



RIViR Paper #4. State of the Evidence: Evidence on Recognizing and Addressing Intimate Partner Violence in Healthy Relationship Programs

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Purpose of Paper

Federally funded healthy relationship programs are required by the terms of their grants to take a “comprehensive approach” to addressing intimate partner violence (IPV) and teen dating violence (TDV), but research evidence on effective strategies for doing so is still emerging. The purpose of this paper is to summarize for researchers the available evidence on strategies for recognizing and addressing IPV and TDV in healthy relationship programs, and to identify key gaps for future investigation. It proposes that programs would benefit greatly from evidence in three main areas: (1) building organizational readiness; (2) creating survivor-centered, trauma-informed opportunities for safe disclosure (including screening); and (3) protecting survivor safety when IPV or TDV is disclosed. Evidence is severely limited in all three areas. This paper suggests many opportunities for future research, particularly studies to better understand how healthy relationship program participation may affect IPV/TDV experiences for different participants and studies to compare different approaches for creating IPV/TDV disclosure opportunities in healthy relationship program settings. The latter will be a primary research focus for the RIViR project during 2016-2018.

Background

IPV and TDV Are Common in Healthy Relationship Program Populations

Healthy relationship programs, which work to promote positive, healthy dating and committed relationships, must be prepared to recognize and address abuse, including intimate partner violence and teen dating violence. The term “intimate partner violence” (IPV) refers to physical, sexual, or psychological harm or reproductive coercion by a spouse, partner, or former partner.¹ “Teen dating violence” (TDV)² refers to such harms when they occur in the context of youth dating experiences, typically

Project Overview

The purpose of the Responding to Intimate Violence in Relationship programs (RIViR) project is to understand how to best identify and address intimate partner violence (IPV) in the context of healthy relationship programming. The project takes a comprehensive approach by considering:

- actions to be taken prior to IPV identification;
- strategies and tools to identify IPV at initial assessment and throughout the program; and
- recommended protocols for when individuals disclose IPV, such as linking individuals to appropriate resources and referrals.

The project focuses on research evidence and supplements this information with expert input where evidence is lacking, so that technical assistance providers and practitioners can understand the current knowledge base as they develop specific guidance and program approaches.

The project will develop a series of papers for research and practice audiences and other stakeholders on five core topics:

Paper #1. Prevalence and Experiences: IPV prevalence and experiences among healthy relationship program participants

Paper #2. Current Approaches: Current approaches to addressing IPV in healthy relationship programs

Paper #3. Healthy Relationship Program Influences: Evidence for understanding how healthy relationship programs may influence IPV

Paper #4. State of the Evidence: Evidence on recognizing and addressing IPV in healthy relationship programs and key research gaps

Paper #5. Screeners and Protocols Assessment: Assessment of whether different approaches to IPV disclosure opportunities reliably identify IPV and result in appropriate assistance to survivors

The project team partners with a range of research experts, IPV advocates, and healthy relationship program practitioners to ensure the project is relevant to healthy relationship program contexts and safely and appropriately addresses IPV. All papers are vetted with these experts, and will be released beginning in 2016.

¹ This is the Centers for Disease Control and Prevention definition for intimate partner violence (2014, November 25). Retrieved from <http://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html>, which is widely understood to encompass a variety of specific behaviors in intimate relationships (e.g., financial abuse) that cause harm.

² Another term for this experience is Adolescent Relationship Abuse (ARA). ARA includes a abuse that happens in relationships among minors in the context of dating or similarly defined relationships.

among middle and high school aged youth.³ IPV is very common in populations served by federal “healthy relationship programs,” funded by the Administration for Children and Families through its Healthy Marriage and Relationship Education initiative for moderate- and low-income couples and individuals, including both adults and youth. For example, 26 percent of participants in the evaluation of the Building Strong Families healthy relationship program reported experiencing physical violence from their partners in the past year, while 11 percent of participants in the evaluation of the Supporting Healthy Marriage demonstration reported physical violence from their spouses in the past 3 months.⁴ (See [Intimate Partner Violence Prevalence and Experiences Among Healthy Relationship Program Populations](#) for more information.) Although evidence on the prevalence of TDV among youth-serving healthy relationship program populations is not available, a national survey of the general youth population found that 69 percent of adolescents who had dated also reported experiencing physical or verbal abuse from a dating partner.⁵

A Note to Healthy Relationship Program Practitioners

As researchers work to address the evidence gaps documented in this paper, practitioners’ efforts will continue to be informed by practice-based literature. Please refer to the text box on page 5 of this paper for a detailed list of practice-based resources for healthy relationship programs on (1) building organizational readiness, (2) creating opportunities for safe disclosure, and (3) protecting survivor safety when IPV or TDV is disclosed.

Healthy Relationship Programs Must Address IPV and TDV

Federal healthy relationship program grantees (funded by the Administration for Children and Families, Office of Family Assistance [OFA] in 2006, 2011, and 2015) must take steps to address IPV and TDV. The current OFA grantees, funded in 2015, were required to consult with a local domestic violence program or coalition and to take a “comprehensive approach to addressing domestic violence.” The funding announcement outlined an example approach, including training staff and creating a memorandum of understanding with a local domestic violence program.

Sources of Information for this Paper

The RIViR project focuses on determining how research evidence can inform strategies for better recognizing and responding to IPV/TDV in the context of healthy relationship programming. Existing evidence on this topic is quite limited, however.

This paper uses practice-based literature (including non-peer-reviewed literature) and expert opinion to briefly summarize the key elements of an approach to recognizing and addressing IPV/TDV in a healthy relationship program, and highlights areas in which empirical literature is and is not available to inform the development of such approaches. It draws on: the RIViR evidence-informed frameworks (see [\[insert hyperlink to Paper 3 when released\]](#)), which describe how healthy relationship programs can influence IPV/TDV and how those mechanisms of influence might vary for different participants; a review of research evidence on factors supporting successful implementation of IPV screening in a variety of contexts; a systematic review of literature on empirical validation of standardized tools for identifying IPV; and selected empirical literature from other fields (e.g., organizational development).

Throughout this paper, it is noted whether **any** empirical information to guide an aspect of program approaches is available. Among the many limitations of the current evidence base, it is particularly important to note that most of these sources are focused on addressing IPV in programs serving adults, with very little evidence available related to addressing TDV or to youth-serving (particularly school-based) healthy relationship programs.

³ Centers for Disease Control and Prevention: National Center for Injury Prevention and Control (2014). *Understanding Teen Dating Violence*. Retrieved from: <http://www.cdc.gov/violenceprevention/pdf/teen-dating-violence-factsheet-a.pdf>

⁴ McKay, T., Cohen, J., Kan, M., Bir, A., Grove, L., & Cutbush, S. (2016). “Intimate partner violence prevalence and experiences among healthy relationship program target populations (RIViR Paper 1: Prevalence and Experiences).” Prepared for Administration for Children & Families, U.S. Department of Health and Human Services.

⁵ Taylor, B.G. & Mumford, E.A. (2016). A national descriptive portrait of adolescent relationship abuse: Results from the National Survey on Teen Relationships and Intimate Violence (STRiV). *Journal of Interpersonal Violence*, 31(6):963-988.

Prior OFA-funded healthy relationship programs have taken a range of different approaches to addressing IPV and TDV. These have included partnering with a local domestic violence program, developing a domestic violence protocol that outlines the steps the program will take to identify and address IPV/TDV, training staff on IPV/TDV, delivering information about IPV/TDV during relationship education courses, offering opportunities for participants to disclose IPV/TDV (including screening),⁶ and implementing a variety of strategies for responding to such disclosures. (See [Current Approaches to Addressing Intimate Partner Violence in Healthy Relationship Programs](#) for detailed information on the 2011-2015 grantees' actual approaches to recognizing and addressing IPV.)

To guide future research, this paper summarizes the available evidence in three key areas related to recognizing and addressing IPV/TDV in healthy relationship programs: (1) building organizational readiness to recognize and address IPV/TDV; (2) offering survivor-centered and trauma-informed opportunities for participants to disclose IPV/TDV; and (3) protecting survivor safety whenever IPV/TDV is disclosed.

Building Organizational Readiness to Recognize and Address IPV/TDV

Practice-based literature and expert opinion suggest that the process of building organizational readiness to recognize and address IPV/TDV includes three major steps:

1. Create and maintain a strong reciprocal partnership with a local domestic violence program;
2. Develop and maintain a domestic violence protocol or a set of school-sanctioned policies and procedures for addressing IPV/TDV; and
3. Provide training to program staff (and school personnel, in school-based programs) on IPV and TDV.

No *direct* evidence on **creating and maintaining strong reciprocal partnerships** between healthy relationship grantees and domestic violence agencies was found, but some evidence is available from related research. Although healthy relationship program impact studies have documented grantees' organizational structures and partnerships as part of their implementation evaluations, this implementation research has not typically focused on partnerships with domestic violence programs.^{7, 8, 9} Detailed evidence from general research on partnership development among community-based organizations (not exclusively focused on healthy relationship programs and domestic violence programs) is instructive, however. With regard to characteristics that grantees might consider in choosing a partner, qualitative¹⁰ and quantitative¹¹ work suggests that organizations with a long or successful history of collaboration work better together. Qualitative work on an organizational partnership for addressing IPV has also found that organizations that were located in and served the same communities perceived the highly localized nature of their collaboration as helpful in accomplishing their shared goals.¹²

⁶ We use the term "opportunities for IPV/TDV disclosure" to refer to open-ended conversations about IPV/TDV and to activities commonly referred to in research and health care communities as "screening." Advocates have cautioned against relying on the term "screening," arguing that it invokes a disease model and medical primary prevention approach in which a pre-symptomatic or mildly progressed condition is identified early, and minimizes the agency of survivors in choosing to disclose their experiences (e.g., Greville, 2016).

