) stress coordination of investigation and intervention services by bringing together professionals and agencies as a multidisciplinary team to create a child-focused approach to child maltreatment cases, including sexual abuse, physical abuse, and neglect. There exist hundreds of CACs across the country in various stages of development. These centers may be based within hospitals, government agencies, or exist as free-standing institutions. To receive accreditation from the National Children's Alliance, CACs must meet the following standards: (1) Child-appropriate/child-friendly facility; (2) Multidisciplinary team consisting of representatives from law enforcement, child protective services, prosecution, mental health services, medical services, and victim advocates; (3) Organizational capacity; (4) Cultural competence and diversity; (5) Forensic interviews; (6) Medical evaluation; (7) Therapeutic intervention; (8) Victim support/advocacy; (9) Case review; and (10) Case tracking. Details on each of these standards can be found at the National Children Alliance's website www.nca-online.org. Regardless of location or accreditation status, the ultimate goal of any CAC is to bring the multitude of services offered in assessments of suspected child maltreatment directly to the at-risk child in a child-friendly setting.

In offering these services, CACs provide care for families with many of the risk factors for co-occurrence of DV and various forms of child maltreatment. These risk factors include lower socioeconomic class, maternal mental illness, caretaker substance abuse, household/family stressors, and unrelated caretakers in the home (Finkelhor, Gelles, Hotaling, & Straus, 1983; Shipman, Rossman, & West, 1999). Because of this, universal assessments for DV seem appropriate and the standard of care in the CAC setting. For the purposes of this study, we use the term "assessment" to refer to the process by which a woman is evaluated for the presence or absence of domestic violence. The term "screening" implies the application of an instrument or tool to a set group of patients regardless of their reasons for seeking medical care. This is in contrast to "case-finding," which may be defined as the application of an instrument or tool to a group of patients with specific signs, symptoms or risk indicators. Because of the unique population of children and families evaluated in the CAC setting, we have selected the word "assessment" as components of both screening and case-finding may apply.

The hypothesis of this study is that the majority of CACs are not conducting universal assessments for DV. In addition, it is hypothesized that centers that do conduct assessments do so in a variety of methods, some of which have been shown to be less comfortable for the patient and less effective in the identification of DV. Given the importance of DV assessments in the evaluation of suspected child abuse, this study was designed to identify the frequency, methods and practices in assessments for DV within CACs and to determine what factors are associated with CACs that conduct DV assessments.

## Participants and methods

The study protocol was reviewed and approved by the institutional review board of Columbus Children's Hospital.

To establish content validity, a pilot survey was designed with input from four experts in child abuse pediatrics and research methodology. The survey was developed and distributed to 11 accredited and accreditation-eligible member CACs of the National Children's Alliance (NCA) located in the state of Ohio. Feedback was elicited from respondents to address the domains of: universal nature of DV assessments, method of DV assessments, potential barriers to universal assessments, and referral practices in a CAC. The survey was then adapted and distributed using an online service (www.surveymonkey.com) to all 376 accredited and accreditation-eligible member CACs of the NCA.

The first section of the survey acquired demographic information, including a description of the CAC (non-profit, government-based, hospital-based, umbrella organization, affiliation with a teaching hospital), number of child assessments performed annually, location of practice (urban, suburban, or rural), and size of population served. The next section assessed the CAC director's familiarity with current DV assessment recommendations using two "gold standard" references (Family Violence Prevention Fund, 2002; Schechter & Edleson, 1999) and acquired information on required DV training for CAC staff. The third section of the survey assessed the frequency and methods with which the CAC assesses and documents caregivers for DV and children for exposure to DV. Respondents were asked to identify barriers to conducting assessments using previously published barriers identified by health care professionals (Erickson, Hill, & Siegel, 2001). The final section of the survey assessed referral practices for caregivers who are found to be victims of DV.

