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Women Initiating New Goals of Safety

A Screening, Brief Intervention and Referral to Treatment (SBIRT) Model for Addressing Intimate Partner Violence

SOCIAL INTERVENTION GROUP | sig

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Women Initiating New Goals of Safety
GETTING STARTED GUIDE

Why WINGS?

Intimate Partner Violence (IPV) is a serious public health threat among women who use drugs and/or alcohol (WWUD). Rates of all types of IPV among WWUD have been found to be 3-5 times higher than among the general population of women. Yet, only 1 out of 20 WWUD who experience IPV ever receives any IPV-related services. Failure to address IPV among WWUD has been found to increase the likelihood of continued drug use, relapse, attrition from drug treatment and a host of other negative physical and mental health consequences. WINGS is a single-session intervention that aims to address a critical gap in IPV services for WWUD by identifying WWUD in the community at risk for IPV, enabling them to develop social support and safety planning skills to reduce their risks for IPV, and linking them to IPV-related services and substance use treatment.

What is WINGS?

WINGS is an evidence-based, single-session Screening Brief Intervention and Referral to Treatment and Service (SBIRT) Tool that is designed to address intimate partner violence (IPV) among women who use drugs or engage in heavy drinking (WWUD). WINGS embraces a harm reduction approach to enable women to identify and address their risks for IPV and to elicit intrinsic motivation for improving relationship safety using Motivational Interviewing skills. WINGS employs a non-judgmental stance to meet women where they are with respect to their intimate relationships and to enable them to set and enact their own goals to improve relationship safety based on whether they wish to stay with or leave their partners. The WINGS SBIRT model is guided by Social Cognitive Theory (SCT) (Bandura, 1992; Bandura, 1994), and is designed to enhance motivation, intentions, positive outcome expectances, self-efficacy, social support and resources (e.g. services) for identifying and reducing risks for IPV and increasing relationship safety. WINGS is designed for WWUD of different ages with female and/or male partners in relationships with a range of partners from casual dating partners to spouses.

WINGS may be delivered by a facilitator, counselor, social worker, case manager/case worker, nurse, other helping professional or a peer advocate with sufficient training. We developed a computerized self-paced version of WINGS that covers the same core SBIRT components as the facilitator version of WINGS and has been found to be equally effective in identifying different types of IPV, increasing IPV self-efficacy, and increasing social support and access to IPV services.

The Core Elements of WINGS

Evidence-based interventions, such as WINGS, have components that should be included without alteration (unless the latest scientific evidence requires that they be changed due to immediate or long-term harm - physical, mental, or social - or where changes will yield greater benefits to the focus population) to ensure the intervention's effectiveness. These components are called Core Elements. Core Elements are required components that represent the theory and internal logic of the intervention and most likely produce the intervention's main effects. Researchers identify Core Elements through research and practice. Core Elements define an intervention and must be implemented with fidelity to increase the likelihood that prevention providers will have program outcomes that are similar to those in the original research. WINGS core elements are:

1. Raise awareness about different types of IPV that WWUD are at risk of experiencing and how substance misuse may trigger or be triggered by experience of different types of IPV
2. Screen to identify different types of IPV women may be experiencing or perpetrating and provide individualized feedback for IPV (no, some, or high risk)
3. Elicit motivation to address IPV and relationship conflict
4. Conduct Safety Planning to reduce risks of exposure to IPV
5. Enhance Social Support to address relationship conflict and IPV
6. Set goals to improve relationship safety and reduce risk of IPV
7. Identify and Prioritize Service Needs, Linkage to IPV and other Services

These core elements of both modalities of WINGS are designed to enable WWUD to identify and disclose different types of IPV, to develop self-efficacy to protect themselves from IPV, to identify and address the ways in which drug and alcohol use triggers and is triggered by IPV, to develop and implement a safety plan that considers substance-related risks for IPV, to enhance social support in their networks, to improve access to services

to reduce risks of experiencing IPV, and to set and enact goals to improve relationship safety and reduce risk of violence . The computerized self-paced tool of WINGS employs interactive exercises and video testimonials of women, and a narrator who leads women through the different session activities. Participants can click an audio button to hear the text for each screen. Below is a detailed description of how both modalities deliver the core elements of WINGS.

These seven Core Elements must be maintained without alteration to ensure fidelity to the intervention and its effectiveness. Fidelity is conducting and continuing an intervention by following the Core Elements, protocols, procedures, and content set by the research study that determined its effectiveness. The Core Elements should not be altered, unless the latest scientific evidence requires that they be changed due to immediate or long-term physical, mental, or social harm, or where changes will yield greater benefits to the focus population. However, implementing agencies can adapt activities and delivery methods for different at-risk populations and for their organizational settings. Adaptation describes the process of customizing delivery of interventions to agency circumstances and ensuring that messages are appropriate for focus populations without altering, deleting, or adding to the intervention's Core Elements.

Comparing Facilitator version of WINGS and Computerized Self-Paced WINGS

On page 10 is a table that describes how the different core elements of WINGS are implemented in the Facilitator version of WINGS and Computerized Self-Paced WINGS. Both versions of WINGS were found to be effective and both take approximately 45-60 minutes on average to conduct. In deciding which version will work best for your agency, it is important to consider staffing issues, budget, mission, computer resources, space and what would work best for your target population of clients or participants.

	Facilitator WINGS	Computerized Self-Paced WINGS
Psycho-education	Facilitator describes high rates of intimate partner violence (IPV) among WWUD and women in the criminal justice system; reviews different types of IPV using the Power and Control Wheel adapted for WWUD; describes drug-related triggers for IPV and IPV-related triggers for drug use.	Video testimonials from women in the criminal justice system on their experience of different types of IPV and their negative effects; interactive presentation on high rates of IPV and Power and Control Wheel adapted for WWUD; visual presentation of drug-related triggers for IPV and IPV-related triggers for drug use.
Enhancing motivation to improve relationship safety	Facilitator asks participants to identify negative effects of relationship conflict and IPV on their physical and mental health and their children; facilitator then asks participants to identify motivations to improve relationship safety.	Participants select different negative effects of relationship conflict on their physical and mental health and their children from a drop-down menu; participants identify motivations to improve relationship safety from a drop-down menu.
Screening and IPV risk assessment	Facilitator administers abbreviated Revised Conflict Tactics Scale (CTS2) with participants that covers physical, injurious, verbal, and sexual abuse subscales (8 items) and the Psychological Maltreatment of Women Inventory (PMWI) that assesses psychological IPV (8 items); facilitator informs participants whether they are at high, medium, or low risk for IPV.	WINGS tool prompts participants to complete an Audio Computer-Assisted Self-Interview (ACASI) that covers the same CTS2 and PMWI items; participants receive computerized feedback on whether they are at high, medium, or low risk for IPV.
Safety planning	Facilitator asks participants about different safety planning items to reduce their risk of exposure to IPV using the IPV Safety Planning Checklist developed by a national consensus panel of experts on co-occurring IPV and drug use.	WINGS tool asks participants to complete different safety planning items to reduce their risk of exposure to IPV using the IPV Safety Planning Checklist developed by a national consensus panel of experts on co-occurring IPV and drug use.

Enhancing social support	Facilitator asks participants to identify family members and friends to whom they can turn for support, advice, and practical help to prevent or reduce their risks for experiencing IPV and to resolve relationship conflict; facilitator then asks participants to identify steps they can take to strengthen different types of support in the next week.	Participants are presented with an interactive social network support tree that prompts them to identify up to five family members and friends to whom they can turn for support, advice, and practical help to prevent or reduce their risks for experiencing IPV and to resolve relationship conflict; the tool then prompts participants to identify steps they can take to strengthen different types of support in the next week.
Goal-setting to reduce or prevent IPV	Facilitator asks participants to identify personal relationship safety goals including (1) stay together, no change, (2) stay together, stop IPV, (3) separate or divorce from partner, no further contact, (4) separate or divorce from partner, but allow partner's continued involvement with children; facilitator then asks participants to identify other steps they can take towards these goals such as finding housing, getting a job, getting counseling or legal help, and avoiding drugs and alcohol.	The tool asks participants to identify personal relationship safety goals including: (1) stay together, no change, (2) stay together, stop IPV, (3) separate or divorce from partner, no further contact, (4) separate or divorce from partner, but allow partner's continued involvement with children; tool then prompts participants to identify other steps they can take towards these goals such as finding housing, getting a job, getting counseling or legal help, and avoiding drugs and alcohol.
Identification of service needs and referrals	Based on participant goals, facilitator helps participants identify and prioritize services that they may need and refers them to appropriate services; facilitator then asks participants to come up with a step-by-step action plan for pursuing services in the next week and provides participants with service resource manual and printout of their safety plan.	Based on participant goals, tool prompts participants to identify and prioritize services that they may need and refers them to specific appropriate services; the tool then prompts participants to create a step–by-step action plan for pursuing services in the next week. The same services included in Traditional WINGS were programmed into the multimedia tool, so that when a participant selected a service, such as 'couples/ marital counseling' or 'help getting housing' the same list of two or three local service providers would appear on the screen. Participants receive a printout of the services they selected and their action plan to pursue services as well as a hard copy of the service resource manual and printout of their safety plan.

Science behind WINGS

A randomized controlled trial which tested the effectiveness of the Facilitator WINGS versus the Computerized Self-paced WINGS among 191 WWUD in community corrections found that both modalities of WINGS were equally effective in identifying high rates of different types of IPV in the past year as well as linking women to IPV services, increasing social support and enhancing IPV self-efficacy from the baseline pre-intervention assessment to the 3-month follow up assessment (Gilbert et al., 2016). Another randomized controlled trial that evaluated the effectiveness of a group-based computerized HIV and IPV prevention intervention (WORTH), which included the WINGS SBIRT components among 306 WWUD in community corrections, found that participants assigned to Computerized WORTH were more likely to reduce incidence of sexual, physical and injurious IPV at the 12 month follow-up than participants assigned to the Wellness Promotion Attentional Comparison Condition (Gilbert et al., 2016). The promising findings of these intervention studies suggest the feasibility and effectiveness of the WINGS SBIRT model in addressing IPV among WWUD whether delivered by a helping or lay professional or administered using a computerized self-paced tool.

Getting Started: Assessing Organizational Readiness to Implement WINGS

Before implementing WINGS, it is important to ensure that your organization has the resources, commitment and capacity to conduct this brief intervention. The key factors to consider when assessing whether or not your organization is ready to implement either modality of WINGS include:

(1) To what extent does WINGS fit with the organizational priorities, values and mission of your organization?

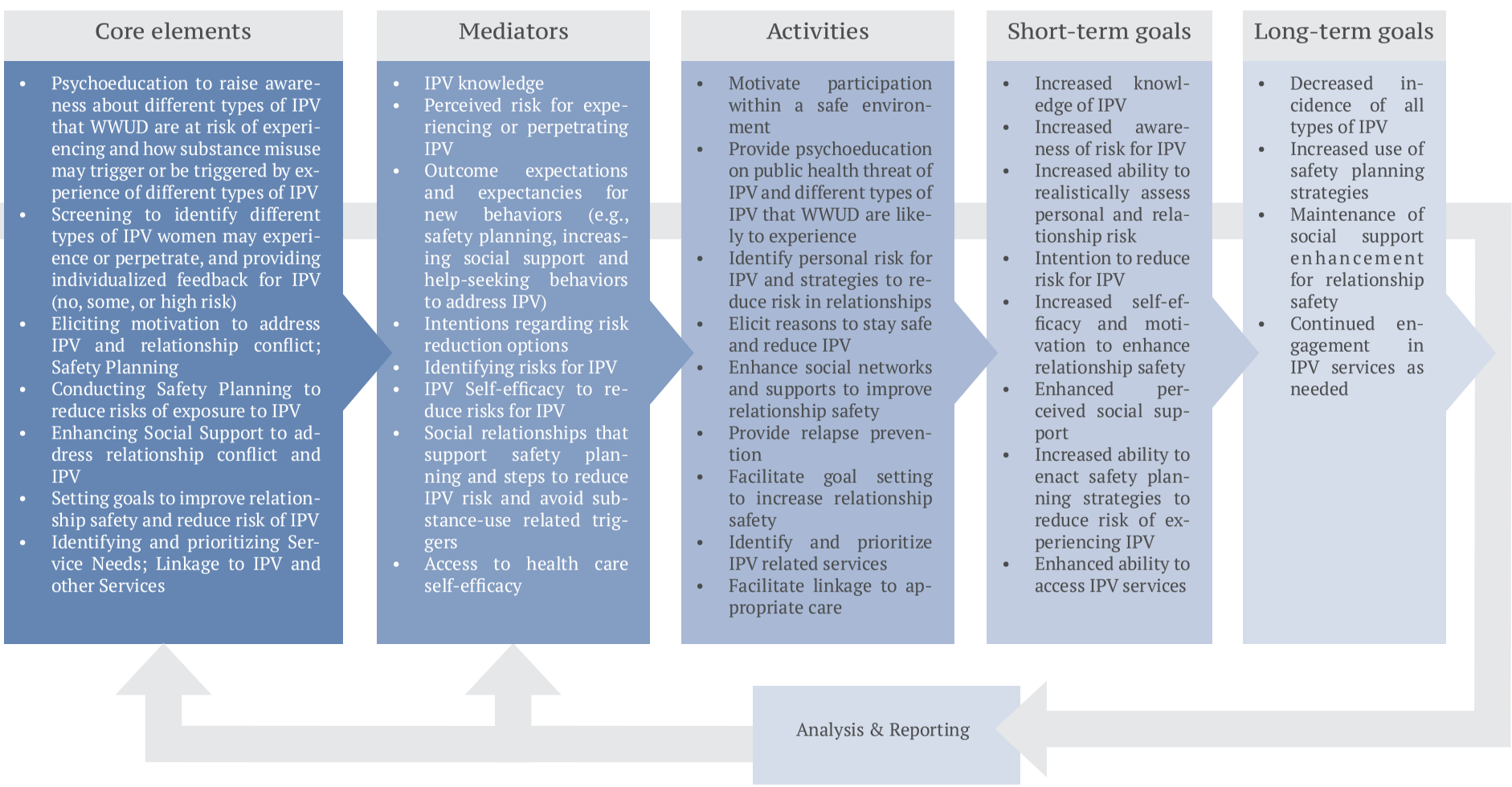
(2) To what extent are the leadership and senior management of the organization committed to implementing an IPV SBIRT model to identify women at risk of IPV and link them to appropriate services? What steps can you take to increase their commitment to implement WINGS?

(3) Does your organization have existing partnerships with different types of IPV related service providers (see WINGS referral handbook for example)? If not, what types of service agreements or partnerships do you need to develop to have a functional network of service referrals in place for clients/participants who complete WINGS?

(4) Are there staff in the organization who have time and training to conduct WINGS? What staff would be most willing and able to conduct this intervention?

(5) Does your organization have the space and resources to implement WINGS? The facilitated modality of WINGS should be delivered in a private office.

WINGS Behavioral Change Logic Model



The computerized self-paced tool can be delivered in a Kiosk or any space the woman feels she can maintain the privacy of her phone, tablet or computer screen. Given your organizational setting, which modality of WINGS do you think will work best? The space and resources needed to deliver the computerized self-paced WINGS and traditional WINGS vary. Please see the Implementation manual for the computerized self-paced WINGS for more details on resources needed to implement this SBIRT tool.

By conducting an organizational assessment of readiness to implement WINGS with other staff and leaders of your agency, you can begin to identify factors that may help or impede the delivery of WINGS. If there is consensus that it is feasible to implement WINGS in your organization, this organizational assessment can help you generate a plan to launch WINGS that will address potential organizational barriers to implementation as well as draw on agency assets to help facilitate the delivery of WINGS.

Organizational Assessment Activities

Agency capacity issues The first Getting Started activity is addressing the capacity issues. Capacity issues are focused on securing the "buy-in" of stakeholders in the agency.

Buy-In Securing "buy-in" is crucial because it assures the support of agency administration and allows for agency resources to be utilized for intervention implementation. Obtaining "buy-in" is most effectively accomplished by identifying at least one agency administrator or staff person to "champion" the intervention; that is, to advocate for its integration into existing service provision at the agency.

A WINGS champion A WINGS champion could be an individual or a group of people. The champion should be selected by an agency administrator. Regardless of the number of champions, the central issue is convincing the agency that implementing WINGS would enhance the quality of its prevention services and that the agency is capable of implementing WINGS. A champion is someone within the agency who is a mid-to-upper level administrator who generally serves as a link between administration and staff. If you are reviewing this document, you may be on your way to becoming a WINGS champion. The champion needs to be adept at answering questions and mediating any changes in organizational structure; they can serve as a negotiator of any necessary trade-offs or compromises. The champion becomes the intervention's spokesperson, anticipating the reservations of staff and answering questions about the intervention's needs and resources. The champion must have an excellent knowledge of the intervention, including its Core Elements and costs. In addition, the champion can use the marketing materials available in the intervention package. The champion can use the information presented in this manual and the rest of the package to further field any questions or concerns about WINGS.

Your agency's intervention champion can use the following stakeholder's checklist to obtain support for implementing either or both the Facilitator Version of WINGS and the Computerized Self-paced WINGS. The stakeholders are those people on your Board of Directors/Executive Board, in your community or agency, your staff, or your funding source who have a stake in the successful implementation of an intervention. The stakeholder's checklist contains those items the champion can use to convince the stakeholders that WINGS is an intervention that your agency can and should implement because it meets the needs of the community your agency serves.

Stakeholder Checklist for WINGS

1. Assess the community to determine whether they will support WINGS

2. Identify your stakeholders

Potential stakeholders may include:

Staff members from your agency who will have a role in the operation of the intervention:
- Directors/Administrators who will obtain support.
- Supervisors who will monitor the intervention.
- Staff who will interact with participants at any level.

Local agencies from which you could recruit participants, facilitators, or both:
- Agencies offering education and prevention services for WWUD and/or women experiencing IPV.
- Health care providers and mental health professionals serving WWUD and/or women experiencing IPV.
- Social service agencies reaching WWUD and/or women experiencing IPV.
- Organizations that serve WWUD and/or women experiencing IPV.

Organizations that could provide assistance or other resources:
- Merchants for incentives, refreshments
- Agencies, merchants, printers, publishers, broadcasters, and others that can advertise the intervention.
- Agencies that can provide space to provide the intervention.
- Agencies that can provide child care.
- Agencies that can provide transportation.
- Other collaborating agencies to provide information for the Resource Manual.

Agencies with which your agency maintains good community or professional relations:
- Local health department.
- Local medical and mental health associations.
- Substance Abuse Treatment organizations and government oversight divisions
- Your funding source(s).
- Others.

3. Inform stakeholders

Decide in advance what specific roles you want each stakeholder to play. Who will you ask to:
- provide financial support?
- refer WWUD to the intervention?
- serve as an intervention facilitator?
- be a resource to which you can refer participants?
- assist in advertising the intervention?
- provide a room in which the session can be held?
- supply refreshments for participants?
- donate small incentives or prizes for participants?
- speak supportively about WINGS in conversations with their associates?

Send letters that tell stakeholders about WINGS, its importance, when your agency will be making the intervention available, and what specific role(s) you think that they might play in the success of the intervention. Offer an opportunity for them to learn more.

Call stakeholders to assess their interest. If they are interested, schedule a time to meet (e.g., one-on-one, lunch-and-learn at your agency with a group of other stakeholders, or a presentation at their agency for several of their staff or association members).

4. Get stakeholders involved

Hold a meeting, show WINGS marketing materials if the setting and time allow, answer questions.
- Describe several specific roles they could play.
- Emphasize the benefits of their involvement to themselves, their agency, the community, and WWUD at risk of IPV and answer questions.
- Invite them to commit to supporting WINGS by taking on one or more roles. Keep track of commitments.

Soon after meeting:
- send a thank you letter that specifies the role(s) to which they committed.
- If they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider later.
- For persons who committed to a role that is important to pre-implementation, put them to work as soon as possible.
- For person who committed to involvement later in the process, send them brief progress updates and an idea of when you will be calling on them for their support.

Hold periodic celebratory meetings for supporters to acknowledge your appreciation for and the value of their contributions, update them on the intervention's progress, and keep them engaged.

Pre-Implementation

Pre-Implementation prepares the implementing agency to perform the intervention. It is during this period that your agency can make any necessary organizational changes, assess resource needs, and develop marketing and evaluation plans.

Pre-Implementation is also the time to explore the needs for adapting WINGS for different populations of WWUD and specific agency settings. Pre-Implementation activities are focused on the following:

- Staffing requirements
- Securing the Intervention resources
- Adapting the Intervention
- Program Review Board
- Developing an evaluation plan
- Planning for any possible legal and ethical issues
- Marketing WINGS and recruiting participants

Staffing requirements

In order for WINGS to run smoothly you will need an Agency Coordinator or Point person; and at least one, but preferably two, trained facilitator(s), or capacity to implement the computerized self-paced WINGS.

Facilitation practice is highly recommended prior to delivering WINGS. Participants for practice sessions can be recruited from staff or agency volunteers; however, if volunteers participate, it is important to make sure they understand their role and the goals of the practice sessions. One of the goals of the facilitation practice is to give the facilitators an opportunity to spend time learning how to use the implementation manual, which includes all session activities, and the intervention forms, before the intervention begins.

During facilitation practice, facilitators can develop a better understanding of complicated relational dynamics that may influence WINGS implementation, and develop strategies for dealing with them. Many of these are highlighted and illustrated using video vignettes and modeling in the Training of Facilitators Curriculum or online resource. Facilitators can actively practice handling challenging situations that may come up and providing referrals to meet the participant's needs. The practice sessions will increase facilitators' comfort level with the facilitation process and promote flexibility in adjusting the WINGS session agenda to meet the needs of the participants. In addition, facilitation practice will help facilitators assess the strengths and weaknesses of their facilitation skills.

Staffing Requirements

Agency Coordinator

The list of items below contains some of the Program Coordinator's primary responsibilities. The Agency Coordinator may be responsible for additional tasks during the course of the intervention.

The Agency Coordinator for WINGS is primarily responsible for the following tasks:

- Preparing the agency for the intervention
- Ensuring commitment from Senior Leadership and funding to support implementation of WINGS
- Collaborating with other agencies
- Securing the intervention needs
- Preparing intervention materials
- Training and managing WINGS facilitators
- Setting up training and technical assistance
- Recruiting participants
- Establishing and overseeing the evaluation plan
- Overseeing the intervention and facilitators
- Conducting supervision sessions
- Managing the budget
- Assuring quality
- Monitoring fidelity

Facilitators

Roles and responsibilities of Facilitator:

- Prepare for session
- Balance the needs of the participant and the structure of the session
- Facilitate discussion with participant while following the session's curriculum
- Practice and review materials
- Validate women's experiences and build self-efficacy to address IPV
- Inform participants of the duty to warn, confidentiality, and other relevant laws
- Implement session activities
- Handle emotional or behavioral issues
- Emphasize women's role in driving any changes to increase relationship safety
- Create safe, welcoming, and non-judgmental environment for WWUD
- Affirm past experiences while communicating an expectation for safer, healthier future experiences
- Assist women in identifying service needs and making referrals using a Resource Manual which provides information about other local and accessible services for WWUD at risk of IPV (see Appendix I for sample)

Program Coordinators and relevant staff members may want to observe the practice sessions and provide facilitators with feedback as needed. Some potential self-evaluation questions are:

1. How did the session facilitation go?
2. What went well? Why did it go well?
3. What did not go well? Why did it not go well?
4. How can I address issues that did not go well?
5. What should I make sure to cover or raise in a similar session?

Additionally, practice will provide the facilitators an opportunity to assess and evaluate their knowledge of the intervention content. Some sample evaluation questions are:

1. Does the woman understand the session's goals and activities?
2. What did the participants learn? What should they have learned?

Characteristics of Facilitators

The handout on page 21 lists of the characteristics to look for and the characteristics to avoid when selecting facilitators for WINGS. The facilitators will guide the participants through the content of WINGS. As you will see, many are also applicable when choosing any facilitator for a behavioral-based intervention.

Skills of Facilitators

WINGS may be delivered by a counselor, social worker, mental health professional (MHP), nurse or case manager. With appropriate training and supervision, WINGS may also be delivered by skilled peer advocates and lay persons who are familiar with substance abuse and IPV issues. Training and on-going supervision serve to build and maintain intervention capacity within agencies.

As with any behavioral intervention or service to an individual, the facilitator may have to deal with participants who are having suicidal or homicidal thoughts or who are experiencing or perpetrating life-threatening or severe IPV, as well as those who are exhibiting substance misuse problems. Facilitators may have to talk briefly after the session with participants if something is bothering them, and to assist in referring them to an agency or other professional who may help them. It is necessary for the successful facilitation of the session to allow time for the woman to talk about how she is feeling after some activities. The intervention (at any point or all the way through) may be emotionally moving or life changing for some participants. Due to the intense dialogue and serious issues raised, the facilitator will need to check in with their own emotions as they work through the intervention.

Facilitator Characteristics

Facilitators SHOULD HAVE the following characteristics:

- Trustworthy
- Flexible
- Active listener
- Follows up on identified needs
- Ability to follow the protocol for delivering WINGS
- Ability to promote communication
- Maintains eye contact
- Understanding of participant dynamics
- Understanding and non-judgmental
- Ability to manage and control problems
- Dynamic and friendly
- Respect for confidentiality
- Patient
- Knowledge of substance misuse and IPV
- Invested in cultural competence
- Good observer
- Authentic
- Empathetic and supportive
- Ability to respond appropriately to crisis situations that participants may disclose
- Ability to make appropriate referrals to services
- Interested in working with participants
- Creates warm and welcoming environment
- Respectful of others and their opinions
- Ability to build rapport
- Willingness to learn from participants
- Ability to adjust agenda times to meet needs of the woman
- Focuses on participant's needs instead of own personal agenda
- Aware of own comfort level, skills, and limits
- Ability to work with people where they are/take a client centered approach
- Shares and discloses personal information appropriately

Facilitators SHOULD NOT have the following characteristics:

- Anxious with participants
- Acts superior to participants
- Dominates discussion
- Withdraws physically or emotionally from participants
- Lacks sensitivity to the needs of others
- Needs to be the center of attention
- Inflexible and non-adaptive
- Places their own personal needs before the needs of the participant
- Oriented towards an individual other than the participant
- Pushes personal agenda
- Presents erroneous information as fact
- Presents a heteronormative perspective

The WINGS intervention includes discussions about personal behaviors such as sexual practices, drug or alcohol use, other triggers for IPV and other relationship issues. Topics of intimate, physical, emotional, and sexual coercion may arise. It is not unusual that some participants may feel uneasy talking about these topics. It is important for facilitators to be able to distinguish between normal discomfort and an unexpected, negative reaction that may have been brought on by participation in the WINGS intervention. These reactions must be taken seriously and handled in a consistent manner based on agency protocol. If a negative reaction occurs, facilitators should follow the agency's protocol. Agencies implementing WINGS should develop a plan for addressing participants who may experience suicidal or homicidal thoughts, violent outbursts or disclosures, or other negative reactions. This plan will assist the facilitator in knowing where and how to refer participants for either additional assessment or treatment services.

Facilitation practice should promote learning, improve facilitation skills, and help facilitators develop strategies for dealing with difficult situations and adhering to session content while providing high quality facilitation to the participants.

Skills of Facilitators

WINGS may be delivered by a counselor, social worker, mental health professional (MHP), counselor, nurse or case manager. With appropriate training and supervision, WINGS may also be delivered by skilled peer advocates and lay persons who are familiar with substance abuse and IPV issues. Training and on-going supervision serve to build and maintain intervention capacity within agencies.

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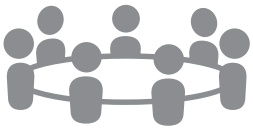
Materials

In order to implement WINGS, in addition to specific supporting materials for each session, your agency will need to ensure that it has the following list of supplies. The following items are not included in the package. An agency will need to get them before implementing WINGS, along with the supplies.

- Safety Plan
- Goal Setting Form
- WINGS resource manual
- Food/snacks (optional)
- Participant incentives (optional)
- Poster putty and/or masking tape
- Resource Manual (location specific)
- Pencils/pens

Location, room logistics, and time

WINGS should take place in a private and secure location, sessions should be offered at flexible times: during the week days, some evenings, and ideally sometimes on weekend days. The availability of the facilitators and the room also needs to be considered.



Incentives

In the original research study, incentives were given to encourage intervention participants to arrive on time. Incentives also can be used to keep participants engaged during sessions. Good food is a great way to hold participants' attention. Incentives are not a Core Element or Key Characteristic of WINGS so your agency is not required to provide incentives. We encourage your agency to consider using incentives (e.g. travel reimbursement, supermarket coupons) for WINGS that are consistent with other programs or services for the same reasons they were used in the original research.

We also encourage your agency to be creative with using and delivering the incentives. If your agency does not have the financial capabilities to purchase gift cards and gift certificates, it may be possible to solicit donations from the community and offer those donations as incentives.

Other intervention materials

Other resources needed for the intervention are in the WINGS intervention package. These materials are:

- Implementation Manual
- Session Outline of Core Activities that may serve as a checklist for Facilitator
- Safety Plan
- Evaluation materials
- Supporting print materials (goal cards, posters, fact cards, handouts)
- Marketing materials

Overview of implementation plan

Planning

Your agency/organization must have the infrastructure, capacity, qualified staff, and training to implement WINGS, coordinate services for participants, and adapt WINGS with scientific rigor, and must also have an advisory board for program oversight.

Implementation

Recruit women who use drugs and/or alcohol using brief screening form. Schedule session for delivering WINGS with recruited WWUD who meet criteria for being at risk. Ensure fidelity of the intervention's Core Elements using the supervision check lists.

Monitoring/evaluation

It is strongly encouraged to monitor and evaluate the process and outcome of implementing WINGS in your agency. You may administer brief pre- and post-assessments to evaluate the effectiveness of WINGS in linking women to IPV-related services and reducing risk of experiencing or perpetrating IPV. Maintain an evaluation database, analyze the data, and produce the reports.