⁷ Dion, M.R., Hershey, A.M., Zaveri, H.H., Avellar, S.A., Strong, D.A., Silman, T., & Moore, R. (2008). Implementation of the Building Strong Families Program. Retrieved from <http://www.mathematica-mpr.com/~media/publications/PDFs/bsimplementation.pdf>

⁸ McKay, T., Lindquist, C., Corwin, E., & Bir, A. (2015). The Implementation of Family Strengthening Programs for Families Affected by Incarceration. Office of the Assistant Secretary for Planning and Evaluation Research Brief. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/139276/rpt_MFS-IP.pdf

⁹ Gaubert, J.M, Gubits, D., Principe Alderson, D., & Knox, V. (2012). The Supporting Healthy Marriage Evaluation: Final Implementation Findings. OPRE Report 2012-12. Washington, DC: Office of Planning, Research and Evaluation. Retrieved from http://www.mdrc.org/sites/default/files/shm%20imp%20full%20pdf_1.pdf

¹⁰ Chen, B., & Graddy, E. A. (2010). The effectiveness of nonprofit lead-organization networks for social service delivery. *Nonprofit Management and Leadership*, 20(4), 405-422.

¹¹ Tran, J. H. (2014). Community-based participatory research for building community-based organizational capacity: A programmatic assessment. *Dissertation Abstracts International*, 74.

¹² Merkes, M. (2004). The Darebin Family Violence Working Group: a partnership approach. *Australian Journal of Primary Health*, 10(2), 104-111.

With regard to efforts to build a positive organizational relationship once a partner organization is selected, Vaterlaus et al. (2012)¹³ and Merkes (2004)¹⁴ each found that higher levels of perceived trust and mutual benefit among those involved in inter-organizational partnerships was qualitatively associated with more positive perceptions of the partnership's effectiveness. Several studies (including one focused on a partnership for addressing IPV and one focused on partnerships for delivery of relationship education) indicate that early work to develop mutual goals, a shared vision for the partnership, and shared understandings of cultural responsiveness all contributed to the partnerships' longer-term perceived success.^{15,16,17,18,19,20,21,22}

With regard to formalizing organizational partnerships, preliminary evidence supports the practice of developing written memoranda of understanding or formalizing joint decision-making processes for the partnership, and ensuring that the joint work is adequately funded or otherwise resourced.^{23,24,25,26,27} Educating staff members at various levels of both partner organizations about the importance of the partnership, and then actively engaging them in maintaining it (such as through regular in-person, telephone, and email communications and documentation of those communications) has also been seen in qualitative work and one quantitative study to foster mutually beneficial partnerships.^{28,29,30,31,32,33}

Finally, Kingsnorth (2015)³⁴ offers qualitative evidence for the usefulness of reviewing and revising partnership agreements regularly based on evolving goals and priorities. Once partnerships have been established, qualitative evidence suggests that maintaining them via regular communication and regular updates to agreed-on procedures contributes to ongoing perceived success in the partnership.^{35,36,37}

¹³ Vaterlaus, J.M., Skogrand, L., Bradford, K., & Higginbotham, B.J. (2012). Sustaining university-community partnerships in providing relationship education: A longitudinal qualitative case study. *Journal of Community Engagement and Scholarship*, 8(1):4-14.

¹⁴ Merkes, M. (2004). The Darebin Family Violence Working Group: a partnership approach. *Australian Journal of Primary Health*, 10(2), 104-111.

¹⁵ Callaly, T., von Treuer, K., van Hamond, T., & Windle, K. (2011). Forming and sustaining partnerships to provide integrated services for young people: An overview based on the headspace Geelong experience. *Early Intervention in Psychiatry*, 5(Suppl 1), 28-33.

¹⁶ Carlton, E.L., Whiting, J.B., Bradford, K., Dyk, P.H., & Vail, A. (2009). Defining factors of successful university-community collaborations: An exploration of one healthy marriage project. *Family Relations*, 58:28-40.

¹⁷ Hanusaik, N., Sabiston, C. M., Kishchuk, N., Maximova, K., & O'Loughlin, J. (2015). Association between organizational capacity and involvement in chronic disease prevention programming among Canadian public health organizations. *Health Education Research*, 30(2), 206-222.

¹⁸ Kingsnorth, S., Lacombe-Duncan, A., Keilty, K., Bruce-Barrett, C., & Cohen, E. (2015). Inter-organizational partnership for children with medical complexity: The integrated complex care model. *Child Care, Health and Development*, 41(1), 57-66.

¹⁹ Merkes, M., 2004 (as above).

²⁰ Pennec, M., & Raufflet, E. (2016). Value creation in inter-organizational collaboration: An empirical study. *Journal of Business Ethics*. [Epub ahead of print: 2016 Jan 12.] doi:10.1007/s10551-015-3012-7.

²¹ Radermacher, H., Karunathna, Y., Grace, N., & Feldman, S. (2011). Partner or perish? Exploring inter-organisational partnerships in the multicultural community aged care sector. *Health & Social Care in the Community*, 19(5), 550-560.

²² Ybema, S., Vroemisse, M., & van Marrewijk, A. (2012). Constructing identity by deconstructing differences: Building partnerships across cultural and hierarchical divides. *Scandinavian Journal of Management*, 28(1), 48-59.

²³ Barnes, P. A. (2011). Local public health system partnerships: A mixed methods multi-state study. *Dissertation Abstracts International*, 71, 4795.

²⁴ Chen, B., & Graddy, E. A. (2010). The effectiveness of nonprofit lead-organization networks for social service delivery. *Nonprofit Management and Leadership*, 20(4), 405-422.

²⁵ Grazier, K. L., Hegedus, A. M., Carli, T., Neal, D., & Reynolds, K. (2003). Integration of behavioral and physical health care for a Medicaid population through a public-public partnership. *Psychiatric Services*, 54(11), 1508-1512.

²⁶ Merkes, M. (2004). The Darebin Family Violence Working Group: a partnership approach. *Australian Journal of Primary Health*, 10(2), 104-111.

²⁷ Radermacher, H., Karunathna, Y., Grace, N., & Feldman, S. (2011). Partner or perish? Exploring inter-organisational partnerships in the multicultural community aged care sector. *Health & Social Care in the Community*, 19(5), 550-560.

²⁸ Callaly, T., von Treuer, K., van Hamond, T., & Windle, K. (2011). Forming and sustaining partnerships to provide integrated services for young people: An overview based on the headspace Geelong experience. *Early Intervention in Psychiatry*, 5(Suppl 1), 28-33.

²⁹ Corbie-Smith, G., Adimora, A. A., Youmans, S., Muhammad, M., Blumenthal, C., Ellison, A., & ... Lloyd, S. W. (2011). Project GRACE: A staged approach to development of a community—Academic partnership to address HIV in rural African American communities. *Health Promotion Practice*, 12(2), 293-302.

³⁰ Kingsnorth, S., et al., 2015 (as above).

³¹ Merkes, M., 2004 (as above).

³² Nelson, J. C., Raskind-Hood, C., Galvin, V. G., Essien, J. K., & Levine, L. M. (1999). Positioning for partnerships: Assessing public health agency readiness. *American Journal of Preventive Medicine*, 16(3 Suppl), 103-117.

³³ Radermacher, H., et al., 2011 (as above).

³⁴ Kingsnorth, S., et al., 2015 (as above).

³⁵ Kingsnorth, S., et al., 2015 (as above).

³⁶ Merkes, M., 2004 (as above).

³⁷ Nelson, J. C., et al., 1999 (as above).

Guidance for Healthy Relationship Program Practitioners

This paper describes available evidence related to healthy relationship programs' approaches to recognizing and responding to IPV/TDV. In addition to the limited research literature presented in this paper, rich practitioner resources are available.

The most comprehensive available resource is [Promoting Safety: A Resource Packet for Marriage and Relationship Educators and Program Administrators](#) (Menard, 2015 [updated]). This five-part series provides practitioners with ways to understand and respond to IPV issues:

- [Part One](#) focuses on understanding the scope and impact of domestic violence.
- [Part Two](#) focuses on strategies for building partnerships between healthy relationship programs and local domestic violence programs.
- [Part Three](#) focuses on domestic violence protocol development in healthy relationship programs.
- [Part Four](#) focuses on strategies for identifying IPV and TDV in healthy relationship programs.
- [Part Five](#) focuses on responding to disclosures of IPV and TDV in healthy relationship programs.

A number of other resources are available on specific topics, including building organizational readiness; creating opportunities for safe disclosure; and protecting survivor safety when IPV/TDV is disclosed.

1. Building Organizational Readiness to Recognize and Address IPV/TDV

- [State domestic violence coalitions](#) work with community-based domestic violence programs across the U.S. and can help to locate potential local domestic violence program partner organizations.
- [Building Bridges between Healthy Marriage, Responsible Fatherhood, and Domestic Violence Programs](#) (Ooms, Boggess, Menard, Myrick, Roberts, Tweedie, & Wilson, 2006) summarizes a series of discussions on partnership between practitioners in the domestic violence, healthy relationship, and responsible fatherhood fields and presents recommendations for ongoing work.
- [Creating Accessible, Culturally Relevant, Domestic Violence and Trauma Informed Agencies: A Self Reflection Tool](#) (ASRI and National Center on Domestic Violence, Trauma, and Mental Health, 2012), includes a step-by-step process for building organizational readiness to interact with IPV/TDV survivors in a sensitive and culturally responsive manner that centers safety and minimizes re-traumatization of survivors.

