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# Coordinated Public Health Initiatives to Address Violence Against Women and Adolescents

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## Abstract

Intimate partner violence (IPV) is a well-recognized public health problem. IPV affects women's physical and mental health through direct pathways, such as injury, and indirect pathways, such as a prolonged stress response that leads to chronic health problems. The influence of abuse can persist long after the violence has stopped and women of color are disproportionately impacted. Successfully addressing the complex issue of IPV requires multiple prevention efforts that target specific risk and protective factors across individual, interpersonal, institutional, community, and societal levels. This paper includes examples of community-based, state led and federally funded public health programs focused on IPV along this continuum. Two community-based efforts to increase access to mental health care for low income, women of color who had experienced IPV, Mindfulness-Based Stress Reduction, and a telehealth intervention are discussed. Core tenets of a patient-centered comprehensive approach to assessment and responses and strategies for supporting a statewide comprehensive response are described in Project Connect: A Coordinated Public Health Initiative to Prevent Violence Against Women. Project Connect provides technical assistance to grantees funded through the Violence Against Women Act's health title and involves developing, implementing, and evaluating new ways to identify, respond to, and prevent domestic and sexual violence and promote an improved public health response to abuse in states and Native health programs. Health care partnerships with domestic violence experts are critical in order to provide training, develop referral protocols, and to link IPV victims to advocacy services. Survivors need a comprehensive response that addresses their safety concerns and may require advocacy around housing or shelter, legal assistance, and safety planning. Gaps in research knowledge identified are health system readiness to respond to IPV victims in health care settings and partner with domestic violence programs, effects of early IPV intervention, and models for taking interventions to scale.

## Introduction

> *If this [domestic violence] were an infectious disease, we would have a treatment center in every neighborhood. There is a huge disconnect between the prevalence of domestic violence and what is done in the health system.*[1]

Intimate partner violence (IPV) is a well-recognized public health problem.[2] IPV affects women's physical and mental health through direct pathways, such as injury, and indirect pathways, such as a prolonged stress response that leads to chronic health problems. Thus, the influence of abuse can persist long after the violence has stopped. The more severe the abuse, the greater its impact on a woman's physical and mental health, and the impact over time appears to be cumulative.[3]

According to the Centers for Disease Control and Prevention's 2010 National Intimate Partner and Sexual Violence Survey (NISVS), more than one in three women have experienced physical violence at the hands of an intimate partner (defined as ''romantic or sexual partner'') and nearly one in ten women in the United States (9.4%) have been raped by an intimate partner in her lifetime.[4] Women were more likely than men to experience multiple forms of IPV. The NISVS reported that nearly half of female victims (47%) were between 18 and 24 years of age when they first experienced violence by an intimate partner. Among those who ever experienced rape, physical violence, or stalking by an intimate partner, more than 22% experienced some form of intimate partner violence for the first time between the ages of 11 and 17 years.

The NISVS reported that women of color are disproportionally impacted, with higher lifetime rates reported for rape, physical violence, and stalking by an intimate partner. Health disparities in access to health and mental

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health care for those individuals with adverse outcomes following exposure to IPV create an enormous public health challenge as well.[5] Traditional mental health systems often fail to provide culturally competent interventions that are developed from an understanding of trauma and its effects for restoring well-being and fostering empowerment, especially among women of color. Cultural beliefs about mental health and culturally sanctioned ways of expressing suffering and coping[6] may not be well understood or accepted by many mental health professionals. This can reinforce barriers of distrust and resistance to seeking treatment and maintain the stigma associated with using the mental health system. Further barriers to accessing care are created by geographic location, the cost of transportation, and lack of childcare.

Eighty-four percent of female victims disclosed their victimization to someone, primarily a friend or family member, and 21% disclosed their victimization to a doctor or nurse at some point in their lifetime.[7] These data highlight the important role of health care providers in the lives of women who experience IPV and informed both the Affordable Care Act coverage requirements for screening and brief counseling and the U.S. Preventative Services Task Force recommendations supporting screening and intervening for IPV. However, given the astounding costs of IPV, exceeding $5.8 billion each year,[8] it is critical to examine how this problem is being addressed in terms of intervention programs.

Successfully addressing the complex issue of IPV requires multiple prevention efforts that target specific risk and protective factors across individual, interpersonal, institutional, community, and societal levels. The World Health Organization (WHO) report *Preventing Intimate Partner and Sexual Violence Against Women: Taking Action and Generating Evidence* summarizes the literature on effective prevention and intervention strategies for IPV, including promoting gender equality, building communication and relationship skills, and changing social and cultural gender norms that contribute to IPV. Here we provide a few examples along a continuum of public health programs focused on IPV. These include community-based interventions that build individual resilience; statewide initiatives that strengthen community capacity for responding to IPV; and institutional support of health care and domestic violence program collaborations.

