



Opportunities for Intimate Partner Violence Disclosure in Adult-Serving Healthy Marriage and Relationship Education (HMRE) Programs

FINAL REPORT

August 2020
OPRE Report 2020-93

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STUDY HIGHLIGHTS AND KEY RECOMMENDATIONS

1



Intimate partner violence (IPV) is the most common form of interpersonal violence in the United States (Sumner et al., 2015). Its consequences can be serious: 41% of female IPV survivors and 14% of male survivors experience physical injuries; other survivors experience acute or long-term physical or behavioral health problems and economic consequences (Breiding et al., 2014).

Healthy relationship programming can play an important role in preventing and responding to IPV (Niolon et al., 2017). Healthy marriage and relationship education (HMRE) initiatives, funded by the Office of Family Assistance (OFA) in the Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services, present an opportunity for reaching adults who are experiencing IPV and connecting them with help. ACF's Office of Planning, Research and Evaluation (OPRE) funded RTI International to conduct the Responding to Intimate Violence in Relationship Programs (RIViR) study to compare different approaches for offering HMRE program participants the chance to share IPV experiences and be connected to services.

RIViR was the first study to compare IPV assessment approaches (including questionnaire-style tools and universal education tools) in HMRE programs. It examined the accuracy, acceptability, and feasibility of three tools for identifying program participants who were experiencing IPV and connecting them with support. It focused on two research questions:¹

1. How do three tools for inviting IPV disclosure compare in their ability to guide HMRE programs' responses to participants' IPV-related needs?
2. How well do the tools work from the perspectives of program participants, staff, and partners?

The study identified strategies for HMRE programs to build organizational capacity and readiness for identifying and responding to IPV; create survivor-centered, trauma-informed opportunities for IPV disclosure; and protect the safety of IPV survivors.

¹More information on the study approach and the full text of these research questions follows in Section 2: Study Purpose and Design.

Findings suggest that HMRE programs working to build organizational capacity and readiness for addressing IPV should do the following:

Cultivate reciprocal relationships with local domestic violence programs and other culturally competent local agencies.

Thriving partnerships are built on mutual understanding of one another’s work and reciprocal training activities. Partners should share HMRE programs’ commitment to culturally competent and linguistically appropriate services for their shared target populations.

Involve staff with similar life experiences as participants.

Participants feel comfortable opening up about their lives, including IPV experiences, when they perceive some common ground with staff or other participants. Shared cultural backgrounds or other shared life experiences can help facilitate these connections.

Create a welcoming, safe, caring, and interactive atmosphere for HMRE services.

Staff play a key role in creating a comfortable environment in which participants can access information or disclose IPV. Doing so requires not only warmth and relatability but also an interactive approach to HMRE program activities.

To create survivor-centered, trauma-informed opportunities for IPV disclosure, RIViR study results suggest that HMRE programs should do the following:

Treat opportunities for IPV-related conversation as an integral part of the program.

Recognize that some participants have enrolled in the program specifically to access greater insight, support, or resources for managing IPV. Frame IPV assessment as central to the work of promoting healthy relationships.

Address confidentiality protections (and limitations).

Opportunities for disclosure should be offered in a way that maintains the trust that the HMRE program has built. Information about how programs will protect participants’ confidentiality—and any exceptions to confidentiality, such as mandated reporting—should be addressed up front, before inviting a disclosure.

Use brief, plain-language IPV assessment tools.

Participants appreciate short assessment tools and straightforward language. They sometimes struggle to choose a response when presented with a long list of options—though talking through response options with staff seems to create an opening for dialogue.

Deliver questionnaire-style tools in a conversational spirit.

Questionnaire-style tools like the Intimate Justice Scale (IJS) are much more sensitive for purposes of inviting IPV disclosure. That is, compared to universal education approaches, questionnaire-style tools are less likely to miss individuals who are experiencing IPV. They can give participants a chance to reflect on their relationships and engage staff in conversation about their experiences. Allowing a few extra minutes for questions and discussion helps maximize this opportunity.

Create repeated opportunities for participant-initiated conversation about IPV. Creating more space in HMRE program activities for interaction—both in the group and individually with staff—gives participants the chance to raise IPV-related questions and experiences when doing so feels most relevant and comfortable to them.

Finally, results suggest that programs can help to protect the safety of IPV survivors by supporting and informing HMRE program participants who do and do not choose to share their IPV experiences with staff. HMRE programs should do the following:

Follow up on what participants share. It is critical for HMRE program staff to follow up promptly with participants who have questions or concerns about IPV, whether they are raised during a formal IPV assessment, in class, or in a casual interaction. Follow up more than once with an offer of resources or further conversation.

Work collaboratively and creatively to support survivors in accessing services and staying safe. Led by the participant's wishes, HMRE program staff can team up internally and with their domestic violence program partners to devise and implement individualized strategies for safely delivering services and meeting participants' other needs.

Make sure all participants know where to find help. Some participants will not choose to talk about IPV experiences with HMRE program staff—nor should they have to in order to get help. Offering universal education early and repeatedly helps ensure that all participants have the information they need when they need it.

Offer a variety of resources. Some participants may want to access services from the local domestic violence program partner, whereas others might prefer anonymous, remote resources (such as websites, chat resources, or hotlines). Other survivors may need connections to housing, child care, or legal help to stay safe.

Stay in communication. Consistent communication from HMRE program staff members builds trust—and helps ensure that individuals with critical safety issues do not slip through the cracks. Prompt responses to participant-initiated communication and proactive follow-up with participants (after they complete or drop out of the program) are crucial.

No prior study has tested rigorous approaches to IPV assessment in HMRE programs. Data from HMRE impact evaluations suggest that IPV is a common experience, even within the short reference periods on which these studies have focused. In an evaluation of the Building Strong Families HMRE program, 26% of participants reported having experienced some form of physical violence at the hands of a partner in the past year. In an evaluation of the Supporting Healthy Marriage demonstration, 11% of adult participants reported having experienced physical violence from their spouses in the past 3 months. (For more information on IPV prevalence and experiences among HMRE program participants, see [Preventing Intimate Partner Violence](#) and [Prevalence and Experiences: Intimate Partner Violence Prevalence and Experiences Among Healthy Relationship Program Target Populations](#).) Prior OFA-funded HMRE programs have worked to address IPV by building partnerships with local domestic violence programs, developing domestic violence protocols that outline steps for identifying IPV and connecting individuals with resources, and offering trainings for staff and participants. (See [Current Approaches to Addressing Intimate Partner Violence in Healthy Relationship Programs](#) for more information on prior OFA-funded grantees' approaches to addressing IPV.)

STUDY PURPOSE AND DESIGN

2



IPV is defined as physical, sexual, or psychological harm or reproductive coercion by a spouse, partner, or former partner. IPV is a common occurrence; around 36% of women and 29% of men have experienced it in their lifetimes. Among those who do, as many as 81% of women and 35% of men exhibit consequences such as injury and effects on physical and mental health (Black et al., 2011). One in six homicide victims, including one in two female homicide victims, is killed by an intimate partner (CDC, 2019). Evidence from studies in health care settings indicates that brief IPV-focused interactions by professionals who do not have specialized expertise in IPV—for example, asking questions about relationships and referring survivors to community resources—can reduce future episodes of violence and help survivors to connect with the services they need (Bair-Merritt et al., 2014).

HMRE programs are designed to provide comprehensive relationship education services as well as job and career advancement activities to enhance economic stability and improve overall family well-being. OFA-funded HMRE programs serve varied populations, including adult couples, adult individuals, and youth of high school age. Adult-serving HMRE programs reach diverse populations, including young adults, formerly and currently incarcerated individuals, expectant parents, and those in substance abuse treatment. Programs offer relationship education, parenting classes, mentoring, case management, and other services.

Federal authorizing legislation requires all HMRE programs to document that they have consulted with a local domestic violence program or coalition and to address domestic violence (Social Security Act, 42 U.S.C. 603). OFA guidelines further encourage the development of a comprehensive approach to addressing domestic violence. Many HMRE programs already take steps to identify individuals who are experiencing IPV at the time they enter the program. Typically, programs use questionnaire-style tools that ask about specific behaviors—for example, “How often does your partner physically hurt you?” (Krieger et al., 2016). The accuracy of such tools in HMRE program populations is unknown. Furthermore, there is a lack of consensus regarding which (if any) existing IPV assessment tools might be considered the gold standard against which others should be compared (Rabin et al., 2009). Universal education approaches to engaging adults around IPV issues are also of growing interest but have been little studied (McKay et al., 2016).

To address these gaps, the RIViR project partnered with HMRE programs to examine and compare different approaches to recognizing and responding to IPV in HMRE programs. The study included separate tests of such approaches in youth-serving HMRE programs (described in OPRE Report #2020-79, “[Opportunities for Teen Dating Violence Disclosure in Youth-Serving Healthy Marriage and Relationship Education Programs](#)”) and in adult-serving programs (described in the current report). Three HMRE programs collaborated with the RIViR team to examine IPV among their adult participants:

- Nepperhan Community Center, Inc.’s EmpowerYOU program, located in the greater New Rochelle and Yonkers, New York, area (<https://www.nepperhan.org/>);
- Volunteers of America, Dakotas’ Relationship University program, located in Sioux Falls, South Dakota (<https://www.voa-dakotas.org/>); and
- Youth and Family Services’ Stronger Family Program, located in Rapid City, South Dakota (<http://www.youthandfamilyservices.org/>).

These three programs were selected for their successful enrollment and HMRE service delivery with diverse adult populations and their shared commitment to recognizing and supporting IPV survivors.

The overarching objective of the study was to examine how IPV assessment tools (including questionnaire-style and universal education approaches) work for identifying HMRE program participants who are experiencing IPV so that they can be referred for further services. The study examined both the accuracy of the tools in assessing IPV and the acceptability and feasibility of administering them in HMRE programs, including the conditions needed for their successful use. The full research questions that guided the qualitative and quantitative components of the study were as follows:

1. How well do three tools for inviting IPV disclosure compare to one another in their ability to guide HMRE programs’ responses to their participants’ IPV-related needs, particularly whether to refer a participant to the program’s local domestic violence program partner?
2. How well do the tools work from the perspectives of HMRE program participants, staff, and domestic violence program partners in terms of perceived helpfulness and ease of implementation?

HMRE program staff used three web-based tools to offer adult participants an opportunity to share their experiences with IPV in different formats. The tools explored participants’ experiences of physical violence, controlling behavior, sexual coercion, and psychological aggression. One questionnaire-style tool combined questionnaire-style items from the Universal Violence Prevention Screening Protocol and the Women’s Experiences with

Battering questionnaire (UVPS/WEB). This tool focused on experiences during the past year. The other questionnaire-style tool was the IJS. This tool focused on experiences in the current relationship (for participants who were partnered at the time they entered the HMRE program) or most recent relationship (for participants who were not). The third tool guided HMRE program staff and participants in a universal education conversation, which covered healthy and unhealthy relationships, IPV concerns, and available resources. This tool offered examples of controlling behavior, physical violence, sexual coercion, and psychological aggression; staff recorded whether participants did or did not raise any IPV-related concerns. (The content of the three tools, as well as the thresholds used for determining whether participants' responses constituted a disclosure of IPV, appears in Appendix B.)

All three HMRE programs selected for the RIViR study delivered classroom-style instruction to English-speaking adults in community-based settings. Trained HMRE program facilitators in each site delivered relationship education courses, as well as other supplemental activities specific to the site (for example, case management). IPV assessments were offered over the course of these services. Staff at two of the sites administered all tools to participants in one-on-one meetings held in an office or other private space. One site implemented the questionnaire-style tools with all participants simultaneously during regular class sessions; participants answered the questions themselves using tablets handed out by the facilitator. The first of the three IPV assessments was always given individually to participants by a program staff member, however.

The three tools were given to participants in random order, and each took approximately 5–10 minutes to complete. After the third, participants self-administered a brief set of survey questions about their responses to the tools, including their comfort, openness, familiarity with available resources, and perceptions of their interactions with HMRE program staff about IPV. Participants received a \$5 gift card after completing each tool.

The RIViR study team also conducted on-site qualitative interviews with HMRE program staff, their local domestic violence program partners, and participants in each site. Interviews aimed to understand how participants and service providers saw the tools and the process of implementing them. Interviews were recorded and transcribed.

To address the first research question, the study team conducted a latent class analysis to compare assessment results from all three tools. To address the second research question, the team used regression analysis to compare participants' responses (comfort, openness, resource knowledge, and perceptions of the interaction with staff) after completion of different tools. The team also conducted a formal, inductive analysis of qualitative interview data in ATLAS.ti to identify major themes.

Research evidence and practice-based knowledge suggest that HMRE programs need more information on (1) building organizational capacity and readiness to recognize and address IPV; (2) creating survivor-centered, trauma-informed opportunities for safe disclosure (including IPV assessment); and (3) protecting survivor safety (McKay et al., 2016). The following sections describe RIViR study findings in each of these areas.

Recognizing and Responding to IPV Among Spanish-Speaking HMRE Participants: A Case Study

The current study focused on testing IPV screening and universal education approaches used by HMRE programs with English-speaking participants. Little prior validation work was available to inform selection and testing of a Spanish-language screening tool in HMRE settings. For this reason, the RIViR expert panel and federal partners did not recommend including a set of Spanish-language screening tools in the RIViR field test.

Recognizing the importance of HMRE grantees' work with preferential Spanish speakers and the need to understand approaches to recognizing and responding to IPV with Spanish-speaking participants, RTI carried out a case study to better understand such approaches. It built on findings from the Hispanic Healthy Marriage Initiative implementation evaluation and was carried out jointly with the National Latin@ Network for Healthy Families and Communities (NLN).^{*} Two HMRE programs, the University of Denver's Motherwise program and Family Services of Merrimack Valley (FSMV), partnered with RTI and NLN on this effort.

The case study brought together insights and perspectives from Motherwise and FSMV staff, their local domestic violence program partners, and Spanish-speaking Latinx HMRE program participants to address three aims:

1. Understand current approaches taken by two OFA-funded HMRE programs to recognizing IPV among Spanish-speaking Latinx HMRE program participants.
2. Describe partnerships between HMRE programs and local domestic violence program partners and any other strategies for addressing IPV when identified.
3. Identify key resources, assets, and challenges relevant to implementing culturally and linguistically appropriate strategies for IPV recognition and response in HMRE programs.

These two HMRE programs built strong partnerships with local domestic violence organizations and worked closely with them to ensure that IPV screening in Spanish was available to all participants. They combined universal education and traditional screening approaches, offering educational information about IPV in Spanish to all participants.

Interviews highlighted several implementation priorities for HMRE programs that seek to recognize and respond to the IPV-related needs of Spanish-speaking participants, including

- creating welcoming physical environments that set people at ease;
- tailoring activities to meet participants' cultural and practical needs, such as sharing homemade food, offering simultaneous activities for children, and providing information on immigration-related legal protections for IPV survivors;
- gathering community input on linguistic and cultural adaptations of programs' approaches to recognizing and responding to IPV; and
- staffing HMRE programs to reflect the communities they serve.

Participants and staff also emphasized that Spanish-speaking participants were predominantly immigrants. They reported that approaches to inviting IPV disclosure needed to include efforts to help address issues associated with immigration that might prevent participants from feeling comfortable disclosing or seeking help.

Detailed information on the case study methods and results—including quotes from participants, staff, and local domestic violence partners—appears in Appendix C.

*Three staff from Casa de Esperanza/NLN contributed to case study design, data collection, analysis, and reporting: Ruby White Starr, Josie Serrata, and Martha Hernandez Martinez. Dr. Serrata and Ms. Hernandez Martinez, each of whom has extensive expertise in research with Latinx survivors of domestic violence, assumed primary responsibility for drafting the focus group interview guide, conducting the focus group, analyzing focus group data, and preparing a written summary from which extensive material for this report section was drawn. Casa de Esperanza/NLN staff also offered input on the case study design, HMRE and domestic violence staff interview guides, and analysis and reporting of HMRE and domestic violence staff interview data.

BUILDING
ORGANIZATIONAL
CAPACITY AND
READINESS TO
RECOGNIZE AND
ADDRESS IPV

3



HMRE programs applied a variety of strategies to build organizational capacity and readiness for addressing IPV. Analysis of qualitative interview data with HMRE program staff, adult participants, and domestic violence program staff highlighted effective strategies and underlying assets that supported successful implementation. This section focuses on organizational capacity and readiness strategies that might be useful to other HMRE programs that are preparing to recognize and address IPV.

3.1 Organizational Capacity

RIViR sites' organizational capacity for recognizing and addressing IPV was shaped by partnership development, staffing and other resources, and training.

3.1.1 Partnership Development

Each HMRE site worked in close partnership with its local domestic violence program in preparing to recognize and address IPV. Each of the three programs regarded these partnerships as important; however, the nature and extent of their engagement varied widely.

In one site, the partnership with the local domestic violence program was relatively new. In this partnership, the focus was primarily on training of HMRE staff by domestic violence advocates and a review of the HMRE programs' protocols and procedures for responding to IPV. HMRE program staff and domestic violence program staff expressed some uncertainty about one another's work. HMRE program staff noted that the domestic violence program's services did not seem like a fit for some individuals who were experiencing IPV and worked to link them to other supportive services (such as legal or housing assistance) instead. Staff from both organizations saw the domestic violence program's specialized expertise as potentially complementary to the core services offered by the HMRE program, but they rarely teamed up for active service coordination or planning.



“I reached out to [local domestic violence partner] when we did our trainings, and they were on board immediately. I mean, they’re a great organization, and they want to advocate for people to have increased education and information.”

(HMRE program staff member)

In the other two sites, the partnership strongly emphasized reciprocal information exchange and active collaboration at the organizational and individual case levels. In each of these partnerships, staff built on a long history of collaboration between their organizations on a different set of programs. They found that their joint work to respond to IPV among HMRE program participants further deepened the sense of mutual understanding and respect.

“It’s gotten much closer [with local domestic violence partner] in regards to this project kind of pushing us to work closer together, get to know one another’s resources better, and get on the same page.”

(HMRE program staff member)

In one of these more established partnerships, the two organizations cultivated a mutual understanding of their organizational missions and operations through extensive reciprocal training: staff from the local domestic violence program and the HMRE program trained one another on the services they offered and their philosophies and strategies for service provision. HMRE program staff delivered their full healthy relationship curriculum on site at the domestic violence program for all interested staff. Domestic violence staff helped HMRE program staff to understand how domestic violence advocacy worked and offered coaching on how to describe these services to individuals who might need them. The two organizations consulted as needed on how to safely serve individuals facing IPV and referred individual cases to one another for direct services when appropriate.

3.1.2 Staffing and Other Resources

Staffing approaches, and staff themselves, exerted a powerful influence on sites’ capacities for recognizing and responding to IPV. HMRE program staff who had clinical or victim advocacy experience said they found it helpful—but several noted that connecting with people over difficult and highly personal topics was a natural extension of their work as relationship educators.

“It was an extension of our program.... We like it to be welcoming, we like it to be safe, no judgment... that’s from day one, in their first class.”

(HMRE program staff member)

Participants and staff each emphasized that shared culture or other shared life experiences made it much easier for participants to relate comfortably to staff. Participants also cited staff warmth and relatability as key assets that shaped their feeling that the program provided an environment in which IPV issues could comfortably be addressed. Participants felt at ease when staff cultivated a sincere, person-to-person connection (not strictly a role-based, scripted style of interaction). HMRE program staff observed that efforts to convey empathy, non-judgment, and sensitivity to participants in all interactions laid the groundwork for their later efforts to talk about IPV.

“She’s a Native woman like me, from our culture. We look for connections, how we connect tribally. We got into that conversation, and so we go from there and start going over the [intake] forms, what brought you in today... and [participant] told her story.”

(HMRE program staff member)

“She was very warm, welcoming, and understanding about my situation.”

(HMRE program participant)

Staffing levels and staff availability also shaped sites’ ability to identify and respond to IPV. One site struggled with staff turnover and a general sense of being understaffed relative to their regular job responsibilities. This challenge created global challenges in consistently implementing IPV-related procedures. At the other two sites, staff perceived their overall staffing levels as adequate, but they had to shift staffing plans for their healthy relationship classes to have extra help on days when they would be administering IPV tools.



“If you’re by yourself and you don’t have maybe somebody, an assistant, to help you, it is hard. It gets a little harder to do these sessions, to offer the sessions, because maybe two or three people are walking in at the same time.”

(HMRE program staff member)

Several other resources besides staffing shaped program capacity for addressing IPV. To access web-based IPV assessment tools, a reliable Internet connection in the locations where program intake or service delivery occurred was essential. Sites occasionally struggled with bandwidth limitations. One site had to pause IPV assessment altogether for a period of 2 weeks when its offices did not have a working Internet connection. Having access to a private, sound-proof space (such as an office or conference room) adjacent to the room in which service delivery took place also made it easier to arrange a private time and place for IPV assessments. Incentives for participating in IPV assessment were seen as helpful, but the \$5 denomination of the gift cards used in RIViR implementation (due to research-related restrictions) was regarded as too low.

3.1.3 Training on Approaches for Recognizing and Addressing IPV

Depending on their previous experiences with IPV assessment in the context of HMRE programming, RIViR sites' precise training needs varied. Each of the three sites received a 12 hour, on-site training on IPV assessment and responses as it prepared to implement the three RIViR assessment approaches. All HMRE program leaders and staff attended the trainings. HMRE program staff reported that these trainings helped them feel well prepared for IPV assessment interactions. Face-to-face interactions, particularly the opportunity for group and paired role-play activities, were especially useful during training. One site leader noted that time to practice on-the-spot safety planning (in addition to IPV assessment and referral) would have been helpful.

“How the training happened, as far as going and practicing the tools, was great.... The other thing that might be helpful, and I think we did that in training, is to walk through exactly what we would do if DV was actively happening and we needed to act and get her to a shelter.”

(HMRE program staff member)

Amid busy program schedules, HMRE program staff sometimes had few designated opportunities to connect with each other for internal planning and strategizing about IPV-related issues. In this context, the regular calls and interviews conducted for the RIViR study offered a chance to reflect and strategize. Staff and leadership often used these opportunities to compare strategies or adjust their approaches to align with intended outcomes—for example, survivor-centered and trauma-informed service delivery. Similarly, if regular contact between HMRE and domestic violence program staff was

limited, trainings and interviews furnished a key opportunity for connection. Local domestic violence programs' attendance during key portions of the RIViR trainings also ensured that their staff were exposed to, and comfortable with, the IPV assessment and referral approaches being implemented.

3.2 Organizational Readiness

Organizational readiness for addressing IPV was shaped by the overall fit between an organization's IPV-related efforts and its overall program goals, careful planning and preparation, and strong communications protocols.

3.2.1 Fit With HMRE Program Goals

HMRE program staff and participants often commented in qualitative interviews on the strong, natural fit between addressing IPV and achieving their overall HMRE program goals. For staff, fitting IPV assessment and follow-up into their work with program participants was made easier by the understanding that addressing IPV and promoting healthy relationships were not two disparate activities competing for their time, but mutually reinforcing and complementary objectives.

“[IPV assessment] just opens the door to have that difficult conversation.... It really added more value to the program.... It was really, really necessary.”

(HMRE program staff member)

3.2.2 Planning and Preparation

OFA guidelines offered a framework for IPV-related planning and preparation, prompting HMRE program staff to formalize their protocols related to IPV. Sites benefited from local domestic violence program partners' expertise in preparing for this scenario. They also put contingency plans and communication procedures in place to facilitate safe, coordinated responses to unanticipated issues. Developing procedures for safer IPV assessment, referral, and service delivery in couples-based HMRE programs required particularly thoughtful planning and brainstorming.

Day-to-day procedures, such as routine IPV assessment, benefited from careful integration into existing client contacts. Diagramming where IPV assessment and follow-up fit in programs' enrollment and service delivery flow charts proved helpful. Sites also

found it helpful to place blank assessment-related forms or other reminder flags (without sensitive information) in the case files or electronic case records they used for tracking their other contacts with participants.

3.2.3 Communications Protocols

To be ready to raise and address IPV issues, HMRE program staff needed strong and consistent communications protocols within the team and with participants. Regular within-team communications created opportunities for brainstorming, troubleshooting, consistency, and transparency regarding how IPV-related issues were being addressed.

“We meet every other week and talk about the tools and what’s working and not working.... We actually pull up the roster and look at who’s up for their second or third [IPV assessment], where people are who haven’t gotten their second or third... and what’s going well and not well, any things that are out of the ordinary.”

(HMRE program staff member)

Communications between staff and participants were equally critical. Participants placed a high value on consistent communications from staff, including responsiveness to participant-initiated communications about IPV. This was essential for ensuring that programs did not breach participants’ trust or fail to respond when they were in danger; for example, by not returning a voicemail asking for help or not following up to offer resources when a participant volunteered concerns about IPV during class time.

The following practice-based resources might also be helpful to HMRE programs in building readiness and capacity for addressing IPV:

- The most comprehensive available resource is [*Promoting Safety: A Resource Packet for Marriage and Relationship Educators and Program Administrators*](#) (Menard, 2008 [updated 2015]). This five-part series provides HMRE programs with guidance on responding to IPV issues:
 - Part Two focuses on strategies for building partnerships between HMRE programs and local domestic violence programs (see p. 27).
 - Part Three focuses on IPV protocol development in HMRE programs (see p. 43).
- [*Creating Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed Agencies*](#) includes a step-by-step process for building organizational readiness to interact with IPV survivors in a sensitive, culturally responsive, and trauma-informed manner (ASRI & National Center on Domestic Violence Trauma & Mental Health, 2012).
- [*State domestic violence coalitions*](#) can help to identify local domestic violence programs with expertise in serving local communities.
- The discussion report [*Building Bridges between Healthy Marriage, Responsible Fatherhood, and Domestic Violence Programs*](#) offers guidance on building strong partnerships between HMRE programs and domestic violence agencies (Ooms et al., 2006).

CREATING SAFE,
SURVIVOR-CENTERED
OPPORTUNITIES FOR
IPV DISCLOSURE

4



4.1 Rates of IPV Disclosure

More than half of participants (53.5%) disclosed IPV during at least one of the IPV assessments (Table 4-1). Participants who were not working, were not in a steady romantic relationship, had children, received public assistance, had an unstable housing situation, had an income of less than \$500 per month, or self-identified as multiracial or another race/ethnicity (not White, Black, Native American, or Hispanic/Latinx) were more likely to disclose IPV.

Participants were considered to have disclosed IPV if their responses met the validated cutoff criteria associated with the questionnaire-style assessments, or if staff said that they shared any IPV-related concerns during the universal education conversation. The tool content and more information on how IPV disclosure was defined can be found in Appendix B.

Disclosure rates shown in Table 4-1 reflect whether participants' responses to any of the IPV assessment tools met the previously validated threshold for IPV (in the questionnaire-style tools) or raised any IPV-related concerns (in the universal education tool). The UVPS/WEB focused on past-year experiences and captured whether participants had been in a romantic relationship in that time, whereas the IJS asked about experiences in the current or most recent relationship (but did not capture relationship status). The universal education tool asked whether participants were currently in a relationship. The prevalence of IPV among participants who reported that they were currently in a relationship or had been in one in the past year was slightly (about 5%) higher than in the full sample.

Table 4-1. Rates of IPV Disclosure Among Participants by Various Characteristics

Characteristic	Frequency, %	Characteristic	Frequency, %
Overall		Educational Attainment	
Full sample	53.5	Less than high school	52.4
Site		High school diploma or GED	51.0
Site 1	57.8	More than high school	56.8
Site 2	46.0	Employment and Income	
Site 3	58.6	Working	48.7
Sex and Gender Identity*		Not working	58.8
Male	54.0	Income under \$500/mo.	61.3
Female	53.1	Income \$500–\$2000/mo.	49.8
Cisgender	53.2	Income over \$2,000/mo.	50.0
Not cisgender	33.3	Receive public assistance	57.1
Race/Ethnicity and Nativity		Do not receive public assistance	49.3
White	53.1	Housing Situation	
Black	49.6	Own home	46.0
Hispanic	46.9	Rent home	52.2
Native American	58.7	Rent-free living situation	54.5
Other race	66.7	Other living situation	62.9
Born in the United States	54.7	Family Structure	
Not born in the United States	41.1	In a steady relationship	45.3
Age		Not in a steady relationship	61.6
Younger than 25	53.2	Have children	57.4
25–34	56.0	Do not have children	44.0
35 or older	51.7		
Sexual Orientation			
Heterosexual	52.6		
Gay/lesbian/bisexual/other	60.6		

Notes: GED, general equivalency diploma. *Sex was obtained from program administrative data. Gender identity is not mutually exclusive of indication of sex.

4.2 Understanding the Context for IPV Disclosure

4.2.1 Developing Rapport Between HMRE Program Staff and Participants

Before they participated in IPV assessments, participants had usually had at least one individual interaction with HMRE program staff. In qualitative interviews, participants shared very positive first impressions of HMRE program staff. Most often, participants observed that staff came across as caring and nonjudgmental in these early interactions. Participants felt especially at ease when they had a point of reference for staff outside of the program, whether a mutual connection in the community or a history of participation in other programs with the organization.

Interviewer

“Do you remember how comfortable you felt meeting with that staff person right at the beginning?”

Participant

“Yeah, I was pretty comfortable.... They were pleasant and understanding, open-minded, nonjudgmental.”

As they continued participating in the program, participants cited reminder calls and other staff-initiated individual communications as building rapport. Such communications seemed to create a sense of being checked in on and valued as an individual; participants valued this feeling. In contrast, a lack of staff responsiveness to participant-initiated communications (whether in person or by telephone) tended to erode trust and rapport.

