UCLA Pritzker Center
For Strengthening Children and Families

COLLABORATIVE REFORM IN CHILD WELFARE FOR FAMILIES EXPERIENCING DOMESTIC VIOLENCE

in the Antelope Valley

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ACRONYMS AND TERMS USED IN THIS REPORT

Acronyms

CPH: Child Protection Hotline
CSW: Children's Social Worker
DCFS: Department of Children and Family Services
ER: DCFS Emergency Response Unit
LA: Los Angeles
SCSW: Supervising Children's Social Worker

Terms

Domestic violence is used to refer to a pattern of abusive behavior within intimate relationships, where one partner exerts power and control over the other (U.S. Department of Justice, 2023). Our use of the term domestic violence incorporates the concept of intimate partner violence.

High-conflict relationships refer to couples whose conflicts are mutual and negatively affect the relationship, the partners, or other family members, especially children, and may include mutual aggression or violence (Cummings & Davies, 1994).

In this report, we refer to study participants as follows:

Parent survivors: parents who had experiences of both domestic violence and the child welfare system as adults. In the text, we identify when parent survivors were exposed to domestic violence during childhood and/or experienced foster care placements. Further, we reference the race of parent survivors only in the section, race, intersectionality, and perceived discrimination from parent survivors' perspectives.

DCFS staff: staff, primarily from the Emergency Response unit, though including other units and specialty positions who participated in the study focus groups, pre- and post-domestic violence training assessments, and domestic violence consultations. This included Children's Social Workers (CSWs) of various ranks (i.e., I, II, and III), Supervising CSWs (SCSWs), and staff with other job titles. When the report specifically references CSWs and SCSWs, these abbreviated job titles are used (e.g., results of pre- and post-domestic violence training assessments and domestic violence consultations).

Domestic violence service staff or provider: Valley Oasis shelter and housing staff, including supervisors, who solely or primarily worked with domestic violence survivors and participated in the study focus groups.

EXECUTIVE SUMMARY

Study Background

In 2020, a collaboration between the UCLA Pritzker Center and stakeholders across Los Angeles County and a subsequent report explored the role of domestic violence in the child welfare system. This collaboration spurred interest in documenting the child welfare system experiences of parent survivors of domestic violence, domestic violence service providers, and child welfare staff. To do so, a collaboration between Valley Oasis and the LA County Department of Children and Family Services (DCFS) Lancaster Regional Office was formed. Collectively, staff from both organizations and researchers from the UCLA Pritzker Center formed a study implementation team, meeting monthly to develop and coordinate collaborative activities and parallel research design and data collection. Grants from Blue Shield Foundation of California, Van Nuys Charities, and Pritzker Foster Care Initiative provided critical support for this study.

Background on the Antelope Valley

The Antelope Valley is located in the western Mojave Desert in northern LA County and 60 miles outside the City of LA. Significant population growth and taxed service systems present prominent challenges in the region. Resource gaps are particularly concerning for families with children given that children account for 27% of the population and more than one in five children experience poverty (American Community Survey, 2022). Emergency room visits prompted by domestic violence were highest in the Antelope Valley compared to other parts of LA County from 2010-2014 (LA Domestic Violence Council, 2020). The Antelope Valley is also home to the largest number of foster care placements in LA County, serving children from families all over the county. Strained service systems struggle to provide timely services to families experiencing domestic violence and the child welfare system in the Antelope Valley. For these reasons and because the area is also a site of significant innovation and investment by community, county, non-profit, and philanthropic leaders, this research study was situated in the Antelope Valley.

Study Aims

The study aims were built around the three phases of the study.

Phase 1 was designed to understand the day-to-day experiences of parents who were domestic violence survivors (parent survivors) and domestic violence service providers when interacting with the child welfare system and child welfare staff when interacting with parent survivors.

During phase 2, researchers presented preliminary findings from Phase 1 to implementation team members from DCFS Lancaster and Valley Oasis, who determined how to collaboratively respond.

This set up phase 3, which involved evaluating the two collaborative interventions: cross-system training and domestic violence consultations for DCFS Lancaster Emergency Response (ER) unit staff.

Study Findings: Phase 1

Parent survivors who participated in this study experienced child welfare system involvement in various geographic locations, including LA County, across California, and in other states. Importantly, all parent survivor focus group participants were receiving services at Valley Oasis at the time of data collection. Therefore, the findings reflect experiences with services from LA County DCFS and child welfare service systems more broadly.

In focus groups, parent survivors responded to questions concerning the domestic violence services they and their children used, difficulty they may have had accessing these services, how they felt about seeking and the effectiveness of domestic violence services, how services accounted for the needs of people considering race, ethnicity, and other intersectional identities, and child welfare worker coordination of domestic violence and other services. Traumatic experiences were at or near the surface for parent survivors, in part due to their early and repeated exposure to violence and victimization in

childhood and replicated with adult partners. Yet, for some parent survivors the reproduction of power and control by some child welfare workers furthered parent survivors' trauma responses. Many parent survivors vividly communicated feeling hopeless while recounting the systemic barriers to service access and their attempts to overcome these barriers.

Transformative uses of power by child welfare workers helped several parent survivors overcome service access barriers, mitigating their hopelessness and the burdens and uncertainty they faced as they uprooted their and their children's lives. However, after connecting with services, often those required in their child welfare case plans, parent survivors encountered barriers to participation. Barriers included limited public transportation and childcare, domestic violence survivor and parenting classes incompatible with parent survivors' work schedules, and the narrow scope of mental health services. Black women parent survivors also identified the anti-Black racism purporting them to be "magnificently strong" that put them last in line to be helped.

Also concerning, both DCFS Lancaster staff and domestic violence service providers conveyed the emotional demands of their work and described feelings, behaviors, and thought processes suggestive of secondary traumatic stress (STS). This was especially acute for DCFS Lancaster staff who spoke about wanting to help families but repeatedly saw families turned away from services and added to waitlists due to limited service capacity in the Antelope Valley. Worse yet, they recognized that the consequences of a parent survivor being turned away from services may mean children being removed from that parent. Repetition of this pattern took a toll on DCFS Lancaster staff, thus compromising engagement with parent survivors.

Study Findings: Phase 2

In response to an early version of these findings, DCFS Lancaster implementation team members understood the imperative to deepen staff members' knowledge of domestic violence dynamics and understanding of the subsequent trauma to parent survivors. Implementation team members from DCFS Lancaster and Valley Oasis brainstormed how to respond collaboratively. They decided to implement advanced domestic violence learning opportunities and offer domestic violence consultations available upon request for Emergency Response (ER) Children's Social Workers (CSWs). Both interventions were facilitated by domestic violence consultants from Valley Oasis. Valley Oasis implementation team members requested child welfare system training so that their domestic violence advocates were better positioned to support parent survivors experiencing a child welfare investigation or open case.

Study Findings: Phase 3

Findings demonstrated that ER CSWs entered the training with knowledge of trauma symptoms, safety planning, signs of potential domestic violence when first meeting families, and reasons for staying in abusive relationships, especially for Black survivors. Following the training, participants' knowledge increased significantly in differentiating contributors to domestic violence from the cause of domestic violence and identifying the progression of the cycle of violence. While certain assessment questions and training topics may have had limitations, knowledge change measures and observations during the training suggest two additional and important considerations. Participants began questioning their assumptions about domestic violence and their questions were not resolved in a one-day training. Changing long-ingrained societal messages about domestic violence requires concentrated and sustained opportunities for learning about domestic violence and applying that knowledge in daily interactions with families. Findings from the domestic violence consultations offer deeper insight into how ER workers are seeking guidance to further their understanding of domestic violence.

Domestic violence consultations were sought by ER CSWs for assistance working with families engaged in domestic violence and high-conflict relationships and often navigating law

enforcement responses to reports of domestic violence. ER CSWs and the domestic violence consultant discussed complicating factors like children witnessing or experiencing violence during domestic violence incidents, homelessness, and substance and alcohol use. Protective measures like implementing safety plans or restraining orders to protect parent survivors and their children and child removal from homes affected by domestic violence were also discussed. Further, the domestic violence consultant clarified domestic violence-related dynamics and services, offered recommendations for accessing resources for families, and provided direct support to parent survivors by facilitating shelter access and referring their children to therapy. These findings suggest that domestic violence consultations provide promise for tailoring domestic violence information to the family circumstances ER CSWs are charged with investigating. This approach may enhance ER CSWs' knowledge of domestic violence and ability to apply that knowledge and tailored engagement and intervention strategies in their work with parent survivors and children.

Study Recommendations

Study recommendations were developed in response to the findings documenting the barriers parent survivors faced when attempting to access and while participating in services. Parent survivors, domestic violence service staff, and DCFS staff shared perspectives on these barriers and recommendations for mitigating them. The barriers documented often exceed the scope of the child welfare system. Overcoming the barriers will require collaboration across LA County departments, non-profit service providers, and with domestic violence advocates and parent survivors.

Recommendations for improving service access involve increasing capacity to serve parent survivors in

- domestic violence shelters,
- domestic violence survivor classes,
- mental health services, as well as capacity to serve their children, and

developing an interdisciplinary workgroup to assess capacity and effectiveness of services for people who commit domestic violence.

Recommendations for supporting service participation center action within DCFS at multiple levels and interdisciplinary collaboration across LA County with multiple stakeholders. At the DCFS supervisory level, recommendations involve expanding the capacity of child welfare workers in several areas:

- managing the power and control dynamics inherent between child welfare workers and parent survivors,
- recognizing parent survivors' acts of protection for themselves and their children,
- differentiating high-conflict relationships from domestic violence, and
- increasing recognition of signs of secondary traumatic stress.

At the DCFS organizational level, recommendations entail engaging in organizational culture change to

- support awareness of and mitigate anti-Black racism and
- develop a supportive workplace response to secondary traumatic stress among the child welfare workforce.

Beyond DCFS, recommendations involve collaborations to expand the availability and scope of

- domestic violence survivor and parenting classes for working parent survivors,
- mental health services for parent survivors and their children,
- childcare for parent survivors' children, and
- public transportation and other, safe, reliable community transportation options for survivor parents.

Readers are encouraged to review the detailed recommendations in the body of this report located in Tables 2 and 3. Notably, many of the barriers and recommendations documented here align with previous work completed by the LA County Domestic Violence Council in collaboration with the Department of Public Health, Department of Children and Family Services, and Inter-Agency Council on Child Abuse and Neglect.

Conclusion

Overall, findings from the evaluation of collaborative reform in child welfare for families experiencing domestic violence in the Antelope Valley document the significance of complex trauma among parent survivors with child welfare contact and the necessity to enhance domestic violence knowledge and related engagement and intervention skills among child welfare workers. The interventions collaboratively developed and implemented offered two avenues for DCFS Lancaster ER CSWs and supervisors to enhance their learning and skill development specific to domestic violence: advanced domestic violence dynamics training and consultations upon request. This evaluation offers evidence supporting the ongoing collaboration between DCFS Lancaster and Valley Oasis to continue addressing the needs of parent survivors and their children in the Antelope Valley.

INTRODUCTION, STUDY PARTNERS, AND STUDY OVERVIEW

INTRODUCTION

In 2020, the UCLA Pritzker Center and stakeholders across Los Angeles County began a collaboration concerning the role of domestic violence within the child welfare system. A report, released in May 2021, outlines this work. The report noted the following points of interest:

- In October 2020, the Los Angeles County Department of Children and Family Services reported that of the nearly 38,618 open cases, at least 19,937, or 51.6%, involved allegations of domestic violence.

- Children may be declared dependent where the court finds the child is neglected pursuant to the parent survivor's failure to protect the child from the conditions that an abusive adult imposes on the household.

- Removing children from their homes and placing them in foster care for an isolated domestic violence incident can result in further trauma for both the domestic violence survivor and the children.

These points of interest generated further attention toward documenting the day-to-day experiences of parent survivors of domestic violence and domestic violence service providers when interacting with the child welfare system, and child welfare staff when interacting with parent survivors of domestic violence. Accordingly, a subsequent research study was prompted. This report documents that study and our findings.

STUDY PARTNERS

The Los Angeles (LA) County Department of Children and Family Services (DCFS) operates one of the largest child welfare systems in the United States. Its operation is spread across 4,060 miles and 19 regional offices. In the Antelope Valley, DCFS has two offices, located in Palmdale and Lancaster. Notably, these two offices serve the largest geographic area in the county, covering 400 square miles including urban, suburban, and rural communities. DCFS chose the Lancaster office for this evaluation due to the high rate of reports involving domestic violence. Among the 19 regional offices, the Lancaster office serves the third-largest population in the county.

