ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HUMAN SERVICES POLICY

BRIEF
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Exposure to Domestic Violence/Intimate Partner Violence Is Associated With Child Welfare System Involvement

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KEY POINTS

- Existing research shows that children's exposure to domestic violence (DV)/ intimate partner violence (IPV) increases the likelihood of involvement with the child welfare system (including child protective services (CPS) involvement and foster care entry). For example, high co-occurrence rates, estimated between 30 and 60 percent, indicate that IPV is present in a substantial share of child maltreatment cases.
- IPV encompasses multiple domains, including emotional abuse, isolation or coercive control, economic control, work or school interference, physical IPV, sexual coercion, injury or escalation, and child-exposed IPV. Among the domains examined in this brief, physical IPV showed the strongest association with CPS involvement.
- Exposure to physical IPV is associated with higher CPS involvement:
    - Families in which children were exposed to caregiver physical IPV were up to twice as likely to experience CPS involvement across all developmental periods examined (birth to age 5, ages 5–9, and ages 9–15).
    - Prior physical IPV exposure increases the likelihood of first CPS involvement by up to 2.5 times across childhood.
    - This association is present throughout childhood and adolescence, with the difference in cumulative CPS involvement between children with and without early physical IPV exposure widening from about 5 percentage points at age 5 to about 10 percentage points by age 9 and remaining at about that level through age 15.
- Administrative data likely underestimates the role of DV/IPV and its relationship to child welfare involvement (including CPS, foster care entry, and permanency placements) due to inconsistent identification and reporting.
- Addressing DV/IPV is an important factor to reducing foster care entries and improving child and family outcomes. Policy responses can focus on improved prevention and family stabilization, while avoiding unintended consequences for non-offending caregivers.

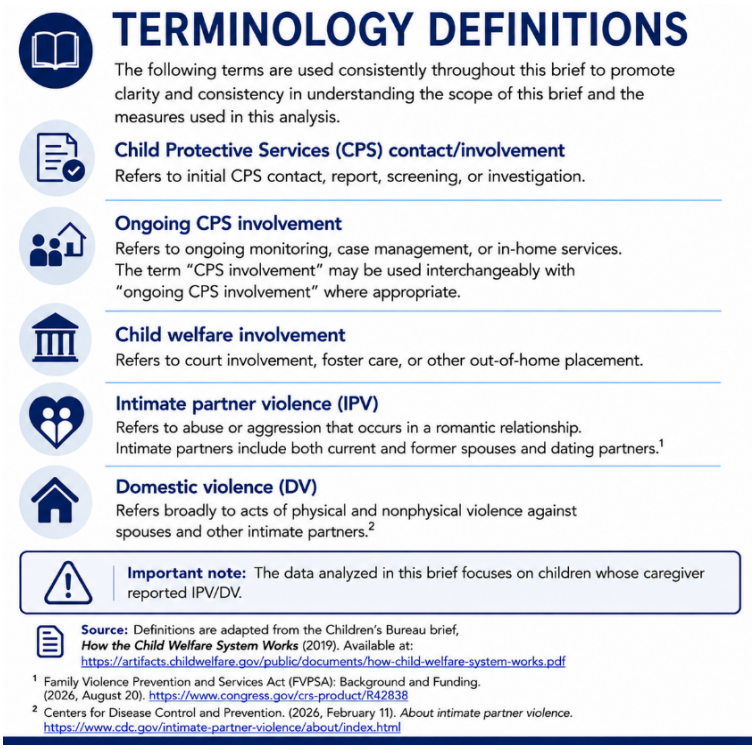
BACKGROUND

Domestic violence is a significant but often hidden factor in child welfare involvement and foster care entry because it is frequently recorded under broader categories like neglect rather than identified on its own. The relationship between domestic violence and child maltreatment is complex. In their work, Shlonsky and Friend[1] propose five ways children may be placed at risk when domestic violence and child maltreatment (also referred to as child abuse and neglect[i,2]) intersect:

- Child maltreatment that is not directly related to concurrent domestic violence
- Child maltreatment that is a direct result of domestic violence
- Emotional harm because of child exposure to domestic violence
- Physical harm to a parent from domestic violence which may inhibit that parent's abilities to meet child needs
- Emotional harm to a parent from domestic violence which may inhibit that parent's abilities to meet child needs

This brief uses various terms to discuss specific types of violence and intervention. The Family Violence Prevention and Services Act (FVSPA) defines domestic violence broadly to include acts of physical and nonphysical violence against spouses and other intimate partners.[3] The Centers for Disease Control and Prevention defines intimate partner violence as abuse or aggression that occurs in a romantic relationship; intimate partners refer to both current and former spouses and dating partners.[4] Though the terms, 'domestic violence' and 'intimate partner violence' refer to distinct concepts, they are sometimes used interchangeably. Throughout the brief, we clarify when research findings, their interpretation, or our analysis refer specifically to intimate partner violence rather than other forms of domestic violence to promote accuracy and consistency. Additionally, in the data analysis, child exposure to IPV refers to children whose caregiver reported experiencing IPV; it does not necessarily mean that the child witnessed or was otherwise directly aware of the violence. This differs from child victimization, which refers to direct abuse or neglect of the child. When referring to each term, this brief uses the terminology highlighted Figure 1.