**Table 1**
CAC demographic information.

| | | |
|---|---|---|
| Population size | <50,000 | 11.2% |
| | 50,000–250,000 | 45.5% |
| | 250,000–500,000 | 19.8% |
| | 500,000–750,000 | 9.0% |
| | >750,000 | 14.2% |
| Annual assessments | <150 | 18.0% |
| | 150–400 | 46.7% |
| | 401–750 | 18.3% |
| | >750 | 17.0% |
| Community setting | Urban | 43.4% |
| | Rural | 35.9% |
| | Suburban | 20.7% |
| Title of person competing the survey | Executive director/president | 70.9% |
| | Clinical director/manager | 22.3% |
| | Social worker | 5.6% |
| | Medical director | 0.9% |
| | Physician | 0.3% |

Initial solicitation was attempted using the NCA's listserve and yielded a 29% response rate. After 2 weeks, telephone calls were initiated by a research assistant to non-responders, with up to 3 attempts made to establish contact for each center. Once a center agreed to participate, the contact person was sent up to 2 email reminders. From this effort, contact information from the initial NCA listing was updated and the goal response rate of at least 80% was obtained. Data were entered into a research database and were analyzed using Stata version 9.2.

## Results

Three hundred and twenty-three of 376 (86%) surveys were completed. Demographic information for the participating CACs is shown in Table 1.

### *Education*

The National Council of Juvenile and Family Court Judges' "Green Book" and the Family Violence Prevention Fund/Office for Victims of Crime's "Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health" were identified as two of the most current, widely available resources that establish clear recommendations for conducting DV assessments for multidisciplinary teams. Ninety-five of the 323 (29.4%) CAC directors stated they were familiar with either one or both of these resources.

Ninety-three of 323 (28.8%) CAC directors required their CAC staff to have annual training in DV. Of these 93 centers, 41 (44%) required less than 6 hours per year in training.

### *DV assessment frequency*

Slightly more than half (186 of 323 or 57.6%) of the centers conduct DV assessments of female caregivers. For the purposes of this study, a "universal assesser" was defined as a CAC that assesses female caregivers for DV more than 75% of the time. Only 29.4% of all CACs meet this definition of conducting universal assessments. Barriers to conducting DV assessments are shown in Table 2. Male caregivers are assessed for DV by 144 of 323 (44.6%) centers. Children are assessed for exposure to DV by 232 of 323 (72.0%) centers.

**Table 2**
Reported barriers to conducting DV assessments.

| | *N* | % |
|---|---|---|
| Lack of center protocol/environment to screen | 63/137 | 46.0 |
| Insufficient training on DV | 47/137 | 34.3 |
| Other | 42/137 | 30.7 |
| Medical/social needs of the child are priority | 38/137 | 27.7 |
| Insufficient time to conduct assessments | 27/137 | 19.7 |
| Insufficient time to counsel positive screens | 24/137 | 17.5 |
| Fear of offending/angering the caregiver | 15/137 | 11.0 |
| No available resources for positive screens | 10/137 | 7.3 |
| DV is not an issue in our patient population | 1/137 | 0.7 |

**Table 3**
DV assessment practices.

| | *N* | % |
|---|---|---|
| **Assessment of female caregivers** | 186/323 | 57.6 |
| *Method of assessment* | | |
| Face-to-face interview | 168/186 | 90.3 |
| Written survey | 38/186 | 20.4 |
| Computerized survey | 2/186 | 1.1 |
| Other method | 12/186 | 6.5 |
| *Interview conducted by* | | |
| Social workers/advocates | 119/168 | 70.8 |
| Mental health professional | 65/168 | 38.7 |
| Child protective services | 48/168 | 28.6 |
| Physician/nurse | 48/168 | 28.6 |
| Other | 44/168 | 26.2 |
| *Percent of interviews conducted with* | | |
| Family present sometimes/frequently/always | 75/168 | 44.6 |
| Child present sometimes/frequently/always | 42/168 | 25.0 |
| Friend present sometimes/frequently/always | 36/168 | 21.4 |

*DV assessment practices*

Data from the subset of centers who conduct DV assessments of female caregivers were analyzed to determine how assessments are conducted. Almost all (90.3%) centers conduct DV assessments using face-to-face interviews, or discretionary inquiry. Interviews were conducted by a variety of staff, including social workers/advocates (70.8%), mental health professionals (38.7%), child protective service workers (28.6%), physicians or nurses (28.6%) and other CAC staff, including the CAC director, law enforcement, and family advocates (26.2%), assessments were often conducted with other people present, including family (44.6%), friends (21.4%), and children (25.0%).