4.2.2 HMRE Program Content and Group Dynamics

Participants enrolled in HMRE programs with a variety of goals, but chief among them was an interest in gaining perspective on past, current, and future intimate relationships (including abusive relationships) and accessing resources (including resources related to IPV).

“I hoped to get some valuable information on domestic violence, like any feedback and stuff like that, so that I know [how] not to go and get myself into another situation like that again.”

(HMRE program participant)

Interviewer

“What did you hope to get out of the [HMRE] program originally?”

Participant

“I’d hoped to get access to resources. Because my relationship was going downhill, and it was heading into a domestic violence issue, and I knew it, and I know it just gets worse.”



Some accessed the program as part of a holistic set of services designed to meet other basic needs (for example, housing and employment), whereas others expressed interest in facilitating personal growth, improving their relationships with their children, or gaining information that could benefit others in their networks. Participants recalled actively choosing to participate in the IPV assessments (and simultaneously in the research study), often in hopes of benefiting others.

Interviewer

“What did you hope to get out of it?”

Participant

“Anything to better myself or to give—so I can learn information to help others around me, like resources and stuff.”

The content and camaraderie of HMRE programs created an optimal environment for many participants to reflect on their past and present relationships and, in many cases, to recognize and share experiences with IPV. Curriculum content provided a meaningful, substantive context in which participants could reflect on past patterns of unhealthy or abusive relationships, consider dynamics in their current relationships (if relevant), and formulate intentions for future relationship decisions. Participants emphasized that the healthy relationship curricula helped them learn to recognize signs of unhealthy or abusive behavior—in one participant’s words, “the red flags of abuse.”

“It opened up my eyes to realize what signs to watch out for with looking for new relationships.”

(HMRE program participant)

Participants also explained how group dynamics in the healthy relationship classes prompted deeper reflection on difficult personal relationship experiences and issues. One participant described it as a “family” atmosphere; another explained, “They created an environment where everyone just felt comfortable with each other and non-defensive.” Some noted that it was peer-to-peer exchanges—particularly the opportunity to get feedback or to benefit others in the class who might face similar situations—that motivated them to open up about their own experiences. Being part of a class with people of similar cultural backgrounds or who shared certain life experiences (such as recovery from addiction) set participants at ease and further invited this kind of sharing.

“I would share, like, when we had our group’s discussions. You know, I was actually in a really good group of girls.... We were all really supportive of each other, and, like, I didn’t feel ashamed or embarrassed or whatever to share anything.”

(HMRE program participant)



4.2.3 Outside Influences on IPV Perceptions and Disclosure Decisions

Influences beyond the HMRE program also shaped participants’ perceptions of IPV and decisions about whether or how to share their experiences. HMRE and domestic violence program staff and participants each cited cultural and experiential influences that they felt normalized abusive dynamics. Interviewees mentioned exposure to abusive relationships in childhood in their family homes, the foster care system, or orphanages.

“A lot of people grow up thinking stuff like that is normal, and it’s not.”

(HMRE program staff member)

Several suggested that Native women participants faced particular cultural barriers to speaking up about their personal experiences and asking for the help they needed, whether from staff or in the group setting.

“We were from the reservation. [Other Native women], they’re trying to get help and they don’t know how to speak up. When I was little and I lived on the reservation, I noticed my parents struggled and now they’re not together, so these parents are sitting there, I can tell that they’re struggling, [and] can see it in their face, but they just don’t know how to speak up.”

(HMRE program participant)

What participants chose to share in the context of the HMRE program was also shaped by their access to other sources of support. Participants varied widely in their formal and informal support networks outside of the HMRE program; some had very little of either. For those who were less socially connected, churches offered another important source of support (though not necessarily a forum for sharing personal or stigmatized experiences).

4.3 Perceptions of IPV Assessments

4.3.1 Overall Acceptability of IPV Assessments

Participants saw the HMRE program as offering a safe environment for learning and sharing about relationships, including IPV issues.

Interviewer

“Any safety concerns with participating in the [HMRE] program?”

HMRE program participant

“I was in [an abusive] relationship at the time, but I wasn’t concerned about participating in the program. I felt safe there.... He wasn’t there. He was at work when I went there. It’s in a safe spot. They keep the doors locked. You know, all the people that are involved in that program are very familiar with domestic violence—and other things, you know. That happened to be my particular issue. Other people had other issues. But I felt very safe, and I felt that confidentiality was maintained.”

HMRE program staff expected resistance to IPV assessments but reported a largely positive reception. Negative responses were very rare; the one example offered in qualitative interviews was a defensive response from a participant who was already in treatment for IPV perpetration. Staff noted some that some participants navigated the interaction with joking and bravado while other became serious or even tense. They also found that participants were pleasantly surprised at the short length of the IPV assessment tools. Staff reported that participants who did not have IPV concerns sometimes found the multiple IPV assessments repetitive (or wondered if staff were comparing their answers for consistency); however, participants rarely objected to the repeated nature of the IPV-related conversations.

Indeed, participants consistently perceived IPV assessments as worthwhile. In qualitative interviews, they reported feeling that HMRE program staff knew enough about their situations to help them stay safe.

Interviewer

“What do you think makes people feel comfortable sharing about their own relationship issues, like disrespect or conflicts getting physical?”

HMRE program participant

“[That] whoever’s listening, is actually listening, you know. Giving them that respect, and then not interrupting them, you know, responding in a respectful, kind way.”

Participants also appreciated reminders that their choices to participate in an assessment or not (and to answer or skip a given question) would be respected. Staff concurred, observing that warning participants about the sensitive content before each conversation helped to promote comfort. At one site, many participants had a known history of IPV victimization and had already received services for it. Among these already-connected survivors, needs and desires to discuss their IPV experiences with HMRE program staff varied widely. Staff made every effort to respect these preferences.

“Most of my [participants] have already been through some DV situation and have gotten help with it, so we don’t end up talking a whole lot.”

(HMRE program staff member)

4.3.2 Acceptability of Universal Education Conversation

HMRE program staff observed that the universal education tool was somewhat harder to administer in a “natural” tone and did not tend to provoke much conversation. Staff attributed these challenges to the fact that the tool required reviewing two lists of example healthy and unhealthy relationship characteristics with participants, which tended to set a didactic tone.

“When you’re speaking to them [during universal education], it’s like there wasn’t that much interaction.... I feel like I was lecturing again a little bit.”

(HMRE program staff member)

Staff recounted that participants sometimes volunteered agreement or disagreement with these examples, but otherwise tended to share little. Staff mentioned that although the content of the examples was not novel (in the context of a healthy relationship course), the universal education conversation did offer a valuable opportunity to connect the content to participants’ own lives and relationship circumstances. However, they noted that the example of reproductive coercion did not feel relevant to participants.

Staff and participants both liked the “safety card” that accompanied the universal education conversation. They found the resource information helpful, but some suggested including a wider variety of local IPV-related resources (beyond the local domestic violence partner). Participants who experienced this conversation reported strong familiarity with the IPV-related resources that were available to them and confidence that they could seek help from HMRE program staff with IPV issues. Overall, though, qualitative interviews suggested that HMRE program staff and participants found the universal education conversation less comfortable and (for staff) somewhat more challenging to implement than the questionnaire-style tools. Staff noted that the conversational approach relied heavily on their rapport with participants.

“It’s a sensitive subject, so it can’t be approached without any feeling or thought. It has to be something that you’re sensitive to. You don’t have to portray that to the client, but you have to be comfortable talking with them about it, being empathetic and non-judgmental.... A lot of the success really falls on how the staff will give the [tool].”

(HMRE program staff member)

4.3.3 Acceptability of Questionnaire-Style Tools

Staff and participants agreed that the questionnaire-style IPV assessments, unlike the universal education conversation, promoted both reflection and dialogue. Participants repeatedly expressed that answering the closed-ended questions in these short tools had provided them with a chance to reflect and gain perspective on their relationships.

“For some reason, you got more feedback when there was a question—because that opened up a conversation.”

(HMRE program staff member)

“You fill this [tool] out, and then, you realize, when you’re answering these questions, like, you start to feel like, ‘What’s normal?’ You know? And then, you fill this out, and it’s like, ‘Yeah, he did do this. And yeah, this happened. And yes, I do feel this way.’ And then, you start to think, ‘You know what? There’s a problem here.’”

(HMRE program participant)

Staff observed that using printed cards showing response options for each question had helped with clarity and ease of administration. Some staff preferred the more straightforward questions in one tool (the UVPS/WEB) and the more straightforward response options included in the other (the IJS). Staff also suggested that rephrasing certain items in more common language could help with comprehension; problematic words or phrases in the tools included “resents,” “retaliates,” “a look that goes straight through me,” “programmed to react,” and “more insensitive than caring.” Staff also said that participants had an easier time answering yes/no questions, questions with fewer Likert-type (strongly agree to strongly disagree) response options, and those that included a neutral response option. Yet they observed that it was participants’ careful consideration of the response options—seeking input from HMRE program staff—that most often prompted dialogue about their experiences.

4.3.4 Participant Responses to IPV Assessments

Survey items regarding participants’ perceptions of the tool they had just completed, their interactions with staff, and their confidence about and familiarity with safety-related options and resources are shown in Table 4-2. On these surveys, participants who had just completed the universal education tool were more likely to indicate feeling comfortable with the tool than those who had just completed one of the two questionnaire-style tools. This correlation, which contradicted findings from the qualitative interviews, may have

been confounded by disclosure status. Participants were much more likely to disclose IPV using a questionnaire-style assessment tool than during a universal education conversation, and individuals who disclosed IPV tended to report less comfort than those who did not (see also Section 5.4). Overall, participants indicated a preference for completing questionnaire-style tools via electronic means (such as a tablet or mobile phone) and a preference for completing the universal education tool in conversation with a staff member.

Table 4-2. Differences in Responses to IPV Assessment Tools

	Questionnaire-Style		Conversational
	UVPS/WEB N (%)	IJS N (%)	Universal Education Tool N (%)
Tool very clear	138 (89.6)	157 (89.7)	143 (97.3)
Very comfortable with questions/ conversation*	106 (69.3)	133 (75.6)	128 (87.7)
Very open in answering questions/talking with staff	142 (92.2)	167 (94.9)	126 (85.7)
Concerned about privacy none of the time	137 (89.0)	150 (87.2)	129 (87.8)
Know options for keeping safe	146 (94.8)	172 (97.7)	139 (95.9)
Very likely to share resources with others	121 (80.1)	129 (73.3)	106 (73.6)
Prefer electronic mode*	92 (60.1)	97 (57.4)	37 (26.6)
	Mean (SD)	Mean (SD)	Mean (SD)
Comfort with staff†	-0.01 (0.65)	-0.01 (0.62)	-0.02 (0.66)
Number of resources they know how to access	1.43 (1.17)	1.38 (0.98)	1.40 (1.03)

Notes: IJS, Intimate Justice Scale; UVPS/WEB, Universal Violence Prevention Screening Protocol and the Women's Experiences with Battering questionnaire.

*UVPS/WEB and IJS are both significantly different from universal education tool, controlling for site differences.

†Comfort with tool/staff is an average of six items, which were standardized to be on the same response scale (that is, recoded so the mean of each item is 0 and the standard deviation is 1).

4.4 Overcoming Challenges and Optimizing Implementation

All three adult-serving RIViR sites successfully implemented all three IPV assessment tools with participants over the course of their program participation. To do so, they faced two major implementation challenges: time constraints and program attrition. The site staff generated a host of ideas and strategies for strengthening the implementation of IPV assessment, including optimizing the timing, framing, and setting for these interactions.

4.4.1 Overcoming Program Time Constraints

HMRE program staff worked hard to make time for IPV assessments while delivering their curricula and program activities. Participants and staff all perceived all of the three tools as short. However, several circumstances created time challenges. First, administering an IPV-related tool during the initial program intake meeting sometimes proved difficult to balance with extensive intake and evaluation-related paperwork that needed to be completed during that same meeting. Staff in couples-based programs found this especially challenging. IPV assessments and certain portions of program intake had to be offered individually, so the process of requesting consent for participation in the IPV assessment and then administering one of the three RIViR tools added up to 15 minutes per person to an already lengthy meeting; couples who came in together for the intake meeting could find themselves spending as much as 2 hours at the HMRE program office for an intake that might previously have taken 90 minutes. Staff also noted that they needed to allow more time for responding to requests for clarification when completing the tools with participants who had less formal education.

“It does add time, especially if it’s someone where you have to take the time to explain the questions, but that’s not often.”

(HMRE program staff member)

In one of the three sites, the time allocated to IPV assessments reflected the view among staff and leadership that such conversations were an integral part of HMRE services. Those staff saw the time spent in these interactions as enhancing, rather than detracting from, their other work with participants. This site, which used a group-based approach to administer some of the assessments (in which participants could privately and simultaneously self-administer their IPV assessments using tablets), found that time pressures were addressed by dedicating some class time to participation and designating a second staff member to pull participants out of class individually for the universal education conversation.

“I’ll take a few minutes while I’m teaching the class, just let them be out of class for 5 minutes and do it with the intern or the other staff, or they come back in one-on-one, so they’re not really missing much. And that worked perfectly.”

(HMRE program staff member)

In all three sites, participants shared that they found each of the IPV assessment tools fairly short. They affirmed that the time such interactions took was worthwhile. However, in the two sites where staff reported feeling pressed for time, participants echoed this—observing that the interactions felt rushed or time pressured.

One site, concerned that administering IPV assessments could result in individuals’ joining the class late, made a further decision to disallow IPV assessments within 30 minutes of the class start time. This resulted in serious challenges completing the assessments, as staying late on a weekday evening or finding transportation to and from the program offices to have a separate meeting for the IPV assessment proved untenable for many participants. Inviting participants to complete IPV assessments during a food break worked well.

4.4.2 Optimizing the Timing of IPV Assessments

Quantitative analysis did not detect statistically significant differences in IPV assessment results based on how long participants had been enrolled. The number of days that elapsed between program enrollment and participation in the IPV assessment influenced neither the accuracy of the IPV assessments nor rates of disclosure. Neither did participants’ other responses to the tools—for example, how comfortable they felt with staff or how familiar they were with options for staying safe—vary as a function of time since enrollment. However, individuals were more likely to disclose IPV on each of the two questionnaire-style IPV assessment tools (the UVPS/WEB and the IJS) when it was administered first out of the three tools. In addition, false positive rates, or the proportion of individuals classified as experiencing IPV who actually were not, were higher on the IJS when it was administered first.

In qualitative interviews, however, staff and participants expressed that IPV assessments worked better later in the program. At that point, they noted, staff and participants had built trust and rapport and staff were more familiar with individuals’ circumstances. This comfort level was particularly helpful for the universal education conversation, which, one staff member noted, could feel “like false intimacy” without solid rapport. Staff also suggested that participants’ comfort levels and their perspectives on their relationships

tended to build over the course of program participation and repeated IPV assessments. Participants highlighted how the content of the assessments and the healthy relationship course prompted an internal reflection process, which participants could share with staff or other participants later in the course.

“During that time, you are just connecting, you’re making them comfortable,... making [participant] laugh, and it’s just creating a bond and her feeling comfortable.... I think that’s what’s important. Truly just being yourself and just creating a bond, so they can feel the confidence.”

(HMRE program staff member)

4.4.3 Optimizing the Framing and Setting for IPV Assessments

Staff suggested that framing the IPV assessments as a natural extension of the program’s focus on healthy relationships worked well. While making sure participants were fully aware that they would be asked questions about abuse, staff made an effort to normalize the IPV assessments and emphasize their universal relevance in the context of promoting healthy relationships.

“I’ve never presented the [assessment] as a domestic violence survey. I’ve always done it as a healthy relationships survey.... I think that word alone, in and of itself, will just probably turn some people off.”

(HMRE program staff member)

They also emphasized that a caring tone and genuine interest helped to turn the IPV assessment into an opportunity for getting to know a participant as an individual. This framing supported more effective delivery of the IPV assessment tools. Some staff saw this additional opportunity to build trust and understanding with individual participants as fueling their ability to facilitate meaningful and engaging interactions during the group-based relationship education activities.

“I don’t want [participants] to feel that impersonal vibe from us.... It’s more like, I really care about you, right? And I want to know these answers, too.... It’s more like, how can I help you with this? How can we continue this journey together and help support you to get into a healthier relationship?”

(HMRE program staff member)

Staff generally administered the IPV tools in the same community-based offices where they conducted program intake and delivered relationship education classes. They reported that it was essential to have at least one private, soundproof space adjacent to the spaces used for enrollment and service delivery in order to smoothly integrate IPV assessments into typical program case flow. In addition, HMRE program staff sometimes devised strategies for completing IPV assessments in private in the context of a “transport” or other field-based interaction with participants. Staff noted that the use of tablet-based tools made it easier to securely manage participants’ responses.

“Somebody will contact me and ask me to give them transportation somewhere to a resource, and then... I say, ‘Hey, so, since we’re together, do we want to go ahead and do this [IPV assessment]?’”

4.4.4 Managing IPV Assessments in the Context of Program Attrition

That some participants would drop out was expected over the course of the HMRE programs. Managing IPV assessments in the context of attrition presented occasional challenges, however. Although staff and participants tended to agree that later in the program was better for IPV assessments, attrition meant that fewer participants completed the assessments offered later in the course.



“My only problem is they do one screener and then they change their phone number, or their phone number is, you know, disconnected. And then we can’t finish the other ones because they stop coming to class.”

(HMRE program staff member)

In addition, program attrition also meant lost opportunities for consistent follow-up after a disclosure. HMRE program staff cited a few examples of participants who disclosed IPV during an assessment, received a referral, and then dropped contact with the program. Staff persistence, resourcefulness, and flexibility helped to meet these challenges. For example, staff were often willing to visit participants in person to re-engage them. When they did, many were able to identify private locations where they could safely conduct an IPV assessment outside of the office.

4.5 Effectiveness of Tools for Identifying Participants in Need of IPV-Related Help

Each of the three tools administered for the RIViR study captured different aspects of IPV. The UVPS/WEB included items on controlling behavior, physical violence, psychological aggression, and sexual coercion. The IJS included items on controlling behavior, physical violence, and psychological aggression. The universal education tool included discussion of controlling behavior, physical violence, sexual coercion, and psychological aggression. However, this tool simply asked staff to record whether a participant expressed any IPV-related issues or concerns, rather than attempt to identify which dimensions of IPV were suggested by what a participant shared.

4.5.1 Rates of Disclosure

Rates of IPV disclosure differed substantially across the three tools. As shown in Table 4-3, participants were much more likely to disclose IPV experiences during a questionnaire-style assessment than during the universal education conversation.

Table 4-3. Frequency of IPV Disclosure by Approach

	Questionnaire-Style		Conversational
	UVPS/WEB	IJS	Universal Education Tool
IPV disclosure	33.0%	50.5%	4.2%

Note: IJS, Intimate Justice Scale; UVPS/WEB, Universal Violence Prevention Screening Protocol and the Women's Experiences with Battering questionnaire.

How the questionnaire-style tools were administered also appeared to make a difference in the chances of disclosure. In one RIViR site, the first tool in the series of three was always administered face to face by a staff member; after that, participants self-administered the questionnaire-style tools in a group setting as part of regular class time. The universal education conversation was always presented as a one-on-one conversation. In this site, participants who completed the IJS face to face with a staff member were more likely to disclose IPV than those who completed the tool themselves using a tablet.²

² Qualitative data suggest that this result could be related to the fact that participants who completed the IJS face to face with a staff member often asked for, and received, clarification from staff on selecting the best-fitting responses to the questions. It could also reflect the quantitative observation that disclosures on a questionnaire-style tool were more likely when it was administered first.

4.5.2 Overall Accuracy of the Tools for Identifying IPV

The accuracy of the three tools for identifying participants in need of IPV-related help also varied, as shown in Table 4-4. All three tools were highly specific; that is, they were highly likely to indicate an absence of IPV among participants who had not experienced IPV. The sensitivity of the tools tended to be lower; all three failed to identify some proportion of participants who were experiencing IPV. The proportion of IPV survivors who were not identified as such by a given tool ranged from 88% (universal education tool) to 9% (IJS). In general, the two questionnaire-style tools had higher sensitivity and the universal education tool had higher specificity.

A psychometric analysis was conducted to estimate the accuracy of each of the three tools, including

- **sensitivity**, the probability that a tool will indicate the presence of IPV when a participant has experienced IPV;
- **specificity**, the probability that a tool will indicate the absence of IPV when a participant has not experienced IPV;
- **false negative rate**, the proportion of participants who had experienced IPV who were flagged as not having experienced IPV; and
- **false positive rate**, the proportion of participants who had not experienced IPV who were flagged as having experienced IPV.

Two types of latent class models, described in detail in Appendix Section A.5, were used for these estimates (Table 4-4). One approach compared each tool to a composite of all items from all tools to generate estimates of sensitivity and specificity. The other compared the full tools to each other to generate false negative and false positive rates. Both approaches yielded similar results.

Table 4-4. Accuracy of the Tools in Identifying IPV

	Questionnaire-Style		Conversational
	UVPS/WEB	IJS	Universal Education Tool
Sensitivity	35.4%	54.8%	4.6%
Specificity	94.5%	97.3%	100.0%
False negative rate (95% CI)	20% (11%, 32%)	9% (3%, 20%)	88% (82%, 93%)
False positive rate (95% CI)	10% (6%, 15%)	33% (27%, 40%)	1% (0%, 3%)

Notes: IJS, Intimate Justice Scale; UVPS/WEB, Universal Violence Prevention Screening Protocol and the Women's Experiences with Battering questionnaire. Estimates of sensitivity and specificity were developed by comparing results from each tool to a synthetic gold standard incorporating the complete set of items from all three tools. Estimates of false negative and false positive rates were developed using a latent class model that compared the three tools to one another. (Additional detail is provided in Appendix A.)

Overall, the tools ranked in the following order with regard to accuracy:

1. The IJS had the highest sensitivity and lowest false negative rate but also the highest false positive rate.
2. The UVPS/WEB was intermediate between the other two tools with regard to most tests of accuracy but had the lowest specificity of the three.
3. The universal education tool was much less sensitive than the other tools (and had the highest false negative rate) but was also the most specific (and had the lowest false positive rate).

An analysis of hybrid tools (created by recombining items across tools) found that combining the IJS items with other individual items or item sets from the other tools produced more accurate tools. Sensitivity was boosted to over 60% with several of these new, hybrid item sets (see Appendix Table A.5 for detailed information on these tools).

4.5.3 Suitability of the Tools for Diverse Populations

Each of the questionnaire-style tools was more accurate with some groups of participants than with others. The UVPS/WEB had higher false negative rates (proportion of individuals experiencing IPV who were not flagged as such) among individuals with no children. The IJS had higher false positive rates (proportion of individuals not experiencing IPV who were flagged as experiencing IPV) among individuals who were not in a serious relationship.

Differences in life experience and in staff-participant fit also affected the knowledge and intentions that participants took away from their IPV-related conversations with staff. Participants who had less than a high school degree and those who were born outside the United States reported knowing how to access fewer IPV-related resources after completing their third IPV-related interaction with HMRE program staff than did native-born participants and those with more education. Women, participants living with children, and those whose final IPV-related conversation was facilitated by a staff member of the same gender were more likely than their peers to report that they would share information about IPV-related programs or services with someone they knew.

The following practice-based resources might also be helpful in creating safe, survivor-centered opportunities for learning about and disclosing IPV:

- The guide [*Universal Trauma-Informed Education for Addressing Intimate Partner Violence*](#) offers recommendations for survivor-centered approaches to IPV education and disclosure opportunities (Greville, 2016).
- The presentation [*Trauma-Informed Screening Methods: Lessons from Behavioral Health Settings*](#) summarizes key elements of a trauma-informed approach to addressing interpersonal abuse, including offering disclosure opportunities in a trauma-informed manner (Warshaw, 2013).
- The Healthy Marriage Resource Center's publication [*Promoting Safety*](#) includes a chapter on creating opportunities for IPV disclosure in HMRE programs (Menard, 2008 [updated 2015]).



PROTECTING IPV SURVIVOR SAFETY

5



5.1 Following Up With Participants Who Disclose IPV

Staff took different approaches to following up on IPV disclosures based on when and how the disclosure occurred. When participants disclosed IPV during a one-on-one assessment, HMRE program staff talked through available resources with them during the same interaction. When they disclosed in a group-based setting, follow-up occurred in a separate, private conversation. The shorter the delay between a disclosure and a follow-up conversation, the better, staff said. Staff felt most at ease when they received a disclosure during a one-on-one conversation and could begin offering resources, strategizing for safe service delivery (if the participant wished to continue in the HMRE program), and talking through privacy and confidentiality concerns. When disclosures occurred as part of a class discussion or during group administration of a tablet-based tool, staff had to reach out to participants to arrange another time to talk—a step that they noted added delay, logistical complication, and risk.

5.2 Referring Participants for IPV-Related Services

5.2.1 Knowing Whom to Refer

HMRE program staff sometimes faced complex decisions about whom to refer for IPV-related services. Disclosures in the context of couples-based services could be especially complicated—particularly when both members of a couple reported having experienced physical violence or controlling behavior by the other. HMRE program staff did not have the expertise to differentiate dynamics of abuse (and resistance to abuse), nor was it intended that they do so in administering the RIViR assessment tools. As domestic violence program staff noted, HMRE program staff—by virtue of their professional focus—could not be expected to be perfectly equipped for handling very complex or specialized aspects of IPV disclosure.

“They’re tackling a lot of issues... I think, for many of our clients, they do have a variety of needs, and so, their ability to hit all of those needs, I think, is a big thing.... You can’t make experts out of people who need to know lots about lots of different topics.”

(Domestic violence program staff member)

Relying only on what participants reported in the assessment tools, however, meant that HMRE program staff often classified couples as “mutually” abusive—a characterization that a domestic violence advocate would rarely apply. In these situations, both partners could be referred for IPV-related services but neither could receive individualized support from HMRE program staff on staying safe in the context of the HMRE program (as they otherwise would if only one were identified as the survivor). These challenges were apparent in an example recounted by HMRE program staff of identifying someone as a survivor of “mutual” IPV only to learn that he was already receiving services from the local domestic violence program as a perpetrator.

“One person had been in a mutually unhealthy relationship and had been accused of being the instigator and they felt very much like they had to explain to me, like, you know, this can be both ways and women can be like this as well.... They opened up a little more and talked to me about it. It seemed like they were concerned about wanting to say that it can be mutual, and ‘I was treated this way as well.’ This person had already gone through services at the [local domestic violence agency], through the offenders’ program, so I didn’t really have to refer them.”

(HMRE program staff member)

5.2.2 Knowing When to Refer

HMRE program staff navigated several complexities regarding when to refer individuals for IPV-related services. When staff followed up with participants about their IPV experiences, they often learned that they pertained to a relationship that the participant considered to be over. HMRE program staff did not want to miss the chance to connect a participant with help, recognizing that abusive relationships might well be “on and off.” Yet they struggled to envision how the local domestic violence program would be helpful in such situations and found that when they did mention these services, participants usually declined the referral. Domestic violence program staff suggested that offering a referral for noncrisis services was ideal in such situations, even if the participant declined it.

“We can help with long-term pieces, even after somebody has left. Because people have challenges from the day that they move to, you know, 10 years later sometimes, depending on what the situation is. So, I don’t know that everybody always thinks about those kinds of long-term things; it’s kind of like this is the immediate crisis, and then, if they’re not in that immediate crisis, I don’t know that they always refer.”

(Domestic violence program staff member)

“We do want it to be a warm handoff, and now anyone who has talked about DV even if it’s a past relationship, we still talk about [local domestic violence program] and let them know that they might find it relevant even if they’ve moved on.”

(HMRE program staff member)

Other participants disclosed IPV multiple times over the course of program participation. When this occurred, staff exercised judgment regarding whether to continue following up with participants each time. They typically did continue to offer resources and discuss options with participants after each disclosure. HMRE program staff observed that multiple follow-up conversations, rather than feeling repetitive or annoying to participants, sometimes gave participants an opportunity to process their experiences and explore options at their own pace with consistent support.

As shown in Table 5-1, HMRE program staff reported an intention to refer more than half of participants who disclosed IPV on one of the questionnaire-style tools. The actual referral rate for those who disclosed during the universal education conversation was higher (78%). This higher referral rate could be attributed to the fact that the universal education conversation included built-in prompts regarding referral resources. It could also reflect the fact that the indicator of IPV disclosure in the universal education tool was based on an open-ended dialogue between the participant and HMRE program staff about the presence of IPV; therefore, it already took into account the meanings made of their experiences (as opposed to being generated based on a numeric threshold that might not align with staff or participant perceptions, as in the questionnaire-style tools).

Table 5-1. Rate of IPV Disclosure–Based Referrals

	Questionnaire–Style		Conversational
	UVPS/WEB	IJS	Universal Education Tool
Percentage of disclosures for which staff indicated an intention to make a referral (or completed a referral)	62.0%	58.6%	78.3%

Note: IJS, Intimate Justice Scale; UVPS/WEB, Universal Violence Prevention Screening Protocol and the Women’s Experiences with Battering questionnaire.

5.2.3 Knowing Where to Refer

Local domestic violence programs served as the primary referral recipient for HMRE program participants who were experiencing IPV. Some participants did access these services as a result of referrals from the HMRE program. Many others noted that they felt familiar with available resources and comfortable approaching HMRE program staff if they needed help. Sometimes HMRE program staff referred participants who disclosed IPV to other organizations to meet more specific needs. They focused on identifying a broader set of local organizations, such as those offering legal help or emergency housing, so that they could connect participants with culturally responsive and linguistically appropriate services, sometimes partnering with more than one local domestic violence program to meet this need.