2. Creating Opportunities for Safe IPV/TDV Disclosure

In addition to the guidance in [Promoting Safety](#) on creating opportunities for disclosure, these resources (not specific to healthy relationship programs) describe trauma-informed strategies creating disclosure opportunities:

- [Universal Trauma-Informed Education for Addressing Intimate Partner Violence \(Greville, 2016\)](#) summarizes key considerations for staff who will be designing and implementing opportunities for IPV/TDV disclosure in a survivor-centered manner. (This article is not based on ACF-sponsored work, nor has ACF formally reviewed its contents.)
- [Trauma-Informed Screening Methods: Lessons from Behavioral Health Settings \(Warshaw, 2013\)](#). Although not specific to healthy relationship programs, this slide presentation summarizes the elements of a trauma-informed approach to IPV at the organizational and interpersonal levels. Slide 10 focuses on offering IPV disclosure opportunities in a trauma-informed manner.

3. Protecting Survivor Safety When IPV/TDV Is Disclosed

In addition to the guidance in [Promoting Safety](#) on responding to disclosures, practitioners can also access a variety of culturally-specific resources on protecting survivor safety in the specific communities they serve. Such resources are available from the four culturally specific institutes funded under the Family Violence Prevention and Services Act (FVPSA):

- [Asian Pacific Institute on Gender-Based Violence](#)
- [Institute on Domestic Violence in the African American Community](#)
- [National Latin@ Network](#)
- [Northwest Network of Bi, Trans, Lesbian and Gay Survivors of Abuse](#)

Although one qualitative descriptive account was found that documented the process of **developing and maintaining a domestic violence protocol** for a healthy relationship program,³⁸ assessing the effectiveness of domestic violence protocol contents or development processes has not been a research priority.

Evidence from studies in health care and other settings is available to inform approaches for **providing training to staff**. Studies in a variety of clinical and non-clinical provider samples have shown that those who received training on IPV were better able to offer opportunities for IPV disclosure and to recognize IPV than those who did not receive training.^{39,40,41,42,43} Other studies have found that providers who lack training fail to respond appropriately to IPV disclosure⁴⁴ and that both clinical and non-clinical providers want more training on IPV.⁴⁵ O’Campo et al.’s (2011)⁴⁶ systematic review found that providing a combination of initial and ongoing training contributed to provider self-efficacy for IPV screening, while in Chang et al.’s (2009)⁴⁷ qualitative comparison, repeated opportunities for IPV-related training were seen to increase providers’ comfort, willingness, and ability to assist survivors.

The evidence (if any) that is available to guide approaches to each of these aspects of building organizational readiness is summarized in **Table 1**. (Where content is **bolded and in color** in the table, this indicates that at least some empirical evidence exists on a strategy. For example, this table shows that some research evidence exists on the role of a prior history of positive collaboration in creating and maintaining a strong reciprocal partnership. Additional information and citations for the research referenced in the table are included in the surrounding text.)

Table 1. Aspects of Organizational Readiness for Recognizing and Addressing IPV/TDV

Organizational Readiness Steps	Aspects of Program Approach to Be Considered/Developed	Evidence to Guide Approach?
1. Create and maintain a strong reciprocal partnership with a local domestic violence program.		SOME
Identify a local domestic violence program.	<i>Programs may consider:</i> <ul style="list-style-type: none"> • Domestic violence program fit for community served by healthy relationship program • Prior history of positive collaboration • Geographic location in the same community • Referral from state coalition 	SOME
Work toward a relationship built on trust and mutuality.	<i>Program approaches may include:</i> <ul style="list-style-type: none"> • Educating and cross-training both staffs to build mutual understanding and support of one another’s mission, goals, and work • Identifying ways each organization can support the other • Developing shared goals and values (e.g., the importance of survivor safety, fostering healthy relationships, and meeting the needs of the local community) 	SOME

³⁸ Whiting, J.B., Bradford, K., Vail, A., Carlton, E.T., & Bathje, K. (2009). Developing a domestic violence protocol for marriage education: Critical components and cautions. *Journal of Couple & Relationship Therapy: Innovations in Clinical and Educational Interventions*, 8(2):181-196.

³⁹ Rodriguez, M. A., H. M. Bauer, et al. (1999). Screening and intervention for intimate partner abuse: practices and attitudes of primary care physicians. *Journal of the American Medical Association*, 282(5):468-474.

⁴⁰ Stayton, C. D. and M. M. Duncan (2005). Mutable influences on intimate partner abuse screening in health care settings: a synthesis of the literature. *Trauma, Violence, and Abuse*, 6(4):271-285.

⁴¹ Thompson, R.S., Rivara, F.P., Thompson, D.C., et al. (2000). Identification and management of domestic violence: a randomized trial. *American Journal of Preventive Medicine*, 19(4):253-63.

⁴² Dersch, C., Harris, S.M., & Rappleyea, D.L. (2006). Recognizing and responding to partner violence: An analog study. *The American Journal of Family Therapy*, 34:317–331.

⁴³ Storey, J. E., Gibas, A.L., Reeves, K.A., & Hart, S.D. (2011). Evaluation of violence risk (threat) assessment training for police and other criminal justice professionals. *Criminal Justice and Behavior* 38:554.

⁴⁴ Renker, P. R. (2008). Breaking the barriers: the promise of computer-assisted screening for intimate partner violence. *Journal of Midwifery and Women’s Health*, 53(6):496-503.

⁴⁵ Colarossi, L., Breitbart, V., & Betancourt, G. (2010). Barriers to screening for intimate partner violence: A mixed-methods study of providers in family planning clinics. *Perspectives on Sexual and Reproductive Health*, 42(4), 236-243.

⁴⁶ O’Campo, P., Kirst, M., Tsamis, C., Chambers, C., & Ahmad, F. (2011). Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review. *Social Science and Medicine*, 72(6), 855-866.

⁴⁷ Chang, J. C., Buranosky, R., Dado, D., Cluss, P., Hawker, L., Rothe, E., & ... Scholle, S. H. (2009). Helping women victims of intimate partner violence: Comparing the approaches of two health care settings. *Violence and Victims*, 24(2), 193-203.

Organizational Readiness Steps	Aspects of Program Approach to Be Considered/Developed	Evidence to Guide Approach?
	<ul style="list-style-type: none"> • Recognizing and reconciling cultural differences in experience and perspective of the individuals directing the respective partnership agencies • Developing a shared understanding and commitment to cultural responsiveness • Agreeing on procedures for information sharing and joint confidentiality protections • Documenting areas of disagreement and when and how they will be resolved • Involving an outside facilitator to help establish agreement, if necessary 	
Formalize the relationship.	<p><i>Program approaches may include:</i></p> <ul style="list-style-type: none"> • Creating a memorandum of understanding or other paper agreement outlining the nature and scope of the relationship • Budgeting adequate resources for the staff time required (e.g., funding the domestic violence program's involvement in the healthy relationship program) • Identifying a specific point of contact at each organization 	SOME
Maintain the relationship.	<p><i>Program approaches may include:</i></p> <ul style="list-style-type: none"> • Communicating frequently and openly (meeting regularly, checking in directly about how each partner feels the collaboration is working, addressing conflict, making suggestions for continuous improvement and growth) • Reviewing the protocol and memorandum of understanding at least annually, and updating as necessary 	SOME
2. Develop and maintain a domestic violence protocol or a set of school-sanctioned policies and procedures for addressing IPV/TDV.		SOME
Meet with partners to plan joint efforts at addressing IPV and TDV.	<p><i>Joint decisions may include:</i></p> <ul style="list-style-type: none"> • How to ensure that program participation is voluntary and trauma informed • How to create safe, confidential opportunities to disclose IPV/TDV • How to ensure that all IPV and TDV issues are addressed by well-trained personnel • How to address additional factors that can influence whether participation in healthy relationship program activities may be helpful or harmful • How to manage state-specific mandatory reporting responsibilities associated with receiving abuse reports • For school-based programs, consistency with applicable school and school district protocols for disclosures of abuse and appropriate roles of onsite school staff in decision-making, documentation, and supporting or referring youth • Plans for training staff on agreed-upon processes a cross grantee organization, domestic violence program partner, and local school and school district • Plans for joint review and updating or revising as needed 	SOME
Communicate joint plans in a domestic violence protocol.	<p><i>Program approaches may include content such as:</i></p> <ul style="list-style-type: none"> • Mission of the healthy relationship program • Scope and purpose of the protocol • Key terms and underlying principles guiding the approach to addressing IPV or TDV • Procedures for creating opportunities for disclosures of IPV or TDV (including screening) • Procedures for responding to disclosures • Procedures for maintaining confidentiality • Procedures for cross training on healthy relationship and IPV/TDV issues 	NOT FOUND
3. Provide training to program staff (and school personnel, in school-based programs) on IPV and TDV.		SOME
Develop training plan.	<p><i>Program approaches may include content such as:</i></p> <ul style="list-style-type: none"> • Understanding IPV/TDV • Monitoring for warning signs of IPV/TDV • Creating opportunities for IPV/TDV disclosure • Implementing program's domestic violence protocol 	NOT FOUND
Agree on timing.	<p><i>Programs approaches may include:</i></p> <ul style="list-style-type: none"> • Offering an initial training during program start up and to new staff • Offering ongoing trainings 	SOME

Offering Opportunities for Participants to Safely Disclose IPV/TDV

Offering survivor-centered and trauma-informed opportunities for participants to disclose IPV/TDV is another critical component of a comprehensive approach to IPV/TDV. According to practice-based literature and expert opinion, to do so programs must:

1. Provide information on IPV/TDV and local, state, and national IPV/TDV resources to all program applicants and participants;
2. Give participants the information they need to make informed decisions about IPV/TDV disclosure and program participation; and
3. Offer participants multiple opportunities to safely disclose their IPV/TDV experiences, while recognizing that some survivors may not.