Approximately 1 in 5 (20.4%) centers utilize written surveys. Only 2 of the 186 centers use computers to conduct DV assessments. Less than 1% of the centers used previously published or studied assessment tools in their assessments.

Data regarding assessment practices are summarized in Table 3.

*CAC characteristics associated with assessment practices*

Univariate analysis was conducted using independent variables to identify associations to CACs which assess female caregivers and which CACs conduct universal assessments. Centers which were reported to be aware of DV recommendations were 1.38 (CI 1.16–1.65) times more likely to assess female caregivers, although there was no significant association with respect to universal assessments (OR 1.22, CI 0.86–1.73). Centers with on-site DV resources were 1.23 (CI 1.08–1.39) times more likely to conduct assessments of female caregivers and 1.86 (CI 1.39–2.50) times more likely to conduct universal assessments. Likewise, centers that required annual DV training of their staff were 1.53 (CI 1.29–1.81) times more likely to conduct assessments of female caregivers and 1.59 (CI 1.14–2.20) times more likely to conduct universal assessments. Centers that conduct more than 400 patient visits annually were 1.46 (CI 1.05–2.03) times more likely to conduct universal assessments. Odds ratios and relative risks are summarized in Table 4.

Using multivariate logistic regression to these same variables, the presence of on-site DV resources was independently correlated with both conducting DV assessments of female caregivers and conducting universal assessments. Centers that required annual DV training were also independently correlated with assessments of female caregivers. These data are summarized in Table 5.

**Table 4**
Univariate analysis—predictors of assessments of female caregivers and universal assessments.

| | RR | RR 95% CI | OR | OR 95% CI |
|---|---|---|---|---|
| *Assessment of female caregivers* | | | | |
| Aware of DV recommendations | 1.38 | 1.16–1.65 | 2.40 | 1.43–4.05 |
| On-site DV resources | 1.23 | 1.08–1.39 | 3.06 | 1.36–6.90 |
| DV training requirements | 1.53 | 1.29–1.81 | 3.34 | 1.92–5.80 |
| Annual assessments > 400 | 1.20 | 1.00–1.44 | 1.56 | 0.98–2.53 |
| *Universal assessments* | | | | |
| Aware of DV recommendations | 1.22 | 0.86–1.73 | 1.20 | 0.72–2.02 |
| On-site DV resources | 1.86 | 1.39–2.50 | 3.97 | 2.21–7.14 |
| DV training requirements | 1.59 | 1.14–2.20 | 1.78 | 1.06–2.97 |
| Annual assessments > 400 | 1.46 | 1.05–2.03 | 1.81 | 1.10–2.96 |

**Table 5**
Multivariate analysis—independent associations of assessment practices.

| | Adjusted odds ratio | 95% confidence interval |
|---|---|---|
| *Assessment of female caregivers* | | |
| On-site DV resources | 2.85 | 1.25–6.50 |
| DV training requirements | 2.88 | 1.31–6.32 |
| *Universal assessments* | | |
| On-site DV resources | 3.97 | 2.21–7.14 |

## Discussion

Many studies have examined the challenges of assessing for domestic violence in various clinical settings. This is the first study to evaluate the frequency, methods, and practices of assessments for DV in the setting of the child advocacy center.

Implementation of universal assessments for DV will identify significant numbers of adults who have experienced DV. This has been replicated in many clinical settings (Bradley, Smith, Long, & O'Dowd, 2002; Parkinson, Adams, & Emerling, 2001; Richardson et al., 2002; Siegel, Hill, Henderson, Ernst, & Boat, 1999). Although it seems reasonable that assessment rates for DV would be high in the CAC setting given the co-occurrence of child abuse and DV, this study demonstrates an overall assessment rate of only 58%. A "universal assesser" was defined as a CAC that assesses female caregivers during child assessments more than 75% of the time. Only 29% of CACs conduct "universal assessments" as the term is defined. Given this conservative definition, it is likely that true universal assessment occurs with even less frequency.

