Bridge to Safety:

An evaluation of a pilot intervention to screen for and respond to domestic violence and sexual assault with refugee women in the U.S.

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We hope this evaluation will benefit refugee and immigrant women and girls, and the resettlement agencies, domestic violence and sexual assault service providers, and other organizations that serve them.

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ACRONYMS & ABBREVIATIONS

B2S	Bridge to Safety
CO	Cultural Orientation
DV	Domestic violence
GBV	Gender-based violence
IRC	International Rescue Committee
PA	Principal Applicant
R&P	Reception and Placement
SA	Sexual assault
SNAP	Supplemental Nutrition Assistance Program
USP	IRC US Programs
WPE	Women’s Protection & Empowerment

EXECUTIVE SUMMARY

Migrating women are at increased risk of violence in flight, displacement and resettlement. Recognizing the critical need to prioritize women's safety and well-being, the IRC developed and piloted the Bridge to Safety (B2S) project to strengthen IRC's capacity to respond to refugee and immigrant women survivors of domestic violence and sexual assault (DV/SA) in the U.S. With funding from the Open Square Charitable Gift Fund and the NoVo Foundation, the B2S project was piloted and evaluated from April 2014 – April 2015 in three IRC U.S. Program (USP) offices: Baltimore, Dallas, and Seattle.

The B2S pilot project integrated specific strategies to screen for and respond to disclosures of violence against refugee women resettled by the IRC USP offices. In addition, the B2S project prioritized developing partnerships with local DV/SA service providers to meet survivors' comprehensive needs. The IRC developed and tested two different approaches to DV/SA screening: direct screening (see Appendix A) and open screening (see Appendix B).

The purpose of evaluating the one-year B2S pilot across the three project offices was to 1) assess how the project was implemented, 2) identify promising implementation strategies, 3) improve the project strategy and implementation plan, and 4) inform the B2S roll-out to additional IRC USP offices. Evaluation findings and recommendations were generated from the analysis of: 1) qualitative and quantitative data collected through an end-of-project on-line survey with IRC staff, 2) qualitative data collected through semi-structured interviews with IRC staff, clients, and local service providers at mid- and end-points, and 3) quantitative monitoring data collected on a monthly basis throughout the pilot year.

Summary of Key Findings

Evaluation findings highlight interrelated opportunities and challenges with integrating DV/SA screening and basic survivor response mechanisms into existing refugee resettlement programming. The findings reveal that, overall, non-specialized staff new to working on DV/SA demonstrated skills and commitment to respond appropriately to survivors in the context of refugee resettlement programming. The B2S screening process shows promise in communicating to adult women that the IRC is a safe space for them to discuss their experiences and concerns. The direct screening approach shows promise in increasing disclosures of violence in comparison to the open screening approach; twenty four percent of clients who were screened using the direct screening approach disclosed experiences of violence. However, low disclosure rates in general suggest the possibility that many of IRC's clients do not access formal DV/SA services.

Staff expressed the critical need to systematically incorporate DV/SA-related services into refugee resettlement services. The findings indicate that screening and basic response services alone are not sufficient to address the complex obstacles refugee and immigrant women face in accessing DV/SA services, and that service gaps remain. Establishing more effective collaborations between resettlement agencies, community-based organizations, mutual assistance agencies and DV/SA organizations shows promise in addressing those gaps. Additional funding is needed to meet critical service, prevention, advocacy, and other needs related to violence against refugee and immigrant women in the U.S.

In conclusion, implementing and evaluating the B2S pilot project highlights the extent to which violence against women is an issue of importance to both IRC clients and the staff who serve them, and reiterates the critical need to make addressing violence against women a priority in U.S. resettlement policy and practice.

Summary of Recommendations

1. Strengthen service delivery for immigrant and refugee women and girls who experience domestic violence and sexual assault, as well as other forms of gender-based violence.

2. Develop and strengthen formal and informal partnerships between resettlement agencies, community-based organizations, mutual assistance agencies and DV/SA organizations.

3. Address the needs of direct service staff who are involved in responding to domestic violence and sexual assault to promote their well-being and retention over the long-term.

4. Focus on refugee women's needs, regardless of whether they are listed as principal applicants for resettlement.

5. Increase funding and resources to address violence against refugee and immigrant women and girls in the U.S.

PROJECT DESCRIPTION

Background

The International Rescue Committee (IRC) resettles approximately 10,000 new refugees in the U.S. each year and through an array of programs helps over 35,000 refugees and immigrants across 25 U.S. cities to regain control of their lives in their new communities. Many of IRC's clients come from countries with a high prevalence of violence against women.[i] Refugee women are at increased risk of violence throughout migration – at home, in armed conflict, during flight and displacement, in cities and camps where they seek refuge, and after they arrive to the U.S. [ii]

While migration to the U.S. can be an opportunity to break cycles of violence, too often refugee and immigrant women's experiences of violence remain unseen and unaddressed. Significant stigma and shame associated with being a victim of gender-based violence discourage women from coming forward and seeking help both in their own countries, countries of displacement, and in the U.S. Displacement and migration also contribute to women's isolation, lack of peer support networks and limited awareness of formal support options, and use of available social services. [iii] The psychological, physical, and emotional impacts of domestic violence and sexual assault (DV/SA) can slow the integration process and hinder women refugees and immigrants from achieving self-sufficiency and stability in the U.S. [iv]

In 2012, the IRC carried out a formal assessment across its U.S. Programs offices (USP) that explored the violence refugee and immigrant women experience. Findings from the assessment reiterated that many of IRC's female clients had experienced multiple forms of violence, that they faced barriers to disclosing these experiences to service providers, and that they had complex needs that, if unaddressed, could impact their ability to thrive in the U.S. This preliminary assessment also revealed that while resettlement services staff generally acknowledged DV/SA as a problem, they had varying knowledge and skills about how to respond in the context of their work.

Evidence indicates that routine and systematic screening can help service providers identify clients who have experienced current or past DV/SA, as well as clients who are at increased risk for abuse. [v] Recognizing the critical need to prioritize support for refugee and immigrant survivors of DV/SA, the IRC developed an assessment protocol that integrates DV/SA screening of newly arrived adult female refugee clients into existing resettlement service delivery models. By doing so, the IRC aimed to create opportunities for women to feel safe to disclose experiences of DV/SA and, as needed, to access resources for support and healing. With funding from the Open Square Charitable Gift Fund and the NoVo Foundation, IRC's Bridge to Safety (B2S) project was piloted from April 2014 – April 2015 in three IRC USP offices: Baltimore, Dallas, and Seattle.

Figure 1 - Snapshot of Bridge to Safety pilot offices 2014 – 2015

Services at all three offices include refugee resettlement, case management and employment services through the core programs of Reception and Placement, Matching Grant, and Intensive Case Management.

The IRC in Baltimore:

- Primary countries of origin of refugee clients: Bhutan, Burma, Democratic Republic of Congo, Eritrea, and Iraq
- Serves over 1,000 clients annually. In addition to the services above, services include asylee services, economic empowerment, education and learning, youth services, immigration legal services, and community health promotion.

The IRC in Dallas:

- Primary countries of origin of refugee clients: Afghanistan, Bhutan, Burma, and Iraq
- Serves 900 clients annually. In addition to the services above, services include employment assistance and job readiness training, medical case management, women's groups, immigration legal services, and American Sign Language classes.

The IRC in Seattle:

- Primary countries of origin of refugee clients: Bhutan, Burma, Democratic Republic of Congo, Iraq, and Somalia
- Serves 560 clients annually. In addition to the services above, services include anti-trafficking programs, education and learning, immigration legal services and women's groups.

Bridge to Safety Design Framework

To achieve the goal that refugee and immigrant women survivors of DV/SA are connected to and engage with resources for support and healing, local implementation of the B2S pilot project focused on the following programmatic priorities:

1. Screening newly resettled adult female IRC clients for experiences of DV/SA
2. Providing follow-up support, safety planning and referrals for clients who disclosed experiences of violence, and
3. Establishing new and strengthening existing referral options with local partners

DV/SA screening aims to provide clients space to disclose experiences of violence, feel safe and supported, and access any needed help. At the outset of the B2S project, IRC field staff were concerned that asking direct personal questions about clients' experiences with DV/SA may be culturally insensitive for some refugee clients. In response, the IRC developed and tested two different approaches to implementation of DV/SA screening.

1. **Direct screening** - Casework staff used a guided introductory script followed by five questions about the clients' specific experiences with violence (see Appendix A).
2. **Open screening** - Casework staff used a guided script to explain that IRC is a safe space to discuss experiences of gender-based violence without directly asking any questions about the clients' own experiences (see Appendix B).

The direct screening tool was adapted from the HARK questionnaire, a four question screening tool that has been shown to accurately identify women who have experienced intimate partner violence in the past year. [vi] The IRC modified the tool to include sexual violence and non-partner violence, as well as to include experiences of violence that took place both pre- and post- resettlement. The B2S screening tools and approach were also informed by the seven-item ASIST GBV Screening Tool for Women developed by Johns Hopkins Bloomberg School of Public Health specifically for use in humanitarian settings and pilot tested in Ethiopia, Uganda, and Colombia. [vii]

While individual staff made use of both open and direct screening at their discretion, IRC's Dallas and Seattle/SeaTac offices chose to primarily use the open screening tool and IRC's Baltimore office chose to primarily use the direct screening tool. Both types of screening emphasized confidentiality and were conducted in private with adult women.

The three participating IRC offices were encouraged to conduct B2S screenings as part of routine resettlement services during private in-person meeting with adult female clients within the first 90 days of arrival in the U.S. In practice, screening took place an average of 39 days after arrival. In-person interpreters were used for 35% of screenings, phone interpreters were used for 23% of screenings, and 41% of screenings did not use interpretation, either because they took place in English or because IRC staff spoke the same language as the client. Staff in pilot offices experimented with conducting screening over the phone when logistical barriers prevented an in-person meeting. Staff also experimented with conducting screening in clients' homes as well as at IRC offices. Whether screening took place over the phone or in-person, precautions were put in place to safeguard confidentiality.

For clients who disclosed experiences of DV/SA to IRC staff, in response to screening or otherwise, follow-up service delivery procedures for survivors included assessment, safety planning, service planning, and appropriate referrals to connect survivors to needed health, legal, safety, and support resources. The Bridge to Safety project implemented three service delivery tools to support this process:

1. Assessment for Survivors (see Appendix C)
2. Survivor Safety Plan (see Appendix D)
3. Survivor Service Plan (see Appendix E)

These tools were intended to standardize follow-up service provision for survivors of violence in ways that met clients' needs and could be readily used by IRC direct services staff who are not specialists in DV/SA. Staff who conducted B2S screening and provided follow-up support to survivors received between eight and 14 hours of training on dynamics of violence against immigrant and refugee women, survivor-centered attitudes and approaches, boundaries and staff safety, case management response, and how to use specific tools identified above. These trainings and tools were meant to equip staff to respond quickly and appropriately to survivors reporting to IRC staff.