Pre-Implementation Steps

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline / Notes
Assess agency capacity for implementing WINGS	• commitment to working with women • access to participants and adequate private space for sessions • required material resources • time required for delivering WINGS	Agency administrator	
Secure agency "buy-in"	• determine WINGS is a good fit with current agency services • determine the intervention is acceptable to focus audience	Agency administrator, Agency staff	
Establish infrastructural support	• develop a budget and support mechanisms • develop a plan to prepare for staff attrition • identify social services for referrals • select intervention "champion"	Agency administrator, CAB	
Network with other agencies and community organizations to determine their support for WINGS	• knowledge of intervention • marketing skills • ability to answer questions • knowledge of community and agencies working with participants	Agency administrator, Agency partners	

Identify and involve stakeholders	• knowledge of intervention • marketing skills • organizational skills • ability to answer questions	Agency administrator, Agency staff, Stakeholders	
Create Community Advisory Board (CAB) and hold meetings with CAB to obtain information on recruitment venues, incentives, and marketing	• knowledge of intervention • marketing skills • ability to answer questions • ability to establish WINGS with community members	Agency administrator, Agency staff, CAB, Stakeholders	
Identify possible venues for delivering WINGS	• knowledge of locations frequented by focus population • ability to access possible venues • ability to establish trust with people	Agency staff, CAB	
Identify members of the WINGS intervention team (Program Manager, Admin. staff)	• knowledge of internal staff capacity and skills • knowledge of staff person's interest in taking leadership with WINGS program	Agency administrator, Agency staff	
Identify facilitator(s) in your agency who can deliver WINGS	• knowledge of IPV or SBIRT interventions and/or experience with substance abuse	Agency administrator	
Assemble Resource Manual and create referral system	• knowledge of focus population needs • knowledge of agency resources • knowledge of and familiarity with local resources, including personal contacts	Agency staff	
Develop marketing plan, adapt marketing information sheet, identify recruitment sites, begin marketing	• nowledge of focus population, places to recruit participants, focus population members' preferences • ability to design a marketing plan	Agency staff, CAB	
Train Facilitators on WINGS	• knowledge of tasks and skills required to implement WINGS • trained on background of WINGS intervention and core facilitation skills	Agency administrator, Facilitators	
Obtain intervention resources	• knowledge of the intervention and required materials • knowledge of existing local and • agency resources	Agency administrator	

Conduct facilitation practice	• knowledge of the intervention materials and Implementation Manual	Supervisor, Facilitators	
Recruit potential participants	• knowledge of intervention, focus population, and places/methods to recruit participants • skills to explain the program • ability to interact with strangers • ability to create trust and elicit information	Agency staff, Facilitators	
Adapt intervention materials	• knowledge of intervention, focus population members' preferences	Agency staff, Facilitators	
Select, secure, and schedule venue for conducting sessions	• ability to access locations frequented by focus population	Agency staff stakeholders	
Develop an evaluation plan	• knowledge of the evaluation forms required by a funding agency and those desired by the implementing agency • knowledge of the purposes of the evaluation process	Agency administrator, Agency staff	3-4 weeks before implementation
Schedule sessions	• ability to communicate with potential participants • Mastery of the intervention content and purpose	Agency staff, Supervisor, Facilitators	1-2 weeks before implementation
Schedule debriefing/ supervision sessions for Facilitators with Program Supervisor	• knowledge of Facilitator session implementation schedule • coordination of schedules to identify consistent meeting time	Supervisor, Facilitators	1-2 weeks before implementation
Obtain incentives and refreshments	• knowledge of local resources and focus population members' preferences	Agency staff	1-2 weeks before implementation
Confirm participants and inform them of venue and time	• ability to communicate with potential participants	Agency staff, Facilitators	1-2 weeks before implementation

Implementation Steps

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline / Notes
Practice, prepare, and conduct WINGS session	• knowledge of session content and materials • training on WINGS intervention facilitation • high level of facilitation skills and knowledge of session content and materials needed • ability to provide supervision • discussion	Facilitators, Supervisors	
Debrief and receive supervision on	• knowledge of session content and materials • ability to provide supervision • discussion, knowledge of session content and materials needed • training on WINGS intervention facilitation • facilitation skills	Facilitators, Supervisors	
WINGS	• develop a budget and support mechanisms • develop a plan to prepare for staff attrition • identify social services for referrals • select intervention "champion"	Agency administrator, CAB	

Evaluation Steps

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline / Notes
Generate database for data to be collected	• knowledge of data management techniques and software (e.g., Microsoft Access, Microsoft Excel, SPSS, SAS)	Agency staff	
Collect necessary evaluation forms	• knowledge of WINGS evaluation forms, purpose, intent, and usage • instrument design experience • ability to motivate staff to complete forms • ability to communicate need for evaluation to staff	Agency staff, Agency administrator	
Manage database	• knowledge of data management techniques and software (e.g., Microsoft Access, Microsoft Excel, SPSS, SAS)	Agency staff	
Summarize data from evaluation forms	• ability to use basic commands for aggregating and reporting data	Agency staff	
Analyze and report collected data	• knowledge of analysis techniques • knowledge about how organization and funding agency define success	Agency staff	

Implementation summary

The Implementation Summary on the next page is a framework to visually present a summary of how WINGS is put into practice. The summary shows the relationship among:
The inputs (resources) used by WINGS implementation activities
The implementation activities of WINGS
The outputs (programmatic deliverables or products) that result when the implementation activities are conducted

Inputs

- Facilitator training and Facilitator training materials
- Recruitment strategies and materials
- WINGS intervention package and design
- Agency capacity, including space, staff and champion
- Funding
- External technical assistance
- Support from external "authorities" on IPV prevention
- Develop a monitoring and evaluation plan

Implementation Activities

- Train Facilitators
- Recruit participants (optional testing offered)
- Motivate participation within safe environment
- Provide IPV prevention information
- Identify personal risk for IPV and strategies to reduce risk in relationships
- Develop safety plan
- Enhance social networks and supports
- Facilitate goal setting
- Provide relapse prevention
- Link to appropriate IPV-related substance abuse treatment services
- Conduct monitoring and evaluation plan

Outputs

- Participants recruited
- WINGS session completed
- Follow-up provided as needed
- Evaluation of short- and long-term outcomes (e.g. # of participants who complete WINGS, # of participants who disclose experiencing any IPV in the past year, # of participants linked to IPV services, % of participants who report experiencing fewer incidents of IPV at follow up assessments

Adapting the intervention

Adapting WINGS involves customizing delivery of the intervention and ensuring that messages are appropriate for WINGS participants served by your agency or within your community without altering, deleting, or adding to the intervention's Core Elements. When adapting the intervention, remember to consider the needs of the population to be served, the resources and capabilities of your agency, and the Core Elements of the intervention.

Adaptation refers to the "who," "what," "how," "when," and "where" of WINGS as it will be implemented at your agency.

An example of an adaptation is deciding whether to include a follow up visit for WINGS participants who disclose experiencing IPV to assess their progress in meeting their goals and linking to services. In the original WINGS research, facilitators only met with women for the single WINGS session. However, post-evaluation assessments suggest that some women who are in need of IPV services may benefit from an additional follow-up visit to work through barriers in accessing IPV services or meeting their goals.

Adaptations should not affect the Core Elements of the intervention. Instead, they should enhance delivery of the intervention at your agency, and allow your staff to be creative and to develop ownership of the program.

Developing an evaluation plan

Your agency can conduct the following types of evaluation: formative evaluation, process monitoring, process evaluation, and outcome monitoring. Two key reasons to evaluate the intervention are accountability and program improvement. Accountability can be to the community, staff, clients, or funding source. Implementing agencies must consider their accountability to properly implement any intervention. For WINGS, your agency could look at whether the funds designated for this intervention were spent on its needs, such as: facilitator salaries, benefits and training, marketing materials, and meeting space. Evaluation can help improve the quality of the content and delivery of the intervention by looking at what worked and what did not work. The evaluation plan created by your agency should identify specific goals of the implementation, length of session activities, number of participants to be recruited, and number of participants to attend WINGS. The information gathered can then be used to help your agency fine-tune its program by addressing the areas where your agency plan encountered problems. A monitoring and evaluation plan is available in Appendix II along with recommendations on how to implement the plan and sample forms for implementation.

Formative evaluation

Formative evaluation is the first type of evaluation that your agency should conduct. Formative evaluation is defined as the process of collecting data that describes the needs of the population and the factors that put the woman at risk for IPV. Formative evaluation is the same as the agency "needs assessment" for WINGS.

There are sample evaluation forms in Appendix II.

Process monitoring

Process monitoring is the next type of evaluation that your agency can conduct. Process monitoring is defined as the process of collecting data that describes the characteristics of the population served, the services provided, and the resources used to deliver those services.

Process monitoring answers such questions as:

How many WINGS intervention sessions did we conduct?

What resources have we used to deliver the intervention?

There are sample process monitoring forms in Appendix II.

Process evaluation

Process evaluation is the third type of evaluation your agency can conduct. Process evaluation is defined as the process of collecting more detailed data about how the intervention was delivered, differences between the intended population and the population served, and access to the intervention.

Process evaluation looks at whether the agency maintained fidelity to the intervention's Core Elements and what Key Characteristics the agency identified and adapted. Process evaluation is a quality assurance piece that ensures agencies are delivering WINGS and not some unproven variation of the intervention. Some sample questions include:

Was each Core Element presented as outlined in the manual?

Was the intended focus population enrolled?

Outcome monitoring

The last type of evaluation your agency can conduct is called outcome monitoring. Outcome monitoring is defined as the process of collecting data about client outcomes before and after the intervention, such as knowledge, attitude, skills, or behaviors. Outcome monitoring cannot be done until your agency has done formative evaluation, process monitoring, and process evaluation, and the intervention is being delivered as planned. Outcome monitoring looks at an outcome or change in behavior, such as increase in safety planning behaviors, and answers the question "did the expected outcome occur?"

Your agency may have an evaluation expert on your staff or may hire consultants to perform this analysis.

Planning for evaluation

Before your agency begins to implement WINGS, your staff members need to review the sample evaluation forms in Appendix III and adapt the forms to fit the planned implementation. The following questions need to be answered to plan the evaluation:

Formative Evaluation

What are the prevention intervention needs of your focus population?

Do you provide education and prevention services to women (e.g., heterosexual, same sex, transgender, etc.)?

Do you have the staff, funding, and resources necessary to implement WINGS?

Process Monitoring

What process data are required by the funding agency and in what format?

What other process data could be helpful to know and in what format will they be available?

What type of data collection form will be used?

How will the data be collected?

How will the data be compiled (a computerized data system, a single computer spreadsheet or a written spreadsheet)?

Who is responsible for each step?

How will quality assurance over the evaluation occur?

Process Evaluation

All the same questions as process monitoring, plus how will the comparison between the activities and progress be made and by whom and what actions will occur if discrepancies are found?

How will the results be used to improve intervention delivery?

Outcome Monitoring

What are the outcomes we expect from WINGS?

What outcome data can be collected and in what format?

What type of data collection form will be used?

How will the data be collected?

How will the data be compiled (a computerized data system, a single computer spreadsheet or a written spreadsheet)?

Who is responsible for each step?

How will the analysis be conducted and by whom?

How will the results be reported and to whom?

How will the results be used to improve the program?

Planning for possible legal and ethical issues

One crucial step in preparing for the intervention is setting up the proper policies and procedures that will protect participants, the WINGS facilitators, and your agency. It is important to keep in mind that WINGS is an intervention that deals with talking with WWUD about their experiences of IPV and substance misuse. Delivery experiences of WINGS have included disclosure of experiencing or perpetrating IPV, disclosure of bisexual orientation or experiences, appropriate engagement of gender-non-conforming participants, infidelities, drug or alcohol use, and other sensitive issues. With this in mind, agencies must know their state laws regarding reporting of IPV. Each state has its own set of laws and statutes regarding requirements to disclose to sex partners, and agencies are obligated to inform participants of any duty to warn spouses or sex/needle sharing partners. Your agency needs to have a consent form which explains carefully and clearly, in accessible language, your agency's responsibilities and the participants' rights. Agencies also need to inform participants about state laws regarding the reporting of intimate partner violence, child abuse, sexual abuse of minors, and elder abuse. If health information is shared by participants, this information should not be documented with identifying information. Documenting health information with identifying information is a violation of Health Insurance Portability and Accountability Act (HIPAA) regulations.

Marketing, participant recruitment, and participant retention

Marketing

Another step in preparing for implementation is marketing WINGS to your community. Stakeholders are another useful marketing tool because the members can advise your agency where to place the marketing information sheets and identify other ways to engage your focus population. Agencies may want to concentrate their recruitment efforts where there are substantial numbers of substance-using women. Advertising attempts need not be limited to traditional venues such as substance abuse treatment service organizations, clinics and support groups, but agencies can send fliers, press releases, and public service announcements to local religious organizations and radio and TV stations, or take out advertisements in local papers. You can also post information on the Internet. You are focusing on WWUD at risk of experiencing or perpetrating IPV, who demonstrate some commitment to keeping their relationship safe, so you can also brainstorm local agencies and settings that might serve the community.

Recruitment of participants

As previously mentioned, your agency should have a recruitment plan in place that details how participants will be recruited, recruitment venues and locations, recruitment/marketing tools, and number of participants to be recruited. Explore with staff some basic recruiting questions, such as:

Which of our clients might benefit from WINGS?

Where is the best place to recruit other women?

What are the best recruiting strategies for women in ongoing, sexual or dating relationships?

What might motivate women to attend WINGS?

What might motivate a person to invite their partner to attend WINGS?

Forms

The following section is an explanation of the forms in the package, their location, and how they are used in implementing WINGS. Appendix II contains participant and facilitator forms. The participant forms in Appendix II are the WINGS Participant Feedback Form. The facilitator evaluation forms are also in in Appendix II. Some of these same forms, and others, are also in Appendix V: Monitoring and Evaluation, where a monitoring and evaluation plan of WINGS is described in more detail.

Participant forms

The WINGS Participant Feedback Form

The WINGS Participant Feedback Form should be completed by each WINGS participant at the end of their session. It provides the facilitator and agency staff with feedback on the quality of the participant's experience with WINGS. This information can be used to make adaptations to WINGS for your agency as a supervisory tool to improve performance.

Facilitator Session Outline and Adherence forms

The Facilitator Session Outline in Appendix II is provided to assist facilitators in preparing to implement WINGS. This is a brief outline of the main exercises of the intervention onto which a facilitator may make notes.

The Facilitator Session Adherence Form is completed immediately after the session by the facilitator. The form is intended as a self-evaluation tool to assess how adequately the facilitators believe they covered each activity with notes on any unusual issues that arise. This form may also guide supervision to identify challenging areas as well as to track facilitator progress in mastering the delivery of WINGS.

Other session materials

Resource manual

Participants in WINGS will be asked to identify and prioritize any services they need to reduce their risk of IPV or other more pressing issues they are experiencing by selecting from a wide range of services. The Resource Manual should contain information on a variety of health and human services providers that would benefit any of your agency's clientele, including WINGS participants. These providers may include:

- social services offices
- local HIV/AIDS testing and services programs
- HIV and other STI medical treatment programs
- family planning services
- public sexually transmitted infections (STI) clinics
- housing
- drug and/or alcohol treatment programs
- homeless shelters
- domestic or intimate partner violence shelters
- hospitals
- medical and mental health clinics
- legal advocacy services
- employment services

Each entry in the Resource Manual should include: the name of the agency, address, phone number, contact person, hours of operation, services provided, fees/fee scale, and other information needed to achieve a successful referral. As necessary and appropriate, the facilitators should encourage participants to make use of these resources.

Your agency should compile the Resource Manual and make copies for each facilitator during pre-implementation. Providers included in the Resource Manual should be those that offer services or resources that complement those provided at your agency. Your agency should verify the information and update the Resource Manual at least once a year.

Other Implementation Materials (in Appendix I)

1. Screening Tool to Identify different types of IPV and IPV risk assessment score form
2. Safety Planning Tool
3. Social Network Enhancement Tool
4. Goal Card
5. Service Need Priorities
6. Resource Referral Handbook

Incentives

Offering participants small incentives for coming to WINGS is a nice way to both motivate and reward women for their work to reduce risk of IPV (if permitted by your agency). We recommend using incentives where budgets will allow, or finding local companies that can donate vouchers or coupons for incentives (e.g., a coupon for a free or reduced price on a menu item at a local restaurant). Other small incentives, such as key chains or flashlights, can be purchased inexpensively and in bulk from mail order firms.

Pre-Delivery Checklist

The pre-delivery checklist is a quick reference of items that should be in place before the WINGS session is delivered:

- ☐ Relationship with IPV service provider established
- ☐ Participants recruited
- ☐ Location selected and room set up
- ☐ Table for food/snacks (prepared and optional)
- ☐ Functioning laptop and internet connection (for WINGS computerized self-paced version)
- ☐ Session scheduled
- ☐
- ☐ Facilitation practice session held and completed
- ☐ Resource Manual developed and copied
- ☐ Supplies acquired
- ☐ Qualtrics Software Program for computerized WINGS version only
- ☐ Incentives obtained (optional)
- ☐ All other intervention materials

Supervision for WINGS Facilitators

WINGS deals with issues that may cause varied emotional responses for both the participants and the facilitators. Working with women who are experience severe or life threatening IPV and/or who are drug dependent can be a very challenging experience for facilitators. Supervision with a clinical supervisor is ideal for facilitators of WINGS. If individual supervision is not possible, then group supervision, or a debriefing, will at least allow facilitators time to release emotions related to implementing WINGS in a supportive space.

Your agency may have some specific methods for supervision; the following is designed to add to your agency's existing procedures.

Either the Program Coordinator or one of your agency's clinical supervisors, such as an Education Supervisor, Prevention Supervisor, or Participant/ Client Services Supervisor, would be well-suited to lead supervision sessions for facilitators. These sessions are an opportunity for facilitators to express their feelings about the intervention sessions. Supervision sessions also can be used to explore what is and is not engaging participants and what changes in delivery need to be made. Facilitators can seek advice or brainstorm solutions to issues or questions that came up during sessions with participants.

An excellent tool for supervision is the WINGS Supervision Checklist (in Appendix V). The WINGS Supervision Checklist should be filled out by the facilitators at the end of each WINGS session. It includes a checklist of activities that should have been covered in each session, as well as a series of questions related to the process of the session, which is also helpful for discussion in supervision. These WINGS Supervision Checklists can be used to guide supervision sessions as well as to inform the process evaluation of WINGS.

Here are some specific questions that can be asked in supervision sessions with facilitators:

Session Content and Process Notes:

Does the woman need referral appointments made for her?

Does the woman need help with transportation? Child care?

What went well?

What did not go well?

How could delivery of the session be improved?

What concepts did participants have trouble grasping (e.g., safety planning, goal setting, etc.)?

What concepts need to be reinforced the next time the session is implemented?

Facilitator Skills to Acknowledge and Reinforce:

Did the facilitator use the core principles and skills of Motivational Interviewing (e.g non-judgmental stance, demonstration of empathy, providing feedback on IPV risks, use of reflective listening, providing a menu of options) to deliver the WINGS session?

Was the facilitator aware of and did they validate any issues that the participant raised during the intervention regarding race/ethnicity, age, sexual orientation, and/or gender identity?

Did the facilitator praise positive intentions to reduce risks for IPV that the participant expressed?

Did the facilitator maintain a neutral "observer stance," presenting information or skills and coaching when appropriate, but emphasizing the woman as the expert on her own relationship?

Did the facilitator enable the woman to set appropriate goals based on the risks she identified?

Environment/Space Considerations:

Was the room too hot/cold?

Was the space quiet?

Could the participants be overheard? This is important for confidentiality. Agencies will have trained personnel in State and Federal Law regarding health information and confidentiality.

Were there enough snacks? (Optional. Be prepared for an emergency in case of health-compromised participants.)

How to conduct a supervision session

The purpose for the supervision session is to provide support and feedback to the facilitator.

Supervision may be provided by the Program Coordinator or an Education Supervisor, Prevention Supervisor, or Participant/Client Services Supervisor familiar with the WINGS intervention.

The supervision session should be conducted in an environment where the facilitator(s) can relax and voice their opinions, ask questions, and learn how to more effectively facilitate WINGS.

The facilitator(s) should be given 10-15 minutes to express both negative and positive feelings about the session, including content and process. The amount of time spent sharing may vary if more than one facilitator attends and there are multiple sessions to discuss.

The supervisor ideally should have some working knowledge of IPV prevention, but this is not necessary. Supervisors should be given a copy of the WINGS Implementation Manual and the Training of Facilitators (TOF) curriculum, and be familiar with the WINGS Core Elements, so that they may be reinforced.

Supervisors can use the following questions to help elicit feelings and opinions so that the facilitators can express and explain their emotions, thoughts, and actions.

› How did you identify with or feel about the participant in the session?

› What made you uncomfortable during the session?

› What was the highlight of the session?

› What was the low point of the session?

Supervision should be focused on ensuring that facilitators are able to get support, have questions answered, get direction about how to better engage the participant and balance their facilitation, how to remain neutral, and how to plan and/or brainstorm ways to handle session activities more effectively for their participants.

wings
Women Initiating New Goals of Safety
FACILITATOR'S GUIDE

What is a Facilitator's Guide?

This section of the Implementation Manual provides step-by-step instructions to deliver the WINGS intervention. It takes you through the WINGS intervention session in detail, guided by scripts. The intervention description begins with a listing of the session objectives, the agenda, materials needed, and the scripted activities.

Activities

All activities are guided by scripts and step-by-step instructions. The session was written explicitly for facilitators to use and it is not meant for participants to use alone.

Agendas

Agendas are given for each session with suggested lengths of time for each activity. Facilitators need to be flexible about the schedule. If participants are seriously discussing a topic of importance to them, they should be allowed to continue somewhat past the normal time limit for that segment. Facilitators should make adjustments to the agenda in each session as needed. Facilitators should not leave out any part of the session and should not keep the participants longer than the planned session length.

Scripts

The WINGS session activities are scripted for easy implementation. Scripts are in larger typeface and indented on the pages to make them easy to read. Scripts are not necessarily meant to be delivered word for word. Instead, they are guides to give facilitators language for the activities they are conducting. All facilitators are encouraged to become so familiar with the session scripts that they feel confident using their own words or paraphrasing to conduct each activity.

Appendices

The Appendices contain various materials relevant to the intervention; some may need to be adapted to the lives and cultures of the participants your agency serves. The Appendices have all of the support print materials that go with the session (e.g., Goal cards, WINGS Supervision Checklist), as well as resources and information to help implement WINGS. Sample materials can be printed or photocopied and enlarged as necessary, attached to cards if appropriate. They also may be handwritten, if preferred, on large paper, electronic devices, black/whiteboards, or index cards.

The materials in the Appendices can be adapted in any way appropriate for participants in your agency. For example, since there are many terms to refer to one's intimate partner, use the specific terms or jargon that women identify as more meaningful for them. Terms for gender expression and sexual orientation may be added as needed.

Another example of adaptation is if participants respond well to pictures, you may decide to enhance some activities with more photos or drawings to clarify major terms or processes highlighted in the text to accommodate different learning styles. Additional videos may be included as they are developed for modeling and content revisions.

Appendix I. Session materials

This appendix includes Goal Card and Goal monitoring form, Safety Plan, Social Support Network Enhancement Form.

Appendix II. Participant Evaluation form

There is one participant form: the WINGS Participant Feedback Form (PFF). The PFF is a process evaluation form that provides feedback from the individual participants who attend WINGS to find out what they liked best about and learned from attending WINGS. This form is completed at the end of the session.

Appendix III. Handling challenging situations and behaviors

This appendix describes challenging situations that may arise while implementing WINGS and how to handle them.

Appendix IV. Articles on original WINGS research

The article reporting the effectiveness of the Computerized Self-Paced and Facilitator version of WINGS after 3 months was published in *Criminal Behavior and Mental Health*.

The article highlighting the longer term effectiveness of the WINGS SBIRT model in an integrated HIV and IPV behavioral intervention (WORTH) on reducing IPV after 12 months was published in *American Journal of Public Health*.

The article reporting the effectiveness of implementing an integrated WINGS SBIRT and HIV Counseling and Testing model on reducing IPV and gender-based violence among women who use drugs in Harm Reduction Programs in Kyrgyzstan was published in *Drug and Alcohol Use Review*.

Appendix V. Guidelines for Computerized WINGS

1. Engage women as participants
    - Explain purpose/philosophy of WINGS
    - Address participants' questions or concerns
2. Raise Awareness about IPV and how it is associated with use of drugs and alcohol by women and their partners
3. Identify different types of IPV that participants may be experiencing and provide feedback on risk level of IPV
4. Elicit motivation for reducing relationship conflict and abuse
    - Identify personal values and positive reasons to reduce relationship conflict
5. Develop a safety plan to reduce risks of IPV
6. Identify sources of social support to address relationship conflict and abuse
7. Identify and prioritize service needs
8. Identify appropriate service referrals based on needs and develop a service action plan

WINGS Session Agenda

Welcome	5 min.
Raising Awareness about IPV	15 min.
Screening for IPV and providing feedback on risks	10 min.
Eliciting motivation to address IPV	10 min.
Safety Planning	10 min.
Social Support Building	5 min.
Relationship Safety Goals	5 min.
Service Need Identification	5 min.
Service Referrals and Plan of Action	5 min.
Complete Session:	60 min.

Session Materials
Goal Card and Goal monitoring form
Safety Plan
Social Support Network Enhancement Form

Welcome

To warmly welcome the participant to the session
To let them know about you and why you are doing the session
To communicate your enthusiasm about their participation in WINGS

5 minutes

Welcome to WINGS!

1. What will you learn as a WINGS participant?

To explain the benefits of WINGS

5 minutes

A. Welcome Participants to WINGS

Welcome to WINGS. My name is _____ and I will be working with you today on WINGS. I am delighted that you are interested in participating in WINGS. This is a program for women to evaluate and increase their relationship safety with their intimate partners.

I really enjoy being a part of WINGS because I believe that together we can work to help women in our community take steps to increase their safety in their relationships and reduce risks for intimate partner violence.

B. Ask and validate participants what they know about WINGS and correct any misperceptions

Elicit what participant knows about WINGS, affirm any perceptions of WINGS that may be accurate and correct any misperceptions
"Have you heard anything about WINGS?"

C. Review purpose of WINGS and discuss benefits for participants and their communities

WINGS stands for Women Initiating New Goals of Relationship Safety. WINGS aims to help women who use drugs or alcohol evaluate how safe they feel with their intimate partners and to develop strategies and support for reducing any risks for intimate partner violence. By raising awareness about the widespread problem of IPV in our community, we hope that we can work together to help women develop safer and healthier relationships.

D. Explain why you and your organization are involved in WINGS

We are committed to enabling women to identify risks for experiencing or perpetrating partner violence, and to develop strategies and support to increase their relationship safety and reduce their risk of partner violence. We hope that what you learn in this session will be helpful to you in staying safe in your current and future intimate relationships. We also hope that you can share what you learn from WINGS with other women you know to address the widespread problem of intimate partner violence in our community.

E. Review the outline of the WINGS session with participant and ask them if they any questions about WINGS

In the next hour, we will first discuss the different types of intimate partner violence and relationship conflict that women experience and talk about the ways in which the use of different drugs or alcohol may trigger or be triggered by relationship conflict and intimate partner violence. Then we will ask you to complete a screening tool on different types of intimate partner violence or relationship conflict you may be experiencing or perpetrating and will provide feedback on your risk level for IPV. Afterward, we will talk about the reasons you may have to reduce relationship conflict for your health and well-being,

Facilitator Tip

When working with women of transgender experience, be sure to ask about preferred pronouns.

Facilitator Tip

Be familiar with mandated reporting laws in your state and reporting protocols in your agency for addressing violence by an intimate partner and child abuse.

we will ask you to think about your goals for reducing relationship conflict or IPV, and we will discuss strategies you may use to increase your relationship safety. We will also talk about ways you can increase your social support and access to services to support your goals or improving relationship safety.

F. Review confidentiality protocol and ask permission to begin session

We know that some women are hesitant to talk about their personal issues for fear that others may find out and respond negatively. We again want to remind you that what you say here is confidential and may only be shared with my supervisor (add anyone else). The only time we are required to break this confidentiality is in order to seek help if we hear you intend to hurt yourself, if there's child abuse, or you have a homicidal plan toward someone else. Do you have any questions about this? Are you ready to begin the session?

G. Reinforce participant's decision to join WINGS

I'm really glad you've come to be part of WINGS.

2. Raising Awareness: Brief Psychoeducation on IPV and how it is associated with use of drugs and alcohol

To increase knowledge of and perceived risk for IPV

15 minutes

Introduce how relationship conflict and abuse can occur in loving, intimate relationships: present the positive and negative aspects of intimate relationships

Most relationships have good times and bad times. Intimate relationships can be an important source of support, love, and purpose in life. Conflict can arise when partners have different needs or expectations or when difficult things happen that are outside of both partners' control. While all relationships may

have positives and negatives, we'd like to spend some time today talking about conflict and abuse, which sometimes occur in intimate relationships. We would also like to point out that many women do not expect abuse or violence to happen in their relationships; sometimes things start off great, but over time their partners become more controlling and sometimes abusive. As we talk about these issues, we are not saying these all relate to you or even to people in your network, but you may find that some of the issues sound familiar

Facilitator Tip

As you cover the points in this section, check in with the woman to see if this information makes sense to her. Acknowledge and validate any reactions she may have to these points.

Ask participant if they know women who have experienced loving relationships that turned violent or hurtful.

a. The Cycle of Violence

This chart shows what many women experience when in abusive relationships. First, tension builds and the partner becomes more controlling. Then, the partner may feel like he or she loses control and an abusive incident occurs. Afterward, the partner apologizes and promises to change. Often in a situation like this the woman may have mixed feelings, and may feel that she is walking on eggshells, while other women may feel like it's never going to happen again.

Ask participant whether they know women in relationships who experience this cycle of tension and abuse

Refer to Cycle of Violence handout. Offer a copy to participant if she would like one and if it is safe for her to take a copy.

Introduce Power and Control Wheel and different types of IPV

Intimate partners may hurt each other physically, sexually, emotionally, psychologically and economically. All of these types of violence or abuse are often related to power and control. Such violence can occur from intimate partners who are female or male, and within relationships that are long-term or casual. Sometimes, women may choose to give up a certain amount of control that are keeping with their cultural traditions and customary roles, but we are talking about a type of forced loss of control that can lead to harm.

Ask women if they are familiar with the Power and Control Wheel

Have you ever heard of this wheel? Here is a power and control wheel that was developed for women who use drugs or alcohol which is also relevant for women whose partners use drugs or alcohol. Although substance using women and partners experience similar types of IPV, the specific strategies they use to take power and control in relationships often involve substance use. Refer to Power and Control diagram. Offer a copy to participant if she would like one and it is safe for her to take a copy.

Review each type of abuse in the Power and Control Wheel by first asking participants what they know about each type of abuse and how it affects women in their community

Physical Abuse: One type of violence includes physical abuse with behaviors such as shoving, pushing, slapping, hitting, kicking, pulling hair, or punching.

Ask participant what other ways partners may physically hurt women and what types of physical abuse that women who use drugs or alcohol in their community are likely to experience.

Review Psychological or Emotional Abuse

Psychological or Emotional Abuse: Emotional abuse occurs when a partner isolates a woman from her friends and family or uses controlling behaviors like calling frequently to check where she is, following her to see where she is going, telling her what to wear, who to talk to, or where she can go. Abuse may also occur when one partner tries to control the other partner by such behaviors as threatening to call ACS regarding her children or threatening to report her to the police or probation for criminal activity. Verbal abuse includes behavior such as screaming, yelling, threats, name-calling, putdowns or other angry words that make someone feel hurt, ashamed, or insignificant. Ask participant what other ways partners may physically hurt women and what types of psychological or verbal abuse that women who use drugs or alcohol in their community are likely to experience.

Facilitator Tip

Ask open-ended questions and use reflective listening to explore and acknowledge the different types of abuse that participants mention which are frequent among women in their community.

Review sexual abuse using power and control wheel

Sexual Abuse: Sexual abuse may include being forced to have sex or feeling pressured into unwanted sexual activity. Some examples of sexual abuse are if a partner pressures you to have oral or anal sex when you don't want to or if a partner takes sexual advantage of you when you are under the influence of drugs or alcohol.

Ask participant what other ways partners may sexually hurt women and what types of sexual abuse that women who use drugs or alcohol in their community are likely to experience.

Follow up with open-ended questions: What can happen to women in sexual encounters when their partners are under the influence of drugs or alcohol? What about when they are under the influence of drugs or alcohol themselves?

Economic Abuse: Economic abuse occurs when a partner attempts to make a woman financially dependent, takes her money, or forces her to sell drugs.
Ask participant what other ways partners may economically hurt women and what types of economic abuse that women who use drugs or alcohol in their community are likely to experience.

Ask participant: can you think of other ways that drug or alcohol use by women or their partners may trigger relationship conflict or abuse in intimate relationships, or how experiencing partner abuse may trigger problematic use of alcohol or drugs?

Make sure to mention that encouraging a women to be dependent on drugs or preventing her from getting drug treatment are forms of psychological abuse.

We have discussed a number of ways that the risk of experiencing or perpetrating IPV may increase when a woman or partner is dependent on or under the influence of drugs or alcohol, including (LIST). I want to mention here that encouraging a woman to be dependent on drugs or preventing her from getting drug treatment are also forms of psychological abuse that can occur in intimate relationships.

Does this make sense to you?

Facilitator Tip

Summarize the ways substance use of women and their partners may trigger intimate partner violence that you or the participant has identified in this section.

Review the scope of problem of IPV among women in general and women who use drugs and alcohol.

Approximately 1 in 4 women will experience physical or sexual IPV in her lifetime. Each year there are approximately 16,800 homicides and over 2 million medically treated injuries related to intimate partner violence.

Among women who use drugs or alcohol the rate of experiencing physical or sexual violence is 3-5 times higher than women who don't use drugs or alcohol.

Research suggests multiple pathways linking use of alcohol and different drugs among women and their partners to IPV. The involvement of women and their partners in getting and using drugs increases risk for all types of IPV. At the same time, the emotional and physical pain that women experience from relationship conflict or abuse are major triggers for drug and alcohol use. It can turn into a vicious cycle.

Facilitator Tip

Remember to roll with resistance if the participants indicate that IPV is a not a problem for the women in their community or for them. Use reflective listening to simply restate what they say with a question, "So it sounds like that IPV hasn't been an issue for the women you know?"

Ask participants if they are surprised or not surprised by these high rates of IPV among women?

Ask participants how IPV has affected their social network and reiterate the need for women to work together to address the problem of IPV in their community.

Take a moment and think about how the women you know who have been affected by intimate partner violence. How many women in your network of family, friends, neighbors and co-workers do you know are experiencing physical, sexual, psychological, emotional or economic abuse from their partners?

Because so many women experience violence in relationships, we are introducing the WINGS program to enable women in our community to take steps together to increase their relationship safety.

Ask women to identify any common negative physical or mental health consequences of experiencing IPV, and supplement their answers with the following information.

What are some common negative physical or mental health consequences that you think women who experience IPV may exhibit?

Women who experience abuse by their partners may develop sleep disturbances, sexual dysfunction, depression, anxiety, posttraumatic stress disorder, eating disorders, or female problems. They may become isolated, feel an intense loss of social connections, and may attempt suicide. Such abuse may also make it difficult for women to negotiate condom use with their partners and protect themselves against HIV and other sexually transmitted infections.