“With the client’s permission, I reach out to them. I say, you know, ‘This person needs help, do you have somebody Spanish speaking?’ Because you know, again, this is a very delicate situation and they’ll feel more comfortable speaking with someone that speaks [their] own language, right?”

(HMRE program staff member)

Two challenges arose related to referrals for IPV–related services, however. First, HMRE program staff sometimes lacked confidence in their ability to explain local domestic violence programs’ services and methods of working with clients. Domestic violence advocates acknowledged that their focus on meeting each survivor’s unique needs (rather than providing a prescribed set of supports) could make their services hard to define. As such, HMRE program staff sometimes struggled to make a clear pitch to participants on what benefits these services offered or what participants could expect.

“Advocacy in general is a really hard thing to define.... If somebody needs their locks changed, they can come to us, or if somebody needs rent and deposit assistance, they can come to us, or if they need to pay for their HIV prophylaxis, they can come to us.... It would take up 10 pages for us to list all of the things that people could get paid for or that we could assist with.”

(Domestic violence program staff member)

“A lot of the questions [from participants] I couldn’t really answer. I would have to connect or call, and say, ‘I’ll find out for you.’ Like, what do you do? I just know you house people, but how long? What for?... That will better help me sell that to someone that probably is iffy about calling or getting help.”

(HMRE program staff member)

Second, participants often needed active support to access services from the local domestic violence program. Two of the three sites offered a “warm handoff” referral in which they directly connected participants with services.

“One of the things is talking about the warm handoff, so we don’t just give them a number and say ‘Good luck’; it’s taking the individual there and knowing the person we’re referring them to. It’s a hard thing for somebody to decide, ‘Yes, I’m ready to leave.’ One of the most dangerous times that come up is when people leave.”

(HMRE program staff member)

HMRE program staff in one RIViR site noted that the local domestic violence program discouraged them from this approach, based on a desire to preserve survivors’ confidentiality and self-determination. However, HMRE program staff and domestic violence program staff at this site worried that no participants seemed to have accessed services from the domestic violence program.

5.3 Adapting Service Delivery to Protect Survivor Safety

In addition to offering referrals, HMRE program staff strategized with survivors about how to support their safety while they were participating in the HMRE program. Staff also supported those who disclosed IPV victimization in deciding whether they wanted their partners to be invited to participate in IPV assessment. Survivors' desires varied: some wished to continue participating in healthy relationship classes, whereas others wished to exit the HMRE program; some wished to access IPV-related services at partner organizations and others did not. Staff worked together and with their local domestic violence programs to help survivors access the services they wished to, and opt out of those they did not, without reprisal from abusive partners (who often closely monitored their actions and interactions).

“He knew that I was going there. And then he was like, ‘Well, why are you doing that? And what do you need to do that for?’”

(HMRE program participant)

To meet the unique safety needs of each survivor, HMRE programs developed a variety of adaptations, including

- adjusting the location and timing of IPV assessment and follow-up conversations,
- adjusting the end time of a healthy relationship class,
- arranging for a domestic violence advocate to deliver services in a private room at the HMRE program location during class time, and
- driving a survivor to the local domestic violence program and staying with her until she was seen.

“I reached out to [local domestic violence partner] explaining the situation. I knew that it was going to be hard for [client] to get to their office. That’s when I asked if it was possible for her to come here. I gave her the plan, the idea I had: She can come during our class time, so nothing would spark him. And she was amazing and awesome and said ‘Yes, we do that.’”

(HMRE program staff member)

“I transported her to the shelter, walked in the door, met an advocate who could start the intake, and I left.”

(HMRE program staff member)

Although staff went to great lengths to prevent perpetrators from learning that their partners had disclosed IPV to staff, they could not prevent a couple from having private conversations about the assessments. Participants occasionally fielded heavy questioning from controlling partners about participating in the program or the IPV assessments.

“When we sat down to do these questions, it was hard because at one point... he came downstairs, and he’s like, ‘Come on,’ you know, ‘I have to go to work.’ When she came the following week... she said, ‘Do you think we can do it before class ends?’ So I intentionally wrapped up like 15 minutes prior, because he was like, ‘What were you talking about?’”

(HMRE program staff member)

Despite conscientious staff efforts to protect participants, staff acknowledged that some aspects of couples-based service delivery posed challenges that were beyond their control. Staff recounted how one couple abruptly dropped out of the HMRE program after the female partner disclosed IPV during an assessment; staff suspected that the unwelcome scrutiny might have prompted her abusive partner to refuse further participation.

5.4 Recognizing the Limits of Disclosure–Based Practice

As a result of participating in IPV assessments and universal education, many participants shared IPV experiences with HMRE program staff and received referrals to services. Yet study results also suggest that some participants choose not to disclose, regardless of a program’s approach to inviting disclosure. Efforts to promote safety for survivors of IPV who participate in HMRE programs should therefore also consider those who choose not to disclose their experiences.

Survey results suggest that discussing IPV with staff was an uncomfortable experience for participants. Those who reported IPV during any of the IPV–related interactions expressed more concern that someone might see or hear their answers than those who did not. Those who disclosed IPV on the UVPS/WEB or during the universal education conversation also reported less comfort with staff than those who did not. Quantitative data indicate that many survivors opted to share their IPV experiences despite these concerns—but some likely did not.

Qualitative interviews with participants and HMRE and domestic violence program staff identified several factors that could inhibit disclosure:

- lack of rapport or trust with staff, particularly for IPV–related conversations that occurred very early in the program
- A lack of recognition that the dynamics of one’s relationship might be abusive
- A general (cultural or dispositional) discomfort with personal sharing or help seeking
- Potential safety risks associated with disclosing IPV in one’s current relationship
- Possible concerns related to staff’s mandatory reporting responsibilities

To help ensure that all participants experiencing IPV had the information they needed—regardless of whether they chose to talk about their experiences—staff focused on increasing all participants’ knowledge of available resources. Some staff offered all participants a copy of the universal education “safety card” (which included a resource list as well as examples of healthy and unhealthy relationship characteristics) at the beginning of the program. As one staff member explained, “Things could be there from day one. I would hate to withhold that information.” Some also found it helpful to offer this information repeatedly at various points in program participation.

The following practice-based resources might also be helpful to HMRE program staff working to protect the safety of IPV survivors:

- The [Domestic Violence Resource Network](#), funded by the Family Violence Prevention and Services Program, includes national, culturally specific, and issue-specific resource centers:
 - [National Resource Center on Domestic Violence](#)
 - [Resource Center on Domestic Violence: Child Protection and Custody](#)
 - [Ujima: The National Center on Violence Against Women in the Black Community](#)
 - [National Latin@ Network](#)
 - [National Indigenous Women’s Resource Center](#)
 - [Asian Pacific Institute on Gender-Based Violence](#)
 - [National LGBTQ \[Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning\] Institute on IPV](#)
- Survivors who wish to receive services anonymously by telephone or chat can access several national hotlines, helplines, and chatlines:
 - [National Domestic Violence Hotline](#) for all survivors
 - [loveisrespect Helpline](#) for young abuse survivors
 - [Stronghearts Native Helpline](#) for Native American survivors

The Healthy Marriage Resource Center’s publication *Promoting Safety* includes a chapter on HMRE program approaches to protecting survivor safety (Menard, 2008 [updated 2015]).

CONCLUSIONS

6



Before the RIViR study, no study had compared the accuracy, acceptability, and feasibility of IPV assessment tools for recognizing IPV and connecting survivors with support. RIViR undertook this comparison in the context of federally funded HMRE programs, which offer community-based services to a diverse population of individuals and couples.

With regard to accuracy, the IJS tool performed best. All three tools had high specificity; that is, they were likely to indicate an absence of IPV when a participant had not experienced IPV. All three tools failed to identify some participants who were experiencing IPV, but the proportion of IPV survivors who were not identified as such ranged from 88% with the universal education tool to 9% with the IJS. Overall, the two questionnaire-style assessment tools had much higher sensitivity and the universal education tool had higher specificity.

Study findings highlight both the acceptability and feasibility of implementing high-quality, accurate IPV assessment and universal education in HMRE programs. They indicate that HMRE staff and participants each perceive efforts to identify and respond to IPV as closely aligned with other HMRE program goals and with the needs of participants. Indeed, interviews revealed that participants appreciated IPV-related conversations and that some had enrolled in the HMRE program specifically to get help for a current abusive relationship or gain insight on a past one. Finally, study results call attention to the critical importance of underlying organizational readiness and capacity for IPV-related work—particularly the presence of active, reciprocal partnerships with local domestic violence organizations—and an ability to meet participants' cultural and linguistic needs.

The study was conducted in close partnership with three OFA-funded HMRE programs: Volunteers of America, Dakotas; Nepperhan, Inc.; and Youth and Family Services. These organizations were selected for their successful enrollment and service delivery with diverse populations and their accompanying commitment to responding to IPV. Their work sheds light on the challenges, strategies, and achievements associated with delivering IPV assessment and universal education in adult-serving HMRE programs, but they do not represent all such programs.

Healthy relationship programs like the federally funded HMRE programs have an important role to play in identifying and responding to IPV among the diverse communities they serve—including individuals with no other connection to services who are counting on them for help. Future research might examine whether IPV assessment and universal education in the context of HMRE programming affect outcomes other than IPV disclosure, such as resource knowledge or safety-related empowerment; how staffing and curriculum delivery approaches influence the effectiveness of HMRE programs' IPV-related strategies; and how HMRE programs can best identify, serve, and refer individuals who are themselves using abusive tactics against their partners. These efforts, combined with practitioners' ongoing commitment to implementing and refining strategies for addressing IPV among HMRE program participants, will help to promote conversations about IPV in HMRE programs that meet the needs of all participants.

APPENDIX A – METHODS

A.1 Site Selection

Selection of sites for the RIViR field study involved a series of steps. First, we abstracted information from all current HMRE grantees' grant applications about their target populations and targeted sample sizes, planned program activities, intake and IPV screening procedures, involvement in data collection for evaluation or research, and partnership with a local domestic violence program. Based on selection criteria for the study (see box below) and in consultation with OPRE and OFA staff, we prioritized the list of grantees and invited grantees to an informational webinar. We then requested individual phone calls with each of the high and medium priority grantees to discuss the study and learn more about their current programs, participant populations, staffing, and workflow, including potential opportunities for IPV assessment. We conducted follow-up phone calls with selected grantees that were interested in participating in the study and that offered the best fit with the study requirements. These calls enabled us to gather more information and to begin planning the specific study procedures, including the development of IRB protocols for the sites. In collaboration with OPRE and the sites, we identified three adult-serving sites for the field study.

We applied the following site selection criteria, which spoke to capacity for the required volume of data collection and basic capacity (or "organizational readiness") for addressing IPV and managing potential safety concerns related to implementing IPV screening.

- Case flow: the expected ability of the site to recruit approximately 300 participants during a 9-month window
- Opportunities for at least three independent encounters with participants
- Active, functioning partnership with local domestic violence program
- Presence of domestic violence protocol
- Ability to obtain local IRB oversight (site had a working relationship with a local Institutional Review Board that could also provide human subjects protection oversight for its role in the RIViR study)
- Diverse, English-speaking program population
- Inclusive approach to serving IPV victims and survivors (participants who indicated IPV at intake were not categorically excluded from programming)

The three selected sites each signed a Memorandum of Understanding outlining HMRE program staff responsibilities and were trained in person for two days before beginning RIViR tool administration with their program participants. The sites committed to enrolling 150 to 300 participants each, for a

total of 600 RIViR participants across the three sites. Each site received a stipend for their efforts and incentives to provide to study participants.

A.2 IPV Assessment and Universal Education Procedures

Eligible participants for RIViR were 18 years or older or legally emancipated minors and able to read and speak English. All participants were asked to sign a consent form. Staff went over the consent form during individual intake appointments and collected hardcopy signed consent forms from the participants. Participants were able to decline RIViR study participation and still participate in programming if they desired.

The three tools were offered to participants in random order over the course of the HMRE program. Each assessment took between 5 and 10 minutes and was implemented during normal programming time. Assessments were spaced a minimum of two days apart; on average, the time between the first and third completed tool was 60 days (median = 42 days). Participants who self-administered tools remained in the class space, while participants who received the universal education tool during class sessions moved to a private space for an individual interaction with a HMRE program staff member. During the universal education interaction, participants were shown and given a “safety card” with information about healthy and unhealthy relationship behaviors and local and national resources. Staff used the identification number assigned to participants by the program’s nFORM data management system to access each tool, so that the data could be linked across tools; no names were directly associated with any responses.

The two questionnaire-style IPV assessment tools measured physical violence, sexual coercion, psychological aggression, and controlling behavior. The first tool consisted of the five-item *Universal Violence Prevention Screen* and ten scaled items adapted from the *Women’s Experiences of Battering* to be gender neutral. The second tool consisted of the 15-item *Intimate Justice Scale*. The universal education tool was developed in collaboration with academic and practitioner experts, informed by the Futures Without Violence model. It was delivered in a one-on-one conversation between HMRE program staff and adult participants with support from a tablet-based guide and hard copy safety card. Tool development is described in Appendix Section A.4; the content and coding of the tools is described in Appendix B.

After completing the first IPV tool (whichever of the three tools it was), participants used the tablet to self-administer a few questions about their gender identity and sexual orientation that were not already collected via the sites’ programmatic intake survey. At the end of the third IPV tool, participants self-administered a set of survey questions about their comfort, knowledge, and perceptions of the tools, resources, and IPV-related interactions with HMRE program staff. All data were

automatically electronically transmitted directly to RTI. Program staff at the site that implemented self-administered tools received a spreadsheet from RTI after each session detailing any responses to the self-administered tools that suggested IPV victimization (for use in individual follow-up and referral with participants). RTI provided ongoing technical assistance throughout data collection.

A.3 Study Sample

Table A.1 presents the characteristics of RIViR adult study participants. The sample was largely (99.5%) cisgender and more than two-thirds of participants identified as female. Participants were racially and ethnically diverse: 36% of participants were White, 20% were Black, 18% were Hispanic/Latinx, and 17% were Native American. Most participants were 25 years or older and most had completed at least a high school diploma or GED. The sample was socioeconomically diverse and included a sizable proportion of low-income participants and participants receiving public assistance. Participants reported a mix of relationship situations and household compositions. Nearly 90% of the sample identified as heterosexual.

Table A.1. Demographic Characteristics of Study Sample (N=646)

Sex and Gender Identity^a	Frequency, %
Male	30.9
Female	69.1
Cisgender	99.5
Transgender	0.5
Race/Ethnicity and Nativity	Frequency, %
White	36.4
Black	19.5
Hispanic/Latinx	18.0
Native American	16.6
Other race or multiple races	9.6
Born in the US	91.3
Age	Frequency, %
Younger than 25	19.2
25 to 34	36.4
35 or older	44.3

Sexual Orientation	Frequency, %
Heterosexual	89.5
Gay/Lesbian/Bisexual/Other	10.5
Educational Attainment	Frequency, %
Less than high school	23.3
High school diploma or GED	40.5
More than high school	36.2
Employment and Income	Frequency, %
Working	49.3
Income under \$500/mo.	45.4
Income \$500–\$2000/mo.	36.5
Income over \$2000/mo.	18.1
Receiving public assistance	54.9
Housing Situation	Frequency, %
Own home	13.5
Rent home	53.1
Rent-free living situation	15.4
Other living situation	18.0
Family Structure	Frequency, %
In a steady relationship	52.1
Have children	67.9
Live with children	54.7

^a Assigned sex was obtained from program administrative data. Gender identity is not mutually exclusive of indication of assigned sex.

Compared to participants in the recent, five-site Parents and Children Together (PACT) study of couples-based HMRE programs, a much lower proportion of RIViR participants were in a steady relationship (52.1% of RIViR participants compared to all PACT participants). Like PACT participants, RIViR participants were mostly in their thirties and had low incomes. With respect to race/ethnicity, RIViR included fewer Hispanic/Latinx participants and more Black, White, and Native American participants (Moore et al., 2018).

A.4 Tool Selection and Development

To select tools for inclusion in the RIViR study, the team conducted a systematic review of research literature on commonly used tools for inviting IPV disclosure in 2016. This review produced a summary of psychometric properties of existing tools and the populations in which they had been validated, with a focus on validation in populations and settings similar to HMRE programs.

The review of validation studies for IPV identification tools applied the systematic review procedures specified in the U.S. Preventive Services Task Force procedures manual for evidence review (U.S. Preventive Services Task Force, 2015). We focused on literature published in 1995 and later. Search parameters were designed to identify instances of the terms *intimate partner violence*, *domestic violence*, *spouse abuse*, *partner abuse*, *psychological abuse*, *emotional abuse*, *coercive control*, *coercion*, *controlling behavior*, *financial abuse*, or *economic abuse* that coincided with *screen*, *screeener*, *screening*, *tool*, *screening protocol*, *psychometrics*, *instrument*, *measure*, *questionnaire*, *open-ended screening*, *open-ended assessment*, *qualitative screening*, and *qualitative assessment*. Tools focused on child maltreatment or child abuse were not included. For a tool to be considered validated, the published validation study had to include data on validity, such as correlation with another measure or a relative risk index, or a sensitivity estimate of at least 50%. An inventory of validated, standardized tools was prepared that summarized the results of this review.

Despite validation criteria that would be considered scientifically generous, some promising and important approaches, such as tools for universal IPV education, did not have validation information in the published literature. Further, very little validation information was available on tools for use in non-clinical settings. Validated tools were overwhelmingly tested in primary care, hospitals and other health care settings. Length of the identified tools also presented potential barriers for implementation in HMRE programs. Given that answering IPV-related questions can be a painful experience for survivors, trauma-responsive approaches are designed to elicit only as much information as is needed to serve IPV survivors safely and appropriately. In addition, opportunities for IPV assessment and universal education in HMRE programs necessarily occur in settings in which time is limited (Krieger et al., 2016).

Although shorter tools are advantageous from the perspective of staff and participant burden, they often lack coverage of important constructs. The RIViR literature review found that most brief tools addressed physical violence only, and few assessed controlling behavior. Evidence-informed theoretical work with adults suggests that it is important to include questions about controlling behavior even in brief initial screening, since other forms of IPV may not be present in couples in which one partner has already established abusive control of the other (Johnson, 2010).

From the systematic review of research literature on standardized IPV assessment tools, information about the tools' construct focus, length, psychometric properties (if established), and the populations with which they were validated or tested was compiled. Using this compilation, a short list of standardized tools was proposed for inclusion in RIViR testing efforts. This list was shared with researcher and practitioner experts as well as federal staff. Based on the information available on IPV tools at that time, the Intimate Justice Scale (IJS) was selected for fielding as one questionnaire-style tool and the Universal Violence Prevention Screen and Women's Experience with Battering questionnaires were combined as another (UVPS/WEB).

Incorporating guidance from external experts and federal interagency stakeholders, an additional review was conducted to guide the fielding of a third, universal education (UE) tool that would be focused on universal IPV education and resource sharing. This tool was intended to include an interactive conversation and opportunities for participant-driven discussion about healthy and unhealthy relationships and IPV. To guide this effort, the team also reviewed published literature on procedures for open-ended IPV disclosure opportunities and protocols for universal education. At the time of the review, the literature focused on opportunities for health care providers to ask questions of patients during individual clinical consultation in urgent care or outpatient settings, with little published evidence on universal IPV education or opportunities for open-ended conversations and participant-driven IPV disclosure in non-clinical settings. However, the Futures Without Violence model (Futures Without Violence, n.d.) identified in this review appeared promising and was met with approval from external expert and federal interagency teams. Adapting this model, a universal education tool and accompanying "safety card" containing IPV information and resources were developed for use in HMRE programs. RIViR study safety cards included national resources as well as resources specific to each site, which were chosen in consultation with HMRE program staff.

Finally, the research team reviewed and summarized published evidence on procedures for implementing IPV assessment in HMRE programs, including:

- Common implementation barriers affecting IPV disclosure opportunities
- Influence of timing on IPV disclosure
- Influence of staff qualifications and training on IPV disclosure opportunities

This body of evidence, along with practice-based knowledge (as published in grey literature and shared by the RIViR expert group) was used to guide the development of tool implementation procedures and the content of the two-day training provided to RIViR sites.

A.5 Quantitative Analytic Methods

A.5.1 Analysis of Disclosure Outcomes and Tool Psychometrics

We first examined simple descriptive statistics on IPV disclosure rates by tool (shown in Table 4-3 in the report) and by several basic demographic characteristics (shown in Table 4-1 in the report; model results are presented in Table A.2). Ordinary least squares and logistic regression models with disclosure as the dependent variable tested significance of differences in disclosure rates by demographic characteristics and how long participants had been in the HMRE program at the time they completed each tool, controlling for study site.

Table A.2 Disclosure Outcome by Demographics and Time in Program, Controlling for Site

Dependent Variable	Independent Variable	Coef.	Std.		N
			Err.	P> z	
Any IPV disclosure	Male (vs. female)	0.028	0.174	0.873	639
Any IPV disclosure	Cisgender (vs. not)	0.857	1.235	0.487	640
Any IPV disclosure	Age under 24 (vs. 35 and over)	-0.060	0.226	0.792	644
Any IPV disclosure	Ages 25 to 34 (vs. 35 and over)	0.103	0.180	0.565	644
Any IPV disclosure	Black (vs. white)	0.508	0.332	0.126	626
Any IPV disclosure	American Indian (vs. white)	0.192	0.240	0.424	626
Any IPV disclosure	Hispanic (vs. white)	0.290	0.308	0.347	626
Any IPV disclosure	Other race (vs. white)	0.788	0.321	0.014*	626
Any IPV disclosure	No degree/diploma (vs. beyond high school)	-0.098	0.217	0.651	631
Any IPV disclosure	GED/High School Diploma (vs. beyond high school)	-0.222	0.187	0.236	631
Any IPV disclosure	Heterosexual (vs. other sexual orientation)	-0.346	0.268	0.196	640
Any IPV disclosure	Born in the U.S. (vs. not)	0.291	0.302	0.337	643
Any IPV disclosure	Receive public assistance (vs. do not)	0.433	0.166	0.009*	640
Any IPV disclosure	Rent home (vs. own home)	0.371	0.246	0.131	643
Any IPV disclosure	Live rent-free (relative or someone else rents/owns the home) (vs. own home)	0.456	0.300	0.129	643

Dependent Variable	Independent Variable	Coef.	Std.		N
			Err.	P> z	
Any IPV disclosure	Other living situation (vs. own home)	0.735	0.291	0.011*	643
Any IPV disclosure	Working (vs. not)	-0.499	0.166	0.003*	626
Any IPV disclosure	Income <\$500 (vs. >\$2,000)	0.537	0.233	0.021*	596
Any IPV disclosure	Income \$500–\$2,000 (vs. >\$2,000)	0.023	0.237	0.923	596
Any IPV disclosure	In a steady relationship (vs. not)	-0.699	0.163	0.000*	638
Any IPV disclosure	Live with kids (vs. not)	0.099	0.167	0.554	595
Any IPV disclosure	Have kids (vs. not)	0.536	0.175	0.002*	623
Any IPV disclosure	Days in Program	-0.001	0.001	0.235	644

* p<.05

In order to understand and compare the accuracy of the three tools (i.e., the two questionnaire-style instruments and the universal education conversational approach) in eliciting disclosure of IPV, we constructed two types of latent class models (LCMs; (Biemer, 2011): (1) a synthetic “gold standard” model and (2) latent class analysis (LCA). Under LCMs, items in each tool or a collection of items are used as indicators to represent a latent (unobserved) construct. Proponents of this approach suggest that IPV cannot be directly measured through a survey instrument because of the high level of measurement error involved in estimating sensitive items like IPV (Berzofsky et al., 2014). Therefore, IPV is treated as a latent construct and the three tools, or components of each tool, are treated as indicators of IPV with some level of measurement error. Latent Gold 5.1 was used to conduct the latent class models (Vermunt & Magidson, 2005). We handled missing data using the procedures recommended by (Edwards et al., 2018).

Data and preliminary analysis. We assumed that, collectively, the items within the three tools measured each of four possible constructs: physical violence (PV), sexual coercion (SC), psychological aggression (PA), and controlling behavior (CB). Both questionnaire-style tools asked respondents a series of questions to determine whether the person was experiencing IPV victimization. Table A.3 lists the items for each tool, the scale of measurement and the construct the item was assigned to represent. The universal education tool was delivered in a conversational format and did not require staff to record information on the four component constructs; with this tool, the respondent’s status for the four component constructs was not ascertained. Rather, a single indicator of whether the conversation indicated IPV victimization (any or none) was recorded by the staff administering the module.

Table A.3 Subjective Mapping of Instrument Items to Constructs

Universal Violence Prevention Screen and Women’s Experiences of Battering	Construct Measured	Scale
2. If yes: Within the past year has a partner:		
2a. Slapped, kicked, pushed, choked, or punched you?	PV	(0) No;
2b. Forced or coerced you to have sex?	SC	(1) Yes
2c. Threatened you with a knife or gun to scare or hurt you?	PV	
2d. Made you afraid that you could be physically hurt?	CB	
2e. Repeatedly used words, yelled, screamed in a way that frightened you, or threatened you, put you down, or made you feel rejected?	PA	
3. She or he makes me feel unsafe even in my own home.	CB	(1) Agree
4. I feel ashamed of the things she or he does to me.	PA	Strongly;
5. I try not to rock the boat because I am afraid of what she or he might do.	CB	(2) Agree Somewhat;
6. I feel like I am programmed to react a certain way to him or her.	CB	(3) Agree a Little;
7. I feel like she or he keeps me prisoner.	CB	(4) Disagree a Little;
8. She or he makes me feel like I have no control over my life, no power, no protection.	CB	(5) Disagree Somewhat;
9. I hide the truth from others because I am afraid not to.	CB	(6) Disagree
10. I feel owned and controlled by him or her.	CB	Strongly
11. She or he can scare me without laying a hand on me.	CB	
12. She or he has a look that goes straight through me and terrifies me.	CB	

Intimate Justice Scale	Construct	
	Measured	Scale
1. My partner never admits when she or he is wrong.	PA	(1) Do Not Agree
2. My partner is unwilling to adapt to my needs and expectations.	CB	at All;
3. My partner is more insensitive than caring.	PA	(2);
4. I am often forced to sacrifice my own needs to meet my partner's needs.	CB	(3);
5. My partner refuses to talk about problems that make him or her look bad.	PA	(4);
6. My partner withholds affection unless it would benefit her or him.	CB	(5) Strongly
7. It is hard to disagree with my partner because she or he gets angry.	PA	Agree
8. My partner resents being questioned about the way he or she treats me.	PA	
9. My partner builds himself or herself up by putting me down.	PA	
10. My partner retaliates when I disagree with him or her.	CB	
11. My partner is always trying to change me.	CB	
12. My partner believes he or she has the right to force me to do things.	CB	
13. My partner is too possessive or jealous.	CB	
14. My partner tries to isolate me from family and friends.	CB	
15. Sometimes my partner physically hurts me.	PV	

As a preliminary analysis performed before the LCMs, kappa statistics were examined for items within each IPV construct and across tools. The kappa statistics provide a descriptive measure of the level of agreement between the tools (Cohen, 1968). To calculate the kappa statistics, a value for IPV victimization was assigned to each tool or item based on how the respondent endorsed the items in each tool. A respondent was coded as having experienced IPV victimization (IPV =1) or not (IPV =0) based on the following criteria:

UVPS/WEB: IPV=1 if Q2a =1 or Q2b=1 or Q2c=1 or Q2d=1 or Q2e=1 or
SUM(Q3,Q4,Q5,Q6,Q7,Q8,Q9,Q10,Q11,Q12) \geq 20¹; else IPV=0

IJS: IPV=1 if SUM(Q1,Q2,Q3,Q4,Q5,Q6,Q7,Q8,Q9,Q10,Q11,Q12,Q13,Q14,Q15) \geq 30; else IPV=0²

UE: IPV=1 if interviewer indicates IPV occurred; else IPV=0

Table A.4 presents the tool-level and item-level kappa statistics.

Synthetic “gold standard” analysis. One benefit of using LCMs to analyze tool accuracy is that it avoids the need to designate one instrument or indicator as the gold standard (or most accurate way) for identifying IPV. Instead, the synthetic “gold standard” analysis uses each instrument item as an indicator to measure each IPV construct rather than a summarized indicator at the tool level. This method does not distinguish between the tools. That is, it treats all items as part of a single tool and compares each tool to the full collection of items (i.e., the synthetic “gold standard”).

This analysis was used for two purposes; first, to estimate the sensitivity and specificity of each tool, and second, to determine if a smaller collection of items (drawn from any of the tools) could be efficiently used to measure IPV. To conduct this analysis, the LCM was constructed at the construct level. In other words, the LCM included four latent constructs rather than a single latent construct for IPV. For this analysis, each item was scored for the presence of IPV victimization based on the scoring rules above that were used to determine IPV victimization at the tool level. For items that were summed to determine IPV, the entire set of items was treated as a single “item” for the gold standard analysis.

To estimate sensitivity and specificity, a LCM was fit whereby each IPV construct was considered a latent construct with each item assigned appropriately as an indicator for that construct. For each respondent, the LCM estimated the probability of being a victim of IPV (p_{gs}). For each instrument the sensitivity was then calculated for each tool (A) across the full set of respondents (S) as:

$$Sensitivity = \frac{\sum_{A=1} p_{gs}}{\sum_S p_{gs}}$$

where A=1 indicated that the respondent’s answers to the tool classified them as a victim of IPV. In other words, sensitivity is the ratio of the sum of the probability of being a victim of IPV when the tool

¹ Items Q3–Q12 are reverse coded prior to being summed. In other words, the following scores are given to each response option prior to determining IPV status: “disagree strongly”=1, “disagree somewhat”=2, “disagree a little”=3; “agree a little”=4, “agree somewhat”=5; and “agree strongly”=6

² If a participant refused to answer all items in a sum score (i.e., the WEB or the IJS), IPV was coded as missing for that tool. The only exception is, for the UVPS/WEB, if a participant responded positively to one or more of the UVPS items, then IPV was coded 1 for that tool regardless of responses to the WEB items.

indicated that a person was a victim over the sum of the probability of being a victim across all respondents.

