Journal of Family Violence (2022) 37:235–246
https://doi.org/10.1007/s10896-021-00285-2

ORIGINAL ARTICLE

"We Weren't Ready": Provider Perspectives on Addressing Intimate Partner Violence Among Refugees and Immigrants in The United States

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Accepted: 23 May 2021 / Published online: 17 June 2021

Abstract
This study examined organizational factors influencing the availability and accessibility of IPV services for refugee and other vulnerable immigrant women in the U.S. from the perspectives of social service providers. This qualitative study used a purposive sampling approach to recruit 57 social service providers. Researchers analyzed data generated from individual interviews and focus group discussions using a thematic approach. The analysis generated four themes reflective of structural and systemic factors shaping the availability and accessibility of IPV services for immigrant and refugee women in the U.S.: (1) We weren't ready, (2) No place to go, (3) Time is not on our side, and (4) Can't do it alone. The analysis illuminated the extent to which service demands outweighed organizational capacities and the rigidity of service timelines that failed to meet needs. A pervasive thread of ethical dilemmas emerged, affecting the availability and accessibility of services. Overall, the findings form a compelling argument for structural shifts in policy and funding, and for fostering strong inter-sectoral coordination to combat barriers to services. The study reiterates the importance of addressing inter-agency collaboration in IPV research, policy, and practice.

Keywords Domestic violence · Refugee resettlement · Inter-organizational coordination · Coalition building

Introduction

Intimate partner violence (IPV) affects women prior to, during, and following migration to a new country (Wachter & Cook Heffron, 2021). While social services in the United States (U.S.) address IPV on the one hand and assist resettling refugees on the other, mainstream organizations do not readily lend themselves to working at the intersections of IPV and immigration. Indeed, women who immigrate to the U.S. confront significant barriers to accessing IPV services across economic, social, health, and immigration statuses (Lee & Hadeed, 2009; Reina et al., 2014). In recognition of entrenched barriers women face seeking help, this study examined organizational factors influencing the availability and accessibility of IPV services for refugee and other vulnerable immigrant women in the U.S. from the perspectives of social service providers.

Intimate Partner Violence Services and Immigration

Contemporary IPV social services in the U.S. grew out of the battered women's movement (Arnold & Ake, 2013; Haaken, 2010), privileging the experiences of White, middle class, heterosexual women, creating the foundation for the criminalization of IPV, and emphasizing legal protections over community-based supports (Koyama, 2006; Mehrotra et al., 2016). The legacies of these foundations shape

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mainstream or traditional IPV agencies (recipients of state and federal funding to provide services to "general" populations) and contribute to barriers women of color and immigrants face seeking formal services. Today, IPV agencies and corresponding services vary considerably in both size and scope, ranging from large urban facilities to small, rural, short-term shelters (Dewey and St. Germain, 2014). Services provided by IPV agencies may include client advocacy and case management, counseling and therapeutic services, emergency and long-term shelter, legal services, and assistance with securing transitional housing (Wood et al., 2020). Although the critical need and high demand for IPV services in the U.S. is evident (The National Network to End Domestic Violence, 2020), IPV agencies have consistently experienced limited resources, heavy workloads, and low pay (Wood et al., 2017).

Notable immigration-related risks factors associated with the perpetration and experience of IPV exacerbate entrenched obstacles for survivors to connect with and benefit from viable IPV services (Messing et al., 2013; Sabri et al., 2018; Vidales, 2010). Well-documented barriers disproportionately affect access to services for immigrant IPV survivors, whose experiences and help seeking are complicated by racism, xenophobia, language obstacles, economic insecurity, and persistent disconnects between needs and available services (Wachter et al., 2019; Erez et al., 2009; Menjívar & Salcido, 2002; Reina et al., 2014; Sabri et al., 2018). It is important to note that legal immigration status often introduces differences in access to IPV-related support and services, particularly between those with formal refugee designation and other immigrant groups. Fear of law enforcement, for example, poses significant and additional challenges to undocumented immigrants and those with precarious legal status (Levine & Peffer, 2012). In addition, undocumented immigrant survivors without legal immigration status frequently fear that reporting crimes, seeking services, and requesting assistance will lead to their own or a family member's deportation (Becerra et al., 2017; Erez et al., 2009). Distance from and transportation to service sites, limited organizational and linguistic capacities, postponed services, and ineligibility due to legal immigration status further hinders access among immigrants to traditional IPV services (Cook Heffron, 2019). Furthermore, perceptions of IPV social services as complicating immigration and asylum processes compound existing barriers (Cook Heffron, 2019; Bauer et al., 2000).

The literature highlights limitations of mainstream IPV agencies in serving immigrant and refugee populations with diverse racial/ethnic identities, religious affiliations, and social norms. Critiques amplify lack of expertise in working effectively with diverse groups, mismatch between available services and nuanced client-identified needs, poor outreach to and connections with marginalized communities, and needs for evidence-based community responses (Ahrens et al., 2021; Wachter et al., 2019; Kulkarni, 2019; Lucero et al., 2020; Serrata et al., 2017). Additional critiques trouble the prevailing emphasis on physical manifestations of IPV and safety (Wachter et al., 2019; Mehrotra et al., 2016), shifting focus to broader contextual and structural considerations related to immigration and other factors that contribute to the perpetration and experience of IPV (Dominguez & Menjivar, 2014).