For women who are in recovery from alcohol or drug use, the experience of IPV and controlling behaviors from partners has been found to increase the likelihood of relapse and of dropping out of substance abuse treatment.

What are some negative consequences of IPV on children?

Exposure to violence can also have lasting consequences for children. Kids who see or hear violence often experience grief, fear, and anxiety. Boys who witness violence between their parents are ten times more likely to abuse their partners when they become adults. Girls who witness parental violence are much more likely to be abused by their partners when they grow up.

What are some negative consequences of drug or alcohol misuse of women on their recovery?

Sometimes alcohol and drug use make the pattern of violence worse. People who use drugs and alcohol are more likely to commit acts of violence against their partners. Women who are under the influence of drugs or alcohol may be less likely to escape or resist abusive situations. When an intimate partner keeps someone from attending treatment or threatens to hurt them if they use or don't use drugs, this is a kind of abusive behavior.

What can happen if women get angry and fight back their partners?

Some women who experience violence in relationships may become angry and want to fight back. By fighting back, women may put themselves at risk for

Facilitator Tip

The idea of asking open-ended questions to elicit negative consequences from women is not only to make this activity interactive, but to validate participants' existing knowledge of IPV through reflective listening. This will help build their motivation and confidence to address any IPV they may be experiencing.

receiving criminal charges or going to jail. Women who experience intense relationship conflict are also more likely to turn to drugs or alcohol to cope with the pain from the abuse. This may also increase their risk for being arrested for drug-related charges.

Summarize the range of different health and social consequences that participant and you discussed.

Example: You mentioned a number of different health consequences, including.... You also indicated how IPV may negatively affect the mental health of children. In addition, we discussed how if women fight back they risk being arrested.

Introduce and ask participants to identify barriers to identifying and getting help for relationship conflict or abuse among women who use drugs and alcohol.

Although the problem of IPV is widespread among women who use drugs or alcohol, research suggests only 1 in 20 ever receive any services to address IPV. There are many reasons why women may not want to disclose or get help to address abuse. What do you think are some reasons that women who use drugs may not want to talk about or take steps to address the abuse?

Summarize the reasons that women provide and supplement with additional reasons:

> As we mentioned before, some women may genuinely love their partners and may not want to rock the boat or get them in trouble.
>
> Many women feel that their partner is not the typical abuser or that they are not the typical victim. Women sometimes also want to protect their partners or believe that no one else is going through what they are or will understand their situation.
>
> In addition, women who depend on their partners for housing, child care, money or drugs may be especially reluctant to do anything that will jeopardize their relationship.
>
> For all these reasons and more, some women find it hard to talk about relationship abuse or to get help.

To identify different types of IPV that women may be experiencing or perpetrating and provide feedback on their risk level (no, some, or high risk).

10 minutes

A. Recognizing Relationship Conflict: Introduce Screening Tool for Relationship Satisfaction and IPV

Introduce Purpose and Procedure of Screening Tool. Remind Participant of confidentiality issues and offer support in advance for any distress they may experience during the screening.

"Now you're going to complete a screening on how safe and comfortable you feel in your relationship with your intimate partner(s). We'll be talking about recognizing relationship conflict and different types of abuse now. Remember that you answers are confidential, except if you disclose child abuse, suicidal or homicidal behaviors. No one will see your answers to this survey – your name or confidential information is not attached to it."

"What we talk about might be upsetting to you, especially if it touches on something that's going on in your life. Please remember that we're here to help. "

B. Administer Screening Tool

Facilitator Tip

Read these questions word for word and try not to make any comments on participant responses until you finish the screening tool. If participants do not understand the question, try to repeat it slowly and ask them if they understand, rather than changing the wording of the question.

WINGS Screening Tool

1. In the past year, has your partner(s) showed respect for your feelings about an issue?	❍ No	❍ Yes
2. In the past year, has the relationship with your partner been important to you?	❍ No	❍ Yes
3. In the past year, has your partner(s) called you insulting names, such as fat or ugly, slut or whore, destroyed something that belonged to you or accused you of being a lousy lover?	❍ No	❍ Yes
4. In the past year, have you called your partner insulting names, destroyed something that belonged to your partner or accused your partner of being a lousy lover?	❍ No	❍ Yes
5. In the past year, has your partner(s) twisted your arm, or thrown something at you that could hurt, or pushed, grabbed or slapped you?	❍ No	❍ Yes
6. In the past year, have you twisted your partner(s) arm or thrown something at your partner(s) that could hurt, or pushed, grabbed or slapped your partner(s)?	❍ No	❍ Yes
7. In the past year, has your partner(s) kicked you, slammed you against a wall, beaten you up, or burned or scalded you on purpose?	❍ No	❍ Yes
8. In the past year, have you kicked your partner(s), slammed your partner(s) against a wall, beaten your partner(s) up, or burned or scalded your partner(s) on purpose?	❍ No	❍ Yes
9. In the past year, have you had a good relationship with your partner(s)?	❍ No	❍ Yes
10. In the past year, have you been able to count on your partner(s) to help you out if you had a problem?	❍ No	❍ Yes
11. In the past year, has your partner(s) choked you?	❍ No	❍ Yes
12. In the past year, has your partner(s) punched or hit you with something that could hurt or used or threatened to use a knife or gun on you?	❍ No	❍ Yes
13. In the past year, has your partner(s) insisted you have sex even though you didn't want to?	❍ No	❍ Yes
14. In the past year, has your partner(s) forced you to have sex without a condom?	❍ No	❍ Yes

15. In the past year, has your partner(s) threatened or forced you to have sex (like hitting, holding down, or using a weapon)? ❍ No ❍ Yes

16. In the past year, has your partner(s) showed you that s/he cared even though you disagreed? ❍ No ❍ Yes

17. In the past year, has your partner(s) said s/he was sure you could work out a problem together? ❍ No ❍ Yes

For the next series of questions, please let us know how often the behavior has occurred. Answer options include never, only once, once a month, once a week, and daily.

18. In the past year, your partner has told you that you weren't good enough. ❍ Never ❍ Once ❍ Once a month ❍ Once a week ❍ Daily

19. In the past year, your partner followed you. ❍ Never ❍ Once ❍ Once a month ❍ Once a week ❍ Daily

20. In the past year, your partner tried to turn your family, friends, and children against you. ❍ Never ❍ Once ❍ Once a month ❍ Once a week ❍ Daily

21. In the past year, your partner tried to keep you from seeing or talking to your family or friends. ❍ Never ❍ Once ❍ Once a month ❍ Once a week ❍ Daily

22. In the past year, your partner blamed you for causing their abusive behavior. ❍ Never ❍ Once ❍ Once a month ❍ Once a week ❍ Daily

23. In the past year, your partner harassed you over the phone or through texts . ❍ Never ❍ Once ❍ Once a month ❍ Once a week ❍ Daily

24. In the past year, your partner told you that no one would ever want you. ❍ Never ❍ Once ❍ Once a month ❍ Once a week ❍ Daily

25. In the past year, your partner tried to convince your friends, family, or children that you were crazy. ❍ Never ❍ Once ❍ Once a month ❍ Once a week ❍ Daily

C. Provide any positive feedback on Relationship Satisfaction questions (#1, 2, 9, 10, 16):

"Your answers suggest that overall you have had a good relationship with your partner and that you have cared for each other even when you have disagreed. "

D. Calculate Risk with Participant and Provide Risk Rating for IPV based on following scoring criteria using suggested text below.

"Let's take a minute and figure out your risk rating based on your answers."

Severe Risk for Relationship Conflict or Intimate Partner Violence (Any of the following: Yes on 11 (choking), 12 (punched), 15 (forced sex); once a month or more on 19 (followed you); only once or more on 22 (blamed you for causing abuse):

"From your answers, it looks like there is a serious concern about safety in your relationship. I'd like to ask a few more questions about how you are influenced by the relationship, and then I'd like to go through some steps of safety planning to make sure that you are prepared in case conflict gets out of hand."

> What, if any, concerns do you have about your safety in this relationship?
>
> Do you feel that the abuse has been getting worse, better, or has remained the same over the past year?
>
> What is the worst episode of any abuse or violence that you have experienced in the past year?
>
> How did you respond to this episode?
>
> What would you like to happen in your relationship at this point?

E. Provide summary of concerns about relationship based on participant answers

Reflect back any concerns that violence is getting worse or is life-threatening, and ask participant if they share concerns. Instill realistic hope that participant can take steps to increase her safety.

"I am concerned that you mentioned that physical violence has become more severe and frequent over the past year. It could become life-threatening. What do you think? …It sounds like you have developed some strategies to avoid your risk by staying away from your partner when he is drunk. However, hopefully the next activities will also be helpful to you in reducing your risk for this violence."

Some Risk (Any of the following: Yes on 3, 4, 5, 6, 7, 8, 13, 14; only once or more on 18, 20, 21, 23, 24, 25; only once on 19):

"From your answers, it looks like there are some concerns about safety in your relationship. I'd like to ask a few more questions about how you are influenced by the relationship, and then I'd like to go through some steps of safety planning to make sure that you are prepared in case conflict gets out of hand."

No Risk (None of the above indicators):

If participant identifies no risk factors for abuse, you can let them know that they may leave or continue the session to be able to help family members or friends who are experiencing abuse.

"From your answers, it doesn't look like you are experiencing serious relationship conflict, You are free to leave at this point, but if you would like you can stay here to continue learning about how to help your family or friends who may be experiencing serious relationship conflict or intimate partner violence."

4. Eliciting Motivation to address relationship conflict or abuse

To increase motivation (i.e positive intentions and outcome expectancies) for reducing relationship conflict or abuse

10 minutes

a. Ask participants to identify some negative health, social, economic or legal consequences of relationship conflict or abuse that they have experienced or that women they know have experienced if they report no abuse in the screening.

"Relationship conflicts with partners – which may include emotional, physical, or sexual abuse – are common triggers for using drugs and alcohol to cope with the emotional and sometimes physical pain. Violence often causes women in recovery to relapse and drop out of treatment.... What are some negative health, social, economic or legal consequences that you have experienced from relationship conflict or abuse with your partner (or that women you know have experienced)?"

b. Summarize Cons of Relationship Conflict and ask participants to complete the following questions to elicit any additional concerns about the relationship conflict they are experiencing.

"You mentioned a number of concerns related to the relationship conflict that may be affecting you and your children, including.... Next I will ask you some additional questions about any other concerns you may have about the relationship conflict you may be experiencing.

Are you concerned that relationship conflict or abuse:

Facilitator Tip

Use reflective listening to validate and amplify concerns that participants mention. Ask open-ended questions to explore concerns further. Example: "You mentioned that you are concerned that the relationship conflict is not good for your children. Can you tell me a little more about in what ways it is negatively affecting them?

1. Makes you feel sad or depressed	YES	NO	MAYBE
2. Makes you feel anxious, stressed out, or on edge	YES	NO	MAYBE
3. Makes you feel isolated from your friends and family	YES	NO	MAYBE
4. Makes you feel like using drugs or alcohol	YES	NO	MAYBE
5. Makes you feel hopeless or helpless about your future	YES	NO	MAYBE
6. Makes you feel bad about yourself	YES	NO	MAYBE
7. Is negatively affecting your children	YES	NO	MAYBE
8. Makes you feel like you may end up fighting back or hurting your partner and risk getting charged with assault	YES	NO	MAYBE
9. Is contributing towards physical problems that you are experiencing like headaches, stomach problems, body pains, or female problems	YES	NO	MAYBE
10. Makes you feel like you may be injured in a fight	YES	NO	MAYBE
11. May expose you to HIV or sexually transmitted infections because of unsafe sex	YES	NO	MAYBE
12. Might lead to you becoming pregnant	YES	NO	MAYBE
13. Other concerns that you have (list):	YES	NO	MAYBE

c. Summarize How Relationship Conflict Makes Participant feel

You answered that relationship conflict gives you these feelings and concerns:

It makes you feel… (Summarize from answers above)
You are concerned… (Summarize from answers above)

For those who listed no concerns: It looks like from your answers that at this point you don't have any concerns about relationship conflict or abuse with your partner.

d. Elicit Reasons to Reduce Relationship Conflict and Improve Safety

"After considering the different negative ways that relationship conflict may be affecting your life and your family, what are some reasons why it

would be important for you (or the women you know) to reduce conflict?"

Summarize reasons to reduce relationship conflict and improve safety.

e. Ask participant to complete the following checklist of reasons they may have to reduce relationship conflict.

I will ask you a few questions to see if you have any other reasons that you may want to reduce relationship conflict and improve safety that we haven't discussed yet.

Do you want to feel better about yourself and your future?	YES	NO	MAYBE	N/A
Do you want to feel less isolated from your family or friends?	YES	NO	MAYBE	N/A
Do you want to improve the quality of life for your kids or other family members who are affected by the relationship conflict?	YES	NO	MAYBE	N/A
Do you want to stop feeling scared or anxious when you are around your partner?	YES	NO	MAYBE	N/A
Do you want to improve the relationship you have with your partner?	YES	NO	MAYBE	N/A
Do you want to stop feeling trapped in the relationship?	YES	NO	MAYBE	N/A
Other reasons to reduce relationship conflict:	YES	NO	MAYBE	N/A

f. Summarize motivation and any additional reasons that participants indicate on the checklist to reduce relationship conflict and improve safety

"We hope this activity has been helpful to you in thinking through what role the relationship with your partner plays in your life and thinking through why you may want to reduce relationship conflict or reduce your risk for being hurt by your partner. You identified several reasons to improve your relationship safety, including… If it seems challenging or overwhelming to take steps to address the relationship conflict with your partner, it is important to remember these reasons."

g. Ask participants to rate their motivation and confidence level to reduce relationship conflict or abuse.

On a scale of 1 to 10, how important is to you to reduce relationship conflict now?

On a scale of 1 to 10, how confident are you that you can steps to reduce conflict?

If participant indicates a high rating for importance, ask:

What make it important for you to address the issue?

h. Summarize reasons for addressing violence or hurtful behaviors back to them to reinforce motivation.

If participant indicates a low rating, ask:

You noted that it falls as a (XXX) for you. What makes it a low priority?

Then ask:

What are some reasons that might make you want to take steps to reduce your risk or experience of abusive and threatening behaviors?

Enter reasons here, then summarize reasons back to them to build motivation for addressing this issue:_

If participant indicates a high rating for confidence, ask:

What makes you feel confident about addressing the issue?

i. Summarize reasons to help client build confidence and self-efficacy that they can take steps to reduce their risks of experiencing abuse and threatening behaviors from others.

If participant indicates a low rating (e.g. 3), ask:
What makes you feel not confident about taking steps to reduce abuse or threatening behaviors?

j. Summarize reasons back to the participants and val-

Facilitator Tip

This rating scale should help you assess how much you need to focus on building motivation and/or confidence with participants to increase the likelihood that they will follow through with their relationship safety goals.

idate any difficulties they face for not being able to reduce risk or not feeling confident.

Let them know that the purpose of today's session is to help them identify small steps and strategies they can take to reduce their violence. From here, you want to help them figure out what would help them feel more confident that they can address this issue.

Example: You rated yourself as a 3. What makes you rate yourself a 3 and not a 6? What would help make you feel more confident? We recognize that it can be really difficult sometimes for women to takes steps to protect themselves from being hurt by others. Our goal today is to identify ways and small steps that you can take to reduce your risk of abuse.

5. Create a Safety Plan

To develop a personalized safety plan to reduce risk of being physically or sexually hurt by a partner

10 minutes

a. Introduce the concept of a safety plan and explain how it can help women prevent abuse by a partner

"If you or a family member or friend is experiencing relationship conflict or abuse by a partner, there are steps you can take to reduce conflict and help to prevent being hurt by a partner. You can reduce your risk for being hurt by your partner by coming up with a safety plan that will outline several specific strategies you can use to reduce your risk of being physically or sexually hurt by a partner.

b. Strategies for Safety During a Violent Incident

Women cannot always avoid violent incidents. In order to increase safety, women may use a variety of strategies. You can use some or all of the following strategies to stay safe.

Safety Plan

This plan is for:

_____
Name

It is a good idea to practice how to get out of your house or apartment safely. What doors, windows, elevators, stairwells, or fire escapes would you use? Consider which exits are safest. Below, write down how you would get out.

- ☐ If I decide to leave, I will: _____
- ☐ In order to leave quickly, I can keep my purse, identification, and metro card (or bus/train fare) ready and put them (place): _____
- ☐ I can tell a person that I trust about the violence and request that they call the police if they hear suspicious noises coming from my apartment. One person I can tell is: _____

  Another person I can tell is: _____
- ☐ I can teach my children how to use the telephone and dial 911 to contact the police and the fire department.
- ☐ I can use a code word with my children or my friends so they can call for help. My code word will be: _____
- ☐ It's a good idea to decide where you can go if you have to leave your apartment. Decide this even if you don't think you will experience another violent incident. If I have to leave my home I will go to: _____
- ☐ I can also teach these strategies to some or all of my children.
- ☐ Try to avoid arguments in the bathroom, and kitchen, near weapons, or in rooms without access to an outside door.
- ☐ When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as: _____
- ☐ I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I am/we are out of danger.

Safety Tip

CODE WORDS should not raise suspicion from partner, but should not also be "every day" language that might confuse people. Some examples of code words are "Aunt _ _ _ has not returned my phone call today." Code words for children need to be appropriate for their age. For example, a code word for a 13-year old girl may be "Your cousin _ _ _ called you today and wants you to call her back today". For a younger child "Your grandmother called today and wanted to talk with you about something."Most children under the age of 5 will be too young to understand how to operate under code language, you will need to figure out who you can trust with this task.

You will be given or mailed a copy of this safety plan. Do you have a safe place to keep the safety plan at home or with a friend?

You will also get a list called 'Items to Remember' that provides a suggested list of things to take with you if you have to leave. Where can you keep this list?

Do you have a safe place to keep the 24-hour hotline number and other important numbers?

Safety When Preparing to Leave

A woman may have to leave the residence she shares with her partner when her partner is out of control. Leaving must be done with a careful plan in order to increase safety. A violent partner often strikes back if he or she believes that the woman is leaving a relationship. I can use some or all of the following safety strategies:

- [ ] So that I can leave quickly, I will leave money and an extra set of keys with: _____

- [ ] I will keep copies of important documents (social security cards, birth certificates, immunization records) or keys at: _____

- [ ] It's important to become financially independent. To get help with becoming financially independent from your partner, call 1-800-873-2227 for free assistance in financial matters.

- [ ] To increase my independence, I will open a savings account by (date): _____

  Other things I can do to increase my independence include: _____
  _____

- [ ] Call 311 and ask for the NYC Domestic Violence Hotline (800-621-4673 or 866-604-5350) if you need counseling, legal assistance or emergency housing. If you are feeling threatened by your partner or in more immediate danger, call 911 for the police.

- [ ] If you use your cell phone, the following month the telephone bill may tell your partner those numbers that you called after you left. To keep your calls confidential, you must either use coins at a pay phone or use a calling card for a limited time when you first leave.

- [ ] It is important to find people who will let you stay with them or lend you some money. I will check with the following people to see if I can stay with them or borrow money:
  _____
  _____
  _____

I can leave extra clothes with: _____

Safety Tip

It is a good idea to exchange code words or gestures with these contacts in advance to signal that you need their help to leave your partner.

☐ It's important to review your safety plan occasionally. How often will you sit down and review your safety plan? _____

☐ Ask a trusted friend or advocate to help you review your plan.
The person I will ask is: _____

☐ I will rehearse my escape plan and, as appropriate, practice it with my children.

Sexual Safety Planning

Below are some sexual risk situations that you or women in your community may experience.

☐ If I'm concerned that a partner may insist on engaging in sexual activity that I don't want to do; I can take the following steps to avoid having sex with him or her:

List steps: 1. _____
2. _____
3. _____

I can also do the following: Check all that apply:

- ❍ Tell my partner that I'm too tired or not in the mood for sex.
- ❍ Tell my partner that I need to go visit a family member or friend.
- ❍ Tell my partner that I am sick or coming down with a flu/virus.
- ❍ Leave my partner and find another place to stay for the night.
- ❍ Avoid being in bedrooms or other private rooms with my partner.
- ❍ Ask a friend or family member to stay with them.
- ❍ List names of two friends/family members I can call to stay with:
  Contact person/numbers_____
  Contact person/numbers_____

Safety Tip

It is always helpful to let these key contacts know in advance if you think you might need to stay with them, and work out a plan so that you can get into their home if they are not around.

☐ If my partner or I are under the influence of alcohol or drugs and I am worried that my partner might take sexual advantage of me; I can take the following steps to avoid having sex with him or her.

List steps: 1. _____
2. _____
3. _____

☐ If I am having sex with my partner and am concerned that he or she may sexually hurt me, I can take the following steps to protect myself.

List steps: 1. _____
2. _____
3._____

I can also do the following things (Check all that apply):

❍ Try to stay physically on top of my partner during sexual activities so I can escape if I need to.
❍ Let my partner clearly and calmly know that I don't want to have sex.
❍ Tell my partner I need to go see a family member or friend who is in trouble.
❍ Have all my important personal belongings and my clothes in one place so I can leave quickly and figure out the easiest way to escape.
❍ Keep emergency cash or credit card in my purse to get a taxi or public transportation to a safe place.
❍ Text or call my contacts above to let them know I need a place to go to or ask them to meet me.

To protect myself from HIV or sexually transmitted infections and pregnancy with my partner, I wi ll:_____ (Describe Plan)

I can also do the following (Check All that Apply):

❍ I can ask my partner to use a condom.
❍ I can use a female condom.
❍ I can avoid having vaginal or anal sex.
❍ I can use other forms of contraception (note: only male and female condoms are effective in preventing HIV or STIs).

If I had unprotected sex and think that I may have been exposed to HIV or think I may be pregnant, I can also (Check that all that apply):

❍ See my doctor or emergency care medical staff within 48 hours and ask them to start me on a low dose of anti-retroviral medication to prevent getting HIV.
❍ Get tested for HIV and other STIs
❍ Go to the pharmacy to pick up Plan B in 48 hours to prevent pregnancy

Summarize the key points of the safety plan for participants and any issues that remain unresolved in the plan. Validate and affirm the participants' ideas for and engagement in the safety plan as taking a major step forward in protecting themselves.

6. Expanding and engaging social support network to improve relationship safety

To develop a plan and goals to increase social support to improve relationship safety

5 minutes

A. Ask participants to identify members in their social network who can provide emotional and practical support to them.

Introduce Social Support Mapping Activity

In addition to coming up with a safety plan, it may also help for you to be able to reach out to family and friends who you can turn to for help, advice, and emotional support if you are feeling afraid that your partner might hurt you. There may also be times when it is safer for you to stay with a friend or family member. Your friends or family may also help you out by taking care of your children or pets or helping you financially if you need to leave.

"Different people may be able to help you in different ways. For example, it may be easier to talk with a friend about your relationship problems but ask your aunt for a place to stay. Let's take a few minutes and help you identify who is in your network and who you can turn to for different types of support using this mapping activity. (See Social Support Map Handout)

Ask participant to create map by answering the following questions:

1. Can you tell me the names of one to five people that you trust? Let's write their names onto the birds on this tree.
2. Which of these people can give you emotional support? We'll mark these with a heart.
3. Which of these people can give you practical support, like giving you a place to stay, watching your pets, or lending you money? We'll mark these

with a star.

Ask participants to identify steps they can take to expand and strengthen their social network by reaching out to supportive members.

Can you think of two things you can do to strengthen your support from family or friends in the next week? This may be calling someone who you like to hang out with to get together for coffee or go for walk so that you have a chance to connect with him or her. It may mean calling, texting, e-mailing, or sending a letter to someone who you have lost touch with but who you would like to re-connect with. It may mean choosing someone who you trust and respect to talk with about the relationship conflict or abuse that you are experiencing so that you can get their advice or support on how to deal with it.

Looking at your social network map that you created, what are some ways that you think you can expand or strengthen your relationships with family member or friends who you can turn to for practical and emotional support?

What else can you do?

Summarize ideas, steps or strategies that participant comes up with for expanding and strengthening their network. Then ask them to identify two specific steps they can take in the next week to strengthen their support.

In the next week, I can do the following to strengthen my support _____

_____

In the next week, I can also do the following to strengthen my support: _____

_____

Validate and affirm the participant's ideas for and engagement in strengthening their social support network as taking a major step forward in protecting themselves.

Facilitator Tip

Ask follow-up open-ended questions and use reflective listening and summarizing to help clients think through specific details of when, where, and how they will take steps to strengthen their network.

7. Setting goals to improve relationship safety

To identify overarching goal and outcome for improving relationship safety

5 minutes

A. Identify goals and outcomes for relationship with partner

Let's take a moment and identify the relationship safety goals or outcomes you want with your partner.

If you could choose the best outcome (s) for you and your partner to reduce relationship conflict, what would it be?

My partner and I stay together, with no change

My partner and I stay together. Stop emotional abuse.

My partner and I stay together. Stop physical abuse.

My partner moves out and we have no further contact.

My partner moves out, but continues to be involved with me.

My partner moves out, but continues to be involved with my children.

A. What other outcomes do you hope for with your partner?

Use reflective listening and summarize what the participant would like to happen with their partner to improve relationship safety. Acknowledge any discrepancies and normalize uncertainties that participant may have about these relationship outcomes.

B. Help participant identify personal triggers for relationship conflict or abuse.

What are the main issues that may trigger relationship conflict or physical, sexual, psychological, or economic abuse with your partner?

C. Use reflective listening to acknowledge triggers that participant identifies then ask her if any of the issues below are contributing to relationship conflict or abuse.

(select all that apply)

A. Partner's mental health issues or problem

B. Partner's unemployment

C. Partner's drug or alcohol issue

D. Partner's legal problems

E. Conflict over financial problems

F. Lack of communication with partner

G.Conflict over children

H.Conflict over family and friends

I. My drug or alcohol use

J. My mental health issues or problems managing anger

K. My legal problems

L. Housing problems

D. Summarize the different triggers for relationship conflict or abuse that participant identifies and ask her what she thinks are the triggers that are most important to address

8. Identifying, Prioritizing and Pursuing Service Referrals to improve relationship safety

To identify services that will best address triggers for conflict or abuse and develop a service plan of action

10 minutes

A. Introduce Service Planning Activity

Now you're going to answer some questions about the types of issues that can trigger or contribute to relationship conflict or abuse. Then you'll learn about services and organizations that might be able to help you with your particular needs.

B. Ask participants what services might help her address these triggers and reduce relationship conflict and abuse and then ask her to complete service checklist.

What services might help you work towards these goals with your partner? What else? Let's go through this checklist to see if you may be interested in any other services at this time that may help improve your relationship safety or your well-being in general.

Service Checklist

(select all that apply)

- ❍ Job training for self or partner
- ❍ Help getting housing
- ❍ Legal assistance (i.e. assistance getting restraining order, divorce or child custody)
- ❍ Counseling from a religious organization (pastor, priest, rabbi)
- ❍ Couples/Marital counseling
- ❍ Education/Go back to School/GED
- ❍ Recreation/Social Activities
- ❍ Safety day care for children
- ❍ Mental Health Counseling for self or partner
- ❍ Alcohol and/or drug abuse counseling for self or partner
- ❍ Anger management or batterer's treatment program for partner or self
- ❍ Counseling or group support to deal with partner abuse
- ❍ Emergency domestic violence shelter or residential program
- ❍ Other services that might help you: _____

B. Summarize services that participant identifies and ask her to prioritize service needs

Out of these services, which one is the most important, or addresses your most immediate or life-threatening issues?

_____

Ask participant to list top three service needs in a rank order of importance and then review service manual to identify service organizations that would be best able to meet these needs.

Facilitator Tip

To help participants achieve goals, ask open-ended questions to enable to visualize when, when, where, and how they will achieve a specific goal. Remember the acronym SMART Goals --
S=Specific
M=Measureable
A=Attainable
R=Realistic
T=Time bound

C. For each service, identify agency or organization that would work best for her. If possible, try to find one agency that covers two or more service needs to reduce burden of going to different agencies for participants.

(Open the service manual to the appropriate page)
Here is a selected list of organizations that provide the service you just selected as the most important to you. You can keep this booklet or we can mail it to you.

D. Develop a Service and Self Care Action Plan with Participant

What are you going to do in the next week to address your most important service needs?

_____
_____
_____

What are you going to do in the next week to take time for yourself? Some ideas including going for a walk, writing, taking a bubble bath, creating art, or going to a nail salon.

_____
_____
_____

E. Summarize social support, service and self care goals for participants.

Ask participants how they envision working on each goal in the next week using the SMART goal approach (see Faciliator Tip).

Ask participants to write down the goals they set for themselves using the Goal Cards in Appendix I.

9. Summarizing and Wrapping-up of Session

To highlight progress participant made in session towards thinking about and making plans to increase relationship safety and identify any steps

5 minutes

B. Summarize any progress (e.g. specific incremental steps) that participant made during session towards addressing relationship conflict. Acknowledge any challenges or ambivalence that participants may have about dealing with conflict and validate any strengths or abilities that participants demonstrated in thinking about or taking steps to address.

Thank you so much for meeting with me today and taking the time to discuss this important issue that affects many women. We hope that the information I have shared will be helpful for you and for other women you know who face relationship challenges. You have shown real thoughtfulness in considering the different ways relationship conflict is affecting you and your children. You also identified several steps you can take to expand your social support network and enact your safety plan to reduce your risk of being hurt by your partner.

Reducing conflict is not easy. Sometimes partners can work together to make changes and ensure their relationship will be respectful and safe. Sometimes one partner needs to end the relationship in order to keep herself or her children safe. This is a personal decision, but having support can help women spread their WINGS and choose safety.

We hope you can find support and power within yourself, and also be a support to others.

Thank you again for your time and your participation.

Facilitator Tip

As you summarize participants' progress, try to be as specific as possible about certain steps or ideas they came up with during the session. The idea here is to build their confidence in their abilities to continue taking steps to reduce relationship conflict.

Getting a Copy of Your Plan

Would you like to receive a printed copy of the safety plan and items we've talked about today, or would you prefer to have these sent by email, mailed to you, or mailed to another address?

Provide participant your card or a card with agency contact information and let them know they can call you or someone else in the agency if they have any questions about service referrals or concerns about IPV that they would like to discuss in the future.

Thank the participant for the effort they made in coming to and engaging in the session.

wings

Women Initiating New Goals of Safety

APPENDICES

Appendix I. Session Materials

a. Goal Card and Goal monitoring form

b. Safety Plan

c. Social Support Map

d. Cycle of Violence

e. Power and Control

Goals Cards

MY GOAL:

TARGET DATE:

Goals Cards

MY GOAL:

TARGET DATE:

Goals Cards

MY GOAL:

TARGET DATE:

Goals Cards

MY GOAL:

TARGET DATE:

Goals Monitoring Form

1. Participant ID number: _ _ _ _
2. Date of Goal Setting: __ __/ __ __/ __ __ (dd/mm/yy)
4. Location: __ __ __ __ __ __ __ __ __
5. Staff ID: __ __ __ __

Let's identify the goals you most want to pursue.

If you could choose the best outcome(s) for you and your partner, what would you choose? (Select all that apply.)

- ❍ A. My partner and I stay together, with no change.
- ❍ B. My partner and I stay together. Stop emotional abuse.
- ❍ C. My partner and I stay together. Stop physical abuse.
- ❍ D. My partner moves out and we have no further contact.
- ❍ E. My partner moves out, but continues to be involved with me.
- ❍ F. My partner moves out, but continues to be involved with my children.
- ❍ G. Other desired outcomes:

_____

_____

Safety Plan

This plan is for:

_____
Name

It is a good idea to practice how to get out of your house or apartment safely. What doors, windows, elevators, stairwells, or fire escapes would you use? Consider which exits are safest. Below, write down how you would get out.

- [ ] If I decide to leave, I will: _____
- [ ] In order to leave quickly, I can keep my purse, identification, and metro card (or bus/train fare) ready and put them (place): _____
- [ ] I can tell a person that I trust about the violence and request that they call the police if they hear suspicious noises coming from my apartment. One person I can tell is: _____

  Another person I can tell is: _____
- [ ] I can teach my children how to use the telephone and dial 911 to contact the police and the fire department.
- [ ] I can use a code word with my children or my friends so they can call for help. My code word will be: _____
- [ ] It's a good idea to decide where you can go if you have to leave your apartment. Decide this even if you don't think you will experience another violent incident. If I have to leave my home I will go to: _____
- [ ] I can also teach these strategies to some or all of my children.
- [ ] Try to avoid arguments in the bathroom, and kitchen, near weapons, or in rooms without access to an outside door.
- [ ] When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as: _____
- [ ] I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I am/we are out of danger.