Establishing new and strengthening existing referral options with viable partners, both service providers and community resources, was a vital component of the B2S service delivery model. Each office approached implementation of this component of the project differently, depending on the strength of these partnerships going into the project and availability of local services. During the launch of the pilot, the USP Women's Protection and Empowerment (WPE) Technical Advisor led a mapping exercise with each office to bring to the forefront local partners and service options. Each office created a preliminary action plan for strengthening referral systems and the accessibility of services for IRC clients. In addition, each office was encouraged to maintain a resource directory with referral information for each identified partner.

B2S was designed to be integrated into existing staff and program structures within each of the pilot offices. No additional staff were hired specifically for this project and only a very small budget was provided to support its implementation. This enabled IRC to test whether basic response to DV/SA could be integrated into existing resettlement programming with limited additional human and financial resources. A staff focal point was identified in each office to coordinate B2S pilot activities locally. Implementation of project activities, including roles and responsibilities of resettlement and related staff, varied by office based on local context and capacity.

In Baltimore, resettlement and asylee program caseworkers completed direct screenings with adult female clients loosely in conjunction with refugee health assessment screenings (timeframes varied). On average, screening took 13 minutes. Follow-up support and referrals for survivors were initially provided by the Extended Case Management program team. This program was reduced and restructured midway through the B2S pilot, and thereafter follow-up referrals were provided directly by resettlement and asylee caseworkers, as well as by the Special Needs Health Coordinator. An Advisory Committee of 10 staff from across different programs was set up to conduct outreach with existing and potential local partners.

In Dallas, the Health and Wellness Supervisor completed open screenings with adult female clients following Cultural Orientation. [viii] An Americorps member completed screenings in-home with clients who did not attend Cultural Orientation. On average, screening took 8.75 minutes. Staff from the Health and Wellness program provided follow-up support and referrals. The B2S focal point was tasked with cultivating, developing and maintaining partnerships and referral networks.

In Seattle/SeaTac, resettlement caseworkers completed open screenings with adult female clients following Cultural Orientation. On average, screening of an individual client took 21.2 minutes. Follow-up support and referrals for survivors were provided by resettlement caseworkers, in conjunction with the Intensive Case Management program team. The B2S focal point was tasked with cultivating, developing and maintaining partnerships and referral networks.

Resources provided to implement B2S

Three thousand dollars were provided to each of the pilot offices specifically for local costs related to implementation of Bridge to Safety activities from April – October, 2014. An additional $5,000 was allocated to each office to support project implementation between November 2014 and May 2015. Offices were free to use this seed funding to cover costs at their discretion. Costs generally included staff time, interpretation, transportation, and emergency services for survivors. In addition, a full-time Technical Advisor based at IRC headquarters was dedicated to lead the development of the project, coordinate the field-based B2S Advisory Committee that informed all aspects of the project start-up, provide in-person training to each of the pilot office staff, provide ongoing technical support, establish monitoring systems, co-lead the B2S evaluation and lead the roll-out strategy of B2S to additional IRC USP offices.

EVALUATION METHODOLOGY

A two-person team led the B2S evaluation design with significant input from the three pilot offices, the field-based B2S Advisory Committee, and IRC USP and WPE teams. Key evaluation activities took place at both the mid-point marker (October/November 2014) and at the end of the pilot year (April/May 2015). [ix]

The purpose of evaluating the one-year pilot phase of B2S across three IRC offices was to:

- Assess how the project was implemented
- Identify promising implementation strategies
- Improve the project strategy and implementation plan
- Inform the B2S roll-out to additional IRC USP offices

Seven over-arching questions guided the evaluation process over the course of the year:

1. How was the pilot implemented by the three sites?
2. Did the tools and training provided equip staff to screen and provide basic survivor-centered case management?
3. What resources are required to implement Bridge to Safety?
4. How did IRC engage local partners in improving the availability of support options for immigrant/refugee survivors of DV/SA?
5. Did open/direct screening effectively communicate that IRC is a safe space to talk about experiences with violence and there is help available?
6. Are survivors able to receive the support or services they need and want from service providers and community-based resources?
7. How was the pilot successful in improving the accessibility of services and support options to immigrant/refugee women survivors of domestic and sexual violence?

Data collection methods and procedures consisted of the following:

End-of-project on-line survey. The full survey consisted of 76 questions that generated quantitative and qualitative data and covered the following topics: training, tools, technical and financial support provided to implement B2S; effectiveness and importance of B2S screening; availability, accessibility and IRC staff satisfaction with survivor services provided by local organizations; staff's ability, level of comfort and confidence implementing B2S; and importance of B2S for refugee resettlement.

Using a purposive key informant sampling approach, 27 IRC staff from the three pilot offices were invited to participate in the on-line survey. Twenty four staff (89% of those invited to participate) responded. See Table 1. Seventeen (71%) of the survey respondents personally conducted B2S screening with clients. Nineteen surveys were completed in full.

Semi-structured interviews with IRC staff, clients and local organizations. Interview guides were developed to facilitate semi-structured interviews with IRC staff, clients and local service providers. Questions varied depending on the role of the respondent and covered the following topics: B2S implementation and course corrections, experiences with screening, services provided to survivors, needs expressed by survivors and services available for immigrant/refugee survivors, staff well-being/self-care, roles and responsibilities, experience collaborating with IRC, ideas for implementation and fundraising moving forward.

All participants in the semi-structured interviews were recruited using a purposive key informant sampling strategy. A total of 32 individuals participated in the B2S final evaluation interviews: nineteen IRC staff, four clients, and seven staff from five organizations. See Table 1.

Interviews ranged from approximately 15 – 75 minutes in length and, with the exception of two interviews, took place at an IRC office. All clients went through a formal consent process to participate in the short interview that spanned approximately 10 – 30 minutes. A trained language interpreter assisted with three of the client interviews and consent procedures. Detailed notes were taken in each interview, which were subsequently analyzed to generate the findings and recommendations in this report. No identifying information was recorded.

In addition, quantitative monitoring data generated on a monthly basis during the course of the 12-month pilot and captured in the B2S tracking database was analyzed for the purposes of the evaluation. Data reflected in the tracking database were verified against service delivery forms and case files on site. The tracking database captures the number of B2S screenings conducted by IRC staff, how screening was conducted (in-person or phone, with interpreter or without, what language, how soon after arrival, and amount of time dedicated), the number of disclosures made by clients, types of violence disclosed and needs expressed by survivors. Tracking data was aggregated on a monthly basis and analyzed by the USP WPE Technical Advisor.

Table 1 – Final evaluation participants

End of project on-line survey		
B2S Focal Point		4 (17%)
Case Manager		13 (54%)
Supervisor		4 (17%)
Executive Director		3 (13%)
Total		**24 (100%)**
Semi-structured interviews		
Seattle/SeaTac		
	Staff	7
	Clients	2
	Local service providers	3 (2 organizations)
Dallas		
	Staff	6
	Clients	2
	Local service providers	3 (2 organizations)
Baltimore		
	Staff	8
	Clients	0
	Local service providers	1 (1 organization)
Total		**32**

Rigor and Limitations

Two strategies were employed in the evaluation to ensure rigor: triangulation and debriefing. The questions in the on-line survey and structured interview guides were designed to allow for triangulation on key evaluation questions. Overlap in staff participation across the on-line survey and the semi-structured interviews also allowed participants to share their experiences through different data collection methods. Debriefing was used to increase the rigor of qualitative components and consisted of initial meetings to critically examine methodology, as well as regular meetings throughout the data analysis process. Three limitations with the evaluation should be noted. First, due to the low number of client interviews, findings rely heavily on interviews conducted with IRC staff and local organizations. Second, despite precautions taken to safeguard anonymity and confidentiality, there is the possibility that social desirability bias may have influenced how the participants responded to questions in the on-line survey and the semi-structured interviews.[x] Third, technical issues arose with the on-line survey regarding skip patterns that impacted one section in particular and necessitated a follow-up survey, which may have led to survey fatigue.

It should be noted that the evaluation design and methods do not allow for causal inference, which has implications for how the findings are framed.

Both direct and open screening approaches show promise in communicating to clients that IRC is a safe space for women to talk about their concerns.

Evaluation findings highlight interrelated opportunities and challenges with integrating DV/SA screening and basic survivor response mechanisms into existing refugee resettlement programming.

Screening and safe space

The clients who were interviewed (three during the midpoint and four during the final evaluation) were screened using the open screening approach, which relies on a guided script that does not include specific questions around DV/SA (see Appendix B). All seven women demonstrated that they understood what was communicated to them during the B2S screening process and that they appreciated the message that the IRC is a safe space for women to get help. However, none of the client participants in the evaluation specifically articulated that IRC referred to experiences with gender-based violence during the screening, which may be reflective of the open screening approach.

Overall, clients who were interviewed indicated that their experience being screened was positive. Comments from clients during final evaluation interviews included the following:

> *She [IRC caseworker] said if you have any problem at home or any place you can come and talk to me about it.*
>
> *IRC is a good place for women.*
>
> *I felt happy because she [IRC caseworker] was here for me and would be ready to talk about anything I want.*
>
> *I had a very good feeling when she was sharing this information with me. I don't know about the U.S. but my experience [back home] is that not every place is safe for women. So….that felt good. I think they want to encourage women from other countries that here is freedom for [women].*

Moving forward, systematic monitoring of clients' experiences with B2S screening is important to ensure that the process is communicating the intended message, and to gauge women's responses to the screening process.

Nearly all of the IRC staff who participated in the on-line survey (18 out of 19 respondents) believed that screening is worthwhile, and helps mitigate the consequences of the gender-based violence their clients' experience. Sixty eight percent (13 out of 19) of the on-line survey participants indicated that B2S screening enabled them to respond to the needs of survivors sooner than if they had not been screened. [xi] Fifty three percent of respondents (10 out of 19) indicated that B2S screening practices help clients avoid crises. [xii] Both female and male staff felt positive about their experiences screening female clients and their clients' responses, and generally saw screening as an entry point to talk about related issues.

> *The clients who were not at risk would still tell me about any current safety concerns they had. I had a client and she said that she wasn't experiencing violence…but then we talked about walking home alone and generally about safety tips.*
>
> *I feel like it was really good. It allowed for an interaction with the client that wasn't here otherwise. Those needs fly under the radar unless the situation gets so bad.*
>
> *I've gotten really favorable responses for the most part. My clients have understood what I'm saying and said appreciative things. I think it's communicating that IRC is a safe space.*
>
> *I didn't have any negative experiences. I had people disclose or who would disclose a week afterward. In general, it didn't seem to be that uncomfortable for the women I was speaking with. I felt like it was positive.*

Additional staff responses to the on-line survey reflect the belief that the B2S screening positively impacts how safe clients feel talking about their DV/SA experiences with IRC staff (see Table 2).

