Family Home Visiting Intimate Partner Violence Screening & Referrals Toolkit

Summary

Intimate Partner Violence (IPV) is defined as physical or sexual violence, stalking, reproductive coercion, and psychological aggression by a current or former intimate partner of the victim.[1] It is estimated that 1 in 4 women and nearly 1 in 10 men will experience IPV during their lifetime.[2] Experiencing IPV is associated with an increased risk of many adverse health outcomes including depression, posttraumatic stress disorder (PTSD), substance abuse, and chronic diseases such as heart diseases.[2] Individual risk factors for IPV include pregnancy, living in a low income household, being a racial or ethnic minority, and living in a rural area.[2,3] Although there are individual risk factors, it is important to remember that experiencing IPV is never the fault of the victim.

As many as 1 in 15 children are exposed to IPV between parents, or between a parent and a parent's partner.[5] Children who are exposed to IPV may be at an increased risk of adverse health outcomes, similar to those of their parents, including PTSD, depression, and developmental challenges.[6] Supporting the strengthening of the mother-child bond is a key strategy for helping children exposed to violence.[7] Home visitors can play a critical role in supporting that mother-child bond, and in providing universal education about IPV and available resources.

The MIECHV Performance Measures – Target Timeframes for Screening and Referral (https:/www.health.state.mn.us/docs/communities/fhv/miechvscreenguide.pdf) has been created in addition to this toolkit. The guidance document provides very brief notes on who is included in the measure, when screenings should be completed, what screening tools can be used, and how to track screenings in IHVE.

Periodicity

The Minnesota Department of Health (MDH) recommends that all MIECHV-funded home visiting programs universally screen all primary caregivers for IPV within 6 months of enrollment. It is best practice for all home visiting programs to screen primary caregivers for IPV at least once per year.

MDH recommends that caregivers are screened for IPV at the following times:

- Once per trimester of pregnancy
- At 2, 6, 12, 18, and 24 months postpartum
- Whenever there is a change in partners
- As needed based on home visitor judgement

IPV Screening Tools

Humiliation, Afraid, Rape, Kick (HARK)

The HARK is a four question, self-reported screening tool that represents different components of IPV including emotional, sexual, and physical abuse. The questions can be found on the BMC Family Practice website (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562/table/T1/). Or the Metro Alliance for Healthy Families offers HARK-C Questions (https://www.metroallianceforhealthyfamilies.org/Media/PDF/MAHFDomesticViolenceHARK-C.pdf) as another version of this tool that asks one additional question about if children have been exposed to violence. The HARK-C is appropriate for screening as well. Questions are answered with yes or no and one point is given for every yes answer. A score of one or more indicates that IPV has been experienced in the past year.

Hurt-Insult-Threaten-Scream (HITS)

The HITS is a four question, self-reported or staff administered screening tool that assesses the frequency of certain components of IPV using a five point Likert scale from 1=Never to 5=Frequently. The total score can range from four to 20. A score of 10 or higher indicates that the person screened is at risk of IPV. The tool is available online HITS Domestic Violence Screening Tool (https://www.baylorhealth.com/PhysiciansLocations/Dallas/SpecialtiesServices/EmergencyCare/Documents/BUMCD-262_2010_HITS%20survey.pdf).

Relationship Assessment Tool (RAT)

The RAT tool, formerly known as (formerly known as the WEB tool), is recommended by Futures without Violence (https:/www.futureswithoutviolence.org) as a component of universal education on healthy relationships. A recorded webinar Healthy Moms Happy Babies (https:/www.futureswithoutviolence.org/healthy-moms-happy-babies-webinar) is available to train home visitors on how to incorporate the RAT into their practice is available from Futures without Violence. The RAT consists of 10 questions about different behaviors of partners and the caregiver's feelings. Reponses are recorded on a six point Likert scale with 1=Disagree Strongly and 6=Agree Strongly. The RAT and instructions for use are available at the end of the IPV Protocol (https:/www.health.state.mn.us/docs/communities/fhv/ipvprotocol.pdf). A score of 20 points or higher on the RAT is considered positive for IPV.