Safety Tip

CODE WORDS should not raise suspicion from partner, but should not also be "every day" language that might confuse people. Some examples of code words are "Aunt _ _ _ has not returned my phone call today." Code words for children need to be appropriate for their age. For example, a code word for a 13-year old girl may be "Your cousin _ _ _ called you today and wants you to call her back today". For a younger child "Your grandmother called today and wanted to talk with you about something."Most children under the age of 5 will be too young to understand how to operate under code language, you will need to figure out who you can trust with this task.

Safety When Preparing to Leave

A woman may have to leave the residence she shares with her partner when her partner is out of control. Leaving must be done with a careful plan in order to increase safety. A violent partner often strikes back if he or she believes that the woman is leaving a relationship. I can use some or all of the following safety strategies:

So that I can leave quickly, I will leave money and an extra set of keys with: _____

I will keep copies of important documents (social security cards, birth certificates, immunization records) or keys at: _____

It's important to become financially independent. To get help with becoming financially independent from your partner, call 1-800-873-2227 for free assistance in financial matters.

To increase my independence, I will open a savings account by (date): _____

☐ Other things I can do to increase my independence include: _____
_____

☐ Call 311 and ask for the NYC Domestic Violence Hotline (800-621-4673 or 866-604-5350) if you need counseling, legal assistance or emergency housing. If you are feeling threatened by your partner or in more immediate danger, call 911 for the police.

☐ If you use your cell phone, the following month the telephone bill may tell your partner those numbers that you called after you left. To keep your calls confidential, you must either use coins at a pay phone or use a calling card for a limited time when you first leave.

☐ It is important to find people who will let you stay with them or lend you some money. I will check with the following people to see if I can stay with them or borrow money:

☐ _____
_____
_____

I can leave extra clothes with: _____

☐ EMOTIONAL SAFETY
The experience of being abused and verbally degraded by partners is exhausting and emotionally draining. The process of building a new life takes much courage and incredible energy. To conserve your emotional energy, and to support yourself in hard emotional times, take advantage of the opportunities that are available to you. I can consider doing the following to take care of myself:

☐
1. I can get together with supportive friends and family more often
2. I can pray, meditate, or get help from a church, mosque or temple
3. I can get mental health counseling or attending support groups
4. Other_____

Safety Tip

It is a good idea to exchange code words or gestures with these contacts in advance to signal that you need their help to leave your partner.

☐ It's important to review your safety plan occasionally. How often will you sit down and review your safety plan? _____

☐ Ask a trusted friend or advocate to help you review your plan.
The person I will ask is: _____

☐ I will rehearse my escape plan and, as appropriate, practice it with my children.

Sexual Safety Planning

Below are some sexual risk situations that you or women in your community may experience.

☐ If I'm concerned that a partner may insist on engaging in sexual activity that I don't want to do; I can take the following steps to avoid having sex with him or her:

List steps: 1. _____
2. _____
3. _____

I can also do the following: Check all that apply:

- ❍ Tell my partner that I'm too tired or not in the mood for sex.
- ❍ Tell my partner that I need to go visit a family member or friend.
- ❍ Tell my partner that I am sick or coming down with a flu/virus.
- ❍ Leave my partner and find another place to stay for the night.
- ❍ Avoid being in bedrooms or other private rooms with my partner.
- ❍ Ask a friend or family member to stay with them.
- ❍ List names of two friends/family members I can call to stay with:
  Contact person/numbers_____
  Contact person/numbers_____

Safety Tip

It is always helpful to let these key contacts know in advance if you think you might need to stay with them, and work out a plan so that you can get into their home if they are not around.

☐ If my partner or I are under the influence of alcohol or drugs and I am worried that my partner might take sexual advantage of me; I can take the following steps to avoid having sex with him or her.

List steps: 1. _____
2. _____
3. _____

☐ If I am having sex with my partner and am concerned that he or she may sexually hurt me, I can take the following steps to protect myself.

List steps: 1. _____
2. _____
3._____

I can also do the following things (Check all that apply):

- ❍ Try to stay physically on top of my partner during sexual activities so I can escape if I need to.
- ❍ Let my partner clearly and calmly know that I don't want to have sex.
- ❍ Tell my partner I need to go see a family member or friend who is in trouble.
- ❍ Have all my important personal belongings and my clothes in one place so I can leave quickly and figure out the easiest way to escape.
- ❍ Keep emergency cash or credit card in my purse to get a taxi or public transportation to a safe place.
- ❍ Text or call my contacts above to let them know I need a place to go to or ask them to meet me.

To protect myself from HIV or sexually transmitted infections and pregnancy with my partner, I wi ll:_____ (Describe Plan)

I can also do the following (Check All that Apply):

- ❍ I can ask my partner to use a condom.
- ❍ I can use a female condom.
- ❍ I can avoid having vaginal or anal sex.
- ❍ I can use other forms of contraception (note: only male and female condoms are effective in preventing HIV or STIs).

If I had unprotected sex and think that I may have been exposed to HIV or think I may be pregnant, I can also (Check that all that apply):

- ❍ See my doctor or emergency care medical staff within 48 hours and ask them to start me on a low dose of anti-retroviral medication to prevent getting HIV.
- ❍ Get tested for HIV and other STIs
- ❍ Go to the pharmacy to pick up Plan B in 48 hours to prevent pregnancy

Summarize the key points of the safety plan for participants and any issues that remain unresolved in the plan. Validate and affirm the participants' ideas for and engagement in the safety plan as taking a major step forward in protecting themselves. You will be given or mailed a copy of this safety plan. Do you have a safe place to keep the safety plan at home or with a friend? Do you have a safe place to keep the 24-hour hotline number other important numbers?

Social Support Map

In addition to coming up with a safety plan, it may also help for you to be able to reach out to family and friends who you can turn to for help, advice, and emotional support if you are feeling afraid that your partner might hurt you. There may also be times when it is safer for you to stay with a friend or family member. Your friends or family may also help you out by taking care of your children or pets or helping you financially if you need to leave.

Different people may be able to help you in different ways. For example, it may be easier to talk with a friend about your relationship problems but ask your aunt for place to stay.

1. Can you tell me the names of one to five people you trust? Let's write their names onto the birds on this tree.
2. Which of these people can give you emotional support? We'll mark these with a heart.
3. Which of these people can give you practical support, like giving you a place to stay, watching your pets, or lending you money? We'll mark these with a star.

People I trust

_____

_____

_____

_____

_____

Steps to Increase Support

Can you think of two things you can do to strengthen your support from family or friends in the next week?

- This may be calling someone who you like to hang out with to get together for coffee or go for walk so that you have a chance to connect with him or her.
- It may mean calling, texting, e-mailing, or sending a letter to someone who you have lost touch with but who you would like to reconnect with.
- It may mean choosing someone who you trust and respect to talk with about the relationship conflict or abuse that you are experiencing so that you can get their advice or support on how to deal with it.

In the next week, I can do the following to strengthen my support:

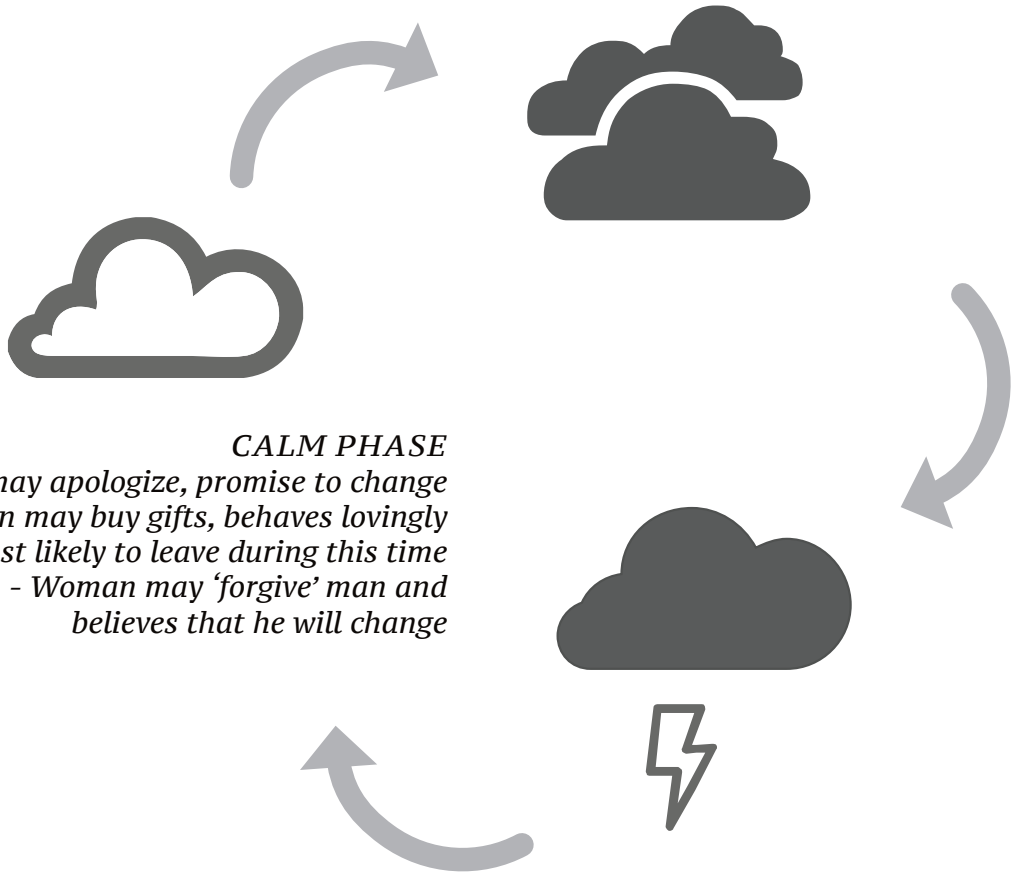
_____

In the next week, I can also do the following to strengthen my support:

_____

Cycle of Violence

TENSION BUILDS
- Man may begin to get angry, agitated
- Woman is anxious and fearful that violence may begin
- Woman tries to keep man calm
- Woman behaves cautiously

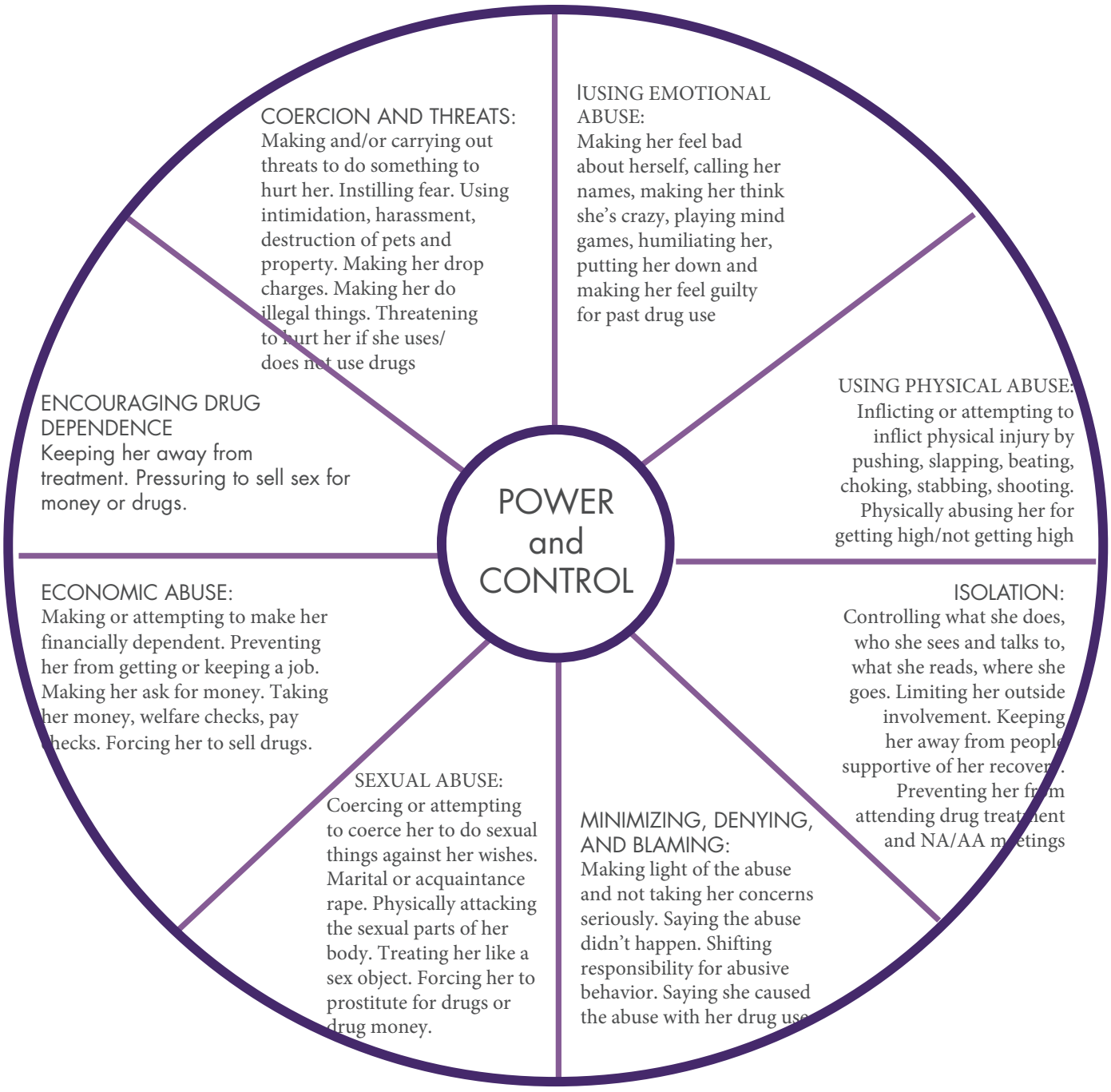


CALM PHASE
- Man may apologize, promise to change
- Man may buy gifts, behaves lovingly
- Woman is least likely to leave during this time
- Woman may 'forgive' man and believes that he will change

CONFLICT EPISODE
- Man loses control, blames woman for provoking him
- Man may deny or minimize abuse
- Woman may be very frightened or emotionally numb
- Woman may flee and decide to leave

Adapted from Lenore Walker, The Battered Woman, New York: Harper and Row, 1979.

Power and Control



Adapted by WINGS from the National Centre on Domestic and Sexual Violence. Originally developed by the Domestic Abuse Intervention Project, Duluth, MN

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Women Initiating New Goals of Safety

Appendix II. Participant and Facilitator Forms

Participant Feedback Form

1. Participant ID number: _ _ _ _
2. Date of Rating: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy)
3. Date of Session: _ _ / _ _ / _ _ (dd/mm/yy)
4. Location: __ __ __ __ __ __ __ __ __ __
5. Staff ID: __ __ __ __

Thank you for participating in the WINGS PROJECT. In order to make our project the best it can be we need your feedback. Please answer the following questions. Your honest opinions are very valuable to us. Thank you.

1. Overall, how satisfied were you with the WINGS Service Session?
   - 0. Not at all satisfied
   - 1. Slightly satisfied
   - 2. Somewhat satisfied
   - 3. Very satisfied
   - 4. Extremely satisfied

2. Overall, how comfortable were you with the facilitator who worked with you in WINGS?
   - 0. Not at all comfortable
   - 1. Slightly comfortable
   - 2. Somewhat comfortable
   - 3. Very comfortable
   - 4. Extremely comfortable

3. Overall, how honest did you feel during the WINGS session?
   - 0. Not at all honest
   - 1. Slightly honest
   - 2. Somewhat honest
   - 3. Very honest
   - 4. Extremely honest

4. How much did the session help you become aware of different types of intimate partner violence?
   - 0. Not at all
   - 1. Slightly
   - 2. Somewhat
   - 3. Very
   - 4. Extremely

5. How much did the session help you identify risks for intimate partner violence?
   - 0. Not at all
   - 1. Slightly
   - 2. Somewhat
   - 3. Very
   - 4. Extremely

6. How much did the session help you explore ways to reduce your risks for intimate partner violence?
   0. Not at all
   1. Slightly
   2. Somewhat
   3. Very
   4. Extremely

7. How helpful was the relationship safety assessment?
   0. Not at all helpful
   1. Slightly helpful
   2. Somewhat helpful
   3. Very helpful
   4. Extremely helpful

8. How much did goal setting help you think about ways to improve your relationship safety?
   0. Not at all
   1. Slightly
   2. Somewhat
   3. Very
   4. Extremely

9. How much did the session help you identify your needs for services and find referrals?
   0. Not at all
   1. Slightly
   2. Somewhat
   3. Very
   4. Extremely

10. How did you feel about using the laptop computer?
   0. Did not like at all
   1. Liked a little
   2. Liked a lot

11. Did you have any problems using the laptop computer?
   0. No
   1. Yes

11(a). If yes,
   0. It was difficult to follow
   1. The keys were hard to find
   2. I did not understand how to use it

12. How did you hear about WINGS?
   0. Flyer
   1. Friend
   2. Other (please explain) _____

13. Do you think you would have preferred to participate in WINGS with a case manager or on a computer?
   0. With a case manager
   1. Independently on a computer

14. What did you like best about the WINGS service session?

_____

_____

_____

15. What did you like least about the WINGS service session?

_____

_____

_____

16. What are your suggestions for improving the WINGS service session?

_____

_____

_____

17. Why did you participate in WINGS?

_____

_____

_____

18. How comfortable did you feel about receiving this service session in this setting?

_____

_____

_____

Facilitation Adherence Form

1. Participant ID number: _ _ _ _
2. Date of Rating: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy)
3. Date of Session: _ _ / _ _ / _ _ (dd/mm/yy)
4. Location: __ __ __ __ __ __ __ __ __ __
5. Staff ID: __ __ __ __

Section/Topic (Allotted Time)	Was Topic Addressed?	If Yes, How Adequately? 1=limited; 2=sufficient; 3=complete (a)	Actual Time Spent on Activity (min) (b)	Comments: Any unusual events occurred? Any additional content added? Reasons for spending too little or too much time on an activity? (c)
1. Welcome and IPV information (5 min)	Y N	1 2 3		
2. Identifying Relationship Conflict: IPV assessment and feedback (5 min)	Y N	1 2 3		
3. Cons of Relationship Conflict assessment, feedback (5 min)	Y N	1 2 3		
4. Empowerment and reducing relationship conflict (5 min)	Y N	1 2 3		
5. Safety Planning (10 min)	Y N	1 2 3		
6. Social Support Map (5 min)	Y N	1 2 3		
7. Goal Setting (5 min)	Y N	1 2 3		
8. Service Referrals (10 min)	Y N	1 2 3		
9. Wrap-up and Good-bye (5 min)	Y N	1 2 3		

1. Please describe material that was covered/discussed that was outside of the written protocol as well as the time spent (in minutes) for each outside topic.

2. Describe anything challenging that occurred during this session.

3. Please describe any unusual or notable events that you observed during the session.

4. How would you rate the participant's engagement throughout the session?

- ❍ Consistently not engaged
- ❍ Mostly not engaged
- ❍ Sometimes engaged
- ❍ Mostly engaged
- ❍ Consistently engaged

5. What, if any, type of help did participants request with referrals for services? What help did you provide?

WINGS Clinical Supervision Feedback Form

1. Date of Rating: __ __ / __ __ / __ __ (dd/mm/yy)
2. Date of Session: __ __ / __ __ / __ __ (dd/mm/yy)
3. Cohort: __ __ __ __ __ __ __ __ __ __
4. Site: __ __ __ __
5. Facilitators Name: _____
6. Clinical Supervisors Name: _____

Use the following Likert scale to rate your impression as it applies to a facilitator's demonstration of skills:

Engagement/General Skills	Unac-ceptable	Weak	Good	Very Good	Excellent	**Comments:** Elements for improvement
1. Rapport and Technique: (i.e., engagement, non-judgmental, empathy, reflection, sequence of delivery and questioning, individual tailoring to participant's needs, boundaries)	U	W	G	VG	E	
2. Skill in Maintaining Session Structure: (i.e., prepares materials, previews sessions, clearly communicate session elements, able to handle logistics, administration, transitions, and management of session; smooth and uncomplicated delivery of session)	U	W	G	VG	E	
3. Skill in Delivery of session Activities: (i.e., comfortable with content and activities, correct delivery and use of topic and materials, covered all sessions elements and material)	U	W	G	VG	E	
4. Skill in Guiding Consequence Identification: (i.e., able to assist participants to identify potential harm from the risk environment)	U	W	G	VG	E	
5. Skill in Guiding Goal-Setting: (i.e., ability to assist participants in setting and reviewing goal progress)	U	W	G	VG	E	
6. Skill in Dealing with Participant Resistance (i.e, reflective listening, feedback, identifying individual motivation for behavior change)	U	W	G	VG	E	
7. Skill in Guiding Problem Solving: (i.e., assisted in identifying barriers to change and solutions to overcome barriers to safety)	U	W	G	VG	E	
8. Ability to integrate the WINGS intervention into current services (i.e, be ready to navigate participants directly services)	U	W	G	VG	E	

Safety Planning & IPV Knowledge	Unac-ceptable	Weak	Good	Very Good	Excellent	Comments: Elements for improvement
9. Skill in Guiding Trigger Identification: (i.e., able to assist client to identify triggers for potential escalations)	U	W	G	VG	E	
10. Skill in Explaining and Modeling communication techniques: (i.e. Reflective Listening, Turn-around refusal, OARS)	U	W	G	VG	E	
11. Skill and comfort of talking about safety planning: (i.e., housing, protecting children, economic and support planning, etc.)	U	W	G	VG	E	
12. Skill and comfort of talking about injection risks and overdose: (i.e., ability to identify injection and overdose risks)	U	W	G	VG	E	
WINGS (or Session) Literacy						**Comments:** Elements for improvement
13. Skills in conveying session concepts and terminology to participants: (i.e., able to explain IPV terms to participants, explain the basics of IPV knowledge, explain basic safety concepts)	U	W	G	VG	E	
14. Skills and comfort in guiding participants to navigate through session: (i.e. giving brief intro during opening part, highlighting any technical issues that came up for others during closing)	U	W	G	VG	E	
15. Skills and comfort in guiding participants through core intervention aims: (e.g. relationship safety, enhancing social support, raising awareness of IPV risks)	U	W	G	VG	E	

Overall Rating	Unac-ceptable	Weak	Good	Very Good	Excellent	
Summary Recommendations:	U	W	G	VG	E	Positive feedback:

Development plan or action steps for next session:

Notes from Clinical Supervision call/meeting for Session under review:

Appendix III. Handling Challenging Situations and Behaviors

Special Situations Introduction

Effective supervision of any staff is one critical step to safeguard personnel. Day-to-day recording and follow-up review of any safety incidents will be important for maintaining the appropriate level of security.

Agencies or organizations who are implementing the WINGS intervention should ensure that everyone in the staff is introduced to the Protocol for Special Situations and follows its requirements.

Any unanticipated or anticipated safety risks specified above that staff are exposed to should be reported immediately to your supervisor. Staff who witness or experience negative incidents should should consult with their supervisor immediately to determine to how to handle the incident (e.g. follow up actions).

The agency or organization should develop a negative incident form for staff who witness or experience negative incidents. An example of this form is in Appendix I.

Immediate Response to Emergency situations

- Do not leave participants alone.
- One to two staff members should remain with the participant who is in distress.
- One to two staff members should remain with other participants who are on site to protect and safeguard them.

Handling challenging behaviors and situations within the session

Challenging Participant Behaviors

(NOTE: For each situation, facilitators will need to decide which responses fit best using their own judgment. The suggested phrases are meant only to act as a guide and each facilitator will want to think about how they might handle each situation.

General responses:

1. Ignore inappropriate behavior and

2. Redirect participant toward appropriate behavior and

3. Reward even the slightest movement toward appropriate behavior.

Cannot Read Well (Literacy issues)

Possible reasons for the behavior:
2. Never had the opportunity to learn
3. Is dyslexic
4. Has an eye ailment/needs eyeglasses

Facilitator's responses:
1. Do not ask woman to read.
2. Do not push people if they pass on reading.
   A. Respond to cues from participant, have another participant assist with prompting if the participant with trouble reading doesn't seem to be hiding it.
   B. "Jane, would you mind if I ask John to read this next section?"
3. Reinforce participant for trying.
   C. Thank you, Jane. I like it when we all get to do a little bit of the reading, so we are all contributing or sharing the load, and it is truly a community effort."
4. Administer the Intro to Baseline demo to screen for literacy issues.

Disruptive, rambles, overly talkative, complaining frequently

Possible reasons for the behavior:
1. Desire for attention.
2. Angry about something and does not know another way to express it.
3. Hides feelings of insecurity/avoidance of sensitive material.
4. Looking for facilitator respect.
5. Is in a lot of pain.
6. Under the influence of alcohol or drugs.
7. Is bothered by disorganized thoughts.

Facilitator's responses:

1. Keep temper in check.
2. If the participant is unable to participate constructively, take the person aside and suggest that she leave to discuss and resume the session in a bit (in extreme situations only). Check in with the participant at the end of the session.
    a. "Joanna, it seems as if it is difficult for you to participate in the session in a way that feels calm and constructive. Are you okay? I'd like to take a minute to help you explore what might be bothering you. Let's step outside for a few minutes and we'll rejoin the session later."

Participant Disengages from Session/Wants to Leave

Possible reasons for the behavior:

1. Became uncomfortable participating
2. No longer interested in participating
3. Has other imminent concerns or issues
4. Feels disrespected by facilitator
5. Feels threatened

Facilitator's responses:

1. Explore reasons why the participant is not participating or wants to leave.
    a. "I'm hearing that you are not really comfortable with what is going on right now, Maria, but I wonder if you would be willing to stick it out for a few more minutes to let us know what's happening for you right now."
2. Explore barriers to participation.
    a. "I appreciate that you are able to express yourself. I wonder if you would be willing to talk a little about what you are thinking right now."
    b. "Would you tell us what it is that makes you feel like leaving the session now?"
3. Explore benefits to continued participation.
    a. "Okay, I respect that. But before you go, let me ask you if you could talk a little about why you decided to come to begin with."
    b. "I'd like to explore the pros and the cons of being here… what are the pros to attendance… what are the cons to attendance… let's review each and then see if you still want to leave."
4. Ask them to remain for the duration and decide at end of the session, and then check in with them.
5. Reinforce participant for believing strongly and for expressing other positions.
    "I respect your opinion and decision to leave, but hope that you would consider staying until the end of the session. But you have every right to leave the session. I hope you will consider continuing, or if there is something you want to talk about that would make you more comfortable continuing, then let's talk about it."

Will Not Talk or Lack of Communication

Possible reasons for the behavior:

1. Insecure, indifferent, bored.
2. Feels superior.

3. Depressed.
4. Cultural or personal norms; topic is taboo.

Facilitator's responses:
1. Thank person for any small response.
    a. "Thanks for your participation; it's great to hear from you."
2. Ask person how you can help them with the session materials, or in general, in order for them to open up.
    a. "You know, everyone has their own style in how they participate, and that's great. I just want to make sure that there isn't anything I'm missing to help you get the most out of this experience. Is there anything I could do differently that would work better for you?"
4. Check in with person periodically.
    a. "You're really quiet today, how are things going?"
5. If person is depressed, provide an opportunity to talk and make appropriate referrals.
    a. "You know, everyone has their own style in how they participate, and that's great. I just want to make sure that there isn't anything happening here or anything going on with you?"
6. If participant doesn't want to talk, then give space for the person to take a break and then resume.

Focuses on the Wrong Topic or Diverges into Alternate Intervention Content

Possible reasons for the behavior:
1. Does not understand the direction of the session.
2. Concerned about the issue raised.
3. Has a personal agenda.
4. Needs to feel assertive.
5. Does not want to deal with the topic that the session is focused on.

Facilitator's responses:
1. Let them know (enthusiastically) that we have a lot of material to cover, and that sometimes you will need to redirect the conversation.
    a. "I want to warn you now that from time to time we might interrupt what is happening and move on to new materials. This is not because we don't think something we're discussing is important. It's all important. But we have to cover certain material in the session to make sure you have all the information you need to be safe."
2. Take the blame.
    a. "I'm sorry, I think I might have been unclear. What I wanted to talk about was _____".
3. Validate the participant's raising of the issue.
    a. "You are right, it is an important consideration and I think it is great you are bringing it up. Unfortunately, we have a lot of material to get through and we aren't able to fit too much else in. If you want to stay for a minute after session, we can talk more about it and I can give you some more information."
4. Try to assess if the topic the person is on has a personal significance.
    a. "I think you bring up a great point. I'm wondering if this has special significance

for you?"
5. Ask the person to think about the correct topic and then discuss their feelings about it.
   a "I'd like to get back to ____. Kim, I would be willing to get our conversation going by talking about how ____ plays out in your relationship?"
6. Explore discomfort.
   a. "I'm sensing that this is something you would rather not be discussing right now. Would you be open to talking about this more?"
7. Adhere as closely to the protocol as possible, yet allow the participant to feel as if they are an integral part of the agenda.

Makes an Incorrect Statement

Possible reasons for the behavior:
1. Does not know the facts.
2. Believes certain myths about the topic

Facilitator's responses:
1. Normalize and elicit response from other partner, but keep discussion brief.
"Let's spend a few minutes on this but then we need to move on to cover all of today's material."
2. Acknowledge if individual has strong opinion about issue, but keep discussion brief.
"I see you feel very strongly about this issue. Some people feel strongly about this." "Let's spend a few minutes on this but then we need to move on to cover all of today's material."
3. Elicit factual information; invite participant to consider this information.
"Many people feel that.....(myth or incorrect comment)... yet the fact is..."
"Would you consider this or these alternative idea(s) and let us know what you think next time?"

Participant Coming On to Facilitator

Possible reasons for the behavior:
1. Attracted to the facilitator.
2. Seeking attention.
3. Trying to put the facilitator on the spot.
4. Trying to make partner jealous or punish partner for some reason.

Facilitator's responses:
1. Ignore it.
   Try to diffuse the situation; use humor if appropriate, being careful not to make fun of the participant.
a. "Wow, Mary, you are quite an extrovert", and then continue with the session
2. Pointedly mention your boyfriend, girlfriend, or spouse. (Make them up if needed.)
3. Take participant aside and talk with her, preferably with another staff person present in the room. Use "I" statements. Normalize that whenever a "helper" shows attention, it is possible for a participant to misread this or feel strong feelings. Reinforce what the sessions

are about. Thank her for the interest and say that you are flattered. Then restate your role as a session facilitator. State that your contract for the job forbids socializing with participants, and doing so would cause you to lose your job.

a. "I am feeling a little uncomfortable because it seems to me as if you might see me as more than a facilitator. Am I right? [allow participant to respond and continue whether acknowledges or denies attraction] "I want you to know that it is not at all unusual for participants in the project to feel attracted to the facilitators... and the reason is simply that we are listening carefully to you and that we are there to help you... this is what strong, intimate relationships are all about."

b. "I also want you to know that because my role here is as a facilitator, and I need to maintain your trust, I cannot socialize with you or other participants outside of sessions. I could lose my job."

Facilitator is Attracted to Participant

Facilitators should not see participants outside the sessions, even after the intervention is completed. (This includes establishing friendships with the participants.) Although the facilitator is not conducting therapy, this is a professional relationship with power differences between the facilitator and participant. There is empirical literature that indicates that it is not uncommon for mental health professionals to feel attracted to their clients. So don't beat yourself up if you feel this at some point. However, clearly it is a problem if you were to want to act on your feelings. These must be discussed with your clinical supervisor and ideally, with your fellow facilitators, in order for you to stay clear about your role and the boundaries of your role. According to the ethical principles established by the American Psychological Association (1992), "Psychologists are sensitive to real and ascribed differences in power between themselves and others, and do not exploit or mislead other people during or after professional relationships." Similarly, the National Association of Social Work code of ethics (1996) forbids establishing intimate relationships with clients.

Dealing with a Participant who is Drunk or Under the Influence of Drugs

Possible reasons for behavior

1. Abuses drugs or alcohol
2. Uses drugs or alcohol to cope
3. Is trying to escape feelings and circumstances

Facilitator's responses:

1. Intervene early on in the session, if not immediately.
2. Avoid confrontation if not necessary; redirect the participant toward more appropriate (attentive, non-disruptive) behavior.

a. "You seem to be a little distracted today, John. What do you think about what was just discussed?"

b. "Are you ready to move on with the session?"

3. Reward the participant for movement toward more appropriate behavior.

c. "I appreciate the way you've been listening to me just now."

d. "I can see your participation means a lot."