Table 2 – Influence of screening on IRC as a safe space for survivors

	Average value (SD)	Range*	# responses
To what extent does screening impact how safe it is for clients to talk about their experiences with domestic and sexual violence with IRC staff?	8.11 (1.29)	5 – 10	19
To what extent *was* IRC (your office) a safe space for clients to talk about their experiences with domestic and sexual violence *before* Bridge to Safety was implemented?	6.05 (2.01)	3 – 10	19
To what extent is IRC (your office) a safe space for clients to talk about their experiences with domestic and sexual violence *now*?	8.16 (1.34)	6-10	19

*10 = extremely important

Staff comments indicated that they believe that the women they've screened are now aware that they can come and talk to IRC about violence they are experiencing.

> *The act of screening clients in a culturally appropriate manner and in a confidential setting communicates that we care about their welfare. While this does not guarantee a client will feel safe to disclose, it does open the door to have this conversation. Some clients don't walk through that door immediately, but may do so later.*
>
> *The screening is an opening to the conversation. The screening tool normalizes the topic and lets the woman know that she is not the only person who has experienced DV. I believe this greatly impacts a woman's ability to share.*
>
> *I think some form of personal one-on-one discussion with all resettled women is the only way to ensure that they view IRC as a resource for their personal safety and not only a resource for the husband or the family as a whole.*

Another comment indicated that screening helps IRC offices to assess the amount and type of support clients may potentially need in the future to manage the consequences of past or current violence they experience(d). Another staff member observed that more women appeared at ease sharing their personal experiences as a result of IRC sharing with female clients what support is available and by creating a confidential and safe atmosphere. Other staff linked their increased capacity to screen and respond effectively to disclosures of violence, as well as the capacity to provide private offices for their conversation should clients request it, as indications that IRC is becoming a safer space.

Screening targets and systematization

Across the three pilot offices, IRC screened 55% of all adult women new arrivals over the course of the pilot year (April, 2014 – April, 2015) although the target screening rate had been set at 80% for each office. See Table 3 for details. A challenge with screening women was due to the nature of refugee resettlement services, which are primarily provided to family units rather than individuals. This meant that adult female refugees who resettle to the U.S. with a male partner or adult male family member had few if any private meetings one-on-one with IRC staff. Pre-existing opportunities to conduct in-person screening were therefore limited. Staff described the difficulty they experienced simply initiating the screening conversation and keeping track of who they needed to screen within the 90-day time-frame given their large and ever-changing caseloads.

Staff comments included:

> *It's up to us to keep an eye out for clients to screen them within a specific time-frame. It's very vital but there's a lot that we are following up on, and it's a lot to try and keep track of.*
>
> *There is no exact formal protocol about how to engage the client [for B2S screening]. It's a fluid process.*
>
> *I think I need to be better at specifically scheduling when they should come in to do the B2S screening. I have a routine appointment and then time allowing I try and tack it on. I need to think about a creative way to call them in specifically for [B2S] and then add some other things that to.*

The challenge is the time-line, when to decide to screen the client. It's hard to decide on a case by case basis. I don't want to [screen] in the second week when I'm trying to establish a relationship with the client. I'll realize in month seven that I haven't done the screening and then knowing that we don't have services post 8 months….so that's a challenge.

Even when they [female clients] come to the office, if no one tells me [that she is here] I miss the one chance to screen. Or there's no interpreter available.

Staff periodically conducted B2S screenings by phone in attempt to reach women with whom they were unable to meet privately in-person. However, it was difficult to reach women by phone as shared cell phones were frequently held by men in the household, and staff identified that women seemed unable to engage openly over the phone. Staff also attempted to conduct B2S screenings in-person in clients' homes, but found it difficult to be able to speak with women alone in their homes, particularly for male staff. Staff identified that clients appeared to feel more comfortable engaging in screening conversation in a confidential and neutral environment provided in the office. When staff relied on their discretion to identify the appropriate time to screen female clients within the first 90 days of arrival, they risked forgetting or never following through at an opportune time. Standardizing procedures for when to screen in-person at an IRC office was shown to increase screening rates, provide an accountability mechanism for staff, and reduce pressure on individual staff to make independent decisions. Additional systematization overall will help IRC offices maximize the effectiveness of the B2S screening process.

FINDINGS

The direct screening approach shows promise in increasing disclosures of violence in comparison to the open screening approach. However, relatively low disclosure rates overall suggest the possibility that many of IRC's clients do not access formal DV/SA services.

During the one year time-frame of the pilot project, 25 women disclosed an experience with DV and/or SA to an IRC staff across the three B2S pilot offices. See Table 4 for details.

- 7% of all screened women disclosed an experience with DV and/or SA (20 disclosures out of 299 total number of women screened)
- 24% of women screened using the **direct screening** approach disclosed experiences of DV and/or SA (17 out of 72 women screened through the direct screening approach)
- 1% of women screened using the **open screening** approach disclosed experiences of DV and/or SA (3 out of 227 women screened through the open screening approach)
- 68% of all disclosures were made by women who had been screened through the **direct screening** approach (17 out of 25 disclosures)
- 12% of all disclosures were made by women who had been screened through the **open screening** approach (3 out of 25 disclosures)

While it is not possible to isolate direct screening from other factors that may have contributed to variations in disclosure rates, this data points to the possibility that direct (in-person) screening may be more effective than open screening in increasing disclosures of violence. This is consistent with existing evidence, which suggests direct questions alleviate barriers to disclosure and provide survivors with a non-threatening and open invitation to seek support. [xiii] It is reasonable to conclude that being explicit about violence in the screening conversation better communicates IRC's commitment to attend to women's experiences with violence, and leads to an increase in client disclosures and help-seeking behaviors in comparison to the open screening approach.

As the direct screening process becomes more systematized, disclosure rates may increase over time. However, overall low disclosure rates during the pilot period (7% of adult women screened) in comparison to U.S. and global [xiv] statistics, and the increased risk of violence against women in forced migration, indicate the likelihood that there are additional survivors among IRC's clients who may have unmet service and other needs. Given the relatively short window of time that most clients receive services from the IRC, it is also possible that IRC's clients directly access local service providers or community-based support systems.

One staff commented as follows:

> *….there are a lot of women who are not disclosing. They are worried that it's not confidential or scared that it will make it worse for them. They are really scared of the police. They are worried about losing the kids. They always ask me if the man can hold their passport. They feel helpless.*

Another staff indicated,

> *I know they have a problem but they don't like to tell. They're afraid of the community…if they have any problem they don't want them to know. She's scared of what people will say.*

Table 3 – B2S screening and arrival trends

	April 2014	May 2014	June 2014	July 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	March 2015	April 2015	**TOTAL**
# of adult women screened per office														
Seattle / SeaTac	2	7	9	20	7	10	6	9	10	14	12	11	8	125
Dallas	3	1	15	10	11	16	11	5	4	0	7	4	15	102
Baltimore	1	1	8	11	1	3	11	13	11	7	5	0	0	72*
Total # of adult women screened	**6**	**9**	**32**	**41**	**19**	**29**	**28**	**27**	**25**	**21**	**24**	**15**	**23**	**299**
# of adult women new arrivals per office														
Seattle / SeaTac	15	12	15	24	4	9	11	16	10	12	7	11	-	146
Dallas	14	11	14	19	14	24	26	19	15	21	15	18	-	210
Baltimore	17	17	21	16	10	8	23	22	8	21	15	11	-	189
Total # of adult women new arrivals	**46**	**40**	**50**	**59**	**28**	**41**	**60**	**57**	**33**	**54**	**37**	**40**	**-**	**545**
% of women arrivals who were screened per office														
Seattle / SeaTac						70%							104%	86%
Dallas						58%							40%	49%
Baltimore						25%*							17%*	21%*
Total % of women arrivals who were screened						**50%**							**47%**	**49%**

*Note: 32 screenings were conducted in the IRC in Baltimore's Asylee program and 38 screenings in their refugee resettlement program. Screening percentages are calculated within R&P services only.

Table 4 – Disclosure trends

	April 2014	May 2014	June 2014	July 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	March 2015	April 2015	**TOTAL**
# of DV/SA disclosures by clients who were screened per office														
Seattle / SeaTac (open screening)	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Dallas (open screening)	0	0	0	0	1	0	0	0	1	0	0	0	0	2
Baltimore (direct screening)	1	1	1	2	1	1	2	3	2	0	3	0	0	17*
# of DV/SA disclosures by clients who were not screened per office														
Seattle / SeaTac	1	2	0	0	0	0	0	0	0	0	0	0	0	3
Dallas	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Baltimore	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total # of DV/SA disclosures	**3**	**4**	**1**	**2**	**2**	**1**	**2**	**3**	**3**	**0**	**3**	**0**	**0**	**25**

*Note: Nine disclosures were made in IRC in Baltimore's Asylee program and 8 disclosures were made in R&P

Training and response protocols helped to increase IRC staff's confidence responding to disclosures of domestic violence.

Having participated in B2S training and implementation, IRC staff feel a change in their comfort level and capacity to respond to disclosures of DV, in particular. Staff comments included:

> *I've seen less tension when this issue is coming up. We're following the steps that we learned through this pilot. Before, we felt really helpless, even though we were doing essentially the same things, and now we just feel more confident.*

> *I think we talk more about DV now and staff are getting more knowledgeable…They are getting a better eye and better ear to sensing if there is a problem. Everyone is getting involved….In one year you are trained enough to feel if there is something [going on] in the family….For a year I have noticed the progress.*

> *Within the office this project has made caseworkers more comfortable addressing these issues with families. It's in the back of their minds when they're interacting with a new family.*

Nine direct services staff responded to a section in the on-line survey that aimed to capture their level of confidence implementing B2S-related activities. While average confidence levels trended towards mid- to high-levels of confidence, there was considerable variance in how individuals responded to each activity. On average, people indicated lower levels of confidence filling out the monthly tracking sheet and exercising self-care, and higher levels of confidence setting boundaries with clients and asking for help. (See Table 5)

The assessment, safety plan, and service plan tools (see Appendices C – E) were less readily used throughout the course of the pilot in comparison to the screening tools. The mid-point evaluation revealed that while procedures for following-up on disclosures of DV/SA were generally clear to staff, caseworkers from the three offices expressed challenges with knowing how to provide support depending on the type, severity and time period of the violence, as well as the client's readiness to seek help. At the mid-point marker, case workers employed the assessment and safety planning tools to varying degrees and inconsistently. Some staff indicated that they had given feedback on the service planning tools during the mid-point evaluation and that they appreciated the modifications that were made in response to simplify them. Overall, however, staff still expressed some discomfort with the service planning tools at the end of the pilot year.

> *At first, the [assessment] tool was overly complicated and detailed. However, it was honed down so that it could be used in a much shorter period of time.*

> *I think that a few of the forms are redundant and could be omitted.*

> *Tools are helpful but time to complete necessary paperwork with client hard to find in single chunks of time.*

> *The safety plan can be self-defeating when going through it and the client has no resources available on the plan.*

This suggests a need for the IRC to streamline response protocols where possible and partner effectively with DV/SA specialists to provide comprehensive specialized response services.

