



# Domestic violence assessments in the child advocacy center<sup>☆</sup>

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## 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.

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## 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

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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](http://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](http://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.

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