Previously published studies detail the barriers individual providers face when conducting DV assessments, including insufficient training, insufficient time, and a fear of offending or angering the caregiver (Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2002). Respondents to this survey reported many of the same barriers on a system-wide level. The most common barriers to DV assessment were identified as a lack of center protocol and/or appropriate environment to conduct the assessment. Twenty-eight percent of CAC executive directors stated their CAC did not conduct DV assessments because the medical and social needs of the child were the primary concern. Some may interpret this to mean that CACs do not appreciate the effects of DV exposure on a child's medical and emotional well-being. It is also possible, however, that it is unclear to those involved with child maltreatment at what specific threshold exposure to DV constitutes "harm." Review of comments demonstrated that some CACs conducted assessments of sexual abuse only, and therefore did not see a need to conduct DV assessments. This is an especially concerning response, because it implies a lack of recognition of the significant co-occurrence of DV and child abuse. It is important to remember that CACs also face barriers unique to the socio-legal system that may prevent them from assessing for DV. For example, laws vary from state-to-state as to whether child exposure to DV constitutes a reportable offense to child protective services. It is possible that CACs located in states with mandatory reporting laws may be reluctant to assess for DV, fearing that detection of DV may lead to legal consequences to a non-offending parent or guardian in which the CAC is attempting to offer help.

Chuang and Liebschutz (2002) have reviewed the existing literature for DV assessments in the primary care setting and identify two primary approaches to DV assessment: verbal-administered and self-administered methods, including written and computer-based surveys. The majority of studies that compare these two methods indicate that face-to-face interview is associated with lower detection rates of DV (Collins, 1999; Freund, Bak, & Blackhall, 1996; McFarlane, Christoffel, Bateman, Miller, & Bullock, 1991; Norton, Peipert, Zierler, Lima, & Hume, 1995). In addition to poorer detection rates, face-to-face interviews appear to be associated with less patient comfort (Anderst, Hill, & Siegel, 2004). Research comparing face-to-face, written and audiotaped assessments for DV in a pediatric emergency department found that women significantly preferred the latter methods (Bair-Merritt et al., 2006). In a study by MacMillan et al. (2006), patients were randomized to one of three DV assessment methods and found that women preferred self-administered methods over face-to-face assessment. Research recently published by one of the authors suggests there are intrinsic characteristics of the screener (race, gender) and assessment environment (presence of family, friends and/or children) that influence a victim's comfort when disclosing DV (Thackeray, Stelzner, Downs, & Miller, 2007). Despite this evidence, almost all respondents in this study report face-to-face inquiry is used as the primary method of DV assessment. Interestingly, only two centers report the use of computers to conduct DV assessments, despite some preliminary research to suggest its efficacy in victim identification (Rhodes, Lauderdale, He, Howes, & Levinson, 2002).

In its summary, the US Preventive Services Task Force (USPSTF) (2004) found insufficient evidence to recommend for or against routine DV assessments, as there was no direct evidence from the literature that DV assessments lead to a reduction in disability and premature death. While there is insufficient published evidence to support benefit in screening every adult for DV at every health encounter (universal DV screening), the authors of this study feel that children presenting to a CAC for concerns of maltreatment represent a high-risk population that would not fit into the models studied by the USPSTF. The benefits of conducting assessments in this specific population of at-risk children seem to outweigh the potential harms, although each need to be studied further. In the period since implementation of universal DV assessments within the authors' (JDT and PVS) CAC, co-occurring DV has been detected in approximately 60% of child abuse assessments.

There are limitations to this study that should be noted. First, the majority of surveys were completed by the executive director of the CAC. It is possible that administrators may not be fully aware of the clinical practices pertaining to DV

assessments in their respective institutions. Second, the National Council of Juvenile and Family Court Judges' "Green Book" and the Family Violence Prevention Fund/Office for Victims of Crime's "Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health" were defined as "current DV recommendations." While these two publications were selected for their wide dissemination and acceptance within the DV academic community as standard recommendations, it is possible that CAC executive directors are familiar with alternative resources and therefore the estimate of respondents' familiarity with current DV recommendations may be artificially low.