Valley Oasis offers a comprehensive domestic violence support model and is the only domestic violence shelter in the Antelope Valley. The Valley Oasis shelter operates 24 hours a day as a 60-day emergency facility with 65 beds, serving men, women, and children who are survivors of domestic violence. It stands out as one of the few shelters nationwide available to men experiencing domestic violence, assisting approximately 330 people annually. The shelter provides services, including a 24-hour hotline, peer counseling, legal aid for restraining orders, and essentials like food, clothing, and transportation. Additionally, it offers counseling to children, social service advocacy, and court accompaniment, all facilitated by trained domestic violence advocates.

STUDY OVERVIEW

Child welfare system involvement can occur across the lifespan and various localities. The parent survivors within this study reflect this experience, as many of them were system-involved as children and subsequently as adults with their own children becoming system-involved. Similarly, domestic violence is an experience that can impact individuals across the lifespan and in some instances, may follow regardless of where one lives. This study offers a point-in-time snapshot of parent survivors' experiences given their current location in the Antelope Valley. Again, this community was chosen as a site for study given the features outlined above. The reflections and insights offered by parent survivors are cumulative and, in some instances, do not pertain to involvement with DCFS Lancaster or LA County DCFS. They are, however, reflective of how parent survivors of domestic violence experience child welfare system involvement.

In an effort to document the experiences of child welfare staff, domestic violence service providers, and parent survivors of domestic violence, a collaboration between Valley Oasis and DCFS Lancaster was formed. Specifically, the collaboration sought to evaluate how DCFS handles referrals alleging child safety concerns involving domestic violence and how training or consultation could improve intervention where domestic violence is of concern.

For DCFS Lancaster, the partnership aimed to enrich the domestic violence-related knowledge of its staff, focusing on the complex dynamics of domestic violence within families. The collaboration sought to enhance the screening and assessment skills of DCFS staff, improve safety and risk assessments using an expanded domestic violence-informed approach, and enhance staff's ability to support parent survivors and their children. Furthermore, the partnership intended to strengthen routine domestic violence assessments for all families engaged with DCFS Lancaster, aiming to keep children with their survivor parents whenever safe and increase children and parent survivors' connections to domestic violence services.

For Valley Oasis, the objectives were twofold: (1) to broaden staff understanding of the goals, constraints, and resources of the child welfare system, including legislative and legal mandates that dictate practices and timelines; and (2) to augment its services for families involved with DCFS, ensuring that their interventions are well-informed by DCFS safety and risk assessment policies. This strategic partnership not only aimed to bridge the gap between domestic violence services and child welfare but also sought to foster a more integrated approach to supporting families affected by these issues.

A study implementation team with members from DCFS Lancaster, Valley Oasis, and the UCLA Pritzker Center was developed to guide the collaboration. Team members from the three organizations convened monthly to provide updates on the project and coordinate upcoming activities. Additionally, team members collaborated between monthly meetings as necessary, depending on the intervention or data collection activities underway, to ensure the achievement of project and study goals.

BACKGROUND ON THE ANTELOPE VALLEY

The Antelope Valley is located in northern Los Angeles County, in the western Mojave Desert, approximately 60 miles outside the City of Los Angeles. The region contends with a growing population and increasing home prices, compounded by rising poverty and unemployment rates (Kaiser Permanente Panorama City Medical Center, 2022; Policy Analysis for California Education, 2017). Resources have not kept pace with needs. Limited grocery stores, food assistance programs, pharmacies, and childcare providers across the Antelope Valley result in the region being characterized as a desert in each category (Child Care Resource Center, n.d.; de la Haye et al., 2022; Wisseh et al., 2021). These resource gaps are particularly concerning in the Antelope Valley given that children under age 18 account for a larger share of its population than in the rest of LA County (i.e., 27% versus 20%) and child poverty rates are higher (i.e., 19-22% versus 18%; American Community Survey, 2022). Further, due to its urban classification as part of LA County, the Antelope Valley does not qualify for many rural development programs despite facing issues like those in rural areas.

In relation to the child welfare system, the Antelope Valley is known as the former home of Gabriel Fernández, a child with ties to DCFS, who tragically died at the hands of his mother and her boyfriend. More broadly, the Antelope Valley is also home to the largest number of foster care placements of any Service Planning Area in LA County. Children under the jurisdiction of the Dependency Court from across the county are placed here. At the end of March 2024, the DCFS Lancaster office served 1,730 children: 75% (1,291) in out-of-home services and 25% (439) through in-home services (DCFS Lancaster Office Profile Q1, 2024).

The Antelope Valley recorded the highest number of emergency room visits related to domestic violence in LA County from 2010-2014 according to a report by the Los Angeles County Domestic Violence Council (2020). This is concerning considering its relatively small population (i.e., 397,272), in contrast to other Service Planning Areas, like South Los Angeles (i.e., 1,050,698) which recorded the second-highest rate of emergency room visits related to domestic violence (Los Angeles County Domestic Violence Council, 2020; LA County ISD, 2020). Several factors may contribute to this disparity, including the economic and social stressors noted earlier. Additionally, the geographic isolation of the Antelope Valley may increase the time it takes residents to locate resources that could prevent or mitigate domestic violence or limit access to resources altogether. Moreover, the cultural and demographic composition of the Antelope Valley may present unique challenges to addressing domestic violence in communities where survivors are reluctant to seek services. Given these factors, the Antelope Valley is an area where interventions targeting both the immediate needs of survivors of domestic violence and underlying economic and social stressors are crucial.

Where there are needs, there is often innovation. This is true in the Antelope Valley. Numerous innovative programs illustrate the investments of community, county, non-profit, and philanthropic leaders. This development continues and is the hallmark of the thriving spirit present in this evolving community.

STUDY METHODS

This study, launched in the Antelope Valley in January 2023, used an exploratory, sequential mixed methods design with the qualitative component informing the quantitative component. Data was collected to understand how domestic violence and child welfare intersected from multiple stakeholder perspectives followed by feasibility and efficacy assessments of the two interventions developed through the collaborative pilot in response to preliminary findings from the stakeholder perspectives. Study methods were approved by the UCLA Institutional Review Board. The data collection and analysis process were three-fold.

First, focus group discussions were conducted between July and October 2023 with three stakeholder groups: parent survivors of domestic violence with child welfare system contact, Valley Oasis domestic violence shelter and housing program staff, and DCFS Lancaster staff, primarily Children's Social Workers (CSWs) from the Emergency Response (ER) unit. Thematic analysis of data was iterative, involving memoing, coding, and team discussions to integrate the codes, resulting in four overarching themes. DCFS Lancaster and Valley Oasis implementation team members used the preliminary focus group findings to shape their subsequent collaboration strategies: cross-system training and domestic violence consultations.

Second, to test the efficacy of cross-system training, the research team developed pre- and post-training assessment questions, reviewed by implementation team members to assess face validity, and then edited based on feedback. The domestic violence assessment questions were also pilot tested by Valley Oasis staff, who provided further feedback that was incorporated to finalize the assessment. In May 2024, Valley Oasis domestic violence consultants provided advanced dynamics of domestic violence training for ER staff. Each training session began with a pre-training assessment to gauge participants' understanding of the topics to be covered and concluded with a post-training assessment to measure knowledge gains. Following the post-training assessments, debriefing sessions were conducted where domestic violence consultants reviewed the correct answers and addressed any questions, ensuring clarity and reinforcing the training objectives among ER CSWs and SCSWs. Statistical analysis appropriate for identifying baseline knowledge and change in the pre- to post-domestic violence training assessments was conducted.

Procedures for the child welfare system training co-facilitated by a DCFS Lancaster Assistant Regional Administrator and an attorney from Children's Law Center followed the same pattern outlined above.

Third, the feasibility of domestic violence consultations was assessed through descriptive analysis of deidentified quantitative data and qualitative case summaries collected by the domestic violence consultant during domestic violence consultations.

Study Limitations

This study had several limitations. Participants were recruited through purposive, convenience sampling through DCFS Lancaster and Valley Oasis, and sample sizes were small, limiting generalizability of the study findings. The pre- and post-training assessment questions were developed in collaboration with content experts, whose assessments of face validity informed the final version of the domestic violence and child welfare assessments. However, the child welfare assessments were not analyzed due to the combination of a very small sample size and unanticipated changes to content in part of the child welfare system training, which invalidated half the assessment questions. Regarding the domestic violence assessment, analysis revealed that training participants' knowledge of domestic violence dynamics was high for several questions in the pre-training assessment. As a result, pre-existing knowledge of domestic was assessed for these items rather than knowledge gains following the training.

(For a full description of study methods, please refer to Appendix A1. Study Methods.)

STUDY FINDINGS

The domestic violence community has been engaged in this work and advocating for parent survivors of domestic violence with children in the child welfare system for decades. During this time, DCFS has increased its efforts to assess child safety and risk within families where domestic violence may be occurring. However, domestic violence advocates and child welfare practitioners working together across these two systems of care is relatively novel. For the domestic violence community, some of these findings and subsequent recommendations may appear elementary. Nevertheless, the findings reveal a need for further understanding of these concepts and guidance on practical application within DCFS–hence their recitation here.

Study findings derived through analysis of each dataset are presented sequentially. The qualitative findings from the focus groups are first, followed by the quantitative results documenting change from the pre- to post-domestic violence training assessments, and concluding with descriptive findings, both quantitative and qualitative, from the domestic violence consultations. Taken together, the findings represent the evaluation of collaborative reform in child welfare for families experiencing domestic violence in the Antelope Valley.

Pre-Implementation Focus Group Findings

These qualitative findings are grounded in survivors' voices. Understanding their lived experiences of domestic violence, participation in domestic violence and other services, and contacts with the child welfare system are essential to enhancing the skillset of those working with survivors of domestic violence within DCFS. Indeed, a preliminary version of these findings motivated the DCFS Lancaster implementation team members, in collaboration with their Valley Oasis colleagues, to provide ER CSWs and SCSWs with domestic violence training and domestic violence consultations to enhance their knowledge of domestic violence dynamics and ability to apply this knowledge to their work.

Importantly, the parent survivors who participated in these focus groups experienced child welfare system involvement in various locations, including LA County, across California and in other states. However, all of them were receiving services from Valley Oasis in Lancaster at the time of their participation. Therefore, the findings are not necessarily reflective of the services provided by the DCFS Lancaster office or DCFS in LA County. Instead, these qualitative findings are meant to be a reference point for DCFS when serving families at the intersection of domestic violence and child welfare. The findings also serve as a baseline from which policy and practice change may be measured in the future.

The qualitative findings from the focus groups are comprised of four overarching themes: (1) complex trauma among parent survivors of domestic violence; (2) the reproduction and transformation of power and control between child welfare staff and parent survivors; and systemic barriers to (3) service access and parent survivors' perceptions of hopelessness and (4) service participation (Table 1).

Complex Trauma among Parent Survivors of Domestic Violence

Parent survivors described patterns of interpersonal trauma stemming from their families of origin, contact with the child welfare system as children, and domestic violence in their adult relationships. This overarching theme and its sub-themes illuminated the context in which parent survivors arrived at the intersection of domestic violence services and child welfare intervention. Intergenerational trauma contributed to normalizing domestic violence, making it difficult for parent survivors to identify power and control in their adult relationships. Parent survivors needed time to identify as victims of domestic violence, then to extricate themselves and their children from relationships characterized by violence. They worried about their children's responses to being uprooted and the numerous changes in living situations they anticipated. Parent survivors felt significant uncertainty as they entered domestic violence shelters but their desires for survival and breaking

Table 1. Qualitative Themes and Subthemes

Complex Trauma among Parent Survivors of Domestic Violence
• Intergenerational trauma and normalization of domestic violence • Family trauma and disruptions • Desires to break cycles of violence • Mandated reporting and observations of parent survivor disengagement in domestic violence services • Race, intersectionality, and perceived discrimination from parent survivors' perspectives
Reproduction and Transformation of Power and Control between Child Welfare Staff and Parent Survivors of Domestic Violence
• How power and control were reproduced by child welfare staff • How power was transformed by child welfare staff to serve parent survivors • Potential secondary traumatic stress among service providers
Systemic Barriers to Service Access
• Recommendations for consideration • Parent perceptions of hopelessness
Systemic Barriers to Service Participation
• Recommendations for consideration

cycles of violence propelled them forward, often through starts and stops. For many parent survivors, mandated reporting requirements for domestic violence service providers hindered their full engagement. For some parents, particularly Black women survivors, discrimination and anti-Black racism delayed or impeded the help they sought.

Intergenerational trauma and normalization of domestic violence. Parent survivors identified intergenerational trauma as a significant factor influencing their lives. Witnessing patterns of violence among their childhood caregivers was common. Some parent survivors also experienced childhood abuse and neglect. In short, violence became normalized in their lives, such that recognizing power, control, and violence in their adult relationships often took time.