Immigrant-centered community organizations privilege shared experiences, identities, norms, and practices, as well as attend to population-specific factors that protect against IPV and impact help-seeking behaviors, such as the likelihood of seeking help from informal support networks rather than from formal IPV services (Marrs Fuchsel & Brummett, 2021; Serrata et al., 2019). These culturally attuned approaches are amplified by national technical assistance providers such as the Asian Pacific Institute on Gender-Based Violence, the National Latin@ Network for Healthy Families and Communities, and Ujima, Inc.: The National Center on Violence Against Women in the Black Community. Casa de Esperanza, Raksha, and International Women's House are examples of organizations addressing IPV within and among specific culture-sharing groups at community and grassroots levels. While organizations have been addressing IPV specifically within Latina communities inclusive of immigrants for several decades, for example, the positive outcomes associated with culturally-affirming interventions and organizational practices are only more recently documented in the academic literature (Serrata et al, 2019).

Refugee Resettlement Social Services

Amidst a complicated immigration history, the U.S. refugee resettlement program officially took shape when Congress passed the 1980 Refugee Act and institutionalized resettlement social services as federal mandate (Gonzalez Benson et al., under review). Among an array of social services provided in a relatively short window of time (first 120–180 days in country), the program prioritizes employment as soon as possible upon arrival to the U.S. (Office of Refugee Resettlement, n.d.). Networks of non-profit agencies and local actors, including faith-based organizations, provide a range of services and support from advance preparation of housing, to receiving individuals and families at the airport, enrolling children in school, and bridging access to healthcare. Federal funding for programs includes cultural orientation, job training and placement, housing support, English language classes, case management, and naturalization services (Office of Refugee Resettlement, n.d.).

Refugee resettlement agencies address multiple service needs among people with refugee status, asylum seekers, and other vulnerable immigrants. Staff with a range of

professional backgrounds and training oversee the delivery of resettlement services shaped primarily by federal funding. Issues related to violence against women are not universal programmatic priorities of the U.S. refugee resettlement program. Of the nearly 190 indicators guiding implementation of the federally mandated cultural orientation, for instance, only one addresses IPV by stipulating that participants are aware that IPV laws exist in the U.S. (Cultural Orientation Resource Center, 2019). Resettlement programs are thus not encouraged, systematically funded, or held accountable to address IPV. Yet, these issues arise regardless of whether agencies have adequate training or resources to respond. It is therefore at the discretion of individual organizations to prioritize and seek funding to support IPV-related initiatives. Some resettlement agencies have developed IPV screening and response protocols, and have sought funding to serve immigrant and refugee survivors of IPV. These efforts, however, tend to be ad hoc and short-lived due to constrained resources, staff turn-over, and lack of systemic support (Wachter & Donahue, 2015). Efforts specific to refugee resettlement organizations do not consistently extend beyond refugees to serve those with other types of legal immigration status (i.e. asylum seekers, migrants, international trafficking survivors, etc.). These programmatic gaps and resulting budget allocations, shaped by federal policy, point to pressing needs for building within-sector capacities, as well as strong referral systems with mainstream IPV agencies, culturally-specific IPV organizations, and immigrant-centered community organizations.

Inter-Organizational Collaboration

Collaboration among nonprofit social service organizations involves working together towards mutual goals. Processes involved in collaboration, however, are not well understood (Thomson & Perry, 2006). Mechanisms that make partnerships successful between organizations with overlapping but distinctly different missions is a notable gap (Gazley & Guo, 2020). Research pertaining to collaborations between IPV and refugee resettlement agencies and other immigrant-serving organizations is especially scant. One study revealed inconsistencies in how refugee resettlement and IPV agencies understood one another's services and discrepancies in how staff understood referral options (Wachter & Donahue, 2015). In this study, some agencies worked collaboratively across IPV and resettlement sectors but without the necessary relational foundation and systems in place to support and sustain collaboration over the long-term (Wachter & Donahue, 2015). Another recent study explored IPV-related service coordination and referral practices across a variety of refugee- and immigrant-serving providers in which providers reported a lack of clear and current information about available services, eligibility requirements, referral processes, and wait lists (Cook Heffron, 2019). Both clients and providers would ultimately benefit from greater attention to cross-sectoral collaboration among refugee- and immigrant-serving agencies and IPV service organizations.

The Current Study

Challenges in addressing IPV-related needs among refugees and immigrants, coupled with notable gaps in the empirical research literature, spurred the current analysis. With the aim of contributing to a nascent area of research, this study sought to examine organizational factors influencing the availability and accessibility of IPV services for refugee and immigrant women in the U.S. from the perspectives of social service providers.

