




# INTIMATE PARTNER VIOLENCE PRACTICE GUIDE

State of Connecticut  
DEPARTMENT OF CHILDREN AND FAMILIES  
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## ***Introduction and Purpose of Practice Guide***

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When intimate partner violence (IPV) co-occurs with child abuse and/or neglect, an appropriate and timely assessment and intervention response promotes positive outcomes regarding child safety, permanency and well-being. In order to intervene effectively and improve the safety and well-being of children, as well as reducing re-traumatization, Department of Children and Families (DCF) staff must address the prevalence of IPV and the impact on children on their caseloads. This practice guide supplements and supports policy. The information and tools presented here reflect current data, trends and research.

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## ***Overview, Mission Statement, Guiding Principles and Goals***

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**Overview** - Every child and adult has the right to live in a safe, nurturing home. Child maltreatment and IPV often occur together and it is important to recognize the signs, screen and assess for IPV and provide a safe intervention response. The mission of Connecticut's DCF is to work together with families and communities for children who are healthy, safe, smart and strong.

**IPV Mission Statement** - To provide a family-oriented, comprehensive response to IPV that offers meaningful and sustainable assistance to families that is safe, respectful, trauma-informed, culturally relevant and responsive to the unique strengths, concerns and needs of the family.

**Guiding Principles** – The safety and well-being of children is best ensured through promoting healthy relationships through a commitment to ongoing growth, effective communication and mutual respect in homes free from IPV. Safety and well-being of children will result in the provision of a full continuum of IPV services through a state and local coordinated response.

### **IPV Goals**

- Establish a comprehensive response to IPV that offers meaningful and sustainable assistance to families that is safe, respectful, trauma-informed, culturally relevant, in their preferred language, and responsive to the unique strengths and concerns of the families impacted by IPV.
- Develop and maintain a full continuum of IPV services that supports safety and well-being of children.
- Increase the internal capacity to respond to families impacted by IPV.
- Continue to provide training to the DCF workforce to respond to IPV.
- Assess and meet the needs of low, moderate and high risk families.

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## **Data**

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- IPV, sexual violence, and stalking are widespread impacting millions of American each year.
  - 20 people per minute are victims of physical violence by an intimate partner in the U.S.
  - IPV can cause far-reaching health issues creating a ripple effect of consequences beyond immediate injury. 27% of women and 12% of men have experienced contact sexual violence, physical violence or stalking by an intimate partner and reported significant short- or long-term impacts, such as post-traumatic stress disorder symptoms and injury.
  - Nearly one in every two women and one in every five men have experienced sexual violence victimization other than rape at some point in their lives.
  - 79% of female victims of rape report they were first raped before age 25.
  - 28% of male victims of rape report they were first raped when ten years old or younger.
  - More than half of female victims and nearly half of male victims of stalking indicate they were first stalked before age 25.
  - IPV impacts all types of people of all races and ethnicities.
  - Exposure to IPV is distressing to children and is associated with traumatic stress and other behavioral health symptoms, both in childhood and in later life.
  - It is estimated that nearly 18% of all children and youth are exposed to some form of physical IPV during their childhoods.
  - One in three adolescents in the U.S. is a victim of physical, sexual, emotional or verbal abuse from a dating partner, a figure that far exceeds rates of other types of youth violence.
  - Nearly 1.5 million high school students nationwide experience physical abuse from a dating partner in a single year.
  - One in ten high school students have been purposefully hit, slapped or physically hurt by a boyfriend or girlfriend.
  - Between 45 – 70% of children exposed to IPV are also victims of physical abuse.
- <http://www.cdc.gov/violenceprevention/pdf/nisvs-fact-sheet-2014.pdf>

In Connecticut, there are approximately 14,500 intimate partner violence incidents annually resulting in at least one arrest (Connecticut Coalition against Domestic Violence, 2014 Fatality Review report). The DCF internal data on families also shows that violence is occurring within homes in Connecticut, as indicated by the following 2016 DCF data:

- In calendar year 2016, DCF received 31,319 reports.
- Of those reports, there were allegations of IPV in 6,168 reports.

- In IPV reports, 58.8% (3,629) were served through the investigation track and 36.4% (2,244) through the Family Assessment Response (FAR).
- In 4.8% (295), the initial FAR response was shifted to the investigation track.
- Approximately 18.4% of families are referred to our community partner agencies with IPV-related concerns.
- In 2016, approximately 39% (1,506) of reports with an indicator or allegation of IPV serviced through the investigation track were substantiated. The total number of investigations with an IPV indicator or allegation was 3,924.
- In 2016, the demographic profiles of the alleged victims were:

<b>Ages</b>	<b>#</b>	<b>%</b>
Ages 0-2	1266	25.5
Ages 3-5	883	17.8
Ages 6-12	1793	36.1
Ages 13-17	812	16.4
Ages >=18	86	1.7

<b>Ethnicity</b>	<b>#</b>	<b>%</b>
Hispanic, any race	1806	36.4
Black	1118	22.5
Other	495	10.7
White	1557	30.3

<b>Gender</b>	<b>#</b>	<b>%</b>
Female	2435	49.1
Male	2475	49.9
Undetermined	50	1

- In 2016, 78% of the IPV reports had co-occurring IPV and substance use, consistent with studies that indicate a very strong intersection between IPV and substance use. Studies of IPV frequently indicate high rates of alcohol and drug use by offenders during abuse. Not only do offenders tend to abuse drugs and alcohol, but IPV also increased the probability that victims will use alcohol and drugs to cope with abuse.
- Consistently over the last 13 years, the number and percent of accepted reports that include allegations of IPV from calendar year 2000 through calendar year 2016 remain consistent at approximately 21%. This reflects only those reports that are received and accepted with allegations of IPV and does not reflect the additional instances of IPV that may be discovered through assessment.

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***Common Terms and Definitions: Intimate Partner Violence and  
Associated Terms***

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**Intimate Partner Violence—Overall Definition**

**Intimate partner violence** (IPV) is a serious, preventable public health problem that affects millions of Americans. The term "intimate partner violence" describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner. IPV can occur between heterosexual or same-sex couples and does not require sexual intimacy. (Centers for Disease Control and Prevention, 2015.)

An **intimate partner** is a person with whom one has a close personal relationship that can be characterized by the following:

- emotional connectedness
- regular contact
- ongoing physical contact and sexual behavior
- identity as a couple
- familiarity and knowledge about each other's lives.

The relationship need not involve all of these dimensions.

**Intimate partner relationships include current or former:**

- spouses (married spouses, common-law spouses, civil union spouses, domestic partners)
- boyfriends/girlfriends
- dating partners
- ongoing sexual partners

Intimate partners may or may not be cohabitating. Intimate partners can be opposite or same sex. If the non-offending partner and the offending partner have a child in common and a previous relationship but no current relationship, then by definition they fit into the category of former intimate partner.

**Non-offending partner/caregiver** - Person who is the target of IPV. (Also referred to as a survivor or victim.)

**Offending partner/caregiver** - Person who inflicts the IPV. (Also referred to as batterer or perpetrator.)

## Intimate Partner Violence vs. Family Violence vs. Domestic Violence

- **Intimate partner violence (IPV)** is a serious, preventable public health problem that affects millions of Americans of all races. The term "intimate partner violence" describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner.
- **Family violence** encompasses any violence between family members, including that between siblings or across generations, in addition to violence between partners.
- **Domestic violence** is often used interchangeably with intimate partner violence, but the term is similar to family violence in that it can also include child or elder abuse, or abuse by any member of a household. This term also implies cohabitation. DCF staff will utilize the term "intimate partner violence" to specifically refer to violence between intimate partners, whether or not they cohabit.  
(National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention, 2015.)

### Types of Violence

**Violent episode** - A single act or series of acts of violence that are perceived to be connected to each other and that may persist over a period of minutes, hours or days. A violent episode may involve single or multiple types of violence.

**Pattern of violence** - The way that violence is distributed over time in terms of frequency, severity or type of violent episode.

**Physical violence** - The intentional use of physical force with the potential for causing death, disability, injury or harm. Physical violence includes but is not limited to: scratching, pushing, shoving, throwing, grabbing, biting, strangulation, shaking, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife or other object), and use of restraints or one's body, size or strength against another person. Physical violence also includes coercing other people to commit any of the above acts.

**Sexual violence** - A sexual act that is committed or attempted by another person without the freely given consent of the victim or against someone who is unable to consent or refuse. It includes forced or alcohol- or drug-facilitated penetration of a victim; forced or alcohol- or drug-facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; non-physically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party.



Sexual violence involves a lack of freely given consent as well as situations in which the victim is unable to consent or refuse:

- Consent - words or overt actions by a person who is legally or functionally competent to give informed approval, indicating a freely given agreement to have sexual intercourse or sexual contact.
- Inability to consent - a freely given agreement to have sexual intercourse or sexual contact cannot occur because of the victim's age, illness, limited English language proficiency or literacy, mental or physical disability, being asleep or unconscious or being too intoxicated (*e.g.*, incapacitation, lack of consciousness, or lack of awareness) through his or her voluntary or involuntary use of alcohol or drugs.
- Inability to refuse - disagreement to engage in a sexual act is precluded because of the use or possession of guns or other weapons, or due to physical violence, threats of physical violence, intimidation or pressure or misuse of authority.

**Sexual trafficking** - The recruitment, harboring, transportation, provision or obtaining of a person for the purpose of a commercial sex act. An example in the context of IPV includes an offender forcing a partner into commercial sex work.