Figure 1



In some states, a child's exposure to DV/IPV alone may be considered a safety concern or form of maltreatment that can lead to child welfare involvement.[5,6,7] The Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services, along with other federal departments and agencies, has taken steps to elevate and address the role of domestic violence and intimate partner violence in

[i] The Children's Bureau defines child abuse and neglect, at a minimum as

- "Any recent act or failure to act on the part of a parent of caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation"; or
- "Any act or failure to act which presents an imminent risk of serious harm."

child welfare involvement, including child protective services (CPS) involvement and foster care entry. For casework and practice context, see Children's Bureau/Child Welfare Information Gateway resources on DV/IPV in child welfare, including *Domestic Violence: A Primer for Child Welfare Professionals* and the Intimate Partner & Family Violence casework page.

Understanding how frequently DV/IPV contributes to child welfare involvement can be complicated by limitations in national administrative data. The Adoption and Foster Care Analysis and Reporting System (AFCARS) records all circumstances related to a child's removal from home but does not identify a single main or primary reason for removal. The National Child Abuse and Neglect Data System (NCANDS) collects child maltreatment data from states. Submission of data for NCANDS is voluntary and although all data submitted is mapped to a common model, underlying state differences in how they screen cases, define types of maltreatment, or must adhere to state-specific requirements should be taken into consideration when making comparisons. NCANDS can identify when domestic violence is reported as a caregiver risk factor, but it does not show whether or how a child was exposed to that violence. As a result, NCANDS estimates tell us how often domestic violence is identified in families involved with CPS, not how often children themselves experience or are exposed to DV/IPV.[8]

The Future of Families and Child Wellbeing Study (FFCWS) provides another way to examine the relationship between IPV exposure and child welfare involvement.[9,10] FFCWS is a longitudinal birth cohort study that has followed nearly 5,000 children born in large U.S. cities from birth into adulthood, collecting repeated information on family relationships, intimate partner violence, and child welfare involvement over time.[11] We analyze these data to examine the relationship between physical IPV exposure and child welfare involvement. Because FFCWS is observational (i.e., families were not randomly assigned to IPV exposure or CPS involvement), the findings presented below identify associations rather than causal effects.[12,13,14] More details on the data and methods can be found in the Appendix.

EXISTING RESEARCH SHOWS THAT CHILDREN'S EXPOSURE TO DV/IPV INCREASES THE LIKELIHOOD OF CPS INVOLVEMENT AND FOSTER CARE ENTRY, AND INCREASES BARRIERS TO REUNIFICATION

Because the federal AFCARS dataset does not explicitly include domestic violence or intimate partner violence as an option among its 15 standardized removal circumstances, these incidents are typically captured under broader categories such as neglect or physical violence. This structural limitation can prevent the tracking of a primary DV/IPV cause and can contribute to under-identification of domestic violence in national foster care data.[15] According to one study, between 30 and 60 percent of families experiencing child maltreatment also experience IPV[16], although estimates vary widely, likely reflecting both difficulty in reporting or underreporting and the co-occurrence of IPV with other forms of maltreatment which may be the primary for child welfare involvement or out-of-home placement.

Child Exposure to DV/IPV Has Been Shown to be Associated with CPS Involvement

Approximately 18 percent of children are exposed to IPV during childhood, which research has shown increases the likelihood of CPS involvement even when no physical harm is reported.[17]