Table 5 – Staff confidence in their ability to implement B2S-related activities

I feel confident in my ability to:	Average (SD)	Range	Total responses
Conduct screening for violence	7.44 (2.19)	4 – 10	9
Assess the immediate needs of clients who have experienced violence	7.56 (1.59)	6 – 10	9
Respond effectively to a client who discloses that she is experiencing domestic violence	7.56 (1.51)	5 – 10	9
Respond effectively to a client who discloses that she experienced sexual violence	7.67 (1.22)	6 – 10	9
Make appropriate referrals to other service providers	8 (1.22)	6 – 10	9
Follow-up with other service providers	7.56 (1.33)	6 – 10	9
Conduct safety planning with survivors	7.56 (1.88)	5 – 10	9
Develop a service plan with survivors	7.67 (1.87)	4 – 10	9
Document the steps I take with survivors regarding their safety or service plan	7.78 (1.39)	6 – 10	9
Fill out the monthly Bridge to Safety tracking form	7.63 (2)	5 – 10	8
Exercise self-care	7 (2.69)	3 – 10	9
Set clear boundaries with my clients	8.22 (1.39)	6 – 10	9
Ask for help when I need it	8.44 (2.07)	4 – 10	9

Gender bias and isolation are among the barriers women refugees face in accessing support services.

Implementing the B2S pilot project brought into focus how infrequently IRC resettlement services staff converse individually and privately with women who resettle to the U.S. with husbands or other male adults. IRC staff had to make a concerted effort to explain to clients, including male spouses and family members, that they wanted to meet privately with women as this was not current practice or necessarily in-line with male clients' expectations or wishes. Casework staff described this challenge as follows:

> *Women were rarely brought into the office if it wasn't absolutely necessary. Without talking or meeting with women one-on-one our clients would not understand that IRC was a resource for [them].*

The tendency to sometimes limit one-on-one interaction to male heads of household appears to be systemic in the U.S. refugee resettlement system. [xv] Male heads of household are typically named as the "principal applicant" on a resettlement case. Adult male clients tend to arrive in the U.S. with slightly better English language skills and more formal education and employment history than adult female clients. [xvi] Cultural and economic barriers also appear to limit women's ability to come to an IRC office. Practically, these factors result in IRC staff interacting and conversing more frequently with male clients, and male clients having better access to information and resources. For example, enrollment of the household in public benefits, including SNAP benefits, is typically done in the name of the PA as the head of household, and a single electronic benefits (EBT) debit card for the household is then issued in the PA's name. Whether this is done by choice or based on policy is not clear.

During the B2S evaluation, a staff member pointed out how this can play a role in perpetuating inequalities and at times fueling family conflicts when women do not have access to the card. "The EBT card creates the problem. The head of the family is usually the man and the card is in his name." The IRC is beginning to work to address systemic gender inequality throughout programs and structural issues within the broader refugee resettlement process and the U.S. social services system, writ large.

Women's access to the IRC and other services is also linked to a general concern IRC staff expressed regarding the isolation women experience in resettlement and the vulnerabilities they experience as a result.

> *We had one case and she was so isolated, the husband wouldn't let her out or give her any money or to do any of the shopping. She had to get a relative…to wire her money and we had to help her get it. In the end she had to call the police on him. He broke her arm. The children didn't go to school for a week and were truant. We have to be able to speak with the woman alone.*

> *The women who do come [to the office] are already more empowered. We're missing the women who are more isolated.*

Staff discussed the need to support women's ability to move around in the community, to have access to the IRC office and English, vocational and life skill classes, as well as childcare options, and to overall be less dependent on male family members. Staff at all levels expressed the need and desire to continue getting IRC's services out in the communities they serve and to go beyond delivering services within "the four walls" of the office in order to reach more women and girls through their work.

DV/SA service gaps for refugee and immigrant women remain.

IRC refugee and asylee clients who disclosed DV/SA and were assessed by IRC staff expressed a range of needs and concerns. Sixteen out of 25 clients (64%) who disclosed an experience with DV/SA specifically expressed a need for follow-up services. Safety was identified most frequently as a need, followed by psychosocial support, which includes counseling, specialized case management, and referrals to community resources. Additional service needs expressed were related to health and legal assistance.

Fifteen IRC staff responded to the on-line survey question: did participating in B2S make you more aware of available services for immigrant and refugee survivors of domestic and sexual violence? Three people responded “a little,” four people responded “somewhat” and eight people responded “a lot.” Comments from the staff included:

> *I did not know about many service providers in the State. I got to know more about legal services available [for survivors].*
>
> *I learned a lot and I am able to link and connect to other service providers.*
>
> *I was already somewhat aware of available services through provision of case management services to survivors, but this program has heightened my awareness.*
>
> *As part of my case management, I conducted outreach to external agencies and attended training events. I was quite aware of the lack of services.*
>
> *You hear about different services that you were not aware existed.*

Gaps in culturally-appropriate services for refugee and immigrant survivors persist across all three pilot sites. In response to the on-line survey question, during implementation of B2S, how has access to services changed for immigrant and refugee survivors of domestic and sexual violence? 20% indicated that “it has gotten a lot better,” 73% indicated “it has gotten somewhat better,” and 6% indicated that “it has not changed.” [xvii] Eighty percent of respondents (12 out of 15) responded that they can identify continuing gaps in services when they consider the needs of refugee and immigrant clients who disclose DV/SA. The specific gaps identified by IRC staff included:

- Availability of emergency domestic violence shelter services, language and interpretation barriers at shelters, and lack of transitional housing options for low-income refugees
- Cultural relevance of services, including service providers’ knowledge and skills supporting refugees and asylees (ex. strategies for ensuring family members in the client’s country of origin are safe from retribution)
- Legal and health services for immigrant and refugee DV/SA survivors

Local DV/SA service providers that work primarily with refugee/immigrant survivors expressed several additional service needs during interviews. For instance, the availability of appropriate (e.g. halal) food was highlighted as a major obstacle preventing some women from considering living, even temporarily, in a domestic violence shelter. They also discussed needing to work on law enforcement’s attitudes towards immigrant/refugee survivors and echoed the need for shelter, transitional and long-term housing options. Local service providers also pointed out their desire for stronger collaborations between immigrant/refugee service providers and DV/SA advocates, both for enhanced service delivery and to coordinate joint advocacy efforts.

Additionally, IRC staff expressed that it is not uncommon for refugee survivors of domestic violence to request “someone to talk to their husband to make the violence stop.” As one IRC staff expressed,

> *I have seen a lot of families break-up and a lot of hearts broken because they come with a huge vision to America and don’t have any understanding of the kind of stress they’ll face here or the cultural adjustment needed to survive…I want to have a preventive and curative aspect. I want much stronger prevention. Families are getting lost every day.*

Staff indicated that requests for mediation and community intervention, as opposed to the separate survivor and

abuser services typically provided in the U.S., were quite common. This suggests a need for additional thought around family interventions and prevention, as well as coordination with community-based response mechanisms in refugee and immigrant communities, especially in light of the fact that most DV service providers are not equipped to respond to these requests. Referral networks could be expanded to include marriage counseling (as appropriate), mediation and abuser interventions, as well as ethnic community-based organizations and associations.

Again, while originally designed to address both DV and SA, the B2S pilot project focused mainly on violence perpetrated within the context of an intimate partner relationship during the pilot phase. IRC staff or local partners generally did not mention or discuss needs related to non-partner sexual violence pre- and/or post-migration.

FINDINGS

Stronger partnerships between IRC and DV/SA organizations are essential to improving support options for IRC's clients.

Local culturally-specific DV/SA service providers are eager to engage with the IRC and other resettlement agencies to provide services for immigrant and refugee women who experience violence. Across the board, the local actors who participated in the final evaluation expressed a high level of respect for the IRC and their work with refugee/immigrant populations. At the same time, local actors expressed the desire for more reciprocal information sharing and a deeper understanding of the services IRC provides and the populations they serve in order to coordinate and provide comprehensive survivor support.

Due mainly to resource limitations, implementation of the partnership component of the B2S pilot project was less emphasized compared to integrating screening into existing programming. How to build successful partnerships may not be readily apparent to staff who are primarily responsible for providing direct services and more support from senior-level staff is needed to enhance this aspect of the programming, in particular.

The evaluation revealed the need for IRC to take a more systematic approach to building and strengthening partnerships by clarifying and documenting what both parties are able to provide. For instance, there were disconnects between what local service providers shared in interviews about their services and what IRC staff understood their services to be at the time of the evaluation. Inconsistencies in how different members of the staff talked about referral protocols with the same local service providers also emerged. In at least two of the offices, the tendency has been to rely on personal contacts as opposed to developing and maintaining a resource directory or referral pathway. As one staff put it,

> *We have really good partnerships but none of it is written down, it's just personal relationships.*

Or as another staff stated,

> *More knowledge of resources has allowed caseworkers to connect with existing resources but organizationally there is no standard procedure in place yet.*

This is a concern particularly given staff turnover in the field. When referral options are tied to personal versus institutional relationships between organizations, the IRC is vulnerable to losing those options in the event of staff turnover. It can also contribute to an overestimation of the staff's understanding of referral resources and how best to access them. [xviii]

In at least two examples, IRC staff stopped referring clients to local service providers and sought other options after having a negative experience, rather than advocating for improved services or clarification of how services are provided. This also highlighted a need for agreed upon and established mechanisms to engage constructively with partners, and staff skills and authority to advocate effectively for quality service provision. Lastly, the IRC prioritized engaging local service providers that specialize in DV, which is reflective of the needs currently expressed by clients and current focus of the pilot project, overall. Nonetheless, the IRC should not lose sight of the potential to engage with local SA service providers to be in a better position to respond to those needs, in addition to DV, as they arise.

IRC staff believe that addressing violence against women is critically important to refugee resettlement work.

Overall, IRC staff expressed a strong commitment to the aims of the B2S pilot project. The majority of front-line staff, both male and female, showed personal investment and passion to address violence against women during the initial resettlement period. This commitment was at times expressed with considerable emotion and compassion, a desire to improve women's lives and for women to live free from violence and subjugation.