IPV Screening

Developing a Screening Process

A home visiting organization must determine screening processes and protocols that provide guidance to home visitors while also protecting the confidentiality and wishes of caregivers. An example of a screening process is available online from MDH IPV Screening Algorithm (https:/www.health.state.mn.us/docs/communities/fhv/ipvscreeningalgorithm.pdf). It should be

remembered first and foremost that the goal of screening is to provide education and resources and is not about getting the primary caregiver to disclose.

MDH recommends that family home visiting programs universally screen all caregivers for IPV using validated tools. Providing universal education on healthy relationships, consent, and safety is a recommended best practice for home visiting and is often considered the first step in a screening process. Universal education benefits all people who are receiving home visiting as this approach can promote safe and respectful conversations on health relationships and can help caregivers to disclose if they are experiencing IPV or have safety concerns. Home visitors can use the Futures Without Violence Safety Card (https:/www.futureswithoutviolence.org/healthy-moms-healthy-babies-home-visitor-safety-card) to guide providing universal education. MDH Family Home Visiting offers Futures without Violence training several times a year. Videos on how to incorporate universal education on IPV are also available online from Futures without Violence trainings (http:/www.futureswithoutviolence.org/health-training-vignettes). The CUES evidence-based intervention (http://ipvhealthpartners.org/adopt/) provides information on steps that a home visiting agency can take to educate all caregivers on IPV and promote prevention.

Examining current screening processes using a Swim Lane Map (https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/swimlanemap.html), also called a process map, can detail the current screening process while identifying gaps in service delivery and opportunities for improvement.

The timing of screening should be informed by MDH periodicity recommendations and should be detailed in a screening protocol. To adhere to periodicity recommendations, home visitors could explore different methods for tracking and reporting when screenings need to be completed. These methods could include using a monthly worksheet or chart or utilizing notes features in electronic health records systems. If a caregiver discloses that they have experienced IPV, no additional screening is necessary unless the caregiver begins a relationship with a new partner. It is recommended that home visitors note this disclosure. Additional information is available in the Documenting and Reporting Data section.

Establishing a Screening Protocol

A screening protocol should include information on how to protect the confidentiality of a caregiver when screening and how to assess the sensitivity of when and where to screen. A caregiver's wishes should always be respected and if a caregiver refuses an IPV screen, the home visitor should not continue with the screening. Screening for IPV is a very sensitive topic. If a caregiver will be seen for multiple visits, consider screening on the second or third visit once a relationship has been established. Assess the safety of the environment. If it does not seem safe, the screening should be deferred until another visit. Never screen for IPV if the partner is present. If a child is in the home and has verbal understanding of what is being said, defer completing the IPV screening in front of them.

A screening protocol should detail how the safety of home visitors and caregivers will be protected while screening for IPV. Prior to screening caregivers, a safety protocol for home visitors should be developed with a supervisor. An example of some safety considerations for home visitors can be found in the IPV Protocol (https://www.health.state.mn.us/docs/communities/fhv/ipvprotocol.pdf)

As noted previously, screening for IPV can be very difficult and sensitive for both caregivers and home visitors. Introducing IPV screening to a family using normalized language can help to ease some discomfort. A screening protocol could include some phrases or questions that home visitors use when bringing up IPV screening for the first time with a caregiver. Examples of phrases and open-ended questions to use when introducing IPV screening are:

- I ask all women about violence in their relationships because we know relationships affect our health.
- I have started to ask all caregivers more about their relationships.
- What happens when you and your partner disagree?
- What feelings do you have when you disagree? (Discomfort, anxious, afraid, calm….)
- How does your child react at those times?
- I learned that at least 1 in 4 women experience abusive relationships in their lives, so I ask all women about this.