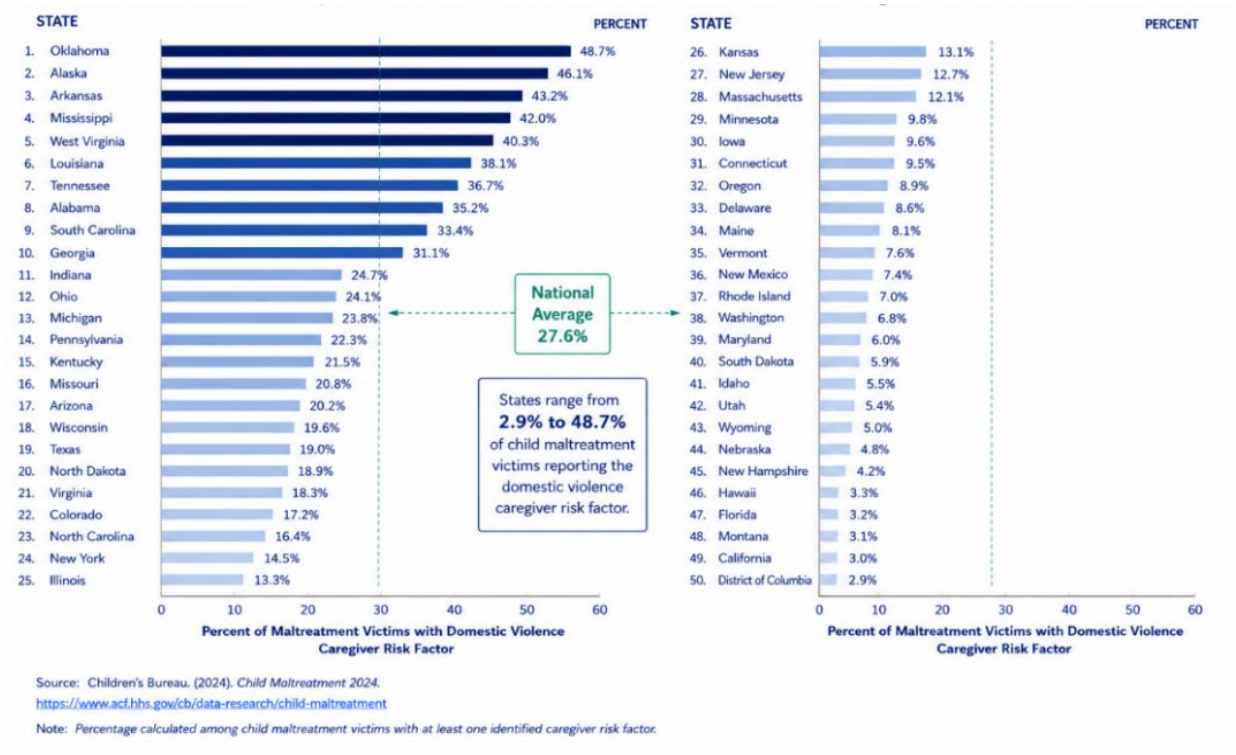
Evidence from child protection investigations also illustrates the relationship between children's exposure to DV and placement. A study of LA county child protection responses (January 2018- March 2021), found that six percent of investigations noted concerns about children's exposure to DV, yet these cases comprised 18% or nearly one in five placements. This is a local, time-bounded estimate rather than a national figure, but it illustrates how a small share of investigations with DV concerns can account for a disproportionate share of placements.[18] Nationally representative data indicate that children who witnessed intimate partner violence in

a given year were nearly four times more likely to experience child maltreatment and CPS involvement during that same period compared with children who had not witnessed such violence.[19]

Research conducted using The Future of Families and Child Wellbeing Study (FFCWS) data and discussed later in this brief shows that children exposed to IPV are more likely to have behavioral and emotional challenges and experience unstable family situations. These factors are known to increase the likelihood of CPS involvement.[20,21]

National child maltreatment data provides additional context on the prevalence of domestic violence as a caregiver risk factor. National child maltreatment data provides additional context on the prevalence of domestic violence as a caregiver risk factor. The *2024 Child Maltreatment Report* identifies domestic violence as the most common caregiver risk factor among child maltreatment victims, affecting approximately 110,000 children. Nationally, domestic violence was identified as a caregiver risk factor for 27.6 percent of child maltreatment victims. State-level rates varied substantially, from 2.9 percent to 48.7 percent (see Figure 2).[22] This difference that likely reflects, in part, variation in how states screen for and document domestic violence rather than true underlying differences in prevalence.

Figure 2: Domestic Violence as a Caregiver Risk Factor Varies Widely Across States



Source: Children's Bureau. (2024). *Child Maltreatment 2024.*
https://www.acf.hhs.gov/cb/data-research/child-maltreatment

Note: *Percentage calculated among child maltreatment victims with at least one identified caregiver risk factor.*

How DV/IPV Can Lead to Foster Care Entry

The foster care entry rate in the United States is approximately 2.5 entries per 1,000 children annually.[23] DV/IPV frequently co-occurs with other family risks, and cases with the highest cumulative risk profiles are far more likely to result in foster care placements, in National Survey of Child and Adolescent Well-Being (NSCAW) data, children in families with the highest cumulative risks (including DV) were ten times more likely to enter foster care than those in low-risk families.[24] One study, which conducted a propensity score analysis, found that children in families where domestic violence was reported faced an elevated risk of out-of-home placement compared to children in families without a reported history of domestic violence.[25]

Additional studies, including research using the Future of Families and Child Wellbeing Study (FFCWS) data, show that IPV often occurs alongside or leads to other challenges, such as financial hardship, mental health challenges, unstable relationships, housing instability, food insecurity, and caregiver stress.[26,27,28,29] These factors increase the likelihood of CPS involvement, repeated CPS contact, greater child welfare system involvement and potential foster care placement.[30,31,32,33] Findings such as these align with ACF priorities related to primary prevention, economic mobility, and family stabilization services, including TANF, home visiting programs, and community-based family support services intended to address upstream risk factors before removal and out of home placement occurs.