**Stalking** - A pattern of repeated, unwanted attention and contact that causes fear or concern for one's own safety or the safety of someone else (*e.g.*, family member, close friend). Stalking is often an indicator of other forms of violence. Abusers use stalking to intimidate and control their victims. (National Coalition against Domestic Violence.)

Stalking acts by an offender can include but are not limited to:

- Repeated and unwanted phone calls, voice messages, text messages, pages and hang-ups.
- Repeated and unwanted emails, instant messages or messages through websites or social media, and cyberstalking through Facebook, Twitter, Instagram.
- Leaving cards, letters, flowers, or presents when the victim does not want them.
- Watching or following from a distance.
- Spying with a listening device, camera or global positioning system (GPS).
- Approaching or showing up in places (*e.g.*, home, work, school) when the victim does not want to see the person.
- Leaving strange or potentially threatening items for the victim to find.
- Sneaking into the victim's home or car and doing things to scare the victim by letting him or her know the offender has been there.
- Damaging the victim's personal property or belongings.
- Harming or threatening to harm the victim's pet.
- Making threats to physically harm the victim.

**Psychological aggression** - Use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally or exert control over another person. Psychologically aggressive acts are not physical acts of violence, and in some cases may not be perceived as aggression because they are covert and manipulative in nature. Nevertheless, psychological aggression is an essential component of IPV for a number of reasons. First, psychological aggression frequently co-occurs with other forms of IPV and research suggests that it often precedes physical and sexual violence in violent relationships. Second, acts of psychological aggression can significantly influence the impact of other forms of IPV (*e.g.*, the fear resulting from being hit by an intimate partner will likely be greater had the intimate partner previously threatened to kill the victim). Third, research suggests that the impact of psychological aggression by an intimate partner is every bit as significant as that of physical violence by an intimate partner. However, further work needs to be done related to the measurement of psychological aggression, particularly how to determine when psychologically aggressive behavior crosses the threshold into psychological abuse and the impact cultural beliefs have on psychological aggression.

Psychological aggression can include but is not limited to:

- Expressive aggression (*e.g.*, name-calling, humiliating, degrading, acting angry in a way that seems dangerous).
- Coercive control [*e.g.*, limiting access to transportation, money, friends and family; excessive monitoring of a person's whereabouts and communications; monitoring or interfering with electronic communication (*e.g.*, emails, instant messages, social media) without permission; making threats to harm self; or making threats to harm a loved one or possession].
- Threat of physical or sexual violence (*e.g.*, "I'll kill you;" "I'll beat you up if you don't have sex with me;" brandishing a weapon) and the use of words, gestures or weapons to communicate the intent to cause death, disability, injury or physical harm. Threats also include the use of words, gestures or weapons to communicate the intent to compel a person to engage in sex acts or sexual contact when the person is either unwilling or unable to consent.
- Control of reproductive or sexual health (*e.g.*, refusal to use birth control; coerced pregnancy terminations).
- Exploitation of victim's vulnerability (*e.g.*, immigration status, disability, undisclosed sexual orientation).
- Exploitation of offender's vulnerability (*e.g.*, offender's use of real or perceived disability; immigration status to control a victim's choices or limit a victim's options, for example, telling a victim "If you call the police, I could be deported.")

**Economic abuse** - Economic abuse can include controlling money, bank accounts or assets belonging to the family; not allowing the victim to work; interfering with the victim's work

to the point that he or she may lose his or her job; making the victim completely responsible for bringing in income to the family; and other acts that set up a financial dependence in the relationship.

(<http://www.nyscadv.org/types-of-abuse-on-9/15/15>).

**Digital abuse** - Digital abuse is the use of technologies such as texting and social networking to bully, harass, stalk or intimidate a partner. Often this behavior is a form of verbal or emotional abuse perpetrated online. Examples of digital abuse include situations in which the offender:

- Tells the victim who he or she can or cannot be friends with on Facebook and other sites.
- Sends negative, insulting or even threatening emails, Facebook messages, tweets, DMs or other messages online.
- Uses sites like Facebook, Twitter, Foursquare and others to keep constant tabs on the victim.
- Puts victim down in online status updates and posts.
- Sends unwanted, explicit pictures and demands some in return.
- Pressures the victim to send explicit video.
- Steals or insists on being given the victim's passwords.
- Looks through phone frequently, checks up on pictures, texts and outgoing calls.
- Tags unkindly in pictures on Instagram, Tumblr, etc.

(<http://www.thehotline.org/is-this-abuse/abuse-defined/#tab-id-6>)

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### *Typologies*

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IPV varies in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not seriously impact the victim to frequent, severe and even life-threatening violence. IPV can occur across all races and among heterosexual or same-sex couples and does not require sexual intimacy. (CDC, 2012)

In Johnson's "Typology of Domestic Violence," he distinguishes between four types of IPV that are defined by the extent to which the offender and his or her partner use violence in order to attempt to control the relationship.

## Patterns of IPV (Johnson, 2011)

### Coercive Controlling Violence

The individual is violent and controlling.  
The partner is not.

### Violent Resistance

It is the partner who is violent and controlling.  
The individual is violent, but not controlling.

### Situational Couple Violence

Although the individual is violent, neither partner is both violent and controlling.

### Mutual Violent Resistance

Both individual and partner are violent and controlling.

### Coercive Controlling Violence:

Coercive controlling violence is the prototype of “domestic violence.” This may come in the form of cultural beliefs regarding dominance over the other person. It is a pervasive pattern of coercive control that combines physical and/or sexual violence with a variety of non-violent control tactics. The Duluth “Power and Control Wheel” has been the graphic representation of partner violence deployed in the service of general control. There are clear offender and non-offender roles. In heterosexual relationships the male partner is usually, but not always, the offender. It should be noted that this type of IPV represents a very small proportion of all IPV. 5% of incidents fall into the very severe category.



### Violent Resistance:

The defining pattern of violent resistance is that the resistor/non-offending partner is violent but not controlling and is faced with an offender who is both violent and controlling. It is thought to be an attempt to escape from a seemingly hopeless situation.

### Situational Couple Violence:

Situational couple violence is the most common form of IPV which may include a cultural arrangement. It occurs when couple conflicts become arguments that turn to aggression. 40% of cases involve a single, mild incident; others involve chronic or very severe incidents. It is often mutual and roughly gender-symmetric (equal number of women and men) in terms of offending.

### Mutual Violent Resistance:

Mutual violent resistance, also referred to as bi-directional violence, is when both partners are using violent behaviors in the relationship, each attempting to control the relationship.

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## ***The Impact of IPV on Non-Offending Partners***

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As with anyone who has been traumatized, the non-offending partner may demonstrate a wide range of effects from IPV. The offender's abusive behavior can cause an array of health problems and physical injuries. Non-offending partners may require medical attention for immediate injuries, hospitalization for severe assaults or chronic care for debilitating health problems resulting from the offender's physical attacks. The direct physical effects of IPV can range from minor scratches or bruises to fractured bones or sexually transmitted diseases resulting from forced sexual activity and other practices. The indirect physical effects of IPV can range from recurring headaches or stomachaches to severe health problems due to withheld medical attention or medications.

The impact of IPV on victims can result in acute and chronic mental health problems. Some victims have histories of psychiatric illnesses that may be exacerbated by the abuse; others may develop psychological problems as a direct result of the abuse. Examples of emotional and behavioral effects of IPV include many common coping responses to trauma, such as:

- emotional withdrawal
- denial or minimization of the abuse
- impulsivity or aggressiveness
- apprehension or fear
- helplessness
- anger
- anxiety or hypervigilance

- disturbance of eating or sleeping patterns
- substance use
- depression
- suicide
- post-traumatic stress disorder.

Some of these effects also serve as coping mechanisms for non-offending partners. For example, some non-offending partners may turn to alcohol to lessen the physical and emotional pain of the abuse. Unfortunately, these coping mechanisms can serve as barriers for the non-offending partner who wants help or wants to leave the abusive relationships. Psychiatrists, psychologists, therapists, social workers and counselors who provide screening, assessment and treatment for non-offending partners can serve as the catalyst that helps them address or escape the abuse.

(<https://www.childwelfare.gov/pubPDFs/domesticviolence.pdf>).

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### ***Impact on Children***

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#### **Children and Domestic Violence – The National Child Traumatic Stress Network (NCTSN)**

##### **Exposure**

Children are exposed to or experience DV or IPV in many ways. They may hear one parent or caregiver threaten the other, observe a parent who is out of control or reckless with anger, see one parent assault the other, or live with the aftermath of a violent assault. Many children are affected by hearing threats to the safety of their caregiver, regardless of whether it results in physical injury. Children who live with IPV are also at increased risk to become direct victims of child abuse. In short, IPV poses a serious threat to children's emotional, psychological and physical well-being, particularly if the violence is chronic.

**“Domestic violence poses a serious threat to children's emotional, psychological, and physical well-being, particularly if the violence is chronic.”**

The forms of exposure can be separated into ten discrete categories. (Holden, 2006.)