Staff discomfort with using screening tools could be related to desire for more training or support around how to introduce screening tools to families. Incorporating discussions of screening practices into reflective supervision can support continued learning with screening tools, maintenance of screening rates, and resolving barriers to screening completion. A screening protocol could include information on how often a supervisor will discuss with a home visitor their experience introducing and completing screenings with families to identify any areas for improvement and connect to additional training opportunities. Futures without Violence trainings (http:/www.futureswithoutviolence.org/health-training-vignettes) include guidance and tips on of how to discuss screening tools with families and can be used to help home visitors become more comfortable with introducing and explaining the value in using screening tools.

A written protocol detailing the screening process should be easily accessible to all home visitors and supervisors. Developing a written protocol with staff input can improve buy-in and standardize practice between home visitors while also ensuring that all caregivers are being screened appropriately. The protocol should contain, at minimum, which screening tool/s will be used, how often caregivers will be screened, information on how home visitors will track screenings, and safety planning for the caregiver and home visitor. An example process and protocol is available online from MDH IPV Screening Algorithm (https:/www.health.state.mn.us/docs/communities/fhv/ipvscreeningalgorithm.pdf).

IPV Referrals

It is recommended that screening should only be completed when follow-up is available through referral to resources. This toolkit provides information on two foundational components of building a referral network:

- Identifying resources and building relationships with organizations in the community.
- Developing a process and protocol to ensure all children and families receive referrals if they screen positive.

Identifying Resources & Building Relationships

Every person has choices if they have experienced IPV. Some of these choices include staying in the home, filing criminal charges or protective orders, or leaving the home. Home visiting agencies should identify resources that can be provided to caregivers who make any of these choices. A comprehensive resource list including referral options for these choices should be developed, maintained for accuracy, and made available to home visitors to use with caregivers who disclose or screen positive for IPV.

Home visitors should familiarize themselves with the emergency resources in their community. Most communities have emergency personnel, including advocates and law enforcement, who are specially trained to respond to IPV crises.

Home visitors should identify shelter resources in their community that caregivers can utilize if they do not feel safe staying in their home. Connecting with shelter staff to learn about how to make referrals and what caregivers can expect when they arrive at the shelter can help home visitors provide reassuring information and a warm hand off.

Many women's organizations, both locally and nationally have crisis response staff and IPV support hotlines that are answered 24 hours a day. In Minnesota, the Day One Crisis Line (1-866-223-1111) can connect caregivers with an advocate in their area who can support the caregiver in contacting shelters, law enforcement, and safety planning. The National Domestic Violence hotline (https://www.thehotline.org) (1-800-799-7233 (SAFE) provides confidential support and can connect women to resources in their area.

Advocates are trained to assist a caregiver in developing a personalized safety plan with details about staying safe in their home, planning for leaving with their child(ren) or pets, and/or telling family and friends about their IPV. If a caregiver is not comfortable with a referral to an advocate, a home visitor can begin this process with a caregiver. Beginning safety planning can help the home visitor better explore and support the caregiver's options. The National Domestic Violence hotline website has many safety planning resources What Is a Safety Plan? (https://www.thehotline.org/help/path-to-safety/). A sample safety plan is available in the IPV Protocol from MDH (https://www.health.state.mn.us/docs/communities/fhv/ipvprotocol.pdf).

Caregivers who currently or in the past have experienced IPV may benefit from connecting with support groups and mental health providers in their area. Home visitors should identify support groups and collect information on when, where, and how often these groups meet in addition to contact information for the support group coordinator. Identifying mental health providers that

specialize in supporting caregivers that have experienced IPV can encourage warm hand offs between home visiting staff and other agencies.

Developing a Referral Process and Protocol

Rapid referral, defined as referral to resources appropriate for the level of support indicated by the screening result, is the goal of screening. Connecting a caregiver to resources as soon as possible can lead to improved outcomes and protect their safety. As a best practice, referrals should be made as soon as possible. Home visitors should become familiar with the organizations in their communities they are referring to. Examining the referral process using a Swim Lane Map (https:/www.health.state.mn.us/communities/practice/resources/phqitoolbox/swimlanemap.html), also called a process map, can help identify barriers and opportunities for improvement to streamline the referral process.

