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Delaware Journal of Public Health

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COVER

Violence is a public health issue affecting people of all ages, races, ethnicities, and demographics. As a result of the undeniable consequences violence has had on community and individual health, increased prevention efforts and policy changes have been implemented nationally and internationally. Through continued public health efforts and approaches, the impact of violence can be reduced, and violent behaviors prevented.

The Delaware Journal of Public Health (DJPH), first published in 2015, is the official journal of the Delaware Academy of Medicine / Delaware Public Health Association (Academy/DPHA).

Submissions: Contributions of original unpublished research, social science analysis, scholarly essays, critical commentaries, departments, and letters to the editor are welcome. Questions? Write ehealy@delamed.org or call Liz Healy at **302-733-3989**.

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IN THIS ISSUE

I am pleased that the Delaware Academy of Medicine and the Delaware Public Health Association have dedicated this issue of the Delaware *Journal of Public Health* to the issue of violence in our state.

The Delaware Department of Justice's primary responsibility with respect to violence is, of course, to prosecute persons charged with violent crimes. We have hundreds of people in our office who work tirelessly every day on these prosecutions, and I am honored to call them my colleagues.

Since taking office a little over 20 months ago, I have also tried to focus the attention of policymakers and the public on the prevention of violent crime. Some of that effort has been focused on enhancing community-based policing in the neighborhoods of our state most directly impacted by violence. But we have been equally committed to encouraging the state to focus more resources on the underlying causes of crime, by heightening investment in summer and after-school programs for children in low-income neighborhoods, public schools with large populations of students who live in poverty, drug treatment programs, and programs that help inmates successfully re-enter the community after serving prison sentences. I am grateful to have the vocal support of many members of the state's medical community in these efforts; as the people who often see and treat the victims of violent crime, some of our health care providers have been among the most passionate advocates for these efforts.

The responsible gun control laws enacted in Delaware that Eleanor Kiesel discusses in her article, the school-based health centers discussed by Lanae Ampersand and Joyce Persing, and the youth interventions discussed by David Chen, Iman Sharif, and Sandra Medinilla, are all important parts of the tapestry of efforts that are required if we are to reduce violent crime over the long run. Improved policing is a necessary, but not sufficient, part of making our state safer.

One additional area where the medical community can assist the state in reducing violence is by assisting the state in reducing the unnecessary prescription of opioid drugs. Any police chief in the state will tell you that a substantial amount of our state's violent crime is related to drug trafficking, and many of the persons in our state who suffer from substance use disorder and purchase those drugs began as recipients of prescription opioids. In the most recent comprehensive studies, Delaware continues to have one of the highest per capita opioid prescription rates in the country for long-term opioids and high-dosage opioids. I have been a vocal advocate for increased communication in our state between medical providers and their patients who receive opioid prescriptions, as well as increased monitoring of many patients who receive long term opioid prescriptions. I hope that our medical community will join this effort.

Once again, I appreciate the interest of the Delaware Academy of Medicine and the Delaware Public Health Association for this issue, and the interest of the state's entire medical community in making this a safer and more secure state.

Matt Denn
Delaware Attorney General

INTRODUCTION

VIOLENCE *is* a public health issue

Timothy E. Gibbs, M.P.H.
Executive Director
Delaware Academy of Medicine and the Delaware Public Health Association

Omar A. Khan,
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President
Delaware Public Health Association

For this edition of the *Delaware Journal of Public Health* we focus on Violence and Public Health, and we are pleased to welcome State of Delaware Attorney General, The Honorable Matthew Denn as our guest editor. To give you a sense of what any state Attorney General faces, the facing page has several infographics that describe the scope of the challenge. Please note, these are national statistics - *not Delaware-specific ones*.