Available evidence on the first two steps comes from studies of IPV/TDV education and disclosure in health care settings. Regarding the first step, to **provide information on IPV/TDV to all applicants and participants**, Miller et al.'s (2016) randomized cluster study found that an intervention that included providing information about IPV (in conversation and on a resource card), harm reduction counseling, and referrals led to increased awareness of available IPV resources and improved self-efficacy for harm reduction strategies.⁴⁸ In Thompson et al.'s (1998) study of universal education on domestic violence, patients identified four aspects of the universal education content as "essential" or "important": information on what constitutes IPV, information on recognizing signs of IPV, information on IPV resources, and information about legal considerations.⁴⁹ Othman et al.'s (2013) qualitative study found that patients who were not aware that IPV/TDV resources were available were less likely to disclose IPV/TDV, suggesting that information on available resources is another important aspect of IPV/TDV educational content.⁵⁰ No evidence on the most effective mode of delivery for universal IPV/TDV education was found.

Regarding the second step, to **give participants the information they need to make informed decisions about IPV/TDV disclosure and program participation**, several studies support the practice of talking with participants about IPV-related confidentiality concerns and protections (for example, mothers' concerns about child protective services involvement, should they disclose IPV). Kulkarni et al.'s (2010) qualitative study found that concerns over how their information would be used or with whom it would be shared prevented survivors from seeking help,⁵¹ while Gielen's (2000) cross-sectional study of women's opinions regarding IPV screening in health care settings found that IPV survivors were particularly concerned about mandatory reporting by their health providers.⁵² In Thompson et al.'s (1998) quantitative study, 69 percent of patients who received IPV-related education rated the information about confidentiality concerns and confidentiality protections as being essential or important.⁵³ Ford et al.'s (1997) experimental study found that adolescents were more likely to disclose sensitive information to physicians following assurances of confidentiality.⁵⁴

Evidence is more limited regarding the practice of talking with participants about the potential IPV-related risks of healthy relationship program participation. Individual and multi-site evaluations of healthy relationship programs have found that healthy relationship program participation led to decreases in various forms of IPV among various populations of adult

⁴⁸ Miller, E., Tancredi, D. J., Decker, M. R., McCauley, H. L., Jones, K. A., Anderson, H., ... & Silverman, J. G. (2016). A family planning clinic-based intervention to address reproductive coercion: A cluster randomized controlled trial. *Contraception*. [Epub ahead of print: 2016 Feb 15.] doi: 10.1016/j.contraception.2016.02.009.

⁴⁹ Thompson, R.S., Meyer, B.A., Smith-DiJulio, K., et al. (1998). A training program to improve domestic violence identification and management in primary care: preliminary results. *Violence and Victims*, 13(4):395-410.

⁵⁰ Othman, S., Goddard, C., & Piterman, L. (2013). Victims' barriers to discussing domestic violence in clinical consultations: A qualitative enquiry. *Journal of Interpersonal Violence*, 29(8) 1497-1513.

⁵¹ Kulkarni, S., Bell, H., & Wylie, L. (2010). Why don't they follow through?: Intimate partner survivors' challenges in accessing health and social services. *Family & Community Health*, 33(2), 94-105.

⁵² Gielen, A. C., O'Campo, P. J., Campbell, J. C., Schollenberger, J., Woods, A. B., Jones, A. S., ... & Wynne, E. C. (2000). Women's opinions about domestic violence screening and mandatory reporting. *American Journal of Preventive Medicine*, 19(4), 279-285.

⁵³ Thompson, R.S., et. al, 1998 (as above).

⁵⁴ Ford, C. A., Millstein, S. G., Halpern-Felsher, B. L., & Irwin, C. E. (1997). Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future health care: a randomized controlled trial. *Journal of the American Medical Association*, 278(12), 1029-1034.

participants,^{55,56,57,58} and to increased reports of IPV among adults in one low-income, urban site with a high rate of community violence.⁵⁹ Potential mechanisms for these effects (for example, whether exposure to healthy relationship program educational content might have increased participants' awareness of, or willingness to report, IPV) have not been studied. It is also not known whether or how the observed effects of healthy relationship program participation on IPV might differ for participants who are already experiencing abuse at the time of program enrollment. (For further discussion of research on this issue, see *[insert hyperlink to Paper #3 once released]*.) Finally, no studies have focused on whether youth-serving healthy relationship programs have any influence on TDV outcomes.

Evidence on the third step, to **offer participants explicit opportunities to disclose IPV/TDV** (including "screening" for physical violence, controlling behavior, and other forms of abuse) is building. Spangaro's (2011) qualitative study found that women who were asked direct questions about IPV (as opposed to providers waiting for a disclosure to be volunteered) were more likely to choose to disclose.⁶⁰ Kiely et al.'s (2010) randomized controlled trial of standardized, electronic IPV screening and social worker follow-up found that it reduced the recurrence of IPV victimization among the pregnant young women who received it.⁶¹ Nelson et al.'s (2012) systematic review noted that research on the effectiveness of IPV screening in health care settings was thin and results were mixed, but concluded that evidence was sufficient for the U.S. Preventive Services Task Force to add a recommendation in favor of screening and brief counseling (including supportive interaction with the survivor and making a referral) for women of child-bearing age.⁶² O'Doherty's (2015) systematic review reiterated that conclusion, but drew attention to a lack of rigorous research on the effectiveness of IPV screening with regard to important outcomes such as increasing linkages to IPV-related resources or reducing the recurrence of IPV.⁶³

A large body of literature reporting the psychometric properties of various standardized tools for identifying IPV among adults, summarized in **Appendix A**, clearly establishes the ability of many standardized tools to accurately identify IPV.⁶⁴ However, tools designed to identify IPV among adults may be inappropriate or ineffective in identifying TDV.⁶⁵ Evidence on standardized tools designed to identify TDV is much more limited than evidence on IPV tools: we found just one formal validation study of a standardized tool for identifying TDV,⁶⁶ the length of which (130 items) makes it an unlikely choice for the healthy relationship program setting.

In addition, very little evidence exists to guide grantees in deciding whether to use standardized tools for identifying IPV/TDV, or more open-ended approaches in which participants have an opportunity to disclose through a somewhat less structured exchange. No research that

⁵⁵ Antle, B. F., Karam, E., Christensen, D. N., Barbee, A. P., & Sar, B. K. (2011). An evaluation of healthy relationship education to reduce intimate partner violence. *Journal of Family Social Work, 14*, 387-406.

⁵⁶ Bradley, R. P. C., & Gottman, J. M. (2012). Reducing situational violence in low-income couples by fostering healthy relationships. *Journal of Marital and Family Therapy, 38*(S1), 187-198.

⁵⁷ Hawkins, A. J., & Erickson, S. E. (2015). Is couple and relationship education effective for lower income participants? A meta-analytic study. *Journal of Family Psychology, 29*, 59-68.

⁵⁸ Lundquist, E., Hsueh, J., Lowenstein, A. E., Faucetta, K., Gubits, D., Michalopoulos, C., & Knox, V. (2014). A Family-Strengthening Program for Low-Income Families: Final impacts from the Supporting Healthy Marriage Evaluation. OPRE Report 2014-09A. Washington, DC: Office of Planning, Research and Evaluation. Retrieved from http://www.acf.hhs.gov/sites/default/files/opre/shm2013_30_month_impact_reportrev2.pdf

⁵⁹ Wood, R. G., Moore, Q., Clarkwest, A., Killewald, A., & Shannon, M. (2012). The Long-term Effects of Building Strong Families: A Relationship Skills Education Program for Unmarried Parents—Final Report. OPRE Report 2012-28A. Washington, DC: Office of Planning, Research and Evaluation.

⁶⁰ Spangaro, J. M., A. B. Zwi, et al. (2011). 'Persist, persist.': A qualitative study of women's decisions to disclose and their perceptions of the impact of routine screening for intimate partner violence. *Psychology of Violence, 1*(2):150-162.

⁶¹ Kiely, M., El-Mohandes, A. A., El-Khorazaty, M. N., Blake, S. M., & Gantz, M. G. (2010). An integrated intervention to reduce intimate partner violence in pregnancy: a randomized controlled trial. *Obstetrics & Gynecology, 115*(2 Pt 1):273-83. doi: 10.1097/AOG.0b013e3181cbd482.

⁶² Nelson, H. D., Bougatsos, C., & Blazina, I. (2012). Screening women for intimate partner violence: A systematic review to update the U.S. Preventive Services Task Force recommendation. *Annals of Internal Medicine, 156*(11):796-808.

⁶³ O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L. L., Feder, G., & Taft, A. (2015). Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews, 7*, Article CD007007.

⁶⁴ Nelson, H. D., Bougatsos, C., & Blazina, I. (2012). Screening women for intimate partner violence: A systematic review to update the U.S. Preventive Services Task Force recommendation. *Annals of Internal Medicine, 156*(11):796-808.

⁶⁵ Martin, C. E., et al. (2012). Urban teens and young adults describe drama, disrespect, dating violence and help-seeking preferences. *Maternal and Child Health Journal, 16*(5):957-966.