Parent survivors with childhood experiences of domestic violence and child welfare system involvement consistently described how interactions with child welfare systems and in foster placements caused further harm. One parent reflected on their turbulent childhood, entering foster care at age 3 and cycling through 33 placements by age 9, declaring, "[Child welfare],

CPS (Child Protective Services), family services, they've failed me as a child, too" (Parent focus group 1, P1). Several parent survivors felt frustrated and angry at the child welfare system for failing to protect them as children. Given these histories, this group of parent survivors held firm convictions that the child welfare system would not serve as a resource to them or their children in the present.

At the systems level, failures at intervention delayed or even precluded parent survivors from seeking help, as one parent survivor reflected,

> When I experienced domestic violence, it was like don't call anybody. If you call any body, then this is what's gonna happen [child was removed] 'cause of what I experience. So now, you just basically traumatized – you're left with PTSD. (Parent focus group 1, P2)

Within families, normalizing violence further hindered many parent survivors from seeking help. One parent survivor described,

> **It took a while for me to decide and to break away. [...] But [...] I just found no way out. [...] I just didn't want to normalize whatever was going on anymore or accept anyone's excuses.** 'Cause I have kids I have to think of—my self and my kids. So, I just put pretty much everything [important documents] online and I left my kids' home—my home as well. It's a slow process, but it's helping. (Parent focus group 3, P4)

The trauma of domestic violence was compounded for parent survivors when child welfare systems or the courts appeared to hold survivors accountable for failing to protect their child from exposure to their partner's violence. Furthermore, violent partners often appeared to face few consequences for the harm they inflicted. Within this context, present-day child welfare workers are often up against parent survivors' deep-seated mistrust, posing significant challenges to intervention for both parent survivors and child welfare workers.

Family trauma and disruptions. Upon entering a domestic violence shelter, many parent survivors described worries about their children's adjustments. Some questioned whether they made the right decision. This parent survivor's reflection illustrated how these questions arose and how she felt. She shared,

> I think it's a sense of like, maybe failure. [...] 'Cause my daughter, she's seven, so she really understands what's going on. Just starting from scratch [...] you just don't know which way it's gonna go. If it's gonna go good... if it's gonna go bad... if she's going to think less of me. **Ripping her away from home is not only emotional for me, but emotional for my daughter. Like, she brings up certain toys or her pets or — we had to leave, you know we didn't get a chance to get everything. So that's just kind of how I feel joining the program. [...] I just didn't feel as willful, strong. It was just a sense of failure.** (Parent focus group 3, P3)

In addition to her sense of failure for having to start over, this parent survivor's reflections illuminated the profound uncertainty that follows leaving an abusive relationship, uncertainty that extends to how their children will perceive this decision and weather the multiple transitions ahead. Parents of children with special needs, like autism, worried greatly about disrupting their child's routines and familiar surroundings, especially when children's expressive language was limited.

Examples like the ones above notwithstanding, some parent survivors shared their children's positive adjustments to life at domestic violence shelters. They attributed the "home vibe" and opportunities for relationships with other children as supporting smoother transitions. Another parent survivor shared her daughter's response to her new living situation,

> I think she's excited to start her new school and she does have a therapist. [...] So, she's excited to show her therapist where we live at and her bed. So, I just try and give her things to maybe look forward to, instead of

> focusing on the negative stuff. So, she's still—we're still working on it and I'm helping her through that. (Parent focus group 3, P4)

This sentiment of new opportunity mixed with the effort required to acclimate was a common feeling among parent survivors for their children. Parent survivors appreciated support from schools, therapists, shelter staff, and other parents, particularly mothers at the shelter. However, they frequently worried about child welfare staff removing their children from their care and their children following familial patterns of domestic violence as they grew up and started dating.

Desires to break cycles of violence. The inevitability of a child welfare investigation was remarkable across most parent survivor focus groups. Many parent survivors feared that child welfare staff would respond to children's domestic violence exposure by placing them in foster care, in what felt like sanctioning the victimized parent for the offending parent's behavior. Avoiding this outcome was at the forefront of parent survivors' minds and efforts. One pathway parent survivors took to strengthen their capacity to keep their children safe was processing their own trauma.

This parent survivor emphasized participating in "a lot of counseling, so I had a lot of time to be able to deal with that and talk to somebody" (Parent focus group 1, P2). Furthermore, she expressed tremendous pride when her oldest daughter turned 18 years old, sharing,

> **I was really, really happy to be able to raise her without having her taken [by child welfare]. I mean, of course, I had [child welfare] called on me, but she never got [taken] and the case never went anywhere but a 30-day. It was over and done with because I strive to be the best parent that I can be given what was given to me. […] I had to break the cycle somewhere. And right there is where it starts.** (Parent focus group 1, P2)

While this parent and others broke the cycle of foster care placement, other parents did not, despite their best efforts.

Parent survivors also aimed to prevent their children from replicating or falling victim to domestic violence. A common refrain was "It stops now" (Parent focus group 2, P2). To achieve this aim, parent survivors talked with their children about healthy and unhealthy relationships; in addition, some children participated in therapy. Unfortunately, several parent survivors with teenage and young adult children lamented that their efforts had not succeeded. The following parent survivor, whose son was a teen parent, communicated significant distress that both her son and his partner were "going through it, too. And a lot of it is pretty much because my son witnessed what his dad did to me. And I keep trying to tell him, '[Son], you know you gotta get in some services. Get some help, son" (Parent focus group 2, P1).

This parent survivor continued, noting that her son was participating in wraparound services and doing well with school and work, but worried that without returning to therapy "his temper" would get him "in trouble again, as he's approaching 18." Parent survivors' goal to break cycles of violence and the real risk of violence continuing to the next generation underscored the critical role that child welfare staff and domestic violence service providers may play when parent survivors seek help or systems intervene.

Mandated reporting and observations of parent survivor disengagement in domestic violence services. The current practice of mandated reporting creates significant distrust between community members and mandated reporters, like domestic violence service providers. As a domestic violence service provider observed,

> **When you have victims that are really scared to open up, right there you let them know you're a mandated reporter [and] their whole thing is, 'Oh, man, you know I'm gonna retain some of the information. I'm not going to say it.'** (Domestic violence service staff focus group 1, P1)

Mandated reporting instilled fear, driving parent survivors to withhold information, potentially hindering assistance that may benefit their families and heightening mandated reporters' suspicions about harm to their children.

Fear also drove mandated reporters. After child fatalities involving domestic violence, mandated reporters' fears amplified. The domestic violence service provider quoted above described increased scrutiny after the circumstances leading to Gabriel Fernández's murder were publicized, stating, "...it opened up a lot of eyes and not only that, just us being mandated reporters, we look at all factors" (Domestic violence service staff focus group 1, P1). Gabriel's murder heightened the pressure on providers to accurately identify domestic violence indicators, given reports that domestic violence coincided with deadly child abuse and neglect in his family. Further, pressure intensified for providers to carry out their mandated reporting responsibilities. In response, they erred on the side of caution, reporting any concerning circumstances for children often beyond immediate safety risks.

Domestic violence service providers discussed feeling conflicting emotions about their primary role to support parent survivors using trauma-informed care and the legal mandate to report suspicions of child abuse or neglect. Providers, like many mandated reporters, concluded that while "you do feel bad for that family. [...] We're here to protect the children" (Domestic violence services staff focus group 2, P2).

The consequences of mandated reporting for parent survivors, their children, and mandated reporters, even when cases "never went anywhere but a 30-day", remained far reaching. Mandated reporting instilled fear in parent survivors such that they were observed to withhold information that could result in a mandated report, potentially foregoing needed help. For children, mandated reporting could mean separation from a protective parent who could not spare their child from exposure to violence inflicted by a partner. And for domestic violence service providers, mandated reporting can be motivated by fear of not reporting a situation that later turns lethal, despite these lethal tragedies being outliers.

Race, intersectionality, and perceived discrimination from parent survivors' perspectives. Parent survivors held different perceptions of discrimination by service providers. Some parent survivors did not perceive overt discrimination. This parent survivor shared about domestic violence service providers, "I felt like they were pretty fair. [...] I just didn't get that discrimination vibe from anyone—I didn't. [...] And I get that vibe, but I didn't get that vibe there" (Parent focus group 8, P2).

Her view was representative of parent survivors in several focus groups. In contrast, other parent survivors felt strongly that they had experienced discrimination across the child welfare system, as children in foster placements, and as adults within the child welfare and court systems.

Black parent survivors bluntly identified anti-Black racism in one focus group comprised of two Black women. After describing perceived racial discrimination in court, the Black parent survivors shared,

> That's just already built into the system to expect the worst of a person with dark skin. Period. (Parent focus group 7, P2)
>
> I agree with her on that. [...] Because it's the world in general. [...] The world is very cor rupted. **And I feel like sometimes Black women are mistreated in the system. I feel like we get thrown under the bus a lot. And we get looked at last as to be help[ed]. Everybody else is ahead of us because we are looked at as being strong, 'You can make it through.' I don't know what makes us extra human, but the world sees us as being just magnificently strong, 'You can make it through.'** Whereas other people need help, but we suffer the same, if not worse. But I don't—that's nothing that can be changed. (Parent focus group 7, P1)

These parent survivors poignantly depicted their experiences as Black women confronted by anti-Black racism in the courtroom, child welfare system, and the world. Some service providers' pejorative perceptions of Black women's endless strength meant they were not being prioritized for help. Participant 1 continued the conversation above by calling for a world where service providers would not base their job performance on a parent survivor's race, sharing such a provider's thought process,

> **'I just know that you need help.' That would be beautiful, beautiful. 'I just know you need help. I know you need x, y, and z, and it's not about the color of your skin.'** (Parent focus group 7, P1)

Ultimately, these Black women survivors wanted to receive the help they sought, just like any other parent survivor trying to leave violence behind and make a way forward for themselves and their children.

In conclusion, complex trauma among parent survivors of domestic violence was not lost on domestic violence service providers or DCFS Lancaster staff. However, at times, conflicting responsibilities, the primacy of child safety over family integrity, and potential secondary traumatic stress compromised engagement with parent survivors. These issues point to the power dynamics inherent in relationships between service providers and parent survivors, particularly child welfare staff and parent survivors, and to the necessity of child welfare staff and other service providers checking their racially biased assumptions of Black women parent survivors.

Reproduction and Transformation of Power and Control between Child Welfare Staff and Parent Survivors

This overarching theme sheds light on the power imbalances inherent in interactions between child welfare staff and parents in the context of domestic violence. Child welfare agencies largely operate pursuant to federal and state law. In some instances, the child welfare agency may act pursuant to court order. Accordingly, for families involved with the child welfare system, their experience may bear some resemblance to engaging with law enforcement. These power dynamics were observed among parent survivors, domestic violence service providers, and DCFS Lancaster staff who participated in this

study. How child welfare staff handle these power imbalances is crucial, given the authority they hold in decisions that can either preserve family unity or lead to family separation.[1]

This theme is divided into three sub-themes: 1) reproducing and 2) transforming power and control between child welfare staff and parent survivors, and 3) potential for secondary traumatic stress among service providers.

How child welfare staff reproduced power and control. Because child welfare staff determine whether a child remains in a parent's care, they wield particular power over parents. Parent survivors and domestic violence service providers noted that this dynamic often left parents feeling intimidated. Domestic violence service providers raised concerns about the demeanor and methods employed by child welfare staff. One domestic violence service provider explained the nature of some interactions,

> **I think more about the approach sometimes that the [child welfare] worker has. They come in very intimidating. And even if the kids should be taken away, there's still a way to do it, you still should respect the parents.** Try to make them as comfortable as possible during the process. Some of them come in like the police. (Domestic violence service staff focus group 2, P1)

Domestic violence service providers argued that even when child removal is necessary, it is crucial to minimize intimidation in order to maintain dignity and reduce the trauma to parent survivors during these stressful interactions. Comparing the tactics of some child welfare staff to those of "the police" sharply illustrated the power disparity between child welfare staff and parent survivors. Moreover, domestic violence service providers expressed concern about child welfare staff using intimidation tactics with parents while in the domestic violence shelter, a space intended to provide safety and dignity to parent survivors.

Parent survivors also described various examples of intimidation. One parent survivor recalled feeling overtly threatened,

> ...they [child welfare workers] use that power to terrify you, 'Oh if you don't do this like we want you to, then we're gonna take your child. There's nothing you can do to get your child back unless you do this' (Parent focus group 1, P1).

Such encounters left many parent survivors feeling belittled, blamed, and fearful of engaging with child welfare workers, particularly concerning the possible removal of their children or issues around reunification.