Violence is a key social determinant of health, and claims too many Delawareans each year. There is also a groundswell of support for unique, community-based approaches for us all to play an part in addressing this set of issues. Most recently, the Delaware ACCEL program hosted a community engagement conference which focused on this area; more information can be found here: https://de-ctr.org/node/1579

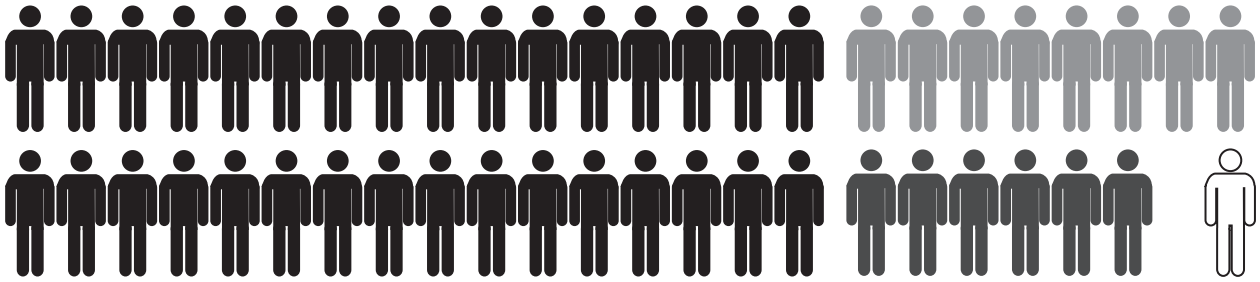
Attorney General Denn brings together a host of important perspectives on this challenging area. We thank him for his leadership in the State, and for advancing the public's health and safety.

We also want to take this opportunity to convey some exciting news regarding programs of the Delaware Academy of Medicine / Delaware Public Health Association. First, we are delighted to announce the hire of Kate Smith, MD , MPH. Dr. Smith is taking the Delaware Medical Orders for Scope of Treatment (DMOST) and Goals of Care Delaware initiatives to the next level. This critical position is funded, in part, by grants from the Highmark Foundation, and the Christiana Care Value Institute Harrington Trust.

Second, we are honored to be working on a new initiative with Claudine Jurkovitz, MD, MPH, which is funded by the Patient-Centered Outcomes Research Institute (PCORI). Dr. Jurkovitz is the project lead for the Engaging Stakeholders for a Patient-Centered Research Agenda for Chronic Kidney Disease in Delaware. Chronic Kidney Disease (CKD) affects more than 20 million people over the age of 20 in the United States. The highest rates of CKD are seen in individuals over 60 years of age. Diabetes and hypertension are the most frequent causes of CKD in the U.S. CKD and end stage renal disease (ESRD) are very costly to treat, in fact nearly 25% of the Medicare budget is used to treat people with CKD and ESRD. In 2013, there were 2,287 patients in chronic renal replacement therapy in Delaware.

We invite you to attend the first of two conferences which are part of a two-year project to engage stakeholders of all types as we address the impact and burden of CKD and ESRD in Delaware. Patients and their supporters, providers, payers, researchers, and policy makers are all encouraged to attend this event. Visit www.delamed.org/CKD for more information.

EVERYDAY VIOLENCE IN AMERICA

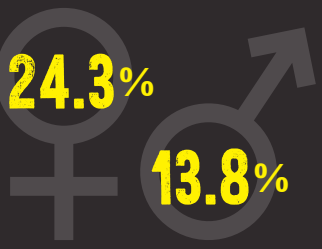


47 CHILDREN AND TEENS SHOT

32 ASSAULT • **8** ACCIDENTALLY • **6** DIE • **1** SURVIVES SUICIDE

24 PEOPLE ARE VICTIMS OF RAPE, PHYSICAL VIOLENCE, OR STALKING EVERY MINUTE

306 ADULTS WILL BE SHOT



PERCENTAGE OF WOMEN AND MEN WHO WILL EXPERIENCE PHYSICAL VIOLENCE IN THEIR LIFETIMES

A WOMAN IS BEATEN **EVERY 9 SECONDS**

1 IN 3 WOMEN
WILL EXPERIENCE DOMESTIC VIOLENCE IN THEIR LIFETIME

2 IN 5 GAY/ BISEXUAL MEN
WILL EXPERIENCE DOMESTIC VIOLENCE IN THEIR LIFETIME

1 IN 4 MEN
WILL EXPERIENCE DOMESTIC VIOLENCE IN THEIR LIFETIME

The information on gun violence comes from the Brady Campaign, http://www.bradycampaign.org/key-gun-violence-statistics

Domestic Violence, Mass Shootings, and Gun Control: A Public Health, Criminal Justice, and Civil Rights Issue

by Eleanor M. Kiesel, Esquire, M.S.W., Ph.D.