Third, no attempts were made to ascribe missing values if a respondent failed to answer a survey question. Each calculation was performed using only the data from centers that answered the questions associated with that calculation (available case analysis). There were, for example, 27% of centers that did not respond to the survey questions regarding on-site DV resources. Most centers that do not conduct DV assessments did not respond to questions about on-site resources. Although it may be safe to assume that those facilities do *not* have on-site resources, those centers were removed from the calculations that involved on-site DV resources.

Finally, and most importantly, these results are limited to the setting of a child advocacy center and should not be generalized to primary care settings. While the debate continues in the medical literature on the effectiveness and potential benefits and/or harms of routine DV assessment, given the specific nature of work conducted in child advocacy centers in addressing child abuse concerns, it would seem more than appropriate to include universal DV assessments in this population. Identification of DV in the home environment is a strong risk factor for child maltreatment. A caregiver experiencing DV may have impaired parenting skills and/or a limited ability to protect him or herself, and equally importantly, the child from ongoing abuse. DV is a key risk factor in child maltreatment assessments and incorporating its detection into the CAC setting contributes to an optimal assessment of the child's safety and well-being.

## Conclusion

Domestic violence continues to be a growing health crisis. Given the high likelihood of identifying family violence in both child and parent, a child abuse assessment conducted within a CAC seems an ideal setting to conduct DV assessments and to offer intervention when this comorbidity is discovered. Unfortunately, many CACs do not conduct routine DV assessment and many of those that do are practicing methods shown to be inferior in providing patient comfort and in case-finding (detection). CACs participating in this study are more likely to assess female caregivers if they have co-located DV resources and they require DV training of their staff and are more likely to practice universal assessment for DV if they have co-located DV resources. This study suggests that CACs should make DV education a priority for continuing staff education and may profit from alliance and co-location with community DV resources to maximize the benefits of a child advocacy center assessment and intervention.

## Acknowledgement

The authors thank Sherry Curran for her assistance with data collection.

## References

Anderst, J., Hill, T., & Siegel, R. (2004). A comparison of domestic violence screening methods in a pediatric office. *Clinical Pediatrics*, *43*, 103–105.
Appel, A., & Holden, G. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal of Family Psychology*, *12*, 578–599.
Bair-Merritt, M., Feudtner, C., Mollen, C., Winters, S., Blackstone, M., & Fein, J. (2006). Screening for intimate partner violence using an audiotape questionnaire: A randomized clinical trial in a pediatric emergency department. *Archives of Pediatrics & Adolescent Medicine*, *160*, 311–316.
Bradley, F., Smith, M., Long, J., & O'Dowd, T. (2002). Reported frequency of domestic violence: Cross sectional survey of women attending general practice. *British Medical Journal*, *324*, 271.
Child Welfare Information Gateway. (2007). Available at http://www.childwelfare.gov/pubs/usermanuals/domesticviolence/ind ex.cfm. Accessed 4/26/2007.
Chuang, C., & Liebschutz, J. (2002). Screening for intimate partner violence in the primary care setting: A critical review. *Journal of Clinical Outcomes Management*, *9*, 565–573.
Collins, B. (1999). *Screening for domestic violence: A written or verbal instrument*. Paper presented at the Society of Teachers of Family Medicine, Seattle, WA, April 1999.
Dong, M., Anda, R., Felitti, V., Dube, S., Williamson, D., Thompson, T., Loo, C., & Giles, W. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect*, *28*, 771–784.
Erickson, M., Hill, T., & Siegel, R. (2001). Barriers to domestic violence screening in the pediatric setting. *Pediatrics*, *108*, 98–102.
Family Violence Prevention Fund. (September, 2002). *Identifying and responding to domestic violence: Consensus recommendations for child and adolescent health*. Family Violence Prevention Fund.
Fantuzzo, J., Boruch, R., Beriama, A., Atkins, M., & Marcus, S. (1997). Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*(1), 116–122.
Finkelhor, D., Gelles, R., Hotaling, G., & Straus, M. (1983). *The dark side of families: Current family violence research*. London: Sage Ltd.
Freund, K., Bak, S., & Blackhall, L. (1996). Identifying domestic violence in primary care practice. *Journal of General Internal Medicine*, *11*(1), 44–46.
Jaffe, P., Wolfe, D., Wilson, S., & Zak, L. (1986). Family violence and child adjustment: A comparative analysis of girls' and boys' behavioral symptoms. *American Journal of Psychiatry*, *143*, 74–77.
MacMillan, H., Wathen, C., Jamieson, E., Boyle, M., McNutt, L., Worster, A., Lent, B., & Webb, M. (2006). Approaches to screening for intimate partner violence in health care settings: A randomized trial. *Journal of the American Medical Association*, *296*, 530–536.
McCloskey, L., Figueredo, A., & Koss, M. (1995). The effects of systemic family violence on children's mental health. *Child Development*, *66*, 1239–1261.
McDonald, R., Jouriles, E., Ramisetty-Mikler, S., Caetano, R., & Green, C. (2006). Estimating the number of American children living in partner-violent families. *Journal of Family Psychology*, *20*, 137–142.