<b>Type of Exposure</b>	<b>Definition</b>	<b>Example</b>
Exposed prenatally	Real or imagined effects of IPV on the developing fetus	Fetus-assaulted in utero; pregnant mother lived in terror; mother perceived that the IPV had affected the fetus
Intervenes	The child verbally or physically attempts to stop the violence	Ask parents to stop; attempts to defend non-offending parent
Victimized	The child is verbally or physically assaulted during an incident	Child intentionally injured, accidentally hit by a thrown object, etc.
Participates	Child is forced or "voluntarily" joins in on the assault	Coerced to participate; used as spy; joins in on the taunting
Eyewitness	Child directly observes the assault	Watches assault or is present to hear verbal abuse
Overhears	Child hears, though does not see, the assault	Hears yelling, threats or breaking of objects
Observes the initial effects	Child sees some of the immediate consequences of the assault	Sees bruises or injuries, police, ambulance, damaged property; intense emotions
Experiences the aftermath	Child faces changes in his or her life as a consequence of the violence	Experience change in parenting; separation from a caregiver
Hears about it	Child is told or overhears conversations about the violence	Learns of the assault from family members or others
Ostensibly unaware	Child does not know of the violence according to the source	Violence occurred away from home or while child was away or occurred when child was not in ear shot of the violence or thought to be asleep

### **Effects**

Not all children exposed to violence are affected equally or in the same ways. This may be a result of their cultural backgrounds. For many children, exposure to IPV may be traumatic, and their reactions are similar to children's reactions to other traumatic stressors. Research suggests that experiencing ongoing violence can change the way a child's brain develops and functions. It can make it difficult for the child to concentrate, learn, feel empathy and develop healthy relationships. ([www.lfcc.on.ca/SilentRealities](http://www.lfcc.on.ca/SilentRealities))

For information on the DCF Strengthening Families Practice Model, go to:

<https://portal.ct.gov/-/media/DCF/Policy/BPGuides/TraumaInformedCareBPGpdf.pdf?la=en>

### **Short-Term Effects of IPV on Children**

Children's immediate reactions to IPV may include:

- generalized anxiety
- sleeplessness
- nightmares
- difficulty concentrating
- high activity levels
- increased aggression
- increased anxiety about being separated from parent
- intense worry about their safety or the safety of a parent

### **Long-Term Effects of Intimate Partner Violence on Children**

Long-term effects, especially from chronic exposure to intimate partner violence, may include:

- physical health problems
- behavior problems in adolescence (*e.g.*, juvenile delinquency, alcohol, substance use)
- emotional difficulties in adulthood (*e.g.*, depression, anxiety disorders, PTSD)

Exposure to IPV has also been linked to poor school performance. Children who grow up with IPV may have impaired ability to concentrate; difficulty in completing school work; and lower scores on measures of linguistic, motor and social skills.

**“ Children may learn that it is acceptable to exert control or relieve stress by using violence, or that violence is linked to expressions of intimacy and affection. ”**

In addition to these physical, behavioral, psychological and cognitive effects, children who have been exposed to IPV often learn destructive lessons about the use of violence and power in relationships which may or may not be a result of their culture. Children may learn that it is acceptable to exert control or relieve stress by using violence, or that violence is in some way linked to expressions of intimacy and affection. These lessons can have a powerful negative effect on children in social situations and relationships throughout childhood and in later life.

### **Ages and Developmental Stages: Symptoms of Exposure**



As with other trauma types, children's responses to IPV vary with age and developmental stage. In addition, children's responses depend on the severity of the violence, their proximity to the violent events, and the responses of their caregivers.

The table below shows a brief list of possible reactions and symptoms by age: young children (ages birth to 5), school-aged children (ages 6 to 11) and adolescents (ages 12 to 18).

Ages Birth to 5	Ages 6 to 11	Ages 12 to 18
<ul style="list-style-type: none"> <li>• Sleep and/or eating disruptions</li> <li>• Withdrawal/lack of responsiveness</li> <li>• Intense/pronounced separation anxiety</li> <li>• Inconsolable crying</li> <li>• Developmental regression, loss of acquired skills</li> <li>• Intense anxiety, worries, and/or new fears</li> <li>• Increased aggression and/or impulsive behavior</li> </ul>	<ul style="list-style-type: none"> <li>• Nightmares, sleep disruptions</li> <li>• Aggression and difficulty with peer relationships in school</li> <li>• Difficulty with concentration and task completion in school</li> <li>• Withdrawal and/or emotional numbing</li> <li>• School avoidance and/or truancy</li> </ul>	<ul style="list-style-type: none"> <li>• Antisocial behavior, (e.g., disruptive acts, hostility, aggression)</li> <li>• School failure</li> <li>• Impulsive and/or reckless behavior, (e.g., school truancy, substance use, running away, involvement in violent or abusive dating relationships)</li> <li>• Depression</li> <li>• Anxiety</li> <li>• Withdrawal</li> </ul>

It is important to remember that these symptoms can also be associated with other stressors, traumas, negative cultural influences, or developmental disturbances, and that they should be considered in the context of the child and family's functioning.

<http://www.nctsn.org/content/children-and-domestic-violence>

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### ***Teen Dating Violence (TDV)***

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Dating violence in teen relationships is widespread; over 10% of all high school adolescents report some form of physical violence in their dating relationships. TDV is defined as psychological, physical and sexual aggression within the dating relationship of an adolescent by a member of either a heterosexual or same sex couple. However, TDV is more prevalent in populations engaging in other high-risk behaviors including alcohol use, drug use, suicidal ideation and high-risk sexual behaviors.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433035/>

Many teens do not report TDV because they are afraid to tell friends and family. A 2011 CDC nationwide survey found that 23% of females and 14% of males who ever experienced rape, physical violence or stalking by an intimate partner, first experienced some form of partner violence between 11 and 17 years of age. A 2013 survey found approximately 10% of high school students reported physical victimization and 10% reported sexual victimization from a dating partner in the 12 months before they were surveyed. (<http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence>) Unhealthy relationships can start early and last a lifetime. Teens often think some behaviors, like teasing and name calling, are a “normal” part of a relationship and can be a result of cultural norms. However, these behaviors can become abusive and develop into more serious forms of violence.

### **TEEN DATING VIOLENCE IN CONNECTICUT**

Results from the 2015 CT School Health Survey (CSHS) indicate that about 29.8% of high school students reported that someone they were dating or going out with purposely tried to control them or emotionally hurt them (such as being told who they could and could not spend time with, being humiliated in front of others or being threatened if they did not do what they were told) one or more times during the last 12 months.\*

Overall in CT, the prevalence of having experienced emotional dating abuse:

- is significantly higher among females (34.5%) than among males (24.7%)
- does not vary significantly by race/ethnicity (Whites 29.3%, Blacks 31.5%, Hispanics 31.7%)
- is significantly higher in grade 10 (33.0%) than in grade 9 (25.2%)

In Connecticut, 8.0% of high school students reported that someone they were dating or going out with physically hurt them (such things as being hit, slammed into something, or injured with an object or weapon) on purpose one or more times in the past 12 months.\* Nationwide, the rate is significantly higher (9.6%).

Overall in Connecticut, the prevalence of having experienced physical dating violence does not vary significantly by sex, race/ethnicity or grade.

In high school, the prevalence of having experienced physical dating violence:

- is significantly lower among females in Connecticut (8.7%) than nationwide (11.7%)
- does not vary significantly between Connecticut and U.S. students by race/ethnicity
- is significantly lower in grade 11 among Connecticut students (6.2%) than among their U.S. counterparts

In Connecticut, 11.5% of high school students reported that someone they were dating or going out with forced them to do sexual things (such as kissing, touching or being physically forced to have sexual intercourse) when they did not want to, one or more times during the past 12 months.\* Nationwide, the rate is 10.6%.

Overall in Connecticut, the prevalence of having experienced sexual dating violence:

- is significantly higher among females (16.4%) than among males (6.4%)
- does not vary significantly by race/ethnicity or grade
- in high school, the prevalence of having experienced sexual dating violence does not vary significantly between CT and U.S. students by sex, race/ethnicity, or grade

(\*Among students who dated or went out with someone during the 12 months before the survey.)

### **Warning Signs of Teen Dating Violence**

Being able to tell the difference between healthy and unhealthy, abusive relationships can be difficult. No two relationships are the same, so what's unhealthy in one relationship may be abusive in the next. Although there are many signs to pay attention to in a relationship, these are common warning signs of dating abuse:

- checking cell phones, emails or social networks without permission
- extreme jealousy or insecurity
- constant belittling or put-downs
- explosive temper
- isolation from family and friends
- making false accusations
- erratic mood swings
- physically inflicting pain or hurt in any way
- possessiveness
- telling someone what to do
- repeatedly pressuring someone to have sex

### **Effects of Teen Dating Violence on Adolescents:**

As indicated in the Adverse Childhood Experiences Study (ACESs) conducted by the Centers for Disease Control and Prevention and Kaiser:

Childhood and adolescent experiences, both positive and negative, have a tremendous impact on the future violence victimization and perpetration, and lifelong health and opportunity. Adolescents exposed to TDV suffer significant short and long-term consequences. The short-term consequences linked to TDV include, but are not limited to depression, suicidal ideation, anxiety, alcohol use, cigarette and drug use, unintended pregnancies and other sexual health risk

behaviors. Long-term consequences associated with TDV include decreased self-esteem, poorer academic performance, disordered eating behaviors, substance dependence, and poor mental health measures.