4. If participant smells of alcohol or appears obviously under the influence (i.e., overly sedated or exhibiting overactive/disruptive behavior), you may need to escort them out of session.
   a. "Jane, I'd like to talk to you for a minute in private, would you come with me for a minute?" When outside: "I'm wondering if you have been drinking or using drugs?"
5. Express concern for participant and state why you asked them to leave the session.
   a. "The reasons why I am concerned are that, first, if you have been drinking or using drugs, then showing up here high is against the session rules, and also second, that just as drugs and alcohol inhibit our ability to protect ourselves, they also keep us from getting as much out of the session as you would if you were sober and straight."
6. However, if this is not the first time you have had to ask this person to stop disruption and leave, say:
   a. "I'm sorry, _____, but I think it might be better if we rescheduled this session."
7. When outside of the session, offer to provide a referral to alcohol or drug use treatment facilities or to local self-help group meetings (e.g., AA, NA).
   a. "I'd like to give you some information about some local groups that you might find helpful and also some facilities that can help you get clean and/or sober."

Dealing with Intoxicated Participants

If you suspect a participant is intoxicated, it is important to approach them with care.

- If they are in the waiting room, introduce yourself and ask them to meet with you in a private room (be sure to have safety protocols in place in case the client becomes aggressive or needs additional help). Please ensure the room is not filled with lots of papers/things as this can be distracting and provoking to an intoxicated person.
- Be respectful and speak calmly and slowly.
- Reflect to them that it appears that they may be intoxicated and that you are concerned.
- Inquire as to what has been happening with them lately/if they have been having a hard time.
- After listening to them and providing support, it's important let them know you think it's best for them to have some time to let the drugs/alcohol leave their system and instead of participating in the study, which they can do another day, you'd like to get them home safely.

Depending on how intoxicated they are…
- You may need to call Mobile Crisis to pick them up.
- Ask them if you can call someone to come get them because you want to make sure they get home safely.
- Call a cab that can take them home – secure agency funds for cab if appropriate.
- Ask them how they may be able to get home safely.
- Provide some numbers they can go home with so that they can connect to resources.

Call participant the following day to check in with them.

General Distress

If in the course of facilitating a session the participant becomes distressed, the following protocol will help identify the participant's level of distress and the facilitator's appropriate response. If you are comfortable dealing with distress, we encourage you to work with the participant for a limited time as best you can to find a resource that will provide support in your absence.

Definitions of types of distress

Moderate/Mild Distress
What you may see from time to time is moderate or mild distress. This is when a participant is emotional, but is able to maintain his/her composure. The moderately or mildly distressed participant may experience any of the following: crying but not uncontrollably, eyes tearing up, voice "choked up", speaking very quietly, avoiding your glance, or being unwilling to stop talking to you and reluctant to leave.

Acute Distress
On rare occasions you may have a participant who becomes overwhelmed emotionally, or is distracted by disturbing thoughts and/or feelings. This is manifested in uncontrollable crying, disorganized thinking, pressured speech (seems to be speaking in a fast and confused manner), or preoccupation with/repeated description of a disturbing incident or memory.

Suicidality/Homicidality
Also on rare occasions you may have a participant who expresses desire to harm herself or others. Immediately seek a referral for an evaluation and clinical services as discussed below.

Dealing with distress

Moderately/Mildly Distressed Participant

If the participant becomes moderately or mildly distressed during the session, an attempt should be made to manage the distress and continue the session. Check in with participant to verify distress and ask them how they would like to proceed.

- "I see that you are feeling sad (or angry, etc.) about something. Can you tell me what you are feeling right now? What made you feel that way?"

- "Sometimes these sessions can cause you to remember or think about things that you do not want to, or that are painful in some way."

• "Would you like to take a short break and catch your breath, and then decide if we can continue?" If needed, take a 5 minute break and check in.

• Then ask "Are you all right" or "Is everything okay?" or another probe to inquire as to the person's emotional state.

• Give the person a few moments and the chance to compose herself; if the person seems all right, thank the person for her time.

If the person still seems somewhat distressed, say:

• "We can either continue with the session and then talk at the end about some places I can refer you to for counseling and more support about this issue, or we can stop the session and reschedule it."

If person is able to continue, then at the end of the session say:

"Let's take a few minutes to review the resource manual and find some counseling and support services for you."

Look through the table of contents, and identify with the person the kind of help she needs. Find up to three options that may be a fit based on:

- proximity
- language requirement
- insurance/ payment eligibility requirements

Photocopy the pages and fill out a referral form.

If person wants to continue, but you assess that they are too overwhelmed and really need to take a break, say:

- "I want to be sure you get the most from the sessions and sometimes upsetting feelings make it too hard to really hear new information and to really participate. I want to suggest that we reschedule this session for a time when you are feeling better."

Acutely Distressed Participant

In the unlikely event that a participant becomes acutely distressed or expresses an urgent

need for assistance at any time during or after the session, state that:

- "I can see that you could really use some help right now; there are a few things we can do right now to get you the help you need."
- "I can sit and talk with you for a while." (If at all possible, facilitator intervention would be preferred)
- "We can contact (local or site specific contact for handling distressed participants), who will be able to refer you to a social worker to talk to."

"We can contact someone else at the WINGS program who may be better suited to talk to you or help you with a referral."

Determine the person's preferred course of action and obtain consent to contact one of the above resources.

If a participant does not accept one of these options, we are limited in our ability to help her. Encourage the person again to accept some assistance from one of these sources. If she still refuses assistance and is unable to compose herself, call your supervisor to inform her of the situation; add and implement that person's directions.

Fill out the Referral Form and an Adverse Events Form.

Suicidal/Homicidal Participant

If a participant expresses an intention to hurt herself or someone else, the facilitator must:

- Ask participant to step outside the session with you.

- Inform the participant that you are required to notify (contact specific to your site), and that he or she will refer the participant to a social worker for counseling.
- Say, "you need to know that we take statements like that very seriously. Although sometimes people say things they do not mean, I would like to talk more about what you just said."

- Use the following set of questions to assess the degree of intent and lethality. Ask the questions directly without being judgmental.

> 1. "Are you thinking about hurting or killing yourself? How strong is your intent to do this?"
>
> [Someone likely to hurt themselves or others will tell you that they are seriously thinking about it.]
>
> 2. "Have you thought about how you would do it?"
>
> [This is an assessment for a specific plan, as well as the relative lethality of the plan. Someone like-

ly to hurt themselves or others will have a specific idea about how to do it and will have the weapons or method in mind. Consider how lethal their plan is.]

3. "Have you thought about when you might do this?"

[This is an assessment for imminent risk.]

4. "What is keeping you from hurting/killing yourself?"

[This gets the person thinking about potentially positive aspects of their life and reasons why they wouldn't harm themselves.]

Also remember possible factors contributing to suicide risk include past suicide attempts (lethality of method, circumstances), family history of suicide, intensity of current depressive symptoms, recent life stressors (partner separation, job loss, retirement, illness), alcohol or drug use patterns, and lack of social supports.

In the event the participant is actively thinking about killing herself, and has an organized plan and means, then inform the person that she needs special care and you will not leave her until she gets that care. You should NOT leave the person alone, and do not attempt to counsel her yourself. You may either:

1. Walk with her over to the nearest Emergency room to get that care;

2. Stay with her while calling a crisis line for support;

3. Call your WINGS manager, back-up mental health counselor, or your supervisor.

"When someone is upset enough to talk about hurting themselves, they need immediate attention, so that is why I asked you to talk with me more about this. I will stay with you now and we will get help for you."

Whatever the decision, you should call your supervisor immediately and let her know what is happening.

Illness/Injury/Imminent Danger

1. If a participant is ill or injured, call 911 for medical attention.

2. If a participant poses an imminent threat to the safety of herself or to other par-

ticipants, call 911 for law enforcement intervention. Separate the involved parties while waiting for law enforcement intervention.

3. Call your supervisor. Inform her of what is happening and actions taken thus far. The supervisor will come to the site to provide supervision and guidance.

4. The supervisor will debrief remaining participants, determine if it is appropriate to continue the session activity, or arrange to make up the study activity if necessary and send the participants home. The supervisor will ensure that appropriate mental health or health services are provided to participants as needed.

5. The supervisor will complete a negative incident report with the involved staff, and debrief the staff.

Distressed Participants

1. Protocol:

   a. Using active listening skills, listen respectfully and without judgment. Make eye contact.

   b. Reflect and validate participant's state and feelings (use language such as "I can see that you're really upset right now; this must be really hard to talk about; it sounds like you're (feeling word) about (issue)") and try to encourage participant to take deep breaths (e.g. "let's try to take some deep breaths together.")

   c. Keep sitting with and listening to the participant until she is able to calm down. You may also want to ask what makes her feel safe and better. "What are some things that make you feel safe? When you leave today, is there something you can do that makes you feel good? Like walk through a park or listen to your favorite music? Play with your kids?" Also, offer her some water and tissues.

   d. Remind the participant that engaging in the study with you today is voluntary and she does not have to continue. There are no consequences to not participating.

   e. If you discover that the participant feels unsafe, then follow protocol on fear of harm.

2. If a participant cannot be calmed, then contact your supervisor.

3. You should work with your supervisor to get the participant to the local emergency room.

a. If the participant is willing, staff may escort the participant to the local hospital emergency department. Campus public safety may be contacted for assistance.
b. If the participant is unwilling or unable to go to the emergency room on his or her own, then the staff will call Campus Safety or 911 for assistance in getting the participant to the local hospital emergency department.

4. The supervisor will debrief with any witnessing participants. The supervisor will ensure that appropriate mental health or health services are provided to participants as needed.

5. The supervisor will complete a negative incident report with the involved staff, and debrief the staff.

Suicidal/Homicidal Ideation

If a participant expresses intention to hurt herself or someone else, the staff member must:

Inform the participant that you are required to notify your supervisor and that he or she will refer the participant to a social worker for counseling. Say:

"I can see that you are really upset right now and I want you to know that we take statements like that very seriously. Even though people sometimes say things they don't mean, I would like to talk to you about this and how you're feeling. I need to be sure you get the help you need."

Use the following set of questions to assess the degree of intent and lethality. Ask the questions directly without being judgmental.

1. "Are you thinking about hurting or killing yourself? How strongly do you feel about doing this?" [Someone likely to hurt themselves or others will tell you that they are seriously thinking about it]

2. "How often do you think about killing yourself? Has the frequency changed over time?" [Someone who is frequently having suicidal ideations poses greater risk.]

3. "Have you ever tried to kill or hurt yourself? When was the last time? And what did you do?" [Prior attempts should be especially concerning, though absence of a prior attempt does not minimize risk.]

4. Specifics:
a. "You mentioned that you have thought about hurting or killing yourself (or someone else); have you thought about how you would do it?" [This is an assessment for a specific plan, as well as the relative lethality of the plan. Someone likely to hurt themselves or others will have a specific idea about how they will do it (specific weapons or method in mind).]

b. "Do you have access to ____ (mode of harm…gun/pills etc.)?" [Someone with access poses great risk.]

5. "How likely are you to hurt yourself today/tonight? What would you do"?

6. "Have you thought about when you might do this?" [This is an assessment for imminent risk and relative lethality. Someone likely to hurt themselves or others will have a specific idea about when they will do it.]

7. "What has kept you from hurting/killing yourself in the past?" [This gets the person thinking about potentially positive aspects of their life and reasons why they wouldn't harm themselves.]

8. "Have you talked to anyone about this? Your psychiatrist, therapist, or doctor? How have they helped you?"

9. "When you think about hurting yourself, what do you do to keep yourself safe? What have you done in the past to keep yourself safe?"

In assessing risk factors, also consider: past suicide attempts (lethality of method, circumstances), family history of suicide, intensity of current depressive symptoms, recent life stressors (partner separation, job loss, retirement, illness), alcohol or drug use patterns, and lack of social supports.

Engage in Safety Planning

1. Help the participant come up with a specific plan of action to protect herself. Who will she call? What hospital will she go to? Who can she ask for help? Give suicide hotline phone numbers: 1-800-999-9999. (National call lines: 1-800-784-2433 and 1-800-273-8255)

2. For mobile crisis (crisis intervention and transport to emergency care), call 1-800-543-3638 (LIFENET)

3. In the event the participant is actively thinking about killing herself, and has an organized plan and means, then inform the person that she needs special care and you will not leave her until she gets that care. You should NOT leave the person alone and do not attempt to counsel her yourself. You should contact your Manager/Supervisor and may:

a. Walk with the participant to the nearest Emergency room to get that care

b. Call Mobile Crisis at 1-800-543-3638 (LIFENET): they will pick up the client and take them to emergency care and provide assessment and care. This is a service provided by the City of NYC;

c. Call a crisis line for support while staying with the participant. 1-800-999-9999. (National call lines: 1-800-784-2433 and 1-800-273-8255)

"When someone is upset enough to talk about hurting themselves, they need immediate attention, so that is why I asked you to talk with me more about this. I will stay with you now and we will get help for you."

3. If a partner accompanied the participant to the session (in waiting room etc.), ask them:

a. Is your partner receiving mental health treatment? How often does she see a psychiatrist/therapist/doctor, if at all?

b. Is your partner taking any medication for her mental health? Does she take meds as prescribed?

c. Do you know when she is suicidal? Does she have a current plan?

d. What do you do when she is suicidal? How do you help to keep her safe?

e. How are you doing? Do you see someone? Do you think it would be helpful for you to see someone? (Offer referral.)

Participant Fears (Imminent) Harm from a Partner or Another Person

1. If distressed, calm participant. (See protocol.)

2. Call 911 if threat is imminent.

3. Engage in safety planning with the participant (see section on suicide assessment).

4. Discuss how to obtain an Order of Protection with participant if applicable (see below).

Information about Seeking and Obtaining Protection Orders (Temporary and Final)

Below is information on how to obtain an order of protection in NYC. For other locations, you should check with your local family or criminal court.

From the NYC DA's Office: http://manhattanda.org/order-protection

What is an order of protection?
An order of protection is a document issued by the court that forbids an individual from engaging in certain behavior. For example, an order of protection can forbid a person from having any contact with the victim. This means that the person can't go to the victim's home, place of employment, or school, or contact the victim via email, phone, text message or any other electronic means. An order of protection can also require an individual not to assault, threaten, harass, or stalk a victim.

How do I obtain an order of protection?
To obtain an order of protection you much have a case pending in court.

There are two types of places where you can obtain an order of protection: Criminal Court and Civil Court.

Family Court is a Civil Court. You can go to Family Court and file a request (called a petition) for an order of protection if you and the individual who you want the order against are: legally married; divorced; related by blood; have a child in common; or have been in an intimate relationship

(An intimate relationship does not necessarily mean a sexual relationship, but is more than just a casual acquaintance. This includes people who are or have been dating, or living together, including those who have been or are in a same-sex relationship.)

In Criminal Court, an order of protection can be issued regardless of the relationship between you and the person you want protection from. In order to obtain an order of protection in Criminal Court, the person must be arrested and there must be a Criminal Court case pending
against him or her. The District Attorney's Office will request an Order of Protection from the court on your behalf.

How long is an order of protection valid?
A Temporary Order of Protection usually lasts from one court date to another court date. A Final Order of Protection will be issued when there is a final disposition in the case. A Final Order of Protection can last from one year to several years, depending upon the seriousness of the case. If the case is dismissed, the order of protection will end.

How do I get a copy of my Criminal Court Order of Protection?

After the Court issues an Order of Protection in Criminal Court, the Witness Aid Service Unit (WASU) of the District Attorney's Office will mail a copy of the Order of Protection to you. Please make sure that the District Attorney's Office has your correct address. You can also request a copy of your Criminal Court Order of Protection by contacting WASU at (212) 335-9040. WASU is located at 100 Centre Street, room 231.

What happens if the Order of Protection is violated?
It is a crime to violate an order of protection. If the individual violates the Order of Protection, you should 911 and report it to the police. You can also walk into the nearest precinct to report a violation. After contacting the police, you should also contact the Assistant District Attorney assigned to your case. If you don't know who your assigned assistant is, contact WASU at (212) 335-9040 for that information. Keep your Order of Protection with you at all times. If you misplace your copy of your Order of Protection, you can get a copy from WASU. NYPD can also determine if a valid Order exists.

I have order of protection, am I safe?
An order of protection does not guarantee a victim's safety. It is extremely important to develop a safety plan. Please contact WASU at (212) 335-9040 to work with a social services worker to develop a safety plan. If you are a victim of Domestic Violence you can also call the 24 hour/toll-free Domestic Violence hotline at 1 (800) 621-HOPE (4673) for other organizations that can help you develop a safety plan.

Is my order of protection valid outside of New York City?
Your Order of Protection can be enforced even if you travel or move to another state. Most Orders of Protection must be given "Full Faith and Credit" in any other state, which means that your Order may be good wherever you go. Some states require that you register your order in the new state before it becomes effective. If you should move to another state, call the Clerk of the Court to determine whether or not you are required to register your Order and what steps need to be taken by you in order for it to be properly registered.

Important FAQ (from: http://www.courts.state.ny.us/courthelp/faqs/domesticviolence.html)

Q. Must I choose whether to ask for an order of protection in Family Court or Criminal Court?
A. No. You can ask for an order of protection against your abuser in both courts at the same time.

Q. I'm being stalked. Can I get an order of protection?
A. Stalking is a form of Harassment. That is one of the crimes that allows you to get an order of protection. Other crimes include Assault, Attempted Assault, Menacing, Reckless Endangerment, and Disorderly Conduct.

Q. What is a petitioner and what is a respondent?
A. In Family Court, a petitioner is a person asking for an order of protection. (In Fam-

ily Court, cases filed for an order of protection are called family offense cases.) A respondent is a person a petitioner wants an order of protection against. In a Criminal Court, that person is called a defendant.

Q. Can I have a lawyer?
A. In Family Court, the petitioner and the respondent each have the right to hire a lawyer. If a petitioner or a respondent can't afford to hire a lawyer, they can ask the court to appoint a lawyer free of charge. In a Criminal Court, the district attorney's office or other prosecutor represents "the people." They help the person who wants an order of protection. The defendant can hire a lawyer or have the court appoint one free of charge if he or she can't afford it.

Q. How do I start a case?
A. Call the police if you feel you are in danger. You can go to your county's Family Court to file a family offense petition, go to the district attorney's office (or other local prosecutor's office), or go to the local Criminal Court. You can choose to do all of these things if you want.

Q. What is an Affidavit of Service in Family Court?
A. An "Affidavit of Service" is a paper that must be filed with the court showing that the respondent has been told about the case. Court staff will help you with important instructions about this document.

Q. What is a Court Attorney in Family Court?
A. A "Court Attorney" is a lawyer who works for a judge.

Q. What kinds of things can be put in my order of protection?
A. Among other things, the judge can order the respondent or defendant:
• not to assault, menace, or harass you or commit crimes of reckless endangerment or disorderly conduct towards you.
• to be removed by the police from where you are living.
• to stay away from you, your residence, your job, and other places you may want.
• not to telephone or e-mail you or write you letters.

The judge can also protect your children in the order of protection. For example, you may ask that any visitation with the children be supervised. In Family Court, the judge can order the respondent to pay temporary support and to give you legal custody of any children you may have with the respondent.

Q. What happens if I miss my court date?
A. If you are a petitioner in Family Court, your case will probably be thrown out and any temporary order of protection you had will be gone on that day. If you are a respondent in Family Court, the case can be done without you there (provided the petitioner gave you notice of the case) and an order of protection can be issued. As a respondent or defendant, a warrant may be issued for your arrest in either a Family Court or a Criminal

Court if you don't show up.

Q. What happens if an order of protection is violated?
A. If a respondent or defendant violates (disrespects) an order of protection, the person with the order of protection can call the police, who can arrest the respondent or defendant. The person with the order of protection can file a "violation petition" in Family Court, talk with the district attorney's office (or other local prosecutor's office) or can go to the local Criminal Court. The person with the order of protection can choose to do all three of these things. Upon proof of the violation, the judge can make changes in the order of protection and put the respondent or defendant on probation. The judge can set a jail sentence.

Q. I moved to New York from the state that gave me an order of protection. Is the order of protection good in New York?
A. An order of protection from another state is still good in New York. You can get help on how to register your order of protection in New York from your local Family Court, Criminal Court, or police station.

http://www.womenslaw.org)

A new law was passed in August 2010, which says that a petition for an order of protection cannot be dismissed or denied based only on the fact that the incident(s) you allege happened a while before you applied for the order

An order of protection can: order the abuser to stop abusing you and your children; tell the abuser to leave and stay away from you, your home, your workplace, and your family (Note: the abuser can be removed from the home or ordered to stay away from the home that you were both living even if his/her name is on the lease or deed); direct the abuser to have no contact with you including no phone calls, letters, or messages through other people (called "third party contact"); order the abuser to pay your attorney's fees that you paid to get (or later enforce) the order; order the abuser to give up his/her guns and gun license (as part of a temporary order or as part of a final order); order the abuser to not intentionally injure or kill, without justification, any pet that belongs to you or a minor child residing in the household; give you temporary custody and arrange for visitation for the duration of the order of protection; make an order for temporary child support in an amount that is "sufficient to meet the needs of the child" even if the details about the income and assets of the abuser are unavailable. You do not have to show an immediate or emergency need for the support. (Note: If the abuser has employer-provided insurance, the judge can make an order that directs the employer to provide such insurance to your child); order the abuser to not do anything that creates an unreasonable risk to the health, safety or welfare of your child; order the abuser to pay for expenses related to the abuse such as medical care and property damage; authorize the person leaving the home (whether it is you or the abuser) to retrieve his/her undisputed personal belongings from the home with a police escort; order the abuser to participate in a batterer's educational program and to pay for it if s/he has the means to do so; and do anything else that is necessary for your protection.

Note: If you meet certain requirements, you can also ask the judge to terminate your rental lease with your landlord without financial penalty to you if you need to leave your rental unit to keep safe.

Whether or not a judge orders any or all of these things depends on the facts of your case.

Q: Can the abuser's gun be taken away as part of a temporary order or final order of protection?
A: Yes, depending on the circumstance.

Q: In which county can I file for an order of protection?
A: You can file a petition in the county where the abuse took place, in the county where you live, or in the county where the abuser lives. However, if you live in NY state but the abuser lives out of state, at least one of the abusive acts that you allege in your petition must have taken place in NY state for the court to be able to grant you an order of protection. If the abuser threatens you on the phone, through texts or emails, these acts could be considered to have "taken place" in NY state if you receive the phone calls, texts or emails in NY.

Q: Can I get an order of protection against a same-sex partner?
A: Yes.

Q: How much does it cost to get an order of protection?
A: There are no fees to file a petition for an order of protection in New York state.

Q: Can I bring a friend or other person with me for support?
A: Most likely, yes. The law says that if you are the petitioner in an order of protection case, you are allowed to have a friend, relative, counselor or social worker present in the court room with you for support - even if you are represented by a lawyer. That person cannot participate in the court case as a lawyer could, however, unless the judge decides on his/her own to question that person.

Q: What are the steps for obtaining an order of protection?
Step 1: Go to court to file the petition.
Step 2: Fill out the forms (Note: Do not sign the form until you have shown it to a clerk. The form might need to be signed in front of a notary public or a judge. If you do not want to put your address on the forms, the court should have a way for you to keep it confidential. Be sure to bring this to the clerk's attention.)
Step 3: A judge will review your petition (After you finish filling out your petition, bring it to the court clerk. The clerk may then type it up while you are present or not. The clerk will take it to a judge who may issue either a summons for your abuser to appear in court on a certain date, or a warrant for his or her arrest, depending upon the circumstances.)
Step 4: Service of process (The court will give you instructions on how the summons, petition, and order of protection can be served on (delivered to) your abuser. The court should also tell you that you have the right to have the Police Department serve the summons, petition, and order. In many counties, you can also use the Sheriff's office instead of the police department - call your local Sheriff's office for their hours of operation and

to make sure there is no fee involved.

Service is important because an order of protection does not go into effect (is not valid) until it is served. Furthermore, the respondent (the abuser) has to be given notice of the court date since the respondent has the right to appear in court on the next court date.

Step 5: The hearing: It is very important that you attend all of the court dates. If you find out you absolutely cannot attend, contact the court clerk immediately and ask how you can get a "continuance" or an "adjournment" for a later court date. If you do not attend, the judge may dismiss your case and any temporary orders of protection will stop being effective. If the court case does not settle, it will go to a hearing or trial.

At the hearing, you will be able to testify in court about the abuse and harassment you have experienced. You can also present witnesses and other evidence to support your case. The abuser will also be allowed to present evidence and testify at the hearing. If you are not represented by a lawyer, you may want to consult with a lawyer before the hearing to understand what documents and evidence is legally admissible in court.

If your abuser does not attend the hearing, the court may issue a "default judgment" and you may receive an order of protection against him in his absence. Another possibility is that the court may hold what is called an "inquest," which is a one-sided trial where you present your evidence and testimony and the judge decides the case based on that alone. It is also possible that the judge may decide to reschedule the hearing for a different day. If you have a temporary order of protection, it may expire on the next court date and another temporary one may be issued that is effective until the following court date.

Be sure to look at the expiration date of the order before each court date so you know if the judge should be issuing another temporary order of protection on your return court date. If the judge does not mention that the order of protection is "extended" or "continued," be sure to ask the judge if a new order is being issued on your behalf. Once the case goes to a hearing or trial, if you win your case, the judge would issue a final order of protection instead of a temporary order of protection.)

Step 6: After the hearing
If you are concerned that the abuser will harass you when you leave the courthouse, ask the court officer if s/he would escort you to the door of the building. If you are afraid the abuser may follow you once you leave the courthouse, explain this to the court officer. The court officer might hold the abuser there for 10 or 15 minutes while you leave so that you can get a head start, which would make it difficult for the abuser to trail you. This could be
especially important if you are living in a shelter or confidential location and you do not want the abuser to know where you are staying.

Review the order before you leave the courthouse. If something is wrong or missing, ask the clerk to correct the order before you leave.

Make several copies of the protective order as soon as possible.
Keep a copy of the order with you at all times.
Leave copies of the order at your work place, at your home, at the children's school or daycare, in your car, with a sympathetic neighbor, and so on.
Give a copy to the security guard or person at the front desk where you live and/or work.
Give a copy of the order to anyone who is named in and protected by the order.
If the court has not given you an extra copy for your local law enforcement agency, take one of your extra copies and deliver it to them.
You may wish to consider changing your locks and your phone number. In some counties, there might be a domestic violence agency that would change your locks for free if you have an order of protection. For example, if you live in NYC, you can contact Safe Horizon's Domestic Violence Hotline at 1-800-621-HOPE (4673) and inquire about their program called Project Safe.

Q: Can I change or extend my order?
A: Modifying an order
Once an order is issued, only a judge can change it. If you want changes to an order, you must request them from the court. Speak with the clerk of court to complete a petition for a modification of your order.

Extending an order
As of August 13, 2010, a new law was passed that allows you to file to extend an order of protection for "good cause" even if no new incidents of abuse have occurred. It can also be extended if the abuser consents to the extension.

Life threatening Intimate Partner Violence

IPV assessment is an important component of the WINGS project.

- If the participant indicates that she does not feel safe going home with her partner today or if you feel that her life is in imminent danger, you should express your concerns to the participant and explore alternatives for safe emergency housing and an escort plan with participant. You should work out a plan for escorting the participant to a DV program with secure emergency housing or to safe place where the participant is confident her partner will not hurt her.
- Have a list of DV programs with contact names to call for availability.
- It is important that the participant feels invested as an active partner in coming up with a plan – give her options, let her weigh the pros and cons of each option and choose the option that works best for her. You may give advice and recommendations, but emphasize that it is the participant's choice.
- Develop an escort plan with participant. One possible plan is where you indicate to the partner that the participant needs to stay for an additional session or assessment that will take another two hours. Indicate to the partner that s/he can leave and that the participant will leave later. If partner is reluctant to leave, offer to pay for a car service for her/him to go home. After the partner leaves,

you should wait for a while and check outside the entrance to make sure s/he is not waiting for the participant. Contact a car service to pick up the participant outside your office and take her to the safe location. You should stay with participant until she is in the car or has arrived at the safe location.

Safety Planning Tips

(from New York State Guide to Finding Safety and Support from DV)

- Educate yourself about intimate partner violence –know what services are available in the community.

- Let go of any expectations you have that there is a "quick fix" to intimate partner violence or to the obstacles a victim faces. Understand that "inaction" may very well be the participant's best safety strategy at any given time.

- Believe the participant and let the participant know that you do

- Listen to what the participant tells you. If you actively listen, ask clarifying questions, and avoid making judgments and giving advice, you will most likely learn directly from the participant what it is she needs.

- Validate the participant's feelings. It is common for abused individuals to have conflicting feelings – love and fear, guilt and anger, hope and sadness. Let the participant know that her feelings are normal.

- Avoid victim blaming. Tell the participant that the abuse is not her fault. Reinforce that the abuse is his or her partner's problem and his or her responsibility, but refrain from "bad-mouthing" him or her.

- Take participant's fears seriously. If you are concerned about the participant's safety, express your concern without judgment by simply saying, "Your situation sounds dangerous and I'm concerned about your safety".

- Build on participant's strengths. Based on the information the participant gives you and your own observations, actively identify the ways in which the participant has developed coping strategies, solved problems, and exhibited courage and determination, even if the participant's efforts have not been completely successful.

- Be an active partner in participant's safety planning effort. The key to safety planning is taking a problem, considering the full range of available options, evaluating the risks and benefits of different options, and identifying ways to reduce risks.

Appendix IV. WINGS Research Articles

Gilbert, L., Shaw, S., Goddard, D., Chang, M., Rowe, J., Almonte, M., & Epperson, M. (2015). The Comparative Effectiveness of a Computerized Service Tool to address IPV among Drug-involved Women under Community Supervision: Results from Randomized Controlled Trial (WINGS). Criminal Behavior and Mental Health. 25:314-329.

Gilbert, L., Goddard-Eckrich, D., Hunt, T., Ma, X., Chang, M., Rowe, J., … & Shaw, S. A. (2016). Efficacy of a computerized intervention on HIV and intimate partner violence among substance-using women in community corrections: a randomized controlled trial. American Journal of Public Health, (0), e1-e9

Gilbert, L., Jiwatram-Negron, T., Nikitin, D, … & Hunt, T. (in press) Feasibility and Preliminary Effects of a Screening, Brief Intervention, and Referral to Treatment (SBIRT) Model to address Gender-based Violence among Substance-using Women in Kyrgyzstan: Project WINGS (Women Initiating New Goals of Safety). Drug and Alcohol Use Review.

Criminal Behaviour and Mental Health
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Project WINGS (Women Initiating New Goals of Safety): A randomised controlled trial of a screening, brief intervention and referral to treatment (SBIRT) service to identify and address intimate partner violence victimisation among substance-using women receiving community supervision

LOUISA GILBERT[1], STACEY A. SHAW[1], DAWN GODDARD-ECKRICH[1], MINGWAY CHANG[1], JESSICA ROWE[2], TARA MCCRIMMON[1], MARIA ALMONTE[3], SHARUN GOODWIN[4] AND MATTHEW EPPERSON[5], [1]The Social Intervention Group, Columbia University, New York, NY, USA; [2]Columbia Center for New Media Teaching and Learning, New York, NY, USA; [3]Bronx Community Solutions, Center for Court Innovation, Bronx, NY, USA; [4]The New York City Department of Probation, New York, NY, USA; [5]The University of Chicago School of Social Service Administration, Chicago, IL, USA

ABSTRACT

Background *The high rate of intimate partner violence (IPV) victimisation found among substance-using women receiving community supervision underscores the need for effective IPV victimisation screening, brief intervention and referral to treatment services (SBIRT) for this population.*

Aims *This randomised controlled trial (RCT) aims to assess the feasibility, safety and efficacy of a single-session computerised self-paced IPV SBIRT (Computerised*

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WINGS) in identifying IPV victimisation among women under community supervision and increasing access to IPV services, compared to the same IPV SBIRT service delivered by a case manager (Case Manager WINGS).

Methods *This RCT was conducted with 191 substance-using women in probation and community court sites in New York City.*

Results *No significant differences were found between Computerised and Case Manager WINGS arms on any outcomes. Both arms reported identical high rates of any physical, sexual or psychological IPV victimisation in the past year (77% for both arms) during the intervention. Both arms experienced significant increases from baseline to the 3-month follow-up in receipt of IPV services, social support, IPV self-efficacy and abstinence from drug use.*

Conclusions *Findings suggest that both modalities of WINGS show promise in identifying and addressing IPV victimisation among substance-using women receiving community supervision. Copyright © 2015 John Wiley & Sons, Ltd.*

Introduction

IPV victimisation is a serious public health threat that disproportionately affects substance-using women receiving community supervision, including probation, parole and alternative-to-incarceration programmes (Campbell and Lewandowski, 1997; Coker et al., 2002; Lipsky et al., 2010; Gilbert et al., 2012). Rates of experiencing physical or sexual IPV in the past year range between 32% and 56% for substance-using women on probation, which are 2–4 times higher than rates found among nationally representative samples of women (Golder et al., 2014). Meta-analyses suggest that the relationship between IPV victimisation and substance use is bi-directional and complex, varying by type of substance and by type of IPV, which includes physical, sexual or psychological abuse (Devries et al., 2014; Gilbert et al., 2015). IPV victimisation can also increase the risk of recidivism as a direct consequence of fighting back as well as an indirect consequence of increased substance abuse, mental health problems and economic insecurity associated with IPV (Stover et al., 2009).