McFarlane, J., Christoffel, K., Bateman, L., Miller, V., & Bullock, L. (1991). Assessing for abuse: Self-report versus nurse interview. *Public Health Nursing*, *8*, 245–250.
McFarlane, J., Groff, J., O'Brien, J., & Watson, K. (2003). Behaviors of children who are exposed and not exposed to intimate partner violence: An analysis of 330 black, white, and Hispanic children. *Pediatrics*, *112*(3), e202–e207.
McGuigan, W., & Pratt, C. (2001). The effect of domestic violence on three types of child maltreatment. *Child Abuse & Neglect*, *25*, 869–883.
Norton, L., Peipert, J., Zierler, S., Lima, B., & Hume, L. (1995). Battering in pregnancy: An assessment of two screening methods. *Obstetrics & Gynecology*, *85*(3), 321–325.
Parkinson, G., Adams, R., & Emerling, F. (2001). Maternal domestic violence screening in an office-based pediatric practice. *Pediatrics*, *108*(3) http://www.pediatrics.org/cgi/content/full/108/3/e43
Rhodes, K., Lauderdale, D., He, T., Howes, D., & Levinson, W. (2002). Between me and the computer: Increased detection of intimate partner violence using a computer questionnaire. *Annals of Emergency Medicine*, *40*, 476–484.
Richardson, J., Croid, J., Petruckevitch, A., Chung, W., Moorey, S., & Feder, G. (2002). Identifying domestic violence: Cross sectional study in primary care. *British Medical Journal*, *324*, 274.
Schechter, S., & Edleson, J. (1999). *Effective intervention in domestic violence & child maltreatment cases: Guidelines for policy and practice*. National Council of Juvenile and Family Court Judges Family Violence Department.
Shipman, K., Rossman, B., & West, J. (1999). Co-occurrence of spousal violence and child abuse: Conceptual implications. *Child Maltreatment*, *4*, 93–102.
Siegel, R., Hill, T., Henderson, V., Ernst, H., & Boat, B. (1999). Screening for domestic violence in the community pediatric setting. *Pediatrics*, *104*, 874–877.
Slep, A., & O'Leary, S. (2005). Parent and partner violence in families with young children: Rates, patterns and connections. *Journal of Consulting and Clinical Psychology*, *73*, 435–444.
Tajima, E. (2000). The relative importance of wife abuse as a risk factor for violence against children. *Child Abuse & Neglect*, *24*(11), 1383–1398.
Thackeray, J., Stelzner, S., Downs, S., & Miller, C. (2007). Screening for intimate partner violence: The impact of screener and screening environment on victim comfort. *Journal of Interpersonal Violence*, *22*, 659–670.
US Preventive Services Task Force. (2004). Screening for family and intimate partner violence: Recommendation statement. *Annals of Family Medicine*, *2*(2), 156–160.
Waalen, J., Goodwin, M., Spitz, A., Petersen, R., & Saltzman, L. (2002). Screening for intimate partner violence by health care providers. *American Journal of Preventive Medicine*, *19*(4), 230–237.
Zolotor, A., Theodore, A., Coyne-Beasley, T., & Runyan, D. (2007). Intimate partner violence and child maltreatment: Overlapping risk. *Brief Treatment and Crisis Intervention*, *7*, 305–321.