Furthermore, parent survivors and domestic violence service providers noted a lack of empathy among some child welfare workers, which participants believed may hinder child welfare workers' ability to understand the emotional impact of their actions on parents. Both participant groups called for more compassion and sensitivity, urging child welfare staff to avoid making harsh judgments based on initial observations, hold parent survivors' behaviors and reactions in the frame of complex trauma, and consider the profound effects their decisions have on families already in distress. As one domestic violence service provider reflected,

> Some [child welfare workers] don't even have children. And I'm sorry but I feel like they don't understand. And they make that parent feel so, so bad. And I know you're doing your job investigating but you don't know and you can't treat someone by what you see. You have to really, I don't know if it's compassion, but don't be so harsh. (Domestic violence service staff focus group 2, P2)

Parent survivors were well aware of the power that child welfare staff have to significantly alter their and their children's lives. Some parent survivors expressed a consistent distrust of child welfare staff, viewing them as detached from

[1] Importantly, various stakeholders, including child welfare agencies, law enforcement, and the courts, contribute to decisions concerning the removal of children from families when safety is jeopardized.

truly assisting families and instead adhering rigidly to protocols without real empathy for the consequences. This distrust was especially poignant among parent survivors who spent time in foster placements as children.

How child welfare staff transformed their power to serve parent survivors. Parent survivors and domestic violence service providers recounted positive experiences with child welfare staff and DCFS Lancaster staff recounted positive experiences with parent survivors, illustrating how power dynamics can be leveraged constructively. This shift illustrated a transformative use of power, contrasting with the patterns that reproduced power and control just presented. For instance, proactive engagement by child welfare staff notably eased the service navigation process. One DCFS Lancaster staff member described their hands-on approach to ensuring service access for parent survivors:

> ...I will directly call the agency. Let them know I'm a [DCFS] social worker calling on behalf of this parent. Sometimes I'll leave a message. They'll call me back. It's not very difficult to get in contact with them, I would say. In my experience, they will call back. They'll eventually send me an enrollment letter or a progress letter. (DCFS focus group 4, P2)

Similarly, a working parent survivor noted the instrumental role her child welfare worker played in facilitating her enrollment in required programs, sharing,

> **They [child welfare workers] want me to do these classes, not only to do domestic violence classes but the parenting classes. So [...] she was real helpful. [...] I just made sure I showed up.** (Parent focus group 5, P1)

This child welfare worker's involvement went beyond just providing information about services by coordinating the logistics necessary for the working parent survivor to enroll in and attend classes, effectively reducing the parent's burden and supporting her pathway toward case closure. Such instances, though not widespread, underscored the significant difference proactive support can make in facilitating service access.

Some parent survivors praised their child welfare workers for their advocacy, guidance, referrals, and tangible support. Emotional support and empathy from child welfare workers were also highly valued, with one parent survivor sharing, "The people [child welfare staff] that work with me and my kids, they're great. They know my history. And they're great. Actually, they're coming to see us tomorrow" (Parent focus group 8, P2). Trust and positive relationships can be developed when child welfare staff engage genuinely and leverage their power, using their understanding of families' histories to effectively tailor support to parent survivors' needs.

Power dynamics within the child welfare system can pose significant challenges for parent

survivors, largely due to the considerable influence child welfare staff have over case outcomes. Many efforts have been made by child welfare systems to enhance their practice. By further enhancing a trauma-informed approach, child welfare systems can continue to reduce the power imbalance when engaging with parent survivors. Transformative actions by child welfare staff that mitigated hopelessness and eased the uncertainty felt by parent survivors included proactive engagement, offering tangible assistance and guidance, and providing emotional support through an empathetic, non-judgmental approach. These strategies can transform the inherent power imbalances into supportive relationships that aid parent survivors in their recovery and transition to stability.

Potential secondary traumatic stress among service providers. Data analyses identified the potential for secondary traumatic stress (STS) among DCFS Lancaster staff and domestic violence service providers. STS arises when people in helping roles are acutely or chronically exposed to the pain and trauma of other people with insufficient time or support to recover between exposures (Armes et al., 2020). Listening to narratives about trauma experienced by children can increase the risk of STS. This exposure can lead to reduced empathy or compassion, limiting service providers' capacity to remain openly engaged with the people they serve. High caseloads, under-staffing, and insufficient organizational structures to help employees identify and mitigate symptoms also can exacerbate STS.

Both DCFS Lancaster staff and domestic violence service providers conveyed the emotional demands of their work and described feelings, behaviors, and thought processes suggestive of STS, such as those described in the subtheme regarding how power and control were reproduced. Common symptoms identified during data analyses included depersonalization from parent survivors, irritability, anxiety, reduced sense of personal accomplishments, and helplessness in response to the systemic barriers faced by parent survivors and their children when trying to access supportive services. The focus here is on the latter two symptoms.

DCFS Lancaster staff spoke about wanting to help families. However, they regularly experienced parent survivors being turned away from services or added to waitlists due to limited service capacity in the Antelope Valley. Repetition of this pattern took a toll on DCFS Lancaster staff. Worse yet, they recognized the consequences of a parent survivor being turned away from services. A DCFS Lancaster staff member communicated that this puts parent survivors and child welfare staff

> in a really difficult position. Because if you talk to a mother and she recognizes the problem, and she wants to get to a different position, and she doesn't have the resources to do it, and there is no agency in the area that has the availability to immediately move them to a different safe space, then we have to make a choice for child safety. (DCFS focus group, P1)

Feeling forced to remove a child because support and resources were not available led to feelings of frustration, discouragement, and anger among DCFS Lancaster staff. Without adequate resources for families, some DCFS Lancaster staff felt ineffective at facilitating opportunities for change among parent survivors and their children – primary reasons for pursuing careers in child welfare. Their empathy toward parent survivors and children may leave DCFS Lancaster staff at greater risk for STS. To protect against feelings of helplessness, some child welfare staff may dampen their emotions or become numb in their work. The potential for impaired empathy and openness among professionals experiencing STS may have grave consequences for engagement with parent survivors, their children, and family outcomes and on professionals' own health.

Applying an STS framework is necessary to facilitate exploring this possibility within professional workspaces and to identify strategies for countering it. Integrating an STS framework organizationally is essential. Without the application of this framework, distress from STS can be prolonged and hinder effective engagement and service provision to families involved with

child welfare systems or domestic violence services.

Systemic Barriers to Service Access, Recommendations for Consideration, and Parent Survivors' Perceptions of Hopelessness

This section presents the common barriers parent survivors encountered as they attempted to access social services often required in their child welfare case plans. Analysis of data from DCFS Lancaster staff and domestic violence service providers added to this theme. The barriers included parent survivors' difficulty identifying domestic violence in their adult relationships and lack of knowledge that help was available, financial difficulties that delayed or precluded leaving a violent relationship, unrealistic expectations held by child welfare staff that parent survivors access services independently, insufficient shelter and emergency housing vouchers to meet the need, and lengthy waitlists for service access (Table 2). Importantly, data analysis revealed evidence that barriers to service access for people who perpetrated domestic violence were prevalent, too, namely limited availability of services and uncertain efficacy of the interventions used.

The barriers identified frequently extended beyond the scope of the child welfare system, demonstrating the siloed and fragmented social safety net that exists for children and families not just in LA County or California but in the United States as a whole. The systemic nature of these challenges is daunting. Thus, overcoming these barriers will require collaboration and coordination across LA County departments, non-profit service providers, and with domestic violence advocates and parent survivors. DCFS is an essential partner in identifying and achieving solutions given its role in assessing families for safety versus risk and protective factors and its knowledge about the needs of families which may be going unmet. Further, DCFS' involvement in this cross-system problem solving is relevant to engaging in reasonable efforts on the systems level to safely prevent child removal and reunify families. Education and buy-in from the county departments identified below will likely be necessary. Processes for meaningfully incorporating parent survivor voices in shaping action toward systemic change is essential. The recommendations are made in light of the current barriers to service access identified by study participants from the Antelope Valley but may be applicable beyond this geographic region.

Some of these barriers to service access and recommendations align with those previously shared in the December 2022 report, The Interconnection between Domestic Violence and Child Welfare in Los Angeles County, by the Los Angeles County Domestic Violence Council, Department of Public Health, Department of Children and Family Services, and Inter-Agency Council on Child Abuse and Neglect.

Table 2. Systemic Barriers to Service Access by Parent Survivors

Systemic Barriers to Service Access	Recommendations for Consideration
Parent survivors commonly reported difficulty identifying domestic violence in their relationships and lacking information that help was available, which impeded help seeking.	In consultation with parent survivors, DCFS, Department of Public Health, Valley Oasis and/or the Los Angeles Domestic Violence Council (LA DVC) may consider developing a public health campaign designed to raise awareness and educate about domestic violence and sources of help in the community at large.
Many parent survivors faced financial difficulties that delayed or precluded leaving a violent relationship and/or were exacerbated upon leaving.	DCFS and the LADVC may consider working with parent survivors with child welfare experience to explore a guaranteed income pilot to address the financial barriers that interfere with leaving a violent relationship or surface when trying to establish an independent household after leaving.
Unrealistic expectations held by child welfare workers that parent survivors should access services independently. Parent survivors were expected to function independently to connect with services required in their child welfare case plans. Some service providers required formal referrals that parent survivors did not have.	DCFS, in tandem with local service providers, may consider developing (1) an information sheet providing guidance about what parent survivors may expect when reaching out for services, including the language capacity of each approved provider, (2) formal referral systems to facilitate "warm hand-offs" between parent survivors and service providers, and (3) service navigator positions to support parent survivors to connect with and enroll in services in their case plans. (4) Create materials in English, Spanish, and other languages as needed.
Lack of shelter space and emergency housing for parent survivors and their children, which were critical for immediate safety and stabilization. The number of available emergency motel vouchers did not meet the need, leaving parent survivors without lodging and exposing them and their children to staying in their cars or homelessness at times.	DCFS, Department of Public Social Services (DPSS), Department of Public Health, Los Angeles Homeless Services Authority (LAHSA), and Valley Oasis may consider collectively exploring additional funding to expand shelter space and increase the number of emergency motel vouchers. The Domestic Violence Shelter Directors Committee and Domestic Violence Alliance could provide consultation.

Table 2. Systemic Barriers to Service Access by Parent Survivors (cont.)

Systemic Barriers to Service Access	Recommendations for Consideration
Lengthy waitlists and wait times hindered parent survivors' timely access to domestic violence survivor classes and mental health services for parent survivors and their children.	The Antelope Valley Resource Initiative (AVRI) conducted a landscape analysis of services in 2019. DCFS, the Departments of Mental Health, Public Health, and Health Services, and Antelope Valley service providers affiliated with the AVRI may consider updating the landscape analysis, adding wait times for enrollment, to determine root causes and opportunities to address them. This may include examining the community business conditions (e.g., local provider regulations, business requirements, insurance barriers, etc.) which negatively impact start-up non-profits from operating locally and creating pipelines to develop local talent to staff service agencies.
Services for people who commit domestic violence are limited and the effectiveness of these services is unclear. Intervention that holds perpetrators of domestic violence accountable and provides pathways for remediating behaviors and healing past trauma are necessary to reduce the prevalence of domestic violence.	DCFS, the Dependency and Criminal Courts, District Attorney, Public Defender, the Departments of Mental Health and Public Health, Project Fatherhood, the LA DVC, Valley Oasis, parent survivors, and people who have committed domestic violence, along with researchers may consider developing a workgroup to assess the evidence for current 52-week Batterers Intervention Programs available in LA County and explore additional intervention options incorporating accountability with remediation and healing opportunities.

Because of these barriers, a recurring theme of hopelessness strongly resonated among parent survivors as they navigated the complex and often unfamiliar terrain toward service access. This sense of futility stemmed from repeated failures to secure services necessary for completing their child welfare case plans, compounding parent survivors' burdens rather than alleviating them. Many parent survivors were forced to become self-advocates, repeatedly inquiring at multiple agencies amidst systemic inefficiencies that frequently led to a vicious cycle of uncertainty. This continual struggle demoralized and exhausted parent survivors, leaving many to feel isolated and unsupported in their efforts to secure a safer environment and various resources for themselves and their children.

These barriers generated feelings of hopelessness and helplessness among both parent survivors and DCFS Lancaster staff (as noted in the subtheme on potential secondary traumatic stress presented earlier). However, parent survivors' stress related to required but inaccessible

services was exacerbated by the potential consequences of inaccessibility namely child removal, delayed reunification, or termination of parental rights. This subtheme underscores the utility of the domestic violence service workforce becoming knowledgeable about how the child welfare system works, including parent survivors' rights when required services are not accessible. Such knowledge would equip domestic violence service providers with the tools needed to support parent survivors navigating the child welfare system and possibly help parent survivors rebuild strength and hope. This subtheme also underscores the need for service navigation as described in the recommendations above.

Systemic Barriers to Service Participation and Recommendations for Consideration

Parent survivors faced numerous challenges after fleeing domestic violence when they attempted to engage in their mandated child welfare case plan. Barriers to parent survivor participation in services were identified by study participants from all three groups, constituting this theme. These challenges included reproducing power and control as described earlier, hesitant or limited parent survivor engagement with child welfare staff, the need for child welfare workers to differentiate domestic violence from high-conflict relationships to ensure appropriate service referrals, racial biases and stereotypes of Black women parent survivors, few programs considering race and other intersectional identities, signs of potential secondary traumatic stress among service providers, dangerous activities in and around motels where emergency vouchers could be used, class schedules incompatible with parent survivors' work schedules, the narrow scope of mental health services, limited and unreliable transportation, and limited childcare availability (Table 3).