The management of releases of information at an organizational level can impact the referral process and protocol. Before a home visitor can make a referral, they will need a release of information from the caregiver they are working with. Questions to consider when examining the referral process and developing a protocol include:

- Do home visitors have access to releases of information for their caregivers?
- When is an appropriate time for home visitors to complete releases of information? Prior to any screening or after a concern is identified?
- How are releases of information stored? Are they accessible to home visitors if needed during a crisis?

The referral process begins when a caregiver is screened using one of the validated IPV screening tools. The referral process and protocol should include next steps for caregivers who don't screen positive for IPV as well as caregivers for which a concern is identified. If no immediate referral is needed, a home visitor should continue to develop a relationship with their caregiver, re-screen as indicated, and continue to educate about health relationships. If a primary caregiver does not screen positive, they could still be in need of services and potentially benefit from a referral. Home visiting organizations should detail in a referral protocol how caregivers that do not screen positive receive follow-up or referrals to appropriate resources. For example, a caregiver may not screen positive using the HARK tool but has shared with their home visitor that they feel they at times are fearful of their partner. The home visitor should support connecting the caregiver to IPV resources and record this referral, regardless of the screening result. Although this referral will not be counted towards performance measure data, it is best practice to provide referrals when clinical judgement indicates the caregiver could benefit from additional services.

Home visiting organizations should determine if the referral process differs if the screening is done in the home or in a public place, such as a WIC office. If a screening is done in a public place, how can home visitors ensure that the caregiver's comfort and private health information are protected if a referral needs to be made?

It is a recommended best practice to score screening tools and provide referrals based on screening results immediately. A referral protocol should include information on how home visitors should respond to screening results both when scored immediately and when the scoring cannot be immediately completed and shared with the caregiver. If the caregiver screens positive for IPV, how will the home visitor inform the caregiver of the screening result and protect their health and safety? Depending on the score, it might be appropriate to connect the caregiver to crisis resources. If the scoring is done outside of a visit, how can home visitors ensure that caregivers are receiving rapid referrals to crisis resources if needed?

The IPV Sample Protocol provides guidance on the type of supports a home visitor can provide to a caregiver that is experiencing IPV. A referral protocol should agency specific guidance on how quickly home visitors are expected to make a referral to services if a concern has been identified. A best practice to implement could be that home visitors make referrals immediately or within 24 hours of identifying a concern when the caregiver is not in imminent danger. If the caregiver is in imminent danger, their wishes for contacting emergency services should be respected but a home visitor should offer an immediate referral and develop a plan for checking in with the caregiver.

Some recommendations for actions that a home visitor can take when a caregiver screens positive for IPV include:

- Assess for imminent danger to caregiver, children and home visitor and call local emergency services, with caregiver consent, if imminent danger exists. Provide support by reinforcing that intimate partner violence is a crime and not the caregiver's fault.
- Provide the caregiver with information on referral options to community and intimate partner violence programs or advocate to seek resources on how to stay safe.
- Assess for other, often co-existing vulnerabilities and refer caregiver to substance abuse, mental health and/or other behavioral health specialist services if applicable.
- If the caregiver is experiencing reproductive coercion, discuss contraceptive methods that caregiver can use without partner knowing
- Give caregiver accessible local contacts, such as IPV advocate or other support structures, and hotline numbers (MN Day One: 866-223-1111 or National Domestic Violence Hotline: 800-799-SAFE) that can be reached if and when caregiver is in need of further assistance.
- Assist caregiver in identifying and accessing social support (i.e. trusted family or friends).
- Plan for follow up visit and make follow up calls using model recommendations or agency protocol.