> *It's a privilege to speak with the sisters and to let them know that we're here if they need help.*

> *I don't have a mom who can support me so I had to stay with my husband [who was abusive]. When I think back to all my family, my neighbors and friends – [they are all in] the same situation, but they still don't want to leave. Since I came here, I learned a lot. I speak with my sisters. I like to help women who have problems.*

> *I feel good doing it. There's always an initial feeling of discomfort at the beginning. You just have to go through with it knowing that it's an issue that needs to be addressed for the betterment of our clients and the community. It's something that's not emphasized enough and needs to be addressed.*

Participants in the on-line survey on average indicated consistent support for IRC USP offices to implement activities associated with screening, responding to DV/SA disclosures, advocacy and fund-raising. Staff across different levels in the three pilot offices also felt that this type of programming is critical to successful refugee resettlement. Moreover, participants were very likely to recommend B2S to other IRC offices (see Table 6). Comments included:

> *[B2S] should be recommended as part of the core services provided. Early detection will help assist many clients who may be afraid to disclose.*

> *I think all offices should implement a screening to emphasize that if there is any violence, they can feel comfortable enough to talk to IRC staff about it.*

In response to the question seeking advice B2S staff had for other IRC offices preparing to implement the project, one staff responded "take care of the clients during the time you have them because it could save their lives." Another staff responded with the following:

> *It's important for all IRC office to begin to develop baseline data with the screening and pursue funding to assist women facing [domestic violence] and [sexual assault]. However, I suggest that each office start by screening a very small sample of clients to learn how to do this work over a period of one year. This will help develop staff capacity to do this work and develop the community partnerships needed to serve clients in need of services.*

Table 6 – Staff support for B2S-related programming

	Average (SD)	Range*	Total responses
How important is it for IRC offices to implement the following activities?			
Screen all adult women for domestic and sexual violence shortly after arrival	9 (1.57)	4 – 10	18
Track completion of screening	8.89 (2.22)	5 – 10	18
Conduct safety planning with survivors	9.17 (.92)	7 – 10	18
Conduct service planning with survivors	8.94 (1.06)	7 – 10	18
Refer survivors to other service providers	9.41 (.87)	8 – 10	17
Follow up with survivors	9.29 (.92)	7 – 10	17
Follow up with service providers to whom IRC refers survivors	8.94 (1.43)	5 – 10	17
Train other service providers on the needs of immigrant and refugee survivors	9.50 (.82)	8 – 10	16
Advocate for the rights of immigrant and refugee survivors of domestic and sexual violence	9 (2.03)	2 – 10	18
Fundraise to develop programming for immigrant and refugee survivors of domestic and sexual violence	9 (2)	2 – 10	18
How important is addressing domestic and sexual violence to refugee resettlement?	9.58 (.69)	8 – 10	19
How likely is it that you recommend B2S to other IRC offices?	9.32 (.95)	7 – 10	19

*10 = extremely important

Senior leadership in each of the three pilot offices were also invested in the project and articulated a thorough understanding of the issues B2S seeks to address. They were aware of B2S implementation progress and challenges, as well as ideas for how to improve implementation. One senior staff said the following:

The question is how to best be a resource for finding support. I think it's a very important aspect of what we do. Whether it's the gender-equality piece, or opening up conversation about violence, or the mental health piece, we need to figure all of that out because it's fundamental to enabling someone to have a healthy life. The trauma people go through to get here plus the trauma of resettlement, we can compound the trauma. It pleases me that we're taking responsibility for opening up these conversations, and then it's on us to find solutions to help support clients with these issues.

While supervisors and directors in the pilot offices recognized the critical need to support refugee DV/SA survivors, they were also vocal about the need for stand-alone resources to support project implementation.

Additional human and financial resources are needed to support B2S implementation.

The pilot shows that with training and technical support it is possible to integrate DV/SA screening and basic response services into refugee resettlement services with minimal additional funding. However, the findings confirm that this approach increases work for IRC staff and that service options for refugee/immigrant survivors remain limited. Additional funding and dedicated staff would more effectively facilitate B2S implementation, help ensure survivors' needs are met comprehensively, and improve staff well-being outcomes.

IRC staff indicated a part- or full-time staff person dedicated to implementing B2S would enable offices to carry out the project with additional depth and attention. Office leadership spoke to the fact that caseworkers are extremely busy, that their pre-existing workloads often exceed financial resources and that adding additional tasks very quickly becomes overwhelming and unsustainable. At least two Executive Directors expressed concern with caseworker burnout and how adding tasks can contribute to burnout and staff turn-over. Staff comments included:

> *What's really needed is someone whose entire attention can go to this. It's a big undertaking – a lot of info, a lot of legwork. It would be dual roles: Partnership with service providers and reaching out to community to find women who are isolated. Identifying a community leader, and meeting with people in the community. It sounds so great but there's just not time for me to do it.*

> *We need the equivalent of a full time staff to adequately screen clients and develop sustainable partnerships in the community to assist them when needed.*

Furthermore, the perception of some IRC staff and senior staff, in particular, was that the financial resources allocated to the pilot offices to implement B2S were not commensurate with the expectations of the work. Monitoring data suggests that the funding provided covered some costs related to screening activities (staff time, interpreter time, and mileage) but that partnership and follow-up service delivery activities were not covered by the funding provided.

A small number of staff spoke to the fact that they recognized the B2S pilot as an opportunity to identify funding opportunities for sustained program support and to ultimately expand IRC's programming for women. At the same time, challenges with creating or tapping into those opportunities remain. Staff expressed the need for B2S-related funding advocacy at the national level and ideally with public sources rather than relying on private or local funding sources.

Specific factors appear to impact the well-being of staff who conduct B2S screening and respond to disclosures of DV/SA.

At the outset of developing the B2S pilot, IRC staff expressed concerns about staff well-being and self-care, and the extent to which casework staff would be able to access support and supervision while supporting survivors of violence. The following factors emerged from the data as influencing the comfort and well-being of IRC staff who carried out B2S screening and direct response services:

- **The extent to which staff are trained, feel prepared, have opportunities to practice, and have positive experiences screening and working with survivors.** Across the board staff said that they felt less intimidated about screening once they received training. As they gained practical experience, they grew more confident and less stressed about responding to disclosures.

- **The extent to which procedures to respond to disclosures of DV/SA are clearly defined in advance.** Where response, partnership, and referral protocols were clearly defined, staff described being able to effectively connect clients to specialized service providers outside of IRC, which reduced workloads and stress. Where protocols and boundaries were less clearly defined IRC staff described being personally involved in cases over long periods of time and experiencing a high level of stress as a result.

- **The extent to which roles are clearly defined and there is a team approach** to providing support for survivors so that no one person is responding alone. The importance of the team approach was expressed by caseworkers and supervisors alike. This also allowed no single member of the team to take on more cases than they could handle at any given time.

- **The extent to which staff who are connected to or live amongst the communities they serve receive additional support**. Staff who are members of the community they serve may face specific challenges in establishing and reinforcing work/life balance and professional/personal boundaries. The resulting stress may be exacerbated for those working with clients experiencing DV. Staff expressed the need for additional or specialized support and/or training to deal with the complexities of living within the same community as clients.

- **The extent to which local office leadership expresses support for integrating B2S screening and survivor response into existing services,** as well as the extent to which front-line staff perceive the leadership as supporting front-line staff devoting time to implement the project. Where staff were not supported or did not feel supported, staff expressed increased levels of stress implementing the project activities.

CONCLUSIONS

Critical learning emerged from the B2S pilot project evaluation. First, with the right tools, training, and technical support, non-specialized staff new to working on DV/SA were able to build skills to respond appropriately overall, and develop a high level of commitment to incorporating DV/SA-related services into resettlement services, despite limited resources.

Second, the B2S screening process shows promise in communicating to adult women that the IRC is a safe space for them to discuss their experiences and concerns. In comparison to the open screening approach piloted by two out of the three offices, monitoring data indicates that a direct approach to screening may yield higher disclosure rates, thereby increasing survivors' access to available services.

Third, DV/SA disclosures remain low overall, which raises questions about the extent to which refugee DV/SA survivors are accessing formal services and the extent to which screening alone is sufficient to address barriers to disclosure that exist for women and girls. The extent to which IRC's clients go directly to DV/SA services and access help through community social support networks is worthy of further exploration. Moreover, B2S-related service provision and partnership have been focused overall on intimate partner violence, which is reflective of the current concerns reported to the IRC. It is important, however, not to lose sight of the unmet needs related to pre- and post- migration sexual violence that clients may be less likely to disclose.

Fourth, integrating screening and basic response services into refugee resettlement is not sufficient to address the complex obstacles refugee women face in accessing support related to experiences of DV/SA. While B2S pilot offices are now equipped with some staff who are well trained to screen for and respond to DV/SA, they lack sufficient human and financial resources to build more comprehensive programmatic responses to DV/SA in refugee communities. Resettlement agencies and DV/SA organizations often work independently from one another, and it requires a considerable investment to bridge divides in the best interest of immigrant and refugee women.[xix] In the roll-out and scale-up of B2S to additional IRC offices, inter-organizational collaboration is an area of particular importance and requires more effective partnerships with key local and national organizations to improve the availability and accessibility of DV/SA services for refugees.

Lastly, the process of implementing the B2S pilot also revealed that survivors' access to services is hampered by IRC's relatively limited individual interactions with their female clients who resettle to the U.S. with husbands or other male adults. The effort required to ensure IRC had one-on-one contact with adult women clients to complete B2S screening reflects entrenched systems from overseas processing through resettlement that put women at a disadvantage vis-à-vis their male counterparts. Resettlement agencies are refugees' main source of information and support for the first six to eight months that they are in the U.S., and connecting directly with women during this crucial window of time has the potential to impact their long-term well-being and success in the U.S.

In conclusion, the B2S project is an important step forward in realizing IRC's vision that refugee and immigrant women and girls are safe, healthy, educated, economically well, and have power to contribute to a society where they are valued, have equal access to opportunity, and live free from violence. Moving forward, the initiative should be framed as an entry point for ongoing program development to meet critical service, prevention, advocacy, and other needs related to violence against refugee and immigrant women. Implementation of the B2S pilot project highlights the extent to which violence against women is an issue of importance to both IRC clients and the staff who serve them, and reiterates the critical need to make violence against women a priority in U.S. resettlement policy and practice.

"Any program that empowers refugee women/girls to better protect themselves, along with improving the responsiveness of our own caseworkers to provide the appropriate resources has to be a step in the right direction." (IRC staff)

RECOMMENDATIONS

In addition to informing the IRC's work moving forward, learning from the B2S pilot and evaluation has implications for immigration and refugee resettlement policy and practice. The following recommendations suggest steps that can be taken at multiple levels by local resettlement agencies, community-based organizations, and DV/SA service providers, as well as by donors and relevant state and federal government agencies.

1. Strengthen service delivery for immigrant and refugee women and girls who experience domestic violence and sexual assault, as well as other forms of gender-based violence.

- Expand DV/SA screening for refugee and immigrant women across refugee-serving agencies, taking into account that female clients of all ages may experience a wide array of violence.
- Establish and regularly update a directory of service providers and referral resources that can meet the needs of refugee and immigrant survivors of violence, noting the availability of interpreter services, culturally-specific food, transportation, and eligibility by immigration status.
- Conduct outreach in refugee and immigrant communities, recognizing that women in general and survivors in particular may be isolated and have particular barriers that prevent them from disclosing violence.
- Partner with independent evaluators and/or academic institutions to evaluate DV/SA services for refugee and immigrant survivors, and promote the quality, availability and accessibility of services.