Exposure to DV/IPV Has Effects on Reunification and Permanency

Research shows that exposure to DV/IPV is associated with barriers to reunification and longer stays in foster care.[34] One study found children who were exposed to domestic violence were significantly more likely to reenter foster care within two years following reunification, compared with children whose cases did not involve domestic violence.[35] Longitudinal evidence using FFCWS data shows IPV can persist across stages of childhood and is associated with disruptions in family and caregiving contexts.[36,37] These findings underscore the importance of considering ongoing IPV when examining children's trajectories through the child welfare system.[38]

Gaps Between Identified Need and Available Services Persist, Increasing the Likelihood of Child Welfare System Involvement

Even when IPV is identified, not all families receive appropriate services. National data indicates that many families involved with the child welfare system who experience domestic violence do not receive services to address those needs, highlighting a gap between identified need and service provision.[39] One study found that cases involving DV-related allegations were substantiated at higher rates than other cases but did not have higher rates of service uptake or use or out-of-home placement.[40] These findings illustrate that identification of DV-related concerns does not necessarily result in greater use of services.

The *2024 Child Maltreatment Report* presents national data on postresponse and prevention services and shows variation across states in service delivery following child welfare investigations.[41] Although publicly available data in the report do not differentiate between reasons for entering foster care, they show that nationally, approximately 57 percent of child maltreatment victims received postresponse services after completion of the CPS response, and approximately 20 percent received foster care postresponse services. Because the data does not allow us to differentiate between children who experience exposure to IPV/DV and those who do not, these percentages nonetheless underscore that many children involved with the child welfare system may not be receiving the post-response services they may need. These figures may still underestimate the true need for services, but because current national data systems do not consistently capture the circumstances driving CPS involvement, we cannot determine the extent of that undercount with the data available.

PHYSICAL IPV EXPOSURE EARLY IN LIFE IS ASSOCIATED WITH CPS INVOLVEMENT THROUGHOUT CHILDHOOD

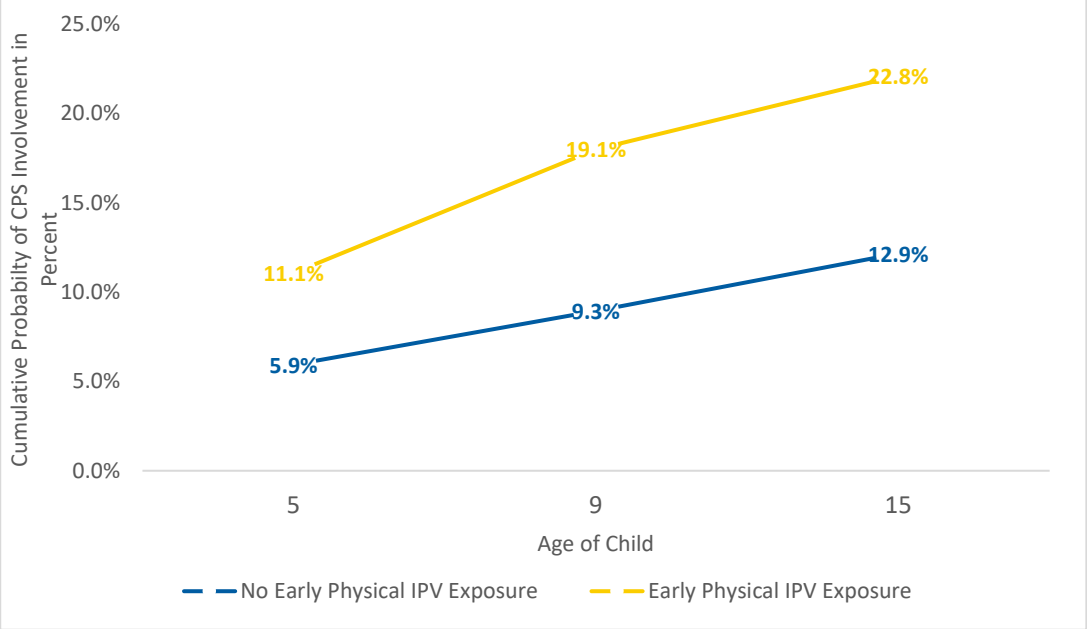
This analysis uses FFCWS data to analyze associations between physical IPV exposure and child welfare system involvement in two complementary ways. The first analysis examines whether early physical IPV exposure (any caregiver-reported physical IPV in the birth, age 1, or age 3 study waves) is associated with the cumulative likelihood of CPS involvement through adolescence. The second examines whether prior physical IPV exposure is associated with the timing of a child's first CPS involvement. Prior exposure is defined as any caregiver-reported physical IPV prior to the age period examined, updated at each age period to reflect reports up to

that point. In both analyses, measures of IPV and CPS involvement are based on caregiver self-reporting. Physical IPV exposure is defined as caregiver reports of physical IPV; the measure indicates that physical IPV was reported in the child's family context but does not indicate that the child directly witnessed the incidents. CPS involvement is defined using caregiver-reported CPS contact or investigation involving the focal child, rather than a formal finding of maltreatment or contact concerning another child in the household; this measure is not linked to or verified against administrative CPS records. Both analyses are descriptive; the findings identify associations rather than causal effects and do not account for other family, social, or economic factors that may be related to both physical IPV exposure and CPS involvement.[ii]