Like the barriers to service access above, addressing many of the service participation challenges is beyond the scope of the child welfare system and requires collaboration across county departments, non-profit organizations, the Los Angeles Domestic Violence Council, and parent survivors. Similarly, several systemic barriers to service participation and recommendations for consideration align with previous work found in The Interconnection between Domestic Violence and Child Welfare in Los Angeles County (December 2022).

Table 3. Systemic Barriers to Service Participation by Parent Survivors

Systemic Barriers to Service Participation	Recommendations for Consideration
Power and control can be reproduced in interactions between child welfare staff and parent survivors, potentially further traumatizing parent survivors.	DCFS may consider increasing training and supervision about power and control dynamics inherent in the relationship between child welfare staff and parent survivors and determining best practices for promoting the transformation of power, including exploration of trauma-informed approaches to working with parent survivors. DCFS may also consider training and coaching to better assess, recognize, and reinforce parent survivors' acts of protection for themselves and their children, which may also counteract coercive control.
Negative perceptions of the child welfare system in the community and among many parent survivors. Parent survivors holding negative perceptions expressed fear and avoidance of the child welfare system, which interfered with parent survivors' full engagement with child welfare workers and, at times, with mandated or recommended service participation.	DCFS may consider additional strategies for bridge building and repair with the community and parent survivors. This could involve augmenting the role of the Community-Based Manager or creating a team under her leadership to partner with All for Kids (formerly Children's Bureau) to conduct a community survey or listening sessions to gather community concerns and potential pathways toward repair.
Domestic violence and high-conflict relationships are not differentiated in referrals from the Child Protection Hotline. Child welfare staff must differentiate between domestic violence, characterized by power and control, and high-conflict relationships, which may involve mutual aggression or violence, in order to recommend services appropriate to each set of dynamics and to evade a mismatch between participant(s) and services.	DCFS and Valley Oasis are encouraged to continue domestic violence consultations upon request by ER CSWs. (See findings in the final section of this report.) DCFS Training Academy in tandem with Valley Oasis and/or the LA DVC may consider developing a differential assessment training simulation on this topic. DCFS, Valley Oasis, and local service providers may collaborate to identify existing resources and gaps in services appropriate to addressing each relationship dynamic, to facilitate referrals and explore resources to expand service options, as needed. Further research may be required. LA County may consider funding a pilot for differential response to calls about domestic violence and high-conflict relationships to the Child Protection Hotline as part of the Mandatory Supporting Initiative.

Table 3. Systemic Barriers to Service Participation by Parent Survivors (cont.)

Systemic Barriers to Service Participation	Recommendations for Consideration
Racial biases toward and stereotypes of Black women parent survivors sometimes placed them last to be helped.	DCFS may consider implementation of the recommendations in the LA County Board of Supervisors' motion, Blind Removals Moving Forward: Color Consciousness and Safeguarding against Racial Bias, dated April 23, 2024 to continue engaging in organizational culture change that supports awareness and mitigation of anti-Black racism through training, supervision, coaching, equity audits of policy impact on Black families, etc.
Few programs considered race and intersectional identities, potentially contributing unique barriers to inclusion and belonging, jeopardizing service relevance or completion for parent survivors who are Black or Indigenous, LGBTQ+, immigrants without documents, men, or from other groups.	DCFS champions for racial, LGBTQ+, and other intersectional identities may consider collaborating with parent survivors and advocates from community organizations and the Departments of Mental Health and Public Health to recommend enhancements to current programs and curricula, incorporating content on the unique conditions and challenges faced by these diverse groups. The Center for the Pacific Asian Family training, Decoding Language and Culture (a fee for service training), may be a resource to consider.
Signs of potential secondary traumatic stress were evident among DCFS Lancaster staff and domestic violence service providers who participated in this study.	DCFS and Valley Oasis are encouraged to increase education about secondary traumatic stress, effects on staff wellbeing and performance, and potential consequences for families served. Develop non-judgmental, supportive, and systematic assessment for and responses to secondary traumatic stress in the workplace.
Dangerous activities in and around motels where emergency vouchers were used. The emergency motel at the time of data collection attracted drug dealing and human trafficking, exposing families to dangerous conditions when parent survivors' actions were often already under child welfare investigation.	Valley Oasis addressed the dangerous motel conditions by developing a working agreement with a different motel. DPSS, LAHSA, local business leaders or the Chamber of Commerce, and Antelope Valley communities may be resources to Valley Oasis as it continues to negotiate challenges using motels for emergency housing for parent survivors and their children.

Table 3. Systemic Barriers to Service Participation by Parent Survivors (cont.)

Systemic Barriers to Service Participation	Recommendations for Consideration
Class schedules incompatible with parent survivors' work schedules. **Virtual classes became problematic for parent survivors without a private or safe space from which to participate**, potentially multitasking with their children present or in fear of a volatile or violent partner discovering their engagement in services.	DCFS, Valley Oasis, and local agencies offering parenting and domestic violence survivor classes may collaborate to assess working parent survivors' needs and the issues related to virtual participation and respond accordingly.
Narrow scope of mental health services left some parent survivors wanting options for processing trauma, healing, and restoring well-being in addition to talk therapy for themselves and their children.	DCFS and Valley Oasis may consider consulting with parent survivors to advocate for a wider scope of services from the Departments of Mental Health and Public Health, including more domestic violence support groups facilitated by people with lived experience and fellowships for licensed mental health practitioners in somatic, arts-based, and culturally informed approaches to healing.
Limited and unreliable public transportation. **Limited support for gas and car repairs for parent survivors**, who often do not have the financial resources upon fleeing domestic violence to fuel and maintain the cars they have.	DCFS may consider requesting the Antelope Valley Transit Authority and Metropolitan Transportation Authority incorporate DCFS, Valley Oasis, and parent survivors as representatives during public comment on necessary additions and proposed changes to service routes. DCFS and Valley Oasis may collaborate on applications for funding to increase safe, reliable community rideshare initiatives and access to gas and car repairs for parent survivors with cars.
Limited availability of safe, reliable, and affordable childcare, critical for parent survivors to participate in services, school, work, and search for employment. Several parent survivors expressed reluctance to leave their violent partners due to concerns about losing childcare and jeopardizing their employment and income.	DCFS and Valley Oasis may consider enhanced collaboration with the LA County Office of Childcare, Department of Public Works, and/or the Office for the Advancement of Early Care and Education to increase availability of quality childcare for parent survivors.

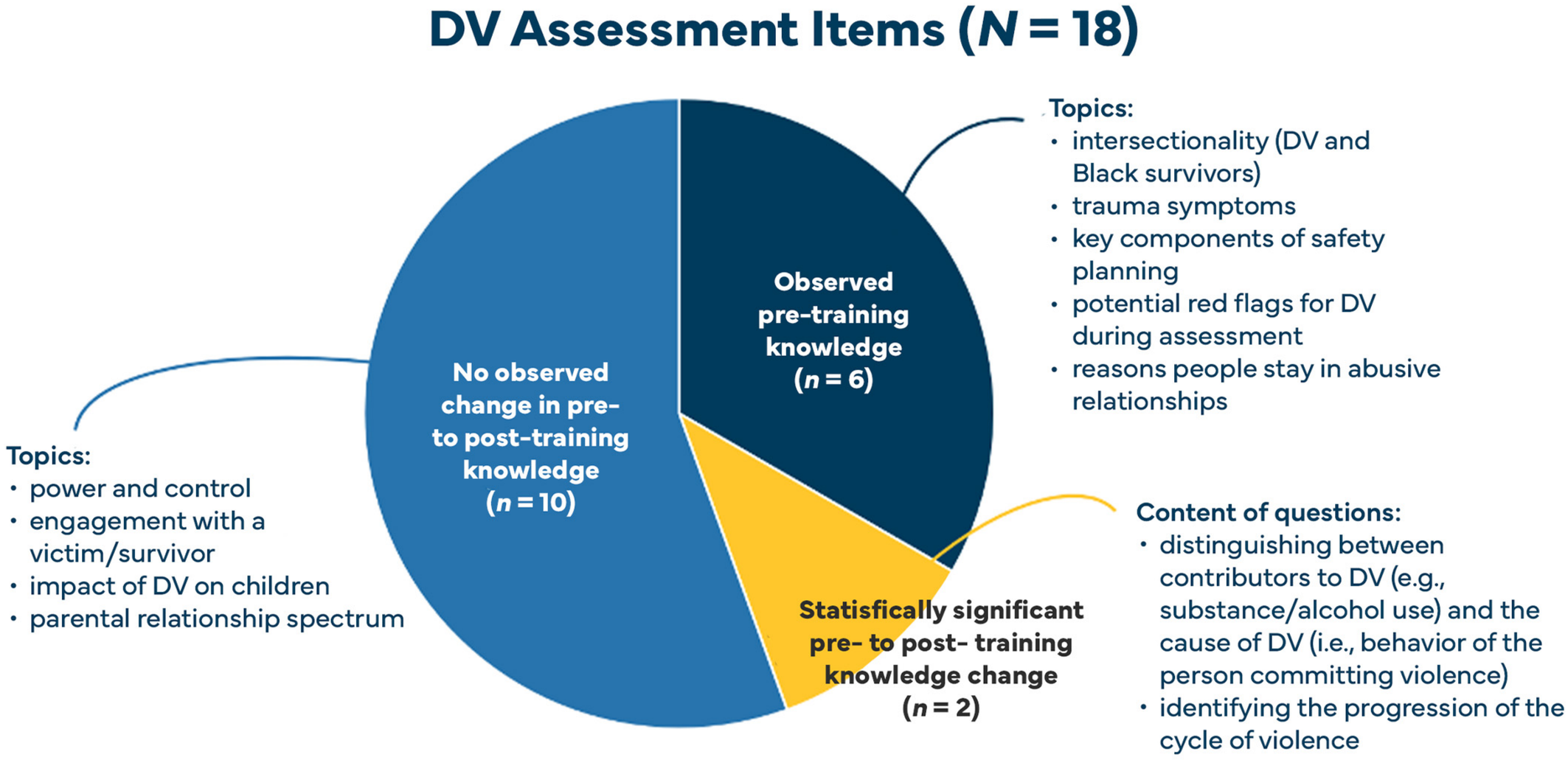
Results of Pre- and Post-Domestic Violence Training Assessments

The pre- and post-domestic violence training assessment consisted of 18 multiple-choice questions covering 11 topics (Figure 1). Descriptive analysis of the pre-training assessment indicated that the majority of DCFS Lancaster ER CSWs (i.e., 93% or higher) entered the training with domestic violence knowledge assessed in six of the questions. These included trauma symptoms, safety planning, signs of potential domestic violence when first meeting families, and reasons people stay, including systemic barriers to Black survivors seeking help (see the dark blue section of the pie chart). Analysis showed statistically significant changes in knowledge from pre- to post-training assessments for two questions. ER CSWs' knowledge increased in differentiating contributors to domestic violence (e.g., substance/alcohol abuse) from the cause of domestic violence (i.e., behavior of the person committing the violence) and identifying the progression of the cycle of violence (see the yellow section below). No statistically significant changes in knowledge were observed for ten of the assessment questions (see the medium blue section below).

Measures of knowledge change and observations during the training suggested two important considerations about the training. First, participants began questioning their assumptions about domestic violence and their questions were not resolved in one full-day training. Second, changing long-ingrained societal messages about domestic violence requires concentrated and sustained opportunities for learning about domestic violence and guidance applying that knowledge in daily interactions with families. The domestic violence consultations offered ER CSWs this opportunity. These findings are presented next.

(Please see Appendix A1, Table A1-5 for descriptive data about domestic violence training participants and Appendix A3, Table A3-1 for descriptive statistics for pre- and post-domestic violence training assessment questions and answers, and Table A3-2 for descriptive statistics on incorrect and correct responses for pre- and post-domestic violence training assessments and results of Bowker's test and the Stuart-Maxwell test.)

Figure 1. Results of Analysis of Pre- to Post-Domestic Violence Training Assessments



Findings from the Domestic Violence Consultations

The domestic violence consultant's role involved offering support and guidance to ER CSWs in addressing the complex dynamics of families potentially experiencing both domestic violence and child maltreatment. The consultant focused on ensuring sensitive risk versus safety assessments attuned to the unique family dynamics, addressing the specific needs of individuals with intersecting identities (i.e., race/ethnicity, sexual orientation, gender identity and expression, immigration status, socioeconomic status, disability, stage of the life course, among others), and facilitating referrals to appropriate domestic violence services for both parent survivors and children. ER CSWs requested and received 48 domestic violence consultations. Findings included descriptive quantitative data and qualitative case summaries documented by the domestic violence consultant during consultations.