Table A.4 Tool-Level Agreement and Item-Level Agreement Within Construct

IPV Overall		
	IJS	Universal Education Tool
UVPS/WEB	0.37	0.08
IJS		0.08
Controlling Behavior (By Question)		
	UVPS/WEB Q2d	IJS Sum of CB Questions
UVPS/WEB Sum of CB Questions (Q3, Q5-Q12)	0.46	0.27
IJS Sum of CB Questions		0.38
Physical Violence		
UVPS/WEB Q2c		
UVPS/WEB Q2a	0.27	
Psychological Aggression		
	UVPS/WEB Sum of Q3-Q12	IJS Sum of PA Questions
UVPS/WEB Q2e	0.57	0.07
UVPS/WEB Sum of Q3-Q12		0.18

Note: Only one item (UVPS/WEB Q2b) addressed sexual coercion; therefore, sexual coercion was excluded from the construct-specific analysis.

The specificity was calculated for each tool (A) across the full set of respondents (S) as:

$$Specificity = \frac{n_{A=2} - \sum_{A=2} p_{gs}}{n - \sum_S p_{gs}}$$

where A=2 indicated that the respondent's answers to the tool classified them as not a victim of IPV. In other words, the specificity is the ratio of the sum of the probability of not being a victim of IPV among

those who did not report IPV over the sum of the probability of not being a victim of IPV across all respondents. The results of this analysis are presented in Table 4-4 of the report.

To assess whether a smaller set of items could be used to accurately determine IPV victimization, we calculated the sensitivity and specificity for each single item in the UVPS (i.e., Q2a–Q2e) and each summed item (i.e., Q3–Q12 of the WEB; Q1–Q15 of the IJS). We also calculated sensitivity and specificity for the universal education tool, which included a single indicator of the presence of IPV, as a whole. The sensitivity and specificity for each item combination was compared to the sensitivity and specificity of the “gold standard” model to determine if a set of three elements could perform as well or better than any of the three intact tools. Table A.5 presents the ten sets of items with the highest sensitivity. All of these combined tools had specificity of at least 92%. In addition, the combination of the sum of WEB items and the sum of IJS items (without a third item) had a sensitivity of 62.2% and a specificity of 96.1%.

Table A.5 Hybrid Tools with Highest Sensitivity

Item 1	Item 2	Item 3	Sensitivity, %
Within the past year, has a partner repeatedly used words, yelled, screamed in a way that frightened you, or threatened you, put you down, or made you feel rejected?	Sum of WEB items	Sum of IJS items	64.49
Within the past year, has a partner slapped, kicked, pushed, choked, or punched you?	Sum of WEB items	Sum of IJS items	63.46
Sum of WEB items	Sum of IJS items	Universal Education Tool	63.18
Within the past year, has a partner made you afraid that you could be physically hurt?	Sum of WEB items	Sum of IJS items	63.10

Item 1	Item 2	Item 3	Sensitivity, %
Within the past year, has a partner repeatedly used words, yelled, screamed in a way that frightened you, or threatened you, put you down, or made you feel rejected?	Sum of IJS items	Universal Education Tool	62.99
Within the past year, has a partner slapped, kicked, pushed, choked, or punched you?	Within the past year, has a partner repeatedly used words, yelled, screamed in a way that frightened you, or threatened you, put you down, or made you feel rejected?	Sum of IJS items	62.64
Within the past year, has a partner forced or coerced you to have sex?	Sum of WEB items	Sum of IJS items	62.56
Within the past year, has a partner threatened you with a knife or gun to scare or hurt you?	Sum of WEB items	Sum of IJS items	62.48
Within the past year, has a partner made you afraid that you could be physically hurt?	Within the past year, has a partner repeatedly used words, yelled, screamed in a way that frightened you, or threatened you, put you down, or made you feel rejected?	Sum of IJS items	62.45
Within the past year, has a partner forced or coerced you to have sex?	Within the past year, has a partner repeatedly used words, yelled, screamed in a way that frightened you, or threatened you, put you down, or made you feel rejected?	Sum of IJS items	62.43

Latent class analysis. The LCA—the second LCM analysis—was conducted to measure the classification error across the three tools. This analysis produced the false positive and false negative rate associated with each tool. To fit the LCMs for this model, we followed the methodology established by (Berzofsky et al., 2014). Under this methodology, we first determined the best grouping variables for the measurement component of the model; for example, demographic characteristics for which there is homogeneous measurement error. The measurement component of the model produced the estimates of the false positive and false negative rates shown in Table A.6. Second, we fit the structural component of the LCM. The structural component estimates the error-free prevalence of IPV (shown in the “Any IPV” columns in Table A.6). To control for differences across the three sites, site was included in the structural component of the model. The grouping variables included committed relationship status (married/engaged/with a steady partner vs. no relationship/steady partner) and living with at least one child. Site was also included in the measurement component of the model.

Table A.6 Estimated Error-Free Prevalence of IPV and False Positive and False Negative Rates for Each Tool

	Any IPV	No IPV	UVPS/ WEB False -	UVPS/ WEB False +	IJS False -	IJS False +	Universal Education Tool False -	Universal Education Tool False +
Est	34	66	20	10	9	33	88	1
Percent, %								
SE	3.5	3.5	5.3	2.3	3.9	3.3	2.8	0.6
95% CI	(27, 41)	(59, 73)	(11, 32)	(6, 15)	(3, 20)	(27, 40)	(82, 93)	(0, 3)

Table A.7 presents a comparison of the fit statistics for the full and reduced LCA models. After determining the most appropriate grouping variables (i.e., site, relationship status, and living with children), Wald tests were used to determine if the model could be reduced by removing nonsignificant interaction terms. As Table A.7 shows, the reduced model was not statistically different from the full model, indicating that the reduced model was sufficient; therefore, this reduced model was selected as the final model. Table A.8 presents the regression parameters associated with the final LCA model using reference cell coding.

Table A.7 Fit Statistics for Full and Reduced LCA Models

LCA Model Selection	Full Model	Reduced Model
	{T _A XABC}	{T _A XA T _A XB T _A XC}
	{T _B XABC} {T _C XABC}	{T _B XA T _B XB T _B XC} {T _C XA T _C XB T _C XC}
N	646	646
# of Parameters	75	33
DF	201	243
LL	-686	-708
BIC (LL)	1858	1631
Dissimilarity Index	0.14	0.18
Wald Test		27.87
DF		42
p-value		0.95

A = Site; B = 2-Level Committed Relationship Indicator; C = 2-Level Live with Children Indicator
T_i = IPV indicator for Tool i; X = Latent IPV indicator; I_{ij} = IPV indicator based on Question j from Tool i

Table A.8 Regression Parameters for the Final LCA Model

Regression Parameters with Reference Cell Coding

Structural Model		
IPV Term	Coefficient	S.E.
1	-0.14	0.33
site (1)	0.10	0.38
site (2)	-1.93	0.51

Measurement Models						
Term	UVPS/ WEB Coefficient	UVPS /WEB S.E.	IJS Coefficient	IJS S.E.	Universal Education Tool Coefficient	Universal Education Tool S.E.
1	-1.99	0.63	-1.56	0.52	-8.76	4.57
IPV (yes)	3.64	1.28	4.48	1.65	6.37	4.63
site (1)	-3.13	3.56	0.58	0.52	0.21	4.99
site (2)	0.05	0.60	0.30	0.47	2.45	3.54
relationship status (not in committed relationship)	0.31	0.47	0.99	0.28	3.60	3.02
live with at least 1 child (no)	-0.38	0.52	0.08	0.29	-2.90	3.97
site (1) * IPV (yes)	6.15	3.94	-1.89	1.61	-0.90	5.06
site (2) * IPV (yes)	0.61	1.36	1.60	3.89	-0.43	3.67
relationship status (not in committed relationship) * IPV (yes)	1.88	1.02	3.54	3.01	-4.62	3.10
live with at least 1 child (no) * IPV (yes)	-2.62	1.31	-1.44	0.96	3.78	4.08

Table A.9 presents the final LCA and synthetic “gold standard” LCM models using Goodman notation (Goodman, 1974) and the associated model fit statistics.

Table A.9. Model Specifications and Model Fit Statistics for LCA and “Gold Standard” Models

Model Name	Model Specification	N	# of		LL	BIC (LL)	Dissimilarity
			Parameters	DF			Index
LCA Model	(Mauro et al., 2019) {T _A X _A T _A X _B } {T _B X _A T _B X _B } {T _C X _A T _C X _B }	646	33	243	-708.50	1630.53	0.18
Gold Standard	{PvSc PvPa PvCb} {ScPa ScCb} {PaCb} {I _{A2a} PV I _{A2a} I _{A2d} I _{A2a} I _{A2e} } {I _{A2b} Sc I _{A2b} I _{A2d} } {I _{A2c} PV I _{A2c} I _{A2d} } {I _{A2d} Cb} {I _{A2e} Pa I _{A2e} I _{A2d} } {I _{Asum(Q3-Q12)} Cb I _{Asum(Q3-Q12)} Pa I _{Asum(Q3-Q12)} } I _{A2d} I _{Asum(Q3-Q12)} I _{A2e} }	646	36	219	-1185.49	2603.93	0.13

A = Site; B = 2-Level Committed Relationship Indicator; C = 2-Level Live with Children Indicator

T_i = IPV indicator for Tool i; X = Latent IPV indicator; I_{ij} = IPV indicator based on Question j from Tool i

Pv = Latent Physical Violence IPV indicator; Sc = Latent Sexual Coercion IPV indicator;

Pa = Latent Psychological Aggression IPV indicator; Cb = Latent Controlling Behavior IPV indicator

A.5.2 Analysis of Responses to Tools

Responses to the RIViR tools were assessed using survey data about participants’ comfort, knowledge, and perceptions of IPV screening tools, resources, and interactions with HMRE program staff. These questions were self-administered by participants on tablets at the time of their third and final tool administration (either a questionnaire-style tool or the universal education conversation with staff). Therefore, approximately one-third of the sample answered the questions in reference to each of the three tools, and we leveraged this variation to examine differences in participants’ perceptions according to the tool with which they were associated. The analysis applied descriptive statistics to examine how participants experienced and perceived the tools/interactions and the outcomes other than disclosure that were associated with these experiences. Specifically, we examined:

- Participants’ perceptions of the questions/conversation
- Participants’ comfort with the screening process (including mode, setting, ability to answer the questions openly, confidence that staff would protect their privacy, feeling respected by staff)
- Participants’ comfort approaching HMRE program staff or others with relationship or safety concerns
- Participants’ knowledge of available resources and options for maintaining safety

To reduce the number of analyses conducted, we examined correlations among the items and combined items about participant comfort and number of resources the participant knew how to access (see “Composite Measures of Participant Responses to Tools,” below). The comfort composite was created by standardizing each item and creating an average across items. The number of resources composite was created by summing all items; “none of the above” answers were scored 0. All other questions were analyzed separately; all were dichotomized because of skewed frequency distributions or, in the case of the question about mode preference, to reduce the number of response categories.

Composite Measure of Participant Comfort with Staff	Composite Measure of Number of Resources Participants Know How to Access
[HMRE program] staff respect my privacy.	A local organization that offers domestic violence services
In this program, I can share things about my life on my own terms and at my own pace.	National hotline for adults being abused by a dating partner or spouse
I can trust [HMRE program] staff.	A hotline for survivors of rape, incest, and abuse
I feel respected by staff in [HMRE program].	
I am comfortable talking about any challenges I am having in an intimate relationship (e.g., with my dating partner, girlfriend/boyfriend, hook-ups, spouse, or domestic partner) with a [HMRE program] member.	
I feel comfortable asking for help to keep safe.	

We then used ordinary least squares regression (for continuous outcomes) and logistic regression models (for dichotomous outcomes) in Stata version 15.1 (Stata Corp LP, 2017) to determine whether the mean values obtained for each of these measures differed significantly across three groups: those who answered the questions in reference to the UVPS/WEB tool, those who completed it in association with the IJS tool, and those who completed it in association with the universal education tool. Because there were significant differences between the three sites on several responses, we controlled for site in all models. Model results from these analyses are shown in Table A.10. Given that there were nine domains per analysis, the significance levels were adjusted, using a Bonferroni correction, to $.05/9 = .0056$.

Table A.10 Responses by Tool, Controlling for Site

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
Overall, how clear were the questions?	UVPS/WEB (vs. UE)	-1.445	0.573	0.012	476
	IJS (vs. UE)	-1.432	0.566	0.011	476
How comfortable were you with the conversation/ questions?	UVPS/WEB (vs. UE)	-1.180	0.310	0.000*	475
	IJS (vs. UE)	-0.872	0.310	0.005*	475
Did you answer the questions very openly?	UVPS/WEB (vs. UE)	0.666	0.384	0.082	477
	IJS (vs. UE)	1.111	0.417	0.008	477
Would you prefer to answer questions like these on a tablet, smartphone, or computer (vs. talking to a staff person in-person or on the phone)?	UVPS/WEB (vs. UE)	1.718	0.286	0.000*	461
	IJS (vs. UE)	1.616	0.279	0.000*	461
How much of the time were you concerned that someone else might see or hear you answering the questions?	UVPS/WEB (vs. UE)	0.088	0.361	0.808	473
	IJS (vs. UE)	-0.068	0.341	0.841	473

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
Do you know your options for keeping yourself safe?	UVPS/WEB (vs. UE)	-0.262	0.556	0.638	475
	IJS (vs. UE)	0.589	0.657	0.370	475
How likely are you to share information about these types of programs or services with someone you know?	UVPS/WEB (vs. UE)	0.339	0.281	0.228	471
	IJS (vs. UE)	-0.054	0.258	0.835	471
Number of resources participants know how to access	UVPS/WEB (vs. UE)	0.018	0.123	0.885	443
	IJS (vs. UE)	-0.026	0.118	0.825	443
Comfort with staff	UVPS/WEB (vs. UE)	0.032	0.079	0.687	477
	IJS (vs. UE)	0.019	0.077	0.802	477

* $p < .0056$, the critical alpha for this analysis based on a Bonferroni correction for multiple comparisons.

We also used the same types of regression models to compare how members of different demographic sub-groups experienced the tools, including by gender, race and ethnicity, age, sexual orientation, education, socioeconomic characteristics, and family structure. We tested whether any of these responses differed according to how long participants had been enrolled in the HMRE program at the time they completed the third tool, staff gender, and staff-participant gender congruence. In addition, we assessed whether these responses differed between those who disclosed IPV and those who did not disclose. The results of these models are presented in Tables A.11 through A.14.

Table A.11 Responses by Demographics, Controlling for Site

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
Overall, how clear were the questions?	Male (vs. female)	0.221	0.376	0.558	474
	Age under 24 (vs. 35 and over)	-0.815	0.451	0.071	475
	Ages 25 to 34 (vs. 35 and over)	-0.338	0.403	0.402	475
	Black (vs. white)	-0.625	0.651	0.337	461
	American Indian (vs. white)	-0.256	0.558	0.647	461

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
	Hispanic (vs. white)	-0.552	0.618	0.372	461
	Other race (vs. white)	-0.675	0.577	0.242	461
	No degree/diploma (vs. beyond high school)	-0.388	0.462	0.400	464
	GED/High School Diploma (vs. beyond high school)	-0.115	0.406	0.777	464
	Heterosexual (vs. other sexual orientation)	0.410	0.471	0.384	474
	Born in the U.S. (vs. not)	0.359	0.550	0.514	474
	Receive public assistance (vs. do not)	-0.230	0.360	0.523	471
	Rent home (vs. own home)	-0.098	0.531	0.854	474
	Live rent-free (relative or someone else rents/owns the home) (vs. own home)	-0.203	0.616	0.742	474
	Other living situation (vs. own home)	-0.153	0.612	0.803	474
	Working (vs. not)	-0.080	0.344	0.817	461
	Income <\$500 (vs. >\$2,000)	-0.365	0.542	0.500	432
	Income \$500-\$2,000 (vs. >\$2,000)	-0.122	0.560	0.828	432
	In a steady relationship (vs. not)	-0.367	0.346	0.289	471
	Live with kids (vs. not)	0.051	0.352	0.885	439
	Have kids (vs. not)	-0.234	0.377	0.535	460
How comfortable were you with the conversation/questions?	Male (vs. female)	-0.341	0.229	0.137	474
	Age under 24 (vs. 35 and over)	-0.697	0.302	0.021	474
	Ages 25 to 34 (vs. 35 and over)	-0.391	0.257	0.128	474
	Black (vs. white)	0.007	0.451	0.988	460
	American Indian (vs. white)	-0.064	0.350	0.855	460
	Hispanic (vs. white)	-0.145	0.410	0.725	460
	Other race (vs. white)	-0.339	0.387	0.381	460
	No degree/diploma (vs. beyond high school)	-0.280	0.305	0.358	463

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
	GED/High School Diploma (vs. beyond high school)	0.142	0.262	0.588	463
	Heterosexual (vs. other sexual orientation)	0.690	0.312	0.027	473
	Born in the U.S. (vs. not)	-0.201	0.428	0.639	473
	Receive public assistance (vs. do not)	-0.217	0.235	0.356	470
	Rent home (vs. own home)	0.125	0.323	0.700	473
	Live rent-free (relative or someone else rents/owns the home) (vs. own home)	-0.063	0.381	0.868	473
	Other living situation (vs. own home)	0.354	0.396	0.372	473
	Working (vs. not)	0.217	0.226	0.337	460
	Income <\$500 (vs. >\$2,000)	-0.197	0.325	0.544	431
	Income \$500-\$2,000 (vs. >\$2,000)	-0.057	0.330	0.864	431
	In a steady relationship (vs. not)	0.199	0.222	0.370	470
	Live with kids (vs. not)	0.010	0.232	0.965	438
	Have kids (vs. not)	-0.050	0.241	0.835	459
Did you answer the questions very openly?	Male (vs. female)	-0.336	0.336	0.317	475
	Age under 24 (vs. 35 and over)	-0.530	0.454	0.243	476
	Ages 25 to 34 (vs. 35 and over)	-0.496	0.376	0.187	476
	Black (vs. white)	0.052	0.681	0.939	462
	American Indian (vs. white)	-0.214	0.511	0.676	462
	Hispanic (vs. white)	-0.627	0.573	0.274	462
	Other race (vs. white)	-0.661	0.531	0.214	462
	No degree/diploma (vs. beyond high school)	-0.777	0.412	0.059	465
	GED/High School Diploma (vs. beyond high school)	0.396	0.418	0.344	465
	Heterosexual (vs. other sexual orientation)	0.303	0.469	0.518	475

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
	Born in the U.S. (vs. not)	0.986	0.512	0.054	475
	Receive public assistance (vs. do not)	0.307	0.341	0.368	472
	Rent home (vs. own home)	-0.387	0.522	0.458	475
	Live rent-free (relative or someone else rents/owns the home) (vs. own home)	-0.085	0.635	0.893	475
	Born in the U.S. (vs. not)	0.986	0.512	0.054	475
	Receive public assistance (vs. do not)	0.307	0.341	0.368	472
	Rent home (vs. own home)	-0.387	0.522	0.458	475
	Live rent-free (relative or someone else rents/owns the home) (vs. own home)	-0.085	0.635	0.893	475
	Other living situation (vs. own home)	-0.325	0.598	0.588	475
	Working (vs. not)	-0.127	0.330	0.700	462
	Income <\$500 (vs. >\$2,000)	-0.776	0.524	0.139	433
	Income \$500-\$2,000 (vs. >\$2,000)	-0.235	0.553	0.670	433
	In a steady relationship (vs. not)	-0.163	0.330	0.622	472
	Live with kids (vs. not)	0.355	0.348	0.308	440
	Have kids (vs. not)	0.132	0.346	0.704	461

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
Would you prefer to answer questions like these on a tablet, smartphone, or computer (vs. talking to a staff person in person or on the phone)?	Male (vs. female)	-0.145	0.218	0.506	459
	Age under 24 (vs. 35 and over)	0.526	0.294	0.074	460
	Ages 25 to 34 (vs. 35 and over)	0.374	0.227	0.100	460
	Black (vs. white)	-0.520	0.392	0.185	446
	American Indian (vs. white)	0.062	0.351	0.859	446
	Hispanic (vs. white)	-0.585	0.369	0.113	446
	Other race (vs. white)	-0.115	0.383	0.764	446
	No degree/diploma (vs. beyond high school)	0.119	0.287	0.678	450
	GED/High School Diploma (vs. beyond high school)	-0.018	0.239	0.940	450
	Heterosexual (vs. other sexual orientation)	0.238	0.335	0.477	459
	Born in the U.S. (vs. not)	0.191	0.351	0.587	459
	Receive public assistance (vs. do not)	-0.327	0.212	0.123	457
	Rent home (vs. own home)	-0.056	0.307	0.855	459
	Live rent-free (relative or someone else rents/owns the home) (vs. own home)	0.481	0.371	0.195	459
	Other living situation (vs. own home)	-0.055	0.360	0.880	459
	Working (vs. not)	0.181	0.207	0.382	446
	Income <\$500 (vs. >\$2,000)	0.007	0.298	0.982	418
	Income \$500-\$2,000 (vs. >\$2,000)	-0.124	0.302	0.681	418
	In a steady relationship (vs. not)	-0.078	0.204	0.702	457
	Live with kids (vs. not)	-0.148	0.215	0.492	425
Have kids (vs. not)	-0.264	0.221	0.233	446	

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
How much of the time were you concerned that someone else might see or hear you answering the questions?	Male (vs. female)	-0.353	0.295	0.231	471
	Age under 24 (vs. 35 and over)	-0.800	0.395	0.043	472
	Ages 25 to 34 (vs. 35 and over)	-0.517	0.332	0.119	472
	Black (vs. white)	-0.396	0.567	0.485	458
	American Indian (vs. white)	-0.398	0.463	0.389	458
	Hispanic (vs. white)	-0.559	0.534	0.295	458
	Other race (vs. white)	-0.565	0.525	0.282	458
	No degree/diploma (vs. beyond high school)	-0.507	0.386	0.189	462
	GED/High School Diploma (vs. beyond high school)	-0.076	0.353	0.830	462
	Heterosexual (vs. other sexual orientation)	-0.577	0.541	0.286	471
	Born in the U.S. (vs. not)	-0.061	0.489	0.900	471
	Receive public assistance (vs. do not)	-0.259	0.305	0.396	468
	Rent home (vs. own home)	-0.860	0.559	0.124	471
	Live rent-free (relative or someone else rents/owns the home) (vs. own home)	-1.465	0.595	0.014	471
	Other living situation (vs. own home)	-0.173	0.671	0.797	471
	Working (vs. not)	0.151	0.296	0.609	458
	Income <\$500 (vs. >\$2,000)	-0.767	0.477	0.108	429
	Income \$500-\$2,000 (vs. >\$2,000)	-0.214	0.506	0.672	429
	In a steady relationship (vs. not)	0.106	0.290	0.715	468
	Live with kids (vs. not)	-0.111	0.311	0.721	437
Have kids (vs. not)	-0.049	0.316	0.878	457	

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
Do you know your options for keeping yourself safe?	Male (vs. female)	-0.201	0.497	0.686	473
	Age under 24 (vs. 35 and over)	-0.800	0.395	0.043	472
	Ages 25 to 34 (vs. 35 and over)	-0.517	0.332	0.119	472
	Black (vs. white)	-0.396	0.567	0.485	458
	American Indian (vs. white)	-0.398	0.463	0.389	458
	Hispanic (vs. white)	-0.559	0.534	0.295	458
	Other race (vs. white)	-0.565	0.525	0.282	458
	No degree/diploma (vs. beyond high school)	-0.507	0.386	0.189	462
	GED/High School Diploma (vs. beyond high school)	-0.076	0.353	0.830	462
	Heterosexual (vs. other sexual orientation)	0.817	0.589	0.165	473
	Born in the U.S. (vs. not)	—	—	—	—
	Receive public assistance (vs. do not)	-0.771	0.536	0.150	470
	Rent home (vs. own home)	0.142	0.702	0.840	473
	Live rent-free (relative or someone else rents/owns the home) (vs. own home)	-0.490	0.761	0.519	473
	Other living situation (vs. own home)	0.577	0.932	0.536	473
	Working (vs. not)	-0.233	0.510	0.647	460
	Income <\$500 (vs. >\$2,000)	-0.609	0.822	0.458	431
	Income \$500–\$2,000 (vs. >\$2,000)	-0.468	0.832	0.574	431
	In a steady relationship (vs. not)	-0.348	0.494	0.481	470
	Live with kids (vs. not)	0.157	0.502	0.754	438
Have kids (vs. not)	0.690	0.490	0.159	460	

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
How likely are you to share information about these types of programs or services with someone you know?	Male (vs. female)	-1.235	0.225	0.000*	470
	Age under 24 (vs. 35 and over)	-0.336	0.289	0.245	470
	Ages 25 to 34 (vs. 35 and over)	0.568	0.261	0.029	470
	Black (vs. white)	-0.018	0.425	0.965	456
	American Indian (vs. white)	0.541	0.369	0.143	456
	Hispanic (vs. white)	0.546	0.425	0.199	456
	Other race (vs. white)	0.108	0.401	0.788	456
	No degree/diploma (vs. beyond high school)	0.345	0.313	0.271	459
	GED/High School Diploma (vs. beyond high school)	0.231	0.251	0.357	459
	Heterosexual (vs. other sexual orientation)	0.216	0.329	0.513	469
	Born in the U.S. (vs. not)	-0.376	0.424	0.375	469
	Receive public assistance (vs. do not)	0.227	0.228	0.320	466
	Rent home (vs. own home)	0.022	0.335	0.949	469
	Live rent-free (relative or someone else rents/owns the home) (vs. own home)	-0.488	0.382	0.202	469
	Other living situation (vs. own home)	-0.150	0.386	0.697	469
	Working (vs. not)	-0.184	0.222	0.408	456
	Income <\$500 (vs. >\$2,000)	-0.043	0.306	0.889	427
	Income \$500-\$2,000 (vs. >\$2,000)	0.300	0.318	0.345	427
	In a steady relationship (vs. not)	0.003	0.219	0.988	466
	Live with kids (vs. not)	0.788	0.237	0.001*	434
Have kids (vs. not)	0.580	0.232	0.013	455	

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
Comfort with staff	Male (vs. female)	0.032	0.065	0.622	475
	Age under 24 (vs. 35 and over)	-0.054	0.089	0.542	476
	Ages 25 to 34 (vs. 35 and over)	0.092	0.071	0.197	476
	Black (vs. white)	-0.074	0.126	0.556	462
	American Indian (vs. white)	-0.274	0.107	0.011	462
	Hispanic (vs. white)	0.009	0.119	0.941	462
	Other race (vs. white)	-0.075	0.120	0.531	462
	No degree/diploma (vs. beyond high school)	-0.230	0.089	0.010	465
	GED/High School Diploma (vs. beyond high school)	-0.006	0.074	0.936	465
	Heterosexual (vs. other sexual orientation)	0.188	0.099	0.057	475
	Born in the U.S. (vs. not)	-0.067	0.106	0.526	475
	Receive public assistance (vs. do not)	-0.135	0.066	0.041	472
	Rent home (vs. own home)	-0.020	0.096	0.832	475
	Live rent-free (relative or someone else rents/owns the home) (vs. own home)	-0.155	0.114	0.174	475
	Other living situation (vs. own home)	0.043	0.113	0.704	475
	Working (vs. not)	0.104	0.065	0.112	462
	Income <\$500 (vs. >\$2,000)	-0.061	0.096	0.524	433
	Income \$500-\$2,000 (vs. >\$2,000)	0.004	0.097	0.967	433
	In a steady relationship (vs. not)	0.041	0.063	0.521	472
	Live with kids (vs. not)	0.012	0.068	0.857	440
Have kids (vs. not)	-0.062	0.068	0.366	461	

* $p < .0056$, the critical alpha for this analysis based on a Bonferroni correction for multiple comparisons.

Note: One model for nativity to the US did not converge because of a lack of variability.

Table A.12 Responses by Time in Program, Controlling for Site

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z 	N
Overall, how clear were the questions?	Days in program	0.000	0.002	0.822	475
How comfortable were you with the conversation/ questions?	Days in program	-0.001	0.001	0.632	474
Did you answer the questions very openly?	Days in program	0.003	0.003	0.376	476
Would you prefer to answer questions like these on a tablet, smartphone, or computer (vs. talking to a staff person in-person or on the phone)?	Days in program	0.000	0.001	0.959	460
How much of the time were you concerned that someone else might see or hear you answering the questions?	Days in program	0.001	0.002	0.530	472
Do you know your options for keeping yourself safe?	Days in program	0.006	0.008	0.442	474
How likely are you to share information about these types of programs or services with someone you know?	Days in program	0.002	0.002	0.222	470
Number of resources participants know how to access	Days in program	0.001	0.001	0.102	442
Comfort with staff	Days in program	0.000	0.000	0.801	476

* p<.0056, the critical alpha for this analysis based on a Bonferroni correction for multiple comparisons.