⁶⁶ Melianchik-Key, K. M. (2011). The initial development and validation of the Teen Screen for Dating Violence. US, ProQuest Information & Learning. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 71*(11-A) pp. 3912.

compared available, standardized IPV/TDV tools with more open-ended, semi-structured opportunities for IPV/TDV disclosure was found in this review. However, in a qualitative analysis of audio taped conversations between patients and emergency health care providers, researchers found that IPV disclosure was more likely when providers probed about IPV experience, created open-ended opportunities for discussion, and were generally responsive or expressed empathy when a patient mentioned a psychosocial issue (for example, “stress”).⁶⁷ This suggests that, regardless of the tool used to structure opportunities for IPV/TDV disclosure in healthy relationship programs, including some more open-ended conversation is desirable.

A limitation of providing opportunities for IPV/TDV disclosure is that not all survivors will choose to disclose their experiences. In Spangaro et al.’s (2010) cross-sectional study of IPV screening participants, 14 percent of those who did not disclose IPV during screening later reported that they *had* experienced IPV, but chose not to disclose their experiences (reasons included not considering the abuse to be serious enough, being afraid of the perpetrator or others finding out, not being comfortable with the person who is doing the screening, and shame or embarrassment).⁶⁸ Among those who choose not to disclose may be some of the most vulnerable survivors: Spangaro’s (2011) qualitative study found that women who felt unsafe in an ongoing abusive relationship, as well as those who were subject to institutional sanctions (such as monitoring from child protective services), were less likely to disclose IPV.⁶⁹

Three studies (one qualitative and two longitudinal quantitative studies) found that IPV disclosures increased when survivors were given multiple opportunities to disclose,^{70,71,72} and that women may also become more likely to disclose IPV once they have an established relationship with a service provider.⁷³

Table 2 summarizes the evidence (if any) that exists to guide approaches to offering opportunities for healthy relationship program participants to disclose IPV/TDV. (Where content is **bolded and in color** in the table, this indicates that at least some empirical evidence exists on a strategy.)

Table 2. Aspects of Offering Opportunities for Participants to Disclose IPV/TDV

Opportunities for Disclosure Steps	Aspects of Program Approach to Be Considered/Developed	Evidence to Guide Approach?
1. Provide information on IPV/TDV and local, state, and national IPV/TDV resources to all program applicants and participants.		SOME
Create universal education content.	<i>Program approaches may include content such as:</i> <ul style="list-style-type: none"> • What constitutes IPV/TDV • Warning signs of IPV/TDV • What local and national IPV/TDV resources are available to help 	SOME
Deliver universal education content.	<i>Program approaches may include:</i> <ul style="list-style-type: none"> • Using a short script read out loud during individual intake meetings • Using an educational module delivered as part of other group-based educational activities or through multi-media tools (e.g., computer-based educational intervention) • Using written resources posted in restrooms or other semi-private places • Including this information as part of program informational materials and/or resource lists containing information on other topics 	NOT FOUND

⁶⁷ Rhodes, K. V., Frankel, R. M., Levinthal, N., Prenoveau, E., Bailey, J., & Levinson, W. (2007). You're not a Victim of domestic violence, are you?": Provider-patient communication about domestic violence. *Annals of Internal Medicine*, 147(9), 620-627.

⁶⁸ Spangaro, J. M., A. B. Zwi, et al. (2010). Who tells and what happens: Disclosure and health service responses to screening for intimate partner violence. *Health & Social Care in the Community*, 18(6):671-680.

⁶⁹ Spangaro, J. M., A. B. Zwi, et al. (2011). 'Persist, persist.': A qualitative study of women's decisions to disclose and their perceptions of the impact of routine screening for intimate partner violence. *Psychology of Violence*, 1(2):150-162.

⁷⁰ Frederick, L. (2008). Questions about family court domestic violence screening and assessment. *Family Court Review*, 46(3):523-530.

⁷¹ O'Reilly, R., B. Beale, et al. (2010). Screening and intervention for domestic violence during pregnancy care: a systematic review. *Trauma, Violence, and Abuse*, 11(4):190-201.

⁷² Spangaro, J. M., A. B. Zwi, et al., 2011 (as above).

⁷³ Feder, G., J. Ramsay, et al. (2009). How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment*, 13(16):iii-iv, xi-xiii, 1-113, 137-347.

Opportunities for Disclosure Steps	Aspects of Program Approach to Be Considered/Developed	Evidence to Guide Approach?
2. Give participants the information they need to make informed decisions about IPV/TDV disclosure and program participation.		SOME
Inform participants about program processes.	<p><i>Program approaches may include:</i></p> <ul style="list-style-type: none"> • Telling participants about specific program activities and potential risks of participation for those experiencing IPV/TDV • Explaining why questions about IPV/TDV are being asked, how answers will be used, and with whom they will and will not be shared • Informing participants of any mandatory responsibilities and procedures 	SOME
3. Offer participants explicit opportunities to disclose their IPV/TDV experiences, while recognizing that some survivors may not.		SOME
Offer an explicit opportunity for participants to disclose IPV/TDV.	<p><i>Program approaches may include:</i></p> <ul style="list-style-type: none"> • Asking about multiple forms of IPV/TDV (not only physical violence) • Using a standardized screening tool (see Appendix A) and/or a set of open-ended questions agreed on with the domestic violence program partner • For couples-based programs, determining how to address additional safety and confidentiality challenges associated with interacting with both couple members • Immediately reviewing information provided by each participant to determine whether s/he should be referred to the local domestic violence program 	SOME
Recognize the possibility of non-disclosure.	<p><i>Program approaches may include:</i></p> <ul style="list-style-type: none"> • Recognizing that not all survivors will choose to disclose • Creating ongoing opportunities for disclosure by <ul style="list-style-type: none"> ○ Training staff to build trust and rapport with participants ○ Making time for staff to be available individually and informally, particularly after any program activities or group conversations related to IPV/TDV 	SOME

Protecting Victim Safety When IPV/TDV Is Disclosed

When IPV/TDV is disclosed by a program participant (or prospective participant), healthy relationship programs must work with their local domestic violence program partners to protect survivor safety. Key steps in this process, based on practice-based literature and expert opinion, include:

1. Ensure that immediate and ongoing safety needs are identified and addressed promptly.
2. Work with the survivor and domestic violence program partner to determine how the survivor might be served by the healthy relationship program (whether leaving the program or choosing to continue to participate in any program activities).

The imperatives of survivor safety and confidentiality have made it difficult to rigorously assess the effectiveness of efforts to **ensure that immediate and ongoing survivor safety needs are identified and addressed promptly**, and several reviews have found relatively limited evidence to inform approaches.^{74,75,76,77} However, two random assignment studies found that broad-based advocacy to connect survivors with needed resources was effective at reducing re-victimization and improving quality of life among women exiting domestic violence shelters^{78,79} and at reducing depression, fear, and PTSD symptoms among women with domestic violence

⁷⁴ Jewkes, R. (2014) What works to prevent violence against women and girls? Evidence review of the effectiveness of response mechanisms in preventing violence against women and girls. Wallingford, Oxfordshire: Department for International Development, United Kingdom AID. Retrieved from http://r4d.dfid.gov.uk/pdf/outputs/VAWG/What_Works_Inception_Report_June_2014_AnnexF_WG23_paper_prevention_interventions.pdf

⁷⁵ Eckhardt, C.I., Murphy, C.M., Whitaker, D.J., Sprunger, J., Dykstra, R., Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse*, 4(2):196-231.

⁷⁶ Sullivan, C.M. (2012). Advocacy Services for Women with Abusive Partners: A Review of the Empirical Evidence. Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved from <http://www.dvevidenceproject.org>.

⁷⁷ Wathen, C.N., & MacMillan, H.L. (2003). Interventions for violence against women: Scientific review. *Journal of the American Medical Association*, 289(5):589-600.

⁷⁸ Sullivan, C. M., & Bybee, D. I. (1999). Reducing violence using community-based advocacy for women with abusive partners. *Journal of Consulting and Clinical Psychology*, 67:43-53.

⁷⁹ Sullivan, Cris M., Deborah I. Bybee, and Nicole E. Allen. "Findings from a community-based program for battered women and their children." *Journal of Interpersonal Violence* 17.9 (2002):915-936.

police reports.⁸⁰ No evidence for the effectiveness of safety planning efforts implemented by healthy relationship program staff or any other non-domestic violence professionals was found; Ko et al.'s (2011) systematic review found that, across nine cohort studies, there was mixed (and generally weak) evidence for the effectiveness of "safety checklists" implemented by hospital medical staff.⁸¹

No direct evidence is available on the effectiveness of efforts to **ensure that survivors are served appropriately by healthy relationship programs**. As summarized in [*insert hyperlink to Paper 3 when released*], evidence-informed theory suggests that joint survivor-perpetrator participation in couples-based healthy relationship program activities could lead to *increased* IPV in situations in which one partner is using abuse to control the other. Evidence-informed theory, taken alongside evidence from healthy relationship program impact evaluations, also suggests that participation in healthy relationship activities could lead to *reduced* IPV for couples in which abuse arises through conflict escalation in the absence of a one-sided controlling relationship dynamic. However, neither of these possibilities has been tested empirically. The preliminary nature of theory and evidence in this area supports the practice among healthy relationship grantees and their domestic violence program partners of working with individual survivors to weigh the potential risks and benefits of participation in healthy relationship program activities, while being prepared to support a safe "exit" from services when needed.