**Appendix A.**

Child advocacy centers (CACs) provide care for families with many of the risk factors for co-occurrence of domestic violence and child abuse. As a child advocacy center affiliated with the National Children's Alliance, you are being asked to participate in a survey designed to collect information on the prevalence, method and follow-up of caregivers screened for domestic violence in the setting of child advocacy centers. ***You will not be asked about any specific children, families or cases.***

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***CAC Information:***

Name of CAC: _____

Name of person completing this survey: _____

Title/Role of person completing this survey: _____

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1. Which of these best describes your CAC? ***(Check all that apply)***
   - ☐ Non-profit
   - ☐ Government-based
   - ☐ Hospital-based
   - ☐ Part of an umbrella organization – Please Describe:_____
   - ☐ Other – Please Describe:_____

2. Are you aware of the recommendations of **either** the NCJFCJ's "Green Book" or the Family Violence Prevention Fund/Office for Victims of Crime's document "Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health" regarding screening for domestic violence ***(Check one)***
   - ☐ Yes
   - ☐ No

3. Does your CAC require any formal domestic violence training for its staff? ***(Check one)***
   - ☐ Yes – indicate required number of hours of training, per staff member, per year:_____
   - ☐ No

4. Does your CAC screen ***female*** caregivers as victims of domestic violence during a child assessment? ***(Check one)***
   - ☐ Yes – indicate % of child assessments during which a female caregiver is screened for domestic violence: _____
   - ☐ No – female caregiver screening is not routinely conducted in our CAC

5. Does your CAC screen ***male*** caregivers as victims of domestic violence? ***(Check one)***
   - ☐ Yes – indicate % of child assessments during which a male caregiver is screened for domestic violence: _____
   - ☐ No – male caregiver screening is not routinely conducted in our CAC

6. Does your CAC screen ***children*** for exposure to domestic violence? ***(Check one)***
   - ☐ Yes – indicate % of child assessments during which a child is screened for exposure to domestic violence: _____
   - ☐ No – screening for child exposure to domestic violence is not routinely conducted in our CAC

7. When screening for domestic violence, which of the following does your CAC screen for? **(*Check all that apply)***
   - ☐ Past history (occurring > one year ago) of domestic violence
   - ☐ Ongoing or recent history (within the last year) of domestic violence
   - ☐ Routine screening for domestic violence is not conducted in our CAC

8. Which method(s) is/are used to screen for domestic violence in your CAC? ***(Check all that apply)***
   - ☐ Face-to-face interview
   - ☐ Written survey completed by caregiver
   - ☐ Computerized survey completed by caregiver
   - ☐ Other method – Please describe: _____
     _____
     _____

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***Answer questions 9-13 ONLY if your CAC conducts face-to-face interviews to screen caregivers for domestic violence. Otherwise, skip to question 14.***

9. When is the screening interview of the caregiver conducted? ***(Check one)***
   - ☐ Prior to interview/assessment of the child
   - ☐ During interview/assessment of the child
   - ☐ After interview/assessment of the child
   - ☐ Other time – Please describe: _____

10. Which member of the team conducts the screening? (***Check all that apply)***
    - ☐ Social worker
    - ☐ Child protective services worker
    - ☐ Mental health professional
    - ☐ Physician
    - ☐ Nurse
    - ☐ Receptionist
    - ☐ Other member – Please describe: _____

11. Is a child present during the screening? ***(Check one)***
    - ☐ Yes – indicate % of time a child is present during the screening: _____
    - ☐ No – child is not permitted to be present during the screening