Table A.13 Responses by Staff Gender and Staff-Participant Gender Congruence, Controlling for Site

Dependent Variable	Independent Variable	Coef.	Std.		N
			Err.	P> z	
Overall, how clear were the questions?	Staff is all male (vs. all female)	-0.646	0.649	0.320	474
	Staff gender is mixed across tools (vs. all female)	0.251	0.741	0.735	474
	Staff-participant gender congruence (yes/no)	-0.102	0.355	0.773	473
How comfortable were you with the conversation/questions?	Staff is all male (vs. all female)	-0.117	0.406	0.772	473
	Staff gender is mixed across tools (vs. all female)	0.494	0.434	0.255	473
	Staff-participant gender congruence (yes/no)	0.107	0.227	0.638	473
Did you answer the questions very openly?	Staff is all male (vs. all female)	-0.346	0.612	0.572	475
	Staff gender is mixed across tools (vs. all female)	-0.044	0.628	0.943	475
	Staff-participant gender congruence (yes/no)	0.434	0.338	0.199	474
Would you prefer to answer questions like these on a tablet, smartphone, or computer (vs. talking to a staff person in-person or on the phone)?	Staff is all male (vs. all female)	0.021	0.445	0.962	459
	Staff gender is mixed across tools (vs. all female)	-0.588	0.420	0.161	459
	Staff-participant gender congruence (yes/no)	-0.028	0.211	0.894	458

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
How much of the time were you concerned that someone else might see or hear you answering the questions?	Staff is all male (vs. all female)	-0.024	0.603	0.968	471
	Staff gender is mixed across tools (vs. all female)	0.172	0.592	0.772	471
	Staff-participant gender congruence (yes/no)	0.377	0.292	0.198	470
Do you know your options for keeping yourself safe?	Staff is all male (vs. all female)	0.409	0.951	0.667	473
	Staff gender is mixed across tools (vs. all female)	-0.147	0.831	0.860	473
	Staff-participant gender congruence (yes/no)	-0.635	0.522	0.224	472
How likely are you to share information about these types of programs or services with someone you know?	Staff is all male (vs. all female)	-0.660	0.443	0.136	469
	Staff gender is mixed across tools (vs. all female)	-0.435	0.427	0.309	469
	Staff-participant gender congruence (yes/no)	0.820	0.228	0.000*	469
Number of resources participants know how to access	Staff is all male (vs. all female)	0.018	0.190	0.923	442
	Staff gender is mixed across tools (vs. all female)	0.232	0.181	0.200	442
	Staff-participant gender congruence (yes/no)	0.066	0.101	0.511	441
Comfort with staff	Staff is all male (vs. all female)	-0.018	0.125	0.887	475
	Staff gender is mixed across tools (vs. all female)	-0.082	0.119	0.489	475

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
	Staff-participant gender congruence (yes/no)	0.070	0.063	0.271	474

* p<.0056, the critical alpha for this analysis based on a Bonferroni correction for multiple comparisons.

Table A.14 Responses by Disclosure Status, Controlling for Site

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
Overall, how clear were the questions?	Any IPV disclosure (vs. no IPV disclosure)	-0.368	0.353	0.298	476
	Any IPV disclosure on UVPS/WEB (vs. no IPV disclosure on UVPS/WEB)	-1.505	0.557	0.007	153
	Any IPV disclosure on IJS (vs. no IPV disclosure on IJS)	-0.054	0.516	0.917	174
	Any IPV disclosure on UE (vs. no IPV disclosure on UE)	-3.200	1.421	0.024	147
How comfortable were you with the conversation/questions?	Any IPV disclosure (vs. no IPV disclosure)	-0.428	0.229	0.062	475
	Any IPV disclosure on UVPS/WEB (vs. no IPV disclosure on UVPS/WEB)	-0.921	0.405	0.023	152
	Any IPV disclosure on IJS (vs. no IPV disclosure on IJS)	-0.273	0.365	0.454	175
	Any IPV disclosure on UE (vs. no IPV disclosure on UE)	-1.491	1.283	0.245	146
Did you answer the questions very openly?	Any IPV disclosure (vs. no IPV disclosure)	-0.747	0.358	0.037	477
	Any IPV disclosure on UVPS/WEB (vs. no IPV disclosure on UVPS/WEB)	-1.710	0.668	0.010	153

Dependent Variable	Independent Variable	Coef.	Std.		N
			Err.	P> z	
	Any IPV disclosure on IJS (vs. no IPV disclosure on IJS)	0.079	0.706	0.911	175
	Any IPV disclosure on UE (vs. no IPV disclosure on UE)	-1.344	1.266	0.288	147
Would you prefer to answer questions like these on a tablet, smartphone, or computer?	Any IPV disclosure (vs. no IPV disclosure)	-0.066	0.207	0.749	461
	Any IPV disclosure on UVPS/WEB (vs. no IPV disclosure on UVPS/WEB)	-1.095	0.482	0.023	152
	Any IPV disclosure on IJS (vs. no IPV disclosure on IJS)	0.084	0.388	0.828	168
	Any IPV disclosure on UE (vs. no IPV disclosure on UE)	1.409	1.454	0.332	139
How much of the time were you concerned that someone else might see or hear you answering the questions?	Any IPV disclosure (vs. no IPV disclosure)	-1.189	0.334	0.000*	473
	Any IPV disclosure on UVPS/WEB (vs. no IPV disclosure on UVPS/WEB)	-1.834	0.560	0.001*	153
	Any IPV disclosure on IJS (vs. no IPV disclosure on IJS)	-1.380	0.521	0.008	171
	Any IPV disclosure on UE (vs. no IPV disclosure on UE)	-1.382	1.285	0.282	147
Do you know your options for keeping yourself safe?	Any IPV disclosure (vs. no IPV disclosure)	-1.027	0.579	0.076	475
	Any IPV disclosure on UVPS/WEB (vs. no IPV disclosure on UVPS/WEB)	-1.053	0.745	0.157	153
	Any IPV disclosure on IJS (vs. no IPV disclosure on IJS)	—	—	—	—
	Any IPV disclosure on UE (vs. no IPV disclosure on UE)	-3.201	1.533	0.037	145

Dependent Variable	Independent Variable	Coef.	Std. Err.	P> z	N
How likely are you to share information about these types of programs or services with someone you know?	Any IPV disclosure (vs. no IPV disclosure)	-0.273	0.222	0.220	471
	Any IPV disclosure on UVPS/WEB (vs. no IPV disclosure on UVPS/WEB)	-0.574	0.448	0.200	150
	Any IPV disclosure on IJS (vs. no IPV disclosure on IJS)	0.093	0.355	0.792	175
	Any IPV disclosure on UE (vs. no IPV disclosure on UE)	-0.812	1.258	0.518	144
Number of resources they know how to access	Any IPV disclosure (vs. no IPV disclosure)	0.014	0.098	0.890	443
	Any IPV disclosure on UVPS/WEB (vs. no IPV disclosure on UVPS/WEB)	0.109	0.231	0.636	140
	Any IPV disclosure on IJS (vs. no IPV disclosure on IJS)	0.009	0.158	0.952	163
	Any IPV disclosure on UE (vs. no IPV disclosure on UE)	-0.130	0.577	0.823	138
Comfort with staff	Any IPV disclosure (vs. no IPV disclosure)	-0.144	0.063	0.023	477
	Any IPV disclosure on UVPS/WEB (vs. no IPV disclosure on UVPS/WEB)	-0.433	0.124	0.001*	153
	Any IPV disclosure on IJS (vs. no IPV disclosure on IJS)	-0.220	0.106	0.039	175
	Any IPV disclosure on UE (vs. no IPV disclosure on UE)	-1.556	0.392	0.000*	147

* p<.0056, the critical alpha for this analysis based on a Bonferroni correction for multiple comparisons.

Note: One model for any IPV disclosure on the IJS did not converge because of a lack of variability.

Finally, we used regression models to examine moderation of tool differences in responses by participant sex, race/ethnicity, educational attainment, nativity to US, employment status, relationship status, parental status, and IPV disclosure status. These models included main effects of tool and the moderator variable and interaction terms between the tools and the moderator variable. Only one significant interaction was found (participants who were not working reported more openness on the questionnaire-style tools than the universal education tool); however, this analysis was limited by small cell sizes for some interaction effects.

A.6 Qualitative Analytic Methods

The RIViR team conducted onsite qualitative interviews with HMRE program staff, their local domestic violence program partners, and adult participants in each adult-serving study site. Three HMRE program leadership team members (administrative coordinators) and ten HMRE program staff (facilitators and case managers), two domestic violence program staff, and nine adult participants were interviewed in total. All interviews were digitally audio recorded. A professional transcriptionist prepared deidentified, verbatim transcripts for each interview.

The research team prepared a qualitative codebook with deductive codes based on the study research questions and coded each transcript in ATLAS.ti (Muhr, 1991). Structured queries were run in ATLAS.ti to glean textual data related to each research question. Query results were reviewed for inductive themes. A file documenting all evident themes, and the text passages that substantiated them, was prepared and reviewed by the research team.

APPENDIX B – TOOLS AND INSTRUMENTS

Each of the questionnaire-style tools (the first two tools in this appendix) is shown in the form in which it was used for face-to-face administration by HMRE program staff to participants. For the subset of cases in which these tools were self-administered by adult participants on tablets (see main report Section 2: Study Purpose and Design), introductory language was adapted to reflect self-administration.

B.1 Universal Violence Prevention Screen/Women’s Experiences of Battering Items and Scoring

First, I will ask you some questions and you can just answer yes or no.

	Answer		Prefer not to answer
	No	Yes	
1. Have you been in a relationship with a partner in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <i>If yes:</i> Within the past year has a partner:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(a) Slapped, kicked, pushed, choked, or punched you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Forced or coerced you to have sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Threatened you with a knife or gun to scare or hurt you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Made you afraid that you could be physically hurt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Repeatedly used words, yelled, screamed in a way that frightened you, or threatened you, put you down, or made you feel rejected?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Code	Text
1	Yes
0	No
99	Prefer not to answer

Next are a number of statements that people have used to describe their relationships with their partners. I will read each statement and ask you to give the answer that best describes how much you agree or disagree in general with each one as a description of your relationship with your partner. If you do not now have a partner, think about your last one. There are no right or wrong answers; just choose the answer that seems to best describe how much you agree or disagree with it.

	Agree Strongly	Agree Some- what	Agree a Little	Disagree a Little	Disagree Some- what	Disagree Strongly	Prefer not to answer
3. She or he makes me feel unsafe even in my own home.	1	2	3	4	5	6	<input type="checkbox"/>
4. I feel ashamed of the things she or he does to me.	1	2	3	4	5	6	<input type="checkbox"/>
5. I try not to rock the boat because I am afraid of what she or he might do.	1	2	3	4	5	6	<input type="checkbox"/>
6. I feel like I am programmed to react a certain way to him or her.	1	2	3	4	5	6	<input type="checkbox"/>
7. I feel like she or he keeps me prisoner.	1	2	3	4	5	6	<input type="checkbox"/>
8. She or he makes me feel like I have no control over my life, no power, no protection.	1	2	3	4	5	6	<input type="checkbox"/>
9. I hide the truth from others because I am afraid not to.	1	2	3	4	5	6	<input type="checkbox"/>
10. I feel owned and controlled by him or her.	1	2	3	4	5	6	<input type="checkbox"/>
11. She or he can scare me without laying a hand on me.	1	2	3	4	5	6	<input type="checkbox"/>
12. She or he has a look that goes straight through me and terrifies me.	1	2	3	4	5	6	<input type="checkbox"/>

Code	Text
6	Agree Strongly
5	Agree Somewhat
4	Agree a little
3	Disagree a little
2	Disagree Somewhat
1	Disagree Strongly
0	Prefer not to answer

Cases were flagged for follow-up and referral under the following conditions:

Q2A = 1 or Q2B = 1 or Q2C = 1 or Q2D = 1 OR

SUM of Q3 through Q12 >= 20

If Q2E = 1, cases were flagged as having reported IPV but were not flagged to program staff for follow-up and referral on that basis (alone).

Respondents who answered no to Q2A–Q2D and whose summed responses to Q3–Q12 = 11–19 were flagged for possible follow-up and referral if staff identified any other cause for concern.

B.2 Intimate Justice Scale Items and Scoring

I will read each item and ask you if it describes how your partner usually treats you. If you do not now have a partner, think about your last one. Choose a number from 1 to 5, where one (1) indicates that you do not agree at all and a five (5) indicates that you strongly agree. Your answers are private and will not be shared with your partner.

	I do not agree at all		I strongly agree			Prefer not to answer
1. My partner never admits when she or he is wrong.	1	2	3	4	5	<input type="checkbox"/>
2. My partner is unwilling to adapt to my needs and expectations	1	2	3	4	5	<input type="checkbox"/>
3. My partner is more insensitive than caring.	1	2	3	4	5	<input type="checkbox"/>
4. I am often forced to sacrifice my own needs to meet my partner's needs.	1	2	3	4	5	<input type="checkbox"/>
5. My partner refuses to talk about problems that make him or her look bad.	1	2	3	4	5	<input type="checkbox"/>
6. My partner withholds affection unless it would benefit her or him.	1	2	3	4	5	<input type="checkbox"/>
7. It is hard to disagree with my partner because she or he gets angry.	1	2	3	4	5	<input type="checkbox"/>
8. My partner resents being questioned about the way he or she treats me.	1	2	3	4	5	<input type="checkbox"/>
9. My partner builds himself or herself up by putting me down.	1	2	3	4	5	<input type="checkbox"/>
10. My partner retaliates when I disagree with him or her.	1	2	3	4	5	<input type="checkbox"/>
11. My partner is always trying to change me.	1	2	3	4	5	<input type="checkbox"/>
12. My partner believes he or she has the right to force me to do things.	1	2	3	4	5	<input type="checkbox"/>
13. My partner is too possessive or jealous.	1	2	3	4	5	<input type="checkbox"/>
14. My partner tries to isolate me from family and friends.	1	2	3	4	5	<input type="checkbox"/>
15. Sometimes my partner physically hurts me.	1	2	3	4	5	<input type="checkbox"/>

Code	Text
1	1—I do not agree at all
2	2
3	3
4	4
5	5—I strongly agree
0	Prefer not to answer

Cases were flagged for follow-up and referral under the following conditions:

SUM of Q1 through Q15 \geq 30 OR Q15 \geq 2

If Q15 \geq 2, cases were flagged for follow-up and referral but were not considered as having reported IPV for analytic purposes on the basis of that item (alone).

If the sum of Q1–Q15= 16–29, cases were flagged for possible follow-up and referral if staff identified any other cause for concern.

B.3 Universal Education Tool Content and Coding (Adapted from Futures Without Violence Tool)

The universal education tool, adapted by the RIViR team based on a tool developed and tested by the Futures Without Violence initiative, was administered conversationally by HMRE program staff in a tablet-guided mode that included automated skips and fills for ease of administration. Color coding indicates language that was included in skip logic in the computing specifications for the tablet-guided conversation.

This protocol is a guide for giving adult clients some very basic information about unhealthy or abusive relationships, offering them an opportunity to disclose their own experiences with or concerns about intimate partner violence, and supporting them in accessing other resources to increase their safety and making safe decisions about HMRE program participation.

You should meet with clients one on one, where no one will be within earshot to hear your conversation (like a room with the door closed), and ensure that you maintain utmost privacy, within the law. Do not

include any identifying information about clients or other people when entering data into the survey system while conducting the interview.

1. Introduction

IF YOU HAVE NOT HAD ANY OTHER INTERACTION, INTRODUCE YOURSELF AND BUILD RAPPORT: Hi, my name is [NAME], and I work for [HEALTHY RELATIONSHIP PROGRAM]. *Chat briefly with the client about weather, or other non-sensitive topics to establish some initial rapport and comfort.*

I wanted to talk to you a little bit about relationships, since that's the focus of this program. We're going to be talking a lot about healthy relationships, but we also know that sometimes relationships can be complicated.

2. Privacy Statement

The first thing I want to be sure you know is our privacy policy. In general, what you talk to me about is private. That means that I will not repeat what you say to others, including anyone else in the program, your partner (if they are there with a partner), or other staff, unless you specifically give me permission to share something you have told me in order to support you in getting help.

FOR MANDATED REPORTERS ONLY *[If the staff member who will administer this guide is a mandated reporter, please tailor the following text based on your state's mandated reporting law]:* But, there are some kinds of information that I can't keep confidential no matter what. If you tell me that a minor has been abused or assaulted, I am required by law to report that to the (name of child abuse reporting agency) or the local police department. If you tell me something that I need to report, I will also ask you to help me make the report if you want to.

Do you have any questions about your privacy?

Provided information about privacy policy

3. Statement about Healthy Relationship Experiences

This program will involve thinking and talking a lot about relationships. Relationships can be complex, and we have started talking to all of our clients about how you deserve to be treated by the people you are in a relationship with, intimately connected to, or involved with.

IF CLIENT IS ENROLLING AS AN INDIVIDUAL, ASK: Are you currently involved with anyone? Are you currently in a relationship with anyone or hooking up or hanging out with anyone?

IF CLIENT IS ENROLLING AS A MEMBER OF A COUPLE, CLARIFY: I see you came into this program with someone else. I'm assuming that the two of you are in a relationship, is that correct?

Client disclosed being in an intimate relationship

IF NO: We go over information on this card with everyone we talk to because it has such important information. The information might help you help a friend, or help you think about your future relationships.

Show safety card and read the text.

Anyone you're involved with (whether talking, hanging out, hooking up, dating, going out, or married) should:

- Be willing to communicate openly when there are problems;
- Give you space to spend time with other people, whether in person or online;
- Be respectful;
- Not try to get you drunk or high because they want to have sex with you; and
- Be willing to discuss and use safe sex, birth control, and condoms.

These kinds of things are an important part of having a healthy relationship. Studies show that relationships in which people treat each other in these ways lead to better physical and mental health, longer life, and better outcomes for children.

Allow the client to react to what was read on the card.

IF CLIENT IS IN A RELATIONSHIP: *If the client is silent, open up with a question like, What are your thoughts on the information on this card? or Does this sound like your relationship?*

IF CLIENT IS NOT IN A RELATIONSHIP: *If the client is silent, open up with a question like, Do you have any questions about the information on this card?*

Provided general information about healthy relationships

4. Opportunity to Disclose Intimate Partner Violence

Relationships can be complicated, and lots of people have complicated relationships.

Show safety card and read the text.

Sometimes, people experience disrespect in relationships or things that make them uncomfortable for different reasons, such as when a partner:

- Makes you feel stupid or “less than”; OR
- Tries to control where you go, who you talk to, what you do on social media, or how you spend your money; OR
- Hurts or threatens you, or forces you to have sex; OR
- Refuses to talk about or use birth control or condoms; OR
- Makes you feel afraid.

IF CLIENT IS IN A RELATIONSHIP: *If the person or people you are dating or involved with does ANY of these things, participating in a healthy relationship education class with him or her could be risky. For example, that person could react negatively to the information presented by the instructor, or use information you share against you later. Whether you participate in the class or not is completely your choice.*

Gave safety card

Allow the client to react to what was read on the card.

IF CLIENT IS IN A RELATIONSHIP: *If the client is silent, open up with a question like, What are your thoughts on the information on this card? Does this sound like your relationship? Do you have any worries about participating in the healthy relationship class that you want to talk over?*

IF CLIENT IS NOT IN A RELATIONSHIP: *If the client is silent, open up with a question like, What do you think about the information on this card? or Do you have any questions about any of this information?*

<input type="checkbox"/> Client disclosed being a victim of physical violence, emotional abuse, or controlling behavior by his or her partner, or being concerned about any of these issues
<input type="checkbox"/> Client indicated that s/he felt that his/her relationship was healthy
<input type="checkbox"/> Client indicated some worries or concerns about his/her relationship, but not specifically related to IPV

5. Responding and Providing Resources and Referrals

IF CLIENT DISCLOSED IPV EXPERIENCES OR CONCERNS RELATED TO IPV: Thank you so much for sharing this with me. I want you to know that you are not alone and I am here for you. I can help you get resources, if you'd like.

There's an organization you might be interested in called [LOCAL DOMESTIC VIOLENCE PROGRAM PARTNER] that supports youth and adults in addressing problems that come up in relationships and supporting them in staying safe. Would you like me to set up a time to talk with someone? *[Provide additional information to decrease client's anxiety, e.g., the services are free, private, and the client can talk to someone over-the-phone, if that is preferable to them.]*

IF YES: *Ask about schedule considerations and help the client to make a plan to meet with the local domestic violence program staff.*

IF NO: *Okay. I know you know what is best for you and your situation. I want you to know that if you are ever worried about your relationship or your safety, you can come here for help. If client declines your help in connecting them with resources, make sure to go over the remainder of the card (see below).*

I want you to know that on the back of this safety card there are national hotline numbers with folks who are available 24/7 if you want to talk. They can connect you to local shelter services if you need urgent help. The hotline staff really get how complicated it can be when you love someone and sometimes it

feels unhealthy or scary. They have contact with lots of people who have experienced this or know about it in a personal way.

IF CLIENT IS PARTICIPATING AS ONE MEMBER OF A COUPLE, ADD: As I mentioned earlier, participating in a healthy relationship education class with your partner could be risky. Do you still want to participate in the class?

IF YES OR UNSURE: Okay. I'd like to talk with you more about how we can make sure that you can participate safely. *Talk through each program activity with client and any potential risks to safety that it could present. For activities in which s/he wishes to participate, offer and agree on any accommodations that s/he feels would support safer participation. For any activities s/he wishes to opt out of, offer and agree on strategies to protect his/her safety and privacy regarding the decision to opt out. (If s/he decides s/he does not wish to participate in any of these activities, proceed to "IF NO," below).*

IF NO: Okay. I'd like to talk with you more about how we can ensure your safety as you leave this program. *Offer and agree on strategies to protect client's safety and privacy as s/he exits the program, including client's wishes regarding whether and how this information may be shared with his/her partner.*

I'd also like to follow up with you again to check in about this and see how things are going. Is that okay with you?

IF YES: *Make a plan with client for when you will follow up.*

IF NO: Okay. I know you know what is best for you and your situation. I want you to know that I am available to talk, and the hotline is also available 24/7.

IF CLIENT IS NOT IN A RELATIONSHIP OR DID NOT DISCLOSE ANY RELATIONSHIP CONCERNS: We are giving this card to all of our clients so that they will know how to help a friend or a family member having difficulties in their relationship, or know how to get help themselves if they ever need it. It has information about some resources that people have found helpful for staying safe in relationships, and it includes information for [LOCAL DOMESTIC VIOLENCE PROGRAM PARTNER] in case you or a friend ever want to get in touch with them. Also, I am here to talk about these issues.

IF CLIENT SHARED RELATIONSHIP CONCERNS BUT DID NOT DISCLOSE IPV EXPERIENCES: You mentioned things are sometimes complicated in your relationship. I want you to know that if you are ever worried about your relationship or your safety, you can come here for help.

I am giving you a card with a hotline number on it. You can call the number 24/7. The hotline staff really get how complicated it can be when you love someone and sometimes it feels unhealthy or scary. They have contact with lots of people who have experienced this or know about it in a personal way. Also, if you or a friend ever want someone to talk to in person and who is local, please let me know because I can help connect you to someone from [LOCAL DOMESTIC VIOLENCE PROGRAM PARTNER]. I'm available to talk about these issues more, too.

Do you have any questions for me, or anything you'd like to talk more about? *Address any questions.*
I really enjoyed talking with you today. Thank you again.

Referred client to domestic violence program partner

Indiv_Couple	Is this client participating as an individual or as one member of a couple?	1=Individual, 2=Couple
Confidentiality	Provided information about privacy policy.	1=Yes, 2=No
Relationship	Client disclosed being in an intimate relationship.	1=Yes, 2=No
Relationship_Info	Provided general information about healthy relationships.	1=Yes, 2=No
Safety_Card	Gave safety card.	1=Yes, 2=No
Referral	Referred participant to DV partner	1=Yes, 2=No

Code	Text
1	Client disclosed being a victim of physical violence, emotional abuse, or controlling behavior by someone s/he is seeing, or being concerned about any of these issues
2	Client indicated that s/he felt that his/her relationship was healthy
3	Client indicated some worries or concerns about his/her relationship, but not specifically related to IPV

[Items above asked again (i.e., VariableName_2) if the item was skipped during the interview.]

B.4 Supplemental Module Items Assessing Responses to Tools

For adult participants who have just completed a self-administered instrument [to be displayed on their screen]: Next, we are interested in your opinions about the questions you just answered and the [program] staff. [Program] staff will not see how you answer these questions, so please feel free to be open. This information will help us improve the RIViR tools.

For adult participants who have just completed a staff-administered instrument [for staff to read aloud]: Next, we are interested in your opinions about this conversation and your interactions with the [program] staff today. I will give you this tablet so you can privately answer a short set of multiple choice questions. You can touch “submit” when you are finished. The [program] staff, including me, will not see how you answer these questions, so please feel free to be honest. This information will help us improve and inform how we have these conversations in the future. Do you have any questions before I turn the tablet over to you? *[Answer any questions, then touch Next and give tablet to participant.]*

SUP_1. Overall, how clear [IF MODULE FOLLOWS INSTRUMENT 3: was the conversation / IF MODULE FOLLOWS INSTRUMENT 1 OR 2: were the questions]?

Code	Text
1	Very clear
2	Somewhat clear
3	Not at all clear
4	Prefer not to answer

SUP_2. How comfortable were you with the [IF MODULE FOLLOWS INSTRUMENT 3: conversation / IF MODULE FOLLOWS INSTRUMENT 1 OR 2: questions]?

Code	Text
1	Very comfortable
2	Pretty comfortable
3	Not very comfortable
4	Prefer not to answer

SUP_3. Did you [IF MODULE FOLLOWS INSTRUMENT 3: talk with the staff person / IF MODULE FOLLOWS INSTRUMENT 1 OR 2: answer the questions] ...

Code	Text
1	Very openly
2	Somewhat openly
3	Not at all openly
4	Prefer not to answer

SUP_4. Would you prefer to [IF MODULE FOLLOWS INSTRUMENT 3: have conversations / IF MODULE FOLLOWS INSTRUMENT 1 OR 2: answer questions] like these...

Code	Text
1	On an iPad or tablet?
2	On a smartphone?
3	On a laptop or desktop computer?
4	Talking to a [HMRE program] staff member in person, one on one?
5	Talking to a [HMRE program] staff member over the phone?
6	Prefer not to answer

SUP_5. How much of the time were you concerned that someone else might see or hear [IF MODULE FOLLOWS INSTRUMENT 3: the conversation / IF MODULE FOLLOWS INSTRUMENT 1 OR 2: you answering the questions]?

Code	Text
1	All of the time
2	Most of the time
3	Some of the time
4	A little of the time
5	None of the time
6	Don't Know
7	Prefer not to answer

Next, we'd like your impressions of your interactions with [HMRE program] staff today.

SUP_6. [HMRE program] staff respect my privacy.

Code	Text
1	Not at all true
2	A little true
3	Somewhat true
4	Very true
5	I don't know
6	Prefer not to answer

SUP_7. In this program, I can share things about my life on my own terms and at my own pace.

Code	Text
1	Not at all true
2	A little true
3	Somewhat true
4	Very true
5	I don't know
6	Prefer not to answer

SUP_8. I can trust [HMRE program] staff.

Code	Text
1	Not at all true
2	A little true
3	Somewhat true
4	Very true
5	I don't know
6	Prefer not to answer

SUP_9. I feel respected by staff in [HMRE program].

Code	Text
1	Not at all true
2	A little true
3	Somewhat true
4	Very true
5	I don't know
6	Prefer not to answer

Please indicate how much you agree or disagree.

SUP_10. I am comfortable talking about any challenges I am having in an intimate relationship (e.g., with my dating partner, girlfriend/boyfriend, hook-ups, spouse, or domestic partner) with a [HMRE program] staff member.

Code	Text
1	Strongly Agree
2	Agree
3	Neither agree nor disagree
4	Disagree
5	Strongly Disagree
6	Prefer not to answer

Finally, we have a few questions for you about safety. Different people may face a variety of different challenges to safety. When we use the word *safety* here, we mean safety from physical or emotional abuse by another person.

SUP_11. I feel comfortable asking for help to keep safe.

Code	Text
1	Not at all true
2	A little true
3	Somewhat true
4	Very true
5	I don't know
6	Prefer not to answer

SUP_12. Please mark which safety-related programs or services, if any, you know how to access:

	Code	Text
SUP_12_C1	0/1	A local organization that offers domestic violence services
SUP_12_C2	0/1	A national hotline for adults who are being abused by a dating partner or spouse
SUP_12_C3	0/1	A hotline for survivors of rape, incest, and abuse
SUP_12_C4	0/1	None of the above
SUP_12_C5	0/1	Prefer not to answer

SUP_13. How likely are you to share information about these types of programs or services with someone you know?

Code	Text
1	Not likely
2	1
3	2
4	3
5	4
6	Very likely
7	Prefer not to answer

SUP_14. Do you know your options for keeping yourself safe?

Code	Text
1	Yes
2	No
3	Unsure
4	Prefer not to answer

B.5 Administrative Data Obtained From nFORM

The following variables were extracted from the grantees' data collected from RIViR study participants at intake using the Applicant Characteristics Survey and entered into the nFORM data management system.

- Program enrollment date
- Sex
- Age
- Race
- Ethnicity
- Nativity to US
- Native language
- English fluency
- Public assistance
- Living situation
- Highest degree
- Employment status
- Income
- Relationship status
- Parental status

B.6 Demographic Items Assessed After First Tool Administration

1. What sex were you assigned at birth, on your original birth certificate?

Code	Text
1	Male
2	Female
3	Don't Know
4	Prefer not to answer

2. Do you currently describe yourself as male, female or transgender?

Code	Text
1	Male
2	Female
3	Transgender
4	None of these
5	Prefer not to answer

3. [If responses to items 1 and 2 differ] Just to confirm, you were assigned {FILL ITEM 1 RESPONSE} at birth and now describe yourself as {FILL ITEM 2 RESPONSE}. Is that correct?