Descriptive and demographic data provided information about the domestic violence consultations (Table 4). Most consultations took place via phone call (75%). Law enforcement was the most common reporting party (42%) on the Child Protection Hotline (CPH) referrals. Consultations were conducted for cases involving equal proportions of Black and Latinx adults (30%) in the referral (based on the case demographic data collected). Domestic violence was identified equally in the CPH screener narratives (74%) and during investigations (74%) through ER CSW review of the families' referral histories (34%). The domestic violence consultant documented when intersecting identities influenced the domestic violence dynamics, creating special concerns and requiring consideration. For example, socioeconomic status, namely poverty, influenced domestic violence dynamics among seven families for whom ER CSWs sought consultations, though it is likely that more families experienced poverty. While relatively few intersectional identity concerns (n = 17 or 35%) were identified, the domestic violence consultant assisted ER CSWs in recognizing how multiple marginalized identities (e.g., race/ethnicity, family member disability) may have influenced domestic violence dynamics in the cases discussed.

Table 4. Descriptive and Demographic Data from the Domestic Violence Consultations

Descriptive and Demographic Data	*n*	%
Consultation Setting	**48**	**100**
Phone call	36	75
Follow-up call[a]	10	21
ERDD roundtable	2	4
Reporting Party on Child Protection Hotline (CPH) Referral	**38**	**100**
Law enforcement	16	42
Child welfare system staff	4	11
Community member (family, friend, etc.)	2	5
Other	6	16
Not reported[b]	10	26
Demographics of Adults in Referral	**76**	**100**
Black or African American	23	30
Latino/a/e/x, Spanish, Hispanic	23	30
White or Caucasian	3	4
Multiracial	3	4
Not reported	24	32
Domestic Violence Reported in Hotline Screener Narrative	**38**	**100**
Yes	28	74
No	0	0
Not reported	10	26
Domestic Violence Identified during Investigation	**38**	**100**
Yes	28	74
No	0	0
Not reported	10	26

Table 4. Descriptive and Demographic Data from the Domestic Violence Consultations (cont.)

Descriptive and Demographic Data	*n*	%
Source of Domestic Violence Information during Investigation	**38**	**100**
Referral history	13	34
Law enforcement	7	18
Current restraining order	3	8
Interview	1	3
Other	4	11
Not reported	10	26
Intersectional Identity Concerns during Consultations[c]	**17**	**100**
Race/Ethnicity	2	12
Immigration status	1	6
Socioeconomic status	7	41
Disability	2	12
Religion/Faith	1	6
Relative in law enforcement	1	6
Other	3	8

[a] Follow-up calls involved two or more calls referring to the same domestic violence incident and families. Data about follow-up calls were only included once for each data point in the table, except Consultation Setting.

[b] The consultation data collection form was developed as the consultations were provided. This resulted in some missing data, primarily from the initial consultations.

[c] Intersectional identity concerns during consultations were only noted by the domestic violence consultant when the concerns influenced the domestic violence dynamics, per the domestic violence consultant. Not every consultation included intersectional identity concerns.

Qualitative case summaries for each consultation were recorded for 46 of the 48 (96%) domestic violence consultations. Domestic violence consultations were sought by ER CSWs for assistance working with families engaged in domestic violence involving physical violence (e.g., choking and punching) and high-conflict relationships with mutual aggression or violence (e.g., throwing objects or scratching). In addition to the intersectional identity concerns identified in the quantitative data, qualitative case summaries documented that ER CSWs and the domestic violence consultant discussed other complicating factors like children witnessing or experiencing violence during domestic violence incidents, potential housing insecurity and homelessness, and substance and alcohol use.

Protective measures like implementing safety plans or restraining orders to protect survivors and their children and child removal from homes affected by domestic violence were also discussed. Further, the domestic violence consultant clarified domestic violence-related dynamics, educated ER CSWs and parent survivors about services, and offered recommendations about how to access resources for families. The domestic violence consultant also directly supported parent survivors by facilitating shelter entries and referring their children to trauma-informed therapy.

Taken together, these quantitative and qualitative findings suggest that domestic violence consultations helped tailor domestic violence information and responses to the family circumstances ER CSWs were charged with investigating and responding to. Domestic violence consultations may enhance ER CSWs' knowledge of domestic violence and ability to apply that knowledge to their work with parent survivors and their children through tailored engagement and intervention strategies. Based on these analyses, the recommendation for DCFS Lancaster and Valley Oasis to continue devoting resources to ongoing domestic violence consultations upon request by ER CSWs was presented.

APPENDICES

APPENDIX A1: STUDY METHODS

Exploratory sequential mixed methods were used in this study to evaluate collaborative reform in child welfare for families experiencing domestic violence in the Antelope Valley. The methods were approved by the UCLA Institutional Review Board and sequenced as follows. First, qualitative data were collected to understand how domestic violence and child welfare intersected in the Antelope Valley through focus group discussions with three stakeholder groups. Next, in response to preliminary focus group findings, DCFS Lancaster and Valley Oasis implementation team members decided to collaborate on two interventions: cross-system training and domestic violence consultations, leading to phase three in the sequence. Quantitative data from pre- and post-training assessments were collected from participants in the full-day domestic violence training and half-day child welfare system training. And deidentified quantitative data and qualitative case summaries were collected during the domestic violence case consultations.

Participant Selection and Recruitment

Focus Groups

Purposeful sampling was used to recruit participants for the focus groups (Patton, 2015). Focus group participants included (1) parent survivors of domestic violence with child welfare system contact who were engaged in Valley Oasis programs, (2) Valley Oasis domestic violence shelter and housing program staff (i.e., domestic violence service providers), and (3) DCFS Lancaster staff, primarily Children's Social Workers (CSWs) from the Emergency Response (ER) unit.

The recruitment process for each participant group varied. The UCLA Pritzker Center research team shared a recruitment flyer with Valley Oasis staff, inviting both staff and parent survivors to an in-person information session held at a community organization in Lancaster. Valley Oasis staff invited parent survivors currently or formerly engaged in the agency's programs. The information session facilitated introductions between parent survivors, Valley Oasis staff, and the research team. During the session, the research team shared the study purpose and data collection plan and answered questions from parent survivors and Valley Oasis staff. In addition, lunch and supplies from Baby2Baby were shared with parent survivors. At the end of the information session, interested parent survivors and staff signed up as prospective participants for the focus groups. Subsequently, the recruitment continued as Valley Oasis staff conducted further outreach to eligible parent survivors until the target of 18 participants was achieved. Parents were aware that they would receive a $50 e-gift card for participating.

Valley Oasis staff members were recruited in part through the information session and later received an email from their supervisor containing information provided by the research team about the study and an invitation to sign up for a focus group. The email contained a Google form allowing the staff to confirm their interest in participating and then choose one of two focus groups dates offered.

DCFS Lancaster staff were informed about the study through an email about the study inviting their participation. This referral email was written by the research team and sent by the DCFS Lancaster Regional Administrator. The Regional Administrator also reached out to staff members thought to have valuable input on the topic. Similar to recruitment procedures for Valley Oasis staff, the email contained a link to a Google form for the staff to indicate their interest and availability to participate.

The research team confirmed focus group dates and times with each participant via direct email, which included the Zoom link or, for several parent survivors, the physical location of the focus group.

Pre- and post-domestic violence training assessments

DCFS Lancaster Assistant Regional Administrators for the ER unit invited CSWs and SCSWs to participate in the domestic violence training. Four sessions were held to accommodate the size of the staff and limit the number of participants in each session to about 14 people. CSWs and SCSWs who participated in the training were eligible to complete the pre-training assessment and those who remained for the full day were eligible to complete the post-training assessment.

CSWs and SCSWs present at the beginning of the domestic violence trainings were invited by the research team coordinator to complete the pre-training assessment accessed by scanning a QR code on their phones. CSWs and SCSWs present at the end of the trainings were similarly invited to complete the post-training assessment. Participation was voluntary.

Pre- and post-child welfare system training assessments

The Valley Oasis shelter director invited shelter staff to participate in the child welfare system training. One session was held to accommodate the full staff. Shelter staff who participated in the training were eligible to complete the pre-training assessment and those who remained for the full day were eligible to complete the post-training assessment.

Shelter staff present at the beginning of the child welfare system training were invited by the research team coordinator to complete the pre-training assessment accessed by scanning a QR code on their phones. Shelter staff present at the end of the training were similarly invited to complete the post-training assessment. Participation was voluntary.

Data Collection and Analysis

Qualitative data collection from focus group discussions

From July to October 2023, focus groups were held with parent survivors, DCFS staff, and Valley Oasis staff (see Table A1-1 below). These discussions aimed to enhance understanding of domestic violence services in the Antelope Valley and DCFS's coordination of these services, thereby gathering recommendations for service improvement from various perspectives.

The focus groups were structured to address specific topics:

- Parent survivors discussed their experiences accessing and participating in domestic violence and other services in the Antelope Valley, the alignment between their needs and the services provided—paying particular attention to factors such as race, ethnicity, sexual orientation, gender identity, immigration status, and age—child welfare service coordination, and recommendations for improving service delivery and coordination.
- Valley Oasis domestic violence service staff focused on the suitability of domestic violence and other services to family needs and intersectional identities, child welfare case coordination, and potential enhancements to service provision and coordination.
- DCFS Lancaster staff evaluated the types and adequacy of domestic violence services relative to family needs and intersectional identities, their own case coordination practices, and potential improvements for services and coordination within the Antelope Valley.

These focus groups were conducted mainly via Zoom in English, with some sessions in person and/or in Spanish. Each session lasted about one hour. Sessions were audio-recorded and transcribed by research team members for coding and analysis.

Table A1-1. Number of Focus Groups per Participant Subgroup

Participant Subgroup	Data Collection Dates	Number of Focus Groups	Number of Participants	Attendance Rate
Parent survivors	July - October 2023	11*	18	60%
DCFS staff	July - August 2023	4	25**	83%
Valley Oasis staff	July 2023	2	10	77%

Notes:
* From the 11 focus groups, six resulted in interviews, given that just one registered participant attended at the agreed time and date.
** From the 25 DCFS staff participants, 12 DCFS staff were from Emergency Response, six were from Continuing Services, and the rest (i.e., 7) were from other units and in specialized roles.

Qualitative data analysis of focus group discussions

The research team employed a thematic analysis approach to analyze the qualitative data from focus group discussions (Clarke & Braun, 2016). This analytical approach was used to explore the patterns within and across the data from the three stakeholder groups. Patterns within the parent survivor data yielded themes that contextualized experiences and observations offered across the three groups. Data analysis involved systematically exploring the data to identify emerging themes, outlined by the following steps: systematizing the collected qualitative data, becoming familiar with the transcripts, creating a codebook, coding the data, integrating codes, and interpreting the findings.

Initially, the research team transcribed all recordings. Next, during the familiarization phase, team members reviewed and wrote individual memos for each of the 17 transcripts. These individual analytic memos were discussed in smaller groups, ranging from four to five members, who then prepared group analytic memos. These group memos were presented to the entire research team, culminating in the creation of six comprehensive research team analytic memos (i.e., one memo for the four DCFS staff transcripts, one for both Valley Oasis staff transcripts, and four for parent survivor transcripts). This process ensured a thorough understanding of the data, facilitating the creation of a codebook.

Subsequently, the codebook was collaboratively developed, drawing upon theoretical frameworks, prior research experiences, and insights from the data collection process and reading the transcripts. The codebook was applied uniformly across all focus group transcripts. Per Saldaña's (2016) recommendations, the codebook was regularly reviewed during team meetings to maintain coding consistency, evaluate its effectiveness, and adjust the coding scheme as necessary. Following the creation of the codebook, a coding plan was devised, and the coding tasks were distributed among team members. Each transcript was coded and subsequently reviewed by another team member to ensure coding consistency.

After coding was completed, the analysis continued with a code report (or excerpt) analysis, where each team member reviewed the coded excerpts for each code, wrote detailed memos, and then collaborated with two or three colleagues who had analyzed the same excerpts. This collaboration led to the formation of code-specific analytic memos. These memos were further examined in relation to other code-specific memos to interpret the interconnectedness of different data elements (represented by the code reports). Finally, the research team synthesized these insights by thoroughly discussing and analyzing the analytic memos, leading to the development of the qualitative themes, subthemes, and recommendations detailed in the findings section of this study.

Quantitative demographic data collection and analysis of focus group participants

After each focus group, participants across the three stakeholder groups were asked to complete a demographic survey using a Google form or on paper for most in-person parent survivor focus groups. Demographic data were analyzed using descriptive statistics (Tables A1-2 - A1-4).