Stories of gun violence are ubiquitous in the United States. An article in *The New Yorker* in June, 2016, regarding mass shootings, terrorism, and a possible connection to domestic violence caught my attention and led me to review current research on this topic, culminating in this brief analysis.

By way of background, and full disclosure, I am a managing attorney with Delaware's oldest and largest civil legal services program, Community Legal Aid Society, Inc., where my colleagues and I represent victims of domestic violence in obtaining orders of protection. I also hold a Masters and Ph.D in social work and so bring an academic and research-based framework to the challenges confronting our clients. In the low income communities we serve, domestic violence can often have a more severe and wide-reaching impact due to the intersection of a multitude of societal challenges and the lack of resources facing this population. Domestic violence has often been referred to as domestic terrorism because domestic violence and terrorism are similar—both rely on the use of violence and intimidation to obtain certain objectives, and the threat of gun violence is employed frequently.

Given the increase in gun violence throughout American society, it is more important than ever to provide free legal services to individuals in poverty who find themselves in dangerous domestic situations. I have heard many stories from clients who had been emotionally and physically abused during the time that they were with their partners. Most of them experienced being isolated by their abuser from family and friends, as well as being denied access to joint economic resources. Although men can be victims of domestic abuse in both same-sex and heterosexual relationships, statistically, many more women suffer domestic abuse than men and are more seriously injured by their abusers (Stark, 2007). While physical, emotional, and verbal abuse are the major techniques through which abusers exercise for power and control over their victims, all too often their conduct escalates to threats of, and in some cases actual, gun violence. Luckily, clients who leave their abusers in time and seek an Order for Protection from Abuse from the Family Court, have the chance to experience a home life absent of threats and/or serious injury or death.

Posted by kmitchell5, Community Contributor

The idea of living in one's own home without fear may be taken for granted by many, but it is a new experience for many of my clients, and for many victims of abuse in the United States and around the world.

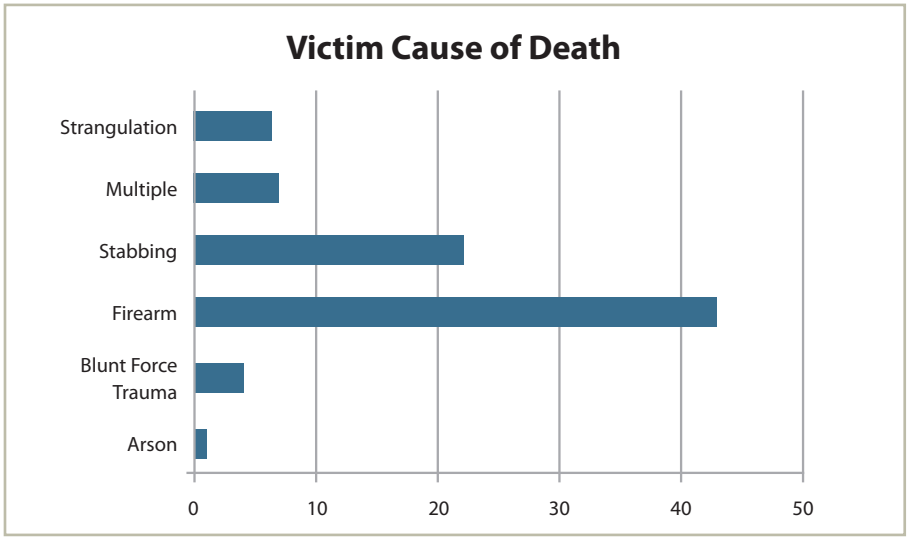


FIGURE 1. *Graph of the Intimate Partner Data, Victim Cause of Death. Reprinted from DVCC Annual Report 2015, retrieved from http://dvcc.delaware.gov/pdf/Final%20Annual%20Report%202015.pdf. Both Figure 1 and 1.1 were reprinted with the permission of DVCC.*