[\(http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433035/\)](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433035/)

- Violent relationships in adolescence can have serious ramifications by putting the victims at higher risk for substance use, eating disorders, risky sexual behavior and further IPV.
- Being physically or sexually abused makes teen girls six times more likely to become pregnant and twice as likely to get a sexually transmitted infection (STI).
- Half of youth who have been victims of both dating violence and rape attempt suicide, compared to 12.5% of non-abused girls and 5.4% of non-abused boys.  
 [\(http://www.loveisrespect.org/resources/dating-violence-statistics\)](http://www.loveisrespect.org/resources/dating-violence-statistics)

### **What Parents, Caregivers, Social Workers Need to Know About the Cycle of Teen Dating Violence**

If dating violence concerns in a teen's romantic relationship are recognized, it is important to intervene as soon as possible by discussing the issue and expressing concerns. The teen may feel defensive and refuse to see what is happening. Advice from a counselor from a local domestic violence organization that is culturally sensitive and has linguistically appropriate services may be of help. The National Domestic Violence Hotline (1-800-799-7233) or the Connecticut Statewide Hotline (1-888-774-2900) will be able to refer to the local organization. If the violence is occurring at home or with another family member, contact the same hotline or domestic violence organization for help. Domestic violence that occurs in the home between parent and child or siblings or other family members is just as serious as teen dating violence and needs to be addressed.  
 [\(http://teenhealth.about.com/od/relationships/a/cycleofabuse.htm\)](http://teenhealth.about.com/od/relationships/a/cycleofabuse.htm)

Additional resources:

- <http://www.loveisrespect.org/>
- <http://www.cdc.gov/chooserrespect/>
- <http://www.breakthecycle.org/>
- <http://www.thatnotcool.com/>
- <http://www.thesafespace.org/>

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### ***Impact on Offending Partner***

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In the same way that work with victims of IPV should begin with helping them to understand how IPV may have affected them as individuals and as parents, work with offenders should do the same. Some of the ways in which being offenders of IPV may have affected abusers include:

- loss of trust from partner
- loss of intimacy
- loss of respect
- loss of self-respect
- fear of getting caught
- possible arrest and jail time if police are called
- possible loss of job and friends
- possible loss of partner and children

An offender's relationships with his or her children may be affected because the children:

- are afraid of the offender
- run away when the offender tries to show them affection
- withhold information about their lives
- don't ask the offender for help or support
- do not talk freely with the offender
- are not able to have fun with the offender because they are afraid of what might happen
- lie to the offender to protect themselves and their non-offending parent
- use violence against the offender
- do not respect the offender

(Parenting After Violence: A Guide for Practitioners" Darla Spence Coffey, MSW, Ph.D., <http://www.instituteforsafefamilies.org/>)

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### ***Cultural Considerations in Intimate Partner Violence***

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IPV occurs in all types of relationships regardless of race, ethnicity, class, gender identity, religious affiliation, age, immigration status, ability or socio-economic status. Social Workers must take the time to identify the cultural needs of the families they are

working with but must also understand that, depending on where the client is from, there could be additional challenges due to culture, language, religion, sex and sexual orientation or socioeconomic status. Because offenders and non-offenders of IPV may experience the abuse in culturally specific ways, Social Workers should consider the cultural background and the unique issues faced by the non-offender and his or her children in order to tailor services to meet their needs. There are legal remedies for undocumented victims of IPV. These include U-Visa's, VAWA /Visa's and T-Visa's. Additional information can be found in the DCF Immigration Policy 31-8-13. (<https://www.childwelfare.gov/topics/systemwide/cultural/services/domviolence/on9/23/15>)

Should staff require additional support, the DCF Office of Multicultural Affairs is an invaluable resource. Additionally, the DCF Academy for Workforce Development frequently provides trainings and webinars addressing race, ethnicity, gender, religion and immigration. Please consult the Academy for Workforce Development Training Catalog.

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### ***Child Protective Services and Intimate Partner Violence***

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It is commonly understood that there is a direct link between IPV and issues around child protection. It is imperative that child protection workers identify and use interventions that protect families from IPV and eliminate harm to children's physical or psychological safety without further victimization. DCF shall emphasize child and family safety and well-being; respond differently to families based on their individual needs and situation including culture and language, and will continue to build upon their knowledge of IPV to better serve the families impacted by IPV.

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### ***Careline Response***

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Screening for intimate partner violence occurs on every child maltreatment report received by DCF as part of the screening/triage process including the use of Structured Decision Making (SDM). Even if IPV is not the primary concern of the reporter, Careline staff will gather information regarding possible IPV. (Early identification of IPV is not always possible, as the reporter may not have knowledge of an IPV offender in the home.) As described in the DCF Policy 33-1, "Careline," and the Practice Guide, during each Careline call, the Careline staff inquire about IPV. Should the reporter have information about IPV, the Careline staff shall ask questions to gather as much information as possible. These questions may include:

- What prompted the disclosure?

- Where were the children during the incident?
- Did the children observe any of the incident?
- What was their reaction to the incident?
- Were the children injured?
- Were the parents injured?
- Was either parent hit, threatened or coerced?
- Describe the severity of the incident.
- Were weapons involved?
- What is the non-offending parent's initiative and ability to protect his or her physical or psychological safety and the physical or psychological safety of the child?
- What steps were taken to prevent the offender's continued access to the home, *e.g.*, shelter, police, restraining order?
- Were the police notified? Who made the notification? Who was arrested? What were the charges?
- Did the caller witness the IPV?
- Is there a history of intimate partner violence?
- How frequent are the incidents?
- What is the race, ethnicity, culture and language of the parties involved?

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### ***Engagement***

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Family Engagement is the basis of effective child protection practice that promotes the overarching principles of safety, well-being, and permanency. As defined by the Child Welfare Information Gateway, "Family Engagement is a family-centered and strengths-based approach to partnering with families in making decisions, setting goals, and achieving desired outcomes."

In working with families impacted by IPV, it is a challenge to keep children safe without penalizing the non-offending parent.

Partner with the non-offending parent:

- About the nature of the abuse.
- What have they tried in the past?
- What do they want?
- Don't assume the non-offending parent wants to end a relationship.
- Reassure the non-offending parent that she or he is not responsible for the violence by the offending partner or for stopping the offender's violent behavior.
- Determine the non-offending parent's ability to protect him- or herself and the children.

- Determine how the non-offending parent views the involvement of law enforcement.
- Help the non-offending parent plan for her or his physical and psychological safety, and the physical and psychological safety of the children.
- Ask about the barriers the non-offending parent is encountering.
- Inquire about how culture, race and/or ethnicity may have influenced the situation.
- Are there any cultural beliefs that have contributed to the abuse?
- Be prepared to know what resources are available in the community.

Listen to the children:

- About what they have seen, heard and felt.
- Reassure children that they are not responsible for the violence.
- Reassure children that it is not their fault if they did not tell anyone.
- Discuss with children ways they can be safe.

Listen to the offending parent:

- What is the offender's ability and willingness to protect the children?
- What does he or she want for the children?
- Discuss with the offender his or her strengths and commitment to the family.
- Discuss that both partners are equally responsible for the safety and well-being of the children.
- Discuss that violence is a choice.
- What are the cultural beliefs about dominance and IPV?



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## **Assessment Considerations**

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Most concerning items:

- threat to kill
- torture tactics
- threatened with a weapon
- access to a gun
- strangulation
- constantly jealous

Highest/most at risk:

- when ending/leaving the relationship
- when starting a new relationship

Assessment of risk to children:

- proximity
- history of violence
- severity and frequency
- threats to child's safety, *e.g.*, kidnapping
- child's perceptions of violence
- child's behavioral and emotional reactions to the violence: is he or she frightened?  
is he or she aggressive?
- absence of support or safe havens for the child
- history of direct abuse of child

Other areas of inquiry:

- Does the child intervene in the IPV?
- Are the children demonstrating symptoms of traumatic stress?
- Does the non-offending parent believe the partner is dangerous?
- What is the quality of the offending person's parenting?
- Is the non-offending parent currently seeking protection?
- Are services in place? Are they reducing or removing the risk?

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## ***Assessment and Interview Guidance***

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### **Assessment**

Routine assessment for IPV should occur at every phase of the child protection services (CPS) process. If a report made to the Careline and is accepted but does not contain allegations of IPV, the Social Worker shall regularly assess child and family needs and cultural beliefs, and determine IPV's potential presence throughout the life of the case. During the Investigation or Family Assessment Response (FAR) process, the Social Worker will screen and assess to see if IPV has occurred in the relationship, the extent and severity of the violence and the physical and psychological impact of the IPV concerns on the children, non-offending parent and the offender.

### **Social Work Preparation at Intake**

In addition to the intake preparation steps listed in DCF Policy 34-2, "Investigations," and Policy 34-3, "Family Assessment Response," the Social Worker shall take the following steps to prepare for an investigation or FAR involving IPV prior to initiating contact with the family:

- Identify the cultural beliefs, norms and family practices.
- Consult with the Regional Resource Group (RRG) Intimate Partner Violence Specialist (IPVS) if appropriate. As a member of the RRG, the role of the IPVS is to provide consultation, support, leadership and coordination to improve outcomes for children and families impacted by domestic violence. Work is done in consultation with the Social Workers but it can also include direct consultation with families and offering resources that are beneficial to the entire family system and that are trauma-informed and pertinent to their cultural and linguistic service needs.
- Review LINK history to see if there were prior indicators of IPV or exposure to IPV as a child or youth.
- Gather background information such as police reports and protective and restraining order checks from the Judicial Branch Protective Order Registry.

**Prior to starting the investigation or assessment, consider the following:**

- The investigation or FAR is an opportunity to address the needs of the entire family.
- Address risk, safety and protective factors in order to prevent unnecessary removal of the child.
- Assisting in enhancing the safety of the non-offending partner as an opportunity to reduce risk to the child.
- Assume that both caregivers have an equal responsibility for the emotional and physical well-being of the child.
- Understanding the offender's abusive and coercive tactics toward the non-offending partner and the child can improve the safety and well-being of the child.
- Offenders can be helped to play a more positive role in the lives of the child.
- The use of violence, abuse and control are choices made by the offender.
- Send appropriate messages of responsibility for the abuse.