Early Physical IPV Exposure is Associated with Nearly Twice the Likelihood of CPS Involvement and this Difference Persists Through Age 15

The results show that children with early physical IPV exposure had a consistently higher cumulative probability of first CPS involvement throughout childhood than children without early exposure (Figure 3). By age 5, 11.1 percent of children with early physical IPV exposure had experienced CPS involvement, compared with 5.9 percent of children without early exposure. The difference became larger as children aged: by age 9, 19.1 percent of children with early exposure had experienced CPS involvement, compared with 9.3 percent of those without early exposure; by age 15, the corresponding percentages were 22.8 percent and 12.9 percent. In other words, children with early physical IPV exposure were nearly twice as likely to have experienced CPS involvement by age 5, about twice as likely by age 9, and about 1.8 times as likely by age 15. The absolute difference between the two groups also increased from about 5 percentage points by age 5 to about 10 percentage points by age 9 and 15. These findings show that the association between early physical IPV exposure and CPS involvement was already evident in early childhood and persisted through adolescence.

Figure 3. Cumulative Probability of CPS involvement by Early Physical Intimate Partner Violence Exposure



Note: Estimates represent the cumulative probability of first CPS involvement by each age among children with and without early physical IPV exposure. Numbers of children at risk varied because of the longitudinal survival-analysis structure and available observations. See Appendix Table A1 for full model.

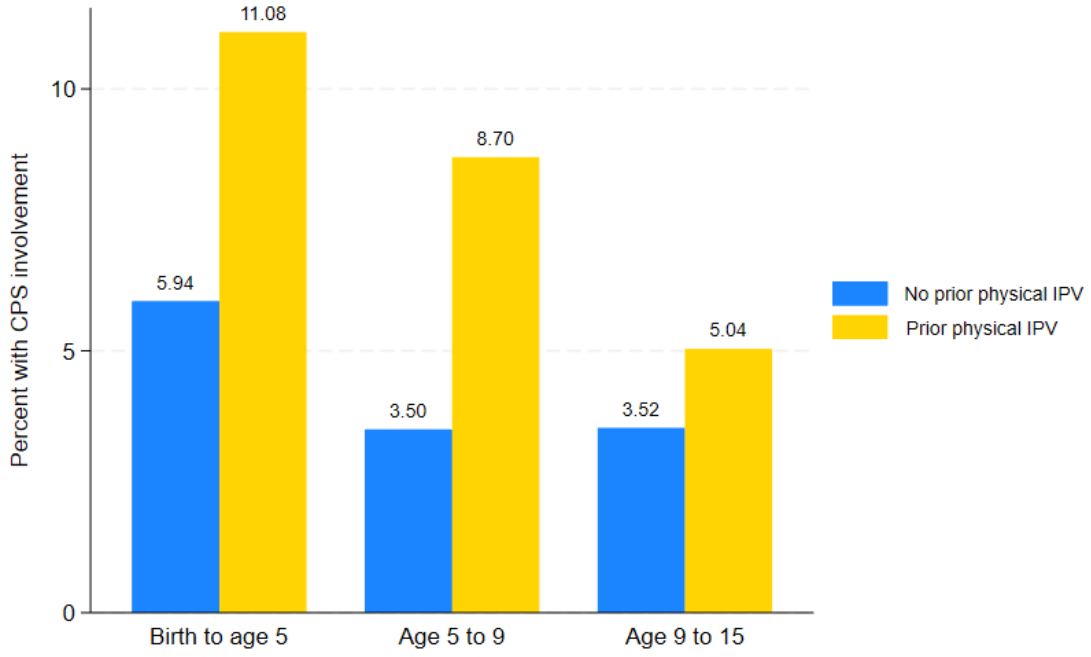
[ii] Full methodology can be found in the Appendix.

Prior physical IPV exposure increases the likelihood of first CPS involvement by up to 2.5 times across childhood.

We also found that prior physical IPV exposure was associated with a greater likelihood of first CPS involvement during every age period examined. Among children who had not previously experienced CPS involvement, 11.1 percent of those with prior physical IPV exposure experienced their first CPS involvement between birth and age 5, compared with 5.9 percent of those without prior exposure (Figure 4). Between ages 5 and 9, 8.7 percent of children with prior exposure experienced their first CPS involvement, compared with 3.5 percent of children without prior exposure. The difference remained during later childhood and adolescence: between ages 9 and 15, 5 percent of children with prior exposure experienced their first CPS involvement, compared with 3.5 percent of those without prior exposure.