Research has begun to document important cultural and contextual differences in IPV/TDV service needs, for example, in Rana & Marin's (2012) review on the IPV service needs of immigrant women and in Groblewski's (2013) summary of qualitative work on the IPV service needs of low-income African American women.^{82,83} However, no evidence is available regarding how healthy relationship programs might best address these differences in service needs. Evidence also points to systematic differences in access to IPV- and TDV-related services: Individuals who live in rural, low-income, or predominantly Black or American Indian communities in the U.S. are more likely to experience unmet needs for these services.⁸⁴ Such findings lend support to the practice among grantees and their domestic violence program partners of taking cultural and contextual differences in IPV/TDV service needs and service access into account when determining how the healthy relationship program can best serve each survivor.

Table 3 summarizes the available evidence on approaches to protecting survivor safety when IPV/TDV is disclosed in the context of a healthy relationship program. (Where content is **bolded and in color** in the table, this indicates that at least some empirical evidence exists on a strategy.)

⁸⁰ DePrince, A.P., Labus, J., Belknap, J., Buckingham, S., & Gover, A. (2012). The impact of community-based outreach on psychological distress and victim safety in women exposed to intimate partner abuse. *Journal of Consulting and Clinical Psychology, 80*, 211-221.

⁸¹ Ko, H.C.H, Turner, T.J., & Finnigan, M.A. (2011). Systematic review of safety checklists for use by medical care teams in acute hospital settings - limited evidence of effectiveness. *BMC Health Services Research, 11*:211.

⁸² Rana, S., & Marin, L. (2012). Addressing Domestic Violence in Immigrant Communities: Critical Issues for Culturally Competent Services. VAW Net Applied Research Brief. Washington, DC: National Online Resource Center on Violence Against Women. Retrieved from http://www.vawnet.org/sites/default/files/materials/files/2016-09/AR_DVImmigrantComm.pdf

⁸³ Groblewski, J. (2013). Domestic Violence in Context: Unmet Needs and Promising Strategies. Madison, WI: Center for Family Policy and Practice. Retrieved from <http://cffpp.org/our-publications/domestic-violence-in-context/>

⁸⁴ Iyengar, R., & Sabik, L. (2009). The dangerous shortage of domestic violence services. *Health Affairs, 28*(6):w1052-w1065. Retrieved from <http://content.healthaffairs.org/content/28/6/w1052.full>

Table 3. Aspects of Protecting Victim Safety When IPV/TDV Is Disclosed

Protecting Victim Safety Steps	Aspects of Program Approach to Be Considered/Developed	Evidence to Guide Approach?
1. Ensure that immediate and ongoing safety needs are identified and addressed promptly.		SOME
Coordinate with domestic violence program for assessment and safety planning.	<p><i>Program approaches may include:</i></p> <ul style="list-style-type: none"> Recognizing that participants who experience IPV and TDV require individually tailored assistance, rather than a blanket response Offering initial, basic safety planning help immediately, before the survivor leaves the program site Connecting the survivor to a local domestic violence program staff member for comprehensive assessment and tailored safety planning For school-based programs, coordinating with personnel on measures to increase survivor safety at school and school-related activities (following agreed-on notification procedures) 	SOME
Coordinate with domestic violence program for advocacy.	<p><i>Program approaches may include:</i></p> <ul style="list-style-type: none"> Linking the survivor with other local service providers based on her/his preferences for what services or resources, if any, s/he wants and needs Working with domestic violence program to identify resources to which perpetrators may be referred—if they determine it is safe and consistent with the survivor’s wishes to do so 	SOME
2. Work with the survivor and domestic violence program partner to determine how the survivor might be served by the healthy relationship program.		NOT FOUND
Determine which, if any, healthy relationship activities are appropriate.	<p><i>Program approaches may include</i></p> <ul style="list-style-type: none"> Working jointly with the survivor and domestic violence program staff to determine together what healthy relationship program activities (if any) would be safe and helpful If needed, safely exiting survivors and/or perpetrators from the healthy relationship program or from specific program activities For school-based programs, offering to connect survivor to in-house school staff with clinical training or other appropriate school-based resources 	NOT FOUND
Address contextual issues that affect service access.	<p><i>Program approaches may include:</i></p> <ul style="list-style-type: none"> Identifying strategies for helping individuals connect with specialized and culturally responsive resources, even if those services are not readily available in the local community Taking differences in access to services into account when determining how a participant will and will not be supported by the healthy relationship program 	NOT FOUND
Ensure ongoing follow-up and safety monitoring.	<p><i>Program approaches may include:</i></p> <ul style="list-style-type: none"> Engaging healthy relationship program staff in monitoring safety during any program activities in which the survivor decides to participate Coordinating between healthy relationship program staff and domestic violence program partner staff to agree on a plan for follow-up with the survivor 	NOT FOUND

Gaps and Recommendations for Future Research

This review of empirical, theoretical, and practice-based literature—informed by consultation with a panel of research experts, advocates, and service providers—finds that research evidence to inform healthy relationship programs’ approaches to recognizing and addressing IPV/TDV is very limited and evolving.

1. Although no research on building organizational readiness to address IPV/TDV in healthy relationship programs was found, evidence from organizational partnership studies and health care services research is instructive. Evidence from the literature on organizational partnerships among community-based organizations is available to guide grantees in implementing expert-recommended practices to **create and maintain a strong partnership with a local domestic violence program**. This research supports the practices of: identifying a prospective domestic violence program partner that is (a) based in the same local community and (b) shares a history of prior successful collaboration with the healthy relationship program

grantee; working toward an inter-agency relationship built on trust and mutuality by educating staff at each partner agency on the other's work, identifying ways the partnership can benefit both organizations, and cultivating shared goals and values (including a shared understanding of and commitment to cultural responsiveness); formalizing the inter-agency relationship through a written agreement and adequately funding the work expected of the domestic violence program partner; and maintaining the inter-agency relationship through frequent, open communication and regular updates to protocols and agreements.

Based on the state of the evidence in this area, we recommend that researchers and practitioners in the fields of healthy relationship programming and IPV continue to draw on the rich literature on strategies for effective partnerships among community-based organizations generally. In addition, we recommend that implementation studies funded as part of future healthy relationship program impact evaluations include a particular focus on the implementation of organizational partnerships between healthy relationship grantees and their local domestic violence program partners. Research questions for that work might include:

- *What partnership-building steps or processes do staff at each agency identify as contributing to successful implementation outcomes (e.g., adherence to intended organizational roles and responsibilities, full implementation of work planned for domestic violence program partner, ongoing engagement in referral and follow-up)?*
- *What partnership-building processes or issues limit implementation success?*
- *What partnership characteristics (e.g., duration, funding, agreements, communication processes) do staff at each agency identify as contributing to successful implementation outcomes?*
- *What partnership characteristics do staff identify as contributing to better outcomes for survivors?*

No published evidence in any body of literature was found to inform efforts by healthy relationship grantees to **develop and maintain a domestic violence protocol or set of school-sanctioned policies and procedures for addressing IPV/TDV**. Rigorous research on the effectiveness or impact of domestic violence protocols or school-sanctioned policies and procedures for addressing IPV/TDV is difficult to conduct safely and meaningfully. However, based on the state of the evidence in this area, we recommend that future local and multi-site evaluations of healthy relationship programming include a focus on implementation and outcome research questions related to domestic violence protocol development and implementation. These questions might include:

- *What elements do domestic violence protocols or school-sanctioned policies and procedures for addressing IPV/TDV include?*
- *How are IPV/TDV-related protocols, policies, and procedures communicated to staff in all involved organizations (including grantees, local domestic violence programs, schools, and school districts)?*
- *How do staff at each organization define successful **implementation** of these IPV/TDV-related protocols, policies, and procedures? How do staff define successful **outcomes** of these IPV/TDV-related protocols, policies and procedures (e.g., linking participants affected by IPV/TDV to resources, perceived safety among participants affected by IPV/TDV)?*
- *What aspects of protocol development, protocol content, and/or protocol-related communication do staff identify as contributing to (or detracting from) successful implementation?*
- *What aspects of protocol development, protocol content, and/or protocol-related communication contribute to (or detract from) successful outcomes?*

With regard to healthy relationship program efforts to **provide training to program staff (and school personnel, in school-based programs) on IPV and TDV**, some evidence from research on IPV-related training for health care providers is available. Although this literature does not address approaches to developing training content, it does have some implications for training timing: research with health care providers suggests that a combination of initial and repeated IPV/TDV training is helpful in increasing comfort among non-domestic violence professional

staff (perhaps including healthy relationship program staff) for talking about and responding to IPV/TDV. Future research is needed to examine the relationship between staff training content and outcomes such as healthy relationship program staff comfort with discussing, recognizing, and addressing IPV/TDV and adherence to the program’s domestic violence protocol or school-sanctioned TDV policies and procedures.

2. Opportunities for IPV/TDV disclosure in healthy relationship programs have not been investigated empirically, but extensive research on such approaches (particularly the use of standardized assessment tools) has been conducted in other settings. Practice-based knowledge suggests that programs take a variety of approaches to creating opportunities for disclosure at several points in the program enrollment and participation process (e.g., during intake, during relationship education sessions, and during informal interactions with participants around program activities), but these strategies have not been investigated empirically in healthy relationship programs. However, extensive research on opportunities for IPV/TDV disclosure in health care settings—whose staff, like healthy relationship program staff, are not domestic violence professionals—is instructive. This body of research provides some support for the idea that healthy relationship program efforts to **provide information on IPV/TDV to all participants** should include content on what constitutes IPV/TDV, warning signs of IPV/TDV, and what local and national IPV/TDV resources are available to help. Experimental or quasi-experimental research is needed to identify whether providing such information to healthy relationship program participants is associated with improved awareness of available resources, increased likelihood of accessing available resources, or increased rates of IPV/TDV disclosure.