("Domestic Violence Manual for Child Welfare Professionals," Oklahoma Department of Human Services.)

**During the initial contact with the family, the Social Worker should:**

- Interview all family members separately, starting with the non-offending parent and the child to partner and assess safety. If both parents are present, collect general family information and refrain from direct inquiry about the IPV, until such time that one-on-one conversations can take place.
- Conduct interviews in a location that is safe and comfortable for the non-offending partner and child.
- Observe the home environment and family members for physical signs of IPV. Physical signs may include:
  - visible injuries or injuries explained as through "accidents;"
  - signs of anxiety; or
  - broken furniture, broken doors and windows, holes in the walls.
- Offer culturally and linguistically competent resource information to the adult non-offending partner; *e.g.*, safety planning, emergency and non-emergency resources, legal, financial services. (It is important to give multiple resource options, not just one such as a Protective Order).
- Explain the role of the IPVS and possibility of a consultation with the IPVS or a local domestic violence agency.
- State concern for individual safety as well as the safety of the child.
- Inquire about specific strategies the non-offending partner has utilized regarding safety that have been effective in the past.
- Convey non-blaming attitude; employ supportive interventions and responses:
  - validate the partner's experiences;

- build on the partner’s strengths; and
- help the partner to explore support system options.
- Advise the parent of additional interviews, the process of the investigation or FAR and what to expect, especially as it relates to the offending parent or partner.
- If appropriate, plan with the non-offending parent a safe strategy for interviewing the offending partner (when, where, how, what to anticipate, resources needed to plan for safety).
- Develop an IPV safety plan. In partnership with the IPV specialist, the Social Worker may use VIGOR, an evidence-based safety planning tool (description to follow), as appropriately determined through the Structured Decision Making Safety Assessment.
- Discuss the potential for traumatic stress reaction in children and identify resources to address traumatic stress in children.
- Utilize the assessment considerations listed above.

**Screening and assessment questions should include:**

**For caregivers:**

- Tell me about your relationship. How long have you and your partner been together?
- How do you and your partner get along?
- Does your partner act jealous or controlling, for example accusing you of cheating; keeping you from going to work, school, church or other places; cutting you off from friends or family; constantly calling or texting to check on you? Has anything like this happened in your relationship (current or past)?
- Has your partner made you feel afraid, scared?
- Has your partner ever tried to make you feel bad about yourself or put you down, for example calling names, criticizing?
- How do you and your partner resolve conflict?
- What happens when you disagree?
- Do arguments ever escalate to yelling? Pushing? Shoving?
- Do arguments escalate to hitting? Throwing items? Threatening?
- Have the police ever been called to your home during an argument? If yes, describe.
- Are there any cultural beliefs that contribute to the way your partner treats you?
- Have the children witnessed any yelling? Pushing? Shoving? Hitting?
- How have the children reacted to any violence in the home?
- Consider using the Connecticut Trauma Screen to screen for traumatic stress symptoms and suggest further resources for addressing traumatic stress.

**For offenders:**

- What happens when you have conflicts or strong disagreements?

- What do you do when you feel angry, jealous or possessive of your partner?
- Does your partner seem afraid of you? In what ways?
- Has your partner ever been hurt during an argument?
- Where is the child when the arguments happen? Has the child ever been hurt?
- What do you think is the most important aspect of being a parent? What does it take to be a good parent?
- How do you think the child is affected by what you did?
- How do you feel you are role modeling for your child's future relationships?
- Do you feel your child was traumatized by this experience?
- If you need to leave the home, do you have a place to stay?
- In your culture, are partners deemed equal? Please explain.

**For children** (ages 4 and older - to be adapted to child's developmental level):

- Do the adults in your family ever argue or fight?
- Do the adults in your family ever yell and scream or say mean things to each other?
- Do you ever feel scared when the adults argue?
- Do the adults ever hurt each other, like by pushing, shoving, hitting or throwing things? Or hurt in any other ways?
- How safe do you feel at home?

**For teens** – screening for Teen Dating Violence (ages 13 and above):

- Are you in a relationship or seeing anyone?
- Tell me about your relationship.
- How do you and your girl- or boyfriend get along?
- Does your girl- or boyfriend act jealous or controlling; for example, accusing you of cheating; keeping you from going to work, school, church or other places; cutting you off from friends or family; constantly calling or texting to check on you? Has anything like this happened in your relationship (current or past)?
- Has your girl- or boyfriend made you feel afraid, scared?
- Has your girl- or boyfriend ever tried to make you feel bad about yourself or put you down; for example, by calling names, criticizing?
- What happens when you disagree?
- Do arguments ever escalate to yelling? Pushing? Shoving?
- Do arguments escalate to hitting? Throwing items? Threatening?

(New York Children's Services "Domestic Violence Screening and Assessment Protocol for Prevention Services.")

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## ***Assessing Protective Factors***

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Protective factors are conditions or attributes of individuals, families, communities, cultural beliefs or the larger society that, when present, promote well-being and reduce the risk for negative outcomes. These factors may “buffer” the effect of risk exposure and, importantly, may help individuals and families negotiate difficult circumstances and fare better in school, work and life. Victims of IPV may have compromised abilities to provide for the safety of others, including their children. The first step to assess the protective factors is to engage the family in a discussion around their strengths and needs to help identify the supports, resources and services that may be needed to increase the health and well-being of the family.

Working with families to increase their protective factors will help them utilize and build upon their natural support networks within their own families and communities that are culturally and linguistically appropriate.

### **Protective factors include:**

**Nurturing and Attachment:** Building a close bond helps parents better understand, respond to, and communicate with their children.

A child's early experience of being nurtured and developing a bond with a caring adult affects all aspects of behavior and development. When parents and children have strong, warm feelings for one another, children develop trust that their parents will provide what they need to thrive including love, acceptance, positive guidance and protection.

Research shows that babies who receive affection and nurturing from their parents have the best chance of healthy development. A child's relationship with a consistent, caring adult in the early years is associated later in life with better academic grades, healthier behaviors, more positive peer interactions and an increased ability to cope with stress.

**Knowledge of Parenting - Child and Youth Development:** Knowing what to look out for at each age can help children reach their full potential.

There is extensive research linking healthy child development to effective parenting. Children thrive when parents provide not only affection, but also respectful communication and listening, consistent rules and expectations and safe opportunities that promote independence. Successful parenting fosters psychological adjustment, helps children succeed in school, encourages curiosity about the world and motivates children to achieve.

**Parental Resilience:** Recognizing the signs of stress and enhancing problem-solving skills can help build parents' capacity to cope.

Parents who can cope with the stresses of everyday life, as well as an occasional crisis, have resilience; they have the flexibility and inner strength necessary to bounce back when things are not going well. Multiple life stressors, such as a family history of abuse or neglect, health problems, marital conflict, domestic or community violence and financial stressors such as unemployment, poverty and homelessness may reduce a parent's capacity to cope effectively with the typical day-to-day stresses of raising children. (Child Welfare Information Gateway.)

**Social Connections:** Developing strong connections to the community can help support the family in times of need.

Parents with a social network of emotionally and culturally supportive friends, family and neighbors often find that it is easier to care for their children and themselves. Most parents need people they can call on once in a while when they need a sympathetic listener, advice or concrete support. Research has shown that parents who are isolated, with few social connections, are at higher risk for child abuse and neglect.

**Concrete Supports:** Many factors affect a family's ability to care for their children. Families who can meet their own basic needs for food, clothing, housing and transportation - and who know how to access essential services such as childcare, health care and mental health services to address family-specific needs - are better able to ensure the safety and well-being of their children.

Partnering with parents to identify and access resources in the community may help prevent the stress that sometimes precipitates child maltreatment. Providing concrete supports may also help prevent the unintended neglect that sometimes occurs when parents are unable to provide for their children.

("Promoting Protective Factors for Children Exposed to Domestic Violence," <https://www.childwelfare.gov/pubs/factsheets/guide-domesticviolence>)

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### ***Co-occurrence of Substance Use, Mental Health and/or Trauma***

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Individuals are often impacted by co-occurring IPV and substance use, mental health and/or trauma. The most important priority to address when working with families affected by co-occurring IPV, substance use and mental health is to ensure the safety of all family members. Identifying services entails figuring out what the needs are of the non-offending parent, offender and the children and addressing the needs at the same time. Provider collaboration is essential when working with clients with co-occurring IPV and substance use or mental health needs (or all three).

Exposure to IPV and parental substance use can have far-reaching effects on children's development. Many of the risks associated with exposure to IPV are similar to those associated with exposure to parental substance use, and both increase children's risk for developing social, emotional, behavioral and cognitive disorders. Despite these similarities, the problems of parental substance use and IPV also create unique challenges for children, which manifest in different ways.

("Meeting the Needs of Families Affected by Co-occurring Substance Use and Intimate Partner Violence," National Abandoned Infants Assistance Resource Center University of California, Berkeley, <http://aia.berkeley.edu>.)

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### ***Documentation***

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It is important to document IPV without blaming the non-offending parent, but holding the offender accountable for his or her behavior. The case record should reflect detailed information on the offender's behaviors; type of abuse; duration and severity of abuse; threats of violence towards the non-offending partner, themselves or the children; use or threats of use of weapons; history of violence and if with more than one partner; and abuse or neglect as a child (exposure to IPV as a child). Co-occurring mental health and substance misuse should be documented as both can exacerbate an offender's violent behavior.