Put differently, children with prior physical IPV exposure were nearly twice as likely to experience their first CPS involvement from birth to age 5, about 2.5 times as likely between ages 5 and 9, and about 1.4 times (40 percent more) as likely between ages 9 and 15. Because prior physical IPV exposure was updated at each follow-up, these findings show that physical IPV reported before each CPS assessment was consistently associated with a higher likelihood of subsequent first CPS involvement as children moved through childhood and adolescence. The difference was most pronounced in early and middle childhood but remained evident through age 15.

Figure 4. First CPS Involvement by Prior Physical Intimate Partner Violence Exposure



Note: Percentages represent first CPS involvement within each age interval and are not cumulative. Children were classified according to whether caregiver-reported physical IPV occurred before the CPS involvement assessment for the corresponding interval. There were 9,114 child-period observations overall: 2,933 from birth to age 5, 2,975 from ages 5 to 9, and 3,206 from ages 9 to 15. See Appendix Table A2 for full model.

Taken together, these findings show a consistent association between physical IPV exposure and CPS involvement across childhood. Children exposed to physical IPV early in life had a higher cumulative likelihood of CPS involvement through adolescence, and children with prior physical IPV exposure were more likely to experience their first CPS involvement during each age period examined. The differences emerged early, were especially pronounced during early and middle childhood, and remained evident through age 15. Notably, this association most closely tied specific to physical IPV: preliminary analyses of a cumulative IPV measure that,

including emotional abuse, coercive control, and economic control, found that physical IPV had comparable relationship with CPS involvement.[42] Although these descriptive findings do not establish that physical IPV exposure causes CPS involvement, they demonstrate that caregiver-reported physical IPV is an important marker of children's subsequent involvement with CPS and underscore the value of identifying and responding to IPV in families with children. These findings should be interpreted cautiously as IPV and CPS involvement share many social, economic, relational, and neighborhood risk factors.[43] A more robust analysis would adjust for key confounders, examine possible mechanisms separately, and report sensitivity checks using alternative IPV and CPS definitions.

Although CPS involvement is part of the process for assessing safety and possible maltreatment, not every CPS contact results in a finding of maltreatment. Our analysis indicates that children exposed to caregiver physical IPV are more likely to have CPS contact, but CPS involvement alone does not establish that a child is unsafe. Available data may underestimate the prevalence of IPV among families involved with the child welfare system because IPV is not always disclosed or identified. This under identification can limit our understanding of the extent to which IPV co-occurs with child welfare involvement, including CPS involvement and foster care entry.[44,45,46]

DATA LIMITATIONS AND MEASUREMENT CHALLENGES MAKE IT HARD TO SEE THE FULL DV/IPV AND CHILD WELFARE CONNECTION

Survey data has inherent limitations in measuring the connection between IPV and the child welfare system. For example, the IPV and CPS measures included in FFCWS data rely largely on parent or primary-caregiver self-reports and are therefore subject to reporting and measurement error. Research using FFCWS has found substantial underreporting of CPS involvement relative to administrative benchmarks, as well as inconsistencies in reports across waves and between parents and young adults; stigma and social-desirability concerns may contribute to nonreporting.[47,48] Self-reported IPV measures may similarly be affected by reluctance to disclose abuse, differences in how respondents interpret survey questions, and inconsistent reporting over time.[49,50] Reports may also differ across informants: studies have found poor agreement between coparents' reports of IPV and discrepancies between FFCWS caregivers' and children's reports of physical and psychological maltreatment.[51,52] These sources of measurement error and missingness may result in underestimates of the prevalence of IPV or CPS involvement and may attenuate or otherwise bias the estimated association between them. In addition, the FFCWS sampling frame and longitudinal attrition may limit the generalizability of findings to all U.S. families.[53]

Administrative data also have important limitations. NCANDS is a voluntary national data collection through which states submit case-level information on child abuse and neglect using standardized data elements, although variation in state screening, reporting, and coding practices affects how child maltreatment and associated risk factors are represented in the data.[54,55,56,57] Some cases are recorded as "other" if they do not fit standard categories, which can hide the impact of IPV on the risk for child maltreatment.[58] As a result, administrative data may undercount the presence of DV/IPV among families involved with the child welfare system. Consistently documenting DV/IPV when suspected child maltreatment is reported could improve understanding of risk and support appropriate responses,[59,60] but requiring this information could increase administrative burden given variation in screening practices and data systems.

Overall, available data suggest that DV/IPV is an important but potentially undercounted factor in child welfare cases and may occur alongside other family challenges rather than appearing as a single, clearly identified reason for child welfare involvement.