Actively engaging caregivers in the referral process can help to improve caregiver comfort with the process. A referral protocol should detail strategies for home visitors to use to engage caregivers in the referral process and could include guidance on the following:

- Offering options

- Developing a plan together
- Prioritizing based on a family's needs
- Starting the referral process together
- Making an initial connection through a warm hand-off

A referral protocol should detail how home visitors are tracking referrals and completing follow-up. Please see the **"IPV Follow-Up"** section for more guidance on this topic.

Ways to provide follow up support for home visitors supporting a caregiver experiencing ongoing IPV or an IPV crisis should be identified and included in a referral protocol. Compassion fatigue, secondary trauma, and fear could all be experienced by home visitors. Identifying interventions, such as de-briefs with a supervisor, and community resources to support home visitors helps support staff and organizations in developing capacity to support caregivers while also protecting their own health and safety.

Crisis Response

There may be circumstances where it is appropriate to connect a caregiver to emergency resources. A component of reviewing the referral process and developing a protocol is examining the logistical aspects of providing crisis resource referrals, such as:

- What options are available for transporting a caregiver to an emergency room, a shelter, or a police station?
- How can home visitors support child safety during an IPV crisis?
- How will the health and safety of home visitors be monitored and protected when supporting caregivers experiencing an IPV crisis?
- What needs to be considered to assure documentation is completed accurately and timely?

MDH has developed an IPV crisis intervention algorithm (https://www.health.state.mn.us/docs/communities/fhv/ipvcialgorithm.pdf) that can serve as a guideline for home visitor response to an IPV crisis.

IPV Follow-Up

Following up on a referral involves the home visitor, caregiver, and other service providers.
It is best practice to incorporate family-centered decision-making into follow-up expectations. Family-centered decision-making involves working closely with the caregiver to determine what their highest priority is, what types of resources they prefer to receive or not receive, preferred communication strategies, and how they would like to be supported.
For many caregivers, acting on an IPV referral can be frightening, stressful, or put them in danger. A home visitor can support the caregiver in making a personal plan of follow up on the referral. The home visitor and caregiver might agree on a plan for the home visitor to follow up with a phone call or visit in a few hours or days to provide support. The home visitor could use

motivational interviewing to identify barriers to acting on the referral. Barriers could include fear, inability to contact without partner finding out, or confusion about next steps. Home visitors could complete a Fishbone Diagram (https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/fishbone.html) to identify barriers to referral completion or timely follow-up. A home visitor could also use "teach back" strategies to ensure that caregivers understand what the next step is in the referral process.

Home visitors can utilize relationships with referral partners to support follow-up. Information sharing, with permission from the caregiver, between a home visitor and service provider can reduce barriers by allowing home visitors to check on a referral status, support coordinating appointments or transportation, and provide information on the caregiver and their family. For example, a home visitor with permission from the caregiver and a signed release of information could connect with domestic violence shelter staff to share information on the caregiver's experience and preferred ways to be contacted to facilitate a warm hand off between services.

Developing and utilizing a referral tracking system can improve referral follow-up by identifying internal and external barriers to referral completion. A referral tracking system could have many different forms, but many home visiting organizations might find it convenient to use electronic record systems to support home visitors managing referrals with different statuses. **All home visitors will be required to use IHVE to record and report referral data in addition to any internal referral tracking and documenting.** A referral tracking system should at minimum include the date a referral is made, what the referral is for, the status of the referral, and a plan for following up with the caregiver and/or the service provider receiving the referral. A referral status could include:

- Not yet in process-family has not acted on referral
- In process-family has contacted service provider and is awaiting action
- Scheduled-family has an appointment scheduled with service provider
- Complete-family received at least one service or appointment from service provider
- Declined- family is not pursuing services
- Unavailable-referral providers was contacted and cannot provide services to family
- Ineligible-referral provider was contacted and family is not eligible for services

Documenting and Reporting Data

All home visitors should follow guidance provided in the MDH IHVE Data Collection Manual (https://www.health.state.mn.us/docs/communities/fhv/ihvedatacollmanual.pdf) when documenting and reporting data. The instructions for the screening form can be found on page 53. The instructions for the referral form can be found on page 61.