Methodology

The current analysis draws from a study (2016 – 2018) that sought to understand women's help seeking for IPV in resettlement and their access to support and services in a city in the southern region of the U.S. While the full study included women who had resettled to the U.S., the current analysis examines the perspectives of a subsample of service providers who work with immigrants and refugees on issues related to IPV.

Recruitment

The International Rescue Committee (IRC), a refugee resettlement agency, recruited a purposive sample of people who work with social service and government agencies (n = 53). Recruitment ended when the data collection phase of the project concluded. Agency staff emailed a wide range of providers in the metropolitan area to invite people to participate in the study. The agency did not offer any monetary incentive to these participants.

Participants

The majority of participants were in direct service roles at the time of data collection. Participants represented 16 discrete agencies: four refugee resettlement agencies, three refugee and immigrant health and mental health organizations, six IPV organizations (three of which specifically served immigrant communities), two legal service agencies, and one government entity. Just over half of the sample (n = 29) worked for a resettlement agency. See Table 1 for additional information.

Table 1 Study Participant Demographics (n = 53)

Gender	
Female	43
Male	10
Age	
18 – 29	16
30 – 39	24
≥ 40	13
Region of Origin	
South and Southeast Asia	4
Central and East Africa	10
West and North Africa	5
Eastern Europe	2
Middle East	1
Central America and Caribbean	4
North America	27
Years of Formal Education	
6–12	7
4 years postsecondary (attained undergraduate degree)	27
≥ 4 years postsecondary (attained graduate degree)	19
Participant Role	
Direct services (e.g. case manager, therapist, language interpreter, attorney, advocate)	32
Not direct services (e.g. management, administration, coordination, education, policy)	21

Data Collection

Data collection methods involved individual interviews and focus group discussions. With the intention of being as accommodating as possible, the method of data collection was chosen in response to providers' interests in participating in the project (e.g. if only one person from a given agency expressed interest, researchers conducted an individual interview). As such, two members of the research team (first and third authors) conducted five individual interviews and 16 focus group discussions in total. The number of participants in focus groups ranged from two to four people. Interviews averaged 68 min and focus group discussions averaged 72 min in duration. Data collection took place in private rooms at the resettlement agency or the workplaces of the participants, based on their preference and availability. Semi-structured discussion guides queried various aspects of participants' professional experiences. Topics included: organizational services and programs for refugee and immigrant women, needs, service use, access issues, challenges; systems-level challenges and opportunities, inter-agency referrals, collaboration, and coordination; and policy and practice recommendations for better serving immigrant and refugee women. All interviews and focus groups were audio recorded, transcribed, reviewed for precision, and de-identified.

Ethical Considerations

The University of Texas at Austin Institutional Review Board reviewed and approved the study. The agency followed approved guidelines to recruit and protect the identity of all participants. Agency staff responsible for recruitment participated in human subjects training, received additional training from the first author, and were bound to expectations of confidentiality. All participants engaged in detailed informed consent procedures to participate and allow researchers to audio-record the interview/focus group prior to starting. The IRC invited participants and local social service agencies to participate in a presentation and discussion of the findings and recommendations when the study was completed.

Data Analysis

The team-based approach employed in this analytical process, including regular meetings to discuss emerging ideas, allowed the researchers to establish rigor as per established standards for qualitative research (Creswell & Creswell, 2017). Researchers engaged in a reflexive process to reduce the possibility that pre-existing perspectives unduly affected the validity of the analysis (Padgett, 2016). Additionally, researchers documented key activities and decisions in a detailed audit trail. Thematic analysis (Guest et al., 2012) guided the examination of organizational and service- and system-level factors influencing IPV services available to immigrant and refugee women. All data generated by interviews and group discussions were analyzed at an individual level. The analysis commenced by two team members reading all the transcripts, taking notes, and discussing emergent ideas. The lead researcher used structural codes to parse and manage the data (e.g. "organizational factors"), and then used an inductive approach to code data within those structural codes. Next, she grouped inductive codes into preliminary categories and labeled them (e.g. unprepared, referral options, time constraints, and coordination). Based on these categories, the team worked together to refine themes at a broader level of abstraction (Saldaña, 2012), which culminated in the four themes presented in the findings section below. Researchers used qualitative analysis software (NVivo, Version 11) to manage and code data.

Findings

The analysis generated four themes reflective of factors shaping the availability and accessibility of IPV services for immigrant and refugee women in the U.S.: (1) We weren't ready, (2) No place to go, (3) Time is not on our side, and (4) Can't do it alone.

