Preventing and Responding to Intimate Partner Violence:

An Implementation Framework for HRSA-Supported Settings of Care

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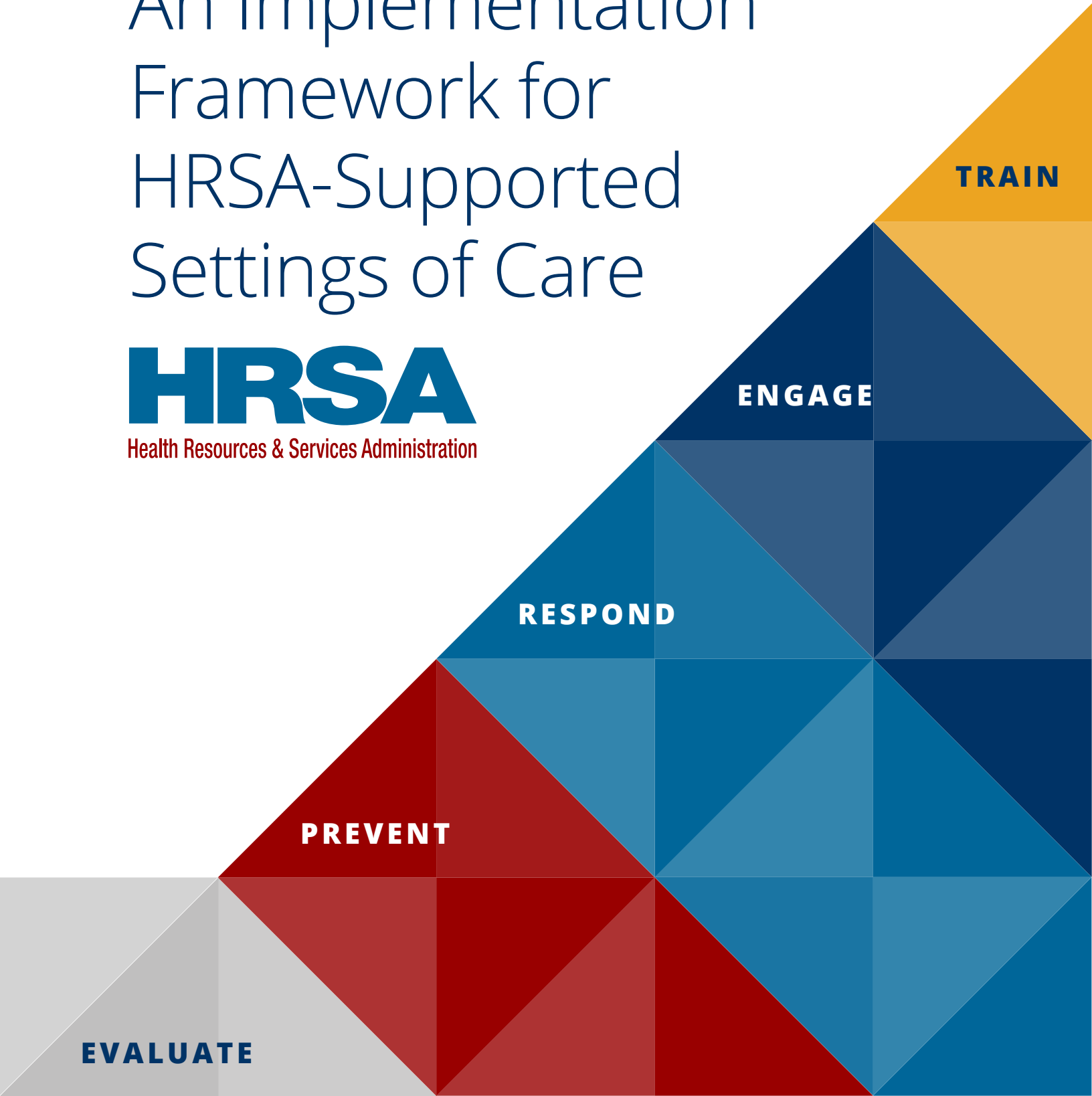Health Resources & Services Administration

TRAIN

ENGAGE

RESPOND

PREVENT

EVALUATE

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Table of Contents

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Acronyms

ACRONYM	DEFINITION
ACF	Administration for Children and Families
AHRQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control and Prevention
CLAS	Culturally and Linguistically Appropriate Services
CUES	Confidentiality, Universal Education and Empowerment, and Support
DV	Domestic Violence
EHR	Electronic Health Record
HITEQ	Health Information, Technology, and Quality Center
HRSA	Health Resources & Services Administration
HV CoIIN	Visiting Collaborative Improvement and Innovation Network
IHS	Indian Health Service
IPV	Intimate Partner Violence
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
NRCDV	National Resource Center on Domestic Violence
NSVRC	National Sexual Violence Resource Center
PTSD	Post-Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury

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Note on Language

Intimate partner violence (IPV) includes physically and emotionally abusive behaviors by a current or former intimate partner, dating partner, or spouse. These behaviors may include physical or sexual violence, sexual coercion, stalking, cyber abuse and cyberstalking, controlling behaviors, and psychological aggression.[1-6] HRSA recognizes that IPV is a form of *gender-based violence*, which consists of harmful acts directed at an individual based on their gender.[7] IPV may intersect with various other forms of and experiences with violence within relationships, families, households, or communities, including domestic, interpersonal, and sexual violence and human trafficking.

Domestic violence (DV) is a consistent effort of one intimate partner to maintain power and control over another through emotional abuse, financial control, intimidation, physical assault, battery, sexual assault, or other abusive behavior.[i,8] While people often use "DV" and "IPV" interchangeably, this Implementation Framework primarily uses the term "IPV," except when referring to organizations that use the term "DV."

Interpersonal violence describes "the intentional use of physical force or power against other persons, and encompasses child abuse, community violence (e.g., among individuals who are not related, but may know each other), family violence (e.g., violence within or between family members), and domestic and intimate partner violence (e.g., violence between current or former partners)."[9,10] *Sexual violence,* or *sexual assault*, is any nonconsensual sexual act proscribed by federal, tribal, or state law, including when an individual lacks capacity to consent (e.g., sexual harassment, rape, sexual exploitation, and unwanted sexual contact).[11,12] *Human trafficking* describes an individual performing labor or engaging in commercial sex by force, fraud, or coercion and relates to IPV in the overlapping patterns of behavior employed by both traffickers and people who use violence against intimate partners.[13]

The Implementation Framework recognizes the intersections between IPV and these other forms of violence that impact individuals and communities served by HRSA-supported settings of care. It underscores that preventing and addressing IPV requires recognizing and addressing these other forms of violence that increase the risk for and impacts of IPV. The Framework also focuses on the experience of IPV from adolescence to adulthood. While child abuse and elder abuse are important issues that also intersect with IPV, they are beyond the scope of this Framework.

This Framework uses "people who have experienced violence" and "people who use violence" rather than "survivor" or "victim" and "perpetrator," respectively. This language acknowledges the dynamic nature of violence, in that people who experience violence may use violence themselves and vice versa.

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[i] For more information on what constitutes abusive behavior, see **https://ncadv.org/learn-more/what-is-domestic-violence/ abusive-partner-signs**.

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Executive Summary

This Implementation Framework provides HRSA-supported settings of care with actionable steps to prevent and respond to intimate partner violence for adolescents and adults in the communities you serve. The steps in this document align with the aims of HRSA's agency-wide *2023-2025 Strategy to Prevent IPV*.

The Framework describes five building blocks for enhancing your organizational capacity to prevent and respond to intimate partner violence and suggests key activities to establish or strengthen those building blocks. These building blocks are grounded in HRSA's recognition that each organization is unique and has a range of experience in implementing IPV prevention and response initiatives. Thus, this Framework is NOT a prescriptive document with requirements or mandates. Implementation tips and examples can help bridge the gap between federal activities (like the Strategy) and actions you and your peer organizations can take at the local level.

Building Blocks — Activities

Building Blocks	FOUNDATIONAL	INTERMEDIATE	ADVANCED
1: Training and Supporting the Workforce	**1.1:** Engage all staff in IPV 101 training using best practices and dynamic approaches.	**1.2:** Conduct ongoing trainings for all staff on IPV-specific content.	**1.3:** Support staff well-being regarding their own exposures to IPV and other stressors.
2: Engaging Partners and Community	**2.1:** Identify key partners and assess community needs.	**2.2:** Engage diverse voices and partners in program planning.	**2.3:** Strengthen and formalize partnerships and arrangements with community members.
3: Delivering Trauma-Informed and Culturally Responsive Care	**3.1:** Assess organizational policies and processes.	**3.2:** Create an organizational environment that supports trauma-informed and culturally responsive practices.	**3.3:** Employ trauma-informed and culturally and linguistically responsive practices.
4: Coordinating and Implementing IPV Prevention and Response	**4.1:** Conduct an internal needs assessment and select IPV prevention and response initiatives.	**4.2:** Secure funding for IPV-related prevention and response initiatives.	**4.3:** Implement new or enhance existing IPV prevention and response initiatives.
5: Using Data to Drive Decision Making	**5.1:** Assess existing data collection mechanisms and processes for IPV-related data.	**5.2:** Analyze local and other relevant available data.	**5.3:** Use data to evaluate existing or identify the need for new IPV-related initiatives.

iv   Preventing and Responding to Intimate Partner Violence:
An Implementation Framework for HRSA-Supported Settings of Care

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Introduction

This Implementation Framework provides Health Resources and Services Administration (HRSA)-supported settings of care with actionable steps to prevent and respond to intimate partner violence (IPV) for adolescents and adults within the local communities you serve.[ii] This Framework provides sample activities and resources for preventing and responding to IPV in your community and aligns with HRSA's *2023-2025 Strategy to Prevent IPV*.

"HRSA-supported settings of care" include HRSA's extensive portfolio of awardees, grantees, recipients, and subrecipients of funding.

The 2023-2025 Strategy builds upon the successes of the prior *2017-2020 Strategy* and sets forth activities in support of three overarching aims:

- Aim 1: **Enhance HRSA coordination** of efforts to address IPV

- Aim 2: **Strengthen infrastructure and workforce capacity** to support IPV prevention and response services

- Aim 3: **Promote prevention of IPV** through evidence-based programs

An equitable and community-driven approach

In alignment with HRSA's commitment to achieving health equity, both the Strategy and the Framework center the needs and priorities of people who have experienced or are at risk of experiencing violence. Equity-focused efforts aim to break cycles of violence by responding to violence itself and its root causes. Equitable approaches acknowledge the diverse identities and contexts of individuals and communities to inform the design and delivery of IPV prevention and response programming. Trauma-informed and culturally responsive care through an equity lens reduces disparities experienced by populations disproportionately impacted by IPV.[14]

Organizations like yours with direct connections to individuals at risk of, experiencing, or using violence are key to preventing and mitigating violence. HRSA recognizes each organization is unique and has a range of experience in implementing IPV prevention and response initiatives. Thus, this Implementation Framework is NOT a prescriptive document with requirements or mandates. These implementation tips and examples can help bridge the gap between federal actions (like the Strategy) and activities you and your partners take at the local level toward the same vision.