It is imperative that Social Workers provide detailed documentation around the offender's behaviors, including documenting how he or she was physically violent, verbally abusive or financially controlling, and the details. For example, be descriptive, such as, "The offender was physically violent with the non-offending partner by punching, kicking and strangulation during this most recent incident of IPV." Describe the patterns, such as "Offender has engaged in an escalating pattern of physical violence and intimidation that involved multiple incidents of physical assault and threats of homicide to other partner and children." It is also important to separate the individual goals and objectives for the parents, such as "The parent will refrain from any future violence with the partner, and has agreed to engage in services." This should include any cultural factors that may have contributed to the behaviors.

Avoid documentation such as: "mother and father engaged in intimate partner violence" or "the couple engaged in violence." Individualize the statements and refrain from documenting statements such as "parents have a history of intimate partner violence" or "parents both deny abuse." A description of behaviors, rather than global non-descript statements, provides more detail and offers valuable information in order to assess and provide services to address the IPV.



Avoid blaming the non-offending parent for the offender's actions by avoiding phrases such as "Non-offending partner allows or enables the violence, minimizes the IPV or fails to protect the children." Use language that focuses on the offender's role in creating harm or risk to the children such as "Despite the mother/father's efforts to protect the children, the offender is creating conditions injurious and harmful to the child."  
(Based on "Safe & Together Model" by David Mandel.)

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### ***IPV Safety Planning***

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IPV safety planning is different than CPS safety planning (using SDM tools). An IPV safety plan is an individualized plan that victims have developed to assist them with dealing with dangerous situations. To help increase physical and psychological safety for children and adult IPV non-offenders, Social Workers should partner with the non-offending parent and children (if appropriate) to develop an IPV safety plan or build on the plan that they may have already established. Safety plans must be individualized.

- IPV safety plans address risk to both the child and the adult non-offender from the offender's specific behaviors.
- Social Workers should discuss and review the safety plan whenever meeting with the non-offender alone to review if anything has changed in regard to the offender's behaviors or with the identified plan itself (supports, resources, etc.). Revisions should be made as needed.
- Age-appropriate safety plans can be explored with the non-offender and the children to increase their safety and support and resiliency.

(Washington State, Department of Social and Human Services: "Social Worker's Guide to Domestic Violence," January 2016.)

Safety planning must include:

- planning for immediate safety and safety during assaults
- planning for escape
- planning for long-term safety
- planning for safety with children

**Note:** IPV safety plans should not be shared with the offender. Consult with the legal staff if an offender or attorney asks for a copy.

## **THE VIGOR - VICTIM INVENTORY OF GOALS, OPTIONS, & RISKS**

### **Basic Principles**

- The client is the expert in his or her own life. Victims can judge their danger better than any standardized checklist, especially when their perceptions are validated.
- Can be flexibly adapted for victims from different racial and ethnic backgrounds, different socioeconomic backgrounds, different cultural backgrounds, different sexual orientations and different sexes.
- Joins with victims/non-offending parents in dealing with the full complexities of their lives.

The result is not a generic checklist of safety precautions, but rather a personalized plan that links coping responses to specific risks.

Fleeing on an emergency basis with few belongings and possibly not even with the children will not minimize many risks faced by the typical non-offending parent.

### **Four Steps to Completing the VIGOR**

#### **1. Identify risks and priorities**

Think about the different problems the family may be dealing with. Most people who have been hurt by a partner face the risk of future physical danger. Other life areas need to be considered too. They may not all apply to the non-offending parent. While assisting each family with the development of the safety plan, considerations should include:

- Personal safety: physical, verbal, sexual safety and well-being.
- Others' safety/well-being: children, family, pets, friends and others.
- Financial risks: money issues related to work, school, moving, legal fees, bills, insurance, debt, etc.
- Legal risks: concerns about police, divorce, child protection, immigration, other legal actions.
- Social risks: ways relationships with family, friends, co-workers, etc. might be affected. Consider the cultural, ethnic and linguistic factors.
- Psychological risks: feelings about the situation, emotional risks like stress or sadness.
- Cultural risks: outcast within the family and community. Note that in some cultures it may not be acceptable to leave no matter how bad the situation.
- Other risks: anything not covered by above categories.

## **2. Identify Strengths**

The family may have more resources than initially thought, or the Social Worker may use the strengths to get some ideas about what the family may need in order to meet goals.

- Personal and psychological: ways in which the non-offending parent is strong and can keep safe. Include all kinds of strengths, such as courage and faith.
- Housing resources: access to a safe place to live (own home, name on a lease, affordable housing, etc.).
- Financial resources: source of income or other financial support
- Legal resources: documents, legal help, or other things that can help deal with courts and agencies.
- Social and community resources: include family, friends, AA or other 12-step programs, religious groups, or other organizations.
- Privacy and protection: ability to increase privacy settings on computer or phone, or make home more secure.
- Cultural resources: faith-based and cultural supports.
- Other resources: things that can help that are not included above.

## **3. Protective Strategies and Options - help in safety planning**

Start to identify the options and choices about what to do. Many choices can be used together.

- Housing options: stay with family or friends, rent apartment or other new housing, go to a shelter, stay with partner.
- Financial options: open bank account, get job training, apply for job, start saving money, borrow money, sell items to raise money.
- Legal options: apply for order of protection or restraining order, file for divorce, seek full custody of children, look into crime victim compensation.
- Social options: join community group, talk to supportive friends and family, speak to clergy.
- Psychological options: join support group, individual counseling, exercise, write in a journal.
- Community options: work with advocate, job training, employment agency, apply for public assistance (TANF, food assistance, Medicaid, Medicare, state health insurance for children, etc.).
- Privacy and protections: change privacy settings on social networking sites, change locks, change phone numbers and passwords, get pre-paid phone.

## **4. Make choices based on Risk Priorities and Options**

Once the goals, risks and options have been identified, assist the family with considering what the best choices to create the best plan are.

- List the biggest or most important risks
- What can be done: what choice helps with risks? What choice does not help with the risks? Does the family have what it needs in order to do this? How can they get what they need to do this?
- Something else that can be done – similar to the question above.
- Add additional steps as needed.

## **Protective Strategies that may help with Safety Planning**

### **Housing**

- Go to shelter
- Stay in own home and ask partner to leave
- Stay with family or friend
- Apply for subsidized or public housing (such as Section 8)
- Move to another house or apartment, buy or rent new housing
- Stay in a hotel
- Seek assistance with getting a down payment for a new home

### **Financial and employment**

- Keep current job or seek new full-time or part-time work
- Get job training
- Pay down debt and save money
- Open new account or get separate bank accounts
- Continue education (apply for college funding such as Pell Grant)
- Apply for disability (SSDI)
- Keep bank statements and other financial records
- Put all financial assets in own name
- Ask boss or co-workers to re-arrange schedules

### **Legal and law enforcement options**

- Call the police or ask police to drive by home frequently
- Apply for order of protection/restraining order
- Obtain a divorce or separation
- Petition for custody of children and child support
- Pursue alimony
- Seek legal assistance
- Report partner's abuse to child protective services
- Keep all identifying documents in safe place (birth certificate, Social Security card, licenses, etc.)

### **Social options**

- Rely on support of family and friends
- Make new acquaintances, expand social and cultural circle
- Share testimony/share story to help others
- Get social support and advice from advocates at shelter
- Volunteer in community or otherwise work to help others
- Arrange to see family or friends when partner is at work
- Put pets in “doggy daycare,” kennel or other safe housing
- Ask family or friends to go to court, social services or other agencies

### **Psychological options**

- Exercise
- Keep a journal/write about experience
- Abstain from drug and alcohol use
- Take a vacation
- Stop thinking he or she will change
- Find a hobby
- Focus on self and children

### **Religious and spiritual options**

- Visit with pastor, minister, reverend, other religious figure
- Rely on church community
- Take comfort from inspirational stories in religious texts
- Seek social support from other members of the congregation
- Ask church for help with bills, home repair, transportation, food, clothing, furniture and other necessities

### **Community resources**

- Seek domestic violence program services, such as transportation, referral and court accompaniment
- Find childcare for children
- Use community resources to obtain food, clothing and help with prescriptions
- Participate in single mom or dad programs
- Look for job training
- Take a self-defense class or firearm safety class
- Seek services for behavioral health

### **Cyber protection/privacy/guarding against identity theft**

- Get a private phone number
- Have two phones (don't give second number to partner)
- Avoid Facebook/do not use social media

- Change password for phone, email, other accounts
- Keep personal information private (in general)
- Get a PO box instead of having mail sent to home
- Change accounts
- Increase internet security

### **Other Safety Steps**

- Get a dog
- Change locks or add new or stronger locks to home
- Avoid unnecessary alone contact with spouse or use a mediator for necessary contact
- Change routines to avoid abuser
- Be more cautious, be more aware of surroundings
- Create a safety plan and share with kids
- Alert neighborhood and community watch
- Install outdoor lights all around the house
- Provide childcare facilities and childcare workers with a list of safe people who can pick up your kids
- Use code words

### **How to use the VIGOR**

1) Download the VIGOR

- <http://www.thevigor.org/wp-content/uploads/2016/01/VIGOR-English.pdf>
- <http://www.thevigor.org/wp-content/uploads/2016/01/VIGOR-Latin-Spanish.pdf>
- <http://www.thevigor.org/wp-content/uploads/2016/01/VIGOR-Spain-Spanish.pdf>
- <http://www.thevigor.org/wp-content/uploads/2016/01/VIGOR-French.pdf>

2) Download the list of protective strategies.