We Weren't Ready

Providers explained that the mainstream IPV service sector in this context was ill equipped to pivot services to address the specific needs of diverse clients, including refugees and immigrants. As one IPV provider poignantly stated, "A lot of the programs weren't ready. We weren't ready." (Int3)[1] Participants indicated that IPV programming and services had not evolved to reflect the demographic changes in population that have occurred both in the metropolitan area and across the state where the research took place. Staff employed by mainstream IPV agencies did not reflect the ethno-cultural identities of those residing in the areas where their organizations operated, nor did they have the necessary language skills on staff to engage with non-English speakers, including on crisis hotlines. For example, one IPV provider described how the organization had historically served Black women and now served large numbers of Spanish-speakers but had an extremely limited number of bilingual people on staff. This same provider went on to describe their organization's comprehensive IPV services but indicated that their agency faced significant challenges serving immigrants, sharing "The immigrant population is not accessing our [services]…we're not user-friendly." (Int1) Participants spoke to the complex processes involved for women to seek help and/or access shelter services, and how those complexities compounded every step women new to the U.S. take in search of freedom from the violence they experienced at home. An IPV provider indicated, "There is not a program that case manages and walks with [immigrant] families or even single women through the most basic steps involved." (Int3) Reiterating this perception, another participant who was not with an IPV organization shared,

> There's a shortage of domestic violence organizations that understand how to work with refugee populations…I can count on one hand the trained, culturally competent domestic violence case managers available to us, and that's just not enough. (FG13)

Providers from IPV organizations described a lack of suppleness and adaptability of the service sector overall, which created undue barriers for refugee and immigrant women experiencing IPV. An IPV provider offered a salient counter-example of an organization that adapted to the demographics of the neighborhood in which they were located by hiring Spanish-speaking staff and serving the local Latinx community, without losing their commitment to serving the specific community they were founded to serve. The participant described this organization as grassroots, adaptable, research- and needs-driven, and thus "a true reflection of the community they're serving." (Int1).

Resettlement agency staff also reflected not feeling ready or prepared to respond to refugee and immigrant women's IPV-related needs on both individual and organizational levels. Resettlement workers expressed a sense of helplessness in their attempts to conduct meaningful direct practice with women who had experienced multiple traumas, because of a lack of training, supervision and mentorship, organizational support, and time to engage meaningfully with clients who disclosed. Resettlement staff tasked with screening for and/or responding to IPV described feeling as if they were on their own to figure out how to do this work. A resettlement provider tasked with screening for and responding to issues related to mental health and IPV shared, "I feel like most of the stuff I'm doing, no one trained me on it. I just have to learn and do it, and I've figured it out along the way." (FG4) Staff indicated that training and professional development was something their employers expected them to do on their own time, using their own resources. Providers expressed an imperative for resettlement agencies to build knowledge and skills across staff to address the scope of need among their clients.

Staff described challenges inherent in resettlement agencies, responsible for serving both spouses in cases of IPV. Resettlement providers felt enmeshed in the full complexity of clients' families and unsure of how to deal with the ripple effects of helping women to take action. For example, one participant explained: "If we are able to find a shelter, what now? There's no guidance or support really for the caseworker in making those calls….Because we work with all aspects of a family's life, it gets very messy. It's a huge undertaking." (FG7) Resettlement providers highlighted concerns around staff safety and having insufficient guidelines or supervision to inform decision-making in supporting clients dealing with IPV.

A logistical expression of not being ready was also illustrated in how resettlement agencies organized their office space. As participants explained, the typical open layout of resettlement offices is not conducive to ensuring privacy and maintaining confidentiality when a member of the same tight-knit community may easily walk-by, see or hear a woman speaking alone to caseworker (for any reason, including IPV concerns), and relay that information back to the woman's spouse. Staff described feeling burned out by their individual attempts to address needs within professional settings they felt were inadequately set up or resourced to do well. As one participant explained, "It's exhausting seeing clients so affected by a system that does not cater to their needs or quality of life." (FG4) Furthermore, resettlement staff working on issues of IPV expressed concerns around encouraging women to report their experiences without

[1] Labels refer to the interview or focus group (i.e. Int1-5, FG1-16) in which people participated.

having the necessary systems, training, and support in place to do it well.

No Place to Go

IPV service providers spoke to the demand for services – shelter services in particular – outweighing the capacity of large mainstream organizations. As one representative from the IPV sector aptly described,

> We constantly say 'no' because we're constantly full. And that makes our day very long because we're navigating with partner agencies, but then they too are getting full. We are running out of space and so what's going to happen is this train wreck is going to crash and there's going to be lives at stake because there is no place to go. (Int3)

This provider went on to describe that on any given day, their organization would receive up to 30 phone calls inquiring about shelter for women and their children. The participant estimated that approximately three to five of those calls are on behalf of women from immigrant and refugee communities. Other IPV workers reiterated the strain on shelters and the urgent need for more beds. As one provider passionately pointed out,

> We need more housing collaborations. That is going to be the most important component. Where do they live? Where do the children go to school? How do they get the medical attention that they need? And are you going to send them a bill? ...Lives are going to be lost. If there's no place for a domestic violence [survivor] to go who is a refugee or an immigrant because of her status, then she stays. (FG11)

Another IPV provider reiterated that the number of beds and (lack of) openings available in shelter is just one consideration; for example, some shelters were very small (i.e. four beds) but provided additional socio-linguistically responsive services, such as support groups in multiple languages.