[ii] The Framework focuses on IPV from adolescence to adulthood. While child abuse and elder abuse are important issues that can also intersect with IPV, it is beyond the scope of this Framework. Thus, this Framework does not cover prevention and response activities for child abuse and elder abuse.

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Opportunities to Prevent and Respond to IPV

IPV is a major public health issue that will affect nearly 1 in 2 people in their lifetimes, including nearly half of women and 44 percent of men.[1] It also affects nearly two-thirds (61 percent) of bisexual women[15-17] and over half (54 percent) of trans/non-binary individuals.[18,19]

The consequences of IPV extend beyond the people who experience violence themselves; IPV also affects children in the household, friends, extended family, and employers.[20-24] IPV can also contribute to intergenerational trauma and perpetration of violence.[25,26]

The impacts of violence can persist throughout the lifespan[27,28] and affect an individual's:

Physical health, e.g., reproductive, cardiovascular, gastrointestinal, and nervous system conditions, and traumatic brain injury (TBI).[29,30]

Behavioral health, e.g., post-traumatic stress disorder (PTSD), depression, suicidal ideation,[31,32] use of alcohol and other substances as coping mechanisms, substance use disorder (SUD),[33-37] and high-risk sexual behaviors.[38]

Economic outcomes, e.g., diminished access to opportunities, absenteeism, reduced workplace productivity, and lost earnings.[39,40]

Quality of life, e.g., decreased sense of safety, school or work attendance, and needing to access advocate services.[41]

HRSA-supported settings of care interact with individuals and communities in various places and at different points in their lives. This provides an opportunity for organizations like yours to prevent and respond to IPV at multiple points of care delivery using equitable, community-driven, culturally responsive, and trauma- and evidence-informed approaches.

Within the HRSA-Supported Setting

In the Community

In People's Homes

At Partner or Community Organizations

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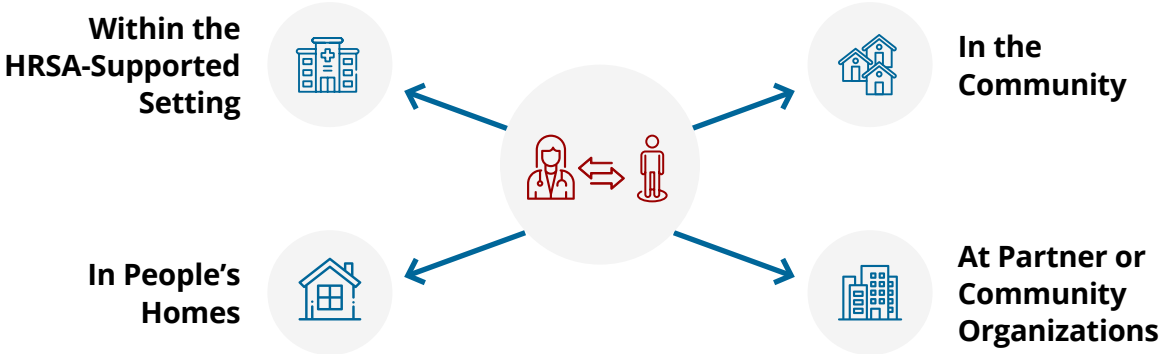
The Implementation Framework

The Implementation Framework describes building blocks for establishing an organizational environment that supports preventing and responding to IPV. The section highlights implementation tips for HRSA-supported settings of care that are new to IPV prevention and response or looking to enhance existing initiatives. While all building blocks can help your organization meet your needs related to IPV, you can start at the building block that best aligns with resources currently available within your organization and your strategic priorities.

Building Blocks

Activities

	FOUNDATIONAL	INTERMEDIATE	ADVANCED
1: Training and Supporting the Workforce	**1.1:** Engage all staff in IPV 101 training using best practices and dynamic approaches.	**1.2:** Conduct ongoing trainings for all staff on IPV-specific content.	**1.3:** Support staff well-being regarding their own exposures to IPV and other stressors.
2: Engaging Partners and Community	**2.1:** Identify key partners and assess community needs.	**2.2:** Engage diverse voices and partners in program planning.	**2.3:** Strengthen and formalize partnerships and arrangements with community members.
3: Delivering Trauma-Informed and Culturally Responsive Care	**3.1:** Assess organizational policies and processes.	**3.2:** Create an organizational environment that supports trauma-informed and culturally responsive practices.	**3.3:** Employ trauma-informed and culturally and linguistically responsive practices.
4: Coordinating and Implementing IPV Prevention and Response	**4.1:** Conduct an internal needs assessment and select IPV prevention and response initiatives.	**4.2:** Secure funding for IPV-related prevention and response initiatives.	**4.3:** Implement new or enhance existing IPV prevention and response initiatives.
5: Using Data to Drive Decision Making	**5.1:** Assess existing data collection mechanisms and processes for IPV-related data.	**5.2:** Analyze local and other relevant available data.	**5.3:** Use data to evaluate existing or identify the need for new IPV-related initiatives.

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Building Block 1:
Training and Supporting the Workforce

Individuals seeking care encounter multiple staff members during a visit to a HRSA-supported setting. ALL staff – including providers, advocates, front desk staff, educators, and anyone else a person may encounter during a visit – should understand the impact of IPV and know how to connect someone to IPV services and supports. Every interaction is an opportunity for staff to recognize the signs of IPV and create a safe and supportive environment for individuals who have experienced or are at risk of experiencing IPV. Training all staff on IPV risk factors, prevention and response, stigma, trauma-informed and culturally responsive care, and other IPV-related topics enhances practical skills and knowledge and benefits all members of your organization. Regular, recurring training improves the sustainability of your organization's knowledge and programs and promotes continued organizational growth. Additionally, ongoing training enhances your organization's capacity to implement IPV prevention and response programs (see Building Block 4).

Potential Training Topics

- How intersecting identities shape an individual's experience of violence and the systems that respond to violence

- Partnerships, referrals, and resources for individuals experiencing IPV

- Teen dating violence, healthy relationships, and age and developmentally appropriate IPV prevention programs

- Federal and state-level laws, policies, and regulations that affect experiences of and responses to IPV

- Provision of trauma-informed care[42,43]

- Cultivation of safe, supportive, and culturally responsive spaces within organizational settings[44]

- Shared decision-making approaches

- IPV risk factors, including the impact of structural racism; intergenerational trauma; homophobia; adverse childhood experiences; and other risk factors for violence

- Range and intersection of various forms of IPV such as abuse, sexual violence, and stalking

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- Lasting impacts of IPV including physical health, behavioral health, economic and housing stability, quality of life, etc.

- Information on resources including supportive services and legal, housing, and financial services for individuals affected by IPV, suicide and crisis mental health services (e.g., 988 and HRSA's Maternal Mental Health Hotline (1-833-TLC-MAMA)), SUD support services, and medical services

Staff may also experience violence themselves, know of colleagues, family members, or friends experiencing violence, or experience secondary trauma or PTSD from IPV-related work. Meeting staff's needs is essential to creating a safe and supportive environment for IPV prevention and response for everyone.

Secondary trauma: Trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. It can occur among all professionals who provide services to those who have experienced trauma (e.g., health care providers, peer counselors, first responders, clergy, intake workers).[45]

Key Training and Supporting the Workforce Activities

FOUNDATIONAL
1.1: Engage all staff in IPV 101 training using best practices and dynamic approaches

INTERMEDIATE
1.2: Conduct ongoing training for all staff on IPV-specific content

ADVANCED
1.3: Support staff well-being regarding their own exposures to IPV and other stressors

ACTIVITY 1.1: Engage all staff in IPV 101 training using best practices and dynamic approaches.

Training all staff within your organization supports implementation of high-quality evidence-informed prevention and response initiatives, addresses stigma and bias, and enhances practical skills and knowledge. Effective trainings should use principles that support adult learning, including multiple learning modalities, and incorporate practice-based learning opportunities and dynamic approaches (e.g., role-play).

You can:

- Conduct a one-time, synchronous, all-staff training on the basics of IPV.

- Connect with local, state, and national providers (e.g., coalitions against sexual assault and domestic violence [DV]) to identify new resources, webinars, and training opportunities to make available to staff within your organization.

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- <u>Collaborate with community partners</u> to provide the training (e.g., reimburse a local service provider that conducts similar trainings or has subject matter expertise).

- Diversify training modalities to encourage engagement and learning (e.g., offer both instructor-led and self-directed learning options).

- Consider training designs that allow staff to practice likely IPV prevention and response scenarios within your organization, e.g., a role-play of a patient encounter with IPV disclosure.

- <u>Evaluate training curricula</u> to understand which approaches work and which do not and adjust training curricula accordingly.

Resources

- <u>Train Providers and All Staff</u>, IPV Health Partners
  - This site provides tools to support comprehensive preliminary training on IPV, including PowerPoint decks and curated training videos.

- <u>Core Competencies for Sexual Violence Prevention Practitioners</u>, National Sexual Violence Resource Center (NSVRC)
  - This resource outlines core content areas for prevention staff training to prepare them for their roles.

- <u>How to Captivate and Motivate Adult Learners: A Guide for Instructors Providing In-Person Public Health Training</u>, Centers for Disease Control and Prevention (CDC)
  - This tool supports trainers in planning, executing, and evaluating training curricula for adult learners.

ACTIVITY 1.2: Conduct ongoing trainings for all staff on IPV-specific content.

Conduct routine, ongoing trainings that build on the IPV 101 training and deepen understanding of complex and sensitive IPV-related topics. Embedding IPV trainings into organizational policies, daily operations, and professional development opportunities reflects an organizational commitment to prevent and respond to IPV. Role-specific trainings can also provide "just-in-time" information as different professional disciplines have differing knowledge needs (e.g., nurses may need more information on screening and clinical coordinators may need more information on resources and counseling).

You can:

- Update and implement policies related to the cadence of training (e.g., during onboarding, annual staff trainings).