Research on IPV/TDV disclosure in health care settings also suggests that programs that aim to **give participants the information they need to make informed decisions about IPV/TDV disclosure and program participation** should include a clear discussion of how personal IPV/TDV-related information will be used and with whom it will and will not be shared (including any applicable mandatory reporting responsibilities). Future qualitative research on staff-participant conversations regarding confidentiality could help to identify the language and communication approaches that best support participants in understanding confidentiality and reporting procedures related to IPV/TDV, and how perceptions of those procedures influence their willingness to disclose IPV/TDV experiences.

Evidence from IPV/TDV measure validation studies and from qualitative and cross-sectional quantitative research on IPV/TDV disclosure can begin to guide healthy relationship programs’ strategies to **offer participants explicit opportunities to disclose their IPV/TDV experiences**. This body of research suggests that staff should ask about experiences of multiple forms of abuse, not just physical violence; that many available standardized screening tools (see **Appendix A**) do accurately identify IPV; and that including at least some open-ended questions can help to encourage disclosure. Research on IPV disclosure in health care settings suggests that it is also important to recognize the possibility of non-disclosure. Healthy relationship programs can expect that some survivors, including some of the most vulnerable, will choose not to disclose IPV/TDV to staff when given an opportunity. Health care setting studies also indicate that offering repeated opportunities, particularly in the context of ongoing efforts to build staff-participant trust, could result in increased disclosure of IPV/TDV.

The focal importance of identifying IPV/TDV among healthy relationship program participants, and the gaps in the current evidence base, underscore the importance of future research on IPV/TDV disclosure opportunities in healthy relationship program settings. Validation research is needed on standardized tools for facilitating TDV disclosure, both in general and in healthy relationship program settings and populations specifically. Research is also needed to learn how well standardized IPV/TDV tools and open-ended approaches to inviting disclosure each differentiate participants who may need IPV/TDV-related help from those who do not.

Research questions should include:

- *What are the psychometric properties of common, standardized IPV and TDV identification tools as implemented with adult and youth healthy relationship program participants?*

- *How do standardized tools and more open-ended IPV/TDV disclosure opportunities compare in their ability to differentiate adults and youth who need specialized assistance from a local domestic violence program and those who do not?*
- *How do these standardized tools and more survivor-centered, open-ended IPV/TDV disclosure opportunities compare in terms of staff and respondent burden, training requirements, ease of implementation, acceptability to respondents, and perceived helpfulness among respondents and program staff?*

3. Strategies for protecting the safety of healthy relationship program participants who disclose IPV/TDV have not been studied; however, some relevant evidence from IPV intervention research and healthy relationship program impact studies is available. Evidence from IPV intervention research indicates that safety planning and broad-based advocacy delivered by a domestic violence professional can reduce re-victimization, improve quality of life, and improve mental health among women in court and shelter populations. This suggests that healthy relationship programs' efforts to **ensure that immediate and ongoing safety needs are identified and addressed promptly** should link the survivor to a local domestic violence program staff member for a comprehensive IPV/TDV assessment, safety planning, and advocacy to connect the survivor to the resources s/he needs. Although it would be helpful to have better information on whether offering some initial, onsite safety planning by grantee staff (as some healthy relationship programs do; see [Current Approaches to Addressing Intimate Partner Violence in Healthy Relationship Programs](#)) leads to better outcomes for survivors, it is unclear whether such research could be carried out safely and ethically in healthy relationship program settings.

Some evidence from healthy relationship program impact studies and from evidence-based IPV theory exists to guide programs' efforts to **work with the survivor and the domestic violence program partner to determine how the survivor might be served by the healthy relationship program**. Impact studies have shown that healthy relationship program participation can lead to decreased or increased IPV among adults, while IPV intervention research and evidence-based IPV theory suggests that the form of IPV/TDV an individual or couple is experiencing might shape whether participation in healthy relationship program activities has a positive or negative effect on IPV/TDV. This theory has not been tested empirically, however. The current evidence (and the gaps therein) suggests that healthy relationship program staff should continue to work closely with local domestic violence program staff and survivors to make a case-by-case determination about what program activities, if any, would be safe and helpful for survivors. It suggests that staff should collaborate to safely exit survivors from any program activities that would be unsafe or unhelpful (for example, joint participation in couples-based relationship seminars for a couple in which one partner is using various tactics to control the other). Future work is also needed to identify how best to engage with participants or prospective participants whose perpetration behavior comes to light in the course or intake or service delivery, either by their own disclosures or those of their partners.

Finally, research on IPV/TDV service needs and service receipt indicates that cultural background and immigration status shape survivors' experiences and service needs, and that various contextual factors (such as living in a rural, high-poverty, or predominantly Black or Native American community) can impede access to IPV/TDV services. This evidence supports the need for healthy relationship programs to continue developing service delivery strategies that help survivors to connect with specialized and culturally responsive IPV/TDV resources, and take differences in service access and appropriateness into account when determining how a participant can be best served by the healthy relationship program.

Future research is needed to investigate **whether and how participation in particular forms of healthy relationship program services affects IPV/TDV experiences**, and whether these effects differ depending on context (e.g., rural or urban community), participants' personal characteristics, or the nature of participants' prior IPV/TDV experiences. Such an investigation might be accomplished in the context of a multi-site healthy relationship program impact study that included survey items on IPV/TDV experiences and personal characteristics, and was adequately powered for sub-group analyses and tests of moderation. Given the particular lack of research on TDV and participation in youth-serving healthy relationship programs, it is

important that such future work include youth and youth-serving programs. Based on findings from that inquiry and ongoing consultation with advocates and practitioners, future studies might also explore the effectiveness of identified strategies for protecting IPV/TDV survivor safety in the context of healthy relationship programs, such as safely exiting survivors from some services and connecting them with culturally responsive resources that are specific to their identified needs.

Conclusion

This paper reviewed available research in three major areas related to healthy relationship program efforts to implement a comprehensive approach to IPV/TDV as required by OFA:

- Building organizational readiness for recognizing and addressing IPV/TDV;
- Offering survivor-centered, trauma-informed opportunities for participants to safely disclose IPV/TDV; and
- Protecting survivor safety when IPV/TDV is disclosed.

The evidence base to guide program approaches in these areas is limited and evolving. This paper suggests many opportunities for future research, with a particular focus on better understanding how healthy relationship program participation might affect IPV/TDV experiences for different participants, and on comparing various open-ended and standardized approaches for creating IPV/TDV disclosure opportunities in healthy relationship program settings. Addressing this latter gap will be a primary research focus for the RIViR project during 2016-2018.

As research continues, practice-based guidance remains available to healthy relationship programs through their partnerships with local domestic violence programs, through various resources developed for healthy relationship practitioners on IPV and TDV (particularly [Promoting Safety: A Resource Packet for Marriage and Relationship Educators and Program Administrators](#)), and from the four FVPSA-funded culturally specific institutes.

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Appendix A: Standardized Screening Tools

Empirically Validated Standardized Tools on Intimate Partner Violence and Teen Dating Violence ⁸⁵					
TOOL	FORM(S) OF IPV MEASURED	FOCUS	# OF ITEMS	# STUDIES ⁸⁶	POPULATION(S) WITH WHICH VALIDATED
Empirically Validated, Behaviorally Specific Tools (Multiple Forms of IPV)					
Abuse Screening Inventory	Physical violence Emotional abuse Sexual violence (separate scales)	Victimization	1 each	1 of 1	Swedish women, 15-58 years, 24.5% high school degree, 20.8% senior high school degree
Unnamed Bonomi (2005) Measure	Physical violence Emotional abuse	Victimization	3	1 of 1	English- and Spanish-speaking women > 18 who had previously reported an IPV incident to police or who had received an IPV-related civil protection order, < high school degree = 11%, high school degree or vocational training = 32%
Brief Inpatient Screen	Physical violence Emotional abuse Sexual violence	Victimization	1 (with 3 parts)	1 of 1	Women ages 18-64 admitted to medical or surgical services (inpatient)
Composite Abuse Scale	Physical violence Emotional abuse Severe abuse Harassment	Victimization	10, 9, 17, and 7	1 of 1	Australian women nurses
Gay Abuse Screening Protocol (GASP)	Physical violence Emotional abuse Sexual violence	Victimization	2	1 of 1	English-speaking gay men > 18 years old, involved in a gay relationship for > 6 months, 9% < high school degree
Humiliation, Afraid, Rape, Kick (HARK)	Physical violence Emotional abuse Sexual violence	Victimization	4	1 of 1	Women > 17 years old in an intimate relationship in the last year recruited from a primary practice
Hurt, Insult, Threaten, Scream (HITS)	Physical violence Emotional abuse	Victimization	4	3 of 4	Tested with various adult populations: <ul style="list-style-type: none"> Female patients > 21 years old at a family medicine clinic who had lived with the same partner for at least 12 months

⁸⁵ This table includes empirically validated tools, defined as those with a published measure of accuracy or validity (e.g., correlation with another known measure) or sensitivity greater than or equal to 50%. The final section of the table includes four additional tools tested in specific populations, which did not meet review criteria for empirical validation based on published studies, but may be of interest to readers due to a lack of empirically validated IPV tools tested in those populations.