Resettlement agency staff who struggled to find options for immigrant and refugee clients in need of immediate assistance expressed the perception that local IPV shelters never had an opening when needed. Resettlement providers shared stories of trying for hours on end, sometimes days, to secure safe shelter for an individual, usually to no avail. In addition to a pervasive sense of hopelessness around being able to secure women shelter in times of great urgency, resettlement providers also referred to the challenges associated with IPV shelter services for their refugee and immigrant clients once they did find an opening. Participants reiterated how mainstream IPV shelters were not set up to accommodate diverse needs of their clients (i.e. shaped by religious and cultural practices), further discouraging immigrant and refugee women from moving out of an abusive household. Resettlement workers discussed additional structural barriers that played into reasons why their refugee clients did not pursue shelter services. One provider elaborated on the significance of geography and the extent to which refugees may be place-bound due to resettlement processes underway. She explained,

> The way resettlement is set up, [refugees] are resettled in large groups, close to each other so that they can become self-sufficient and self-reliant. For women to move out of that area means they're cutting their own infrastructure. So for her to move out and go to some shelter, she loses the contact with her social circle… Her needs, whatever they are, like employment, rental assistance, childcare, they have to be within the confinement of this real small service area that she cannot really leave. (FG2)

Echoed by others, this participant revealed important insights into the importance of women staying close and connected to the particular service areas to ensure the continuity of formal support, as well as to informal networks integral for accessing emotional and practical support.

The perception that there were never any shelter options for refugee and immigrant clients when they need them reflected an "ethical conundrum" shared among resettlement agency staff to encourage clients to disclose IPV while feeling that they did not have enough concrete resources to offer them in response. One staff shared,

> It's a catch-22 because we're coaching our clients to disclose in a way. We're opening the door, but then we actually most of the time don't have concrete resources to offer when they do, so it's almost to live an ethical conundrum. (FG7)

Further complicating the difficult task of securing IPV services for refugee survivors were interventions by law enforcement. In the absence of geographically, culturally, and logistically accessible IPV services, survivors are often encouraged to call 9–1-1 as a life-saving intervention. In many cases, however, the response is life threatening rather than saving, reinforcing dynamics of power and control and further endangering survivors. Another participant in the same focus group shared, "I've literally had a police have the abuser translate [for the survivor], and the victim told me afterwards that he was, in their language, threatening her life." (FG13).

Time Is Not On Our Side

Challenges associated with time emerged as a salient theme across IPV and resettlement service providers. IPV providers

explained how the time involved with decisions and actions women engage in to seek help, go into shelter, and ultimately transition out of shelter were considerably longer for women new to the country. In light of the short-term nature of many IPV programs (e.g., three months), time was a daunting challenge confronting refugee and immigrant women, particularly those with precarious legal status. Providers made a compelling case for re-envisioning housing programs to reflect the length of time immigrant and refugee women needed to make it through each step of the process necessary to secure stable housing and to avoid a sense of overwhelm that can halt progress. One provider implored,

> There has to be a window of opportunity to allow her to get grounded on her feet. It isn't just to take her away from a situation for her only to have to return back after three months….What is it going to take? We're doing the best that we can, but time is not on our side. We make those concessions because that's the heart of who we are. But with that we say no to so many others. (FG11)

Others reiterated the need for more time to support survivors to find stability and safety, emphasizing that, within the time constraints, the work they are able to do with survivors focuses more on crisis management rather than long-term healing.

Time was a particularly salient theme for refugee resettlement providers. Participants described the context in which they attempted to address IPV over the course of their daily work. Resettlement providers described the usual service period for new arrivals as six months to help clients settle in, navigate new surroundings, and secure employment. During this period, the resettlement agencies cover the cost of housing for people who resettle to the U.S. through the federally funded resettlement program. At the four-month marker, as one resettlement staff described, "Ok, guys, we are done. We paid four months [of housing], you're going to work, we are done. Exit." (FG2) Therefore, disclosures of IPV can significantly complicate typical and rigid time-lines of support for their clients. Providers spoke about helping clients to deal with IPV under these constraints as challenging because they may need assistance with finding a place to stay, getting a temporary protective order, and finding a job, elongating the usual period for services. A resettlement provider elaborated,

> Maybe you got a job for her and you think are you done. Now she's working, she's stable, and she's safer. But she'll call you again because maybe her husband started again to abuse her even if they are not together. I'll say like six months but it can go up to two, three years for a victim who doesn't have documentation. (FG2)

Indeed, providers highlighted the extent to which the timeline for assisting people with unresolved immigration statuses in abusive situations is dramatically longer due to limited employment options and barriers to access mainstream services.

Resettlement service providers discussed juggling a multitude of tasks on behalf of refugee and immigrant clients within strict deadlines, limiting the staff's ability to connect in-depth with clients due to time and energy constraints. Workers posed the impossible dilemma of time as having to choose whether to take "five minutes to talk to a woman about her rights" (FG4) in recognition that five minutes is woefully insufficient. A different provider further reiterated the absurdity of the dilemmas they faced as front-line workers, "If I have time, I'll remind this woman of her rights, but I need to make sure she gets a social [security card] first." (FG4).