- Integrate IPV information and education into existing training opportunities (e.g., onboarding, staff in-service meetings, rounds, annual staff trainings), programs, tools, frameworks, and capacity-building initiatives.

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- Feature IPV-specific content in trainings on topics intersecting with IPV, the social determinants of health (SDOH), and health outcomes.
- Consider opportunities for role-specific IPV training (e.g., more robust training for health care providers).
- Account for staff time and compensation during trainings.
- Work with relevant community partners to identify potential cross or joint training opportunities, and potential guest speakers.

Resources

- Health Partners on IPV + Exploitation, National Training and Technical Assistance Partners
  - This resource includes free, public webinars on the intersection of IPV and other critical public health and identity issues. It also includes opportunities to apply to participate in a guided IPV learning collaborative with other HRSA-supported health centers and other Health Program grantees.

- A Train the Trainers Curriculum on Addressing Intimate Partner Violence, Reproductive and Sexual Coercion, Futures Without Violence
  - This "train-the-trainer" curriculum includes sample agendas to tailor training on responding to IPV to lengths of one hour, four hours, and full day. While the training curriculum is for reproductive health settings, you can adapt it for behavioral health providers, social service workers, and educators.

- A Train the Trainers Curriculum on Responding to Adolescent Relationship Abuse, Futures Without Violence
  - This curriculum focuses on training health care providers to work with adolescents to address relationship abuse. However, you can adapt it for youth counselors, behavioral health providers, social service workers, and educators. It includes sample agendas for tailoring according to time available (i.e., one hour, four hours, full day).

- Not Neutral: The Impact of Mandatory Reporting on Domestic Violence Survivors webinar, National Resource Center on Domestic Violence (NRCDV) and National LGBTQ Institute on IPV
  - This webinar discusses effects of mandatory reporting practices. Refer to the resource to identify practical approaches to encourage disclosure of IPV.

ACTIVITY 1.3: Support staff well-being regarding their own exposures to IPV and other stressors.

Acknowledge staff's own experiences with violence and trauma, including secondary IPV trauma. In addition, staff also experience other stressors like burnout that affect their well-being. All staff, regardless of their role within the organization and their level of interaction with an individual who has experienced IPV, may benefit from proactive (e.g., wellness classes and programs

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offered to all staff) and reactive (e.g., counseling, leave) support mechanisms that address both their experiences with violence and other stressors. Meeting staff's needs is essential to creating a safe and supportive environment for IPV prevention and response for everyone.

You can:

- Provide spaces for conversations with staff about stressors and strategies for improving work–life balance to prevent burnout and turnover.

- Acknowledge and provide support services and resources to staff who have experienced violence and trauma, including those who experience secondary trauma.

- Review and update organizational policies to assess alignment with trauma-informed principles (e.g., allow for staff to take time off and/or reassess workloads when needed).

- Assess your facilities to ensure the space is welcoming, allows for private conversations, and promotes a safe haven for staff.

Resources

- Addressing Health Worker Burnout, U.S. Surgeon General
  - This advisory includes action items for health care organizations to implement evidence-based policies, programs, and solutions that identify, address, and help prevent adverse health outcomes and burnout for health workers (beginning on page 21).

- Workplaces Respond to Domestic & Sexual Violence: A National Resource Center, Futures Without Violence
  - This technical assistance hub organizes resources on violence response by topic, by resource type, and by person accessing the resource (e.g., an employer or friend of someone who has experienced violence).

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Building Block 2:
Engaging Partners and Community

Sustainable, multisectoral partnerships and engagement with individuals experiencing violence are essential to effective violence prevention and response.[46] Strengthening collaboration can help organizations build rapport and trust with those they serve and increase capacity to effectively meet those individuals' needs. Partnerships with local health centers, DV agencies, first responders, legal and justice systems, and other social service organizations ensure access to needed resources that adequately address the needs created by a previous, current, or potential threat of violence.

Types of Potential Partners

- Community-based organizations (e.g., community centers, identity-based community groups, food banks, workforce development organizations, housing supports, caregiving support, behavioral health and substance use providers)

- Organizations that provide IPV services (e.g., emergency shelters)

- State-, city-, county-, and local-level government agencies (e.g., health departments, housing authorities)

- First responders (e.g., medical professionals, law enforcement, if appropriate)

- Legal and criminal justice community (e.g., lawyers, court advocates, the judicial system, medical-legal organizations)

- Consulates

- Educational organizations such as schools, community colleges, and universities

- Faith-based communities

- Advocacy organizations

Engaging community members with lived experience of and who have witnessed violence offers you a chance to collect critical input from people who ultimately benefit from the design and delivery of supportive services. Community members (including people who have experienced or witnessed violence) can provide insight into community needs to inform program, policies, and services. It is important to understand which communities and populations IPV impacts, and prioritize engagement with those populations to develop equitable programs and services.
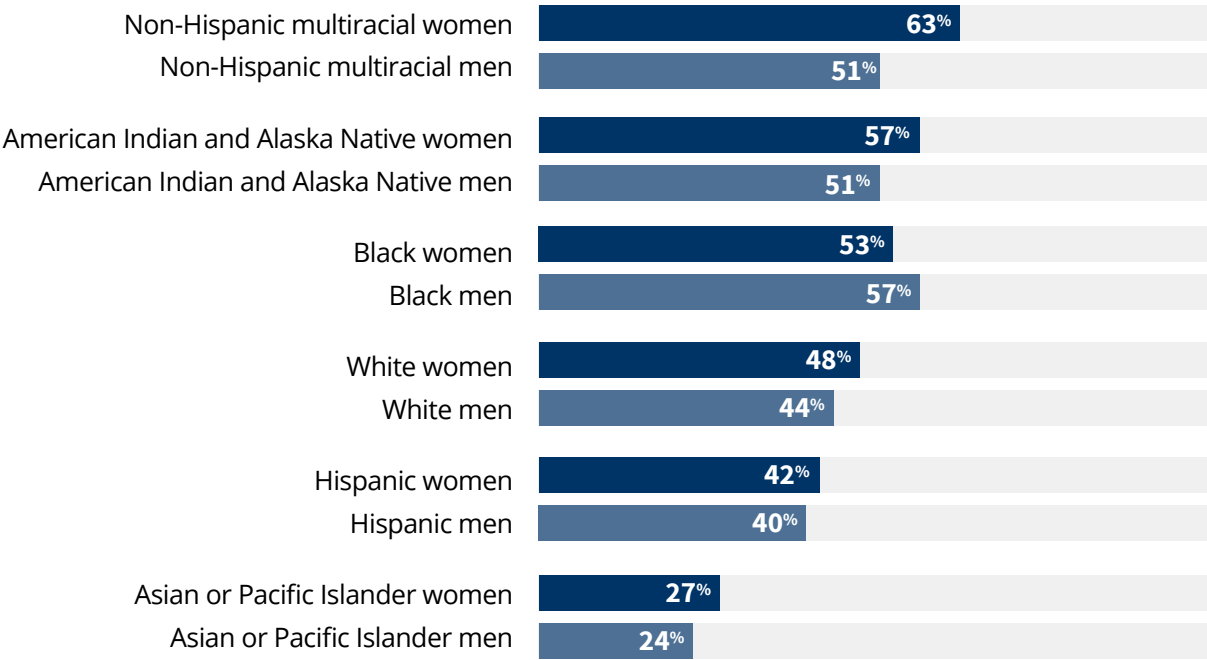
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Who Experiences IPV?

IPV affects nearly half of women and 44 percent of men.[1] A majority of individuals first experience IPV before age 25.[1]

Various other communities also disproportionately experience IPV, including:

- People with disabilities[47,48]

- People living in rural areas[49]

- Young people ages 12 to 18[50,51]

- Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI+) communities[15-19,52]

- People who are pregnant[53]

  o The risk of homicide is 35 percent greater for pregnant and postpartum women[54] and nearly half of pregnancy-related homicides are associated with IPV.[55]

- People with HIV[41],[56-59]

- Individuals who use substances[60]

  o 40-60 percent of IPV incidence include substance use[60]

- Specific racial and ethnic communities[1] (Exhibit 1)

Exhibit 1: IPV Prevalence Among Adults, by Race, Ethnicity, and Gender*

Non-Hispanic multiracial women	63%
Non-Hispanic multiracial men	51%
American Indian and Alaska Native women	57%
American Indian and Alaska Native men	51%
Black women	53%
Black men	57%
White women	48%
White men	44%
Hispanic women	42%
Hispanic men	40%
Asian or Pacific Islander women	27%
Asian or Pacific Islander men	24%

Data source: Leemis, R. W., Friar, N., Khatiwada, S., Chen, M. S., Kresnow, M., Smith, S. G., Caslin, S., & Basile, K. C. (2022). The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence. National Center for Injury Prevention and Control Centers for Disease Control and Prevention.

*The National Intimate Partner and Sexual Violence Survey does not break out prevalence by race and ethnicity and gender identity or sexual orientation.

While research studies tend to consider and report on categories like age, race, sexual orientation, and gender identity separately, individuals can identify with and experience membership in multiple categories simultaneously. There is also less research available about experiences of IPV among highly specific groups (e.g., rural bisexual women; non-binary white individuals living with disabilities).

Key Engaging Partners and Community Activities

FOUNDATIONAL
2.1: Identify key partners and assess community needs

INTERMEDIATE
2.2: Engage diverse voices and partners in program planning

ADVANCED
2.3: Strengthen and formalize community partnerships and arrangements with community members

ACTIVITY 2.1: Identify key partners and assess community needs.

Regularly assess community needs and conduct partnership analyses to identify: 1) the strengths, needs, and priorities of the population you serve; 2) existing and potential community partners; 3) and ways to integrate and fill gaps within existing care delivery systems.

You can:

- Conduct partnership analyses on a recurring basis to identify key community partners that can support your organization's strategic goals and priorities and entities that fill service gaps within your organization.

- Use local data sources and community needs assessments to understand the health needs, demographic, and cultural composition of your community, and identify and fill service gaps within your community.

- Regularly analyze and use the data to identify which prevention and response initiatives you can implement to respond to community needs.

Resources

- Assess Needs and Resources Toolkit, County Health Rankings
  - This resource outlines several key activities that capture many dimensions of community asset mapping.

- Community Toolbox: Identifying Community Assets and Resources, Center for Community Health and Development, University of Kansas
  - Chapter 3, Section 8 of this resource provides checklists, examples, tools, and trainings to conduct community asset maps and partnership analyses.

11 Preventing and Responding to Intimate Partner Violence:
An Implementation Framework for HRSA-Supported Settings of Care

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ACTIVITY 2.2: Engage diverse voices and partners in program planning.