Community supervision settings present an untapped opportunity to identify and address IPV victimisation among a large number of substance-using women, who are beyond the reach of social services and health care. Currently, about one million women receive community supervision nationwide, approximately 70% of whom have a history of drug use (Guydish et al., 2011; Maruschak et al., 2013). To date, however, there remains a dearth of screening, brief intervention and referral to treatment (SBIRT) interventions, which can identify and address IPV victimisation among substance-using women in community supervision settings.

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A recent systematic review (Nelson et al., 2012) found that self-paced computerised screening tools are effective in increasing rates of IPV disclosure among women in health care settings. RCTs conducted by Ahmad et al. (2009) and MacMillan et al. (2009) found that computerised screening tools were more efficacious in initiating patient-provider discussion of IPV and subsequently linking participants to care, compared to standard care. A self-paced computerised IPV SBIRT tool may have advantages over a case manager-delivered SBIRT service, as substance-using women in community supervision settings may fear legal repercussions from disclosing IPV or substance use to staff (Nelson et al., 2012).

A recent systematic review of 'brief' (three or fewer hours of contact) IPV SBIRT interventions targeting women in health care settings identified core components, including: screening for IPV, feedback on IPV risks, safety planning, setting goals to reduce IPV, linking women to IPV services (e.g. case management, counselling, group support, legal aid and emergency shelter) and increasing social support (Eckhardt et al., 2013). To our knowledge, no IPV SBIRT interventions have been developed and tested among substance-using or justice-involved women. However, SBIRT interventions have been effective in identifying and reducing drug use among justice-involved populations (Mericle et al., 2011). Interventions that address IPV victimisation among substance-using women have been found to effectively reduce drug use by addressing IPV-related triggers for substance use and PTSD-trauma associated with IPV (Fowler and Faulkner, 2011).

This RCT evaluates the feasibility, safety, acceptability and efficacy of a single-session self-paced computerised IPV SBIRT intervention (Computerised WINGS), as compared to the same single-session IPV SBIRT intervention delivered by study case managers (Case Manager WINGS) in community supervision settings. Based on prior research (Ahmad et al., 2009; MacMillan et al., 2009; Nelson et al., 2012), we hypothesised that, compared to Case Manager WINGS, Computerised WINGS participants would be more likely to disclose IPV victimisation and receive IPV services (primary outcomes) as well as increase IPV-related self-efficacy, social support and abstinence from drug use (secondary outcomes) from baseline to the 3-month follow-up. This RCT also evaluated whether within each study arm there were significant increases in receipt of IPV services and secondary outcomes from baseline to the 3-month follow-up.

Methods

Overview of design

We conducted this study in collaboration with the New York City Department of Probation, the Center for Court Innovation and Bronx Community Solutions. We formed a Community Collaborative Research Board (CCRB) consisting of women on probation, probation staff, service providers from the Community Court, substance abuse treatment providers and IPV service providers, who

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provided feedback on the design and implementation of WINGS. Study procedures received approval from the Columbia University Institutional Review Board and the Center for Court Innovation Review Board. Investigators and data collectors were masked to treatment assignment until the final 3-month follow-up assessment was completed in April 2013. Data were locked in September 2013, and the study arms were unmasked.

Participants

WINGS recruited women from two probation sites and a community court-administered alternative-to-incarceration programme. From May 2012 to January 2013 we screened 427 women, 245 of whom met eligibility criteria (see Figure 1), including: (1) being aged 18 or older, (2) having a mailing address, (3) reporting illicit drug use, binge drinking or receiving drug treatment in the past six months and (4) reporting an intimate relationship with a male and/or female partner in the past year. Of the 245 eligible women, 191 (77.9%) consented to participate and were enrolled in the study, and 171 completed the 3-month follow-up assessment (89.5% retention rate). Participants received compensation of $40 for completing the baseline assessment, $50 for the 3-month follow-up assessment and travel reimbursement of $10 for attending the intervention session.

We randomly assigned 191 women to receive either Computerised or Case Manager WINGS. The computer-generated randomisation algorithm was designed to balance the number of women per arm and site (Wei et al., 1986). No significant differences were found between study arms on socio-demographic characteristics or baseline primary or secondary outcomes.

Procedures

Research assistants actively recruited women from study sites by handing out flyers and inviting women to be screened. Eligible women who consented to participate completed a baseline survey within 14 days of screening. Participants were randomised with in 10 days of the baseline interview. Immediately after randomisation, participants completed either the Computerised WINGS or Case Manager WINGS. Study staff contacted participants by text, email or phone to schedule their 3-month post-intervention assessment. Participants completed assessments using audio computer-assisted self-interviewing (ACASI).

Measures

All outcome measures were administered at the baseline pre-intervention assessment and again at the 3-month follow-up assessment, except for the identification of IPV victimisation, which was only conducted during the screening activity of intervention for both study arms (see Table 2 for details of individual study arms).

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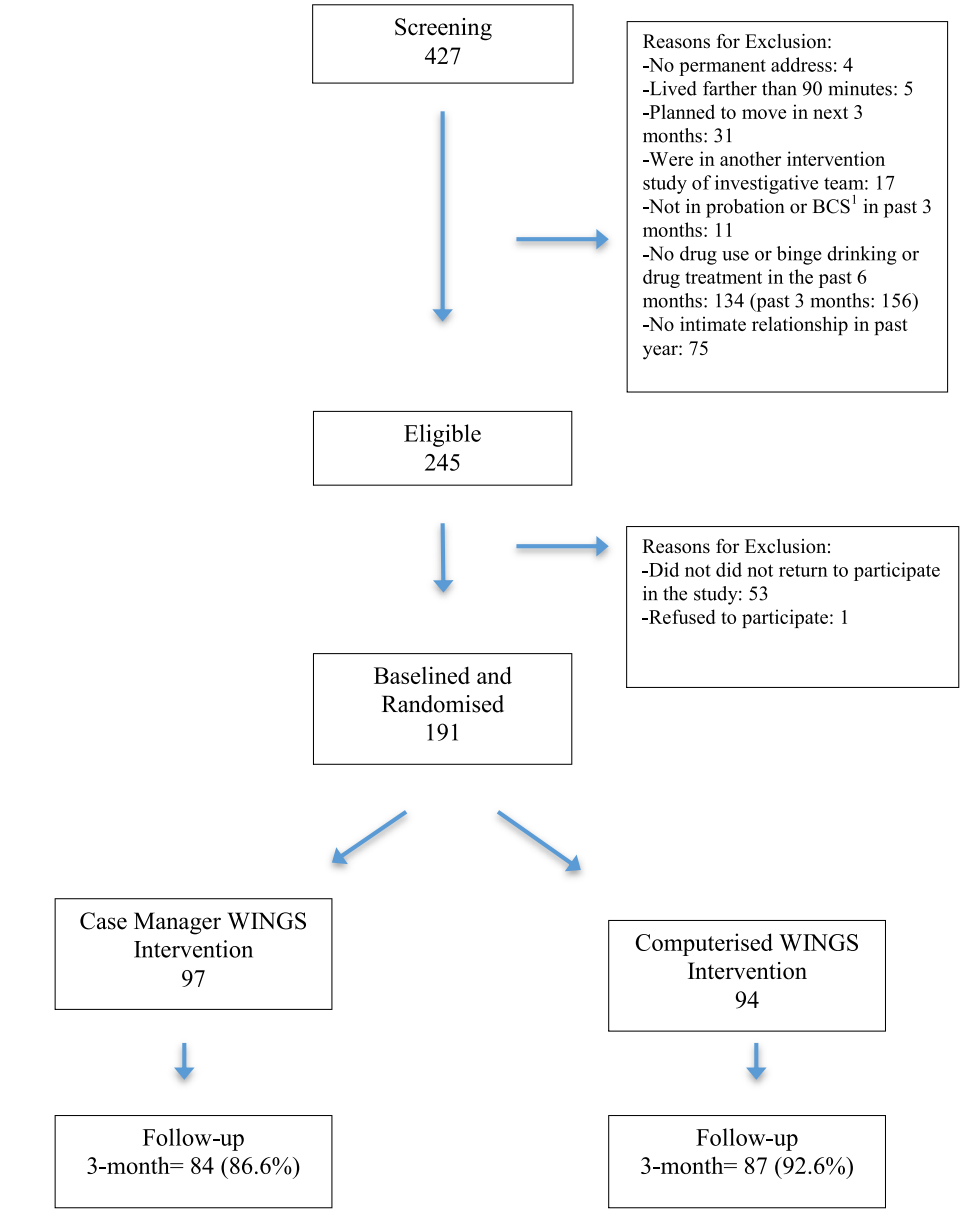

[1]- BCS: Bronx Community Solutions

Figure 1: WINGS participant allocation

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Primary outcomes

Identification of IPV victimisation was assessed using a shortened 8-item version of the Revised Conflict Tactics Scale (CTS2) that has been used in prior studies (Reichenheim and Moraes, 2004; Jiwatram-Negron and El-Bassel, 2015). This shortened version includes four subscales measuring any sexual, physical and severe verbal abuse within the past year (responses are dichotomised yes/no). Internal consistency of the CTS2 subscales ranges between .79 and .95 (Straus et al., 1996). Severe psychological abuse was assessed with a shortened 8-item version of the Psychological Maltreatment against Women Inventory (PMWI) that yielded a reliability of ($\alpha = 0.88$) (Tolman, 1999). Each item is rated on a 5-point frequency scale, ranging from 'never' to 'very frequently'.

Receipt of IPV services was assessed with a single item that asked, 'have you received any services, counselling or group support for partner abuse in the past 90 days,' which has been used in prior IPV prevention research (Wathen and MacMillan, 2003; Klevens et al., 2012; Eckhardt et al., 2013).

Secondary outcomes

IPV prevention self-efficacy was assessed using the Domestic Violence Self-Efficacy Scale (DVSE) (Riger et al., 2002), an 8-item scale with a reliability of ($\alpha = 0.88$) that measures perceived competency in managing abuse and conflict with partners. Participants rated statements such as 'I know when my partner hurts me it is not my fault' on a 5-point Likert scale, ranging from 'never' to 'always.'

Social support was measured using the 6-item Enriched Social Support Inventory (ESSI) (Vaglio et al., 2004) with a reliability of ($\alpha = .86$), which assessed the availability of emotional and instrumental support and advice for relationship conflict or problems with intimate partners and other issues with a 5-point Likert scale, ranging from 'none of the time' to 'all of the time'.

Frequency of drug use was assessed with an item from the Risk Behavior Assessment (NIDA, 1991), which measured the number of days without drug use in the past 30 days. This single outcome measure captures abstinence and drug use across multiple categories of drugs.

Socio-demographic and background variables included age, ethnicity/race, education, employment status, criminal justice history, residential status, marital status, intimate partner status (whether participant had an ongoing intimate and/or sexual relationship with a man or woman in the past three months), use of drugs and binge drinking (five or more drinks in a 6-hour period) in the past 90 days (SAMSHA, 2013), access to drug treatment and whether or not participants exchanged sex for money or drugs.

Intervention

The WINGS intervention is guided by Social Cognitive Theory (SCT) (Bandura, 1992; Bandura, 1994), which has been applied to IPV SBIRT models (Wathen and MacMillan, 2003; Eckhardt et al., 2013). The core components of

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Description of Study Intervention Arms	
Case Manager WINGS	**Computerised Self-Paced WINGS**
Psycho-education: Case manager describes high rates of intimate partner violence (IPV) among female drug users and women in the criminal justice system; reviews different types of IPV using the Power and Control Wheel adapted for drug users; describes drug-related triggers for IPV and IPV-related triggers for drug use	**Psycho-education:** Video testimonials from women in criminal justice system on their experience of different types of IPV and its negative effects; interactive presentation on high rates of IPV and Power and Control Wheel adapted for drug users; visual presentation of drug-related triggers for IPV and IPV-related triggers for drug use
Enhancing motivation to improve relationship safety: Case manager asks participants to identify potential negative effects of relationship conflict and experiencing IPV on their physical and mental health, well-being, and children; case manager then asks participants to identify motivations to improve relationship safety	**Enhancing motivation to improve relationship safety:** Participants select different negative effects of relationship conflict on their physical and mental health, well-being, and children from a drop-down menu; participants identify motivations to improve relationship safety from a drop-down menu
Screening and IPV risk assessment: Case manager administers abbreviated Revised Conflict Tactics Scale (CTS2) with participants that covers physical, injurious, verbal, and sexual abuse subscales (8 items) and the Psychological Maltreatment of Women Inventory (PMWI) that assesses psychological IPV (8 items); facilitator informs participants whether they are at high, medium, or low risk for IPV	**Screening and IPV risk assessment:** WINGS tool prompts participants to complete an Audio Computer-Assisted Self-Interview (ACASI) that covers the same CTS2 and PMWI items; participants receive computerised feedback on whether they are at high, medium, low risk for IPV
Safety planning: Case manager asks participants different safety planning items to reduce their risk of exposure to IPV using the IPV Safety Planning Checklist developed by a national consensus panel of experts on co-occurring IPV and drug use	**Safety planning:** WINGS tool asks participants to complete different safety planning items to reduce their risk of exposure to IPV using the IPV Safety Planning Checklist developed by a national consensus panel of experts on co-occurring IPV and drug use
Enhancing social support: Case manager asks participants to identify family members and friends to whom they can turn for support, advice, and practical help to prevent or reduce their risks for experiencing IPV and for resolving relationship conflict; case manager then asks participants to identify steps they can take to strengthen different types of support in the next week	**Enhancing social support:** Participants are presented with an interactive social network support tree that prompts them to identify up to 5 family members and friends to whom they can turn for support, advice, and practical help to prevent or reduce their risks for experiencing IPV and for resolving relationship conflict; the tool then prompts participants to identify steps they can take to strengthen different types of support in the next week
Goal-setting to reduce or prevent IPV: Case manager asks participants to identify personal relationship safety goals including (1) stay together, no change, (2) stay together, stop IPV, (3) separate or divorce from partner, no further contact, (4) separate or divorce from partner, but continue to be involved with children; case manager then asks participants to identify other steps they can take towards these goals	**Goal-setting to reduce or prevent IPV:** The tool asks participants to select personal relationship safety goals including: (1) stay together, no change, (2) stay together, stop IPV, (3) separate or divorce from partner, no further contact, (4) separate or divorce from partner, but continue to be involved with children; tool then prompts participants to identify other steps they can take towards these goals such as finding housing, getting a job, getting counselling or legal help, and avoiding drugs and alcohol
Identification of service needs and referrals: Based on participant goals, case manager helps participants identify and prioritise services that they may need and refers them to appropriate services; case manager then ask participants to come up with a step-by-step action plan for pursuing services in the next week and provides participants with service resource manual and printout of their safety plan	**Identification of service needs and referrals**: Based on participant goals, tool prompts participants to identify and prioritise services that they may need and refers them to specific appropriate services; the tool then prompts participants to create a step–by-step action plan for pursuing services in the next week. Participants receive a printout of the services they selected and their action plan to pursue to services as well as a hard copy of the service resource manual and printout of their safety plan

Figure 2: Description of study intervention arms

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WINGS (described in detail in Figure 2) enable substance-using women to identify and disclose IPV, provide feedback on their risks for IPV, develop self-efficacy to protect themselves from IPV, raise awareness of drug-related triggers for IPV, develop safety plans considering substance-related risks for IPV and enhance social supports and linkages to IPV services.

Case managers, who had at least an Associate's degree and two years related experience, were trained to administer both WINGS conditions in a private room at the study sites. The case manager for Computerised WINGS provided a 2-minute orientation to help participants navigate the computerised tool, and responed to any questions after the session. The Computerised WINGS tool had a female narrator who introduced each activity and participants could click an audio button to read the text for each screen.

Data analysis

We used intent-to-treat analyses to examine study hypotheses. Intent-to-treat analyses used all randomised participants, including participants unavailable for follow-up assessment. Multiple imputation (MI) was used to handle missing data because of loss to follow-up. Ten imputed datasets were generated. MI uses a participant's measured information to predict values of variables for which that individual's information is missing (Little and Rubin, 1987). MI relies on more plausible assumptions than do *ad hoc* imputation methods such as mean replacement, missing value treated as failure, or last observation carried forward. Although MI relies on the assumption of missing at random, which is not testable, we examined the differences in sociodemographic variables between those who were retained and those who were not retained at follow-up and no significant differences were found.

Generalised linear models were employed to examine study hypotheses by estimating whether or not identification of IPV and changes in study outcomes over the 3-month follow-up period differed between the two arms among women who reported any physical, sexual or psychological abuse (including any severe verbal on CTS2 and any psychological on PMWI). Generalised linear models were also used to estimate the changes on study outcomes from baseline to the 3-month follow-up within each arm. Random-effects linear, logistic and Poisson regressions were used for the continuous, dichotomous and count outcome measures, respectively. For identification of IPV, the models included dummy coding for intervention conditions (0 = Case Manager and 1 = Computerised) with random effects for type of site to estimate differences between arms. For all other outcomes, the models included dummy coding for conditions, assessment time (0 = baseline and 1 = follow-up), and interaction terms between condition and time with random effects for repeated measures and sites. Statistical analyses were performed using Stata 12.

Simulations conducted with Power Analysis & Sample Size (PASS) 2005 software showed that 90 subjects per intervention arm (a total of 181 subjects)

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were needed at baseline to achieve 80% power at the 0.05 significance level to detect medium-size effects (Prob(Y = 1) from 0.20 to 0.41) on the primary outcomes using multiple logistic regression.

Results

Participant characteristics

Of 191 randomised participants, 94 (49.2%) were assigned to Computerised WINGS, and 97 (50.7%) were assigned to Case Manager WINGS. The average age of participants was 34.2 years (SD = 11.4). Two-thirds identified as Black (67%, n = 128) and 29.8% (n = 57) as Latina. Nearly three-quarters (71.2%, n = 136) were single or never married. Among the total sample, 133 participants (69.6%) reported an ongoing intimate, dating and/or sexual relationship in the past 3 months with only a male partner; 26 (13.6%) had relationships with both male and female partners; 9 (4.7%) had relationships with only a female partner and 22 (11.5%) indicated that they had formerly had intimate relationship in the past year, but not in the past 3 months. Of the sample, 16.2% (n = 31) reported using crack cocaine in the past 30 days, 6.3% (n = 12) used heroin, 51% (n = 98) used any illicit drug and 42.9% (n = 82) reported binge drinking. Less than one-fifth (18.3%, n = 35) had received drug or alcohol treatment in the past 90 days. Four-fifths (79.6%, n = 152) were on probation in the past 90 days, and one-fifth (20.4%, n = 39) were enrolled in an alternative-to-incarceration programme. Nearly one-third (n = 60, 31.4%) reported exchanging sex for money or drugs in the past. No significant differences in these baseline characteristics were found between study conditions.

Fidelity and safety

Computerised WINGS participants completed the intervention session in an average of 44.63 minutes SD = 22.93, range = 15–123 and it took an average of 46.66 min (SD = 10.39, range = 24–76) for Case Manager WINGS participants to complete the session. Session adherence data confirmed that 99% of participants completed all activities for Computerised WINGS. Quality assurance of digital recordings of Case Manager WINGS indicated that 98% of participants completed all intervention activities. No adverse incidents were detected by staff or quality assurance reviews of WINGS sessions.

Acceptability

The majority of Computerised WINGS participants (88%, n = 73) and Case Manager WINGS participants (84%, n = 73) reported that they were very

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Table 1: Identification of different types of intimate partner violence (IPV) victimisation in prior year during screening activity of intervention by study arm (N = 191)

Types of IPV victimisation in prior year	Arm	# (%) or mean (SD)	Difference between Case Manager and Computer (OR or *b*, 95% CI and p-values)
Any Physical IPV (as measured by CTS2)	Case Manager	41 (42.3%)	0.89 [0.50, 1.58]
	Computer	37 (39.4%)	
Any Sexual IPV (as measured by CTS2)	Case Manager	25 (25.8%)	1.28 [0.68, 2.42]
	Computer	29 (30.9%)	
Physical or Sexual IPV (as measured by CTS2)	Case Manager	46 (47.4%)	1.02 [0.58, 1.80]
	Computer	45 (47.9%)	
Severe Verbal or Psychological IPV (as measure by CTS2 and PMWI)	Case Manager	75 (77.3%)	0.86 [0.44, 1.66]
	Computer	70 (74.5%)	
Physical, Sexual, Psychological or Severe Verbal IPV	Case Manager	75 (77.3%)	1.02 [0.52, 2.01]
	Computer	73 (77.7%)	
Psychological Maltreatment of Women Inventory (PMWI) score	Case Manager	7.3 (8.4)	−0.30 [−3.29, 2.69]
	Computer	7.0 (12.2)	

Note: SD= Standard Deviation; OR= Odds Ratio; CI= Confidence Interval.
*p < .05.
**p < .01.
***p < .001.

satisfied with the intervention at the 3-month follow-up. There were no significant differences in level of satisfaction between conditions.

Outcomes

There were no significant differences between conditions with respect to identification of IPV during the screening activity of the intervention (see Table 1) or improvement in receipt of IPV services or secondary outcomes (i.e. social support, IPV self-efficacy and abstinence from drug use) from baseline to 3-month follow-up (Table 2). The rates of disclosing physical, sexual or psychological IPV in the past year during the screening activity were nearly identical for both conditions (77.7% for Computerised and 77.3% for Case Manager WINGS). Both arms experienced statistically significant increases in receipt of IPV services

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Table 2: Effects of Computerised and Case Manager WINGS on linkage to intimate partner violence (IPV) services and secondary outcomes among the participants who experienced physical, sexual and psychological IPV (N = 148)

		Total sample		Multiple regression results with random effects set for measures and sites		
		# (%) or *mean* (*SD*)				
	Arm	Baseline (N = 148)	3 months (N = 130)	OR b IRR	CI [95%]	Difference of change between Case Manager and Computer
Received IPV services (past 90 days): *OR*	Case Manager	3 (4.0%)	11 (16.2%)	7.72*	[1.51, 39.45]	0.51 [0.07, 3.92]
	Computer	6 (8.3%)	12 (19.4%)	3.94*	[1.01, 15.38]	
IPV self-efficacy: *b*	Case Manager	20.93 (6.02)	22.85 (5.79)	1.91*	[0.10, 3.72]	0.36 [−2.20, 2.91]
	Computer	20.29 (6.80)	22.18 (6.12)	2.27*	[0.44, 4.09]	
Social support: *b*	Case Manager	19.92 (6.66)	21.49 (5.68)	1.63*	[0.11, 3.14]	1.44 [−0.77, 3.66]
	Computer	19.39 (6.96)	22.11 (5.89)	3.07**	[1.48, 4.67]	
Days not using drugs (past 30 days): *IRR*	Case Manager	13.21 (12.81)	17.12 (13.02)	1.30**	[1.17, 1.45]	0.91 [0.78, 1.07]
	Computer	13.93 (13.41)	16.23 (13.26)	1.19**	[1.05, 1.35]	

Note: SD= Standard Deviation; OR= Odds Ratio; CI= Confidence Interval.
*p < .05.
**p < .01.
Note: There was one missing response for 'Received IPV services,' 'IPV self-efficacy' and 'Social support;' and two missing responses for 'Days not using drugs' in the computerised condition.

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(primary outcome) as well as increases in available social support to address IPV, IPV self-efficacy and decreases in the number of days without using drugs from baseline to the 3-month follow-up.

Discussion

No significant differences were found between the Computerised and Case Manager-WINGS arms with respect to primary or secondary study outcomes, contrary to our hypothesis. The nearly identical high rates of IPV victimisation in the prior year identified in both arms are consistent with the high end of the range of rates found for comparable samples of substance-using women (El-Bassel et al., 2005; Gilbert et al., 2012; Kraanen et al., 2013; Devries et al., 2014). The high rates of IPV victimisation identified in this sample underscore the urgency for IPV SBIRT models that may be deployed in community supervision to identify at-risk women and link them to services.

The findings indicate that both Computerised and Case Manager modalities of WINGS are feasible, safe and show promise in identifying IPV victimisation and linking substance-using women to IPV services, as well as increasing their social support, IPV self-efficacy and number of abstinent days from drug use. There was some variability in the degree of change in the outcomes over the 3-month follow-up period by study arm. The Case Manager WINGS yielded higher rates of receipt of IPV services over this period, compared to the Computerised WINGS, which may suggest the importance of having a case manager assist with referrals to services. Computerised WINGS, however, yielded higher rates of social support over the 3-month follow-up period, compared to the Case Manager WINGS.

The high participation and retention rates, absence of reported adverse events, high fidelity of implementation and high client satisfaction ratings suggest the feasibility, safety and acceptability of WINGS whether it is delivered by computer or a case manager, consistent with prior intervention research that supports the efficacy of IPV SBIRT services among women in health care settings (Wathen and MacMillan, 2003; Eckhardt et al., 2013).

Limitations

This study had several limitations. The different time frames for reporting IPV victimisation during the intervention (past year) and the follow-up (past three months) precluded assessment of IPV as a study outcome. The lack of an attentional control group makes it difficult to ascertain whether or not treatment gains within each study arm may be attributed to WINGS or other non-intervention specific effects. Conversely, this study has numerous strengths including: random assignment, small loss-to-follow-up, an active comparison group, high fidelity of

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implementing both intervention conditions confirmed by quality assurance and blind assessment of outcomes.

Conclusions and recommendations for future research

Our study findings expand the evidence base for the use of SBIRT models in community supervision settings to address IPV victimisation and other co-occurring problems that may increase likelihood of recidivism (Mericle et al., 2011). As women who experience IPV often perpetrate IPV (Johnson, 1995; Johnson, 2008), future research should evaluate the efficacy of IPV SBIRT interventions in identifying and addressing perpetration of IPV or mutual IPV in addition to victimisation among this target population. The lower costs of implementing Computerised WINGS may increase the likelihood of it being scaled up in community supervision settings. Furthermore, it remains unclear whether community supervision staff would be able to implement Case Manager WINGS with the same fidelity and efficacy as our highly trained study case managers who identified themselves as non-criminal justice staff. Further research with an attentional control group and longer-term follow-up with IPV outcomes is needed to evaluate the effectiveness and cost-effectiveness of implementing Computerised and Case Manager modalities of WINGS on identifying and reducing IPV victimisation. Such research may inform an optimal approach to scaling up WINGS to address the widespread problem of IPV among substance-using women under community supervision.

Author disclosures

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Contributors

L. Gilbert was responsible for conceptualising and designing the study, analysing and interpreting the outcomes, and writing the manuscript. S.A. Shaw assisted with designing and managing the study, data analysis and writing the manuscript. D. Goddard-Eckrich assisted with conceptualising the study and managed the implementation of the trial. M. Chang contributed to data analysis and interpretation. J. Rowe assisted with conceptualising and designing the computerised WINGS intervention. T. McCrimmon assisted with reviewing and summarizing literature for the introduction and providing feedback on drafts. M. Almonte

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assisted with implementation of the study and data collection. S. Goodwin assisted with implementation of the study and data collection. M. Epperson assisted with conceptualising the study and review of the manuscript.

Conflicts of interest

The authors of this study report no conflicts of interest.

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Address correspondence to: Louisa Gilbert, Social Intervention Group, Columbia University School of Social Work, 1255 Amsterdam Avenue, Room 832, New York, NY, USA. Email: lg123@columbia.edu

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Feasibility and preliminary effects of a screening, brief intervention and referral to treatment model to address gender-based violence among women who use drugs in Kyrgyzstan: Project WINGS (Women Initiating New Goals of Safety)

LOUISA GILBERT[1], TINA JIWATRAM-NEGRON[1], DANIL NIKITIN[2], OLGA RYCHKOVA[3], TARA McCRIMMON[1], IRENA ERMOLAEVA[4], NADEJDA SHARONOVA[5], AIBEK MUKAMBETOV[6] & TIMOTHY HUNT[1]

[1]*Global Health Research Center of Central Asia, Columbia University, New York, USA,* [2]*Global Research Institute, Bishkek, Kyrgyzstan,* [3]*Open Society Foundations, New York, USA,* [4]*Asteria Foundation, Bishkek, Kyrgyzstan,* [5]*The Podruga Foundation, Osh, Kyrgyzstan, and* [6]*Open Society Foundations, Bishkek, Kyrgyzstan*

Abstract

Introduction and aims. *Intimate partner violence (IPV) and other forms of gender-based violence (GBV) are serious public health threats among women who use drugs or engage in binge drinking in Kyrgyzstan. This study aimed to evaluate the feasibility and preliminary effects of a two-session IPV and GBV screening, brief intervention and referral to treatment model (WINGS) with HIV counselling and testing for women who use drugs or engage in binge drinking in Kyrgyzstan, using a pre/post-design.* ***Design and methods.*** *We screened 109 women from harm reduction non-government organisations in Kyrgyzstan, of whom 78 were eligible, 73 participated in the intervention study, and 66 completed a 3-month post-intervention follow-up. To assess the effects of the intervention, we used random-effect Poisson and Logistic regression analyses for continuous and dichotomous outcomes respectively.* ***Results.*** *At baseline, 73% reported any physical or sexual IPV victimisation, and 60% reported any physical or sexual GBV victimisation in the past year. At the 3-month follow-up, participants reported experiencing 59% fewer physical IPV incidents in the prior 90 days than at baseline ($P < 0.001$) and 27% fewer physical GBV incidents than at baseline ($P < 0.01$). From baseline to the 3-month follow-up, participants also reported a 65% reduction in the odds of using any illicit drugs ($P < 0.05$) and were more likely to report receiving GBV-related services ($P < 0.001$).* ***Discussion and conclusion.*** *The high rates of participation, attendance and retention and significant reductions in IPV and GBV victimisation and drug use from baseline to the 3-month follow-up suggest the feasibility and promising effects of this brief intervention.* [Gilbert L, Jiwatram-Negron T, Nikitin D, Rychkova O, McCrimmon T, Ermolaeva I, Sharonova N, Mukambetov A, Hunt T. Feasibility and preliminary effects of a screening, brief intervention and referral to treatment model to address gender-based violence among women who use drugs in Kyrgyzstan: Project WINGS (Women Initiating New Goals of Safety). *Drug Alcohol Rev* 2016;00:000–000.]

Key words: intimate partner violence, gender-based violence, substance use, women, screening.

Introduction

Emerging evidence suggests that gender-based violence (GBV) is a serious public health threat and human rights violation among women who use or inject drugs or engage in binge drinking (WWUD) in Kyrgyzstan and other countries with heroin epidemics [1–3]. The term 'GBV' incorporates prevalent forms of violence against WWUD, including intimate partner violence (IPV), non-partner physical and sexual assault and trafficking [4]. Population-level prevalence estimates of IPV and other GBV victimisation among WWUD are scarce worldwide. However, research among different populations of WWUD has estimated that between 20 and 57% have experienced IPV in the past year, which is much higher than rates found among general female

Louisa Gilbert PhD, Associate Professor, Tina Jiwatram-Negron PhD, Post-Doctoral Fellow, Danil Nikitin MS, Project Director, Olga Rychkova MSc, Program Officer, Tara McCrimmon MPH, Project Coordinator, Irena Ermolaeva BA, Director of Asteria, Nadejda Sharonova BA, Director of Podruga, Aibek Mukambetov PhD, Program Officer, Timothy Hunt MS, Director of Training and Capacity Building. Correspondence to Dr Louisa Gilbert, Social Intervention Group, Global Health Research Center of Central Asia, Columbia University School of Social Work, 1255 Amsterdam Avenue, Room 832, New York, NY, USA. Tel: 212-851-2395; E-mail: lg123@columbia.edu

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populations [5–7]. Compared with general populations of women, WWUD also experience substantially higher rates of sexual assault from a range of non-intimate partners, including drug dealers, pimps and commercial clients as well as from police and prison guards [1,3,8,9].

Accumulating research has established multiple bi-directional relationships between different types of IPV and GBV victimisation and different types of drug and alcohol use [3,6,7,10]. Failure to address IPV and GBV among WWUD may significantly increase their risks for continued drug use, relapse and premature attrition from drug treatment [6,7,11,12]. Exposure to IPV and GBV victimisation has also been found to directly and indirectly increase the risk of HIV/sexually transmitted infection acquisition as well as to result in poorer treatment outcomes among women living with HIV [3,13]. Taken together, this research underscores the importance of redressing GBV victimisation in harm reduction programs, needle and syringe programs (NSP) and HIV treatment programs serving WWUD.