Pressure to fulfill grant requirements, ensure program compliance, and meet targets had a direct impact on how front-line resettlement providers grappled with time. Front-line resettlement staff referred to "a numbers game" and "pressure coming from the top to meet quotas", making it difficult to take extra time with clients (FG4). Workers tasked with conducting IPV and mental health screenings candidly shared feeling dread when they saw female clients with their husbands in the office. As one provider explained, "It's like I should probably ask some IPV questions but do I have an hour to go through with this? Is this something I want to get sucked into?" (FG4). Another participant in the same focus group recalled,

> When I used to do the screenings, we had suicide ideation, IPV, all those questionnaires. When I would start, I would think, please, please don't disclose anything, because I still had five other clients to screen and I know if we took a suicide ideation whirlwind, everyone's going to be knocked out, I'll lose numbers, and I need meet the quotas. (FG4)

Can't Do It Alone

IPV providers tended to speak about inter-agency coordination in positive ways and to see their work as necessitating strong partnerships. They gave examples of efforts they made to solicit and share information to bridge disparate social services on behalf of their organizations' clients. They emphasized the importance of dialogue and conversation, and networking and forging interpersonal connections in order to personalize future calls for assistance. For instance, IPV providers explained the importance of knowing the work of other agencies and being able to refer to people by name to serve clients better, as opposed to an anonymous call or having an individual client cold call another agency.

One provider described regularly giving presentations and inviting people to visit their shelter facilities and connect with crisis line staff. This provider explained, "Because now when you call, there's a face to that person, and they're going to work harder to get you in, to get your person in, or harder to maybe find another the shelter if we're full." (Int1) Legal advocates indicated starting to visit the shelters their organization referred clients to, so that they could personally vouch for a place as somewhere they themselves would stay and to get a better sense of potential fit for a particular client.

IPV providers spoke with considerable pride of their partnerships and shared examples of when they were able to call upon partners to address urgent needs and solicit advice. One IPV provider described inter-agency coordination as "putting my village together" and coming together as "team players." (Int3) Providers reiterated the importance of building and sustaining relationships through frequent communication, and not just calling upon one another in emergencies. As one provider noted, "I make it my business to not just call when there is a need, but to keep the lines of communication [open]. Also, what do we have to offer to you?" (Int3). This provider was particularly passionate about the collaborations needed in this line of work, which she spoke about in relational terms: "I care about my partner agencies as much as I care about the ladies [IPV survivors]… Caring and being there for each other is just as important" (Int3). Mainly IPV providers described caring for one another in the professional realm as demonstrating empathy, understanding for the challenges and difficulties colleagues face in their daily work, inquiring into how colleagues are doing, and taking care of one's self. Coming together as part of a task force, for instance, allowed individual agencies to build a united force, work from a place of honesty and transparency, and together, be the voice of the community not the voice of any one agency.

In stark contrast, refugee resettlement workers expressed feeling discouraged and a sense of hopelessness around the viability of IPV-related referrals and inter-agency coordination. Again, the overriding perception among resettlement providers was that IPV-related services were mostly unavailable to immigrant and refugee clients, and that help was not there in times of need. A resettlement provider recalled questioning the purpose of screening for IPV if there was little hope in actually connecting women to services. On a slightly more positive note, another resettlement provider shared successful experiences linking clients with shelter services at a non-mainstream IPV organization, which catered to diverse survivors. She elaborated,

> For those couple of cases that we have been able to refer, they've been great. They followed up in terms of case management takeover, TPO [temporary protection order], helping with the court process. But for those clients that they didn't have room for initially, which is the majority, there's no support or follow-up. (FG7)

Noticeably absent from resettlement provider discourse was a sense of the need for and power of collaboration, and perhaps most significantly, what resettlement providers were doing to invest in mutually beneficial and collaborative partnerships with other social service agencies. While some resettlement providers indicated that IPV referrals more or less functioned, these contributions were somewhat muted. In contrast to participants from the IPV sector, resettlement workers did not share examples of successful referrals or collaborations they felt they could count on with confidence. Providers embedded in refugee and immigrant (non-IPV related) work alluded to fissures, silos, and competition over limited resources, hampering collaboration. One provider shared,

> It feels like we're working in a silo, like we're this refugee and immigrant service world, and we're doing our own thing… There is competition of resources here because there are a lack of resources. (Int2)

Community-based organizations also highlighted pervasive resource constraints and expressed the need for agencies to stay in their designated lanes.