In the most recent Center for Disease Control (CDC) large scale survey, The National Intimate Partner and Sexual Assault Survey (2010) Summary Report, found that more than 1 in 3 women (35.6%) have experienced certain aspects of intimate partner violence such as, rape, physical violence, and/or stalking by an intimate partner. Most men and women who experience domestic violence have their first encounter before they reach the age of 25: 69% of female victims, and 53% of males experienced their first incidence of domestic violence as defined above before age 25 (CDC, 2010). In Delaware, in fiscal year 2015, there were 22,678 reported incidents of criminal, and non-criminal (police involvement but no arrest) domestic violence (defined as violence between family members), and of those incidents, 5,607 were intimate partner violence, and 75% were female victims (DVCC, 2015). A 2015 report by the Delaware Domestic Violence Coordinating Council, Fatal Incident Review, found that between 1996 and 2015 there were 111 domestic violence homicides reviewed, of which 83 were intimate partners. Of the intimate partner homicides, 77% were female victims, and 52% of the perpetrators used firearms (DVCC, 2015).

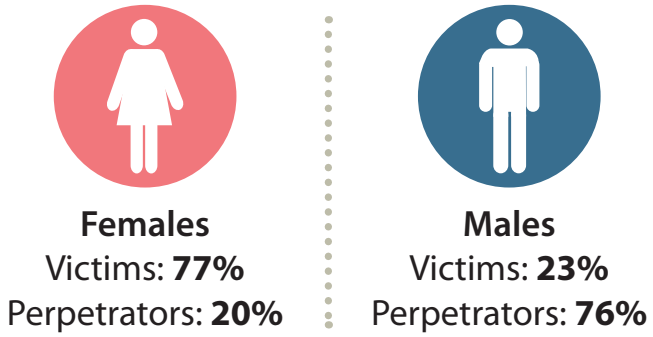


FIGURE 1.1. *Chart of the Intimate Partner Data, Victims and Perpetrators by Gender. Adapted from DVCC Annual Report 2015, retrieved from http://dvcc.delaware.gov/pdf/Final%20Annual%20Report%202015.pdf.*

Researchers have only recently begun to examine a potential connection between access to guns, mass shootings, and domestic violence. According to Clark McCauley, a professor at Bryn Mawr College, there has been no empirical support for the assertion of a causal connection between mass shootings of strangers and domestic violence (Taub, 2016), however, it may not simply be a coincidental that a number of perpetrators of mass shootings had also committed acts of domestic violence. Micah Johnson, the shooter in Dallas, had a report of sexual harassment and a request for a protective order against him while he was stationed in Afghanistan in the military (Welker, 2016); the killer in the Orlando shootings, among other incidents of abuse, had beaten his first wife for not finishing the laundry; the Virginia Tech killer had been charged with stalking a female student; one of the two Boston Marathon bombers had been arrested for domestic assault and battery of a women (Talbot, 2016); in February, 2016, a man shot 17 people at his Kansas workplace, killing three, 90 minutes after being served with a restraining order filed by an ex-girlfriend (Taub, 2016); and, the mass shooting of a Planned Parenthood healthcare center in Colorado Springs, Colorado, that left three people dead and nine wounded was perpetrated by a man who had incident(s) of domestic violence (Turkewitz et al., 2015).

Battered spouses, their families, and friends have been victims of mass shootings for years. "An analysis of the criminal justice history of hundreds of thousands of offenders in Washington State," writes Pamela Shifman and Salamishah Tillet in a February 3, 2015 Op-Ed piece for The New York Times, "suggests that a felony domestic violence conviction is the single greatest predictor of future violent crime among men" (para. 4). Everytown for Gun Safety issued a report in August 2015, which analyzed FBI mass shootings statistics and domestic violence and concurs with Shifman and Tillet. Among other interesting findings, Everytown found that the link between intimate partner mass shootings, those where four or more people were killed with a gun, and prior reports of domestic violence is significant: in 57% of cases of mass shootings from 2009 to 2015, the perpetrator shot and killed a current or ex-spouse, girlfriend, or other family member, and at least 16% of those perpetrators had previously been charged with domestic violence offenses. Further, the Everytown for Gun Safety report indicates that in 87% of the cases of mass shootings where there was sufficient information to determine whether the shooter was a person prohibited by law from possessing a gun: 38% of the shooters had been adjudged to be a person prohibited from possessing a gun. During this relevant time period, 133 mass shootings occurred in 39 states, or almost two per month from 2009 to 2015 (Everytown for Gun Safety, 2015). In 11% of the mass shooting incidents, high-capacity magazines (assault weapons) were used and 155% more people were shot, resulting in 47% more fatalities (Everytown for Gun Safety, 2015). What possible cause could an average citizen have to obtain an assault weapon?