3) Work through the four steps. Use the list of protective strategies to help come up with ideas.

4) You can complete the VIGOR more than once, if the family situation changes.

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### ***Considered Removal - Family Team Meetings***

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Considered Removal Child and Family Team Meetings (CR-CFTM) are embedded in DCF's evolving Strengthening Families Practice Model. This practice model is built upon a foundation of family engagement, which defines and supports a purposeful, intentional, respectful and supportive engagement with families who become involved with DCF.

**See:** "Considered Removal - Child and Family Team Meetings (CR-CFTM)" Practice Guide, p. 13, for guidance on conducting CR-CFTMs when IPV is a factor.

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### ***Case Planning***

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When case planning in circumstances in which IPV is present, the Social Worker should take into consideration:

- A comprehensive history of IPV is important for the development of effective case plans and for maximizing the safety of all family members.
- Separate meetings should be scheduled for case planning, administrative reviews and routine team meetings when IPV is involved. If separate meetings cannot be scheduled, every attempt to provide a safe environment for the adult victim shall be made.
- In cases when a protective order is in place, separate meetings shall be scheduled. If there are any questions about the status of any orders of protection issued by the Superior Courts, an inquiry with the respective Family Relations Office should be made.

**Cross reference:** DCF Policy 36-1 through 36-11-2, Case Planning and the "Case Planning Best Practice Guide."

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### ***IPV and the Court System***

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#### **Juvenile Court Involvement**

A neglect petition filed with the Superior Court for Juvenile Matters may be necessary to increase safety for the children in the home.

- When preparing a neglect petition, write allegations in language that is not victim-blaming. For example, allegations may be that "the child was exposed to IPV" for the grounds of "conditions injurious." Use the phrase, "despite the non-offending

parent's efforts to protect the child, the offender is creating conditions that are a threat to the child's safety," instead of "The non-offending parent has failed to protect." This reduces the blame placed on the adult victim.

- Include in the allegations any behavioral signs of IPV in the children, especially statements expressing fear.
- Use reports and other documentation as evidence to make the case for protection of the child in hearings and in court reports.
- Request that the court place appropriate restrictions on the offender and require that the offender participate in services through the Specific Steps.
- Services for non-offending parents and children may also be written into the Specific Steps.

### **Temporary Restraining Orders and Civil Restraining Orders**

Victims of family violence in Connecticut have the right to request relief from the abuse they are suffering in the form of a temporary restraining order (TRO) or a civil restraining order. These orders help protect the victim from further abuse and might include provisions such as requiring that the abuser leave the home or prohibiting the abuser from contacting the victim.

TROs are effective until the court date (seven to fourteen days). Civil restraining orders are granted at the TRO hearing and can be in effect for up to one year with the possibility of requesting an extension.

Active TROs and Restraining Orders are maintained by the Judicial Branch and can be viewed in the Protective Order Registry (POR) available in every Area Office. If there are any questions about the status of any restraining order issued by the Superior Courts, an inquiry with the respective Family Relations Office should be made.

**Legal reference:** C.G.S. § 46b-15.

### **Criminal Protective Orders**

Criminal protective orders are made at the time of arraignment in criminal court after an arrest. Judicial Department Family Relations Officers or the State's Attorney often request protective orders. They provide similar protection as the civil restraining order, but can only be made following an arraignment after arrest. They typically remain in effect until the end of the criminal case. However, Standing Criminal Protective Orders (SCROs) can be issued and remain in effect for a lifetime or until further action by the court.

Active criminal protective orders and SCROs can be viewed in the Judicial Branch's Protective Order Registry (POR) available in every Area Office. If there are any questions about the status of any orders of protection issued by the Superior Courts, an inquiry with the respective Family Relations Office should be made.

**Legal reference:** C.G.S. § 46b-38c and C.G.S. § 53a-40e.



### **Early Lease Termination**

Victims of family violence in Connecticut have the right to terminate their leases early and without penalty if they reasonably believe that it is necessary to vacate the dwelling due to fear of imminent harm to themselves or their children. Victims must give 30 days' notice to the landlord and satisfy certain requirements to prove they are a victim of family violence.

**Legal reference:** C.G.S. § 47a-11e.

### **Leave from Employment**

In Connecticut, employers with three or more employees must allow workers experiencing family violence to take up to 12 days off in a calendar year for certain issues resulting from the violence, such as the victim needing to seek medical care or attend a related court hearing. The leave only has to be paid if the employee is eligible for paid leave and if the leave will not exceed the maximum amount of leave due to the employee during any calendar year.

**Legal reference:** C.G.S. § 31-51ss.

### **Address Confidentiality**

In Connecticut, a victim of family violence or sexual assault has the right to keep his or her address confidential by using the Address Confidentiality Program offered through the Office of the Secretary of the State. This program provides a substitute mailing address so that the address can be kept private.

Applications may be submitted through one of the state's 18 domestic violence agencies or one of the state's sexual assault programs. To learn more about this program, visit the Office of the Secretary of the State's website.

**Legal reference:** C.G.S. § 54-240a

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### ***Intimate Partner Violence Specialists (IPVS)***

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As members of the RRG, the role of the IPVS is to provide consultation, support, leadership and coordination to improve outcomes for children and families impacted by IPV. The IPVS will utilize a family, strength-based approach that integrates non-clinical and clinical approaches to support child protection practice and service provision and coordination. This approach focuses heavily on supporting frontline workers with specific cases and, in some instances, includes direct consultation with families. The IPVS will have the opportunity to offer guidance to Social Workers especially as it pertains to information and resources that can help the entire family system. The IPVS will also have the opportunity to promote systems change. The positions will focus heavily on education and training both within the agency and in the community.

**Cross reference:** DCF Policy 38-2, “Regional Resource Group” and “Regional Resource Group Practice Guide.”

**Responsibilities:**

**Support and Advocacy:**

- provide consultation to DCF staff throughout the duration of cases involving intimate partner violence, including help with referrals to other services such as emergency shelter, community support and therapeutic intervention as deemed appropriate;
- team with DCF staff in meeting with families, at home or elsewhere;
- empower and support DCF staff to work with families with intimate partner violence involvement;
- assist DCF staff with the case planning;
- provide networking support with professionals (prosecutors, attorneys, probation and parole officers, others) involved in concurrent cases affecting family members;
- participate in case consultation, permanency teaming or other identified meetings such as SAMSS, MAPS, case assessment conferences, Administrative Case Reviews, domestic violence dockets, Multi-Disciplinary Teams and Considered Removal Meetings, as needed; and
- act as the gatekeeper for IPV services contracts.

**Direct Interaction with Families:**

- complete client visits either in the client's home or elsewhere;
- provide support to clients to assist them in understanding intimate partner violence and its impact, safety planning, protection protocols, referrals and additional information as necessary;
- provide information about and help with applications for the victims of crime;
- provide assistance to families in obtaining protective and restraining orders; and
- offer resources that are culturally relevant and responsive to the unique strengths and needs of the family.

**Systems Change:**

Training:

- provide training, instruction and guidance including both coordination of training and provision of training about the legal, social and health-related aspects of intimate partner violence and about community resources; and
- provide community education, including training for a range of professionals and organizations that interact with the same families.

Community Liaisons/Gatekeeper:

- strengthen the collaboration between the CPS staff and other agencies that deal with intimate partner violence, including IPV service providers, law enforcement and probation and parole; and
- maintain continuing interaction with the community.

Information Gathering and Dissemination:

- gather information and data, including tracking cases and referrals;
- develop and disseminate information about resources for victims, perpetrators and children that are culturally sensitive and linguistically appropriate to the community's varied populations; and
- provide information about trends and best practices related to domestic violence.

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***Coordinating with Community Resources***

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Social Workers should look to coordinate with community providers when working with a family impacted by IPV. Coordination can occur between CPS, fatherhood programs, treatment providers, health care professionals, school/education centers, juvenile court, probation and parole, the Department of Social Services, intimate partner violence agencies, the faith community, etc. Social Workers must obtain releases of information from individuals in order to discuss information pertaining to a non-offending parent, offender or children involved in the case.

The Connecticut Coalition Against Domestic Violence (CCADV) is the state's leading voice for victims of intimate partner violence and those agencies that serve them. They are a membership organization of Connecticut's 18 domestic violence service agencies that provide critical support to victims including counseling, support groups, emergency shelter, court advocacy, safety planning and lethality assessment, among other services.

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***Enhancing Social Worker Safety and Support***

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Social Workers should always consider their own safety when working on child abuse and neglect cases with intimate partner violence indicators. Social Workers should review the case for information and, if there is a pattern of behaviors indicating a safety risk, develop a plan with the Supervisors to mitigate the risk.

When meeting with offenders of IPV, always be aware of an exit route, carry your cell phone, and watch the offender's behavior to see if he or she becomes agitated or is standing up, gesturing, posturing, making threats, shaking.

If a Social Worker needs to end an interview some approaches are:

“It looks like we have gone as far as we can in this discussion. Let's continue this at another time”. “It looks like we don't agree about all things. I think it makes sense to think it over and come back to this later.”

Social Workers should also discuss with their Supervisors meeting with the offender at the office.