### Community-Based Interventions

Current evidence-based mental health trauma treatments often focus on a narrow range of trauma symptoms, although more recent evidence has shown that some interventions may lead to improvements in a broader set of trauma-related outcomes, such as sleep.[9] Nevertheless, interventions that focus on more than symptom reduction, that are easier to access and that avoid the stigma of mental health treatment may offer more acceptable approaches for reducing chronic suffering following trauma. Two examples of alternative community-based approaches (mindfulness-based stress reduction [MBSR] and *CONNECT*, telehealth intervention) that are intended to reduce health care disparities are presented next. Both approaches were designed to build resilience and to reduce barriers for low-income women of color who had experienced IPV.

MBSR is a standardized 8-week group program that teaches mindfulness skills that can be applied to a wide variety of everyday life situations to alleviate distress and suffering.[10] In this National Institute of Mental Health (NIMH)-funded study, MBSR[11,12] was offered to women who had experienced IPV and who reported current posttraumatic stress disorder (PTSD). The program was offered in community-based long-term shelter programs for domestic violence, substance abuse, or homelessness and in a local community hospital. In collaboration with women in these community programs, as well as program staff and administrators, the structure of the MBSR program was adapted to the needs of this group of women reporting a history of IPV and current PTSD symptoms. Participants reported positive outcomes in their lives[13] beyond significant reductions in posttraumatic stress and depression symptoms:

> ''It [MBSR] taught me to love myself and not let others put me down or make me feel bad (p. 32).''

> ''I am easier and gentler with myself, less perfectionistic, more confident, and effective (p. 29).''

> ''It helped me get through my problems and believe in myself. I accepted my fears and became more empowered (p. 29).''

Importantly, the MBSR program changed how women experienced themselves, not just their symptoms.

*CONNECT,* a second NIMH-funded intervention was designed to be delivered via telephone and incorporates layered modules: (1) safety and advocacy; (2) mindfulness and acceptance skills adopted from acceptance and commitment therapy (ACT);[14] and (3) psychoeducation. In an NIMH-funded pilot randomized clinical trial, *CONNECT* was offered to female survivors of interpersonal violence who were identified through routine screening in a primary care setting and who screened positive for current PTSD. The telehealth modality reduced barriers by identifying survivors who might benefit where they were already accessing services (e.g., primary care). Telehealth delivery also allowed for greater flexibility in the delivery of the intervention through flexible scheduling, increased privacy and individual pacing and offered help for unmet needs (''I kept my emotions in for 17 years, and it was helpful for me to talk and work through things slowly. It helped me to not explode;'' ''I realize how the abuse still affects me today.''). It is not enough to develop promising programs for IPV and its lasting adverse effects. It is necessary to make them easily available in order to make a real difference to more than a handful of individuals.

### Taking Programs to Scale in Statewide Public Health Settings

These interventions and others like them hold great promise and must be tested and disseminated more broadly to truly change the standard of care for victims of abuse. For nearly two decades, the National Health Resource Center on Domestic Violence (HRC) has been supported by the U.S. Department of Health and Human Services, Administration for Children and Families' Family and Youth Services Bureau to improve health care's response to domestic violence. The HRC, led by Futures Without Violence (FWV), a national nonprofit dedicated to ending violence against women and children, has been developing tools and strategies for how to take successful local programs, particularly

healthcare-based IPV interventions to scale statewide in public health programs.

Most recently, FWV was funded by the federal Office on Women's Health to launch Project Connect: A Coordinated Public Health Initiative to Prevent Violence Against Women to fund and provide technical assistance to grantees funded through the Violence Against Women Act, FWV's Project Connect involves developing, implementing, and evaluating new ways to identify, respond to, and prevent domestic and sexual violence and promote an improved public health response to abuse in 13 geographically and ethnically diverse states and 7 native health programs. Each site identified family planning, adolescent health, or other maternal child health or perinatal program settings to develop policy and public health responses to domestic and sexual violence. Through Project Connect, other multisite initiatives, and related research, the lessons that follow have emerged.

### *Core tenets of a patient-centered comprehensive response*

Research indicates that clinic-based assessment for partner violence can be a step in recognizing abusive behaviors[15,16] and that assessment and response can improve health and safety. New findings in reproductive health[17] and in Project Connect sites, demonstrate that the following approaches are instrumental to a successful IPV assessment and response:

- Combining a discussion of abuse and how it impacts health with other patient or provider administered assessment tools,
- Discussing abuse as it relates to the reason for the visit is meaningful to the patient and logical for the provider,
- Utilizing a brochure for patients and providers to guide the conversation is an effective and valued tool,
- Universal education for all patients and assessment promotes prevention and intervention within each clinical encounter, and
- Supportive referrals to victim services providers matter.