Table A1-2. Parent Survivor Focus Group Participant Demographics (*N* = 18)

Demographics	*n*	%
Race/Ethnicity (missing = 5)	**13**	**100**
American Indian/Alaskan Native	2	15
Black or African American	7	54
Latinx	2	15
White	1	8
Multiracial	1	8
Gender	**18**	**100**
Female	18	100
Sexual Orientation (missing = 5)	**13**	**100**
Straight	12	92
LGBTQ+	1	8
	Range	**Average**
Age (missing = 5)	28-45	34
	Range	**Average**
Number of Children (missing = 5)	1-5	3

Table A1-3. DCFS Staff Focus Group Participant Demographics (*N* = 25)

Demographics	*n*	%
Race/Ethnicity (missing = 5)	**20**	**100**
Black or African American	8	40
Latinx	7	35
Other	5	25
Gender (missing = 5)	**20**	**100**
Female	15	75
Male	5	25
Highest Degree (missing = 5)	**20**	**100**
Bachelor	15	75
Master or PhD	5	25
Current Job Title (missing = 6)	**19**	**100**
CSW I	5	26
CSW II	4	21
CSW III	7	37
Other	3	16
Unit	**25**	**100**
Continuing Services	6	24
Emergency Response	12	48
Other	7	28
	Range	**Average**
Years in Current Position (missing = 7)	1-11	4
	Range	**Average**
Years at DCFS (missing = 6)	1 or less-20+	9

Table A1-4. Valley Oasis Staff Focus Group Participant Demographics (*N* = 9)

Demographics	*n*	%
Race/Ethnicity	**9**	**100**
Latinx	8	89
Other	1	11
Gender (missing = 1)	**8**	**100**
Female	8	100
Highest Degree (missing = 1)	**8**	**100**
High school	4	50
Some college	2	25
Associate or Bachelor	2	25
Current Job Title (missing = 1)	**8**	**100**
Case Manager	4	50
Other	4	50
	Range	**Average**
Years in Current Position (missing = 1)	1 or less-6	2
	Range	**Average**
Years at Valley Oasis (missing = 1)	1 or less-3	1

Quantitative data collection and analysis of pre- and post-domestic violence training assessments

The full-day domestic violence training developed and facilitated in May 2024 by Valley Oasis domestic violence consultants was evaluated via a pre- and post-training assessment of domestic violence knowledge among attendees. The assessment tool and demographic questions were developed in Qualtrics survey software. CSWs and SCSWs were provided with a five-digit code that they entered into the survey to anonymously link the pre- and post-training assessments for each person. This facilitated statistical analysis of changes in scores for matched pairs. The pre- and post-training assessment questions were developed by the research team based on training content, reviewed by implementation team members to assess face validity, then edited based on feedback. The domestic violence assessment questions were pilot tested by Valley Oasis staff who provided further feedback that was incorporated to finalize the

assessment. The assessment consisted of 18 multiple choice questions covering 11 topics, including definition of domestic violence, the cycle of violence, power and control, intersectionality and domestic violence, trauma, safety planning, engagement with a victim/survivor, impact of domestic violence on children, the parental relationship spectrum, privacy, confidentiality and privilege, and reasons people remain in relationships involving domestic violence.

Demographic data for CSWs and SCSWs were analyzed descriptively (Table A1-5). The pre-training assessment data were analyzed descriptively to determine baseline knowledge of domestic violence among the CSWs and SCSWs in attendance. Then pre- and post-training assessments were matched, resulting in paired data (N = 43). Non-parametric statistical methods were used to account for the relatively small sample size and data distribution characteristics. Bowker's test of proportional change and the Stuart-Maxwell test of marginal homogeneity were used. Both are appropriate for analyzing matched-pair data from an independent sample (Bowker, 1948; Maxwell, 1970; Stuart, 1995). Bowker's test was used to assess whether the proportion of responses from pre- to post-assessment (e.g., correct responses at both times, incorrect at pre and correct at post, etc.) remained the same. The Stuart-Maxwell test assessed whether the proportion of total correct versus incorrect answers remained the same from pre- to post-assessment. A statistically significant result for both tests indicates that the proportions did not remain the same, therefore changed, from pre- to post-assessment.

Table A1-5. Demographics for CSW and SCSW Participants in the Domestic Violence Training

Demographics	*n*	%
Race/Ethnicity	**43**	**100**
Black or African American	10	23
Latinx	20	47
White	6	14
Other race, ethnicity, or multi-racial	7	16
Gender (missing = 1)	**42**	**100**
Female	35	83
Male	7	17
Current Job Title (missing = 1)	**42**	**100**
Children's Social Worker (CSW)	36	86
Supervising CSW	6	14
Years at DCFS	**Range**	**Average**
	1 or less-20+	7
	n	**%**
DCFS Training Academy Included Domestic Violence Training	**43**	100
Do not recall	9	21
No	6	14
Yes	28	65
	n	**%**
Most Recent DCFS Domestic Violence Training	**43**	100
Never participated	9	21
Less than 1 year ago	8	19
1-2 years ago	16	37
3 or more years ago	10	23

Quantitative data collection of pre- and post-child welfare system training assessments

The half-day child welfare system training was developed and co-facilitated in May 2024 by a DCFS Assistant Regional Administrator and Children's Law Center attorney. The child welfare knowledge assessment tool and demographic questions were developed in Qualtrics survey software. Valley Oasis shelter staff were provided with a five-digit code that they entered into the survey to anonymously link the pre- and post-training assessments for each person. The child welfare training assessment was developed by the research team, reviewed by one of the trainers, and edited based on feedback. The assessment consisted of eight multiple choice questions covering topics related to the role of the child protection hotline, the most common outcome of referrals investigated by DCFS, and the court process. Due to the combination of a very small sample size (N = 10) and unanticipated changes to content in part of the child welfare system training which invalidated half the assessment questions, these data were not analyzed.

Quantitative and qualitative data collection and analysis of domestic violence consultations

Finally, anonymous descriptive quantitative data and qualitative case summary data collected by the domestic violence consultant from Valley Oasis during the domestic violence consultations were analyzed. From March to July 2024, the domestic violence consultant completed 48 domestic violence consultations, as requested by CSWs and SCSWs and during two multidisciplinary Eliminating Racial Disproportionality and Disparities (ERDD) roundtables.

The data gathered from the consultations were organized in a spreadsheet by the domestic violence consultant (see Appendix A4). This spreadsheet detailed characteristics of the consultations, such as the date, follow-up call status, and the identity of the reporting party, which included individuals such as teachers, school personnel, law enforcement, medical professionals, and child welfare system staff. Additionally, it included demographic details like the race/ethnicity of the adults identified in the Child Protection Hotline referral, the presence of domestic violence in the screener narrative (yes/no), and if domestic violence was identified during the investigation (yes/no), the source of that information was documented (e.g., referral history, law enforcement history, current restraining orders, interviews, or other sources), along with any concerns related to intersectional identities relevant to discussion during the case consultation. These data were analyzed descriptively and are found in Table 4 in the body of the report.

The qualitative data from these consultations were captured through brief, anonymous qualitative case summaries written by the domestic violence consultant. These summaries focused on the safety threats or concerns discussed during the consultations, documented in 46 instances (Table A1-6). The summaries were analyzed descriptively. A systematic coding process was implemented using a codebook. Coding was uniformly applied to all case summaries. Using first-cycle coding methods, specifically descriptive coding as suggested by Saldaña (2016), facilitated the cataloging of various topics and documenting actions and processes noted during the consultations. The analytical process concluded with a descriptive data analysis to synthesize the findings comprehensively.

APPENDIX A2: FOCUS GROUP DISCUSSION PROTOCOL

Focus group questions

Parent Survivors

1. What kinds of domestic violence services have you used?
   a. What services related to domestic violence, if any, have your children received?
   b. How did you learn about these services? Who referred you or your child?
   c. If a DCFS caseworker referred you, how did they help you or your child connect with the services?
   d. What challenges, if any, did you or your child encounter accessing these DV services?

2. How did you feel about seeking services? How did you feel about your child receiving services (if they did)? What contributed to that feeling? How did you manage that?

3. Was anything helpful about the domestic violence services you used? If so, what?
   a. What about the services your children used (if any)?
   b. Were the services what you expected? How? How not?

4. How was your experience working with staff in the domestic violence program(s)? What were your relationships like with them?
   a. How would you describe your child's relationship with staff in the domestic violence program(s)?
   b. Who in the program influenced you most and how? What was their role?

5. How do these DV services account for the needs of people based on race/ethnicity, culture, immigration status, gender, age, or sexual orientation?

6. Was anything missing from the domestic violence services? If so, what?

7. How, if at all, did the DCFS social worker ensure that you and your child were well connected to DV and other services?
   a. What worked well when connecting with DV and other services? What did not work?
   b. How might DCFS social workers improve how they connect and coordinate services with families experiencing DV?
   c. What else would you like us to know about your experience working with the DCFS social worker?

8. Throughout our time, you have been making suggestions about how to improve DV services and DCFS service coordination. What else do you wish was available for survivors of domestic violence?

9. Based on our conversation today, is there anything else you would like to add?

Valley Oasis staff

1. Please share your name and role within Valley Oasis, and how long you have worked with families experiencing domestic violence.

2. When working with families experiencing DV and DCFS investigation or case, what comes to mind?

3. What domestic violence services exist for families in the Antelope Valley?
   a. How do these DV services meet families' needs?
   b. What challenges, if any, do you see families encounter when trying to access DV services?

c. How do these DV services account for the needs of people based on race/ethnicity, culture, immigration status, gender, age, or sexual orientation?
d. Where are there DV service gaps in the Antelope Valley?

4. How is your work with families experiencing DV affected when DCFS is also involved?
   a. What is your experience trying to coordinate services with DCFS?
   b. What barriers arise? How do you attempt to work around these barriers?

5. What services are families experiencing both domestic violence and DCFS involvement telling you they need?
   a. Have families shared their feelings about the services and programs offered to them by DCFS? If yes:
      i. What services have families found most helpful? What services have they found least helpful?
      ii. What do they wish was different about their contact with DCFS or DCFS service coordination, especially given their experiences with DV?

6. When working with families in situations of domestic violence and DCFS involvement, are there any services you wish were available?
   a. Would these services be different depending on differences in race/ethnicity, culture, immigration status, gender, age, or sexual orientation? If so, how?

7. The next set of questions is similar and focuses on recommendations for serving specific populations in the Antelope Valley. What recommendations, if any, would you make for better serving
   a. Black families experiencing domestic violence and involved with DCFS?
   b. Latino/Hispanic families experiencing domestic violence and involved with DCFS?
   c. LGBTQ+ families experiencing domestic violence and involved with DCFS?

8. Based on our conversation today, is there anything else you would like to add?

DCFS staff

1. Please share your name and role within DCFS Lancaster, and how long you have worked at DCFS.

2. How do you define domestic violence?
   a. What other aspects might you include in what has already been shared?

3. What services do you refer families to when they are experiencing domestic violence?
   a. How do these DV services meet families' needs?
   b. What challenges, if any, do you see families encounter when trying to access DV services?
   c. How do these DV services account for the needs of people based on race/ethnicity, culture, immigration status, gender, age, or sexual orientation?
   d. Where are there DV service gaps in the Antelope Valley?

4. What barriers do you as a staff member experience as you try to connect families with domestic violence services?
   a. What barriers do you experience as you try to coordinate DV and other services with families? And other service providers?
   b. How do you attempt to work around these barriers?

5. What services are families experiencing domestic violence telling you they need?
   a. Have families shared their feelings about the services and programs offered to them? If yes:
      i. What DV services have families found most helpful? What services have they found least helpful?
      ii. Do they wish anything was different about DV services?

6. When working with families in situations of domestic violence, are there any services you wish were available?
    a. Would these services be different depending on differences in race/ethnicity, culture, immigration status, gender, age, or sexual orientation? If so, how?

7. The next set of questions is similar and focuses on recommendations for serving specific populations in the Antelope Valley. What recommendations, if any, would you make for better serving
    a. Black families involved with DCFS and experiencing domestic violence?
    b. Latino/Hispanic families involved with DCFS and experiencing domestic violence?
    c. LGBTQ+ families involved with DCFS and experiencing domestic violence?