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***Intimate Partner Violence – Family Assessment Intervention  
Response (IPV-FAIR)***

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The **IPV-FAIR Model** is a comprehensive response to families impacted by intimate partner violence. The model is a combination of home-based and clinic-based services. It is strength- and ecologically-focused with safety being the highest priority while assessing and addressing the needs of each family member. IPV-FAIR will engage all members of the family. The model will offer or refer clients to individual, group, family, and/or support interventions for the family based on assessed needs and will provide services and linkages for the children affected by IPV to adequately address trauma.

**Target Population**

**Inclusionary criteria and triage guidance:**

- Individuals who are impacted by IPV and have caregiving responsibilities for a child or children, whether they cohabit or not.
  - Priority access will be given to individuals with children between the ages of 0 – 5 years.
  - There may be a civil or family court order and/or arrest for IPV.
  - Services are appropriate for individuals impacted by IPV who have multiple needs that cannot be resolved or addressed by referring to one service in the community or who are isolated and lack supports and resources in the community.

- Program should also include children who have been removed from the home for whom the permanency plan is reunification.
- If one member of the family is not included in FAIR, the rest of the family may continue to engage in this service (*e.g.*, one parent is incarcerated, one caregiver is refusing to cooperate, unable to engage a caregiver).
- Special Considerations: High risk families may be appropriate with additional coordination with DCF and additional supports to plan for safety. These include:
  - Offender has used, or threatened to use, a gun, knife or other weapon.
  - Offender has threatened to kill or injure.
  - Offender has tried to strangle.
  - Offender has been violently or constantly jealous.
  - Offender has forced sex upon partner.
  - Offender is highly coercively controlling.
  - Offender has not taken responsibility for the violence.

**Exclusionary Criteria:**

- Families that decline to participate in the service.
- Clients whose mental health or substance use issues would prohibit active participation in the service.
- Families whose needs can be met through other community services.

**Capacity:**

- FAIR is a four to six month intervention engaging all family members.
- The clinician/client ratio is 1:10.
- The program treatment team consists of a Clinician and a Family Support Navigator.
- The annual service capacity per team will range between 20-30 families dependent upon the length of service. Annual capacity for a program is 40 – 60 families.

**Family Contact:**

- Families will be seen one to three times per week.
- Clinical services must be provided to all family members based on assessed needs, minimally once per week.
- The length of a typical session is approximately 45 minutes to one hour.
- Family members will be seen in their homes and at the program or clinic to increase safety and service accessibility. In-home contact is the expectation, allowing for safety and risk to be continually assessed. Some services may be provided at the clinic site.

- The frequency of the in-home contact will be determined through continued assessment of the family situation, as identified needs may change during the service period. Phone contact may supplement face-to-face contact.
- The IPVS and Social Worker will continue to provide assistance with engagement.

**Interventions:**

Safety remains the top priority while considering the identified needs of the family. Engaging all members of the family is an important component of FAIR.

**Clinical Interventions:**

Clinicians will provide flexible individual, group, family and/or support interventions to meet the changing needs of families over the course of treatment. Clinical interventions may include, but are not limited to: genograms, cognitive behavioral therapy, psychotherapy, trauma-focused cognitive behavioral therapy, parent-child dyadic work, and Fathers for Change (see description below).

**Non-Clinical Interventions:**

Family Support Navigators will facilitate engagement; eliminate barriers to success; assist with all non-clinical needs which may include case management, psycho-education, family engagement, strengthening the parent/child relationship through communication, bonding, attachment, development, insight/ability to respond to child's needs; and parent education and skill building on knowledge of impact of IPV on their well-being and the well-being of their children, structure and limit setting, supervision, discipline, child development, effective communication, conflict resolution, crisis management and problem-solving.

**Fathers for Change:**

Consistent with DCF's efforts at increasing fatherhood engagement, the FAIR service will include Fathers for Change as an intervention model as appropriate. Fathers for Change is an emerging best practice developed at the Yale University Child Study Center by Dr. Carla Stover, currently at the University of Southern Florida. The Fathers for Change model is an integrated approach to IPV that acknowledges the status of men as fathers in the conceptualization and delivery of interventions for IPV. The Fathers for Change model also addresses co-morbid substance use disorders and IPV perpetration with an emphasis on paternal parenting. Fathers for Change is designed to be offered individually to fathers who have young children (under the age of ten) with a history of intimate partner violence, defined as threatened or actual sexual or physical violence against an intimate partner. The Fathers for Change intervention includes 14 topics to be delivered in 60 minute sessions of individual treatment over 16 – 20 weeks. The intervention combines psychodynamic, family systems and cognitive behavioral theory and techniques and builds on interventions like Substance Abuse Domestic Violence (SADV) CBT with the goals of: 1) cessation of violence and aggression; 2) abstinence from substances; 3) improving

co-parenting; 4) decreased negative parenting behaviors; and 5) increased positive parenting behaviors. Fathers for Change also has an optional couples' component to include his partner (if she wishes to participate and it is safe). An initial toxicology test is a component of Fathers for Change. FAIR does not require a specific drug test vendor to be used. An initial toxicology screen may be requested of the mother if determined to be necessary. Additional testing of fathers and/or mothers will be determined through assessment. At this time, Fathers for Change is designed to be used with heterosexual couples in which the offender is the male. With discussion with the model developer, the treatment may be adapted for same sex partners or female offenders.

**Evaluation:**

The Connecticut Children's Medical Center – Injury Prevention Center is conducting the evaluation for IPV-FAIR.

To identify a provider in your area, please go to the contract management website at <http://contractmanagement.dcf.ct.gov/search.asp>.

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***Multi-Systemic Treatment - Intimate Partner Violence (MST-IPV)***

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MST-IPV, an evidence-based treatment model, provides intensive in-home family and community-based treatment to families with active DCF cases due to the physical abuse and/or neglect of a child in the family **and** due to the impact of intimate partner violence (IPV) within the family.

**Target Population:**

MST-IPV serves families with a child under the age of 18 and impacted by IPV who meet the following criteria:

- Families who have come to the attention of DCF due to the physical abuse and/or neglect of the children in the family **and** due to the impact of IPV within the family.
- A caregiver in the home is also experiencing IPV which is impacting the safety and well-being of the caregiver and children in the home.
- The family had a new report of physical abuse and/or neglect in the last 180 days.
- If the target child or children are in the home at the time of the report, the CPS goal is to keep the family together.
- If the target child or children are in an out-of-home placement at the time of referral, the CPS goal is to safely reunite the family as quickly as possible.
- The ongoing risk to child safety is sufficient to warrant the opening of an Ongoing Services case.

**Referral and Service Initiation:**

- The provider is available to accept referrals Monday through Friday, 52 weeks per year within the hours of operation.
- The MST-IPV supervisor notifies the gatekeeper (Regional Resource Group) of availability for referrals.
- The MST-IPV supervisor will follow the referral process which includes collaborating with the gatekeeper to determine if a case cannot be accepted due to geographic, low safety or other issues at the time of the referral. Otherwise, all referrals will be accepted.
- If the family is not eligible for MST-IPV for any reason or if MST-IPV is not immediately available, the MST-IPV supervisor offers assistance in finding other resources for the family referred.
- An initial home visit will take place within three business days of acceptance of the referral by the MST-IPV supervisor. The DCF Social Worker will contact the family and schedule the intake session at a time that is agreeable to all parties.

**Caseload and Length of Service:**

Caseload = four families per full-time clinician.

The provider will conduct a minimum of three home visits per week.

The average length of service is six to nine months. Services may be extended beyond this period with authorization from the DCF Regional Administrator or designee. Authorization should only be sought for service extension for those cases that have been deemed clinically appropriate for extended service after consultation with the MST-IPV expert.

**Services and Interventions:**

The clinical approach is:

- A set of nine principles and a structured analytic process for assessing drivers of referral behaviors (IPV and child maltreatment), prioritizing risk factors and implementing evidence-based interventions that directly address these risk factors.
- A focus on family strengths, engagement, safety and sustainability of progress.
- Improving parent management practices and minimizing family conflicts.
- On an “as indicated” basis, parents may receive a course of Reinforcement Based Therapy (RBT) for substance use, utilizing Motivational Interviewing to help



engage and motivate parents and cognitive-behavioral techniques to reinforce abstinence and abstinence-supporting behaviors.

The service components are:

- a personal safety plan that is specific to each family;
- a functional analysis of abuse or neglect and IPV incidents and the inclusion of findings in case planning and treatment interventions.
- treatment of caregiver mental and physical health needs, including post-traumatic stress disorder, that interfere with parenting;
- interventions to reinforce the caregiver accepting responsibility for abuse or neglect and partner conflict or violence that has occurred;
- interventions to assist partners with managing conflict without violence;
- interventions to help parents who live apart co-parent their children peacefully;
- training in anger management, where anger is the result of skills deficit and in the absence of instrumental anger, and communication skills;
- integration of the DCF Social Worker in the ongoing intervention process;
- as needed, interventions that focus on substance use treatment for all family members (or members of the household);
- assistance with housing, employment, pro-social recreational activities and budget management;
- inclusion of the time of a psychiatrist or APRN who is dedicated to MST-IPV; and
- quarterly investment check-ups with each family that includes the DCF Social Worker.

### **Crisis Response**

MST-IPV provides 24-hour emergency and crisis intervention services to children and their families by phone or pager. In some cases, face-to-face interventions will be required and will be provided, at the discretion of the therapist and supervisor. The team contacts the local Emergency Mobile Psychiatric Services in those cases where the MST-IPV services cannot stabilize the crisis situation for the caregivers or the children.

To identify a provider in your area, please go to the DCF Contract Management site at <http://contractmanagement.dcf.ct.gov/search.asp>.