ACF PROGRAMS CAN STRENGTHEN FAMILIES TO REDUCE IPV-RELATED CPS CONTACT AND CHILD WELFARE INVOLVEMENT

Prevention efforts and supportive programs can help reduce IPV-related CPS contact and other child welfare involvement. Economic stability and strengthened caregiving environments play a central role in lowering these risks. Strong social support networks and community cohesion, including support offered by trusted faith-based organizations, community centers, and more, can reduce isolation and increase informal support. Research finds that building trusting and supportive relationships through informal support networks with family members, friends, neighbors, and other caring adults in the community can help reduce the risk of child maltreatment related report.[61,62]

ACF-funded community-based services can help connect families to valuable services and resources to mitigate risks to child welfare involvement, including those associated with IPV. These services include:

- Community-Based Child Abuse Prevention (CBCAP) programs support services, resources and support (i.e., parent education, voluntary home visiting, respite care services, and others) that strengthen protective factors and support family stability to prevent child maltreatment and child welfare involvement.[63]
- Tribal Maternal, Infant, and Early Childhood Home Visiting (Tribal MIECHV) provides grants to tribes to develop and implement culturally grounded, evidence-based home visiting programs for expectant families and families with young children.[64] It is part of the broader MIECHV Program which supports voluntary, evidence-based home visiting services for pregnant women and parents with young children living in communities across the country where services are needed most, which can help address and prevent child maltreatment and child welfare involvement.[65,66,67,68] Trained home visitors build trusted relationships with families to educate parents about key health topics, conduct screenings for families' health needs, promote healthy child development and positive parenting skills, and help families meet their economic goals. The Health Resources and Services Administration (HRSA) administers the MIECHV Program, including funds to 56 states and jurisdictions, and partners with ACF to carry out Tribal MIECHV.
- The Office of Head Start (OHS) provides comprehensive early learning, family support, and health services to pregnant women, infants, and young children birth to age five. Head Start Preschool and Early Head Start programs can work with families experiencing DV/IPV and offer screening, warm referrals to community DV services, and two-generation supports (e.g., parent education, education on relationships/marriage, mental health consultation) that strengthen protective factors and reduce risks associated with child welfare involvement.[69,70,71]
- The Office of Child Care (OCC) oversees the Child Care and Development Fund (CCDF), which provides federal funding to states, territories, and Tribes to help eligible families access affordable child care. Stable, high-quality child care reduces caregiving stress and promotes consistent routines for young children, both protective conditions for families experiencing IPV.[72,73] CCDF also gives states flexibility to make child care easier to access for families experiencing DV/IPV, and some states explicitly prioritize families experiencing DV or provide them with special access to assistance.[74,75] OCC guidance has also encouraged coordination with local DV agencies to help families find safe, reliable care.[76,77]
- Temporary Assistance for Needy Families (TANF) provides cash assistance and other economic supports that can reduce financial instability for families experiencing DV/IPV, strengthen family stability, and help address conditions associated with child welfare involvement.[78]
- Healthy Marriage and Responsible Fatherhood (HMRF) programs promote communication, conflict resolution, and positive father engagement, which may reduce IPV risk and strengthen protective caregiving environments.[79] Specifically, the Preventing and Addressing Intimate Violence When Engaging Dads (PAIVED) provides evidence-based guidance for integrating IPV-informed approaches

into fatherhood programs, helping strengthen protective factors and support safe, healthy engagement of fathers in families experiencing IPV.[80]

- Domestic violence services and early intervention, including safety planning, shelter, and supportive services, are supported through the Family Violence Prevention and Services Act (FVPSA) program and can stabilize families and prevent escalation to foster care placement.[81]
- Both Social Services Block Grant (SSBG) and Community Services Block Grant (CSBG) provide flexible funding for services that can assist vulnerable children and families. SSBG supports state- and territory-determined social services, while CSBG supports locally determined, community-based anti-poverty services through states, territories, Tribes, and eligible local entities. Where available, these services may help families experiencing DV/IPV address economic, housing, safety, and other needs that affect family stability, and address conditions that may contribute to child-welfare involvement.[82,83,84]

Given that these programs are scattered across program offices, ACF may seek opportunities to better coordinate programs and oversight in a manner that will improve outcomes.

Expanding upstream prevention through ACF programs may reduce both IPV exposure and downstream child welfare involvement by addressing economic stress, parenting capacity, and family stability before crises escalate.[85,86] ACF may further explore evidence-based services and interventions for IPV in the Title IV-E Prevention Services Clearinghouse, given the nexus of IPV with the statutorily authorized service categories. Improved IPV screening and coordination across ACF-funded systems, including child welfare, domestic violence services, and early childhood programs, can help families receive appropriate services while prioritizing safety and reducing unnecessary foster care entry.[87,88]

CONCLUSION

DV/IPV is an important factor in CPS contact and child welfare system involvement. IPV-related concerns frequently come to the attention of Child Protective Services (CPS), although child welfare responses vary depending on the circumstances of the case and whether IPV co-occurs with other maltreatment concerns.[89,90] The analysis in this brief found that children whose caregivers were victims of IPV were more likely to experience CPS involvement than children without early IPV exposure. IPV also frequently intersects with broader challenges facing families, including economic hardship, caregiver mental health concerns, substance use, and other sources of family instability, that may shape families' contact with and experiences of the child welfare system.[91,92]

Strengthening coordination of programs, including economic supports, home visiting, and IPV services, along with improved identification and exploration of Title IV-E prevention services, may reduce both IPV-related harm and unnecessary child welfare system involvement.