All perpetrators of domestic violence do not escalate to mass shootings, but the connection between access to guns, mass shooting, and domestic violence may be significant, because for many intimate partner homicides, if a gun had not been readily available, lethal violence would likely not have occurred. David Adams in his book, *Why Do They Kill?*, interviewed men who had shot and killed an intimate partner. He asked specifically if they would have killed their partner if a gun was not readily available (Adams,

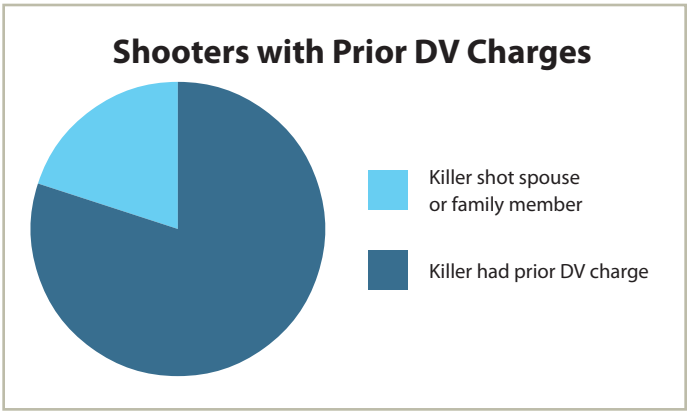


FIGURE 2: *Graph of the perpetrators of domestic violence shooting with past dv charges. Adapted from August, 2015, Everytown for Gun Safety, retrieved from https://everytownresearch.org/reports/mass-shootings-analysis/. Reprinted with permission of Everytown for Gun Safety.*

2007). Adams found that 78% of the killers would not have killed if a gun had not been available (2007), while the other perpetrators said they would have simply used another weapon. These men said that a gun readily available made it easier to kill (Adams, 2007).

Equally important to providing direct services, including legal services, to victims already experiencing domestic violence, is the need to find and implement strategies designed to prevent future tragedies. One of these strategies is to enact better gun control laws. Yet, currently people with restraining orders associated with intimate partner violence are prohibited from owning and buying guns in fewer than half of the states in the U.S. (Mascia, 2016).

Thankfully, three important events related to gun control have occurred nationally and in Delaware. First, HB325 (Osienski) was signed into law by Governor Markell in June, 2016. This law closes the loop hole that allowed gun purchasers in Delaware to obtain a weapon before a background check was completed. The law extends the allowable waiting period for completion of a background check from 3 day to 25 days, with the aim of eliminating the possibility of a prohibited person from gaining access to a gun if they purchase arms through a licensed arms dealer. On June 20, 2016, the U. S. Supreme Court, in a case from Maine involving gun restrictions and domestic violence perpetrators, ruled that people convicted of intimate partner crimes, even misdemeanors, or crimes related to reckless conduct, could be prohibited from owning firearms. While these measures represent a step forward, more than 80 incidents of gun violence took place while the Democratic leadership in Washington, D.C., lodged a sit-in to try to force Congress to enact better gun control legislation. Delaware was one of the states that incurred an incident of gun violence during that 72 hour period.