⁸⁶ # studies meeting criteria/#total # studies with data

Empirically Validated Standardized Tools on Intimate Partner Violence and Teen Dating Violence ⁸⁵					
TOOL	FORM(S) OF IPV MEASURED	FOCUS	# OF ITEMS	# STUDIES ⁸⁶	POPULATION(S) WITH WHICH VALIDATED
					<ul style="list-style-type: none"> • Self-identified victims of IPV residing in crisis shelters or presenting to an emergency department • Female veterans seen for medical appointments, > 18 years old, in a relationship in the past year, 17% < high school degree or GED • English-speaking bilingual men > 18 years old living with a male or female partner for the past year, presenting for a health visit at a clinic or emergency department; Phase II: English speaking or bilingual males > 18 years old identifying as IPV victims for treatment Partnered women > 18 years old
(Extended) Hurt, Insult, Threaten, Scream (E-HITS)	Physical violence Emotional abuse Sexual violence	Victimization	5	1	Female veterans seen for medical appointments who were in a relationship in the past year, 22.5% < high school degree or GED
Intimate Partner Violence Control Scale	Physical violence Emotional abuse Sexual violence Economic abuse Coercive control Male privilege	Victimization	84	1 of 1	Adult women served by a domestic violence shelter
Mediator's Assessment of Safety Concerns (MASIC)	Physical violence Emotional abuse Sexual violence Coercive control	Victimization	37	1 of 1	Family mediation clinic clients in a heterosexual relationship
NorVold Abuse Questionnaire	Physical violence Emotional abuse Sexual violence (sub-scales separately validated)	Victimization	13	1 of 1	Swedish women aged 18-64

Empirically Validated Standardized Tools on Intimate Partner Violence and Teen Dating Violence ⁸⁵					
TOOL	FORM(S) OF IPV MEASURED	FOCUS	# OF ITEMS	# STUDIES ⁸⁶	POPULATION(S) WITH WHICH VALIDATED
Ongoing Abuse Screen (OAS)	Physical violence Emotional abuse Sexual violence Fear	Victimization	5	1 of 2	Emergency department patients
Ongoing Violence Assessment Tool (OVAT)	Severe physical violence Emotional abuse	Victimization	4	2 of 2	Emergency department patients
Partner Violence Screen (PVS)	Physical violence Perceived safety (sub-scales separately validated)	Victimization	3	2 of 4	Various adult populations: <ul style="list-style-type: none"> • English-speaking female emergency department patients with noncritical medical problems • Spanish- and English-speaking female patients > 18 years old admitted to a trauma service
Perpetrator Rapid Scale (PERPS)	Physical violence Sexual violence	Victimization	3	1 of 1	Spanish or English speaking males and females >18 in the triage or lobby area of ED
Relationship Behavior Rating Scale (RBRS) - Revised⁸⁷	Physical violence Emotional abuse Sexual violence Physical injury	Victimization	30	1 of 1	Male and female undergraduates enrolled in psychology courses who reported a current romantic relationship of at least 3 months during the past year
STaT (Slaps, Throws, and Threatens) Screen	Physical violence Emotional abuse Sexual violence	Victimization	3	2 of 2	Two adult populations: <ul style="list-style-type: none"> • English-speaking women 18-65 seen in urgent care • English-speaking women 18-64, seen in the non-acute section of the emergency department, <8th grade education = 3%, some high school = 23%
STaT Spanish version	Physical violence Emotional abuse	Victimization	2	1 of 1	Spanish-speaking female hospital outpatients, 18-64 years old
Teen Screen for Dating Violence	Physical violence Emotional abuse Sexual violence Coercive control	Victimization Perpetration	130	1 of 1	Convenience sample of youth aged 13-21 recruited through mental health and school counselors, clinicians, and college campus faculty; primarily White (67%), heterosexual (88%), and female (70%).

⁸⁷ Shortened and revised from RBRS

Empirically Validated Standardized Tools on Intimate Partner Violence and Teen Dating Violence⁸⁵					
TOOL	FORM(S) OF IPV MEASURED	FOCUS	# OF ITEMS	# STUDIES⁸⁶	POPULATION(S) WITH WHICH VALIDATED
Universal Violence Prevention Screen	Physical violence Emotional abuse Coercive control	Victimization	3 ⁸⁸ (single items)	1 of 1	Low-income, African American female emergency department patients who indicated experiencing some form of intimate partner violence
Women Abuse Screening Tool (WAST)	Physical violence Emotional abuse	Victimization	7 (and 1 total)	1 of 1	<ul style="list-style-type: none"> • Women living at a shelter for women abused by a male partner • Convenience sample of nurses, social workers, clerical staff, etc. who had not experienced abuse
Women's Abuse Screening Tool- Short Form (WAST-Short)	Abuse	Victimization	2 of 7 WAST items	2 of 3	<ul style="list-style-type: none"> • Women ages 18-6 at their own health care visit • Women living at a shelter for women abused by a male partner • Convenience sample of nurses, social workers, clerical staff, etc. who had not experienced abuse
Empirically Validated, Behaviorally Specific Tools or Scales from Larger Measures (Single Form of IPV)					
Dutton (2006) Measure	Coercive control	Victimization	156	1 of 1	Urban men and women > 17 years old
Unnamed - Emotional abuse as a multifactorial construct	Emotional abuse Coercive control	Victimization Perpetration	54	1 of 1	Undergraduate in college, never married, in current dating relationship
Index of Spouse Abuse (ISA)- Physical	Physical violence	Victimization	15	1 (full ISA not validated)	Women 18-65 years, insured by a managed care organization or Medicaid, who had ever been in an intimate, sexual relationship with a man for > 3 months < High school: 11%
Intimate Justice Scale	Coercive control (scored to estimate risk of physical violence)	Victimization	15	1 of 1	Women > 19 years old; clients in mental health, social service, and medical agencies; in a heterosexual relationship > 1 year; 26% high school degree

⁸⁸Universal Violence Prevention Screen includes 5 single items; 3 of the 5 items had adequate sensitivity

Empirically Validated Standardized Tools on Intimate Partner Violence and Teen Dating Violence ⁸⁵					
TOOL	FORM(S) OF IPV MEASURED	FOCUS	# OF ITEMS	# STUDIES ⁸⁶	POPULATION(S) WITH WHICH VALIDATED
Jellinek Inventory for Assessing Partner Violence	Physical violence	Victimization Perpetration	2 2	1 of 1	Dutch substance abuse treatment patients > 18 years old who met DSM-IV criteria for substance abuse or dependence
Partner-Directed Insults Scale	Emotional abuse Coercive control	Victimization (women) Perpetration (men)	47	1 of 1	Two student populations: <ul style="list-style-type: none"> • US university students > 18 years old in a committed heterosexual relationship • New Zealand university students
Partner Violence Interview	Physical violence Sexual violence	Victimization Perpetration	14	1 of 1	Homeless young men and women 18-21 years old in a private non-profit shelter/transitional housing facility
Subtle and Overt Scale of Psychological Abuse	Emotional abuse	Victimization	65	1 of 1	New mothers 18 -40 years old involved in a romantic relationship for at least 6 weeks, 20% < high school degree
Trauma Questionnaire	Domestic violence Threats of domestic violence	Victimization	2 ⁸⁹ (single items)	1 of 1	Female veterans seen for medical appointments
Women's Experiences with Battering (WEB) Scale	Coercive control	Victimization	10	2 of 2	<ul style="list-style-type: none"> • Convenience samples of women served by domestic violence programs and women not served by domestic violence programs • Women 18-65 years, insured by a managed care organization or Medicaid, who had ever been in an intimate, sexual relationship with a man for > 3 months
Empirically Validated, Risk-Based Tools					
Chinese Risk Assessment Tool for Victims (CRAT-V)	Risk of any IPV	Victimization	26 ⁹⁰	1 of 1	Women of Chinese ethnicity > 16 years old, married or cohabiting, and able to speak Cantonese, Mandarin, or English
Chinese Risk Assessment Tool for Perpetrators	Risk of any IPV	Perpetration	35 ⁹¹	1 of 1	Men of Chinese ethnicity > 16 years old, married or cohabiting, and able to speak Cantonese, Putonghua, or English

⁸⁹There are 10 items on the scale and a composite, each was validated individually and all but the two included here are not IPV.

⁹⁰ CRAT-V included one factor – sexual abuse history in past year – without a number of items; we've considered it to be 1 item.

⁹¹ CRAT-P doesn't explicitly say that one of the factors – Criminal History – is only 1 item but the text says it is categorical; we've considered it to be 1 item.

Empirically Validated Standardized Tools on Intimate Partner Violence and Teen Dating Violence⁸⁵					
TOOL	FORM(S) OF IPV MEASURED	FOCUS	# OF ITEMS	# STUDIES⁸⁶	POPULATION(S) WITH WHICH VALIDATED
(CRAT-P)					
Domestic Violence Screening Instrument– Revised (DVSI-R)	Risk of any IPV	Perpetration	11	1 of 1	Persons > 16 years old convicted of any family violence
Unnamed Datner risk(2007) Measure	Physical violence	Victimization	5	1 of 1	Pregnant teens and pregnant adult women
Other Published (Non-Validated) Tools Tested with Specific Populations					
Conflict in Adolescent Dating Relationships Inventory (CADRI)	Physical violence Emotional abuse Sexual violence Coercive control	Victimization Perpetration	25	NA	Two youth populations: <ul style="list-style-type: none"> • Students in 9th to 11th grade • Community sample of dating couples, 14-19 years old
Safe Dates Evaluation Tool (Physical)	Physical violence	Victimization Perpetration	16 each	NA	Middle school aged youth in rural North Carolina
Safe Dates Evaluation Tool (Emotional)	Emotional abuse Coercive control	Victimization Perpetration	16 each	NA	Middle school aged youth in rural North Carolina