Concerns presented by those working in the resettlement sector pointed to a broader range of issues at play, which were exacerbated in cases of IPV but relevant to all types of referral needs. Resettlement providers struggled with internal referrals to departments within their agencies, as well as external referrals. Trust played a significant role in being able to refer refugee and immigrant clients to someone new, even within the same organization. Additional myriad factors complicated clients' access to external referrals, such as language, transportation, and length of Medicaid benefits. A provider who collaborated closely with resettlement agencies expressed that referral and coordination systems do not work well, in general, due to lack of planning, support, and follow-through on the part of the referring agencies that do not account for the access barriers immigrants and refugees face. Geographic location of external referrals was a key factor, as clients oftentimes did not have the means or confidence to travel to new parts of the metropolitan area. Some resettlement organizations, focused on promoting client self-reliance, took a hard stance on not accompanying clients to new external referrals, which workers perceived as discouraging clients. As one resettlement worker described,

> When clients need those services, some of their resistance comes from the way that we're referring them to a place. "You have an appointment at this place, on this day, with this person. Here's the address," versus, "Come here. Your appointment will be in this room.

> We'll come and get you from class." We're expecting them to know how to do their own navigation. (FG3)

The barriers to collaboration and coordination transcended organizational-level collaboration and extended to working collaboratively with clients. In the approach to referrals in which clients were expected to find their own way, clients would refrain from pursuing the additional assistance and then be deemed (by some) as "defiant", "difficult", or "non-compliant" by the referring agency for not doing so. In this sense, resettlement providers highlighted how organizational policies created obstacles for clients to seek assistance from external providers, even when viable services existed.

Discussion

Grounded in the perspectives of providers, the findings highlighted factors across service sectors that shape the availability and accessibility of IPV services for refugee and immigrant women, including challenges associated with the readiness and adaptability of organizations to address dynamic IPV-related needs. The themes raised problems of funding, structure of programs and logistics, coordination and collaboration among disparate providers, and the extent to which mainstream agencies are insufficiently equipped to offer IPV services responsive to needs of racially, ethnically, linguistically, religiously, and culturally diverse groups. The analysis illuminated the extent to which service demands outweigh organizational capacities and the rigidity of service timelines fail to meet needs for stable housing, employment, safety, and healing. In addition, a pervasive thread of ethical dilemmas emerged across the four themes, with implications for the availability of IPV-related services for refugee and immigrant women. Overall, the findings form a compelling argument for structural shifts in policy and funding, and for enhancing inter-sectoral collaborations and forging strong connections with both formal and informal support systems to combat barriers to services and ultimately re-envision social service infrastructures.

The findings revealed significant organizational challenges spurred by structural forces that fostered ethical dilemmas among agency staff. Across sectors, providers described confronting time constraints, restricted capacities, and limited referral options. Resettlement providers asked themselves, Should I make time for IPV screening? Should I provide women information on their rights in the U.S.? Should I make a referral to an IPV organization? On the surface, the answers seem obvious. However, these decisions are fraught as providers navigate competing priorities with varying degrees of training, skills, and organizational support. Indeed, increasing constraints on time with clients, spurred in part by federal funding requirements (Dewey & St. Germain, 2014; Maier, 2011; Postmus, 2003), put resettlement providers in the impossible position of having to calculate what other services will be sacrificed if they take proactive steps to address IPV. The findings highlighted similar constraints and ethical conundrums facing IPV providers, whose organizations struggled to evolve to meet the needs of changing demographics in the communities they serve, and who must make significant and time-intensive adjustments to assist refugee and immigrant clients and their families in meaningful ways.

The study revealed how resettlement providers weighed the value of IPV screening and referrals against perceptions that relevant and responsive IPV services are largely unavailable and efforts to refer clients will ultimately fail. Glaring gaps in organizational collaboration seemed to feed these perceptions. Limited confidence and trust in the accessibility and applicability of services have the danger of giving providers pause before responding to IPV, if at all. While the failure to make a referral has obvious implications, inappropriate, misplaced, and lukewarm referrals also do harm. Barriers to realizing successful referrals, such as gaps in transportation support and sufficient accompaniment, lead to poor referral uptake and outcomes. Negative referral experiences can result in an immediate loss of trust and shut down in communication between providers, ultimately constricting already limited service options for vulnerable clients (Wachter & Donahue, 2015). Alternatively, referrals that are effective and result in successful connections can snowball into additional service options, which are beneficial for clients and important for providers' self-efficacy and wellbeing as well. It is therefore critical that providers continuously reassess and strengthen referral systems by establishing trust and open lines of communication, proactively addressing access barriers, and investing in cross-training (Kapur et al., 2017; Kirst et al., 2012; Shannon et al., 2016).

Inclusive of referral systems, the current study findings emphasize the need for greater inter-agency collaboration overall, and for resettlement agencies, in particular, to embrace a systematic approach to building and strengthening partnerships. The knowledge, resources, power, and community connections brought by diverse providers form the foundation for working towards a shared understanding of interconnected needs. Yet, how to create successful partnerships and functional referral systems may not be readily apparent to staff who are primarily responsible for providing direct services (Wachter & Donahue, 2015). Partnership building requires specific training, guidance, and resources, often overlooked in staff onboarding, supervision, and professional development. Strategies for creating and sustaining robust partnerships include holding regular inter-agency meetings, formalizing operating procedures for referrals and information sharing, developing communication protocols for addressing challenges and concerns, and collaboratively

identifying mechanisms for addressing gaps in services (Busch-Armendariz et al., 2014; Kapur et al., 2017; Wachter & Dalpe, 2018). Training and support for socio-linguistically competent staff, as well as trauma-informed organizations, services, and programs attuned to the needs of racially, ethnically, culturally, and religiously diverse clientele are paramount (Wachter et al., 2019; Serrata et al., 2017, 2019).