Engage people with diverse backgrounds, experiences, and perspectives in conversations about IPV. Establish partnerships for IPV-related initiatives to have a greater reach and increase community support and utilization of your programs and services. Lasting IPV prevention and response requires community approaches that draw on the strengths and resources of social service providers, advocates, law enforcement, school systems, and medical providers as well as of individuals who have experienced violence.

You can:

- Convene partners on an ongoing basis and before applying for new funding to identify opportunities for efficient and effective collaboration, establish a common vision, set roles and responsibilities, and determine funding distribution.

- Use community-based and participatory frameworks to thoughtfully and respectfully incorporate voices of individuals with lived experience of violence on an ongoing basis without tokenizing or re-traumatizing individuals. Use town halls, community meetings, surveys, interviews, or other engagement approaches.

Resources

- Back to Basics: Partnering with Survivors and Communities to Promote Health Equity at the Intersections of Sexual and Intimate Partner Violence, NRCDV and NSVRC
  - This resource describes the strengths behind forging connections between health equity and the organization's work.

- Involving People Most Affected by the Problem, Community Toolbox, Center for Community Health and Development, University of Kansas
  - This resource offers strategies, learning checks, and training resources on engaging people affected by a problem or issue.

ACTIVITY 2.3: Strengthen and formalize partnerships and arrangements with community members.

Strengthen and formalize partnership and referral networks to ensure access to comprehensive care for individuals who have experienced, are at risk of experiencing, or use violence. Interprofessional, multisectoral collaborations in your community can help individuals address all care concerns – not just the needs that your setting can meet.

You can:

- Formalize arrangements for partnership, data sharing, and bidirectional referrals to ensure partners understand priorities and expectations, even when staffing changes.

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- Leverage memoranda of understanding and data use agreements to establish partnership agreements with collaborators that prioritize secure information exchange, safety, and privacy protection.

- Leverage existing or create new community advisory boards, planning councils, or patient advisory councils to formally and consistently incorporate the voices of individuals with lived experience into program planning, implementation, and evaluation.

- Develop closed-loop and bidirectional referral networks between IPV services, community-based organizations, and health settings to ensure safe and private follow-up and reinforcement of services.

Resources

- Building Sustainable and Fruitful Partnerships between Community Health Centers and Domestic Violence Advocacy Organizations, Futures Without Violence
  - This resource provides a step-by-step guide for health centers to develop or strengthen partnerships within and outside communities.

- Collective Power: A Practical Blueprint for Sexual Assault Programs to Create Community Partnerships and Collaborations, ValorUS
  - This blueprint, initially a framework for California's sexual assault programs, can support your organizations' efforts in developing partnerships within the community.

- Memorandum of Understanding Template, Health Partners on IPV + Exploitation
  - This template is hosted on the HRSA Bureau of Primary Health Care-supported Health Partners on IPV + Exploitation and can be used for partnerships between community health centers and DV programs.

13 Preventing and Responding to Intimate Partner Violence:
An Implementation Framework for HRSA-Supported Settings of Care

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Building Block 3:
Delivering Trauma-Informed and Culturally Responsive Care

Populations disproportionately affected by IPV and other SDOH can benefit from trauma-informed and culturally responsive care. Applying a health equity lens to all our work helps reduce disparities by addressing the various factors that affect an individual's access to care.[14] Individuals experiencing violence also face challenges with other SDOH, stigma, cultural norms, and past experiences with trauma that may affect their ability or willingness to seek care and services. Individuals experiencing violence often have a history of trauma, adverse childhood experiences, and/or have experience with structural racism, which increases the risk for future violence. Responding to violence requires considering and addressing potential challenges with partnerships, jurisdictional issues, cultural context, and intergenerational trauma.

Trauma-informed care: All people at all levels of the organization or system "**realize** the widespread impact of trauma and understand potential paths for recovery; **recognize** the signs and symptoms of trauma; **respond** by fully integrating knowledge about trauma into policies, procedures, and practices, and actively **resist** re-traumatization."[43] It also aligns with the following five principles: Safety, trustworthiness & transparency, peer support, collaboration & mutuality, and empowerment, voice & control.[43]

Culturally responsive care: Integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.[61]

Considerations for Providing Trauma-Informed and Culturally Responsive Care

- Acknowledge stigma and providers' own implicit biases (e.g., forms of bias that occur automatically and unintentionally that can impact judgement, decisions, and interactions with individuals)[64] and how they impact the quality of services they provide to a person who has experienced violence.

- Understand trauma and how it can affect families, groups, organizations, and communities, as well as individuals (for people at all levels of the organization)[43]

- Avoid stereotypes and cultural biases in your language and messaging (e.g., use person-first, nonjudgmental, and medically accurate language, provide gender-responsive services, display messages in multiple languages).

- Be aware of the intersecting identities that shape an individual's experience of both violence and the systems that respond to violence.

- Be aware of and address stigma around behavioral health, sex work, gender identity and sexual orientation, substance use, HIV/AIDS, and IPV.

- Promote availability of bilingual staff and interpretation services.

- Acknowledge the impact of structural racism, intergenerational trauma, adverse childhood experiences, and other risk factors for violence.

Key Delivering Trauma-Informed and Culturally Responsive Care Activities

FOUNDATIONAL

3.1: Assess organizational policies and practices

INTERMEDIATE

3.2: Create an organizational environment that supports trauma-informed and culturally responsive practices

ADVANCED

3.3: Employ trauma-informed and culturally and linguistically responsive practices

ACTIVITY 3.1: Assess organizational policies and practices.

Regularly assess whether your organization has existing policies and services that are fully trauma-informed and culturally responsive. Based on these assessments, identify areas to improve existing protocols and practices, meet training needs, and identify and implement new policies.

You can:

- Assemble a team to regularly assess your organization's approach to incorporating a culturally responsive and trauma-informed approach to service delivery.

- Assess existing organizational policies and services and the physical environment from an equity, trauma-informed, and culturally responsive lens on an ongoing basis to inform updates to or identify gaps in existing policies and practices.

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- Regularly assess the demographic composition of your workforce for representativeness of the demographics of the local community and population served.

- Develop an action plan for updating organizational policies and services or creating new ones to be more trauma-informed and culturally responsive based on findings from the assessments.

Resources

- Trauma-informed Organizational Toolkit for Homeless Services, National Center on Family Homelessness

  - Section 1 of this resource includes a tool to self-assess your organization's capacity to provide trauma-informed care.

- Concept of Trauma and Guidance for a Trauma-Informed Approach, Substance Abuse and Mental Health Services Administration (SAMHSA)

  - This resource includes guidance for organizations to implement a trauma-informed approach in 10 implementation domains.

ACTIVITY 3.2: Create an organizational environment that supports trauma-informed and culturally responsive practices.

Provide trauma-informed and culturally responsive care to address the historical and cultural context that may underlie an individuals' experience with trauma and violence. Your organizational environment sets the tone for whether an individual feels comfortable receiving or disclosing information, taking materials and resources home, and discussing issues and experiences further. Organizational policies establish norms and create concrete standards to which staff can adhere.

You can:

- Develop and implement policies and procedures (e.g., workflows, checklists, policy documents) that promote IPV prevention and ensure a balance of safety and confidentiality in all necessary communication.

- Regularly review and update written policies and procedures about IPV prevention and response, trauma-informed care, culturally responsive services, and data collection and data sharing.

- Regularly assess the demographic composition of your workforce for representativeness of the demographics of the community and population you serve.

- Update your organization's physical environment to promote space for providing trauma-informed and culturally responsive care (e.g., private rooms, signage).

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Resources

- Creating Trauma-Informed Services: Tipsheet Series, National Center on Domestic Violence, Trauma & Mental Health
    - This tip sheet describes five core components for a trauma-informed approach in DV advocacy services.

- Culture, Language, and Health Literacy, HRSA
    - This resource provides HRSA–curated tools for building health care provider capacity to provide culturally responsive care.

- Futures Without Violence Store, Futures Without Violence
    - This store provides (free for download) signage, brochures, and other culturally specific materials that they recommend disseminating in various settings.

ACTIVITY 3.3: Employ trauma-informed and culturally and linguistically responsive practices.

Offer materials (e.g., printed handouts, check-in questionnaires, office signage) and services (i.e., actual interactions with clinical staff, administrators, and other staff) in plain language and in an individual's primary language, that reflect the individual's values and past trauma. This approach helps to improve relationships between individuals and staff, increase people's comfort and confidence navigating and accessing care, and increase satisfaction.[45,62,63] Ensure all staff receive training in trauma-informed and culturally responsive care and provide opportunities for individuals to discuss their trauma.[64]

You can:

- Ensure providers and staff understand individuals' preferences. This can happen by extending appointments beyond 15 minutes and providing space where providers and other staff can see each person alone for at least part of every visit. For at-home visits, consider use of a white noise machine or encourage individuals to find a private room in their home to openly discuss their trauma histories and preferences.

- Offer accessible electronic and information technology, including websites and social media; TTY/TDD hotlines; interpreters, including qualified sign language interpreters; translated and plain language materials; accessible walkways, entrances, restrooms, hallways, rooms and beds; and other approaches that facilitate physical and virtual accessibility.[iii]

- Ensure all staff receive continuous training on trauma-informed and culturally responsive care.

- Engage individuals in shared decision making (e.g., explain all potential care options, ask who they want involved in their care) and develop a care plan.

[iii] Pursuant to Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12131-12134; Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. § 794; and Section 508 of the Rehabilitation Act of 1973 (Section 508), 29 U.S.C. § 794(d).

17 Preventing and Responding to Intimate Partner Violence:
An Implementation Framework for HRSA-Supported Settings of Care

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- Share information about IPV and trauma in newsletters, email signatures, and campaigns, and include posters and signage throughout the organization about IPV prevention and supports, healing from trauma, and behavioral health resources.

- Include diverse staff (e.g., providers, advocates, community health workers, promotores de salud, health navigators, doulas, midwives, peers, and extension workers) with an array of expertise across disciplines (e.g., primary care, behavioral health, ancillary supports) in care and service delivery.

Resources

- Educational Videos for Health Care Providers and Advocates, Futures Without Violence
  - This resource provides educational videos on how to implement trauma-informed practices in your organizational settings.

- Language Justice Toolkit, Communities Creating Healthy Environments
  - This toolkit provides actionable steps to increase language access across service delivery, event planning, and organizational policies.