2. Develop and strengthen formal and informal partnerships between resettlement agencies, community-based organizations, mutual assistance agencies and DV/SA organizations.

- Build the capacity of refugee/immigrant serving organizations, including community-based organizations and mutual assistance agencies, to respond effectively to disclosures of violence and of DV/SA service providers to understand and address the needs of refugee and immigrant women.
- Create mechanisms to sustain and strengthen partnerships over time, by holding regular meetings, establishing communication protocols for addressing challenges and concerns, and jointly identifying strategies for addressing gaps in services.
- Increase information-sharing and learning exchanges between and within resettlement agencies, community-based organizations, mutual assistance agencies and DV/SA organizations through activities such as conferences, open houses, and joint coalition meetings.
- Increase representation of refugee communities in State DV/SA Coalitions to advocate for the needs of refugee women and communicate about the violence they experience.
- Incentivize partnerships between resettlement agencies, community-based organizations, mutual assistance agencies and DV/SA organizations through the creation of joint funding opportunities and accountability mechanisms.
- Advocate for addressing the rights of refugee and immigrant women by forging linkages with other social justice movements.

3. Address the needs of direct service personnel who are involved in responding to DV/SA to promote their well-being and retention over the long-term.

- Recognize and affirm the extent to which staff are, or become, personally and professionally committed to issues of violence against women.

- Create ongoing staff development opportunities and learning exchanges at all levels, within and across offices and organizations.
- Ensure mechanisms exist for staff to feel part of a team (both internal and external to their organization), to ask questions, share in decision-making and problem-solving and to debrief about the stress and challenges of their work.
- Help staff establish realistic boundaries with the communities they serve and the extent of their services, recognizing that they are often from and part of the communities they serve.

4. Focus on refugee women's needs, regardless of whether they are listed as principal applicants for resettlement.

- At the national and local levels, assess how refugee resettlement practices may place women at a disadvantage for accessing information, services and programs.
- Examine the extent to which resettlement agencies engage female refugee clients who are not listed as principal applicants for resettlement.
- Assess the extent to which case management services for refugees and immigrants are conducive for women to speak candidly about their experiences and concerns.
- Identify opportunities to build community-based social support networks to decrease isolation and connect women with tailored peer and professional support services, as per their needs and requests.
- Establish funding and accountability mechanisms to incentivize resettlement agencies to prioritize the needs of women and girls and facilitate their connection to other services.

5. Increase funding and resources to address violence against refugee and immigrant women and girls in the U.S.

- Increase dedicated funding in the U.S. to support GBV prevention programming and response services in refugee and immigrant communities to meet women's critical post-migration needs.

REFERENCES & NOTES

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[III] Bhuyan, R., & Velagapudi, K. (2013). From One "Dragon Sleigh" to Another Advocating for Immigrant Women Facing Violence in Kansas. *Affilia*, *28*(1), 65-78.

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[VI] Sohal, H., Eldridge, S., & Feder, G. (2007). The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. *BMC Family Practice*, *8, 49*. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562/

[VII] John Hopkins Bloomberg School of Public Health (October 2013). *Development of a tool kit to confidentially screen for GBV among refugees to improve access to services: evidence from Ethiopia*. Retrieved from: http://www.svri.org/forum2013/Presentations/DevelopmentToolkit.pdf

[VIII] Refugees participate in both a pre-arrival and post-arrival Cultural Orientation designed to help them develop realistic expectations about life in the US. Many USP offices provide post-arrival cultural orientation in a group education setting within the first month of arrival, while others offer one-on-one cultural orientation to new arrivals.

[IX] The mid-point evaluation activities focused primarily on the questions that could inform any necessary course corrections, and consisted of qualitative interviews with IRC staff in each of the pilot offices, analysis of monthly monitoring data collected throughout implementation, and interviews with IRC clients who participated in screening.

[X] Social desirability bias is the tendency for respondents to answer questions in a manner that they perceive will be viewed positively.

[XI] 26% (5 out of 19) of online survey participants said "maybe" and 1 person responded "no."

[XII] 42% of online survey participants said "maybe" and 1 person responded "no."

[XIII] Todahl, J., & Walters, E. (2011). Universal screening for intimate partner violence: a systematic review. *Journal of Marital and Family Therapy*, *37*(3), 355-369.

[XIV] Nearly 1 in 5 women in the US have been raped in their lifetime, and 1 in 4 have been a victim of severe physical violence by an intimate partner. (National Intimate Partner and Sexual Violence Survey. (2014). *National Data on Intimate Partner Violence, Sexual Violence, and Stalking*. Retrieved from: http://www.cdc.gov/violenceprevention/pdf/nisvs-fact-sheet-2014.pdf Thirty-five percent of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. Some national studies show intimate partner violence prevalence rates as high as 70%. (World Health Organization. (2013). *Global and Regional Estimates of Violence against Women: Prevalence and health effects of intimate partner violence and non-participant sexual violence*. Retrieved from: http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf

[XV] Principal applicants are identified by UNHCR when refugees apply for resettlement. Percentage of male principal applicants is calculated based on IRC fiscal year 2014 arrivals. In 2014 at the IRC (across all offices), 70% of PA's were male. This percentage is likely to be similar for other resettlement agencies as well.

[XVI] Based on RPC bio-data for newly arrived refugees at IRC.

[XVII] Based on 15 responses.

[XVIII] The information around what partners provide and how to access those services should be verified, documented, and disseminated among the various staff positions, and the resource directory should be regularly updated.

[XIX] For related research on this issue see: Busch-Armendariz, N., Wachter, K., Cook Heffron, L., Snyder, S., & Nsonwu, M.B. (2014). *The continuity of risk: A three city study of Congolese women-at-risk resettled in the US.* Austin, Texas: The Institute on Domestic Violence & Sexual Assault.

APPENDIX A: DIRECT SCREENING TOOL

CONFIDENTIAL

Direct Screening for Violence

Directions: This screening will help identify clients who have experienced gender-based violence in the past or are experiencing violence now and need help. Complete screening in-person as part of an existing individual meeting; a separate meeting should not be scheduled only for screening. Screenings must be conducted in a private space with no one else present other than the client and an interpreter (in-person or phone) if needed and if the client consents. Information from this screening MUST BE KEPT CONFIDENTIAL and can only be shared if the client signs a release of information or if the client is a danger to her(him)self or others.

A note to the interviewer: There are a lot of factors that will affect whether or not survivors feel comfortable disclosing their experiences to you. Some survivors are more comfortable with someone of the same sex, ethnic group, or who speaks the same language as themselves, whereas others are more comfortable with someone of a different sex, ethnic group, or language. If you have the impression that the client you are screening may not be comfortable disclosing experiences of violence to you, discuss with your Supervisor the possibility of identifying a different staff member to complete this screening.

Introduction: *"Some of the women we see at IRC have been hurt by a family member, someone they know, or a stranger. This can happen in the US, back home, or anywhere. Sometimes women are too afraid to talk about being hurt since they think it is very personal, that no one will understand, or that it was their fault. Because many women experience violence, and because there is help available, we have started asking every woman if she is being hurt by anyone. I am going to ask you a few questions about your experiences. You do not have to answer any of these questions if you do not want to. All you have to do is tell me you don't want to answer. You don't need to explain why. [If you want to talk to someone but prefer to talk to a woman, let me know and I can connect you to one of my colleagues for support.]*

It is important for you to know that I will keep what you tell me confidential, including any notes I write down. This means I will not tell anyone other than my supervisor (including anyone in your family) what you tell me unless you ask me to or unless it is information I need to share because you are a danger to yourself or others, or because a child is in danger. I want you to know these limitations to our confidentiality so that I do not break your trust and so that you can make decisions about what you want to share with me based on these limitations. Do you have any questions about what I just explained to you?"

AFTER completing the screening, if there is no indication of violence or if the client does not want to answer: *"Even if you do not face these problems now or do not want to talk about these problems now, I want you to know that IRC is a safe place to come for help with family relationship problems and experiences of violence. Sometimes clients tell me they do not want to talk about things that happened in the past, but sometimes bad things that happened in the past can still affect us in the future in ways we don't want them to. I want you to know that you can come to IRC for support if you need it."*

For the interviewer:

Client Name/ID:	Completed By:	Date:	Staff Time Spent:
Language Used:	Interpreter Present? ☐ Phone ☐ In-person ☐ No		Interpreter Time Spent:
Date of Arrival:		If client discloses violence, date of disclosure:	

1. Does someone in your family try to control where you go, what you do, or what you say in a way that makes you feel afraid or helpless? ☐ Yes ☐ No ☐ Don't know ☐ No answer

2. Have you ever been threatened or physically hurt by your partner or someone you know? ☐ Yes ☐ No ☐ Don't know ☐ No answer

   a. Have you ever had any serious injuries as a result? ☐ Yes ☐ No ☐ No answer ☐ N/A

3. Have you ever been forced to participate in sexual activities that made you feel uncomfortable or unsafe? This could be by your partner, a stranger, or someone you know. ☐ Yes ☐ No ☐ Don't know ☐ No answer

4. If any of these situations has happened to you, have you ever told anyone about it before? If so, who did you tell and what happened?

____

____

5. Do you feel safe going home after this appointment today? ☐ Yes ☐ No ☐ Don't know ☐ No answer

For the interviewer: Check the appropriate box and complete follow-up action based on the screening responses:

☐ YES, **current** violence and follow-up needed:
1. Inform Supervisor
2. Complete Assessment (if applicable), Safety Plan, and Service Plan (during current or follow-up meetings)
3. Discuss with survivor safe ways to follow-up and monitor her situation

☐ YES, **past** violence and follow-up needed:
1. Inform Supervisor
2. Complete Assessment (if applicable),Safety Plan and Service Plan (during current or follow-up meetings)
3. Discuss with survivor safe ways to follow-up and monitor her situation

☐ YES, **past** violence and NO follow-up needed
1. Express empathy and support
2. Complete screening again in the future if additional information suggests violence may be present

☐ NO, violence is not suspected at this time.
1. Complete screening again in the future if additional information suggests violence may be present

APPENDIX B: OPEN SCREENING TOOL

CONFIDENTIAL

Open Screening for Violence

Directions: This open screening establishes IRC as a safe space to talk about experiences of gender-based violence. Complete screening in-person as part of an existing individual meeting; a separate time should not be scheduled only for screening. No one other than the client and an interpreter (in-person or phone, if needed and if the client consents) should be present during the screening conversation. This open screening invites survivors of violence to confidentially share their experiences if they need help or support.

A note to the interviewer: There are a lot of factors that will affect whether or not survivors feel comfortable disclosing their experiences to you. Some survivors are more comfortable with someone of the same sex, ethnic group, or who speaks the same language as themselves, whereas others are more comfortable with someone of a different sex, ethnic group, or language. If you have the impression that the client you are screening may not be comfortable disclosing to you, discuss with your supervisor the possibility of identifying a different staff member to complete this screening.