All screenings and referrals should be documented in IHVE as soon as possible after they occur. Documenting and reporting when a referral progresses through different statuses, such as when a family schedules an appointment or receives services, provides information on whether families are receiving referral services quickly, or if there are barriers that prevent families from acting on a referral. Regardless of the amount of time between when the referral is provided and when the referral status changes, it is important to report this information to document how home visitors support connecting families to resources.

Please note that IHVE data collection forms vary between electronic record systems. For technical assistance, contact the support email address listed below for the system your organization is using.

- Nightingale Notes: support@champsoftware.com
- PH-Doc: supportdesk.wpark@avenuinsights.com
- IHVE REDCap forms: Health.FHVData@state.mn.us

Home visitors will not be required to report via IHVE any information on caregivers that were not screened even if the caregiver disclosed experiencing IPV. Only the date of screening, screening tool used, screening result, and referrals provided must be reported to MDH. Home visitors should follow agency policy and protocol for documenting what took place at the home visit. To support caregivers experiencing IPV and improve ability to provide information to emergency or legal services, home visitors should also consider documenting the following:

- Document exact location on body if there are injuries.
- Document the name and relationship of possible abusers.
- Document details of intervention made and all actions taken. (I.e. police reports, restraining orders, medical reports, and intervention of child protective service).

Resources

- Domestic Violence Personalized Safety Plan (http://www.ncdsv.org/images/DV_Safety_Plan.pdf)
- Futures Without Violence Webinars (https://www.futureswithoutviolence.org/resources-events/webinars/)
- Preventing Intimate Partner Violence Across the Lifespan Technical Package (https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf)
- Wilder Research Home Visiting Engagement and Retention (https://www.wilder.org/wilder-research/research-library/home-visiting-engagement-and-retention)
- Minnesota Coalition for Battered Women (http://www.mcbw.org/)

References

1. Centers for Disease Control and Prevention. (2015). Intimate Partner Violence Surveillance Uniform Definitions and Recommended Data Elements (https://www.cdc.gov/violenceprevention/pdf/intimatepartnerviolence.pdf)
2. Centers for Disease Control and Prevention. (2019). Violence Prevention Fast Facts (https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html)
3. Health Resources & Services Administration. (2017). The HRSA Strategy to Address Intimate Partner Violence (https://www.hrsa.gov/sites/default/files/hrsa/HRSA-strategy-intimate-partner-violence.pdf).
4. Anderson, K., & van Ee, E. (2018). Mothers and Children Exposed to Intimate Partner Violence: A Review of Treatment Interventions. International journal of environmental research and public health, 15(9), 1955. PubMed: Mothers and Children Exposed to Intimate Partner Violence (https://www.ncbi.nlm.nih.gov/pubmed/30205465)
5. Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2011, October). Children's exposure to intimate partner violence and other family violence. Juvenile Justice Bulletin, 1–12. Washington, DC: U.S. Government Printing Office. NCJRS: Children's exposure to intimate partner violence and other family violence (https://www.ncjrs.gov/pdffiles1/ojjdp/232272.pdf)
6. Wathen, C. N., & Macmillan, H. L. (2013). Children's exposure to intimate partner violence: Impacts and interventions. Paediatrics & child health, 18(8), 419–422. Retrieved from NCBI: Children's exposure to intimate partner violence (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3887080/).
7. Bancroft, L., Silverman, J, & Ritchie, D. (2002). The batterer as parent. Thousand Oaks, CA: Sage Publications.

Contact

If you have questions regarding this toolkit or continuous quality improvement efforts within the MDH Family Home Visiting Section, please email health.fhvcqi@state.mn.us.

Minnesota Department of Health
Child & Family Health/Family Home Visiting
85 E 7th Place, Suite 220
PO Box 64882
St. Paul, MN 55164-0082
651-201-4090
health.fhvcqi@state.mn.us
www.health.state.mn.us

04/01/20

To obtain this information in a different format, call: 651-201-4090.