- An Implementation Checklist for the National Culturally and Linguistically Appropriate Services (CLAS) Standards, U.S. Department of Health and Human Services, Office of Minority Health
  - This resource provides a list of implementation practices and testimonials for implementing culturally and linguistically appropriate services.

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Building Block 4:
Coordinating and Implementing IPV Prevention and Response

Responding to IPV and risk factors for violence across the lifespan requires activities across the spectrum of prevention. There is no one-size-fits-all approach to IPV prevention and response. However, every organization can and should implement something. You can determine the appropriate strategy and related initiative that best address the needs of your community and population and that you can implement with existing or new organizational resources (e.g., funding, personnel, partnerships, technology). Implementing IPV prevention and response interventions requires establishing or enhancing organizational infrastructure (e.g., connection and case management technology, communication access and collaboration systems, self-care applications, data collection systems, grant writing, management) and identifying IPV champions and advocates within the organization. Ensuring you have adequate infrastructure promotes ongoing support of quality improvement and protocol innovation within care delivered to individuals experiencing or at risk of violence.[66]

Three kinds of public health prevention strategies, primary, secondary, and tertiary, can address risk for IPV and its co-occurrence with other epidemics like HIV/AIDS, SUD, and mental illness.[iv,v,vi]

Primary Prevention:
Preventing IPV before it happens

Secondary Prevention:
Immediately responding when IPV occurs

Tertiary Prevention:
Responding to IPV's lasting impacts over time

[iv] Sharps, P. W., Njie-Carr, V. P. S., & Alexander, K. (2021). The syndemic interaction of intimate partner violence, sexually transmitted infections, and HIV infection among African American women: Best practices and strategies. *Journal of Aggression, Maltreatment & Trauma, 30*(6), 811-827.

[v] Sullivan, K. A., Messer, L. C., & Quinlivan, E. B. (2015). Substance abuse, violence, and HIV/AIDS (SAVA) syndemic effects on viral suppression among HIV positive women of color. *AIDS Patient Care and STDs, 29*, S42-S48.

[vi] Illangasekare, S., Burke, J., Chander, G., & Gielen, A. (2013). The syndemic effects of intimate partner violence, HIV/AIDS, and substance abuse on depression among low-income urban women. *Journal of Urban Health, 90*(5), 934-947.

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Examples of IPV Prevention and Response Initiatives

Preventing and responding to IPV includes a broad range of interventions that you can adapt or adopt based on what works best for your organization. While these examples include initiatives for working with adolescents and adults, it does not cover prevention and response initiatives for child abuse and elder abuse.

Appendix B contains links to resources for each type of example listed below.

Primary Prevention: Proactive efforts to promote positive healthy relationships across individuals, relationships, communities, and societies.[67,68] Primary prevention does not treat violence as an inevitable occurrence but rather works to prevent violence before it occurs.

- **Promote safe and healthy relationship skills** across the lifespan through social-emotional learning programs for young people and healthy relationship programs for adults (e.g., healthy communication, conflict resolution, and emotional regulation) to reduce risk factors for experiencing or using violence across all ages.

- **Engage adults and peers in prevention efforts**, including engaging men and boys as allies, implementing bystander empowerment and education programs, and implementing family-based programs.

- **Promote protective environments** to create a community climate that reinforces individual-level skill building. This includes conducting early childhood home visitation, improving school and workplace climate and safety, and strengthening employer-employee family supports.

Universal Education and IPV Identification: HRSA-supported settings, regardless of their scope of work and role in community and individual level health outcomes, can offer universal education and screening.

- **Provide universal education to all individuals** with evidence-based information about healthy and unhealthy relationships and health promotion strategies. By making information on resources and supports available to everyone, regardless of disclosure, your organization can normalize discussing IPV and help build relationships between staff or providers and the individuals they serve.

- **Educate individuals on mandatory reporting** and other related policies to increase awareness of mandatory reporting requirements and confidentiality and reduce the harmful impact of screening. Posting informational handouts, conversation starters for providers, and materials publicly throughout the organization is useful.[69]

- **Use evidence-informed screening methods** to identify those in need of care and possibly prevent further incidents of violence.[70] Your organization can use standardized screenings that can help identify and respond to IPV and factors contributing to IPV (including SDOH).[71,72]

20 Preventing and Responding to Intimate Partner Violence:
An Implementation Framework for HRSA-Supported Settings of Care

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Reducing Barriers to Care. Individuals who have experienced or are at risk of experiencing IPV often face several organizational and structural barriers to care. This includes bias and stigma,[73-76] systemic inequities, and unwelcoming care and service environments that can lead to distrust.[77,78] Other factors like a lack of privacy[79] and physical or social isolation also negatively impact access.[49,73,78] Public health emergencies like the COVID-19 pandemic can exacerbate challenges in access to care, limit resources, or lead to staff burnout.[80] Coordinated delivery of IPV prevention and response initiatives help diminish these barriers and also help alleviate the impacts of staff burnout and limited resources.

- Meet people "where they are" by expanding locations and methods for service delivery in the community (e.g., mobile vans, telehealth or virtual visits, mobile health technologies[81]) to reduce barriers associated with transportation, access, and disclosure preferences.

- Integrate or co-locate IPV, medical, and social services to create a "one-stop shop" for facilitating rapid connection to appropriate care and wraparound, holistic services or provide access to IPV services in relatively innocuous settings (e.g., at a health center). Integration and co-location of services mitigates stigma associated with visiting locations known for IPV services or tied to the legal or criminal justice system.

- Use interdisciplinary, coordinated care teams to provide appropriate, specialized IPV care to personalize care for each individual and streamline their access to care services and providers. Your organization should engage various types of staff and expertise across disciplines (e.g., primary care, behavioral health, ancillary supports), including a range of providers and advocates, (e.g., community health workers, promotores de salud, health navigators, peer supports) in care teams.

Key Coordinating and Implementing IPV Prevention and Response Activities

FOUNDATIONAL

4.1: Conduct an internal needs assessment and select IPV prevention and response initiatives

INTERMEDIATE

4.2: Secure funding for IPV-related prevention and response initiatives

ADVANCED

4.3: Implement new or enhance existing IPV prevention and response initiatives

ACTIVITY 4.1: Conduct an internal needs assessment and select IPV prevention and response initiatives.

Regularly reassess internal needs to identify and map your organization's resources (e.g., staff, expertise, time, space, funding, other programs), strengths, and potential areas for growth to community needs, and create a plan for IPV prevention and response within your organization. Implementing and sustaining IPV prevention and response initiatives requires alignment with organizational priorities and capitalizing on organizational strengths.

21 **Preventing and Responding to Intimate Partner Violence:**
An Implementation Framework for HRSA-Supported Settings of Care

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You can:

- Review organizational documents (e.g., strategic plan, organizational charts, annual reports) to identify organizational priorities and strengths.

- Conduct internal needs assessments to determine organizational readiness to implement various initiatives and staff perspectives on priority topics through focus groups, key informant interviews, staff meetings, and surveys.

- Meet with staff (either through one-on-one meetings or department-specific meetings) to gain input on which activities the organization should implement. Use online surveys and virtual collaboration platforms (e.g., digital whiteboards) to gather feedback and ideas.

- Based on the findings from the community needs assessment, partnership analysis, and internal needs assessment, identify primary, secondary, or tertiary prevention approaches that you find most appropriate for your community and setting.

- Develop an action plan for IPV prevention and response initiatives for your organization, including specific populations that will participate in your efforts (e.g., school-age youth, families, faith-based communities, adults), organizational champions or leaders, and organizational resources available.

Resources

- Domestic Violence Quality Assessment/Quality Improvement Tool, Futures Without Violence
  - This resource provides health care facilities with guiding questions to assess quality of care related to the promotion of healthy relationships and interventions related to IPV within health care delivery.

ACTIVITY 4.2: Secure funding for IPV-related prevention and response initiatives.

Pursue available funding opportunities that can help build or expand infrastructure to support IPV prevention and intervention approaches, directly fund service delivery for people who have experienced violence, or implement primary prevention trainings. Diverse funding streams (e.g., grants, financial donations, in-kind donations) can enhance long-term sustainability of IPV prevention and response initiatives and prevent interruptions in service delivery.

You can:

- Consider how diversified funding sources can help invest in and sustain innovative and community-specific program elements.

- Seek out and apply to potential funding opportunities that help build capacity or expand initiatives that prevent or respond to IPV.

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- Highlight <u>partnerships</u> and work with partners in responses to funding opportunity announcements and notices of funding opportunities submitted to HRSA and other federal agencies or grant programs.

Resources

- These federal agencies provide IPV-specific grant funding:
  - <u>HRSA Grant Opportunities</u>
  - <u>Department of Justice, Office on Violence Against Women Grant Programs</u>
  - <u>Office of Family Violence and Prevention Services, Office of the Administration for Children and Families (ACF)</u>
  - <u>Indian Health Service (IHS) Domestic Violence Grant Program</u>

ACTIVITY 4.3: Implement new or enhance existing IPV prevention and response initiatives.

Enhance existing initiatives or implement new ones based on findings from internal assessments and community needs. Ensure your organization has the necessary infrastructure to support implementation and promote sustainability of IPV initiatives.

You can:

- Implement and adapt initiatives that address community and organizational needs and that are feasible given organizational assets and constraints.
- Create organizational workflows, checklists, and other processes to support implementation of new and existing IPV prevention and response initiatives.
- Leverage supportive services already offered by your organization and determine how those services can contribute to IPV prevention.
- <u>Monitor and evaluate</u> initiatives to identify opportunities to expand, codify, or sustain those activities.

Resources

- <u>Prepare Your Practice</u>, IPV Health Partners
  - This resource provides sample workflows, PowerPoint presentations, policy toolkits, and tools to prepare organizations to respond to IPV.
- <u>The Implementation Mapping Tool</u>, ExpandNet
  - This tool provides a methodology and template to organizations looking to scale up or develop interventions.

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Building Block 5:
Using Data to Drive Decision-Making

Data collection and tracking mechanisms can help your organization provide more equitable health services through a strong understanding of the need for IPV services; demographics of the population experiencing IPV (e.g., race, ethnicity, sexual orientation, gender identity); rates of engagement in care (e.g., linkage, retention); care experience (e.g., length of visits, time to make an appointment, time between referrals, satisfaction); and differences across settings.