Code	Text
1	Yes
2	No
3	Don't Know
4	Prefer not to answer

4. Which of the following terms best represents how you think of yourself?

Code	Text
1	Straight (that is, not lesbian or gay) / Straight (that is, not gay)
2	Lesbian or gay / Gay
3	Bisexual
4	Something Else
5	Don't Know
6	Prefer not to answer

B.7 Qualitative Interview Guides

B.7.1 Healthy Relationship Program Staff Interview Guide

Instructions for interviewer:

- Text to be read aloud verbatim in normal font.
- Instructions (not to be read aloud) in all caps and bolded
- Probes are bulleted and in italics
- Tailored information (i.e., things the interviewer does need to say aloud, but in a tailored way) are in italics inside brackets.

IN PREPARATION FOR EACH INTERVIEW, REVIEW BACKGROUND INFORMATION ON THE SCREENING AND REFERRAL PROCESS AND THE HR GRANTEE'S OVERALL SERVICE DELIVERY APPROACH.

FOR FACTUAL QUESTIONS DURING THE INTERVIEW, ASK THE STAFF MEMBER FOR CONFIRMATORY OR UPDATED INFORMATION THAT REFLECTS AN UNDERSTANDING OF THE INFORMATION THEY HAVE PREVIOUSLY PROVIDED.

Domains/ Interview Sections	Interview Guide Questions
Introduction and Interview Overview	<p>Thank you for taking the time to meet with us today! I'm [interviewer's name] and this is [note-taker's name]. As you know, your organization has participated in a study in which we are testing tools to help identify intimate partner and teen dating violence among participants in HMRE programs. For the purposes of this conversation, I'll refer to these tools as "screeners." As part of our research, we want to understand how these screeners were used in practice, and hear your opinions about them.</p> <p>The interview will last about an hour. Your participation is voluntary, and you may decline to answer any question or stop the interview at any point. With your permission, we may audio record the interview to help ensure that we capture everything you say in the interview. Your responses will be combined with responses from others here and at the other study sites, and will not be attributed to you individually. If we quote you, we won't include any information that would reveal your identity.</p> <p>We will not ask you any personal questions and it is unlikely that these questions will make you feel uncomfortable. But if you do, you can skip any of the questions or end the interview. The other risk is that someone might find out what you tell us during the interviews. To prevent this, we are doing the interview in a private setting, and we will handle and store all of your information in a secure manner. [If interview is with a group: To protect everyone's privacy, please do not share what is said during this interview with others.]</p> <p>There are no direct benefits to you from participating in this interview. However, the results could help us learn more about how these tools could be improved for other HMRE programs.</p> <p>If you have any questions about this study, you can contact Tasseli McKay at RTI. If you have any questions about protecting your privacy in this study or your rights as a study participant, you can contact RTI's Office of Research Protection.</p>

Domains/ Interview Sections	Interview Guide Questions
	<p><i>(If in person, provide card with numbers. If by phone:)</i> I can send you these numbers after our call if you'd like.</p> <p>Before we begin, we would like to ask if it would be okay for us to record the interviews for note-taking purposes. Is this okay with you? <i>(Get verbal okay)</i>. Do you have any questions before we get started?</p>
<p>Incorporating the Screeners into the Workflow</p>	
<p>Use of Screeners in Practice</p>	<p>Before we start the interview, I just want to remind you NOT to refer to any individual program participants by name. If you would like to give an example, please do so without providing names or other personally identifiable information.</p> <p>First, we want to hear about how the screeners were carried out in practice and used in your HMRE program.</p> <p>Can you take me through the process by which the screeners were typically used in practice?</p> <p>IF GRANTEE TESTED BOTH ADULT AND YOUTH SCREENERS, ASK THESE QUESTIONS ABOUT THE ADULT SCREENERS FIRST, AND THEN THE YOUTH SCREENERS.</p> <ul style="list-style-type: none"> ▪ <i>Probe for how, when, where, and with whom the screening instruments were implemented.</i> ▪ <i>Probe for how long each screener took to administer.</i> ▪ <i>Probe for any differences in administration of the different screeners.</i> ▪ <i>Probe for other examples of how the screeners may have been administered outside of “typical use”.</i>
<p>Barriers to Screener Administration</p>	<p>Were there [other] challenges in “fitting” these screeners into your work?</p> <ul style="list-style-type: none"> ▪ <i>Probe for any issues related to timing (i.e., was it challenging to find appropriate time to screen individuals three separate times throughout the program).</i> ▪ <i>Probe for any issues in staff coverage (i.e., if there were always enough staff to administer the screener).</i> ▪ <i>Probe for any issues related to space (i.e., if there were enough private spaces to administer the screeners).</i> ▪ <i>Probe for any issues related to administering the screeners one on one.</i>

Domains/ Interview Sections	Interview Guide Questions
	<ul style="list-style-type: none"> ▪ <i>For Youth Screeners Only: Probe on any issues in administering the screeners in the school/group setting.</i> <p>Were there any challenges specific to one or more of the screeners?</p> <ul style="list-style-type: none"> ▪ <i>Probe: That is, were any screeners more difficult to incorporate into your work than others? Why or why not?</i> <p>Were there any other challenges or barriers to implementing these screeners in your work?</p> <p>What, if anything, would have made it easier for staff to implement the screeners?</p>
Factors that Facilitated Administration of Screener	<p>What factors helped staff in your program to be able to incorporate the screeners into your workflow?</p> <ul style="list-style-type: none"> ▪ <i>Probe: In other words, did your program have anything or do anything that helped make it easier to use the screeners, such as one-on-one intake meetings, or private spaces to administer the screeners, that helped integrate use of the screeners into your program?</i> ▪ <i>Probe on timing, staffing, space, training</i> ▪ <i>If applicable, probe on differences of how youth and adult screeners were incorporated into the workflow.</i> <p>Was one type of screener easier to implement than the others? For example, did the mode (self-administered vs. staff administered; closed-ended vs. staff administered open-ended) matter?</p> <p>What does a program need to be able to implement the screeners successfully?</p> <ul style="list-style-type: none"> ▪ <i>Probe for necessary space, staffing, training, participant time</i>
Staff Responses to Screeners	
Staff Response to Closed-Ended Screeners	<p>Now let's talk about the screeners themselves.</p> <p>First we'll talk about the closed-ended screeners. SHOW PARTICIPANT THE SPECIFIC CLOSED-ENDED SCREENERS IMPLEMENTED BY THE PROGRAM.</p> <p>Were the closed-ended screeners easy to use? Explain.</p> <ul style="list-style-type: none"> ▪ <i>If applicable, probe on differences of ease of use of youth and adult screeners.</i> <p>Did you feel comfortable using the closed-ended screeners? Explain.</p>

Domains/ Interview Sections	Interview Guide Questions
	<ul style="list-style-type: none"> <i>If applicable, probe on differences of comfort in using the youth and adult screeners</i>
<p>Staff Response to Open-Ended Screeners</p> <p>Other General Responses</p>	<p>Now, let's talk about the open-ended screener(s). ORIENT PARTICIPANT TO THE SPECIFIC OPEN-ENDED SCREENER(S) IMPLEMENTED BY THE PROGRAM.</p> <p>Were the open-ended screeners easy to use? Explain.</p> <ul style="list-style-type: none"> <i>If applicable, probe on differences of ease of use of youth and adult screeners.</i> <p>Did you feel comfortable using the open-ended screeners? Explain.</p> <ul style="list-style-type: none"> <i>If applicable, probe on differences of comfort in using the youth and adult screeners</i> <p>Is there anything else you want to share about what you thought of the screening instruments?</p> <ul style="list-style-type: none"> <i>Probe about different opinions regarding the different screeners</i>
Respondent Responses to Screeners	
<p>Respondent Responses to Screeners</p>	<p>I just want to remind you NOT to use any participants' names when you give examples.</p> <p>How did participants seem to feel about the closed-ended screeners? IF APPLICABLE, ASK ABOUT ADULT AND YOUTH CLOSED-ENDED SCREENERS SEPARATELY.</p> <ul style="list-style-type: none"> <i>Probe on specific reactions participants had or examples of comments that participants made</i> <i>For the youth-serving staff, probe about whether any youth approached the staff after the group data collection to discuss questions or concerns, and the content of those conversations</i> <p>How did participants seem to feel about the more conversational, open-ended screener? IF APPLICABLE, ASK ABOUT ADULT AND YOUTH OPEN-ENDED SCREENERS SEPARATELY.</p> <ul style="list-style-type: none"> <i>Probe on specific reactions participants had or examples of comments that participants made</i> <p>Did participants need any clarification regarding how the questions were phrased or any of the language used? If so, please provide examples.</p>

Domains/ Interview Sections	Interview Guide Questions
 Screener Outcomes 	
Response to IPV or TDV Disclosure	<p>Next, we want to understand what happened when someone disclosed relationship violence during screening.</p> <p>Please explain what happened if someone disclosed relationship violence during the screening administration? IF APPLICABLE, ASK WHAT HAPPENED IF AN ADULT PARTICIPANT DISCLOSED IPV, AND THEN ASK WHAT HAPPENED IF A YOUTH PARTICIPANT DISCLOSED TDV.</p> <ul style="list-style-type: none"> ▪ <i>Probe for specific options, assistance, and materials (e.g., safety cards) provided</i> <p>Has your program changed the way that it has responded to relationship violence since using these screeners? If so, how? Do you know the reason(s) why?</p>
Case Example: Worked Well	<p>I would like to ask you for a couple of examples of participants who completed the screening process with you. First, we want to hear about an example of a case in which the screening process worked well; that is, where someone whom you felt needed help was identified and connected with services you felt were appropriate. Please do not give me any identifying information (like name, date of birth, address) about this person as I ask you questions about them.</p> <p>Probe (only if respondent cannot recall a specific case): If you can't think of a specific case, feel free to tell me generally about how things tended to work in cases that went well.</p> <p>FOR AGENCIES THAT SERVE BOTH YOUTH AND ADULTS, ASK QUESTIONS FOR BOTH.</p> <p>ASK OF AGENCIES SERVING ADULTS:</p> <p>Was the participant enrolled with their partner?</p> <p>At what point in the program did this person disclose IPV?</p> <p style="padding-left: 40px;">If it was in the context of a screening, which screener was it?</p> <p style="padding-left: 40px;">Can you explain what happened during their disclosure?</p> <p>After the participant disclosed IPV, what information/options were provided to them?</p> <p>Were there any immediate safety issues? If so, how were these safety issues dealt with?</p>

Domains/ Interview Sections	Interview Guide Questions
	<p>To the best of your knowledge, what services did they receive?</p> <p>Anything else to add about this participant’s experience with the screener?</p> <p>ASK OF AGENCIES SERVING YOUTH:</p> <p>At what point in the program did this person disclose TDV?</p> <p style="padding-left: 40px;">If it was in the context of a screening, which screener was used?</p> <p style="padding-left: 40px;">Can you explain what happened during their disclosure?</p> <p>After the participant disclosed TDV, what happened? Was there a formal school protocol that was followed? What information/options were provided to them?</p> <p>Were there any immediate safety issues? If so, how were these safety issues dealt with?</p> <p>To the best of your knowledge, what services did they receive?</p> <p>Anything else to add about this participant’s experience with the screener?</p>
<p>Case Example: Did Not Work Well</p>	<p>Now, I’d like to ask you for a case in which the screening process did not work well. Can you tell me what happened there? Again, please don’t give me any identifying information.</p> <ul style="list-style-type: none"> ▪ <i>Probe (only if respondent cannot recall a specific case): If you can’t think of a specific case, feel free to tell me generally about how things tended to work in cases that did not go well.</i> <p>FOR AGENCIES THAT SERVE BOTH YOUTH AND ADULTS, ASK QUESTIONS FOR BOTH.</p> <p>ASK OF AGENCIES SERVING ADULTS:</p> <p>Was the participant enrolled with their partner?</p> <p>At what point in the program did this person disclose IPV?</p> <p style="padding-left: 40px;">Which screener was used?</p> <p style="padding-left: 40px;">Can you explain what happened during their disclosure?</p> <p>After the participant disclosed IPV, what information/options were provided to them?</p> <p>Were there any immediate safety issues? If so, how were these safety issues dealt with?</p> <p>To the best of your knowledge, what services did they receive?</p>

Domains/ Interview Sections	Interview Guide Questions
	<p>Anything else to add about this participant’s experience with the screener?</p> <p>ASK OF AGENCIES SERVING YOUTH:</p> <p>At what point in the program did this person disclose TDV?</p> <p style="padding-left: 40px;">Which screener was used?</p> <p style="padding-left: 40px;">Can you explain what happened during their disclosure?</p> <p>After the participant disclosed TDV, what happened? Was there a formal school protocol that was followed? What information/options were provided to them?</p> <p>Were there any immediate safety issues? If so, how were these safety issues dealt with?</p> <p>To the best of your knowledge, what services did they receive?</p> <p>Anything else to add about this participant’s experience with the screener?</p>
Respondent Challenges with Screening Tools	<p>Did you encounter any participants who did not understand the screener questions? Please tell me about that.</p>
	<p>Did you encounter any participants who didn’t want to answer the questions? Please tell me about that.</p> <p>Did you encounter any participants who may not have disclosed relationship violence during the screener administration, but disclosed in another interaction? Please tell me about that.</p>
Working with the DV Partner	<p>Typically, how have you referred individuals who disclose IPV/TDV during the screening to your DV program partner?</p> <ul style="list-style-type: none"> ▪ <i>Probe on details such as making final decisions about whether and when to refer, who is the main contact at the DV program partner, how are participants typically referred (via a “warm handoff” or just told to go to the DV program partner).</i> <p>Did anything about your partnership or respective roles and responsibilities change as a result of testing these screeners?</p> <p>Did any of your response or referral procedures change? In what ways?</p>

B.7.2 Domestic Violence Program Staff Interview Guide

Instructions for interviewer:

Text to be read aloud verbatim in normal font.

Instructions (not to be read aloud) in all caps and bolded

Probes are bulleted and in italics

Tailored information (i.e., things the interviewer does need to say aloud, but in a tailored way) are in italics inside brackets.

IN PREPARATION FOR EACH INTERVIEW, REVIEW BACKGROUND INFORMATION ON THE SCREENING AND REFERRAL APPROACH AND THE PARTNERSHIP BETWEEN THE HR GRANTEE AND DV PROGRAM.

FOR FACTUAL QUESTIONS DURING THE INTERVIEW, ASK THE DV PARTNER FOR CONFIRMATORY OR UPDATED INFORMATION (E.G., “YOU HAVE WORKED TOGETHER FOR THE LAST X YEARS, CORRECT?”) THAT REFLECTS THE INFORMATION THEY HAVE PREVIOUSLY PROVIDED.

Domains/Interview Sections	Interview Guide Questions
Introduction and Interview Overview	<p>Thank you for taking the time to meet with us today! I’m <i>[interviewer’s name]</i> and this is <i>[note-taker’s name]</i>. As you know, we are testing screening questions and approaches to help identify intimate partner and teen dating violence among participants in HMRE programs like <i>[HMRE program name]</i>. For this conversation, I’ll refer to them as “screeners.” As part of our research, we want to understand a little more about your relationship with <i>[HMRE program name]</i> and your thoughts on whether or how <i>[HMRE program name]</i>’s use of these screeners helped to guide their referrals to you.</p> <p>The interview will last about an hour. Your participation is voluntary, and you may decline to answer any question or stop the interview at any point. With your permission, we may audio record the interview to help ensure that we capture everything you say in the interview. Your responses will be combined with responses from others here and at the other study sites, and will not be attributed to you individually. If we quote you, we won’t include any information that would reveal your identity.</p>

Domains/Interview Sections	Interview Guide Questions
	<p>We will not ask you any personal questions and it is unlikely that these questions will make you feel uncomfortable. But if you do, you can skip any of the questions or end the interview. The other risk is that someone might find out what you tell us during the interviews. To prevent this, we are doing the interview in a private setting, and we will handle and store all of your information in a secure manner. <i>[If interview is with a group: To protect everyone’s privacy, please do not share what is said during this interview with others.]</i></p> <p>There are no direct benefits to you from participating in this interview. However, the results could help us learn more about how these tools could be improved for other HMRE programs.</p> <p>If you have any questions about this study, you can contact Tasseli McKay at RTI. If you have any questions about protecting your privacy in this study or your rights as a study participant, you can contact RTI’s Office of Research Protection. <i>(If in person, provide card with numbers. If by phone:)</i> I can send you these numbers after our call if you’d like.</p> <p>Before we begin, we would like to ask if it would be okay for us to record the interviews for note-taking purposes. Is this okay with you? <i>(Get verbal okay)</i>. Do you have any questions before we get started?</p>
Partnership with Healthy Relationship Program	
Background and Quality of Partnership	<p>Before we start the interview, I just want to remind you NOT to refer to any individual program participants by name. If you would like to give an example, please do so without providing names or other personally identifiable information.</p> <p>How long have you been working with <i>[HMRE program name]</i>?</p> <p>How did the partnership come about?</p> <p>Had you ever worked with them before you became involved in this HMRE program grant with them?</p>
Role of DV Partner	<p>Can you tell me a little about what your role has been in your partnership with <i>[HMRE program name]</i>?</p> <p>Did you collaborate with them to develop a “domestic violence protocol,” or a set of procedures for how to recognize and respond to intimate partner violence or</p>

Domains/Interview Sections	Interview Guide Questions
	<p>teen dating violence among their program participants? Could you tell me about that process?</p> <p>In your opinion, what are the strong points of [HMRE program name]'s current approach to recognizing and responding to domestic violence?</p> <p>In your opinion, what are the weak points or downsides of [HMRE program name]'s current approach to recognizing and responding to domestic violence?</p> <p>Are you involved in training [HMRE program name] staff?</p> <p>At this point, how knowledgeable and familiar would you say the key [HMRE program name] staff are regarding IPV/TDV?</p>
Referral Process	
	<p>Could you describe how the referral process works for adults/youth who have disclosed IPV?</p> <p>Does [HMRE program name] use the same process each time they make a referral (i.e., call you, email you, etc.)?</p> <p>If transportation is needed, does [HMRE program name] provide transportation for the individual, does your agency, or does someone else?</p> <p>Does [HMRE program name] ever follow up with you about an individual in their program after they receive services at your program?</p> <p>Do you think there is enough, too much, or too little coordination or information exchange between your two organizations regarding individual cases?</p>
Changes During the Screener Testing Period	
	<p>Have you or [HMRE program name] made any changes to your processes for working together since they started testing the screeners?</p> <ul style="list-style-type: none"> ▪ <i>Probe: What prompted these changes?</i> ▪ <i>Probe: Will you maintain these changes in your future work together?</i> <p>Have you received more or fewer referrals than before they began using the study screeners?</p> <p>How confident do you feel in your two programs' joint efforts to ensure participant safety using these screeners and this referral process?</p>

Domains/Interview Sections	Interview Guide Questions
Case Narrative	
<p>Case Example: Worked Well</p>	<p>Now, I'm hoping you can talk me through two examples of someone who was referred to your agency from [HMRE program name] and what kinds of follow-up services they received. First, we want to hear about an example of a case that went well; that is, where someone whom you felt needed help was identified and connected with services you felt were appropriate. Please do not give me any identifying information (like name, date of birth, address) of this person as I ask you questions about them. Maybe you can start by saying a bit about how this case was referred.</p> <ul style="list-style-type: none"> ▪ <i>Probe: What services were they offered?</i> ▪ <i>Probe: What services did they receive?</i> ▪ <i>Probe: For how long did they receive services?</i> ▪ <i>Probe: Was there any kind of follow-up with the HMRE program?</i> ▪ <i>Probe: Do you know what this individual's status is now?</i> <p>Why do you think it went well?</p> <p>How do you think the participant felt about their services?</p> <p>How helpful was the screener in serving that purpose?</p>
<p>Case Example: Did Not Work Well</p>	<p>Please talk me through another example of someone who was referred to your agency from [HMRE program name] and what kinds of follow-up services they received. This time, we want to hear about an example of a case that did not go as well. Again, please do not give me any identifying information.</p> <ul style="list-style-type: none"> ▪ <i>Probe: How were they referred (if they were)?</i> ▪ <i>What services were they offered?</i> ▪ <i>Probe: What services did they receive?</i> ▪ <i>Probe: For how long did they receive services?</i> ▪ <i>Probe: Was there any kind of follow-up with the HMRE program?</i> ▪ <i>Probe: Do you know what this individual's status is now?</i> <p>Why do you think it did not go well?</p> <p>How do you think the participant felt about their services?</p>

Domains/Interview Sections	Interview Guide Questions
	How helpful was the screener in serving that purpose?
Feedback on Screeners and Protocols	
	<p>ASK IF NOT ASKED PREVIOUSLY: How do you think the participants felt about the screening and referral procedure?</p> <ul style="list-style-type: none"> ▪ <i>Probe: Do you think the screeners made the participants feel uncomfortable or comfortable? Safe or unsafe?</i> ▪ <i>Probe: How do you think participants felt about the referral process?</i> <p>Based on your experience with these different screening tools being used as the basis for referrals to your agency from [HMRE program name], what do you think are the strengths or advantages of the more conversational screening tool relative to the two tools that used questions with pre-set multiple-choice answers?</p> <p>What are the draw-backs of the more conversational screening tool? Is there anything you would change about it?</p> <p>What do you see as the strengths or advantages of the two tools that used questions with multiple-choice answers? Do you think more highly of one than the other?</p> <p>What are the draw-backs of the multiple-choice-style screening tools? Is there anything you would change about these standardized tools?</p> <p>How effective do you think the screeners were at identifying someone who may be in need of services related to relationship violence?</p> <ul style="list-style-type: none"> ▪ <i>Probe: Based on your experiences with [HMRE program name] do you feel like one screener may have worked better than the others?</i> ▪ <i>Probe: Did any participants mention a specific screener or part of the screening process they liked or didn't like?</i>
I Thoughts	
Final Thoughts	Do you have anything else that you might add that we didn't ask you about?

B.7.3 Adult Participant Interview Guide

Text to be read aloud is in normal font.

INSTRUCTIONS (NOT TO BE READ ALOUD) ARE IN BOLD CAPS.

Probes and language that will be tailored to each site are bulleted and in italics.

[Tailored information (i.e., things the interviewer does need to say aloud, but in a tailored way) are in italics inside brackets.]

IN PREPARATION FOR EACH INTERVIEW, FAMILIARIZE YOURSELF WITH SITE-SPECIFIC PROCEDURE FOR RESPONDING TO PARTICIPANTS WHO MAY DISCLOSE IPV DURING THIS STUDY INTERVIEW. REVIEW BACKGROUND INFORMATION ON THE SCREENING AND REFERRAL PROCESS AND THE HR GRANTEE'S OVERALL SERVICE DELIVERY APPROACH.

Domain	Interview Guide Questions
Introduction and Interview Overview	<p>Thank you for taking the time to meet with us today! I'm [<i>interviewer's name</i>]. I am with RTI International, a non-profit research organization. We are working with the Administration for Children and Families to understand HMRE programs' approaches to talking with people about challenging relationship issues. As part of this work, we want to understand what people think of any conversations they may have had with [<i>HMRE program name</i>] staff about these kinds of issues, like feeling disrespected in a relationship or having conflicts that get physical. Whether or not you've ever had those experiences yourself, we're interested in what you think about the ways that program staff did or didn't talk with you about them and what happened. ADMINISTER INFORMED CONSENT. IF PROVIDED, BEGIN AUDIORECORDING.</p>
Healthy Relationship Program Engagement	
Program Involvement	<p>What brought you to [<i>HMRE program name</i>]?</p> <ul style="list-style-type: none"> • <i>Probe: How did you learn about the program?</i> • <i>Probe: What did you hope to get out of the program?</i> <p>What kinds of things have you participated in as part of the program?</p> <ul style="list-style-type: none"> ▪ <i>Probe for known site-specific program activities, such as relationship education or case management.</i>
Early Staff Interaction	<p>Did you talk to a staff member one-on-one at any point before you began participating in group activities?</p>

Domain	Interview Guide Questions
	<p>How comfortable did you feel around [HMRE program name] staff when you first began?</p>
<p>Initial Decision to Participate in Program</p>	<p>I'm going to ask some questions that might bring up personal issues. I just want to remind you that if you tell me that someone is in danger or a child is being hurt, I might have to report it.</p> <p>Did the conversation with [HMRE program name] staff raise any concerns about you participating in any of the program activities?</p> <p>Looking back, would you want to do anything differently in terms of what you did or didn't participate in as part of [HMRE program name]?</p>
<p>Other Human Services and Support</p>	<p>At the time you enrolled in the program, were you involved with any other programs?</p> <p>Were you receiving any kind of benefits, like Medicaid, food stamps, or TANF? Any child support?</p> <p>What kinds of informal support did you have around you, like from friends, family, or community?</p>
<p>Influences on Self-Perception of Relationship</p>	<p>At the time you enrolled in the program, were you in a relationship or seeing anyone?</p> <ul style="list-style-type: none"> • <i>If seeing anyone, probe for what the respondent thought and felt about his/her relationship at the time he/she entered the HR program.</i> • <i>If not seeing anyone, probe for whether respondent had any relationship-related plans or goals.</i> <p>What kinds of things have shaped how you see [relationships / that relationship]?</p> <ul style="list-style-type: none"> • <i>Probe for social influences (e.g., opinions of friends and family, childhood experiences, parents' or friends' relationships) and any change over time.</i> • <i>Probe for cultural influences (e.g., religious views of relationship, gender roles, #MeToo, media coverage of abuse cases) and any change over time.</i> <p>How would you say participating in [HMRE program name] changed your perspective on [relationships/that relationship]?</p>

Domain	Interview Guide Questions
Follow-up Opportunities for Disclosure	
<p>Opportunity to Raise Personal Concerns During Program Activities</p>	<p>During the time you were participating in the program, did you ever have any worries or issues on your mind about your own relationships? You don't have to tell me any details about what they were; I am just wondering in general terms.</p> <p>IF YES, EVEN IF NOT AN IPV CONCERN:</p> <p>Did you ever have a chance to raise those issues during one of the <u>group activities</u>?</p> <ul style="list-style-type: none"> • Probe for how and when the participant raised the issue OR • Probe for why s/he chose not to raise it during a group activity.
<p>Perceptions of Open- and Closed-Ended Screening Tools</p>	<p>Do you remember sitting with the [HMRE program name] staff and answering some questions that they were reading from a tablet? Did they ask either of these sets of questions, where you had to choose one answer from the set of responses that they gave you? SHOW HARD COPY OF CLOSED-ENDED ADULT TOOLS.</p> <p>Do you remember having a more open-ended conversation about healthy and unhealthy relationships, where the staff person would have also given you this card? SHOW HARD COPY OF SAFETY CARD.</p> <p>IF YES TO EITHER:</p> <p>How did you feel about talking with [HMRE program name] staff about those issues?</p> <p>What did you decide to share? What did you decide not to share? Again, I don't need the details of exactly what it was about.</p> <ul style="list-style-type: none"> • If anything was shared, probe for what influenced the respondent's decision to share (motivation for sharing, setting, relationship with staff person, the words used by the staff person). • If anything was not shared, probe for general sense of what was not shared without pressing for personal detail, e.g., "Would you mind sharing with me what you chose not to bring up with staff? I don't need any details about what it was; I'm just wondering about the general topic." <p>Did you feel like staff knew enough about you and your situation to support you in staying healthy and safe?</p>

Domain	Interview Guide Questions
	<p>AS APPLICABLE:</p> <p>Did you have any concerns about your partner finding out what you said?</p> <p>How did you feel about the time(s) where staff asked you those shorter questions that had pre-set answers?</p> <p>How did you feel about the more open-ended conversation, the one when staff shared the informational card with you? What did you think of the card you were given?</p> <p>Which did you prefer, the questions with pre-set answers or the more open-ended conversation where you were given the informational card? Why?</p> <p>Do you think the time it takes to have one of these conversations is worth it? Why or why not?</p>
Concerns Not Disclosed	<p>Looking back, is there anything that you wish you had shared about your family life or relationships, but didn't have the opportunity, or didn't feel comfortable with the way it was asked? You don't need to give me any details about what it was; I am just wondering in general terms.</p> <p>What do you think would make people you know feel comfortable sharing with [HMRE program name] about their own relationship issues, like disrespect or conflicts getting physical?</p> <p>What could [HMRE program name] staff do to make those one-on-one conversations more comfortable?</p> <p>What could be done differently with the questions on the tablet to make that more comfortable?</p>
Referral to Domestic Violence Program or Other Resources	
Referral	<p>During the time you participated in [HMRE program name], did staff there ever refer you to talk to someone from another organization? For each referral mentioned:</p> <ul style="list-style-type: none"> • Probe for what referral was made and why. Clarify whether the participant is referring to the local domestic violence program partner or some other organization. • Probe for whether referred to a specific person or to an organization (without a named staff person)?