Training on how to implement this patient-centered approach, how to introduce the brochure during clinical encounters, and how to respond can be brief and effective.

### *Need for a comprehensive approach*

These core tenets of a clinical response must be supported by comprehensive systems based responses. O'Campo and colleagues[17] conducted a systematic review of the scholarly literature to reevaluate the evidence on program mechanisms for routine screening and disclosure of domestic violence within a health care context. The authors found that programs that took a comprehensive approach had sustained increased rates of screening, disclosure, and case identification and had (1) institutional support, (2) effective screening protocols, (3) thorough initial ongoing training, and (4) immediate access or referral to on- or offsite support services. The WHO defined similar ''Minimum Requirements for Asking about Partner Violence'' for medical practitioners: (a) a protocol/standard operating procedure for asking about abuse; (b) training on how to ask; (c) a private setting; (d) awareness of confidentiality; and (d) a system for referral in place. The Project Connect sites implemented these and other systems changes, such as integration into electronic health records, creating quality improvement measurements and providing ongoing technical assistance to support sustained responses.

### *Supporting the implementation of a comprehensive response at the state level*

To take these comprehensive approaches statewide, support from state-level decision makers is critical. A major emphasis of Project Connect has been the development of coordinated state-level teams involving the selected public health programs and domestic and sexual violence coalitions for each of the states involved. These teams guide and measure the replication of innovative programs and integration of practice and policy change. Coordinated state-level teams of public health and domestic and sexual violence prevention partners can create lasting health policy and coordinated responses for victims. They can work at multiple levels to develop policy and clinical responses to domestic and sexual violence in women's health programs.

The combination of a patient-centered clinical approach, systems reform at the clinic level, and state health policy reform and coordination can make a difference, even in a matter of a few years. In Project Connect, this approach has resulted in over 5,000 providers trained; over 250,000 patients screened for IPV, and significant policy shifts that will promote sustained response. Providers reported much more confidence in addressing IPV, and DV advocates report a renewed focus on health and wellness as part of their core services.

> ''I was comfortable asking because I had resources to share and knew who I could call if the client needed more help than I could give.''
>
> –Project Connect provider in Michigan

Patients reported satisfaction with the intervention:

> ''They [the clinicians] were just like, 'do you have any friends that have ever been abused or have you ever been abused?' Regardless if you say yes or no…they'll still hand you the [IPV resource] cards. I think it's a good idea, 'cause they tell you, if you ever need any help or if anyone you know needs any help, do you mind passing this on?'''
>
> –Patient seeing Project Connect provider

Examples of policy change include changes in health protocols adding assessment of domestic and sexual violence into statewide nursing guidelines and clinical assessment forms, requiring training on IPV and psychoeducation interventions using brochures, and improving data collection by adding new questions about domestic and sexual violence to statewide surveillance systems.

Large scale, multistate projects such as Project Connect demonstrate the impact of funding strategies that intentionally promote multisectoral collaboration on the public health response to violence against women.

> ''I see the connections and how violence left unaddressed undermines each new effort to promote health. Violence isn't a safety checkbox on an intake form. No longer do I wonder, 'Why isn't this working' when I'm considering program outcomes but, 'how can violence be effectively addressed.'''
>
> –Project Connect provider in Iowa

### Promoting Health Care Partnerships with Domestic Violence Programs

The role of the health care provider in addressing IPV goes beyond identification. It includes providing treatment that recognizes the effects that trauma and abuse may have on patients' health and linking patients to appropriate specialists when necessary. Health care providers who do not have the training to respond to disclosures of abuse or the capacity to respond to patients' needs are unlikely to conduct effective screening and assessment.[18–20] This suggests that partnerships with domestic violence experts are critical in order to provide training, develop referral protocols, and to link IPV victims to advocacy services.

Health care providers who discuss IPV with their patients see a variety of responses. Some patients may disclose a past history of abuse relevant to their medical history and diagnosis. For others, brief education and information about the impact of IPV on their health may plant the ''seeds for change''[21,22] and create an opportunity for women or girls to gain earlier access to the support and services they need to find safety, health, and healing. But for some patients, inquiry may result in disclosures about current abuse, prompting the need for an intervention that allows the IPV victim to explore her options, plan for safety, and access supports, such as domestic violence advocacy services.