Organizations can strategically allocate resources, expand successful initiatives, and plan for new initiatives based on data. In addition, individuals should understand what, how, and why organizations document their sensitive data and all circumstances under which providers or other staff would share their disclosure of violence, for care coordination or otherwise, and who may have access to that information. In addition, organizations should ensure that they are implementing the appropriate privacy and security safeguards for IPV information stored and exchanged through electronic health records (EHRs), patient portals, or other data systems.[82]

Questions to Consider When Thinking About Data

- Are you collecting data on IPV, demographics, and related risk and protective factors?
- Are you tracking it consistently?
- Are you tracking referrals made to other services? Are you tracking whether individuals received referral services?
- Have you trained staff on how to ask the questions on which the data are based?
- Where does this data live?
- Who has access to the data?
- How are you collecting data?
- How often are you collecting the data?
- Who are you sharing the data with?
- How are data protected and securely shared?
- How are the data used?
- How are you informing individuals about how their data is being used, who has access to it, and how it is being protected?

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Key Evaluating and Collecting Data Activities

FOUNDATIONAL

5.1: Assess existing data collection mechanisms and processes for IPV-related data

INTERMEDIATE

5.2: Analyze local and other relevant available data

ADVANCED

5.3: Use data to evaluate existing or identify the need for new IPV-related initiatives

ACTIVITY 5.1: Assess existing data collection mechanisms and processes for IPV-related data.

Always prioritize an individual's safety, confidentiality, and autonomy when documenting sensitive data or an IPV disclosure in EHRs and other data management systems. Routinely review your data collection mechanisms to ensure you are collecting appropriate data (e.g., basic demographic data like race, ethnicity, sexual orientation, gender identity), identifying additional variables, and certifying that data collection maintains privacy and confidentiality. For example, some HRSA-supported settings of care collect data through mechanisms specific to HRSA (e.g., Uniform Data System measures) and their organization (e.g., EHRs, referral and outreach trackers, screening tools, etc.).

You can:

- Assess available capacity and infrastructure for tracking and collecting data (e.g., on referrals to social services, prevalence of IPV, IPV screening results) while protecting privacy.
- Identify additional data collection mechanisms your site needs to appropriately assess the impact of initiatives and community needs.

Resources:

- Privacy Principles for Protecting Survivors of Intimate Partner Violence, Exploitation and Human Trafficking in Healthcare Settings, Health Partners on IPV+Exploitation
  - This tool describes safety and confidentiality considerations when collecting and analyzing health information of people who have experienced violence.

ACTIVITY 5.2: Analyze local and other relevant available data.

Analyze local data (e.g., census data, data from local public health systems) to gain valuable insight into the demographics and lived experiences of individuals receiving services; identify individuals and populations that are not accessing services; measure use of your organization's programs and services; and discern potential gaps in services. Local data can help your organization understand community needs, inform resource allocation, and monitor progress on IPV-related indicators.

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You can:

- Work with partners to identify and gain access to local data sources.

- Identify data variables that are critical for decision making (e.g., data on community violence, community safety, demographic changes).

- Use available data to inform strategic decisions about allocation of IPV prevention and response resources, develop protocols, initiatives or interventions, and assess progress towards creating community level change through implementation activities.

Resources

- Evaluation Toolkit, NSVRC
  - This toolkit provides a step-by-step guide to planning, conducting, and analyzing evaluations.

- VetoViolence Evaluation Guide, CDC Injury Prevention & Control, Division of Violence Prevention
  - This guide provides a step-by-step guide to planning, conducting, and analyzing policy or program evaluations.

ACTIVITY 5.3: Use data to evaluate existing or identify the need for new IPV-related initiatives.

Establish continuous evaluation and quality improvement protocols to adjust initiatives as needed to better serve your population and drive progress on responding to IPV. Incorporate community feedback as part of these evaluations. Program evaluation can include efforts to assess satisfaction, consistency of implementation (i.e., fidelity to a program model and its protocols), staff reflections on barriers and facilitators to implementation, and changes in community outcomes. Effective evaluation, staff, and community feedback can help you identify successful programs and approaches and adopt, adapt, sustain, or abandon interventions according to impact, community need, and organizational capacity.

You can:

- Work with internal or external evaluators to design program evaluation tools, conduct evaluation activities, and analyze results.

- Assess whether an initiative meets previously defined metrics for success, including goals prioritized by the communities the initiative serves.

- Use an implementation science approach to analyze facilitators and barriers to meeting goals and adapt your response to address them.

- Use sustainability assessments to adjust (adapt), increase uptake of successful programmatic elements (adopt), or discontinue (abandon) initiatives that are not working.

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Resources

- Program Sustainability Assessment Tool, Washington University in St. Louis Center for Public Health Systems Science
  - This sustainability assessment tool can help organizations evaluate the capacity of the program. It consists of 40 questions and will rate the program accordingly.

- Sustainability Planning Tools, Rural Health Information Hub
  - This resource houses various tools that can help your organization plan new or build existing sustainability measures.

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Conclusion

IPV has lasting effects on individuals, families, and communities. Integrating public health approaches to preventing and responding to IPV into your organization's practices and services can help you prevent and mitigate these impacts on your local community and the population your serve. The building blocks in this Implementation Framework provide examples of opportunities and approaches your organization can pursue to enhance the services you provide to the millions of individuals impacted by IPV.

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Appendix A: HRSA 2023-2025 Strategy to Prevent Intimate Partner Violence

Appendix A presents an overview of HRSA's *2023-2025 Strategy to Prevent Intimate Partner Violence*. HRSA is employing an all-of-agency approach to identify aims and objectives for its different Bureaus and Offices to pursue collaboratively to continue to improve its efforts to prevent and address IPV.
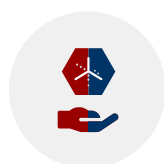
AIM 1.
Enhance HRSA coordination of IPV efforts

1.1: Promote communication and collaboration across HRSA on efforts to address IPV

1.2: Increase HRSA staff knowledge to support IPV prevention and response within HRSA-supported settings

1.3: Leverage data to drive decision-making to improve IPV prevention efforts and access to IPV-specific care

AIM 2.
Strengthen infrastructure and workforce capacity to support IPV prevention and response services

2.1: Increase health care and public health workforce capacity to support IPV prevention and response and understanding of social norms that can contribute to violence

2.2: Encourage HRSA-supported settings to incorporate IPV prevention and response activities into existing and new programs to expand implementation capacity

2.3: Promote development and strengthening of local partnerships and referral networks within HRSA-supported setting to prevent and respond to IPV

2.4: Improve access to IPV-specific care and interventions

AIM 3.
Promote prevention of IPV through evidence-based programs

3.1: Support implementation of upstream primary prevention approaches that promote healthy relationships

3.2: Encourage establishment of safe and supportive settings promoting secondary and tertiary prevention approaches to IPV and its impacts

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Appendix B: IPV Prevention and Response Intervention Resources

Upstream Primary Prevention

Cross-cutting IPV primary prevention resources

- Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices, CDC
  - This technical package describes the rationale, evidence, and strategies associated with varying primary prevention approaches.

- Key Prevention Resources, PreventIPV
  - This site is a compendium of resources to support your organization's understanding of the core principles of primary prevention and its intersection with other forms of violence.

- Resources to Support the Comprehensive Technical Package, NRCDV
  - This technical package consists of resources to guide prevention decision-making. The package also includes prevention tools for health centers.

Promote safe and healthy relationship skills across the lifespan

- Dating Matters: Strategies to Promote Healthy Teen Relationships, CDC
  - This evidence-based teen violence prevention model focuses on teaching young people healthy relationship skills before they start dating.

- Shifting Boundaries: Lessons on Relationships for Students in Middle School, Prevent IPV
  - This evidence-based model for middle school students focuses on prevention of sexual harassment and dating violence.

- Safe Dates: An Evidence-Based Program to Prevent Dating Violence, Hazeldon Betty Ford Foundation
  - This evidence-based curriculum trains young people and adolescents to identify and prevent dating violence.

- The Fourth R: Strategies for Healthy Youth Relationships, Western University Centre for School Mental Health
  - This school-based program involves adolescent students, teachers, parents, and community in reducing violence and related risk behaviors.

- "Is Your Relationship Affecting Your Health?" Safety Card, Futures Without Violence
  - This safety card can start conversations about how a relationship might be unhealthy or abusive. Consider using this resource in a Universal Education model.

Engage adults and peers in prevention efforts

- Engaging Men to End Gender-Based Violence, Futures Without Violence
  - This site provides background information, resources, and implementation guides for working with men and boys as allies to prevent violence against women and girls.

- Bystander Intervention, PreventConnect
  - This site provides background information, resources, and implementation guides for bystander intervention approaches.

Promote protective environments

- A Comprehensive Technical Package for the Prevention of Youth Violence and Associated Risk Behaviors, CDC
  - This resource describes strategies for promoting healthy development at the family-level (pg. 15) and creating protective community environments (pg. 29), among other helpful approaches.

- Promising Futures Program Models & Interventions Database, Futures Without Violence
  - This site features a searchable database of programs designed to enhance services for children, youth, and parents impacted by IPV. You can filter your search by audience demographics (e.g., age, identity group), level or setting of intervention, and more.

- Intimate Partner Violence Electronic Playbook, HRSA Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) 2.0
  - This resource consists of technical documents that drive improvement in outcomes for caregivers of young children who are receiving home visiting services and IPV.

- Person-Centered, Trauma-Informed Service, Administration for Community Living
  - This resource contains information about providing person-centered and trauma-informed services to older adults and provides links to other resources.

Universal Education and IPV Identification

Provide universal education to all individuals

- Confidentiality, Universal Education and Empowerment, and Support (CUES), IPV Health
  - This resource provides health centers with tools they can use to educate patients on healthy and unhealthy relationships and the effects of violence. Resources are also available for providers administering care.

- Futures Without Violence store (for CUES cards, foldable wallet cards)
  - This landing site provides the option to purchase CUES cards, foldable wallet cards, and other resources mentioned above. These materials were developed specifically for providers and patients.

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Educate individuals on mandatory reporting requirements and other related policies

- Webinar: Not Neutral: The Impact of Mandatory Reporting on Domestic Violence Survivors Webinar, NRCDV and National LGBTQ Institute on IPV
  - This webinar discusses effects of mandatory reporting practices. You can refer to the resource to identify practical approaches to encourage disclosure of IPV.

- Compendium of State and U.S. Territory Statutes and Policies on Domestic Violence and Health Care, Futures Without Violence
  - This compendium provides an extensive resource list on mandated reporting and IPV-specific policies.

Implement evidence-informed screening methods

- Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings, CDC
  - This instrument provides an inventory of existing tools for assessing IPV, sexual violence, and victimization in health care settings.

- Family Home Visiting Intimate Partner Violence Screening & Referrals Toolkit, Minnesota Department of Health
  - This toolkit for screening and referrals details beneficial screening methods and referral practices for IPV care and prevention.