Domain	Interview Guide Questions
	<p>What else did [HMRE program name] staff tell you about the services that might be available and how you would go about talking to someone about them?</p> <p>Were there ever any other issues on your mind that you could have used some help with, but you didn't get that help? I don't need any specific details, just a general sense.</p> <ul style="list-style-type: none"> ▪ Probe for whether participant disclosed those additional needs to staff, why or why not, and what happened.
Initial Accessibility	<p>ASK ONLY IF PARTICIPANT DID SEEK OUTSIDE SERVICES RELATED TO IPV:</p> <p>What was your initial impression of the organization where you were referred?</p> <p>Did you end up talking to someone there?</p> <ul style="list-style-type: none"> ▪ Probe for what facilitated or prevented the participant making initial contact with local DV program or other organization, including any logistical, cultural, or economic barriers or facilitators.
Interactions with DV Program or Other Outside Support	<p>ASK ONLY IF PARTICIPANT DID SEEK OUTSIDE SERVICES RELATED TO IPV:</p> <p>What contact did you have with staff from that organization?</p> <p>Did you end up getting any services?</p> <ul style="list-style-type: none"> • If so, probe for what services. • If not, probe for why not. <p>To what extent did you feel supported by the staff there? In what ways?</p> <p>To what extent did you feel that you and your choices were respected? How was that communicated?</p>
Helpfulness of DV Program or Outside Services	<p>ASK ONLY IF PARTICIPANT DID SEEK OUTSIDE SERVICES RELATED TO IPV:</p> <p>All in all, how would you say that the outside services that [HMRE program name] connected you to have affected your relationship or family life?</p> <ul style="list-style-type: none"> • Probe for whether participant feels s/he has access to more resources. • Probe for shifts in perspective on relationship or family life. • Probe for whether the respondent felt like s/he had more options in his/her relationship or family life.
Helpfulness of HR Program	<p>ASK OF ALL PARTICIPANTS:</p>

Domain	Interview Guide Questions
	<p>All in all, how would you say that participating in [HMRE program name] affected your relationship and family life?</p> <ul style="list-style-type: none"> • Probe for whether participant feels s/he has access to more resources. • Probe for shifts in perspective on relationship or family life. • Probe for whether the respondent felt like s/he had more options in his/her relationship.
Final Thoughts	<p>Is there anything I haven't asked that you think we should know about your experiences in [HMRE program name]?</p>
Additional Needs	<p>Before we finish, is there anything we have talked about today that you feel worried or concerned about, or might need some additional help with?</p> <p>IF PARTICIPANT EXPRESSES ACTIVE CONCERNS OR AN INTEREST IN ADDITIONAL HELP, OFFER RESOURCES ACCORDING TO PROTOCOL AGREED ON WITH GRANTEE AND LOCAL DOMESTIC VIOLENCE PARTNER.</p> <p>Thank you so much for taking the time to talk with me today. I appreciate it very much.</p>

APPENDIX C – CASE STUDY REPORT

Recognizing and Responding to IPV Among Spanish-Speaking HMRE Participants: A Case Study

C.1 Background

This section presents findings from a small, two-site case study of HMRE programs' approaches to recognizing and responding to IPV-related needs among Spanish-speaking Latinx participants.

C.1.1 *Impetus for the Case Study*

As described in **Section 2: Study Purpose and Design**, the RIViR field study focused on testing IPV screening and universal education approaches used by HMRE programs with English-speaking participants. The choice of screening approaches to test in the RIViR field study was informed by a systematic review to identify IPV and TDV screening tools that had been validated in populations and settings similar to those of OFA-funded HMRE programs. The review found that most IPV screening tools have been validated with adult heterosexual women in health care settings. Most validation studies did not include men, youth, or Spanish speakers. The three published tools validated with Spanish-speaking Latinx participants were designed for hospital and criminal justice settings:

- The Partner Violence Screen (4 items, physical violence and perceived safety) was validated with Spanish- and English-speaking women admitted to a trauma service (Mills et al., 2006);
- The STaT (Slaps, Throws, and Threatens) Screen (3 items; physical violence, sexual violence, emotional abuse, and coercive control) was validated with Spanish-speaking female hospital outpatients, 18–64 years old (Paranjape et al., 2006); and
- Bonomi's unnamed tool (3 items, physical violence and emotional abuse) was validated with English- and Spanish-speaking women seeking police assistance or civil protection orders for IPV (Bonomi et al., 2005).

RTI worked with our academic partners, OPRE, other ACF agencies, and a panel of IPV and HMRE research and practice experts to consider screening tools for inclusion in the RIViR field test. Based on guidance from experts and federal partners, RTI prioritized the ability to compare open-ended, universal education based approaches to closed-ended (traditional) screening approaches and to accomplish such a comparison for each of two study populations: adults and youth. Given this priority and the relative dearth of relevant, prior validation work to inform the selection and testing of a Spanish screening tool in HMRE populations, it was decided not to include a set of Spanish-language screening tools in the RIViR field test.

To supplement the RIViR field study, this case study was designed to gather initial information on approaches to IPV education, screening, and referral among HMRE programs serving Spanish-speaking Latinx participants.

C.1.2 Gaps in Prior Research

To date, approaches to identifying and responding to IPV among Spanish-speaking HMRE program participants have been relatively little studied. The Hispanic Healthy Marriage Initiative (HHMI) implementation evaluation documented a diversity of HHMI grantees' approaches to IPV protocols, partnerships, screening, education, and referral (Bouchet et al., 2013). It focused on identifying patterns across all HHMI grantees, and as such, did not include an in-depth focus on approaches to partnerships with local domestic violence programs, the development of domestic violence protocols, the provision of direct or referral-based services related to IPV, or aspects of organizational capacity or competence that shaped the approaches that grantees (or their local partners) took.

Building on this knowledge base, RTI and the National Latin@ Network for Healthy Families and Communities (NLN)³ undertook a small case study of these topics in partnership with two HMRE grantees: the University of Denver's Motherwise program, and Family Services of Merrimack Valley.

The case study was designed to address the following aims:

- Understand current approaches taken by two OFA-funded HMRE grantees to recognizing IPV among Spanish-speaking Latinx HMRE program participants
- Describe partnerships between HMRE grantees and local domestic violence program partners and any other strategies for addressing IPV when identified
- Identify key resources, assets, and challenges relevant to implementing culturally and linguistically appropriate strategies for IPV recognition and response in HMRE programs

³ Three staff from Casa de Esperanza/National Latin@ Network contributed heavily to case study design, data collection, analysis, and reporting: Ruby White Starr, Josie Serrata, and Martha Hernandez Martinez. Dr. Serrata and Ms. Hernandez Martinez, each of whom has extensive expertise in research with Latinx survivors of domestic violence, assumed primary responsibility for drafting the focus group interview guide, conducting the group, analyzing focus group data, and preparing a written summary from which extensive material for this report section was drawn. Review and input from Casa de Esperanza/ National Latin@ Network staff also informed RTI's work on the overall study design, HMRE and DV staff interview guides, and analysis and reporting of HMRE and DV staff interview data.

C.2 Methods

C.2.1 Methodology

The research team selected a case study method to accomplish the research aims. Case studies have traditionally been a method of choice when researchers seek to describe a population- or context-specific phenomenon that may generate lessons of broader interest, but are not attempting to make causal inferences nor generalize findings to other populations (Hamel et al., 1993; Ruzzene, 2015).

C.2.2 Case Selection

For this case study, we selected two HMRE grantees that had significant experience serving Spanish-speaking participants. These included one grantee organization with a primary focus on serving the Latinx community and another grantee that served a large number of Spanish-speaking individuals, but did not specifically focus on Latinx communities. We chose Family Services of Merrimack Valley (FSMV), located in Lawrence, Massachusetts, as an HMRE grantee that exclusively served Latinx participants, and University of Denver's Motherwise Program, located in Denver, Colorado, as an HMRE grantee that served a large (but not exclusive) Latinx population.

C.2.3 Data Collection

In each site, we conducted semi-structured, qualitative interviews with HMRE program staff and leadership, as well as staff advocates at each of the local domestic violence programs with which those grantees partnered. RTI researchers with expertise in qualitative data collection and in HMRE program approaches to IPV facilitated all interviews, which were conducted by telephone. We interviewed two case facilitators from each of the two HMRE grantees, as well as two administrators from Motherwise and one administrator from FSMV, for a total of seven interview participants. We also interviewed the HMRE program's key point of contact at each of their local domestic violence partner organizations, for a total of three interview participants. Staff took verbatim notes on interviewees' statements.

We also held a focus group with survivors and non-survivors who had participated in HMRE programming and IPV-related screening and education at the Motherwise program site. Based on their previous work and recommended practice (Fraga, 2016; Lyon & Sullivan, 2007), researchers planned for and enacted measures of safety, including maintaining confidentiality and establishing a supportive and non-judgmental environment during the focus group. In maintaining confidentiality, the facilitator did not ask for signatures for documentation of compensation from participants. (A staff person who helped coordinate the logistics of the group signed a form indicating that each participant was compensated.) During the focus group, the facilitator explained the importance of maintaining confidentiality, welcomed participants to choose pseudonyms, and avoided referring to participants by their first names or any

other term that could help to identify them. The facilitator did not ask about or refer to specific locations or name places that could point to geographic residency. Eight women participated, which allowed for a variety of perspectives and maintained manageability (Krueger & Casey, 2014). Focus group participants were all immigrants. Seven participants were from Mexico and the eighth was from El Salvador. Their observed ages ranged from twenty-five to forty. All participants identified that they had children and were in heterosexual relationships.

C.2.4 Analysis

Focus group data analysis was conducted by NLN staff. The first coder (who also conducted the focus group) utilized Krueger & Casey's (2014) framework to embed herself in the data, which entailed listening to the session in its entirety and reviewing observational notes taken during the facilitation. The first coder then reduced data by direct content analysis, identified themes, and grouped the data that corresponded to each theme and quotes (Miles et al., 2014). The second coder reviewed the data that had been grouped into themes and quotes (Krueger & Casey, 2014), and both coders discussed any discrepancies in opinion and reached consensus. The RTI team used similar analytic methods to theme the qualitative data that resulted from the HMRE staff and domestic violence partner interviews. One analyst led initial theming of the HMRE staff interview data, while the other led initial theming of the domestic violence staff interview data. The two analysts then reviewed one another's findings. Staff from RTI and NLN reviewed and discussed one another's preliminary focus group and staff interview findings and draft summary reports. The findings presented here represent the consensus of both teams.

C.3 Findings

C.3.1 Partnerships Between HMRE Grantees and Domestic Violence Programs

Partnership origins and agreements. Both of the HMRE grantees had formed partnerships with their local domestic violence programs within the last two years, since they began HMRE program implementation. Family Services of Merrimack Valley (FSMV) partnered with the YWCA of Greater Lawrence's domestic violence program. Motherwise partnered with SafeHouse Denver Domestic Violence Services and the Rose Andom Center, a family justice center.

Motherwise explained its dual partnership structure in this way: "We use one organization [SafeHouse Denver] to refer clients to for services, and another organization [Rose Andom Center] to help the clients link up with other outside services, such as immigration assistance, housing assistance, employment."

Partnerships between HMRE grantees and all three of their domestic violence program partners involved formal, contractual relationships with associated financial commitments on the part of the HMRE

grantee. Contractual relationships focused on responsibilities for training, for services provided to HMRE program participants, or for office tenancy (as in Motherwise’s partnership with the Rose Andom Center, with which it was co-located).

Staff at both HMRE grantee organizations shared that considerations related to cultural responsiveness had informed their choices of domestic violence partners or shaped the roles and agreements they had developed with those partners. In particular, it was important to both grantees that bilingual staff be available to meet the needs of HMRE clients whom they referred to their domestic violence partners. It was also important to them that domestic violence partners be equipped to capably address any issues, such as immigration status concerns, that could affect Spanish-speaking IPV survivors’ disclosure, help-seeking, and outcomes.

Leaders of the HMRE programs and the domestic violence programs described their partnerships as based on clear and mutual mission compatibility. Staff at YWCA and FSMV characterized their relationship as very positive, collaborative, and functional. SafeHouse Denver staff characterized the partnership with Motherwise as a “natural connection” based on “tangible places where our goals intersect.” Rose Andom Center also noted clear mission compatibility with Motherwise: “They seem to us to be a very mission-compatible agency. I couldn’t have asked for a better partnership.”

Per their agreements with the HMRE grantees, the three domestic violence programs undertook a range of formal responsibilities under the HMRE grants, particularly training, advising HMRE staff on how to identify IPV and when to refer, and receiving warm handoff referrals. For example, YWCA staff delivered a 9- to 11-hour training to FSMV staff in English and in Spanish on IPV awareness, with a focus on recognizing warning signs or “relationship red flags” and the basics of safety planning. SafeHouse Denver staff trained Motherwise staff on recognizing signs of IPV, when and how to make a referral, and what services were available at the YWCA.

Communication and coordination. In general, communication between the local domestic violence programs and HMRE grantees took three forms:

1. Formal training and informal opportunities for “cross-training,” particularly familiarizing one another with available services at each organization.
2. Standing meetings, whether between staff of the two organizations only or as part of larger networking meetings. Such regular meetings were organized around one of the partner organizations (e.g., a meeting of all of the domestic violence program’s partners or of all of the HMRE program’s partners), or among a wider group of organizations in the community that served Latinx clients.

3. Communication about specific HMRE program participants, which took the form of HMRE staff seeking advice or guidance from domestic violence program staff. Although domestic violence programs could, in theory, share information back to the HMRE grantee with a release of information from the client, this was not common practice.

Staff at Motherwise, SafeHouse Denver, and Rose Arom Center recounted how initial cross-training and open cross-organizational conversations had helped them to resolve early concerns and develop real alignment regarding their joint approach to serving Spanish-speaking IPV survivors. For example, staff from Rose Arom Center and SafeHouse Denver had participated in the Motherwise parenting class orientation and facilitator trainings. SafeHouse Denver staff commented that this was quite valuable in addressing their initial concerns and building the ability to communicate effectively across the two organizations: “We know exactly what their approach looks like. There initially were concerns about their focus on the skill-building piece, and being able to see their curriculum and intentions from beginning to end helps us to understand where we fit and how we communicate that clearly with staff and program clients.” In addition, arriving at a shared understanding of the bounds of their respective service provision had been critical for building trust and collaborating effectively: “Their program is very focused on skill-building, and it’s important to me for them to understand that skill building is no longer a safe intervention tool once you have a disclosure.”

Motherwise staff observed that initial communication with both of their partner organizations—to refine and clarify roles and expectations, to optimize staff “fit” for partnership-related roles, and to streamline the process of referral for IPV-related services—had resulted in stronger, more effective collaboration. FSMV commented that their partnership with YWCA had remained consistently positive, and that HMRE staff particularly appreciated their domestic violence partner’s flexibility and responsiveness with regard to referral handoffs and staff trainings.

HMRE and domestic violence program staff also found standing meetings to be of use in maintaining their working relationships. YWCA staff attended FSMV’s network meetings and director-level meetings to discuss their joint services. The two organizations also met via phone every other month to discuss their ongoing partnership. Motherwise did not maintain formal standing meetings with the Rose Arom Center, because their co-location led to such frequent contact as to make a standing meeting seem unnecessary. At the time of our interviews, Motherwise reported that they were about to institute regular meetings with SafeHouse Denver.

Finally, Motherwise and FSMV each maintained ongoing consulting relationships with their local domestic violence programs regarding how best to serve specific clients. Such client-specific consultations

tended to occur on a case-by-case and “as needed” basis, generally in situations where HMRE staff needed support in determining whether or how to make an IPV-related referral.

Changes to partnership agreements or procedures. During approximately two years of partnership, FSMV and YWCA each reported a stable, consistently positive, and relatively static partnership. In contrast, Motherwise and SafeHouse Denver staff reported making a number of ongoing adjustments to their collaboration over the course of HMRE program implementation. For example, the two organizations recently adjusted their processes to make sure that the first SafeHouse Denver staff member with whom their Spanish-speaking clients make contact is bilingual. Motherwise staff explained, “We discuss with our partners frequently their roles and responsibilities because sometimes they change. It is a continuous conversation.”

Program Participant Perspectives on Partnerships Between HMRE Grantees and DV Programs

Participants at the Motherwise site who attended the presentation by advocates from the local DV program discussed their appreciation for getting the information directly from DV program staff.

Some participants also expressed a sense of comfort in knowing that the DV program was located close to the HMRE program (on a different floor of the same building), feeling that it was accessible if they were to need it.

C.3.2 HMRE Grantees’ Domestic Violence Protocols

Both HMRE grantees collaborated with their local domestic violence partners to develop their domestic violence protocols. Both protocols addressed the following elements of organizational procedure: IPV training, identification, referral, and staying safe during HMRE activities. The Motherwise protocol also included procedures for helping participants make decisions about HMRE participation.

Program Participant Perspectives on IPV Screening Process

Participants stated that they had not seen or did not remember answering the screening questionnaire. After reviewing some of the questions during the focus group, participants suggested that those questions were different from the ones they responded to over the telephone. Participants alluded to the questions being presented to them in a more informal and conversational way, which they appreciated.

Participants felt that timing was critical for obtaining honest feedback during screening. Participants suggested that the best time to ask questions about IPV would be during the personal interview with the facilitator with whom they all had developed trust.

Si es al principio no creo que las respondan, porque primero tienes que generar la confianza. Yo pienso que genera más confianza en tu cita individual y ya si la persona se siente más cómoda y con la confianza de decirlo en el grupo, está perfecto, pero para preguntarlo así directamente yo pienso que genera más confianza personalmente... (If it is at the beginning I do not think that they respond, because first you have to generate the trust. I think it generates more confidence in your individual appointment and that way the person feels more comfortable and with the confidence to say it in the group, it is perfect, but to ask it that way directly I think it generates more confidence personally...)

One participant suggested that IPV screening questions were best suited for the middle of the program (referring to the third session of the six-session program). Another suggested that screening occur just after the class on IPV, so that individuals understand that it is not only physical violence.

Participants stated positively that they felt comfortable with the HMRE facilitators. One commented that, when she brought her partner to the program, the couple talked with the facilitator about things they had never discussed before.

Fue como una terapia, te dan una hoja y tienes que esperar turno y dejarlo hablar... yo sentí que había sacado todo lo que tenía que nunca en mi vida había sacado. (It was like therapy, you get a sheet and you have to wait your turn and let them speak ... I felt that I had taken out everything I had that I had never taken.)

Others expressed that they would feel comfortable discussing it with facilitators if they felt threatened, and that they felt that staff would be capable of providing help.

Porque como dijo ella, ... nos han demostrado que tienen los medios y pues para ayudar a las demás personas. No que muchas veces uno no sabe cómo hacerle o en qué momento hablar o decir. (Because as she said, ... they have shown us that they have the means, and therefore, to help people. Because many times a person does not know how to do it or at what moment to speak or to tell.)

All three local domestic violence programs expressed confidence in the processes used by HMRE grantees to identify and respond to the IPV-related needs of their Spanish-speaking participants. To these organizations, what was most important was that HMRE grantee staff knew how to recognize signs of IPV and to respond and refer appropriately when participants offered disclosures. YWCA staff cited two specific aspects of their joint processes as crucial for supporting survivors: (1) YWCA staff

were available to go to FSMV's offices to serve their clients, which was particularly important for facilitating safe access to their services, and (2) YWCA took a client-centered approach to service delivery, which focused strongly on meeting victims'/survivors' self-defined needs and goals.

Staff at two of the domestic violence programs observed that HMRE grantees (by the nature of their program models) might have contact with perpetrators, and that their joint procedures lacked options for referring perpetrators for intervention. Since none of the domestic violence programs offered services for perpetrators, meeting this need would have required the development of additional community partnerships and additional procedures for safely executing those referrals.

C.3.3 Screening and Referral Approaches

Screening and referral processes. FSMV staff invited IPV disclosures by screening all HMRE participants for IPV during initial program intake. They used a screening approach developed by YWCA. Participants who answered yes to any of the screening questions, or those who volunteered a disclosure at any time thereafter, were referred to YWCA for full assessment and any needed services.

The Motherwise program, which included a focus on IPV in its core relationship education curriculum, took a universal education approach. They emphasized allowing disclosure to occur at the client's own pace. Motherwise facilitators made efforts to meet with their Spanish-speaking clients privately to create opportunities for disclosure further into programming. Staff noted that participants were more likely to disclose after the class session on IPV. For individuals who disclosed at any point, Motherwise staff were trained to go through the same intake form with their program participants that SafeHouse Denver staff would use during their own intake process, and then to share that information with SafeHouse Denver (with client permission) when making the referral. Motherwise referred clients with IPV-related legal needs to the Rose Aodom Center.

HMRE staff and staff from all three domestic violence programs indicated that the process of screening program participants or otherwise inviting disclosures was the same regardless of language or culture.

Disclosure outcomes. Motherwise estimated that staff had referred about 20% of their total client population for IPV-related services, and that about a quarter of them had been Latinx. FSMV reported one referral to date.

Program Participant Perspectives on Barriers to IPV Disclosure

Some participants discussed how the time that elapsed between the occurrence of a violent act and the gravity [what exactly do you mean by gravity here?] of the act may influence whether or not someone would disclose violence. Others suggested that women may not disclose IPV if they do not want to end their relationships or do not feel they can end their relationships. They noted that women may be afraid of consequences for their children, afraid of having to seek employment, afraid of the perpetrator himself, or may believe that they have to tolerate the abuse.

Porque a unos de Latinos [dicen] porque esa es tu cruz y eso te tocó a ti y por eso tienes que aguantar por tus hijos. (Because some Latinos [say] that is your cross to bear and that's just what you have to do and that is why you have to put up with it, for your children.)

Y la otra es que están amenazadas y obligadas a estar allí y no tienen las opciones de salirse... pero yo he visto otras situaciones en las que están allí y no quieren salirse porque voy a tener que trabajar. (And the other is that they are threatened and forced to be there and they don't have the options of how to get out... but I have seen other situations in which they do not want to leave because, "I am going to have to work".)

Another participant addressed the fear that some people experience of not knowing how calling the police might affect their children, how not being native-born affects a person regardless of immigration status, and how places like Motherwise can provide the help someone may need in order for them to feel like they can disclose.

Hay personas que las golpean y no llaman a la policía por el mismo miedo y más aquí por el hecho de no ser americanos aun con papeles o sin papeles, y que va a pasar, que va a pasar con mis hijos. Entonces hay personas que tienen más confianza aún como aquí por ejemplo Motherwise y tener la asesoría que ellos te pueden asesorar legalmente, o igual a la policía, yo pienso que es viable tener el contacto de aquí y tomarlo en cuenta. (There are people who get beaten and they don't call the police because they are afraid to and more so here because they are not Americans, even with papers or without papers, and then what will happen, what will happen to my children. Then there are people who have even more trust, like here for example at Motherwise, and to have the advice, that they can advise you legally, or the same with the police, I think it is feasible to have the contact here and to count on it.)

Asked to reflect on potential challenges to disclosure that Spanish-speaking HMRE participants might face when considering a disclosure, domestic violence program staff suggested that the family focus of HMRE services could deter disclosure, either because “clients are going there to receive other assistance, and may not feel it's appropriate to disclose” or “they may want the father to become a

better parent, but they may choose not to talk about how the father is as a partner.” The couples-based service delivery model (implemented by FSMV) was seen as a specific barrier to disclosure, surmountable with tailored screening procedures: “If they’re doing an interview with both partners, the person won’t disclose in front of their abuser. But they typically interview the male alone by a male staff and the female alone with a female staff, even if the two people initially come together.”

Rose Andom Center staff noted that disclosures would generally be based on a victim’s assessment of “whether it feels safe to identify, whether you believe there will be resources to help, how judgmental those will be, how safe it will be.” SafeHouse Denver staff speculated that having domestic violence advocates present during more HMRE program activities might help make participants feel more comfortable disclosing to them. (At the time of the RIViR case study interviews, SafeHouse Denver advocates attended one of six weekly sessions.)

HMRE and domestic violence program staff all acknowledged that culturally specific barriers or facilitators to disclosure might also be present for their Spanish-speaking Latinx participants. A YMCA staff member noted, “If they have the belief that domestic violence is a personal issue or a couples’ problem that you don’t disclose to others, that may prevent [disclosure]” and, “If they’re not aware of their rights and how the system works, they could be intimidated, especially if they’re afraid of the police.” SafeHouse Denver staff observed, “There may also be cultural and religious pressure to stay in a marriage” and that concerns about potential consequences of police or child protective services involvement also deterred disclosures. Motherwise staff reportedly attempted to ease these concerns by assuring participants that they would not report them to law enforcement or immigration, would not share any information on immigration or citizenship, and were there to help and support them.

Motherwise staff also suggested that Spanish-speaking Latinx HMRE participants had distinct interpersonal preferences surrounding disclosure. A staff member noted, “Spanish-speaking women are less likely to disclose during the IPV classes than English-speaking women...They are more likely to disclose in private with their case managers.” For this reason, Motherwise revised their approach to creating opportunities for disclosure such that facilitators made efforts to speak to Spanish-speaking participants more frequently in private, hoping to ensure that these women had comfortable opportunities for discussing their needs.

C.3.4 Services for Spanish-speaking Latinx Participants Who Disclose

Availability of referral-based services in Spanish. In both case study sites, Spanish-speaking HMRE program participants who were referred to any of the local domestic violence program partners could access a wide variety of IPV-related services in Spanish (see Table 1).

All three domestic violence programs offered all of their core services in Spanish. For victims with other related needs, such as housing or legal services, domestic violence programs attempted to provide tailored referrals to other community partner organizations that had bilingual staff or were known to offer culturally relevant services to the Latinx community. Some also provided interpretation and accompaniment for Spanish-speaking victims who needed forms of outside support that were only available in English (for example, housing agency assistance with low-income housing applications). Rose Andom Center worked to cultivate a number of outside partnerships specifically intended to maximize their integration with and accessibility to Spanish speakers, including participating in a Latina Services Network that was “providing more networking around better serving Latina victims of DV.”

Table 1. Referral-Based Services for Spanish-speaking HMRE Participants Who Disclose IPV

Site	Available Services
Family Services of Merrimack Valley (Grantee)	
YWCA of Greater Lawrence (Domestic Violence Partner)	<ul style="list-style-type: none"> • 24-hour crisis intervention hotline • Individual psychoeducational sessions about the cycle of abuse, forms of abuse, options, confidentiality, and emotional validation • Single-gender group counseling (when at least 5 interested clients) focused on IPV, sexual assault, and coping • Support for survivors with filing restraining orders • Hospital visitation • “Children Who Have Witnessed Violence” program
Motherwise at University of Denver (Grantee)	
SafeHouse Denver (Domestic Violence Partner)	<ul style="list-style-type: none"> • Emergency confidential domestic violence shelter, including a family program and a women’s program • Longer-term individual counseling • Women’s support group • Mother-child support group
Rose Andom Center (Domestic Violence Partner)	<ul style="list-style-type: none"> • Screening, risk assessment, and safety planning • Adult counseling • Child counseling (interpreted) • Advocacy and crisis intervention • Civil legal assistance (protection orders, assessment of divorce custody) • Public benefits applications with an HHS staffer • Low-income housing applications with housing department (interpreted) • Criminal justice intervention (bilingual detectives, bilingual police department victim assistance providers)

Post-referral service engagement. When asked what factors tended to make it more likely that Spanish-speaking clients would access the IPV-related services to which HMRE staff referred them, interviewees named several “warm handoff” practices:

- Making the phone call to the domestic violence program with clients, rather than simply giving them the information;
- Giving clients name and contact information of a specific person to whom they could reach out and from whom they know what to expect;
- Addressing needs for transportation and childcare;
- Establishing client familiarity with the physical spaces to which they might be referred (for example, HMRE participants who had already brought their children to Rose Anom Center for child care seemed to feel more comfortable there); and
- Offering clients the option to talk with domestic violence program staff over the phone from an office at the HMRE grantee organization.

Interviewees noted that accessing domestic violence program services by telephone from the HMRE office often felt both safer and more convenient to clients. They suggested that it was a particularly important option for connecting Latinx immigrant clients with domestic violence partners whose offices were co-located with criminal justice agencies, which staff noted could deter some undocumented immigrants from accessing services in person. Practices like these were seen to help address the needs of Latinx immigrant participants in particular, and to build trust and support participation for all clients.

When Spanish-speaking clients needed outside services, all three domestic violence programs worked to tailor their referrals to focus on organizations that would best meet their linguistic and cultural needs. In the Denver site, this was usually possible; in the other, which was less urban, it was occasionally challenging to connect clients with Spanish-speaking attorneys and therapists (for which wait times could be prolonged). If staff were unable to connect a client with an organization that provided the needed service in Spanish, domestic violence programs in each case study site had resources to provide an interpreter or send a bilingual and bicultural advocate to accompany the client. All three domestic violence programs had connections with legal assistance organizations that could support survivors in managing immigration concerns.

Program Participant Perspectives on IPV-Related Services

Participants expressed agreement that it was important for the HMRE program to address IPV in the Latinx community. Participants also felt it was important for their own processes to learn about IPV and be able to identify it. However, a few participants indicated the need for more information and resources around what constitutes IPV.

Porque muchas veces sufres tú la violencia doméstica y lo ves tan cotidiano que piensas que es normal, y no te das cuenta de lo que estás sufriendo, y aquí te enseñan, te ayudan para que te hacen ver de que estás en un círculo de que no es bueno. (Because you often suffer domestic violence and you see it daily. You think it is normal, and you do not realize what you are suffering. And here they teach you, they help you to make you see that you are in a cycle that is not good.)

Participants mentioned having received information about the issue of IPV, but not necessarily in a uniform manner. Some participants mentioned having learned about the issue only through the book used in the program, while others described IPV content being delivered during the visit of the DV partner organization staff. Participants also reported varied experiences of receiving information about the local DV partner.

Solamente nos dio información de donde están ubicados, el número de emergencia si alguien lo necesitan. (They only gave us information of where they are located, the emergency number if anyone needs it.)

Participants received a brochure and /or card with the phone number of the domestic violence organization where they could receive help, but did not obtain detailed instruction on the process for following up.

Que si estábamos viviendo en violencia nos dieron un folleto y de que había un número y de qué preferencia llamáramos para hacer cita pero que las atendían si no tenían cita. (That if we were living in violence we were given a pamphlet and that there was a number and what preference would we call to make an appointment but that they will attend to them even if they did not have an appointment.)