APPENDIX

Data and Methods

We analyzed longitudinal data from FFCWS, which originally enrolled 4,898 families, following the focal child from birth through age 22.[93] FFCWS data were collected at uneven intervals across childhood and adolescence. This analysis used the first six waves, conducted at the focal child's birth and approximately ages 1, 3, 5, 9, and 15. IPV measures were harmonized across study waves using caregiver reports of violence or abusive behavior from the biological parent or current partner.[94] Multiple IPV domains included in the survey were examined, including emotional abuse, isolation or coercive control, economic control, work or school interference, physical IPV, sexual coercion, injury or escalation, and child-exposed IPV. Preliminary analyses examining these domains individually and cumulatively found that physical IPV had the strongest association with CPS involvement; therefore, our analyses focused on physical IPV. CPS involvement was defined using caregiver-reported CPS contact or investigation involving the focal child, rather than contact concerning any child in the household.

We conducted two complementary longitudinal analyses to examine whether physical IPV exposure was associated with later CPS involvement. Physical IPV exposure is defined as caregiver reports of physical IPV; the measure indicates that physical IPV was reported in the child's family context but does not indicate that the child directly witnessed the IPV.

The first analysis examined whether early physical IPV exposure was associated with cumulative probability of first CPS involvement through adolescence using the Kaplan-Meier estimation. This method is used to estimate the probability that an event has occurred over time while accounting for people who are not observed for the entire study period. In this analysis, it estimates the cumulative probability of a child experiencing their first CPS involvement by different ages, while accounting for children who had not yet experienced CPS involvement or were no longer observed at later study waves. Early physical IPV exposure was defined as any caregiver-reported physical IPV at birth, age 1, or age 3 study waves. Children were assigned to a fixed early-exposure group, either early physical IPV exposure or no early physical IPV exposure, based only on information collected before age 5. This classification remained the same and was used to estimate CPS involvement by ages 5, 9, and 15. This approach examines whether physical IPV exposure during infancy and early childhood is associated with differences in CPS involvement that accumulate as children grow older.

The second analysis examined when children first became involved with CPS across three age periods: birth to age 5, ages 5 to 9, and ages 9 to 15. Unlike the first analysis, physical IPV exposure was updated for each CPS assessment to reflect all physical IPV reported up to that point. This measure of prior physical IPV for the birth-to-age-5 period was based on reports at birth, age 1, and age 3; prior physical IPV for the ages 5 to 9 period incorporated reports through age 5; and prior physical IPV for the ages 9 to 15 period incorporated reports through age 9. Thus, children who had no prior physical IPV exposure during an earlier period could be included in the prior physical IPV exposed group during a later period if physical IPV was subsequently reported. Within each period, we compared the percentage of children experiencing their first CPS involvement among those with and without prior physical IPV exposure. Children could contribute observations to more than one period while they remained eligible to experience the first CPS event.

As described above, the two analyses provide complementary perspectives, one based on a fixed early-exposure period, the other on prior exposure updated at each age interval. Both are descriptive and unadjusted; the findings identify associations rather than causal effects and do not account for other family, social, or economic factors that may be related to both physical IPV exposure and CPS involvement.

Table A1. Cumulative Probability of First CPS Involvement by Early Physical IPV Exposure

Child age	No early physical IPV exposure					Early physical IPV exposure					Risk ratio
	Begin Total	Fail	Failure Function	Standard Error	95% confidence interval	Begin Total	Fail	Failure Function	Standard Error	95% confidence interval	
Age 5	2103	125	0.0594	0.0052	0.0501 - 0.0704	830	92	0.1108	0.0109	0.0913 - 0.1342	1.87
Age 9	2376	84	0.0927	0.0061	0.0814 - 0.1054	898	81	0.1910	0.0131	0.1669 - 0.2182	2.01
Age 15	2355	94	0.1289	0.0069	0.1160 - 0.1431	847	39	0.2283	0.0138	0.2027 - 0.2566	1.77

Table A2. Interval-Specific First CPS Involvement by Prior Physical IPV Exposure

Risk interval	No prior physical IPV exposure, N	First CPS Involvement %	Prior physical IPV exposure, N	First CPS Involvement %	Relative Risk
Birth to age 5	2103	5.94	830	11.08	1.87
Age 5 to 9	1802	3.50	1173	8.70	2.49
Age 9 to 15	1816	3.52	1390	5.04	1.43

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