- IPV Workflow for Telehealth Visits Universal Education for Women Ages 18-59, Brigham and Women's Hospital
  - This resource provides a brief overview of sample questions for screening IPV, universal education practices following the screening, and quick facts on IPV.

- Women's Preventive Services Guidelines, HRSA
  - This resource provides guidelines for women's preventive services and screenings.

- Interpersonal and Domestic Violence, Women's Preventive Services Initiative
  - This resource provides clinical recommendations from the American College of Obstetricians and Gynecologists (ACOG) for screening adolescents and women for interpersonal violence and IPV.

Reducing Barriers to Care

Meet people "where they are"

- Project Echo (Extension for Community Healthcare Outcomes), Agency for Healthcare Research and Quality (AHRQ)
  - This collaborative model brings medical education and case management together in efforts to help clinicians provide care to patients "where they are." This resource can help you develop a similar model of care within the communities you serve in.

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- Addressing Intimate Partner Violence and Human Trafficking in the Health Center Setting, Health Information, Technology, and Quality Center (HITEQ)
  - This site provides information on how health centers can integrate evidence-based, trauma-informed interventions and health information technology to provide care to patients in a post-COVID virtual era.

- Preventions and Upstream Approaches: Lessons Learned about Survivor-Centered Support during the COVID-19 Pandemic, Futures without Violence
  - Pages 4–7 of this brief provide health centers with practical steps in providing holistic care to patients and emphasize equity across the service landscape.

- National Maternal Mental Health Hotline (1-833-TLC-MAMA), HRSA
  - This site provides information on HRSA's maternal mental health hotline for pregnant people and new mothers.

- 988 Suicide & Crisis Lifeline, SAMHSA
  - This site provides information about the National Suicide Prevention Lifeline (now known as the 988 Suicide & Crisis Lifeline)

Integrate or co-locate IPV, medical, and social services

- Advanced Nursing Education – Sexual Assault Nurse Examiner program, HRSA Bureau of Health Workforce
  - In this co-location model, grantees develop academic-practice partnerships that integrate trauma-informed, evidence-based sexual assault and DV services at clinical partner sites, including HRSA-supported health centers and critical shortage facilities.

- Rural Services Integration Toolkit: Co-Location of Services Model, Rural Health Information Hub
  - This site provides a list of resources and examples of rural co-location services.

- Integrating Health Services into DV Agencies and Community-Based Organizations, Futures Without Violence
  - This training guide describes how health centers can partner with other organizations within the community to provide care and prevent incidents of IPV and human trafficking.

Use interdisciplinary, coordinated care teams to provide appropriate, specialized IPV care

- Care Coordination, AHRQ
  - This site provides an overview of care coordination. It also provides actionable steps to implementing care coordination approaches within health care settings and examples of care models that can be adopted into practice.

- Rural Care Coordination Toolkit, Rural Health Information Hub
  - This toolkit contains seven modules to help rural communities identify and implement care coordination programs.

33 Preventing and Responding to Intimate Partner Violence:
An Implementation Framework for HRSA-Supported Settings of Care

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Health Resources & Services Administration

Appendix C – References

[1] Leemis, R. W., Friar, N., Khatiwada, S., Chen, M. S., Kresnow, M., Smith, S. G., Caslin, S., & Basile, K. C. (2022). *The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence.* National Center for Injury Prevention and Control Centers for Disease Control and Prevention.

[2] World Health Organization. (2021). *Violence against women.* https://www.who.int/news-room/fact-sheets/detail/violence-against-women

[3] Brown, C., Sanci, L., & Hegarty, K. (2021). Technology-facilitated abuse in relationships: Victimisation patterns and impact in young people. *Computers in Human Behavior, 124.*

[4] Taylor, S., & Xia, Y. (2018). Cyber partner abuse: A systematic review. *Violence and Victims, 33*(6), 983-1011.

[5] Fissel, E. R., Graham, A., Butler, L. C., & FIsher, B. S. (2021). A new frontier: The development and validation of the intimate partner cyber abuse instrument. *Social Science Computer Review, 40*(4).

[6] Fernet, M., Lapierre, A., Hébert, M., & Cousineau, M. (2019). A systematic review of literature on cyber intimate partner victimization in adolescent girls and women. *Computers in Human Behavior, 100*, 11-25.

[7] The UN Refugee Agency. *Gender-based violence.* https://www.unhcr.org/en-us/gender-based-violence.html

[8] National Coalition Against Domestic Violence. *What is domestic violence?* https://ncadv.org/learn-more

[9] Mercy, J. A., Hillis, S. D., Butchart, A., Bellis, M. A., Ward, C. L., Fang, X., & Rosenberg, M. L. (2017). Interpersonal Violence: Global Impact and Paths to Prevention. In C. N. Mock, R. Nuge, O. Kubusingye, & K. R. Smith (Eds.), *Injury Prevention and Environmental Health. 3rd edition* (Vol. 7).

[10] American Psychological Association. (2017). Interpersonal violence. https://www.apa.org/advocacy/interpersonal-violence

[11] National Sexual Violence Resource Center. (2010). *What is sexual violence? Fact sheet.* https://www.nsvrc.org/sites/default/files/2012-03/Publications_NSVRC_Factsheet_What-is-sexual-violence_1.pdf

[12] Office on Violence Against Women. *Sexual assault. United States Department of Justice.* https://www.justice.gov/ovw/sexual-assault

[13] Office on Trafficking in Persons. *What is human trafficking?* U.S. Department of Health & Human Services. https://www.acf.hhs.gov/otip/about/what-human-trafficking

[14] Health Resources & Services Administration. (2020). *Office of Health Equity.*

[15] Walters, M. L., Chen, J., & Breiding, M. J. (2013). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on Victimization by Sexual Orientation.* National Center for Injury Prevention and Control and Centers for Disease Control and Prevention.

[16] Roberts, T., Gorne, S. G., & Hoyt, W. T. (2015). Between a gay and a straight place: Bisexual individuals' experiences with monosexism. *Journal of Bisexuality, 15*(4).

[17] Friedman, R. M., Dodge, B., Schick, V., Herbnick, D., Hubach, R., Bowling, J., Goncalves, G., Krier, S., & Reece, M. (2014). From bias to bisexual health disparities: Attitudes toward bisexual men and women in the United States. *LGBT Health, 1*(4), 309-318.

[18] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 U.S. Transgender Survey.* National Center for Transgender Equality.

[19] National Coalition of Anti-Violence Programs. (2014). *Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate Violence.* https://avp.org/wp-content/uploads/2017/04/2013_ncavp_hvreport_final.pdf

[20] Gregory, A. C., Williamson, E., & Feder, G. (2016). The impact on informal supporters of domestic violence survivors: A systematic literature review. *Trauma, Violence, & Abuse, 18*(5), 562-580.

[21] Bender, A. E., McKinney, S. J., Schmidt-Sane, M. M., Cage, J., Holmes, M. R., Berg, K. A., Salley, J., Bodell, M., Miller, E. K., & Voith, L. A. (2022). Childhood exposure to intimate partner violence and effects on social-emotional competence: A systematic review. *Journal of Family Violence.*

34 Preventing and Responding to Intimate Partner Violence:
An Implementation Framework for HRSA-Supported Settings of Care

HRSA
Health Resources & Services Administration

[22] Lee, H., Russell, K. N., O'Donnell, K. A., Miller, E. K., Bender, A. E., Scaggs, A. L., Harris, L. I., Holmes, M. R., & Berg, K. A. (2022). The effect of childhood intimate partner violence (IPV) exposure on bullying: A systematic review. *Journal of Family Violence.*

[23] Kimber, M., Adham, S., Gill, S., McTavish, J., & MacMillan, H. L. (2018). The association between child exposure to intimate partner violence (IPV) and perpetration of IPV in adulthood—A systematic review. *Child Abuse & Neglect, 76*, 273-286.

[24] Riger, S., Raja, S., & Camacho, J. (2002). The radiating impact of intimate partner violence. *Journal of Interpersonal Violence, 17(*2), 184-205.

[25] Roberts, A. L., Gilman, S. E., Fitzmaurice, G., Decker, M. R., & Koenen, K. C. (2010). Witness of intimate partner violence in childhood and perpetration of intimate partner violence in adulthood. *Epidemiology, 21*(6), 809-818.

[26] Hines, D. A., & Saudino, K. (2004). Genetic and environmental influences on intimate partner aggression: A preliminary study. *Violence and Victims, 19*(6), 701-718.

[27] Centers for Disease Control and Prevention. (2021). *Fast facts: Preventing intimate partner violence.* https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html

[28] Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T. L., & Gilbert, L. (2017). *Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices.* National Center for Injury Prevention and Control Centers for Disease Control and Prevention.

[29] Black, M. C. (2011). Intimate partner violence and adverse health consequences: Implications for clinicians. *American Journal of Lifestyle Medicine, 5*(5), 428-439.

[30] Liu, L. Y., Bush, W. S., Koyuturk, M., & Karakurt, G. (2020). Interplay between traumatic brain injury and intimate partner violence: Data driven analysis utilizing electronic health records. *BMC Women's Health, 20*.

[31] Warshaw, C., Brashler, P., & Gil, J. (2009). Mental Health Consequences of Intimate Partner Violence. In C. Mitchell & D. Anglin (Eds.), *Intimate Partner Violence: A Health-Based Perspective* (pp. 147-170). Oxford University Press.

[32] Alhusen, J. L., Frohman, N., & Purcell, G. (2015). Intimate partner violence and suicidal ideation in pregnant women. *Archives of Women's Mental Health, 18*(4), 573-578.

[33] Cafferky, B. M., Mendez, M., Anderson, J. R., & Stith, S. M. (2018). Substance use and intimate partner violence: A meta-analytic review. *Psychology of Violence, 8*(1), 110-131.

[34] Rivera, E. A., Phillips, H., Warshaw, C., Lyon, E., Bland, P. J., & Kaewken, O. (2015). *An applied research paper on the relationship between intimate partner violence and substance use.* National Center on Domestic Violence Trauma & Mental Health.

[35] Devries, K. M., Child, J. C., Bacchus, L. J., Mak, J., Falder, G., Graham, K., Watts, C., & Heise, L. (2014). Intimate partner violence victimization and alcohol consumption in women: A systematic review and meta-analysis. *Addiction, 109*(3), 379-391.

[36] Smith, P. H., Homish, G. G., Leonard, K. E., & Cornelius, J. R. (2012). Intimate partner violence and specific substance use disorders: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions. *Psychology of Addictive Behaviors, 26*(2), 236-245.