Recent systematic reviews highlight several gaps in the continuum of integrated interventions to address IPV and GBV for WWUD [3,14]. Although several interventions among WWUD have demonstrated efficacy or promising effects in reducing physical IPV [3,15], only one to our knowledge has reduced sexual IPV [16], and few have even addressed GBV. Moreover, these integrated interventions, which are 10 sessions or longer and require professional clinical skills, have been mostly implemented in drug treatment settings in the USA.

These systematic reviews underscore the urgent need for brief integrated GBV interventions that may be delivered in non-clinical settings to reach broader populations of WWUD at risk for GBV. Such brief GBV interventions may be combined and optimised with a continuum of HIV prevention, testing and treatment models that have been scaled up in NSPs and other harm reduction programs serving WWUD in Kyrgyzstan and other low- and middle-income countries. Given the widespread problem of IPV and GBV among WWUD worldwide, United Nations Office on Drugs and Crime and the World Health Organization recently added GBV screening and prevention services to their recommended comprehensive package of nine core services for NSPs [17].

Growing research worldwide suggests that screening, brief intervention and referral to treatment (SBIRT) models that include core components of IPV screening, safety planning and referrals to IPV services are promising in reducing IPV for women in health-care settings [18,19]. A recent randomised controlled trial tested the effectiveness of a single-session computerised versus case manager-delivered IPV SBIRT models [Women Initiating New Goals of Safety (WINGS)] among 191 WWUD in probation settings in the USA [20]. Both modalities identified equally high rates of physical and sexual IPV in the past year (47% for both conditions), and both significantly reduced drug use and increased use of IPV services at the 3-month follow-up [20]. These study findings suggest that WINGS has potential as a brief low-threshold intervention to address GBV among women in resource-constrained harm reduction settings worldwide.

This study aims to evaluate the feasibility and preliminary effects of implementing a two-session GBV prevention SBIRT model, which was adapted from WINGS and combined with rapid HIV counselling and testing (HCT) in two harm reduction non-government organisations (NGO) in Kyrgyzstan. We present empirical data on recruitment, attendance, retention, acceptability, safety and preliminary effects of WINGS using a pre-post design with 73 WWUD. The primary outcome for this feasibility trial was incidences of experiencing different types of IPV and GBV victimisation in the prior 90 days. Secondary outcomes included the prevalence of using illicit drugs in the prior 90 days and the percentage of women who received IPV or GBV-related services in the prior 90 days. Secondary outcomes also included a proportion of women who disclosed experiencing any type of IPV and GBV in the past year during the screening activity of the first intervention session and a proportion of women who agree to complete HCT by the second intervention session.

Methods

Study design and procedures

This study involved a pre/post-test pilot study of the WINGS SBIRT model, culturally adapted as Wings of Hope in Russian. Data were collected from participants immediately prior to participating in the intervention ('baseline') and 3 months after completing the intervention ('follow-up'). We conducted this study in collaboration with two harm reduction NGOs in Kyrgyzstan, Asteria, in the capital city of Bishkek and Podruga, in the southern border city of Osh. We formed a Community Collaborative Research Board consisting of harm reduction NGO staff, police, Ministry of Interior representatives, substance abuse treatment providers, representatives from United Nations Office on Drugs and Crime, Centers for Disease Control and Prevention and UNAIDS and GBV/IPV service providers. The Community Collaborative Research Board provided feedback on the adaptation, implementation and evaluation of WINGS.

Study procedures received approval from the Columbia University Institutional Review Board and the Institutional Review Board of the Global Research Institute of Kyrgyzstan.

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Recruitment and participation

Outreach workers actively recruited clients from study sites by handing out flyers and inviting women to be screened. They also visited public venues (e.g. parks, abandoned buildings) to recruit WWUD for this study. Women who expressed interest in participating completed informed consent prior to being screened.

Participants. From July to October 2013, we screened 109 women, 78 of whom met eligibility criteria, enrolled in the study and completed baseline assessment. Eligibility criteria included: (i) being aged 18 years or older; (ii) reporting illicit drug use, binge drinking or receiving drug or alcohol treatment in the past 6 months; and (iii) demonstrating basic fluency in Russian. Of the 78 women, 73 (93.5% participation rate) attended the first intervention session, 72 (92.3%) attended the second session, and 66 completed the 3-month follow-up assessment (90.4% retention rate). Approximately half (50.7%, $n = 37$) were recruited in Bishkek and 49.3% ($n = 36$) were recruited in Osh. There were no significant differences on socio-demographic characteristics or any outcomes between the participants who completed the 3-month follow-up versus those who were not retained, except for injection drug use. Those who reported injecting drugs in the prior 90 days at baseline were more likely to complete the 3-month follow-up. Figure 1 depicts the participant flow and yields for each of the study's main activities.

The participants received compensation equivalent to US$3 for completing the screening interview, US$5 for completing the baseline assessment, travel reimbursement of US$3 for attending each intervention session attended and US$7 for the 3-month follow-up assessment.

Procedures. Eligible women who provided consent completed a baseline survey using audio computer-assisted self-interview.

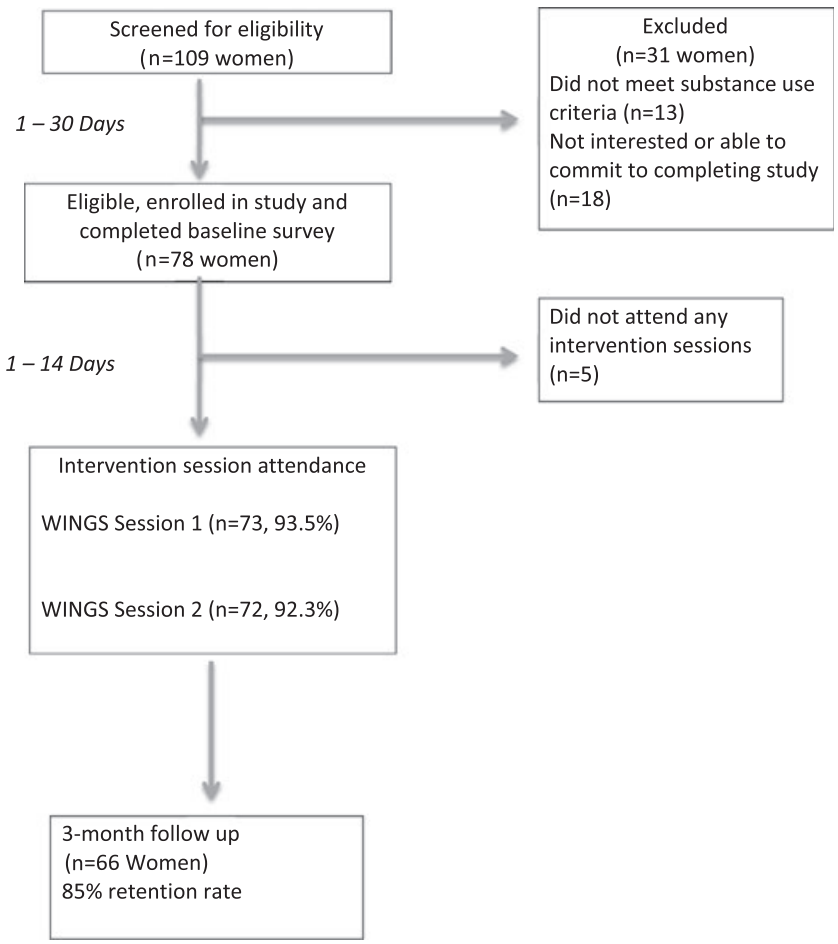

Figure 1. *Recruitment and participation flowchart for a pilot trial of WINGS.*

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Measures. Outcome measures were administered at the baseline pre-intervention assessment and again at the 3-month follow-up assessment. Additionally, IPV and GBV past year prevalence were assessed during the first intervention session, and receipt of HCT was assessed at the end of the second intervention session.

Primary outcomes. *Intimate partner violence* and *GBV victimisation* were assessed using a shortened 15-item version of the Revised Conflict Tactics Scale that has been used in prior studies [25,26]. It includes eight subscales measuring any minor or severe sexual, physical and severe verbal abuse/violence by an intimate partner (IPV) or other (GBV) within the past year (responses are dichotomised yes/no). The participants were also asked whether or not and the number of times they experienced any of these IPV and GBV items on these eight subscales in the prior 90 days at baseline and the 3-month follow-up for the primary outcome. Internal consistency of the Revised Conflict Tactics Scale subscales ranges between 0.79 and 0.95 [27].

Secondary outcomes. *Frequency of drug use* was assessed with an item from the Risk Behavior Assessment [21], which asked the participants whether or not they used any illicit drug, injected drugs and consumed four or more drinks in a 6-hour period (binge drinking) in the past 90 days [22].

Receipt of IPV/GBV services was assessed with a single item that asked, 'Have you received any services, counselling or group support for partner abuse or violence from others in the past 90 days?', which has been used in prior IPV prevention research [19,23,24].

Disclosure of IPV and GBV over the past year was measured during the screening activity of the first intervention session by the same shortened 15-item version of the Revised Conflict Tactics Scale used for the primary outcome described in the preceding texts (the only difference being a 12-month, rather than a 90-day, time frame).

Receipt of HIV Counselling and Testing was assessed by whether or not women agreed to complete HIV testing by the end of their second intervention session. At the 3-month follow-up, a single item assessed whether they had been linked to HIV care.

Socio-demographic and psychosocial background variables included age, ethnicity/race, religion, education, employment status, criminal justice history, residential status, marital status, opioid overdose history, exchanging sex for money or drugs and post-traumatic stress disorder (PTSD). PTSD was measured using the 17-item PTSD checklist—civilian, which has an alpha reliability of 0.97 [25].

Intervention development, content and delivery. Women Initiating New Goals of Safety is an evidence-based SBIRT intervention that was originally tested with WWUD in New York City [20]. WINGS is guided by social cognitive theory [26,27], which has been applied to IPV SBIRT models [19,24]. The core components of WINGS for this study (detailed in Figure 2) were designed to enable women to identify different types of IPV and GBV, develop self-efficacy to protect themselves from IPV and GBV, raise awareness of drug-related triggers for IPV and GBV, develop safety plans to reduce risks for IPV and GBV, enhance social support and link women to IPV and GBV-related services, substance abuse treatment and HCT and HIV care. We adapted WINGS by conducting two focus groups with NGO clients who met study eligibility criteria and two focus groups with NGO staff. The focus group data informed: (i) the inclusion of culturally specific types of IPV and GBV in Kyrgyzstan; (ii) safety planning steps that considered the different contexts in which IPV and GBV occur and (iii) available services for WWUD in Kyrgyzstan.

Non-government organisation caseworkers used a computerised structured interview to administer the IPV/GBV screening and provide automated feedback on their risks (none, medium, high) as well as to administer the other core activities of WINGS. The participants received a copy of their safety plans and social support map, their safety goals and service referrals. One to two weeks later, the participants completed the second session, where they updated their safety plans, addressed barriers to accessing services and were offered optional rapid HCT. The participants who tested positive were linked to HIV care.

Data analysis. Generalised linear models were employed to estimate whether changes in study outcomes significantly differed from baseline to the 3-month post-intervention assessment on the 66 women who completed both assessments. Random-effect linear, logistic and Poisson regressions were used for the continuous, dichotomous and count outcome measures respectively. These models included dummy coding for assessment time (0 = baseline and 1 = follow-up) with random effects for repeated measures and sites. Analyses were adjusted for age, ethnicity, education and the site at which they received the intervention. Statistical analyses were performed using Stata 12 [28].

Results

Socio-demographic and psychosocial characteristics

The participants had a mean age of 41 years (SD = 8.3) (Table 1). The majority were ethnic Russians (60.3%, $n = 44$), 9.6% were ethnic Kyrgyz, and the remaining 30.1% ($n = 22$) identified as 'other'. Nearly half (45.2%,

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Description of core components of WINGS SBIRT

Session 1
Psycho-education: NGO staff describes how conflict may occur in relationships and what IPV is and the different forms; describes how drug use may lead to violence and violence may trigger drug use; describes violence by others (GBV); provides information on how widespread violence is; consequences of violence on individual health and children; discusses/clarifies violence and misinformation about the acceptance of it in religion.
Screening and violence risk assessment: NGO staff administers abbreviated and adapted Revised Conflict Tactics Scale with participants that covers physical, injurious, verbal and sexual abuse subscales to screen for IPV and GBV victimisation in the past year; facilitator informs participants whether they are at high-, medium- or low-risk[a].
Enhancing motivation to improve relationship safety: NGO staff asks participants to identify potential negative effects of relationship conflict and experiencing IPV on their physical and mental health, well-being and children; then asks participants to identify their motivations to improve relationship safety.
Safety planning: NGO staff asks participants different safety planning items to reduce their risk of exposure to GBV using an adapted version of IPV Safety Planning Checklist which includes attention to violence by others.
Enhancing social support and reducing risk: NGO staff asks participants to identify family members and friends to whom they can turn for support, advice and practical help to prevent or reduce their risks for experiencing violence and for resolving relationship conflict; then asks participants to identify steps they can take in the next week to strengthen different types of support. Participants are also asked to map those who may pose a threat/danger to reduce risk of harm.
Goal-setting to reduce or prevent violence: NGO staff asks participants to identify personal relationship safety goals including: (i) stay together, no change; (ii) stay together, stop violence; (iii) separate or divorce from partner, no further contact; (iv) separate or divorce from partner, but continue to be involved with children or (v) distance or avoid engagement with other threatening relationships; then asks participants to identify other steps they can take towards these goals.
Identification of service needs and referrals: Based on participant goals, NGO staff collaboratively helps participants identify and prioritise services that they may need and refers them to appropriate and available services. Staff then asks participants to come up with a step-by-step action plan for pursuing services in the next week and provides participants with service resource manual and printout of their personal safety plan. NGO staff then schedules a follow-up session in 7-10 business days and tracks for confirmation of the linkage to care.

Session 2
Review and update risks: NGO staff provides a brief review of material from previous session, including risk assessment/screening, goal setting, and safety planning. NGO staff engages in a discussion to identify any new risks since previous session.
Assessing and building motivation and confidence: NGO staff administers a brief screening to assess motivation to address violence and identify barriers to implementing safety plan. NGO staff and participants then work to identify strategies/problem solve barriers.
Review and revise safety planning, support map, and goals: NGO staff and participants review and revise safety planning goals, social support enhancement plan, and other goals and service plan
Summary and self-care plan: NGO staff reviews sessions and checks-in with participants about progress towards self-care goals, helping participant identify new ones.
HIV counselling and testing: At the close of the session, participants are offered optional rapid HIV testing and counselling according to Kyrgyzstan Ministry of Health guidelines. Participants who tested positive were linked to HIV care.

[a] Women who did not screen positive for any IPV or GBV and were not in any relationship were asked to complete the post IPV and GBV screening activities (safety planning, social support enhancement, goal setting, identifying and addressing service referrals) from the hypothetical perspective if they were in a situation where they were experiencing IPV or GBV or if they are helping a family member or friend who are experiencing IPV and GBV.

GBV, gender-based violence; IPV, intimate partner violence; NGO, non-government organisation; SBIRT, screening, brief intervention, and referral to treatment; WINGS, Women Initiating New Goals of Safety.

Figure 2. *Description of core components of Women Initiating New Goals of Safety screening, brief intervention and referral to treatment.*

$n = 33$) were married. Approximately three-quarters (76.7%, $n = 56$) reported having children. The majority (61.6%) had a secondary or lower education. Less than one-third (30.1%, $n = 22$) were employed. The majority (81.2%, $n = 60$) had been arrested, and 54.8% ($n = 40$) reported having spent time in a jail or prison. Almost two-thirds (63%) reported engaging in sex trading in their lifetime. Almost nine of every ten women (89%, $n = 69$) met the criteria for PTSD.

Drug and alcohol use

Of the total baseline sample ($n = 78$), 60 (82.2%) reported using any illicit drug, 52.1% ($n = 38$) reported using heroin, and 69.9% met the criteria for binge drinking in the past 90 days. Slightly more than half (54.8%, $n = 40$) reported ever having experienced an opioid overdose. Less than half (41.1%, $n = 40$) were enrolled in any substance abuse treatment in the past 90 days.

Experience of different types of IPV and GBV victimisation in the past year

The participants disclosed very high rates of IPV and GBV over the past 12 months during the first intervention session (Table 2) with 80.8% ($n = 59$) experiencing physical or sexual IPV in the prior year and 61.6% ($n = 45$) experiencing physical or sexual GBV. More than

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Table 1. *Socio-demographics and background characteristics of women who participated in intervention study (n = 73)*

	n (%) or mean, SD
Age (mean, SD)	41.0, 8.3
Ethnicity	
Russian	44 (60.3%)
Kyrgyz	7 (9.6%)
Other	22 (30.1%)
Religion	
Muslim	17 (23.3%)
Christian	49 (67.1%)
Other	7 (9.6%)
Marital status—currently married/common-law marriage	33 (45.2%)
Women asked if they wanted to marry/live with their partner	14 (42.4%)
Education—secondary or lower	45 (61.6%)
Employment—employed, past 12 months	22 (30.1%)
Have children	56 (76.7%)
Place to sleep every night, past 90 days	66 (90.4%)
Ever arrested?	60 (81.2%)
Ever jail/prison?	40 (54.8%)
Sex trading, ever	46 (63.0%)
Intervention site	
Asteria	37 (50.7%)
Podruga	36 (49.3%)
Binge drinking	51(69.8%)
Any illicit drug use in the past 90 days	60 (82.2%)
Any heroin use in the past 90 days	38 (52.1%)
Ever experienced opioid overdose	40 (54.8%)
Enrolled in substance abuse treatment in past 90 days	30 (41.1%)
PTSD symptoms present	65 (89%)

PTSD, post-traumatic stress disorder.

half (56.2%, $n = 41$) experienced severe physical IPV, and 37% ($n = 27$) experienced severe sexual IPV in the prior year. Rates of severe violence by non-intimate partners were also elevated with 32.9% ($n = 24$), disclosing severe physical GBV and 32.9% ($n = 24$) severe sexual GBV. Half (50.7%, $n = 37$) indicated that police were among the perpetrators of GBV.

Preliminary effects of intervention on IPV, GBV and other health-related outcomes

Multivariate analyses examined changes in the outcomes over the time period from baseline to the 3-month follow-up (Table 3). At 3-month follow-up, the participants experienced 0.79 times the number of verbal IPV incidents compared with baseline ($P < 0.05$) and 0.41 times the number of physical IPV incidents compared with baseline ($P < 0.001$). Similarly, the participants experienced 0.73 times the number of physical GBV incidents compared with baseline ($P < 0.01$). At the 3-month follow-up, the participants had increased odds of being linked to IPV or GBV services (adjusted odds ratio = 12.3, $P < 0.001$). However, the participants experienced a significant increase in the number of verbal GBV incidents (adjusted incident rate ratio = 1.34, $P < 0.001$). No significant change was detected in incidents of sexual IPV or GBV from baseline to the 3-month follow-up.

Table 2. *Identification and prevalence of different types of IPV and GBV victimisation in the past year during screening activity of first intervention session (n = 73)*

Type of violence	Intimate partner, *n* (%)	Violence by other, *n* (%)
Verbal	51 (69.9%)	45 (61.6%)
Minor physical	49 (67.1%)	35 (48.0%)
Severe physical	41 (56.2%)	24 (32.9%)
Injurious	–	15 (20.6%)
Minor sexual	48 (65.8%)	33 (45.2%)
Severe sexual	27 (37.0%)	24 (32.9%)
Psychological abuse	34 (46.6%)	29 (39.7%)
Any physical/sexual violence	59 (80.8%)	45 (61.6%)
Ever police violence[1]		
Police among perpetrators	–	37 (50.7%)
Police was sole perpetrator of GBV	–	17 (23.3%)

[1]Assessed during baseline. GBV, gender-based violence; IPV, intimate partner violence.

There were significant decreases in the participants' drug use from baseline to the 3-month follow-up. The participants reported lower odds of any drug use in the past 90 days (adjusted odds ratio = 0.35, $P < 0.05$) and lower odds of any injection drug use in the past 90 days (adjusted odds ratio = 0.39, $P < 0.05$). No changes were noted regarding binge drinking behaviours.

Of the 73 participants who attended the first intervention session, 65 (89%) agreed to complete rapid HIV testing and counselling at the end of the second session. Of these participants, four (7.7%) tested positive for HIV (three were new cases), and three reported that they were successfully linked to HIV care by the 3-month follow-up.

Intervention attendance, acceptability and safety

Over 90% of the participants ($n = 72$) attended both intervention sessions. Of these participants, 63 (87.5%) indicated that they were extremely or very satisfied with the intervention, 60 (83.3%) felt extremely or very comfortable with their WINGS caseworker, and 69 (95%) indicated that they would recommend WINGS to others. No adverse events were detected by study staff or caseworkers.

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Table 3. *Effects of WINGS on incidents of IPV, GBV, substance use and linkage to services in the past 90 days (n = 66 women who completed 3-month follow-up)*

	Sample no. (%) or mean, SD		Relative risk ratio or odds ratio—change from baseline to 3-month follow-up	
	Baseline	3 months	Unadjusted	Adjusted[a]
Intimate partner violence				
No. of verbal incidents: IRR	3.5, 6.1	2.8, 6.7	0.79 [0.65, 0.96]*	0.79 [0.65, 0.96]*
No. of physical incidents: IRR	7, 12.0	2.9, 6.5	0.41 [0.35, 0.49]***	0.41 [0.35, 0.49]***
No. of sexual incidents: IRR	9.4, 18.8	8.9, 20.7	0.94 [0.84, 1.06]	0.94 [0.84, 1.06]
Gender-based violence				
No. of verbal incidents: IRR	3.9, 13.0	5.2, 16.6	1.34 [1.1, 1.6]***	1.34 [1.1, 1.6]***
No. of physical incidents: IRR	3, 6.9	2.2, 12.5	0.73 [0.59, 0.90]**	0.73 [0.59, 0.90]**
No.of sexual incidents: IRR	2.9,7.1	2.6, 7.0	0.89 [0.72, 1.1]	0.89 [0.72, 1.1]
Drug and alcohol use				
Any illicit drug use, past 30 days: OR	56 (84.9%)	43 (67.2%)	0.37 [0.16, 0.86]*	0.35 [0.15, 0.84]*
Any injection drug use, past 30 days: OR	38 (60.3%)	25 (39.7%)	0.43 [0.20, 0.91]*	0.39 [0.18, 0.84]*
Binge drinking, past 90 days: OR	45 (62.2%)	40 (60.6%)	0.50 [0.17, 1.5]	0.50 [0.17, 1.46]
Access to IPV/GBV-related services: OR	15 (22.7%)	55(77.3%)	11.56 [5.12, 26.1]***	12.3 [5.3, 28.4]***

*$P < 0.05$. **$P < 0.01$. ***$P < 0.001$. [a]Adjusted covariates include age, ethnicity, education and intervention site (non-government organisation site). GBV, gender-based violence; IPV, intimate partner violence; IRR, incident rate ratio; OR, odds ratio; WINGS, Women Initiating New Goals of Safety.

Discussion

To our knowledge, this is the first feasibility study of a GBV SBIRT model with HCT that has been implemented with WWUD in harm reduction settings in Kyrgyzstan or other countries. The high participation, attendance, retention and client satisfaction rates and absence of adverse events suggest the feasibility, safety and acceptability of WINGS. The findings also suggest that the intervention was effective in identifying high rates of different types of IPV and GBV in the prior year. These findings suggest that WINGS is not only an effective tool for screening for IPV, consistent with prior research [20], but it may be used to identify a wider spectrum of GBV, including police violence among WWUD in Kyrgyzstan.

The findings also suggest promising effects of the intervention over the 3-month follow-up period in reducing incidents of physical and verbal IPV as well as physical GBV. The lack of significant reduction in reported incidents of sexual IPV is consistent with findings from other IPV intervention studies [14,19] and may highlight the need for enhancing intervention content on sexual safety planning to avoid risky sexual encounters. The increase in number of verbal GBV incidents may be influenced by outlier cases, as suggested by the high-standard deviation values with this outcome. Alternatively, this result may suggest that as women began to enact safety planning strategies to resist risky encounters, they were more likely to experience verbal abuse.

The high proportion of participants who completed HIV testing demonstrates the promise of the intervention in increasing HIV testing rates and linking women to HIV care. The substantial increase in the proportion of women accessing IPV or GBV-related services from 22% at baseline to 77% at the 3-month follow-up indicates that the WINGS SBIRT model may play an instrumental role in linking women to services. The range and magnitude of changes in primary and secondary outcomes found in this study suggest that changes are clinically significant in addition to being statistically significant.

Limitations

The lack of a control or comparison group limits our ability to attribute the statistically significant changes in outcomes to the intervention as such changes could occur naturally over time or as a result of desirability biases, regression to the mean, reactivity to the assessment and other non-intervention related effects associated with engaging in other harm reduction services of the NGOs. The lack of a long-term follow-up makes it difficult to ascertain whether positive changes were sustained over time. The generalisability of the study findings is limited to the two NGOs where the pilot trial was conducted. WINGS did not address or assess for the perpetration of IPV or mutual IPV; this issue should be addressed in future research.

Conclusions

Despite these limitations, the study findings suggest the feasibility and promise of a brief SBIRT intervention in identifying and addressing the widespread problem of

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IPV and GBV among WWUD in Kyrgyzstan. Moreover, the high rates of completing HCT and linkage to HIV care suggest that WINGS may enhance HIV testing and treatment rates among WWUD.

These findings suggest that WINGS may also have relevance to address IPV and GBV in resource-constrained harm reduction settings in other countries where IPV or GBV services for WWUD are nascent or non-existent.

The high prevalence, severity and frequency of all types of IPV and GBV identified among this sample underscore the urgent need for policies and programs to address this serious public health and human rights issue among WWUD in Kyrgyzstan. The lack of systematic collection of IPV and GBV incidence and surveillance data among WWUD in Kyrgyzstan continues to remain a huge obstacle to bringing visibility to and addressing IPV and GBV in this population.

Consistent with findings from other studies on WWUD worldwide [9,29,30], the widespread experience of police violence highlights the critical need for redoubling and coordinating legislative, policy, program and advocacy initiatives to redress police violence against WWUD in Kyrgyzstan. Fear of experiencing police violence remains a huge obstacle for WWUD seeking safety, emergency medical care and legal protection from IPV and GBV. Although WINGS addresses police violence and sex work-related GBV, further refinements to the safety planning, social support enhancement, goal setting and referral activities in the intervention are needed to address the specific needs of women who are experiencing these issues. Similarly, the extremely high rates of PTSD and opioid overdose found in this study highlight the need for additional SBIRT modules that may identify WWUD at risk of these co-occurring issues and link them to appropriate services.

Future research is needed to evaluate the effectiveness of implementing WINGS in a broader range of harm reduction programs using a randomised controlled trial or a stepped-wedge design with a comparison condition, a longer-term follow-up and a larger sample size to detect changes in IPV, GBV and HIV testing and treatment outcomes among WWUD. The large network of NSPs and harm reduction programs in Kyrgyzstan and other countries provide an optimal venue to implement GBV SBIRT models like WINGS to reach a large number of WWUD at high risk of GBV and link them to GBV services as well as to HIV and substance abuse treatment services.

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Efficacy of a Computerized Intervention on HIV and Intimate Partner Violence Among Substance-Using Women in Community Corrections: A Randomized Controlled Trial

Louisa Gilbert, PhD, Dawn Goddard-Eckrich, MS, Timothy Hunt, MS, Xin Ma, MS, Mingway Chang, PhD, Jessica Rowe, MDes, Tara McCrimmon, MPH, Karen Johnson, PhD, Sharun Goodwin, BS, Maria Almonte, MSW, and Stacey A. Shaw, PhD

Objectives. To test the efficacy of a computerized, group-based HIV and intimate partner violence (IPV) intervention on reducing IPV victimization among substance-using women mandated to community corrections.

Methods. Between November 2009 and January 2012, we randomly allocated 306 women from community corrections in New York City to 3 study arms of a computerized HIV and IPV prevention trial: (1) 4 group sessions intervention with computerized self-paced IPV prevention modules (Computerized Women on the Road to Health [WORTH]), (2) traditional HIV and IPV prevention intervention group covering the same HIV and IPV content as Computerized WORTH without computers (Traditional WORTH), and (3) a Wellness Promotion control group. Primary outcomes were physical, injurious, and sexual IPV victimization in the previous 6 months at 12-month follow-up.

Results. Computerized WORTH participants reported significantly lower risk of physical IPV victimization, severe injurious IPV victimization, and severe sexual IPV victimization at 12-month follow-up when compared with control participants. No significant differences were seen between Traditional WORTH and control participants for any IPV outcomes.

Conclusions. The efficacy of Computerized WORTH across multiple IPV outcomes highlights the promise of integrating computerized, self-paced IPV prevention modules in HIV prevention groups. (*Am J Public Health.* 2016;106:1278–1286. doi:10.2105/AJPH.2016.303119)

The intersecting epidemics of intimate partner violence (IPV) victimization and HIV are heavily concentrated among women who use drugs or alcohol (herein defined as substance-using women) in community corrections (i.e., probation, parole, drug treatment courts, community courts, and alternative-to-incarceration programs).[1–4] Rates of experiencing physical or sexual IPV in the past year range between 32% and 56% for substance-using women on probation and are 2 to 5 times higher than rates found among nationally representative samples of women.[5] Additionally, HIV prevalence rates among substance-using women mandated to community corrections in New York City range from 13% to 17%, which are comparable to rates found among women in sub-Saharan Africa.[6,7] Despite the elevated rates of IPV victimization, HIV, and other sexually transmitted infections (STIs) among this population of women, as well as accumulating research linking IPV victimization to HIV and STIs,[4,8] HIV prevention interventions that integrate IPV prevention among substance-using women remain scarce in community corrections settings.

Currently, about 1 million women are on probation, parole, or other types of community corrections nationwide, 70% of whom have a history of drug use.[9,10] Community corrections settings represent an untapped venue to reach numerous difficult-to-reach substance-using women who are at risk for both IPV victimization and HIV. Growing research has documented multiple "entwined and mutually enhancing" biological and behavioral mechanisms linking substance abuse, violence, and AIDS (SAVA) that are fueled by social and economic inequities, which has been conceptualized as the SAVA syndemic.[4,11–13] Substance-using women in community corrections have been disproportionately affected by the SAVA syndemic, because they often live in low-income urban communities that have concentrated HIV epidemics and high rates of violence and incarceration. Incarceration disrupts intimate relationships and pushes households into poverty, increasing the likelihood of women having multiple sex partners and engaging in survival sex.[14,15] Substance-using women in community corrections also are more likely to experience sexual assault, further

ABOUT THE AUTHORS

Louisa Gilbert, Dawn Goddard-Eckrich, Timothy Hunt, Xin Ma, Mingway Chang, Tara McCrimmon, Karen Johnson, and Stacey A. Shaw are with Social Intervention Group, Columbia University, New York, NY. Jessica Rowe is with Columbia Center for New Media Teaching and Learning, New York, NY. Sharun Goodwin is with The New York City Department of Probation, New York, NY. Maria Almonte is with Bronx Community Solutions, Center for Court Innovation, Bronx, NY.

Correspondence should be sent to Louisa Gilbert, PhD, Social Intervention Group, Columbia University School of Social Work, 1255 Amsterdam Ave, Room 832, New York, NY 10027 (e-mail: lg123@columbia.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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increasing their risk for HIV.[16] Despite the large and growing population of women in community corrections programs in the United States affected by the SAVA syndemic, a recent systematic review identified only 4 interventions that reduced HIV risk behaviors for women in community corrections and none that reduced physical or sexual IPV.[16]

A recent meta-analysis identified sexual IPV as an independent risk factor for HIV infection among women.[17] Biologically, the risk of HIV acquisition increases during forced sex with HIV-positive partners as a result of vaginal and anal lacerations and an altered stress response from the immune system.[18] Multiple structural, biological, and behavioral syndemic mechanisms link IPV victimization to substance misuse and a wide range of HIV transmission risks.[4,12] Strong bidirectional associations have been established between use of different drugs and alcohol and all types of IPV victimization among women, including sexual IPV.[19,20] Among substance-using women, IPV victimization not only has been found to increase the likelihood of sharing injection drug equipment,[21] having multiple sexual partners,[8] exchanging sex for money or drugs,[15] acquiring STIs,[8] and not using condoms[8] but also is associated with not getting tested for HIV, not accessing HIV care, not adhering to antiretroviral medication, and failing to achieve viral load suppression.[12,22] Taken together, this research underscores the need for integrated behavioral HIV and IPV prevention interventions that can efficiently target the unique syndemic risks among substance-using women.