Survivors need a comprehensive response that addresses their safety concerns and may require advocacy around housing or shelter, legal assistance, and safety planning for themselves and their children and other family members. So, while screening and assessment is an important first step, it is equally crucial that it be tied to effective linkages to community-based domestic violence services. Further, medical professionals must develop a good understanding of the services and supports that are available in their communities. This means that the need for developing strong referral relationships is recognized.

Domestic violence victim advocacy programs have a unique role in responding to victims or survivors of IPV. Across the United States, more than 2,000 local domestic violence programs offer emergency shelter and transitional housing, crisis response and advocacy, support groups, children's counseling and child care, legal advocacy, and other services. In a one-day snapshot of these services, the National Network to End Domestic Violence[23] reports that 66,581 victims were served in a single day, and more than 9,000 IPV victims could not obtain the service they requested because programs were over capacity. Additionally, advocates are available 24/7 to respond to approximately 3 million calls for help each year from victims of IPV and family members and friends who seek assistance from the National Domestic Violence Hotline and local and statewide crisis lines. In addition, domestic violence coalitions are available in every state to coordinate statewide training and technical assistance, and coordinate systems of care in responding to victims of domestic violence (State Domestic Violence Coalitions can be found at www.nnedv.org/resources/coalitions.html).

Care must be taken to ensure that nonprofit partners have the resources to support an increased investment in training for health care providers, services in health care settings, and responses to referrals from health care providers in crisis situations. Advocates work with victims of IPV with an approach that has been termed ''victim-defined advocacy''; in other words, the approach begins by understanding the victim's perspectives and priorities, and the IPV victim/survivor is recognized as the expert in her own life, the one who knows best what options will best promote safety and well-being for her and for her children.[24] Victims of IPV face complex risks—both safety risks from ongoing abuse and ''life-generated risks'' such as poverty, financial concerns, housing needs, potential legal and immigration issues, and the emotional and practical upheaval caused by relationship problems. Effective advocacy involves understanding the complexity of survivors' lives, partnering with the survivor to explore options and support her choices, knowledge about community-based services and supports, and the ability to advocate for systems to be responsive to the unique needs of IPV survivors. This constellation of knowledge about IPV dynamics, crisis intervention, advocacy, and counseling skills, access to shelter and housing options, and the ability to navigate criminal justice and legal advocacy systems is a unique asset that domestic violence advocacy organizations can provide in partnership with health care systems.

In a review of the evidence on the effectiveness of core domestic violence program services, Sullivan[25] found evidence that those services ''positively impact numerous factors predictive of well-being.'' These include increased survivors' safety strategies, parental self-efficacy, hopefulness, access to community services, and self-esteem as well as reduced distress, depression, anxiety, and PTSD symptoms. By fostering relationships with community-based domestic violence victim service providers, health care providers can be confident in their ability to accurately diagnose and treat their patients while linking to IPV specialists to offer services and resources outside their areas of expertise.

In a busy clinical setting, trained health care providers need to rely on established protocols and existing relationships with domestic violence specialists so that they can immediately connect interested IPV victims to the help they need. Effective partnerships between health care providers and domestic violence programs are tailored to specific clinical settings, such as general practice or reproductive health, and reflect community needs and the resources to assist IPV victims. There are several examples of effective models including: (1) trained clinical staff with referral relationships with local domestic violence programs; (2) co-location of domestic violence advocates in clinic settings for immediate response; (3) hospital-based domestic violence staff; (4) integration of domestic violence responses in the patient-centered medical home; and (5) home-visiting services.[26,27] Health care practices have been shown to increase screening and identification rates and facilitate access to help when they take a comprehensive approach to IPV screening and counseling, create a supportive environment, train staff, establish protocols, and ensure access to on site or off site services and supports.[17]

### Conclusions

While we have made significant strides in understanding the components of effective public health responses to address violence against women, children, and adolescents, many gaps in our knowledge remain. To improve the public health response to intimate partner violence, additional

research is needed to better understand health system readiness to respond to IPV victims and partner with domestic violence programs; best practices for addressing IPV in community-based and institutional health care settings; models for taking those interventions to scale; and the effects of early IPV intervention on improving patient health, safety and well-being.

In recent years, a number of international reviews have synthesized evidence on effective—or at least promising—approaches to preventing and responding to violence against women, including IPV, for example.[28] These reviews suggest a need for comprehensive, long-term collaboration between governments and civil society at all levels of the ecological framework. While individual-level interventions are relatively easy to assess, evaluation of comprehensive, multilevel, multicomponent programs and institution-wide reforms is more challenging, and therefore, while these approaches are almost certainly the key to long-term prevention, they are also the most under-researched.[28]

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