[37] Gutierres, S. E., & Van Puymbroeck, C. (2006). Childhood and adult violence in the lives of women who misuse substances. *Aggression and Violent Behavior, 11*(5).

[38] Breiding, M. J., Black, M. C., & Ryan, G. W. (2008). Chronic disease and health risk behaviors associated with intimate partner violence—18 U.S. states/territories, 2005. *Annals of Epidemiology, 18(*7), 538-544.

[39] Reeves, C., & O'Leary-Kelly, A. M. (2007). The effects and costs of intimate partner violence for work organizations. *Journal of Interpersonal Violence, 22*(3), 327-344.

[40] National Center for Injury Prevention and Control. (2003). *Costs of Intimate Partner Violence Against Women in the United States.* Centers for Disease Control and Prevention.

HRSA
Health Resources & Services Administration

[41] Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M., & Chen, J. (2018). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief—Updated Release.* National Center for Injury Prevention and Control Centers for Disease Control and Prevention.

[42] Center for Preparedness and Response. (2020). *6 Guiding Principles To Trauma-Informed Approach.* Centers for Disease Control and Prevention. https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm

[43] Substance Abuse and Mental Health Services Administration. (2014). S*AMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

[44] Effective Health Care Program. (2019). *Improving cultural competence to reduce health disparities for priority populations.* Agency for Health Care Research and Quality. https://effectivehealthcare.ahrq.gov/products/cultural-competence/research-protocol

[45] Substance Abuse and Mental Health Services Administration. *A treatment improvement protocol: Trauma-informed care in behavioral health services.* https://www.ncbi.nlm.nih.gov/books/NBK207201/pdf/Bookshelf_NBK207201.pdf

[46] Shorey, R. C., Tirone, V., & Stuart, G. L. (2014). Coordinated community response components for victims of intimate partner violence: A review of the literature. *Aggression and Violent Behavior, 19*(4), 363-371.

[47] Hahn, J. W., McCormick, M. C., Silverman, J. G., Robinson, E. B., & Koenen, K. C. (2014). Examining the impact of disability status on intimate partner violence victimization in a population sample. *Journal of Interpersonal Violence, 29*(17).

[48] Breiding, M. J., & Armour, B. S. (2016). The association between disability and intimate partner violence in the United States. *Annals of Epidemiology, 25*(6), 455-457.

[49] National Advisory Committee on Rural Health and Human Services. (2015). *Intimate Partner Violence in Rural America: Policy Brief.*

[50] 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. *Journal of Interpersonal Violence, 31*(6), 963-988.

[51] Halpern, C. T., Spriggs, A. L., Martin, S. L., & Kupper, L. L. (2009). Patterns of intimate partner violence victimization from adolescence to young adulthood in a nationally representative sample. *Journal of Adolescent Health, 45*(5), 508-516.

[52] Brown, T. N. T., & Herman, J. L. (2015). *Intimate Partner Violence and Sexual Abuse Among LGBT People: A Review of Existing Research.* The Williams Institute.

[53] Alhusen, J. L., Ray, E., Sharps, P., & Bullock, L. (2015). Intimate partner violence during pregnancy: Maternal and neonatal outcomes. *Journal of Women's Health, 24*(1), 100-106.

[54] Wallace, M. E. (2022). Trends in pregnacy-associated homicide, United States, 2020. *American Journal of Public Health, 112*(9), 1133-1136.

[55] Palladino, C. L., Singh, V., Campbell, J., Flynn, H., & Gold, K. J. (2011). Homicide and suicide during the perinatal period: Findings from the National Violent Death Reporting System. *Obstetrics & Gynecology, 118*(5), 1056-1053.

[56] Centers for Disease Control and Prevention. (2014). I*ntersection of intimate partner violence and HIV in women.*

[57] Siemieniuk, R. A. C., Krentz, H. B., Miller, P., Woodman, K., Ko, K., & Gill, M. J. (2013). The clinical implications of high rates of intimate partner violence against HIV-positive women. *Journal of Acquired Immune Deficiency Syndromes, 64*(1), 32-38.

[58] Schafer, K. R., Brant, J., Gupta, S., Thorpe, J., Winstead-Derlega, C., Pinkerton, R., Laughon, K., Ingersoll, K., & Dillingham, R. (2012). Intimate partner violence: A predictor of worse HIV outcomes and engagement in care. *AIDS Patient Care and STDs, 26*(6), 356-365.

[59] Machtinger, E. L., Wilson, T. C., Haberer, J. E., & Weiss, D. S. (2012). Psychological trauma and PTSD in HIV-positive women: A meta-analysis. *AIDS and Behavior, 16*(8), 2091-2100.

HRSA
Health Resources & Services Administration

[60] Addiction Resource Editorial Staff. (2021). *Relationship Between Substance Abuse and Domestic Violence.* AddictionResource.net. https://www.addictionresource.net/substance-abuse-and-domestic-violence/

[61] Centers for Disease Control and Prevention. (2021). *Cultural competence in health and human services.* CDC National Prevention Information Network. https://npin.cdc.gov/pages/cultural-competence#what

[62] Kimberg, L., & Wheeler, M. (2019). Trauma and Trauma-Informed Care. In M. R. Gerber (Ed.), *Trauma-Informed Healthcare Approaches.* Springer.

[63] Raja, S., Hasnain, M., Hoersch, M., Gove-Yin, S., & Rajagopalan, C. (2015). Trauma informed care in medicine: Current knowledge and future research directions. *Family & Community Health, 38*(3), 216-226.

[64] National Center on Domestic Violence Trauma & Mental Health. (2011). Creating Trauma-Informed Services: Tipsheet Series (A Trauma-Informed Approach to Domestic Violence Advocacy, Issue. http://nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Tipsheet_TI-DV-Advocacy_NCDVTMH_Aug2011.pdf

[65] Washington State Department of Health, & Injury and Violence Prevention. (2017). *Sexual Violence Prevention Plan.* https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/140-165-SexualViolencePreventionPlan.pdf

[66] Shaw, E. K., Howard, J., West, D. R., Crabtree, B. F., Nease, D. E., Tutt, B., & Nutting, P. A. (2012). The role of the champion in primary care change efforts. *Journal of the American Board of Family Medicine, 2*5(5), 676-685.

[67] Curtis, M. J., & Love, T. (2014). *Tools for Change: An Introduction to the Primary Prevention of Sexual Assault. Texas Assocation Against Sexual Assault.* https://www.acesdv.org/wp-content/uploads/2014/06/Tools-for-Change-Primary-Prevention-of-Sexual-Assault.pdf

[68] Cohen, L., Davis., R., & Graffunder, C. (2006). Before It Occurs: Primary Prevention of Intimate Partner Violence and Abuse. In P. R. Salber & E. Taliaferro (Eds.), *The Physican's Guide To Intimate Partner Violence and Abuse* (pp. 89-100). Volcano Press. https://www.preventioninstitute.org/sites/default/files/publications/Before%20it%20could%20ever%20happen.pdf

[69] Geiderman, J. M., & Marco, C. A. (2020). Mandatory and permissive reporting laws: obligations, challenges, moral dilemmas, and opportunities. Journal of the American College of Emergency Physicians, 1(1), 38-45.

[70] Miller, E., McCaw, B., Humphreys, B. L., & Mitchell, C. (2015). Integrating intimate partner violence assessment and intervention into healthcare in the United States: A systems approach. *Journal of Women's Health, 24*(1), 92-99.

[71] Bair-Merritt, M. H., Lewis-O'Connor, A., Goel, S., Amato, P., Ismailji, T., Jelley, M., Lenahan, P., & Cronholm, P. (2014). Primary care-based interventions for intimate partner violence: A systematic review. *American Journal of Preventive Medicine, 46*(2), 188-194.

[72] Morse, D. S., Lafluer, R., Fogarty, C. T., Mittal, M., & Cerulli, C. (2012). "They told me to leave": How health care providers address intimate partner violence. *Journal of the American Board of Family Medicine, 25*(3), 333-342.

[73] Heron, R. L., & Eisma, M. C. (2021). Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research. *Health & Social Care in the Community, 29*(3), 612-630.

[74] Othman, S., Goddard, C., & Piterman, L. (2014). Victims' barriers to discussing domestic violence in clinical consultations: A qualitative enquiry. *Journal of Interpersonal Violence, 29*(8), 1497-1513.

[75] Narula, A., Agarwal, G., & McCarthy, L. (2012). Intimate partner violence: Patients' experiences and perceptions in family practice. *Family Practice, 29*(5), 593-600.

[76] Salmon, D., Baird, K. M., & White, P. (2015). Women's views and experiences of antenatal enquiry for domestic abuse during pregnancy. *Health Expectations, 18*(5), 867-878.

[77] Lundell, I. W., Eulau, l., Bjarneby, F., & Westerbotn, M. (2018). Women's experiences with healthcare professionals after suffering from gender-based violence: An interview study. *Journal of Clinical Nursing, 27*(5-6), 949-957.

[78] Robinson, S. R., Ravi, K., & Voth Schrag, R. J. (2020). A systematic review of barriers to formal help seeking for adult survivors of IPV in the United States, 2005–2019. *Trauma, Violence & Abuse, 22*(5), 1279-1295.

HRSA
Health Resources & Services Administration

[79] Hudspeth, N., Cameron, J., Baloch, S., Tarzia, L., & Hegarty, K. (2022). Health practitioners' perceptions of structural barriers to the identification of intimate partner abuse: A qualitative meta-synthesis. *BMC Health Services Research, 22*.

[80] Kochhar, R. (2020). *Unemployment rate is higher than officially recorded, more so for women and certain other groups*. Pew Reseach Center. https://www.pewresearch.org/fact-tank/2020/06/30/unemployment-rate-is-higher-than-officially-recorded-more-so-for-women-and-certain-other-groups/

[81] Anderson, E. J., Krause, K. C., Krause, C. M., Welter, A., McClelland, D. J., Garcia, D. O., Ernst, K., Lopez, E. C., & Koss, M. P. (2019). Web-based and mHealth interventions for intimate partner violence victimization prevention: A systematic review. *Trauma, Violence & Abuse, 22*(4), 870-884.

[82] Health Partners on IPV + Exploitation. (2021). *Privacy Principles for Protecting Survivors of Intimate Partner Violence, Exploitation and Human Trafficking in Healthcare Settings*. https://healthpartnersipve.org/wp-content/uploads/2021/10/Privacy-Principles-for-Protecting-Survivors_Final.pdf

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