Building and sustaining effective inter-agency and cross-sectoral work necessitate resources to enable collaborative partnerships to flourish. The findings from this study highlight the need for funding opportunities that incentivize cross-sector collaboration and coalition building, particularly given the fluid socio-political context and shifting funding priorities in the U.S. IPV and refugee resettlement nonprofits are heavily reliant on state and federal funding from disparate government agencies, and there are few, if any, financial incentives for cross-sectoral collaboration. Yet, financial strains can serve as catalysts for innovative collaboration (Gazley & Guo, 2020). With additional resources and incentives, organizations can foster and strengthen conditions for staff to strengthen cross-sector endeavors. Beyond funding considerations, additional research is necessary to advance and expand upon existing models for cross-sector coordination (see Macy & Goodbourn, 2012), and inspire, foster, and sustain collaborative partnerships.

Although not explicit in the current study findings, it is important to note the importance of bridging inter-agency efforts with community-based structures and systems of support to form robust coalitions (Zakocs & Edwards, 2006). Intentional and thoughtful outreach to community-based organizations, particularly those that represent and encompass marginalized constituencies, is especially important in building effective community coalitions. Networks of grassroots, community-based, and immigrant-led organizations provide services to and advocate on behalf of racially, ethnically, culturally, religiously, and linguistically diverse groups with varying immigration statuses across the U.S., yet mainstream social service agencies often fail to build meaningful and mutually beneficial relationships with these important actors and systems of support.

The findings from this study also point to the need for mainstream IPV and refugee resettlement organizations to prioritize connecting with and amplifying formal and informal support channels. Kulkarni (2019) notes that responses and innovations that result from cross-sector partnerships with community organizations, be they formally or informally arranged, better meet short- and long-term needs related to IPV. Furthermore, research highlights the role that informal support networks play in how women seek help for IPV (Wachter & Cook Heffron, 2021), offering opportunities for organizations to enhance informal network-oriented approaches (Goodman & Smyth, 2011).

Finally, cross-movement coalition building is critical to (re)connect mainstream service sectors with seminal and emerging political movements to affect necessary and meaningful structural change. Efforts must recognize, center, and learn from community-based organizations beyond those typically considered within the realm of the IPV and refugee resettlement sectors, including grassroots and politically engaged projects serving and advocating for asylum seekers, previously detained individuals and families, and immigrants historically marginalized based on race/ethnicity, language, sexual orientation, and gender identity. Vibrant contemporary social movements have the potential to awaken dormant struggles and compel disparate sectors to join forces through shared political aims. Engaging in shared advocacy efforts around economic and racial justice, for instance, would forge linkages and foster coalition building across social and political movements.

Limitations

Generalizability is not the aim of qualitative research and readers should situate the findings accordingly. Although researchers made concerted efforts to guard against the possibility of undue influence throughout the study, as is the case with all research, this study was vulnerable to potential biases in the design, data collection, and analysis. It is important to note that the study did not incorporate a comprehensive sample of service providers from all relevant sectors. Moreover, due to the sampling approach and flexible recruitment strategy, the study sample lacked balance in which social service sectors participated, with staff from refugee resettlement agencies making up over half of the sample. Ensuring a more equitable representation of service sectors would be an important consideration in future research. Likewise, the study lacked adequate representation from providers working in other immigration-related social and legal services. In addition, this analysis did not delve into the specific content and focus of IPV services vis-à-vis refugee and immigrant populations, an area of research and practice that deserves ongoing attention.

Conclusion

It is important to consider these findings in light of the contemporary context in the U.S., where collaboration and coalition building are instrumental strategies in addressing pressing social problems. Communities of color and other marginalized groups, as always, shoulder the most serious consequences of negative action and complacent inaction. Although clients and providers bear the burdens of these organizational gaps, the solutions are clearly structural in nature. There is no better time than now to amplify the vital

importance of coalition building across disparate social service sectors committed to serving vulnerable clients. Expected changes in policy due to the recent change in U.S. administration, coupled by violence against women and migration spurred by the global pandemic, will likely lead to increases in refugee and immigrant arrivals and demands for socio-linguistically responsive IPV services. These anticipated shifts should compel us to explore synergies across vital social service sectors, envision bold collaborative models, and work in partnership to actualize bridges to safety for all.

Acknowledgements We thank the research team and language interpreters at the International Rescue Committee (IRC) who made this study possible. We are deeply appreciative of the study participants who shared their invaluable time and expertise. Finally, we want to acknowledge Kathryn Donahue's role in spearheading the Bridge to Safety initiative at the IRC, which served as inspiration for the Bridging the Gaps follow-on project and key elements of this article.

Funding Office of Violence Against Women, Department of Justice, grant number 2016-SI-AX-0004.

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