Sample script: *"We tell all the women we see at IRC that IRC is a safe place to talk about experiences of violence and family relationship problems. This is because some of the women we see here have been hurt by a family member, someone they know, or a stranger. This can happen in the US, back home, or anywhere. Sometimes women are too afraid to talk about being hurt since they think it is very personal, that no one will understand, or that it was their fault. We understand this can be hard to talk about. I don't know if anything like this has happened to you, but I want you to know that you can tell me at any time and I will keep what you tell me private and confidential. [If you want to tell someone but prefer to talk to a woman, let me know and I can connect you to one of my colleagues for support.] IRC can help connect women who have been or are being hurt to support and help. Do you have any questions about this?"*

"Thank you for letting me talk to you about this and IRC is here if you ever need help."

For the interviewer: Clients may disclose experiences of violence right away in response to this open screening or may disclose violence at a later time. If someone does disclose an experience of violence at any time, complete the *Assessment for Survivors* to identify the survivor's needs and concerns. Inform Supervisors of all disclosures of violence. If a survivor is ready to disclose, explain confidentiality and mandated reporting requirements **before** s/he shares her(his) experience.

Sample script: *"It is important for you to know that I will keep what you tell me confidential, including any notes I write down. This means I will not tell anyone other than my supervisor (including anyone in your family) what you tell me unless you ask me to or unless it is information I need to share because you are a danger to yourself or others, or because a child is in danger. I want you to know these limitations to our confidentiality so that I do not break your trust and so that you can make decisions about what you want to share with me based on these limitations. Do you have any questions about what I just explained?"*

For the interviewer:

Client Name/ID:	Completed By: ☐ Phone ☐ In-person	Date:	Staff Time Spent:
Language Used:	Interpreter Present? ☐ Phone ☐ In-person ☐ No		Interpreter Time Spent:
If client discloses violence, date of disclosure:			

APPENDIX C: SURVIVOR ASSESSMENT TOOL

CONFIDENTIAL

Assessment for Survivors

Directions: Complete this assessment if a client discloses experiences of gender-based violence in order to help identify the client's needs. Do this in-person in a private space with no one else present other than the client and an interpreter (in-person or phone) if needed and if the client consents. Information from this assessment MUST BE KEPT CONFIDENTIAL and can only be shared if the client signs a release of information or if the client is a danger to her(him)self or others.

Introduction: *"I am going to ask you more questions so that we can help you get the help you need. As always, you do not have to answer any of these questions if you do not want to. All you have to do is tell me you don't want to answer. You don't need to explain why. Talking about what happened can be difficult – if you start to feel overwhelmed or tired, let me know and we can finish these questions at a different time. It is completely your decision whether or not you want help and I will support your decisions no matter what they are.*

Again, everything you tell me and any notes I take are confidential. This means that I will not tell anyone other than my supervisor (including anyone in your family) what you tell me unless you ask me to or unless it is information I need to share because you are a danger to yourself or others, or because a child is in danger. I want you to know these limitations to our confidentiality so that I do not break your trust and so that you can make decisions about what you want to share with me based on these limitations.

I may write things down while we talk to make sure I remember everything you tell me. I can show you or read to you anything I write down. Do you have any questions about anything I explained to you?"

For the interviewer:

Client Name/ID:	Completed By:	Date:	Staff Time Spent:
Language Used:	Interpreter Present? ☐ Phone ☐ In-person ☐ No		Interpreter Time Spent:

I. Understanding What Happened

1. **Please tell me more about what happened.** Include who perpetrated the violence, if physical violence or weapons were used, whether any medical care was needed or received, and, for survivors who have sought help in the past, what type of care or services they received. If the survivor has already explained what happened, there is no need to ask again.

For the interviewer: Check the appropriate boxes based on the response to Question 1.

Current violence: ☐ Yes ☐ No

Past violence: ☐ Yes ☐ No

Type of violence: ☐ Physical violence ☐ Sexual assault ☐ Rape ☐ Denial of resources ☐ Psychological/ emotional abuse ☐ Other: ☐ Unknown

Perpetrator of violence: ☐ Partner ☐ Other family member ☐ Neighbor/ community member ☐ Stranger ☐ Other: ☐ Unknown

Weapons used: ☐ Yes ☐ No ☐ Unknown

2. **Do you have any concerns right now related to what happened?** The answer to this question will be the starting point for the service plan. Let the survivor know that you will talk about how to address these concerns.

II. Assessing Health Needs

3. **Do you have any health concerns right now related to what happened?**

4. **Would you like to see a doctor?** Make sure the survivor is aware that medical services are confidential and of any costs associated with medical services. If the survivor does go to a doctor, make sure s/he gives the doctor a safe address and phone number to contact her/him. ☐ Yes ☐ No ☐ Don't know ☐ N/A

For the interviewer: Check the appropriate box based on the response to Questions 3 and 4. If health services are needed, be sure to include in the service plan.

YES, health services are needed because:

- ☐ Last incident was within the past week and survivor would like to access available treatment
- ☐ Survivor complains of physical pain and injury
- ☐ Other reason:

NO, health services are not needed because:

- ☐ Health needs are already met
- ☐ There are no health needs
- ☐ Other reason:

III. Assessing Legal Needs

5. **Has there been any court or police involvement because of what happened either now or in the past? If so, what happened?** This could mean involvement of police officers, court, a judge, District Attorney, or lawyers.

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6. **Would you like to hear more information about your legal rights in the United States and options for taking action?** These options include police reports, protection orders, child custody, separation and divorce, criminal investigations, and immigration considerations. Explore which options may apply to the situation. Make sure survivor has enough information to make an informed decision about any options s/he may wish to pursue.

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7. **Are there options for justice available through your community? Are these safe options?** Survivors may choose to pursue either or both formal legal services and informal justice available through the community.

For the interviewer: Check the appropriate boxes based on the responses to Questions 5 – 7. If legal services are needed, be sure to include in the service plan.

YES, legal services are needed because:

- ☐ Family law needs (custody, separation, divorce)
- ☐ Protection order needs
- ☐ Survivor would like to pursue criminal investigation
- ☐ Immigration legal needs
- ☐ Community justice needs
- ☐ Other reason:

NO, legal services are not needed because:

- ☐ Legal needs are already met
- ☐ There are no legal needs
- ☐ Survivor does not want more information about legal options
- ☐ Other reason:

IV. Assessing Risk

For the interviewer: Is the perpetrator currently able to access the survivor? ☐ Yes ☐ No

If YES, complete this section. *If NO*, skip this section and continue to the next section.

8. **Does [the perpetrator] follow you, get extremely jealous or say they can't live without you?** Rather than ways to show love or care, being overly controlling, possessive, or jealous are ways to manipulate the survivor that can escalate to violence. ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

9. **Has the violence gotten worse or more frequent over the past year?** Escalating violence places the survivor at higher risk. ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

10. **Has [the perpetrator] ever said he would kill you or kill himself?** Perpetrators who threaten suicide or homicide must be considered very dangerous. If the perpetrator has killed before (in or out of combat), he may be more dangerous as well. ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

11. **Has [the perpetrator] used or threatened to use weapons against you in the past?** Weapons include guns and knives, as well as other objects that may be used as weapons, such as razors, belts, or sticks. ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

12. **Does [the perpetrator] use illegal drugs or drink too much?** Drugs or alcohol impair judgment and can lead to increased violence. ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

Additional information: Include any further explanation needed for responses to Questions 8 – 12.

For the interviewer: Every 'yes' response could put the survivor at increased risk for violence and should be addressed in the safety plan. Multiple and serious 'yes' responses could indicate a need for emergency services. Discuss with a Supervisor.

Based on the risk assessment, a safety plan is needed: ☐ Yes ☐ No

V. Assessing Psychosocial Needs

13. **Do you feel sad most of the time or cry more than usual?** ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

14. **Do you have trouble sleeping?** ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

15. **Do you often have headaches or other pain in your body?** ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

16. **Have your eating habits changed, such as having a poor appetite or eating too much?** ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

17. **Do you feel hopeless about your situation or your life?** ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

For the interviewer: Check the appropriate boxes based on the response to Questions 13 – 17. If support is needed, be sure to include in the service plan.

YES, psychosocial support is needed because:
- ☐ Responses indicate psychosocial concern
- ☐ Responses indicate suicide risk
- ☐ Other reason:

_NO_, psychosocial support is not needed because:
- ☐ Support needs are already met
- ☐ There are no support needs
- ☐ Other reason:

VI. Assessing Strengths and Resources

18. **What do you do when you feel upset or overwhelmed?** Help the survivor identify her/his sources of support, such as friends or family in the US or elsewhere, faith and religious beliefs, and coping mechanisms.

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19. **What positive things in your life make you feel strong? Some examples might be people, knowledge, skills, income, or housing.** Survivors may not feel able to identify positive things in their lives. Help the survivor by pointing out positive things you have seen, including characteristics and abilities the survivor has.

For the interviewer: Complete a service plan following this assessment. Concerns, strengths, resources, and sources of support identified during the assessment should be included as part of the service plan. If there are safety concerns, complete safety planning with the survivor.

APPENDIX D: SAFETY PLAN TOOL

CONFIDENTIAL

Safety Plan

Directions: Complete this safety plan if the survivor is at-risk. The safety plan should be realistic, easy to remember, and based on the survivor's situation and what s/he wants to do. Most likely, you will not respond to every question. Prioritize the questions most supportive of the individual survivor's safety. Complete the safety plan in-person in a private space with no one else present other than the survivor and an interpreter (in-person or phone) if needed and if the client consents. Information from this safety plan MUST BE KEPT CONFIDENTIAL and can only be shared if the survivor signs a release of information or if the client is a danger to her(him)self or others.

As safety decisions are made together, the survivor can write down the safety plan her(him)self if s/he wants to and is able. Remind the survivor to keep the safety plan in a safe place if s/he keeps a copy. Review all safety decisions multiple times to help the survivor remember the plan. Clearly explain when a survivor should call the case worker and when to call an emergency contact.

Introduction: *"It is important to know that [the perpetrator's] behavior is not your fault. While you are not responsible for their behavior, let's think about ways you can increase safety for you and your children and be prepared if there is an emergency. I will ask you questions to help you think about a plan. You can decide what will work best for you and your children. I will be here to support your decisions no matter what they are.*

As always, everything you tell me is confidential. This means I will not tell anyone other than my supervisor (including anyone in your family) what you tell me unless you ask me to or unless it is information I need to share because you are in danger or a child is in danger. I want you to know these limitations to our confidentiality so that I do not break your trust and so that you can make decisions about what you want to share with me based on these limitations. Do you have any questions?'"

1. **What phone numbers do you need to memorize in case of emergency?** The survivor should memorize 911 and know how to dial from a cell and landline phone. If needed, the survivor may also memorize numbers to call people she trusts, or local emergency response or shelter providers. [See hotline numbers below.]