12. Is another family member, other than the child, present during the screening? ***(Check one)***
    - ☐ Yes – indicate % of time a family member is present during the screening: _____
    - ☐ No – family members are not permitted to be present during the screening

13. Is a friend or acquaintance present during the screening interview? ***(Check one)***
    - ☐ Yes – indicate % of time a friend or acquaintance is present during the screening: _____
    - ☐ No – friends or acquaintances are not permitted to be present during the screening

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***Answer questions 14-15 ONLY if your CAC distributes a written survey to screen caregivers for dom violence. Otherwise, skip to question 16.***

14. When is the written screening survey distributed to the caregiver? ***(Check one)***

- ☐ Prior to the child/caregiver arrival to the CAC (e.g. distributed by mail)
- ☐ After child/caregiver arrival to the CAC, but prior to interview/assessment of the child
- ☐ During interview/assessment of the child
- ☐ After interview/assessment of the child
- ☐ Other time – Please describe: _____

15. Which written screening survey does your CAC use? ***(Check all that apply)***
- ☐ I don't know
- ☐ Abuse assessment screen (AAS)
- ☐ Conflict tactics scale (CTS2)
- ☐ Distressing event questionnaire (DEQ)
- ☐ HITS questionnaire
- ☐ Index of spouse abuse (ISA)
- ☐ Ongoing abuse screen (OSA)
- ☐ Partner violence screen (PVS)
- ☐ Proximal antecedents to violent episodes scale (PAVE)
- ☐ STaT three question screen
- ☐ Wife abuse inventory
- ☐ Other – Please describe: _____

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***Answer question 16 ONLY if your CAC uses a computerized survey to screen caregivers for domestic violence. Otherwise, skip to question 17.***

16. When is the computerized screening survey distributed to the caregiver? ***(Check one)***
- ☐ Prior to interview/assessment of the child
- ☐ During interview/assessment of the child
- ☐ After interview/assessment of the child
- ☐ Other time – Please describe: _____

***Answer question 17 ONLY if your CAC uses an alternative method to screen caregivers for domestic violence. Otherwise, skip to question 18.***

17. When is the alternative method of screening conducted? ***(Check one)***
- ☐ Prior to the child/caregiver arrival to the CAC (e.g. distributed by mail)
- ☐ After child/caregiver arrival to the CAC, but prior to interview/assessment of the child
- ☐ During interview/assessment of the child
- ☐ After interview/assessment of the child
- ☐ Other time – Please describe: _____

18. Are results of the screening of the caregiver for IPV documented? ***(Check all that apply)***
- ☐ Yes – results are documented in the child's medical record
- ☐ Yes – results are documented in a separate chart for the caregiver
- ☐ Yes – results are documented in another place – Please describe: _____
- ☐ No – results are not documented.

19. Do you refer caregivers who screen positive for intimate partner violence? ***(Check all that apply)***
- ☐ Yes – The CAC directly communicates with *outside resources* to establish a referral
- ☐ Yes – Caregiver is provided written information and he/she communicates with *outside resources* to establish a referral

- ☐ Yes – The CAC directly communicates with *on-site counseling* resources to establish a referral
- ☐ Yes – Caregiver is provided written information and he/she communicates with *on-site counseling* to establish a referral
- ☐ No – Referral is not made
- ☐ Other – Please describe: _____

_____

20. Indicate the percentage of time caregivers actually follow-up with the provided referral: _____

21. Once the caregiver has received counseling, is follow-up of services received documented? ***(Check one)***
    - ☐ Yes - Results are documented in the child's medical record
    - ☐ Yes - Results are documented in a separate chart for the caregiver
    - ☐ Yes - Results are documented in another place – Please describe: _____

      _____
    - ☐ No - Results are not documented

22. Please indicate the frequency with which detection of domestic violence influences the decision-making process when evaluating for possible child abuse in your CAC. ***(Check One)***
    - ☐ Always
    - ☐ Usually
    - ☐ Sometimes
    - ☐ Seldom
    - ☐ Never

23. What do you feel is the biggest challenge facing your CAC when screening families for domestic violence? _____

_____

_____

_____