A small but growing body of research indicates that integrated behavioral IPV and HIV interventions are efficacious in reducing sexual HIV risks among women at risk for experiencing IPV.[4,23] Although the IPV prevention content in these HIV interventions has ranged in type, intensity, and modality, common components include raising awareness of IPV, screening for IPV, safety planning, identifying IPV service needs and referrals, and increasing sexual negotiation skills.[4] A recent systematic review of 44 best-evidence US-based HIV prevention interventions identified by the Centers for Disease Control and Prevention[23] ascertained 5 HIV interventions that addressed IPV and reduced 1 or more HIV risks. To our knowledge, however, only 2 integrated interventions have been found to be efficacious in reducing IPV among women.[24,25] To date, no integrated interventions have emerged that have shown efficacy in reducing the syndemic risk of sexual IPV (i.e., forced sex by an intimate partner) among substance-using women.

Emerging literature suggests the promise of brief computerized self-paced IPV prevention intervention tools that may be integrated in HIV interventions for substance-using women.[4] Compared with human-delivered interventions, computerized self-paced IPV prevention interventions have been found to be more effective in identifying and addressing IPV among women in health care settings.[26] Integrating computerized self-paced IPV prevention modules into group-based HIV interventions may have several advantages in addressing IPV among substance-using women over the traditional group format, including a greater likelihood of ensuring that all group members will complete IPV prevention activities, resulting in higher fidelity and precision of implementation. A computerized self-paced module also may ensure greater confidentiality and privacy among substance-using women who may fear legal or social consequences from disclosing IPV in a group setting.[26] To our knowledge, however, no integrated HIV and IPV prevention interventions have used computerized self-paced IPV prevention modules among substance-using women or women in general.

This study addressed a critical gap in HIV and IPV prevention research by testing the efficacy of a group-based computerized HIV and IPV prevention intervention (WORTH—Women on the Road to Health) in reducing the risk of IPV victimization among substance-using women in community corrections. A recent publication from this randomized controlled trial found that WORTH, whether delivered in a format with computerized self-paced and interactive group modules (Computerized WORTH) or in a traditional group format (Traditional WORTH), was efficacious in decreasing the number of unprotected sexual acts over the 12-month follow-up period, which was the primary outcome of this randomized controlled trial, compared with a Wellness Promotion attentional control group among 306 substance-using women in community corrections.[7] The primary aim of this study was to examine whether Computerized WORTH was more efficacious in reducing the risk of different types of IPV victimization at the 12-month follow-up, which was a secondary outcome of this randomized controlled trial, when compared with the Wellness Promotion control condition. We also examined whether Traditional WORTH was more efficacious than Wellness Promotion in reducing risk of IPV victimization at the 12-month follow-up.

METHODS

This randomized controlled trial was conducted in New York City between November 2009 and January 2012. We have described detailed methods, sample characteristics, and sample power calculations elsewhere[7] and included the CONSORT study flow diagram in Figure A (available as a supplement to the online version of this article at http://www.ajph.org).

Recruitment and Eligibility

Research assistants actively recruited and screened 1104 women from multiple community corrections sites by handing out flyers and inviting women to be screened. Of the 1104 women, 306 were eligible and were enrolled in the study. Eligible women reported

- being aged 18 years or older;
- being mandated to community corrections (i.e., probation, parole, community court, drug treatment court, or an alternative-to-incarceration program) in the past 90 days;
- using illicit drugs, binge drinking, or attending a substance abuse treatment program in the past 90 days;
- engaging in unprotected vaginal or anal intercourse within the past 90 days; and
- having at least 1 other HIV risk factor.

We conducted repeated assessments at 3-, 6-, and 12-month postintervention follow-ups at a centrally located community research office, but IPV outcomes were assessed only at 6- and 12-month follow-ups. Participants were reimbursed for completing assessments and intervention sessions up to a maximum of $265. More details on participant recruitment and retention are described in a previous publication.[7]

Randomization and Masking

A study investigator randomly assigned groups of 4 to 9 women to 1 of 3 study conditions; a computer-generated randomization algorithm was designed to balance the number of women per study arm via an adaptive, biased-coin procedure.[27] A total of 103 participants were assigned to Computerized WORTH, 101 to Traditional WORTH, and 102 to Wellness Promotion.

Investigators were masked to treatment assignment until the final 12-month follow-up assessment was completed in April 2013. Data were locked in September 2013, after which study arms were unmasked.

Intervention and Control Conditions

Traditional WORTH, consisting of a 4-session group HIV and IPV prevention intervention, is an evidence-based HIV intervention that was originally tested with women in jail[28] and in drug treatment.[29] For this study, we made minor modifications to WORTH to make it more contextually relevant for substance-using women in community corrections, such as addressing criminal justice–related triggers for unsafe sex and IPV (e.g., resisting drug use with a partner being released from prison).[28,29] The intervention was informed by social cognitive learning theory, which focuses on observation, modeling, and skill rehearsal through role play and feedback from group members.[30] Empowerment theory also guided a strengths-based approach of WORTH to build collective efficacy of women to negotiate safe relationships and counter stigma that they face as women in community corrections.[31]

Interventions were conducted at a community research site. A detailed description of IPV prevention content in Traditional and Computerized WORTH is provided in the box on the next page.[7] IPV-related components included risk reduction problem-solving and negotiation skills, awareness-raising of IPV, IPV triggers for unsafe sex and drug use, IPV screening and feedback, safety planning, social support to increase safety, identification of service needs and linkage to services, and IPV prevention goal setting.[32] For Traditional WORTH, all components, including IPV prevention activities, were conducted in a group setting. Two facilitators led group activities face-to-face once per week, with sessions lasting from 90 to 120 minutes.

Computerized WORTH also consisted of 4 weekly group sessions lasting 90 to 120 minutes, led by 2 facilitators. Computerized WORTH covered the same core components as Traditional WORTH, while employing group and individual interactive computerized games, video enhancements, and visual tools.[32] During each session, participants used individual laptops to independently view video vignettes of 4 fictional role models to promote identification and emotional engagement. Computerized self-paced modules covered the same IPV screening, prevention, and service referral activities that were conducted in the Traditional WORTH arm. Some activities (e.g., safety plan and IPV service referrals) were recorded in an electronic log that was printed for participants.

The Wellness Promotion control arm also consisted of 4 weekly group sessions lasting between 90 and 120 minutes, designed to control for modality and dosage. Core components of this psychoeducational intervention were adapted from an evidence-based wellness promotion intervention[33] and included maintaining a healthy diet, promoting fitness in daily routines, addressing tobacco use, learning stress-reduction exercises including guided meditation, and setting and achieving personal health goals.[33] None of the Wellness Promotion activities focused on IPV prevention.

Measures

IPV victimization outcomes. The primary outcomes for this study focused on different types of IPV victimization in the past 6 months. These outcomes were assessed at baseline, 6-month follow-up, and 12-month follow-up with a shortened 8-item version of the Revised Conflict Tactics Scale,[34] which includes 3 subscales measuring any sexual, physical, and injurious IPV within the past 6 months (responses were dichotomized as yes or no). These subscales contained items that assessed minor or severe IPV by type of IPV. Internal consistency of the Revised Conflict Tactics Scale subscales ranges between 0.79 and 0.95.[35]

Sociodemographic variables. Participants self-reported sociodemographic characteristics including gender, age, ethnicity, marital status, years of education, employment, monthly income, homelessness, the types of community corrections settings where they had enrolled in the past 90 days, and the number of times they had been arrested or incarcerated in jail or prison.

Current and past substance use. We used the Risk Behavior Assessment[36] to assess use of illicit drugs ever and within the past 90 days. To assess binge drinking, we asked whether participants consumed 4 or more alcoholic drinks within a 6-hour period.[37]

Analysis Plan

Consistent with the intent-to-treat approach, we estimated intervention effects by analyzing participant responses based on their experimental assignment. Because some missing data were the result of loss to follow-up at postintervention assessments, we used all available data at any follow-up visit in the statistical models. The 87% or higher retention rate at each follow-up did not differ significantly by condition. Attrition analyses, which compared sociodemographic characteristics of those who completed all follow-up assessments (completers) with those who missed 1 or more follow-up assessments (noncompleters), identified that completers on average were older (42 vs 39 years) and less likely to report homelessness (8% vs 18%). We estimated that with a sample of 112 women per arm, the study would have 80% statistical power, assuming an α level of .05, 2-sided hypothesis testing, no covariance adjustment, and intraclass correlations of 0.05 for the primary study outcomes previously published.[7]

WOMEN ON THE ROAD TO HEALTH (WORTH) INTIMATE PARTNER VIOLENCE (IPV) PREVENTION INTERVENTION COMPONENTS

Aim of WORTH Activity	Traditional WORTH Activity	Computerized WORTH Activity
Enhance sexually transmitted infection (STI) and HIV knowledge and perceived risk and identify attitudes toward safer sex and condom use.	Facilitator uses myth or fact statements and reading of case studies to transfer knowledge and correct misperceptions.	Participants play interactive game, watch culturally tailored videos, and respond to questions on a computer screen.
Identify and avoid unsafe sex and drug-related risks.	In group format, participants discuss triggers, including fear of IPV and substance use; share experiences; and read a case example to apply problem solving to reduce risks for unsafe sex.	Participants review potential triggers for unsafe sex, which include fear of IPV and substance misuse, and identify own triggers for unsafe sex or risky drug use on their computer (self-paced activity). Using a video model, the group applies a problem-solving model to avoid triggers and reduce risks.
Practice sexual negotiation, sexual safety planning, and problem-solving skills.	Facilitator discusses steps of negotiating condom use, reads a case example, and facilitates role play.	Video scenarios model sexual negotiation skills and sexual safety planning to avoid risky sexual encounters. Group identifies steps in negotiation and engages in role-play practice.
Improve linkage to services and promote HIV testing and care.	Facilitator reviews HIV testing options, provides resource manual, encourages participants to identify psychosocial needs, and uses manual to contact organizations to address HIV, IPV, and other services, facilitating group discussion about barriers to service access.	Computerized demonstration of HIV testing and exposure window assessment assists in prioritizing psychosocial needs and links to Web-based information to access community services (self-paced activity). Facilitators can access logs and assist in addressing barriers to accessing services for HIV, IPV, and other issues.
Reduce IPV and enhance supportive network.	Facilitator raises awareness about different types of IPV and supports the completion of individual IPV assessment and safety planning to reduce IPV risks. Participants are asked to identify sources of social support and service referrals that may reduce their IPV risks.	Participants use a video and audio tool to learn about different types of IPV, confidentially identify IPV risks, provide feedback on IPV risks, and develop a safety plan to reduce IPV risks (self-paced activity). Computerized, interactive tool helps women to identify sources of social support and IPV services that may help them reduce their IPV risks (self-paced activity).

We used logistic regression models with random effects to evaluate the effects of the intervention arms on IPV victimization in the past 6 months at each follow-up. All random-effects regression models included the dummy codes for intervention and modality effects and the baseline measure of the outcome of interest to estimate the effects for the follow-up period; we added the follow-up assessment time (in months) and interaction terms between time and dummy codes to yield the effects for each follow-up assessment. We grouped membership and repeated measures of a participant at each time point. We used a bootstrapping strategy that calculates estimates' SEs and *P* values to compensate for multiple comparisons.[38] The data were resampled 2000 times for each regression model. We used SAS version 9.3 (SAS Institute, Cary, NC) for all analyses. We reported odds ratios (ORs) and 95% confidence intervals (CIs) for these effects.

RESULTS

Sociodemographic, substance use, HIV, and lifetime IPV victimization characteristics of participants are reported in Table 1. The mean age of participants was 41.5 (SD = 10.5). A total of 208 participants (68%) identified as Black or African American, and 47 (15.4%) identified as Latina. Two thirds (n = 202; 66.0%) were single and never married. Only 25 women (8.2%) were employed, and 278 (90.8%) had ever been in prison or jail. Of the women, 194 (63.4%) reported using illicit drugs in the past 90 days. About one quarter (n = 81; 26.5%) tested positive for an STI, and 43 (14.1%) tested positive for HIV.

We did not find significant differences in any of the characteristics by study condition (Table 1).

TABLE 1—Background Characteristics and Intimate Partner Violence (IPV) Prevalence, by Study Arm: New York City, 2009–2012

	Total (n = 306), Mean ±SD or No. (%)	Wellness (n = 102), Mean ±SD or No. (%)	Traditional (n = 101), Mean ±SD or No. (%)	Computerized (n = 103), Mean ±SD or No. (%)
Age, y	41.5 ±10.5	42.1 ±9.7	41.9 ±10.8	40.5 ±10.9
Race/ethnicity				
Black	208 (68.0)	68 (66.7)	67 (66.3)	73 (70.9)
Latina	47 (15.4)	15 (14.7)	17 (16.8)	15 (14.6)
Other	51 (16.7)	19 (18.6)	17 (16.8)	15 (14.6)
High school or general equivalency diploma	176 (57.5)	55 (53.9)	66 (65.3)	55 (53.4)
Marital status				
Single	202 (66.0)	66 (64.7)	70 (69.3)	66 (64.1)
Married	49 (16.0)	18 (17.6)	12 (11.9)	19 (18.4)
Divorced/separated/widowed	55 (18.0)	18 (17.6)	19 (18.8)	18 (17.5)
Employment	25 (8.2)	9 (8.8)	7 (6.9)	9 (8.7)
Homeless, past 90 d	29 (9.5)	9 (8.8)	8 (7.9)	12 (11.7)
In inpatient drug treatment facility, past 90 d	63 (20.6)	23 (22.5)	15 (14.9)	25 (24.3)
Hospitalized for mental health or health reasons, past 90 d	40 (13.1)	13 (12.7)	9 (8.9)	18 (17.5)
Incarcerated in jail or prison, past 90 d	73 (23.9)	22 (21.6)	24 (23.8)	27 (26.2)
Ever in jail or prison	278 (90.8)	92 (90.2)	95 (94.1)	91 (88.3)
Community court, past 90 d	70 (22.9)	28 (27.5)	21 (20.8)	21 (20.4)
On probation, past 90 d	107 (35.0)	33 (32.4)	34 (33.7)	40 (38.8)
On parole, past 90 d	40 (13.1)	19 (18.6)	12 (11.9)	9 (8.7)
Drug court, past 90 d	47 (15.4)	13 (12.7)	16 (15.8)	18 (17.5)
Alternative-to-incarceration program, past 90 d	23 (7.5)	9 (8.8)	6 (5.9)	8 (7.8)
Ever used heroin	65 (21.2)	32 (31.4)	17 (16.8)	16 (15.5)
Used heroin, past 90 d	30 (9.8)	18 (17.6)	6 (5.9)	6 (5.8)
Ever used crack/cocaine	246 (80.4)	84 (82.4)	81 (80.2)	81 (78.6)
Used crack/cocaine, past 90 d	118 (38.6)	46 (45.1)	40 (39.6)	32 (31.1)
Ever used marijuana	267 (87.3)	85 (83.3)	90 (89.1)	92 (89.3)
Used marijuana, past 90 d	117 (38.2)	36 (35.3)	42 (41.6)	39 (37.9)
Ever injected drugs	69 (22.5)	32 (31.4)	19 (18.8)	18 (17.5)
Injected drugs, past 90 d	22 (7.2)	11 (10.8)	5 (5.0)	6 (5.8)
Ever used any illicit drug	300 (98.0)	99 (97.1)	99 (98.0)	102 (99.0)
Used any illicit drug, past 90 d	194 (63.4)	67 (65.7)	63 (62.4)	64 (62.1)
Ever engaged in binge drinking	174 (56.9)	54 (52.9)	64 (63.4)	56 (54.4)
Engaged in binge drinking, past 90 d	93 (30.4)	25 (24.5)	36 (35.6)	32 (31.1)
HIV positive	43 (14.1)	13 (12.7)	12 (11.9)	18 (17.5)
Any sexually transmitted infection	81 (26.5)	29 (28.4)	23 (22.8)	29 (28.2)
Ever experienced				
Any physical IPV	185 (60.5)	58 (56.9)	66 (65.3)	61 (59.2)
Any injurious IPV	177 (57.8)	51 (50.0)	67 (66.3)	59 (57.3)
Any sexual IPV	166 (54.2)	54 (52.9)	62 (61.4)	50 (48.5)
Severe physical IPV	170 (55.6)	53 (52.0)	62 (61.4)	55 (53.4)
Severe injurious IPV	151 (49.3)	44 (43.1)	54 (53.5)	53 (51.5)
Severe sexual IPV	117 (38.2)	40 (39.2)	37 (36.6)	40 (38.8)

TABLE 2—Prevalence of Intimate Partner Violence (IPV) Experiences in a Group-Based Computerized HIV and IPV Prevention Intervention (Women on the Road to Health) in Past 6 Months at Baseline, 6-Month Follow-Up, and 12-Month Follow-Up Assessments, by Study Condition: New York City, 2009–2012

	Baseline (n = 306 Randomized), No. (%)			6-Month Follow-Up (n = 277), No. (%)			12-Month Follow-Up (n = 278), No. (%)		
Study IPV Condition	Computerized (n = 103)	Traditional (n = 101)	WP Control (n = 102)	Computerized (n = 94)	Traditional (n = 91)	WP Control (n = 92)	Computerized (n = 91)	Traditional (n = 93)	WP Control (n = 94)
Any physical	16 (15.5)	7 (6.9)	8 (7.8)	14 (14.9)	9 (9.9)	11 (12.0)	8 (8.8)	12 (12.9)	17 (18.1)
Any injurious	11 (10.7)	7 (6.9)	11 (10.8)	8 (8.5)	10 (11.0)	8 (8.7)	7 (7.7)	6 (6.5)	14 (14.9)
Any sexual	12 (11.7)	7 (6.9)	12 (11.8)	12 (12.8)	9 (9.9)	11 (12.0)	7 (7.7)	9 (9.7)	11 (11.7)
Severe physical	15 (14.6)	7 (6.9)	6 (5.9)	8 (8.5)	7 (7.7)	7 (7.6)	6 (6.6)	9 (9.7)	12 (12.8)
Severe injurious	8 (7.8)	6 (5.9)	6 (5.9)	5 (5.3)	8 (8.8)	7 (7.6)	4 (4.4)	6 (6.5)	13 (13.8)
Severe sexual	5 (4.9)	1 (1.0)	3 (2.9)	5 (5.3)	6 (6.6)	6 (6.5)	2 (2.2)	4 (4.3)	8 (8.5)

Note. WP = Wellness Promotion.

Intimate Partner Violence Over Time by Study Condition

Among women in Computerized WORTH, rates of all types of IPV and severe IPV victimization in the past 6 months decreased from baseline to the 12-month follow-up. However, these rates did not decrease in either the Traditional WORTH or the Wellness Promotion control conditions (Table 2).

Intervention Outcomes

In Table 3, we present the results from random-effects logistic regression models of IPV victimization outcomes at 12 months postintervention, comparing Computerized WORTH and Traditional WORTH with Wellness Promotion control participants. The risk of experiencing physical IPV in the past 6 months was significantly lower at 12-month follow-up in Computerized WORTH when compared with the Wellness Promotion control arm (8.8% vs 18.1%; OR = 0.38; 95% CI = 0.15, 0.96; $P = .041$). Compared with Wellness Promotion control participants, Computerized WORTH participants also were less likely to experience severe injurious IPV in the past 6 months at the 12-month follow-up (4.4% vs 13.8%; OR = 0.24; 95% CI = 0.07, 0.87; $P = .030$) as well as severe sexual IPV (e.g., rape or forced sex; 2.2% vs 8.5%; OR = 0.22; 95% CI = 0.06, 0.80; $P = .021$).

Table 3 presents random-effects logistic regression models of IPV victimization outcomes at 12 months postintervention, comparing Traditional WORTH with Wellness Promotion participants. We did not find any significant differences between Traditional WORTH and Wellness Promotion participants in IPV victimization outcomes at 12 months postintervention.

DISCUSSION

In this randomized controlled trial, the risks of experiencing different types of IPV victimization in the previous 6 months were significantly lower at the 12-month follow-up among Computerized WORTH participants compared with Wellness Promotion control participants. Compared with Wellness Promotion control participants, Computerized WORTH participants were 62% less likely to report experiencing any physical IPV at the 12-month follow-up, 76% less likely to report injurious IPV, and 78% less likely to report severe sexual IPV (i.e., forced sex). Although the effects of Computerized WORTH were consistent across the different types of IPV, the significance of effects varied by severity of IPV, with stronger significant effect sizes for severe sexual IPV and severe injurious IPV. The magnitude and sustainability of results across IPV outcomes at the 12-month follow-up suggest the efficacy and clinical significance of Computerized WORTH in preventing IPV.

To our knowledge, this was the first randomized controlled trial to find significant effects of an integrated IPV and HIV prevention intervention on preventing IPV victimization among substance-using women in community corrections and on reducing the risk of forced sex among substance-using women. This outcome is particularly noteworthy given the high rates of sexual IPV and the syndemic mechanisms linking forced sex and HIV transmission found among substance-using women.[18]

The lack of significant differences in IPV outcomes at the 6-month follow-up between Computerized WORTH and control conditions is consistent with some IPV intervention studies, which found stronger effects at 12 months than at 6 months postintervention.[24,39] The delayed effect of WORTH on reducing IPV suggests that it may take more time for women on average to successfully implement their safety planning skills to avoid risks for IPV, access services, and leave abusive partners.

No significant differences were found between Traditional WORTH and Wellness Promotion in the likelihood of experiencing any type of IPV at the 12-month follow-up. The study findings highlight that the modality of delivering group interventions addressing IPV prevention is critical and suggest the efficacy of a hybrid approach of integrating computerized self-paced modules in group-based

TABLE 3—Group-Based Computerized HIV and Intimate Partner Violence (IPV) Prevention Intervention (WORTH—Women on the Road to Health) Effects on IPV Victimization Outcomes, by Duration of Follow-Up: New York City, 2009–2012

Outcome	6-Month Follow-Up, OR (95% CI)	12-Month Follow-Up, OR (95% CI)
Any physical IPV		
WP control (Ref)	1	1
Computerized WORTH	1.13 (0.49, 2.63)	0.38 (0.15, 0.96)
Traditional WORTH	0.80 (0.31, 2.08)	0.67 (0.31, 1.45)
Severe physical IPV		
WP control (Ref)	1	1
Computerized WORTH	0.95 (0.33, 2.76)	0.41 (0.15, 1.12)
Traditional WORTH	0.97 (0.31, 3.04)	0.73 (0.30, 1.79)
Severe injurious IPV		
WP control (Ref)	1	1
Computerized WORTH	0.60 (0.17, 2.13)	0.24 (0.07, 0.87)
Traditional WORTH	1.14 (0.44, 2.98)	0.44 (0.19, 1.02)
Any injurious IPV		
WP control (Ref)	1	1
Computerized WORTH	0.89 (0.34, 2.33)	0.43 (0.15, 1.20)
Traditional WORTH	1.33 (0.58, 3.03)	0.43 (0.18, 1.05)
Severe sexual IPV		
WP control (Ref)	1	1
Computerized WORTH	0.76 (0.21, 2.83)	0.22 (0.06, 0.80)
Traditional WORTH	1.03 (0.29, 3.69)	0.49 (0.15, 1.60)
Any sexual IPV		
WP control (Ref)	1	1
Computerized WORTH	0.96 (0.39, 2.35)	0.55 (0.18, 1.68)
Traditional WORTH	0.81 (0.33, 2.00)	0.87 (0.36, 2.12)

Note. CI = confidence interval; OR = odds ratio; WP = Wellness Promotion.

interventions. Research and multimedia learning theory suggest several factors that may explain the superior outcomes of Computerized WORTH on reducing risk of IPV, including (1) greater confidentiality of using a computerized tool that enables women to identify and address IPV risks, (2) greater fidelity of implementation and likelihood of engaging all group participants in IPV prevention activities, (3) the use of narrative characters that resonate with the target population who can model core skills, and (4) the use of both visual and verbal channels to enhance processing of IPV prevention information.[26,40]

Limitations and Strengths

Because this study was conducted with a heterogeneous sample of substance-using women from a range of community corrections settings, the findings are not generalizable to any one type of community corrections setting or any one type of substance use. Because research suggests that women who experience IPV often perpetrate IPV, which also increases the likelihood of engaging in a range of HIV risk behaviors,[41] future research should evaluate the efficacy of intervention models in identifying and addressing IPV perpetration or mutual IPV in addition to IPV victimization. This study did not assess psychological IPV, which is also associated with a range of HIV risk behaviors.[4]

This study, however, had numerous strengths, including random assignment, small loss to follow-up, an active comparison and control group, high fidelity of implementing intervention conditions confirmed by quality assurance, and blind assessment of outcomes.

Conclusions and Recommendations

Consistent with previous research,[5,6] elevated rates of experiencing physical, sexual, and injurious IPV along with the very high rates of HIV and STIs previously found in this sample of substance-using women in community corrections settings[6,7] underscore the urgent need for scaling up integrated IPV and HIV prevention interventions. The outcomes of this trial expand the evidence base of computerized self-paced IPV interventions that have been found to be effective in identifying and addressing IPV among general populations of women[26] and more recently among substance-using women.[42] The multiple syndemic mechanisms linking IPV victimization and HIV among substance-using women suggest that reducing the risk of all types of IPV, particularly forced sex, is critical for reducing the risk of acquiring HIV and STIs. Study findings further suggest the efficacy of computerized syndemic-focused HIV interventions on reducing risks of different types of IPV, including rape or forced sex, among substance-using women. Computerized self-paced IPV prevention tools have the added benefit of scalability in resource-constrained community corrections settings because they require less staff training and supervision to implement and thus may yield a greater cost benefit while ensuring greater implementation fidelity.[32]

Despite the promising effects of Computerized WORTH in reducing IPV, further research is needed to determine whether certain groups of people (e.g., those with minor IPV, low literacy, older age, or cognitive impairment) may respond better to traditional group formats for IPV prevention. Such research should examine the relative effectiveness of computerized self-paced versus traditional group modules in addressing the key mediators of WORTH to inform the optimal hybrid combination of traditional group and computerized self-paced activities. Identifying the key mediators associated with both IPV prevention and HIV risk reduction also may guide the design of hybrid interventions to most efficiently target

the SAVA syndemic mechanisms among substance-using women in community corrections.

Finally, implementation research is needed to evaluate the effectiveness and cost-effectiveness of delivering Computerized WORTH on reducing IPV victimization and HIV and STIs in community supervision settings. This research may elucidate key organizational, community, and structural factors to consider in scaling up Computerized WORTH in different community corrections settings to curb the IPV and HIV syndemic among substance-using women. AJPH

CONTRIBUTORS

L. Gilbert was responsible for conceptualizing and designing the study, analyzing and interpreting the outcomes, and writing the article. D. Goddard-Eckrich assisted with designing and managing the study and writing the article. T. Hunt assisted with conceptualizing the study, overseeing the implementation of the interventions for all 3 conditions, and interpreting results. X. Ma and M. Chang contributed to analyzing and interpreting the data. J. Rowe assisted with conceptualizing and designing the Computerized Women on the Road to Health intervention. T. McCrimmon and K. Johnson assisted with summarizing the literature and interpreting results. S. Goodwin and M. Almonte assisted with implementing the study and collecting the data. S. A. Shaw assisted with interpreting results and writing the article. All authors contributed to the article.

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HUMAN PARTICIPANT PROTECTION

Institutional review boards at Columbia University and the Center for Court Innovation approved study protocols prior to implementation. We obtained written informed consent from participants.

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Appendix V. Guidelines and Information for using Computerized Self-Paced WINGS Version

The Computerized Self-paced WINGS (Women Initiating New Goals for Safety) covers the same core components as the version of WINGS delivered by facilitators. Although participants are encouraged to complete the computerized WINGS at their own pace, it is important for facilitators administering Computerized WINGS to receive some basic training on the core components of WINGS so they are available to provide additional assistance or respond to any questions participants may have.

This version of Computerized WINGS runs in Qualtrics, a survey platform. For more information on Computerized WINGS or to access a demo version of Computerized WINGS, please email Dr. Louisa Gilbert at lg123@columbia.edu.

This manual covers only information specific to the protocol and adaptation of implementing Com-puterized WINGS. For help with Qualtrics, please visit https://www.qualtrics.com/support/

Resource Requirements

In order to install, adapt, and run WINGS successfully you will need:

- The WINGS Qualtrics file
- A Qualtrics license
- This manual
- A staff member who can act as a case worker
- Equipment on which to run the survey (i.e. computers, tablets, or smart phones, headphones for audio)

Protocol

WINGS was designed to be delivered in an agency setting, with a provider available to answer questions. Participants are asked to work through the survey on their own, but are told that they can ask for help and to speak to a provider at the end of the survey to receive their printed exit materials. Each participant's exit materials appear at the end of their WINGS survey. A provider should print this final page and either give the printout to the participant or ask for a mailing address for it. Once the survey is over, the exit materials cannot be accessed again.

Installation

After you've logged into Qualtrics, you can import the WINGS .qsf file to get started. Follow these steps:

1. Click 'Create Project' button
2. Choose 'From a File'
3. Click 'Choose a .qsf file'
4. Browse for the WINGS.qsf file on your desktop and select it
5. Name your version of WINGS
6. Click 'Create Project"

Now you have an undistributed copy of WINGS that you can adapt to your specific location.

How to Adapt

There are several ways in which you may want to adapt WINGS. WINGS offers service referrals, so you will need to input information about services available in your area. Additionally, you may want to change the protocol, in which case you will need to remove/add sections that refer to the protocol. For example, if you don't intend to have a case worker available during the survey, you'll need to remove references to a case worker.

Entering your local information

Here is a list of questions in the WINGS survey that require local information:

Q107/Increase your safety block
This question currently has 311 and the New York City domestic Violence Hotline listed. Change these numbers to reflect your local hotlines.

Q144-152, 158-161, 172, 174-185/Goal Setting and Service Referrals block
E
ach of these questions is linked to a choice in Q140 asking the participant to choose resources she thinks can help her meet her goals. You will need to enter local service organizations into each question. Note that if a service organization offers more than one type of service, you will need to enter the organization under each type of service provided. So, for example, if an organization offers both counseling for substance abuse and marriage counseling, you would enter that organization's name, address and telephone number under Q150 (alcohol/drug abuse counseling) and also under Q161 (couples/marital counseling).

Changing the Audio

The audio for WINGS is a recorded voice that says every word that is on each page, and is intended to support non-readers. The only exception to this is the service referrals section, in which we do not provide audio because we expect it to be different for every organization.

If you make changes to sections of WINGS, including the hotline numbers in Q107, keep in mind that the audio for those sections will no longer match the text. To resolve this you can a) remove the audio player from changed pages and/or b) record new audio, post to an online hosting service, and embed your new audio. WINGS is currently using Soundcloud to host audio. Soundcloud has a free level of service.

Changing the Protocol

WINGS was designed for a participant to take in proximity to a case worker, and the presence of a case worker is referred to several times. If you intend to change this, you should change all references to the case worker. These are the areas of WINGS where a case worker is mentioned:

Q164, Q165 (Goal Setting and Service Referrals section)

WINGS was also designed to be part of a randomized control trial and therefore begins with a field asking for the participant's ID number. If you are not running a study, just delete this question (Q171).

How WINGS is scored

WINGS uses a scoring mechanism to assess each participant's risk of intimate partner violence and displays either No Risk, Some Risk, or Severe Risk messages to the participant based on this score. The score is set up as follows:

Q35, 36, 5, 4, 6, 7, 37, 39, 40, 41, 38, 42, 43, 44, 46, 47, 48, 49, 50, 51-58 make up the IPV screener. The screener is not scored accumulatively; rather, one or more answers in the "some risk" category will give the participant a score of some risk, and one or more answer in the "severe risk" category will give the participant a score of severe risk.

Some Risk Category:
Q6 yes
Q7 yes
Q37 yes
Q39 yes
Q40 yes
Q41 yes
Q46 yes
Q47 yes
Q51 once, once a month, once a week, or daily
Q53 once, once a month, once a week, or daily
Q54 once, once a month, once a week, or daily
Q56 once, once a month, once a week, or daily
Q57 once, once a month, once a week, or daily
Q58 once, once a month, once a week, or daily
Q19 once

Severe Risk Category:
Q43 yes
Q44 yes
Q48 yes
Q19 once a month, once a week, or daily
Q55 once, once a month, once a week, or daily

How this works in Qualtrics:

Because Qualtrics expects an accumulative score, to make the above work, all 'some risk' answers are given a weight of 1 and the 'some risk' message is tied to a score range of 1-15. All 'severe risk' answers are given a weight of 16 and the 'severe risk' message is tied to a score of 16 or higher. The 'no risk' message is tied to a score of 0.

Data collection:

You can access participant answers inside Qualtrics under Data and Analysis/Data. You can export this data as a .cvs file under Export/Import. For more information and details, please visit Qualtrics online documentation at https://www.qualtrics.com/support/

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