8. Based on our conversation today is there anything else you would like to add?

APPENDIX A3: PRE- AND POST- ASSESSMENT QUESTIONS FOR DOMESTIC VIOLENCE TRAINING

Table A3-1. Descriptive Statistics for Pre- and Post-Domestic Violence Training Assessment (includes questions and answers)

Topics	Questions and Answer Choices (Correct answers are bolded.)	Answers			
		Pre		Post	
		n	%	*n*	%
Definition	1. Which of the following is **not** a valid statement about intimate partner violence?	**43**	**100**	**43**	**100**
	a. 1 in every 3 women worldwide is a victim of intimate partner violence at some point in her life.	5	12	4	9
	b. Intimate partner violence is more common among Black women and men than among other racial or ethnic groups.	9	21	6	14
	c. Intimate partner violence is rare in same-sex relationships.	28	65	25	58
	d. The annual cost in the U.S. for intimate partner violence exceeds $4 billion for medical and health services and over $1 billion for lost productivity.	1	2	8	19
	2. Which of the following causes domestic violence?	**43**	**100**	**43**	**100**
	a. Growing up in a home with domestic violence.	0	0	2	5
	b. The behavior of the person committing the violence.	0	0	11	26
	c. Substance or alcohol misuse or abuse.	0	0	0	0
	d. All of the above.	43	100	30	70

Table A3-1. Descriptive Statistics for Pre- and Post-Domestic Violence Training Assessment (includes questions and answers)

Topics	Questions and Answer Choices (Correct answers are bolded.)	Answers			
		Pre		Post	
		n	%	*n*	%
Cycle of Violence	3. The three phases in the Cycle of Violence are:	**43**	**100**	**43**	**100**
	a. Tension builds → abuse inflicted → apologies, excuses, and amends	30	70	40	93
	b. Apologies, excuses, and amends → abuse inflicted → tension builds	1	2	1	2
	c. Abuse inflicted → apologies, excuses, and amends → tension builds	12	28	2	5
	4. In the tension building phase, which of the following behaviors would not be expected from a person who commits domestic violence:	**43**	**100**	**43**	**100**
	a. Verbal abuse of their partner.	2	5	2	5
	b. Threats toward their partner.	0	0	1	2
	c. Usual patterns of communication break down.	14	33	9	21
	d. Swears they will change and never hurt their partner again.	25	58	29	67
	e. Feelings of jealousy escalate.	2	5	2	5
Power and Control	5. Statistics show that a person experiencing domestic violence is most at risk for serious injury or death when:	**43**	**100**	**43**	**100**
	a. They stand up to the abuser and fight back.	6	14	6	14
	b. They disclose being beaten at home to a third party.	2	5	4	9
	c. They attempt to leave the relationship.	34	79	32	74
	d. They attempt to pacify the partner.	0	0	1	2
	Did not answer	1	2	0	0

Table A3-1. Descriptive Statistics for Pre- and Post-Domestic Violence Training Assessment (includes questions and answers)

Topics	Questions and Answer Choices (Correct answers are bolded.)	Answers			
		Pre		Post	
		n	%	*n*	%
Intersectionality	6. Victims of domestic violence who are Black:	**43**	**100**	**43**	**100**
	a. May not call 911 if their partners are also Black due to fears of their partner being killed by law enforcement.	0	0	3	7
	b. Women are more likely to be convicted of killing their abusive partner while trying to survive domestic violence.	1	2	0	0
	c. May distrust government agencies that respond to domestic violence.	2	5	3	7
	d. All of the above.	40	93	37	86
Trauma	7. How do trauma symptons show up?	**43**	**100**	**43**	**100**
	a. Emotionally	0	0	0	0
	b. Psychologically	0	0	0	0
	c. Cognitively	0	0	0	0
	d. Behaviorally	0	0	0	0
	e. All of the above	43	100	42	98
	Did not answer	0	0	1	2
	8. Which statement about trauma responses is true?	**43**	**100**	**43**	**100**
	a. A person will revert to flight, freeze, or appease and please only after fighting back does not work.	7	16	8	19
	b. One strategy for avoiding or surviving impending violence is for the potential victim to try to appease the perpetrator.	25	58	28	65
	c. In response to a perceived threat to their life, a person can choose to freeze.	11	26	7	16

Table A3-1. Descriptive Statistics for Pre- and Post-Domestic Violence Training Assessment (includes questions and answers)

Topics	Questions and Answer Choices (Correct answers are bolded.)	Answers			
		Pre		Post	
		n	%	*n*	%
Safety Planning	9. What is safety planning?	**43**	**100**	**43**	**100**
	a. Safety plans are designed for each survivor's specific needs.	0	0	1	2
	b. Knowing the survivor's danger zone is vital to creating a safety plan.	0	0	0	0
	c. Children are also involved in safety planning that is kid friendly.	0	0	0	0
	d. Safety planning is an intervention tool that is used with survivors of domestic violence.	3	7	3	7
	e. All of the above.	40	93	39	91
	10. Which of the following is **not** true about safety planning?	**43**	**100**	**43**	**100**
	a. Safety planning is based on the premise that the victim-survivor has a choice about how to respond to threats of, or actual violence and how to get themselves and their children to safety.	9	21	2	5
	b. Moving out of high-risk areas such as bathrooms, kitchen, and the garage is one potential safety planning strategy.	1	2	7	16
	c. Obtaining a concealed carry weapon permit and carrying a concealed weapon is a potential safety strategy.	16	37	17	40
	d. Planning to use substances or alcohol in a safer environment and with people who understand the risk of violence and commit to supporting safety is a potential safety strategy.	17	40	17	40

Table A3-1. Descriptive Statistics for Pre- and Post-Domestic Violence Training Assessment (includes questions and answers)

Topics	Questions and Answer Choices (Correct answers are bolded.)	Answers			
		Pre		Post	
		n	%	*n*	%
Engagement with a Victim/Survivor	11. Before beginning a client interview to assess for the presence of violence, necessary preparation **includes all except** which of the following?	**43**	**100**	**43**	**100**
	a. Assure confidentiality of all information revealed.	20	47	18	42
	b. Choose an environment where others will not overhear the conversation.	4	9	5	12
	c. Discuss legal mandatory reporting requirements.	14	33	10	23
	d. Provide an appropriate interpreter if the client does not speak English.	4	9	9	21
	Did not answer	1	2	1	2
Impact of Domestic Violence on Child(ren)	12. Which of the following is **most** accurate about child exposure to domestic violence?	**43**	**99**	**43**	**100**
	a. Most children exposed to domestic violence are also subject to child abuse at home.	15	35	18	42
	b. Oftentimes, children are not aware that domestic violence is happening, particularly when it takes place while they are at daycare or school.	4	9	4	9
	c. Children may participate in the abuse of their parent.	1	2	5	12
	d. Children are better off when they do not see the violence.	1	2	0	0
	e. b and d.	22	51	16	37

Table A3-1. Descriptive Statistics for Pre- and Post-Domestic Violence Training Assessment (includes questions and answers)

Topics	Questions and Answer Choices (Correct answers are bolded.)	Answers			
		Pre		Post	
		n	%	*n*	%
Impact of Domestic Violence on Child(ren)	13. Child development is affected by growing up exposed to domestic violence. What are potential developmental indicators of exposure to domestic violence?	**43**	**101**	**43**	**100**
	a. Infants may seem unresponsive to your efforts to engage with them.	1	2	2	5
	b. Children may appear calm but complain about stomachaches or headaches.	1	2	0	0
	c. Children and teens may not have language for exposure to DV when they were infants or toddlers.	0	0	1	2
	d. Children and teens may be fully engaged in school and extracurricular activities.	0	0	0	0
	e. Teens may experience emotional dysregulation.	3	7	2	5
	f. All of the above.	37	86	37	86
	Did not answer	1	2	1	2
Parental Relationships Spectrum	14. What is true about all intimate relationships?	**43**	**100**	**43**	**100**
	a. Tensions build and recede.	26	60	18	42
	b. The drive to know who a partner spends time with is common.	2	5	4	9
	c. Open communication between partners is limited.	4	9	4	9
	d. Difficulties are minimized, not recognized, or addressed.	11	26	16	37
	Did not answer	0	0	1	2

Table A3-1. Descriptive Statistics for Pre- and Post-Domestic Violence Training Assessment (includes questions and answers)

Topics	Questions and Answer Choices (Correct answers are bolded.)	Answers			
		Pre		Post	
		n	%	*n*	%
Parental Relationships Spectrum	15. Which of the following are potential red flags for domestic violence that you might see when assessing families?	**43**	**99**	**43**	**100**
	a. When telling you about a family interaction, the victim-survivor parent tells the story out of order.	1	2	0	0
	b. The victim-survivor parent appears unable to remember events.	0	0	3	7
	c. Children are perfectly behaved.	0	0	0	0
	d. Children may appear startled when they hear a key in the front door.	0	0	0	0
	e. The victim-survivor parent does not have access to a phone.	1	2	0	0
	f. All of the above.	41	95	39	91
	Did not answer	0	0	1	2
Privacy, Confidentiality, and Privilege	16. Which statement provides an accurate definition of privacy, confidentiality, or privilege?	**43**	**101**	**43**	**100**
	a. Privacy concerns the protection of someone else's choices about disclosure.	14	33	3	7
	b. Confidentiality refers to the personal choice of whether to disclose information.	9	21	9	21
	c. Privilege is the legal rule that guarantees confidentiality in all circumstances.	6	14	11	26
	d. Privacy involves a personal choice whether to disclose information.	14	33	19	44
	Did not answer	0	0	1	2

Table A3-1. Descriptive Statistics for Pre- and Post-Domestic Violence Training Assessment (includes questions and answers)

Topics	Questions and Answer Choices (Correct answers are bolded.)	Answers			
		Pre		Post	
		n	%	*n*	%
Reasons People Stay	17. Why do some individuals stay in abusive relationships?	**43**	**100**	**43**	**100**
	a. They fear losing custody of their children if they seek help.	0	0	0	0
	b. They want to protect their privacy and sense of competence.	0	0	1	2
	c. They fear being "cast out" by their family.	0	0	0	0
	d. All of the above.	43	100	40	93
	Did not answer	0	0	2	5
	18. What contributes to the cycle of returning to an abusive relationship?	**43**	**99**	**43**	**100**
	a. The victim-survivor's ability to effectively communicate and resolve conflicts with their abusive partner.	1	2	2	5
	b. The victim-survivor's inability to recall traumatic experiences accurately.	0	0	2	5
	c. Traumatic bonding resulting from the victim-survivor's sense of deep connection with their abusive partner.	41	95	38	88
	d. The victim-survivor's desire to seek revenge on their abusive partner.	1	2	0	0
	Did not answer	0	0	1	2

Table A3-2. Pre- and Post-Domestic Violence Training Assessments: Incorrect and Correct Descriptive Statistics and Results of Bowker's Test and the Stuart-Maxwell Test

Item	Pre				Post				Significant Knowledge Gains
	Incorrect		Correct		Incorrect		Correct		
	n	%	*n*	%	*n*	%	*n*	%	
1. Which is not a valid statement about IPV?	15	35	28	65	18	42	25	58	
2. Which causes DV?	43	100	0	0	32	74	11	26	*
3. The three phases in the Cycle of Violence are	13	30	30	70	3	7	40	93	*
4. Tension building phase behaviors not expected from a person who commits DV	18	42	25	58	14	33	29	67	
5. Most at risk for serious injury or death when	9	21	34	79	11	26	32	74	
6. Victim-survivors of DV who are Black	3	7	40	93	6	14	37	86	
7. How do trauma symptoms show up?	0	0	43	100	1	2	42	98	
8. Which statement about trauma responses is true?	18	42	25	58	15	35	28	65	
9. What is safety planning?	3	7	40	93	4	9	39	91	
10. Which is not true about safety planning?	27	63	16	37	26	60	17	40	

Table A3-2. Pre- and Post-Domestic Violence Training Assessments: Incorrect and Correct Descriptive Statistics and Results of Bowker's Test and the Stuart-Maxwell Test

Item	Pre				Post				Significant Knowledge Gains
	Incorrect		Correct		Incorrect		Correct		
	n	%	*n*	%	*n*	%	*n*	%	
11. Necessary prep before assessing for DV include all except?	23	53	20	47	25	58	18	42	
12. Which is most accurate about child exposure to DV?	42	98	1	2	38	88	5	12	
13. What are potential developmental indicators of child exposure to DV?	6	14	37	86	6	14	37	86	
14. Which is true about all intimate relationships?	17	40	26	60	25	58	18	42	
15. Which are potential red flags for DV during assessment?	2	5	41	95	4	9	39	91	
16. Accurate definition of privacy, confidentiality, or privilege?	29	67	14	33	24	56	19	44	
17. Why do some individuals stay in abusive relationships?	0	0	43	100	3	7	40	93	
18. What contributes to the cycle of returning to an abusive relationship?	2	5	41	95	5	12	38	88	

APPENDIX A4: DOMESTIC VIOLENCE CONSULTATION DATA COLLECTION TOOL

Date:	Time of Call:	Type of Call:	If follow up, for call on:	Reporting Party	Specific Reporting Party if "Other" or Multiple Parties	What is the Safety Threat and Worry?	Race/Ethnicity of Parent 1	Race/Ethnicity of Parent 2

	DV in Screener Narrative	DV Identified During Investigation	Source of DV Info	Specific Source(s) if Interview, Other, or Multiple Sources	Intersectional Identity Concerns Raised During Consult	Brief Descripton of Intersectional Identity Concerns


STRENGTHENING CHILDREN AND FAMILIES •