Participants suggested that spreading the word through informal relationships would be a promising way to share information about the local DV partner's resources. They urged, "Difundirse más, en las redes sociales. (Disseminate more, in social networks.)".

Motherwise and FSMV conducted some post-HMRE program follow-up with all participants who were referred for IPV-related services.

C.3.5 Approaches to Culturally Responsive Service Delivery

Culturally welcoming physical environment. Rose Andom leadership also described making choices in their physical environment to be culturally appropriate and welcoming for Latinx clients: “Being new, we’re really looking at our physical environment, what we can be doing in terms of graphics, posters, signage that helps make sure we’re being a more inclusive location and Latina folks coming in can identify that this is a place where they’ll be served and have people who speak their language.” She further explained how the physical environment was intended to send signals of welcome: “Part of it is just that on any given day, you’re likely to hear conversations in Spanish here as you’re walking through the building; it’s a normal part of how things look. We’ve been conscious of it in the food choices here in the kitchen area—we’ve got a great big kitchen area—and one of our staff will bring in things from a Mexican bakery and make sure we have those different kinds of food available. We have a bulletin board in the kitchen with resource information in English and Spanish.”

Tailoring of outreach. The HMRE grantees and domestic violence partner organizations included in this case study varied in the extent to which they conducted active outreach to local Latinx communities; however, none pursued active community engagement. YWCA did not characterize its outreach work as being proactively inclusive of Latinx communities, but leadership noted that educational workshops that staff delivered for local Latinx-serving groups and organizations were provided in a linguistically and culturally responsive manner. SafeHouse Denver, which had previously had a distinct outreach position, noted at the time of our interview that “outreach” duties had been absorbed by leadership. The lack of dedicated staff support for this function had resulted in an emphasis on responsiveness to community requests for involvement over proactive outreach. Such requests occasionally came from organizations serving Spanish-speaking community members, but more often from English-speaking professionals and programs. Finally, Rose Andom Center reported a comprehensive effort to inform and engage the local Latinx community in services, for example:

- Working with the Spanish-language television station to run public service announcements;
- Printing a donated one-page feature on IPV, local services for survivors (including Rose Andom Center and the justice agencies with which it affiliates), and immigration concerns for survivors in the local Latinx magazine;
- Working with a grassroots victim services organization serving the Southwest Latinx community;
- Offering a segment on IPV as part of a Spanish-language training held by the statewide victim assistance unit for 25 volunteers; and

- Partnering with Servicios de la Raza to host an onsite case manager one day a week for individualized assistance.

Tailoring of assessment and safety planning. While all three local domestic violence program partners provided for full linguistic accessibility in their intake and assessment processes, none described adapting their initial assessment to be culturally responsive to the local Latinx community. As one administrator explained, “It looks the same in English as in Spanish,” and this equal linguistic access was the primary focus; none of the domestic violence program partners we interviewed discussed plans or opportunities for cultural tailoring at the time of initial intake and assessment.

Leaders at all three domestic violence programs noted that discussing confidentiality and mandated reporting responsibilities and receiving informed consent were a part of this standard intake conversation with new clients. Although potential reporting to immigration enforcement agents was not an explicit focus, staff at all three programs regularly addressed such concerns with undocumented clients. As YWCA leadership explained, “We let them know that we have no connection with immigration services and are not responsible to report on either party. We usually share that if they disclose they are undocumented.” These contextual issues created potential barriers to client-provider trust that staff found it necessary to address directly. Motherwise facilitators noted that in response to the current federal climate regarding immigration, they had recently adapted their intake process to avoid asking about immigration status: “Clients are assured that immigration status is not questioned or recorded, and this encourages trust and disclosure of needs from clients to staff.”

With regard to safety planning, respondents noted that certain core elements of the safety plan—“filing a restraining order, changing locks, avoiding the kitchen and bathroom and other places with one entrance/exit if there is an argument, changing routes to school or work”—would be consistent regardless of a client’s culture. However, SafeHouse Denver and Rose Arom Center staff each noted that other aspects of the safety planning process were heavily informed by cultural considerations and contextual factors. These included the importance of considering larger household structures and provisions for extended family in safety planning, and addressing clients’ concerns related to documentation status and calling the police: “Perpetrators exploit the fear of being deported, and so we have conversations about what to do if you were picked up by ICE as part of a safety plan and talking through some of the myths. A lot of clients will initially opt out of calling the police as part of the safety plan, because they fear the police calling immigration, and they may change their minds once the advocate gives them more information to inform that.” Staff at all three sites discussed how important it was to educate undocumented survivors about their rights and about the potential effect of involving the criminal justice system on their immigration status, including the positive implications for U visa applications of having abuse formally documented in a police report or court proceeding.

Tailoring of services. Although interviewees noted that many of their clients were women in contact with their abusers, none of the HMRE grantees or their local domestic violence partners tailored their work to include a focus on services for men and (as a matter of victim safety) neither served perpetrators. They did offer a range of services for children and other family members, however. YWCA offered individual and group counseling for any family members of the person referred for services. Motherwise's domestic violence partners, SafeHouse Denver and Rose Andom Center, offered mother-child groups at shelter, child counseling at counseling center for children of mothers who were engaged in services; counseling with a separate counselor for each non-perpetrator family member (SafeHouse Denver); and child counseling and a two-hour workshop for non-perpetrator friends and family on supporting an abused loved one (Rose Andom Center).

Rose Andom Center staff testified to the way Motherwise's efforts to engage children had made the whole program more welcoming and inviting: "The piece I see every day walking back and forth through the building is the child care [Motherwise is] doing with the kids over here. They've had consistent staffing and they are just wonderful. One Rose Andom Center client was bringing her kids consistently over a couple of months who can be a little challenging, and they ran into some kind of wrinkle there and they worked it out and she has continued to come to services and continued to bring her kids in. Their staff are great. That's their area of expertise and I've really appreciated the communication and how they've made things work better for the kids and the moms." Motherwise staff observed that the framing for so-called child care was important, however. Many English-speaking mothers appreciated the offer of child care during programming, whereas Spanish-speaking mothers liked the idea of their children being included in programming but not of "dropping them off" somewhere.

None of the organizations included in the case study reported efforts to actively engage Spanish-speaking clients in offering feedback on how to best tailor their services. Neither organization asked their Spanish-speaking clients for specific feedback on their experiences in the HMRE program. The Motherwise program gathered feedback from participants at the end of each course, although there was not an explicit focus on cultural relevance. FSMV staff reported that they did not have any formal process for eliciting participant feedback on programming or screening. Rather, efforts at cultural tailoring of HMRE and domestic violence program services for Latinx Spanish speakers were initiated by bicultural staff or by participants themselves. All three domestic violence programs cited the expertise of bicultural staff as playing a pivotal role in adapting services. SafeHouse Denver staff explained, "We have one bilingual advocate who's been staffed here for 20 years, so we defer a lot to her, and she's the one who has shaped that programming."

In many cases, clients also played an important role in tailoring services to cultural needs as well as situational factors (such as immigration issues). Both YWCA and SafeHouse Denver noted that group

counseling services for Spanish-speaking clients were shaped by their Latinx clients in culturally relevant ways: sharing food, maintaining very long-term friendship connections among participants. As a YWCA administrator explained, “Although our intention for providing services isn’t different, they organically become different.” SafeHouse Denver staff observed that, “English groups have more rotation in and out, whereas in the Spanish group some have been coming for years, they have long-term relationships with the other women and the facilitator and carry those friendships outside of group as well, and they cook and share food at the group. The topics discussed are the same.” Rose Andom Center staff reported that they had adapted their court-related services in response to clients’ immigration concerns by developing a process whereby these clients could wait at the Center’s office to be called to court rather than waiting around the courthouse where they feared being targeted by immigration enforcement: “We have had victims concerned about waiting over in the courthouse because we had publicity about ICE agents patrolling the halls at the courthouse. We have agreed that victims who don’t feel comfortable in the courthouse can hang out here, have coffee, check their email, and if they have to go over, an advocate will walk them over and stay with them.”

Both the Motherwise and the FSMV programs maintained regular meetings with their staff to ensure that they were being linguistically and culturally responsive to their Spanish-speaking clients. Cultural adaptations were an ongoing process and a regular subject at weekly meetings. “We have weekly facilitator discussions to make sure that we are approaching our clients in the best way possible. Are we being culturally sensitive, are our materials up to date, are we approaching disclosure and safety in the best way possible? These meetings are pivotal to discover what works well and what doesn’t.” FSMV, which served an entirely Latinx client base, tailored a variety of services to different cultural populations. As one staff member explained, “Materials and programming are culturally and linguistically minded. All activities are conducted with a specific culture in mind, Dominican or South American.”

Program Participant Perspectives on Culturally Responsive Service Delivery

Participants voiced general satisfaction with how services related to their needs as Spanish-speaking Latinx/Hispanic immigrant women. They noted that through the program they had learned new communication techniques and ways to relate to their partners, their children and other people in their environments. Participants also reported that they were satisfied with how the program had helped them in other areas of their lives, such as with legal counsel, transportation, material necessities, and school advocacy for their children.

Ayuda mucho decir lo que sientes con ellas. Te dan mucha confianza. Son muy amables. Haces nuevas amistades. Te ayudan en lo que necesites ... sea abogado, escuela, recursos, pañales, ...te ayudan más que nada a saber comunicarte con las personas. (It helps a lot to say what you feel with the other women. They give you a lot of confidence. They are very kind. You make new friends. They help you in whatever you need ... be it a lawyer, school, resources, diapers... they help you more than anything to know how to communicate with people.)

Participants also felt that program staff understood their personal situations and were willing to provide them support within (e.g., transportation) and outside (e.g., legal counsel) the program. All of the participants mentioned the fact that their children were happy in the program, which was very important to them culturally. Several mentioned that their children were happy to attend the program and wanted to continue with the classes. One participant mentioned that, in her opinion, mothers returned to the program more for their children than for themselves.

Ellas dan la facilidad. Yo no tenía transporte y esa es una de las razones por las que a veces uno no puede participar. Igual yo tengo una niña de 4 años y yo no sabía que si la podía traer, y al momento que ofrecieron el servicio [yo lo aceptó]. (They make it easy. I had no transportation and that is one of the reasons why sometimes you can't participate. Also, I have a 4-year-old girl and I did not know if I could bring her. And the moment they offered the service [I took it].)

Another important cultural element participants discussed was respect. All of the participants stated that they felt treated with respect, and this was important for them to feel committed to the program.

Me siento respetada por el trato y la comunicación que tienen con uno, la forma en que hablan conmigo... se toman el tiempo. (I feel respected with how they treat me and the communication they have with a person, the way they talk to me...they spend time.)

In terms of culturally tailored materials, participants noted issues with the video used in their classes. Several women commented on the poor quality of the video production that was used to supplement the manual. They noted that the message in the video was not clear and did not seem to match the content of the manual.

En mi opinión los videos, ... a veces no se les entienden, como que no eran profesionales, la verdad yo pensé que como que no sabían lo que estaban diciendo. (In my opinion the videos, sometimes I don't understand those. It's as though they were not professionals, as if they did not know what they were saying.)

Participants mentioned having received information about the issue of domestic violence but not necessarily in a uniformed manner. Some participants mentioned having addressed the issue only through the book used in the program; others did so during the visit of staff of another organization.

W # 1. Nosotros solo vimos en clase por parte del libro, pero no tuvimos la visita del personal, pero ya al final nos dieron el número... (We only saw in class by the book, but we did not have the visit of the staff, but by the end we were given the number ...)

Solamente nos dio información de donde están ubicados, el número de emergencia si alguien lo necesitan. (They only gave us information of where they are located, the emergency number if anyone needs it.)

La información de la violencia doméstica te la dan ese día en el libro y después viene una persona y te da esa información de donde puedes ir. (The information on domestic violence they give you that day in the book and then a person comes and gives you the information where you can go.)

C.3.6 Organizational Characteristics and Capacity

Staff linguistic and cultural competency. All three domestic violence programs had strong representation of bilingual and bicultural staff in client-facing positions, although they were underrepresented in leadership and supervisory roles. A SafeHouse Denver interviewee explained, “We have a preference for individuals who are not just bilingual but bicultural. It’s similar at both counseling and shelter. The shelter is a residence, and for mirroring the comfort of being around people, that family aspect, being bicultural is just so helpful.”

Staff at three organizations noted that their Latinx staff members’ connections to the Latinx community were an important organizational asset. They noted strong relationships with other community-based organizations that served the local Latinx community, and the importance of these strong community partnerships for effectively serving their Spanish-speaking clients. Leaders from YMCA and Rose Anom Center noted how one or two well-connected individual Latinx staff members made a tremendous difference to the organization’s efforts at building community trust and receiving referrals.

In addition, a SafeHouse Denver interviewee noted that having older women among the Spanish-speaking staff was supportive as well: “There’s an age aspect, too. We have an advocate in her early twenties and one in her early fifties, and the older one has shared that many clients wouldn’t disclose their trauma to a younger advocate because of not wanting to taint this young person because of making her hear these difficult things.” FSMV staff shared that they made a point of employing male facilitators so that they could offer single-gender groups in the Spanish-speaking couples program.

Staff training. In each of the two case study sites, staff interviewees stated that they prioritized hiring bicultural staff over providing cultural responsiveness training to non-Latinx service providers. All three local domestic violence partners took advantage of national and local education and training resources relevant to their work with Latinx communities. For example:

- SafeHouse Denver staff reported participating in continuing education on immigration issues facing their undocumented clients and their implications for IPV-related service provision and participated in occasional webinars on serving Latinx IPV survivors.
- All YWCA staff received training modules on working with Latinx communities and working with immigrant survivors as part of their 40-hour rape crisis counselor training.
- Rose Andom Center staff participated in cross-training with their community’s largest Latinx community services organization, Servicios de la Raza. Trainers presented general information about responding to the needs of the Latinx community, along with specific information on the culturally responsive services available through their organizations.

Both of the HMRE grantees reported receiving initial and refresher trainings from their domestic violence partners. FSMV noted that the training they received was in Spanish. HMRE staff found this very helpful in preparing them to communicate about IPV competently with Spanish speakers. Neither grantee received IPV training that focused on cultural responsiveness.

Language needs of domestic violence and HMRE partners’ service populations. Each of the HMRE grantees studied served a majority Latinx population, but their linguistic and cultural characteristics differed. Motherwise served a 68% Latinx population, about 20% of whom preferred to communicate in Spanish. Its domestic violence partner, YWCA, served a client population that was 80% Latinx, over half of whom were monolingual Spanish-speaking and another 20% of whom preferred to use Spanish in counseling. Culturally, their clients were primarily Dominican and Puerto Rican, with some representation from Guatemalan and Salvadoran communities as well.

FSMV focused exclusively on serving Latinx participants, about 75% of whom preferred to communicate in Spanish. Its domestic violence partners, SafeHouse Denver and Rose Andom Center, each served

about a third Latinx clients. About one third of SafeHouse Denver and one tenth of Rose Andom Center clients communicated primarily in Spanish. Culturally, these clients tended to be immigrants from Mexico and South America.

Language access strategies used. All of the organizations included in the case study strove to make their regular services available in Spanish in the same form as their English-based services. For Motherwise and FSMV, services offered to Spanish speakers were the same as for English speakers, and both used the Within My Reach curriculum. Both programs placed somewhat more emphasis on full linguistic access than on cultural tailoring. They employed bilingual facilitators to maintain close and trustworthy connections to their Spanish-speaking clients. They also offered to speak to their Latinx clients in whichever language they felt more comfortable speaking.

Both HMRE grantees obtained Spanish-speaking materials on IPV from outside organizations (e.g., a resource on strangulation, a resource on the cycle of violence, a safety plan). Translation work was typically done by bilingual/bicultural staff as time allowed or necessity dictated, with an intention to keep wording as close to the original as possible while making adjustments for understanding (rather than literal direct translation). At both sites, bilingual staff consistently reviewed Spanish-language materials to ensure the materials were translated for correctness and fidelity as well as cultural understanding. Similarly, YWCA noted that the language they used in domestic violence educational workshops and other services tended to be tailored as opposed to literally translated. They explained, “For an audience of Spanish speakers, we will often make the language that we use more subtle, whereas for an English-speaking audience we may use the curriculum as set up.”

YWCA and SafeHouse Denver each had a formal Language Access Plan, with most language needs for Spanish speakers met in house. SafeHouse Denver was fully staffed with bilingual personnel in every role and YWCA had more than half bilingual staff, with Language Line access as needed (for example, if connecting clients to providers who speak English). Rose Andom Center did not have a formal Language Access Plan, but noted that their two Spanish-speaking intake staff generally accommodated the needs of Spanish-speaking clients. All three organizations had brochures available in Spanish, and Rose Andom Center noted that some of its justice agency partners also had written materials relevant to domestic violence survivors that were available in Spanish.

Among both the HMRE grantees and the domestic violence partners, some differences in language access strategy were evident based on how large a proportion of the service population was Spanish-speaking. For example, at YWCA (where “Spanish speakers are the largest population that we serve”) all current materials were immediately available in Spanish. At SafeHouse Denver, which served a large but minority population of Spanish speakers, “Our English materials get updated more regularly than the

Spanish, and we're just catching up on that.”

Program Participant Perspectives on Organizational Characteristics and Capacity

Focus group findings indicated that Motherwise created an environment that was welcoming for their Spanish-speaking Latinx participants. Participants who discussed the recruitment process expressed that the warm and cordial invitation they received from the program facilitators motivated their interest in and attendance at the program. Participants expressed a sense of confianza or trust in program staff. For several of them, this was very much influenced by the fact that the staff were Spanish-speaking Latinx individuals themselves.

Bueno, yo pienso que siempre sientes más confianza. Aún como por ejemplo cuando vas al hospital y necesitas traductor, no sientes la misma confianza o la misma comodidad de hablar. Si la persona que está frente a ti es Latina o habla español, yo pienso que sí influye mucho para que varias o sino es que todas estemos aquí: que las representantes sean pues Latinas también. (Well, I think that you always feel more trust. Even, for example, when you go to the hospital and need a translator, you do not feel the same confidence or the same comfort in speaking if the person who is in front of you is not Latino or doesn't speak Spanish. I think this greatly influences why several, if not all, of us are here: that the representatives are Latinas also.)

The participants noted that the treatment they received from facilitators and program staff (including non-Latinx staff) sustained their motivation to continue in the Motherwise program.

Influye mucho el personal porque desde que entras te saludan muy amablemente. (The staff influence this a lot, because from the time you come in they greet you very kindly.)

Incluso las personas que no son latinas o hispanas, tratan de comunicarse en español... como ahora la persona que me recibió, ellas no es Latina y dijo, “Hola.” (Even people, who are not Latino or Hispanic, try to communicate in Spanish ... for example the person who greeted me, she is not Latina and she said, “Hola.”)

Participants noted that they recommended the Motherwise program highly to family, friends and neighbors, and felt confident that their peers would feel comfortable attending.

C.4 Conclusions

This case study brought together insights and perspectives from HMRE grantees, their local domestic violence partners, and Spanish-speaking Latinx HMRE program participants. The efforts of Motherwise, FSMV, and their local domestic violence partners align with those of many programs across the United States that are grappling with offering services to rapidly growing Latinx communities. Like so many other organizations, they exhibit significant areas of strength as well as opportunities for future growth and development in their work with Spanish-speaking HMRE participants. Findings on their work have important implications for the field of HMRE programming in its efforts to appropriately inform, recognize, and refer Spanish-speaking participants who experience IPV.

C.4.1 *Understanding and Recognizing IPV-Related Needs Among Spanish-speaking Participants*

Language can serve as a significant barrier to IPV disclosure for Spanish-speaking Latinx individuals (Vidales, 2010). The Motherwise and FSMV programs documented in this case study had worked with their local domestic violence partners to ensure that IPV screening in Spanish was available to all HMRE participants. Future HMRE programs might benefit from implementing robust language access plans, including plans for Spanish-language IPV screening as well as broader, organizational policy changes to enhance services for non-English speaking participants (NLN, 2016).⁴

The screening processes used by the two HMRE programs did not explicitly address cultural and situational concerns affecting Latinx participants, but staff and participant insights suggest this could be helpful. For example, participants noted immigration status as a primary barrier to disclosure for Spanish-speaking Latinx individuals. This finding is aligned with a growing body of literature on how a climate of immigration-related fear has curtailed IPV-related help-seeking among Latinx community members (O'Neal & Beckman, 2016; Reina & Lohman, 2015; Reina et al., 2014; NLN, 2015). Program participants noted that the Motherwise program helped to address this barrier by creating a sense of safety and familiarity within the program. However, prior work suggests that programs may also need to make substantive adaptations to their IPV screening processes to avoid missing IPV among immigrant Latinx individuals and address culturally specific barriers to disclosure (Silva-Martinez, 2016; Lyon et al., 2016; Lyon & Sullivan, 2007; Leidy et al., 2010; Malhotra et al., 2015). Program participant input suggested that programs should consider omitting questions related to documentation status from

⁴ The National Latin@ Network for Healthy Families and Communities offers a toolkit, [Making Domestic Violence Services Accessible to Individuals with Limited English Proficiency](#). This toolkit may be helpful for HMRE programs or their local domestic violence partners who wish to develop or improve their Language Access Plans as they relate to recognizing and responding to IPV.

program intake and IPV screening processes, and state clearly that documentation status has no bearing on services (Serrata & Notario, 2016).

Finally, program participants believed that Spanish-speaking HMRE participants would be more likely to disclose if they were asked about IPV after receiving educational information about IPV and developing a richer understanding of IPV dynamics. This suggestion also highlights the possibility of inviting disclosure once safety and trust has been established between staff and participants. Future HMRE programs might also consider inviting client feedback on their screening tools in order to identify helpful strategies or problematic items.

C.4.2 Building Partnerships to Meet the Needs of Spanish-speaking HMRE Participants

Little empirical work exists on organizational collaboration between relationship education programs and local domestic violence programs. However, other organizational research finds that partnerships tend to be most effective when the following factors are present: a long history of collaboration; a shared commitment to serving the same local community(ies); early and sustained work to cultivate shared partnership goals, visions, and understandings of culture; explicit and regularly reviewed partnership agreements; involvement of staff at multiple levels of the organizational hierarchy; and frequent, regular communication (as reviewed in McKay et al., 2016).

The partnerships that HMRE grantees and their domestic violence partners described possessed many of these characteristics: organizations had invested time to understand one another's work and develop a sense of aligned missions, they had clear goals for their partnerships and explicit agreements that had been revised over the course of service delivery, and both leadership and line staff participated in cross-organizational communications. In addition, program participants at the Motherwise site identified two aspects of the HMRE-domestic violence program partnership that supported their understanding and comfort: the colocation of the HMRE program with one of its domestic violence partners, and the opportunity to learn about the domestic violence program's offerings directly from an advocate at that program.

In terms of areas for growth, interviewees at both case study sites noted that it could be helpful to increase the frequency of their communications. Further, although both HMRE grantees reported choosing the domestic violence partners in part for their perceived ability to serve Spanish-speaking Latinx participants, cultural competence had not generally been an explicit or ongoing focus of inter-organizational meetings or other direct communication. Future HMRE grantees may wish to identify local domestic violence partners or other organizations that can offer culturally-specific training to support HMRE staff in recognizing and responding to Spanish-speaking Latinx survivors.

C.4.3 Offering Culturally-Responsive Programming

The program participants, leadership, and frontline staff interviewed for this case study all shared a belief in the importance of addressing IPV in the context of HMRE programming with Spanish-speaking Latinx communities. They identified a number of service delivery challenges and strategies that may be relevant to other HMRE grantees and their local domestic violence partners.

Welcoming physical environments. Some of the HMRE grantees and domestic violence programs invested in deliberate efforts to provide environments that were welcoming to their Latinx participants; for others, this was not an explicit focus. Literature suggests that it is important for organizations use their physical environments to communicate that the organization is culturally affirming and diverse. NLN's TA resources include information on strategies for cultivating such environments, which may be relevant to current and future HMRE grantees and their domestic violence partners.⁵

Tailoring activity content to reflect participants' needs. Several of the organizations interviewed for this case study supported the efforts of Spanish-speaking Latinx participants and facilitators to adapt programming to better fit their needs. For example, programs created single-gender groups, or created space for participants to share homemade food with one another during program activities. Such practices are supported by literature suggesting that culturally tailored offerings may help to break down barriers to service-seeking that might otherwise affect Spanish-speaking Latinx participants (e.g., Reina & Lohman, 2015). One of the HMRE grantees tailored their work further, to take into account the needs and preferences of distinct Latinx cultural groups they served. Other HMRE grantees and their domestic violence partners might also consider addressing such differences, including those associated with distinctions in national origin, indigenous background, and acculturation (Valdez-Santiago et al., 2013).

Literature and participant input also emphasize the importance of helping program participants to understand and address situational concerns, such as immigration status (Hancock, 2007; NLN, 2015; Zadnik et al., 2016). The two case study sites each offered a relatively short educational session on IPV, presented by either the HMRE program's own staff or advocates from the domestic violence partner. Participant feedback suggested the need to expand and offer more content and opportunities for discussion to increase their understanding of IPV (e.g., what influences women's decisions about seeking help and staying with or leaving an abusing partner). Participants did not mention knowledge of the legal protections and remedies that a victim can access, such as the U visa. This finding suggests that programs' legal services agency partners could play an important role in raising awareness about

⁵ <https://nationalLatin@network.org/enhancing-community-evidence/cultural-specific-principles>

immigration remedies that might shape HMRE participants' decision-making about IPV disclosure and help-seeking.

Feedback from program staff and participants emphasized the importance of involving other members of an HMRE participant's family in order to make programming more appealing and accessible. Services that HMRE and domestic violence programs offered to children, including child care and children's therapeutic and educational programming, increased participants' sense of comfort and connection to the programs. Prior research on service delivery for Latinx communities, as well as findings from our participant focus group, underscore the importance of offering services for fathers and partners as well (Parra-Cardona et al., 2013; Parra-Cardona et al., 2009). In addition, since many domestic violence programs are not able to serve perpetrators due to victim safety concerns, HMRE programs may need to work with their local domestic violence partners to identify alternate, culturally responsive resources in their communities that can serve those who perpetrate abuse.

Input on linguistic and cultural adaptations. Findings from this case study highlight the varied ways that HMRE grantees and their partners made linguistic and cultural adaptations. To ensure language access, bilingual and bicultural staff at the organizations we studied typically created Spanish versions of English-language materials themselves, or used original, Spanish-language documents obtained from other organizations. Staff felt that these approaches worked reasonably well, but staff noted occasional issues in keeping up with translation of updated or less-used documents. Given these findings, the common issue of bilingual staff burnout, and staff observations regarding the importance of precision in communicating about IPV, other HMRE grantees might consider budgeting for professional translation or using materials developed specifically for Spanish-speaking Latinx participants.

In making cultural adaptations, the organizations in this case study tended to look to their bicultural staff and Latinx participants to initiate adaptations. Prior research suggests that other HMRE programs and their domestic violence partners might do well to extend this work by explicitly consulting their Latinx participants and community members about cultural needs and preferences in order to respond effectively to them (Castro et al., 2004; Bernal et al., 2009; Falconier et al., 2013; Perilla et al., 2012; Serrata et al., 2015). A focus on enriched community engagement could help HMRE grantees to build capacity and relationships within and between their programs and local Latinx communities, and incorporate meaningful input from community members, program participants, and domestic violence partners in their program models and domestic violence protocols. This work could also better position HMRE grantees to connect their Latinx participants with a rich network of safe and culturally-relevant organizations in the community, beyond their domestic violence partners and beyond the personal connections of bilingual, bicultural frontline staff. A Rose Andom Center staff member articulated this need and vision:

The challenge we have here, the unique piece I'm seeing here that does connect with focus group feedback we got years ago, is how we help create a sense of community for survivors distinct from specific services—just someplace to counteract that complete sense of isolation that victims often feel, and somewhere they can start connecting back into a sense of community. That's where I wonder what else we can be doing to help create, promote, and nurture that.

A community capacity approach to raising IPV awareness among program participants (Serrata et al., 2015) could also help to address the culturally diverse and locally specific nature of Latinx communities and their needs (Cripe et al., 2015; Gonzalez-Guarda et al., 2013). Such an approach, which centers peer-to-peer knowledge sharing about IPV, can increase knowledge about IPV and reduce barriers to accessing help (Matthew et al., 2017; Serrata et al., 2016).

Staffing programs to reflect the communities they serve. Data from staff and participant interviews highlight the tremendous efforts and contributions of bilingual and bicultural facilitators, case managers, and domestic violence program advocates at these organizations. Statements from many interviews suggested that trusted, well-networked, and culturally and linguistically fluent staff made an enormous difference in programs' ability to engage, retain, and develop trusting relationships with Latinx participants, including IPV survivors. domestic violence program administrators noted how important the personal networks of their well-connected individual Latinx staff members were to establishing trust and serving as a channel for referrals. Prior work has shown that such staff may also help to create a safe environment for IPV disclosure (Reina, 2014). Indeed, program participants indicated universally that they preferred to be asked about IPV during individual appointments with the bilingual, bicultural course facilitator.

This finding speaks to the importance Latinx individuals place on a sense of connection, mutuality and trust with advocates and peers (Serrata et al, 2015). It also conveys the imperative of hiring, retaining, and preventing burnout among these staff. Other HMRE and domestic violence programs might wish to consider involving bilingual and bicultural community members in leadership positions, where they were underrepresented among our case study sites. Prior work suggests that hiring bicultural leaders and empowering them to shape an organization's plan for professional development, advancement, and investment in its bicultural staff can support increased cultural competence (Goode, 2004) and more effective IPV-related service provision by and for Spanish-speaking Latinx communities.

APPENDIX D – REFERENCES

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