2. **Whom do you trust if you need help?** Think about anyone (neighbors, friends, family, or organizations) that the survivor can trust and how these people can help keep her safe. For example, discuss having a signal with helpful neighbors. Upon seeing this signal from the survivor, neighbors would plan to visit in a group. Survivors can also establish a codeword to let someone know to call for help.

3. **What community or faith leaders, members, or organizations might you involve?** Think about community or religious resources that might be involved in helping keep the survivor safe.

4. **Are there specific signals or triggers that indicate [the perpetrator] may become more violent?** Identify triggers and ideas for avoiding these triggers if possible.

5. **Where are potential weapons in your home? How can you protect yourself against potential weapons in the home (ex: knives, pans, sticks)?** If there are potential weapons in the house, the survivor should know where they are and try to guide any fights away from potentially dangerous areas (kitchen, bathroom, etc)

6. **What important documents do you have?** This includes documents for the survivor and her children, including birth certificates, identification, proof of immigration status, Social Security card, SNAP card, Medicaid card, passport, marriage certificate, and medical and school records. If the survivor does not have access to these documents, help the survivor brainstorm how to make copies and hide them. S/he may consider keeping copies with people s/he trusts. Caseworkers might also keep copies of important documents locked and confidential at the office.

7. **How can you involve your children in planning for safety?** The children should know not to try to stop the fighting and that the fighting is not their fault. The children should know how and when to call 911. The survivor should tell the children's school or daycare provider who is allowed to pick them up. If the survivor goes to a safe shelter, the children should know to keep their location a secret.

8. **How will you know when you need to call the police?** It is best if the survivor decides on specific circumstances under which she would involve the police. Make sure to discuss any barriers to calling the police (access to a phone, language barrier, fear of consequences) so that the survivor feels capable of calling the police if and when needed. You might role-play how this call might sound.

The following questions are for survivors who are considering leaving a violent setting or are ready to leave:

9. **If you are in danger and need to leave, is there a safe place you can go?** Think about temporary and long-term options and review both benefits and risks. If the survivor plans to stay temporarily at someone else's house, discuss whether or not the perpetrator might come look for the survivor there and whether or not someone in the community may inform the perpetrator of the survivor's whereabouts.

10. **If you need to leave, what will you take with you?** Consider all important documents for the survivor and her children, as well as clothing, food, medication, and money. Include specific plans for how to transport the belongings, and explain that survivors may not be able to return home to get their belongings if they enter a domestic violence shelter.

11. **If you need to leave, how will you do it?** If the survivor drives, consider keeping gas in the car and extra copy of the keys in a secret location that is easily accessible. If the survivor does not drive, make a feasible transportation plan. This may involve friends or neighbors that the survivor trusts, or keeping emergency bus tickets.

12. **If you need to leave, what will happen to your children?** If she has custody of the children, the survivor should make every effort to bring the children with her if she leaves so that the perpetrator cannot use the children to threaten the survivor.

13. **If you leave, will you need to do anything to protect your finances?** Think about changing passwords or PIN numbers, updating SNAP benefits, or changing/protecting bank accounts.

14. **Who else might be in danger if you leave?** The survivor may be hesitant to leave a dangerous situation because she is worried about consequences for others both in the US and in other countries. Help the survivor to prioritize her own safety.

15. **A protection order is a legal document in the United States that can prohibit [the perpetrator] from coming near, attacking, sexually assaulting, or contacting you, your children, or other family members. You may also be able to ask for custody of your children, financial support, or that [the perpetrator] be excluded from your home. These are legal options, which means that the police or courts would be involved. I am not an attorney, but I can connect you to someone who can give you more information about legal options. Would you like more information about protection orders or other legal options?** If the survivor already has a protection order, make sure she is aware of what it contains and consequences for not adhering to the protection order. Explain that she and her children should have copies with them at all times.

For the interviewer:

Client Name/ID:	Completed By:	Date:	Staff Time Spent:
Language Used:	Interpreter Present? ☐ Phone ☐ In-person ☐ No		Interpreter Time Spent:

1. I will memorize these phone numbers to be prepared for emergencies: ____________________
2. If I need help, I can contact: ____________________
3. A community leader who can help is: ____________________

   This is how they can help: ____________________
4. S/he is more violent when: ____________________

   When I see these signs I can: ____________________
5. I can try to avoid potential weapons by: ____________________
6. These are the important documents I need to have: ____________________

   I will keep copies: ____________________
7. I will tell my children: ____________________

   I will tell the school, daycare, or babysitter: ____________________
8. I will call the police if: ____________________
9. If I need to leave, I can stay: ____________________

   I will keep this location a secret by: ____________________
10. If I need to leave, I will bring: ____________________

    To make it easy to leave quickly, I will keep my things: ____________________
11. If I need to leave, this is how I will do it: ____________________
12. If I need to leave, my children will: ____________________
13. If I leave, I can protect my finances by: ____________________
14. Anything else I can do to increase safety: ____________________

APPENDIX E: SURVIVOR SERVICE PLAN TOOL

CONFIDENTIAL

Service Plan

Directions: Complete this service plan in-person after the Assessment for Survivors (if applicable) and after addressing any immediate safety concerns. Only complete a service plan if the survivor expresses that she wants to get help. Children affected by the survivor's experience can be included. Identify survivor, IRC, partner, and community resources to meet the survivor's needs. Complete this service plan in a private space with no one else present other than the survivor and an interpreter (in-person or phone) if needed and if the survivor consents. Information in this service plan MUST BE KEPT CONFIDENTIAL and can only be shared if the client signs a release of information for referral or service coordination purposes, or if the client is a danger to herself or others.

Help clarify benefits, risks, and limitations of services available and provide the survivor with information she will need to carry out her decisions. Clarify who is responsible for covering any related costs. For example, if the survivor decides to see a doctor, discuss health insurance, fees, confidentiality, mandated reporting, and how to provide safe contact information.

Note on making referrals: If a survivor is currently living with the perpetrator and there are concerns about confidentiality, referrals need to be made with caution. Write phone numbers on post-it notes with no identifying information, strategize with the survivor how to time appointments discreetly, and make sure providers know not to send identifying texts or voicemails to the survivor.

Introduction: *"Let's think together about ways to get the help you want. I cannot fix or solve things for you. Instead, we will always work together to figure out how best to help you and you will always be the one who makes decisions about what you want to do. I will be here to support those decisions – no matter what they are. Based on what you have told me so far, it sounds like your concerns are … [Summarize the concerns identified during the assessment.] Is this right? Do you have any other concerns related to what happened?*

Let's talk about ways to get help and support. You do not need to decide anything today if you don't want to. I will write down your concerns and any decisions that are made so that we can both remember. I can show you or read to you everything I write on this plan.

As always, everything you tell me is confidential. This means that I will not tell anyone other than my supervisor (including anyone in your family) what you tell me unless you ask me to or unless it is information I need to share because you are a danger to yourself or others, or because a child is in danger. I want you to know these limitations to our confidentiality so that I do not break your trust and so that you can make decisions about what you want to share with me based on these limitations. Do you have any questions?" [Proceed with action planning around each concern one by one.]

For the interviewer: Review the service plan during follow-up meetings with the survivor. For concerns that are still pending resolution, discuss what has been done and what is left to do. Explore any needs for additional support. Follow-up on the survivor's experience with other service providers and community members. Update the service plan as needed.

Ask the following questions during each follow-up contact for ongoing assessment of safety and well-being:

- Safety: **Has your feeling of safety changed since we last spoke? Are you facing any new safety issues in your home or community?**
- Support: **Are you facing any new struggles or worries since we last spoke? Are any of these worries making it difficult for to complete your daily activities?**

APPENDIX E: SURVIVOR SERVICE PLAN TOOL CONT'D

Client Name/ID:	Completed By:	Date:	Staff Time Spent:
Language Used:	Interpreter Present? ☐ Phone ☐ In-person ☐ No		Interpreter Time Spent:

Safety: What are the safety options available to the survivor? Based on the safety assessment, her knowledge of her situation and options, and your knowledge of resources in the community, determine with the survivor how she (and her children) can increase safety. Options may include referral to a shelter or safe house, a temporary safe place in the community, or safety planning for minimizing risk of future harm. Use the survivor's identified strengths and resources. ☐ No safety concerns

Concern:	What survivor will do:	What IRC will do:	Completed?
	Family or community who will support:	Service providers or community who will support:	
Concern:	What survivor will do:	What IRC will do:	Completed?
	Family or community who will support:	Service providers or community who will support:	

Health: Does the survivor have any health needs because of the violence?
☐ No health concerns

Concern:	What survivor will do:	What IRC will do:	Completed?
	Family or community who will support:	Service providers or community who will support:	
Concern:	What survivor will do:	What IRC will do:	Completed?
	Family or community who will support:	Service providers or community who will support:	

Legal: What information does the survivor need in order to make an informed decision about legal options? This might includes police involvement, protection orders, or referral to a lawyer. Safe community justice options may also be available.
☐ No legal concerns

Concern:	What survivor will do:	What IRC will do:	Completed?
	Family or community who will support:	Service providers or community who will support:	
Concern:	What survivor will do:	What IRC will do:	Completed?
	Family or community who will support:	Service providers or community who will support:	

Support: Did the survivor decide she would like regular ongoing support? Is ongoing support needed based on the psychosocial assessment? Options for receiving ongoing support may include continued services from IRC, a referral to another agency, a trusted service provider within the community, or other community resource (friends, family, religious or community leaders). Ongoing support may include case management, counseling, or mental health services. Identify any coping strategies the survivor will use. Use the survivor's identified strengths and resources.
☐ No concerns about support

Concern:	What survivor will do:	What IRC will do:	Completed?
	Family or community who will support:	Service providers or community who will support:	
Concern:	What survivor will do:	What IRC will do:	Completed?
	Family or community who will support:	Service providers or community who will support:	

Additional Concerns:
☐ No additional concerns

Concern:	What survivor will do:	What IRC will do:	Completed?
	Family or community who will support:	Service providers or community who will support:	
Concern:	What survivor will do:	What IRC will do:	Completed?
	Family or community who will support:	Service providers or community who will support:	

Is the service plan completed? Progress on the service plan should be monitored through regular follow-up with the survivor. Once all concerns identified by the survivor have been addressed, assess each area to determine if the service plan has been completed:

☐ Survivor's safety situation is stable. Survivor is physically safe and/or has a feasible plan in place to keep her physically safe.
☐ Survivor's health situation is stable. Medical concerns have been addressed and survivor is able to access medical care if needed.
☐ Survivor's legal situation is stable. Survivor has basic information about legal options or is connected to a legal service provider.
☐ Survivor's psychosocial well-being has improved. Survivor has someone she can talk to that is supportive, is engaging in regular activities, and her emotional state has improved.
☐ Supportive network has been established. Survivor has been able to establish relationships that are helping her with her healing.
☐ Any additional concerns have been addressed.

Staff Signature: ______________________ Date: _____

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