It is also important to recognize from a civil rights perspective, as Amie Newman writes in a June 17, 2016 article about the connection between domestic violence and mass shootings in *Our Bodies Ourselves*, "Violence against women has become normalized in our culture. We allow for and excuse street harassment, sexual harassment, and media depictions of violence against women and girls – all of which desensitize us and contribute to an epidemic of gender-based violence in the US" (para. 11). Consequently, one strategy for reducing gun violence, she suggests, is "to raise awareness of how deeply imbedded violence against women is in the United States, and how important it is to believe women, intervene early, and address the 'toxic masculinity' that contribute to violence" (para. 15). And, as Soraya Chemaly stated in her June 13, 2016 article on domestic violence and mass shootings in *Rolling Stone*, "Acts of public terrorism . . . would be less unpredictable if intimate partner violence were understood as a public health and safety issue, instead of as a private problem" (para. 10). Based on statistics and numerous studies, it is clear that violence against women, particularly domestic violence, is a civil rights issue in the United States and worldwide.

Evan Stark insists that the effects of incidents of coercive control are cumulative and generally lead to serious injury or death (2007), and studies of mass shooters confirm that a mass shooting is not an isolated incident for many perpetrators. There is also evidence that nationally, and likely internationally, there is a culture of power, coercive control, and oppression underlying the violence, and we are not simply dealing with random acts of violence, or religious extremism. As long as people define others as unequal, inferior, and less than human because of their gender, race, ethnicity, religion, sexual identity and/or orientation, ability/disability, or any other apparent difference, violence will likely occur, thus the problem must be attacked from a civil rights perspective, with collaborations from the criminal justice, behavioral and mental health professions, and public health systems. Preventions and interventions measures will need to be devised that can work to invalidate and treat these perceptions that lead to gun violence.

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Eleanor M. Kiesel, Esquire, has been Managing Attorney for Community Legal Aid Society, Inc., Sussex/Kent Counties since 2001. Prior to her position as Managing Attorney, she was a Staff Attorney in the Poverty Program with CLASI. In addition to her law degree, she has a Masters and Ph.D in Social Work. Dr. Kiesel's practice and research interests include intimate partner violence, gender equity, and social/economic justice.

15th Annual John Scholz Stroke Education Conference

Saturday, October 15, 2016

John H. Ammon Medical Education Center
Christiana Hospital
4755 Ogletown-Stanton Road
Newark, DE 19713

7:00 a.m. to 7:50 a.m.
Breakfast and registration
8:00 a.m. to 1:00 p.m.
Conference, lunch included

GLOBAL OBJECTIVES:

At the conclusion of this conference, participants will be able to:

- Recognize the role that lipids play in Stroke
- Discuss how sleep apnea can be a risk factor for Stroke
- Distinguishing gender differences in Stroke presentation
- Predicting Stroke based on carotid stenosis
- Evaluate patients for driving readiness after stroke
- Identify strategies to improve medical compliance in the Elderly
- Using appropriate triage to transfer stroke patients for optimal outcome
- Classifying and predicting mental and cognitive complications of stroke
- Demonstrate cutting edge assistive technologies for stroke rehabilitation
- Selecting the type and timing of speech therapy
- Summarize the value of OT for select patients after acute stroke
- State how physical therapy can be applied after acute stroke
- Discuss the use of acute rehabilitation therapy as primary treatment after stroke
- Describing the connection between heart performance and stroke

TARGET AUDIENCE:

- Neurologists
- Family Physicians
- Internists
- Home Health Professionals
- Nurse Practitioners
- Nursing Professionals and Students

FOR ADDITIONAL INFORMATION AND TO REGISTER:

www.delamed.org/stroke

DSI Delaware Stroke Initiative

DELAWARE ACADEMY of MEDICINE

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PARADIGM SHIFT 2.0:

A Coalition's Decade-long Journey into the Public Health Approach to Violence | *by Noël Duckworth*

Noël Duckworth is the Director of Training and Prevention at the Delaware Coalition Against Domestic Violence and has served as the Principal Investigator for Delaware's DELTA and DELTA Focus Program since 2003.

Understanding and approaching violence as a public health problem has started changing how we approach and resource this issue, including providing anti-violence advocates an additional framework and set of tools under which to operate. Yet, as the Centers for Disease Control and Prevention (CDC) points out in their publication, "*The History of Violence as a Public Health Issue*," just 30 years ago the words "violence" and "health" were rarely used in the same sentence.[1] This strikes a familiar chord with those working in or knowledgeable about the domestic violence movement and the silence that ensued around family and intimate partner violence (IPV) through the latter part of the 20th century. In the 30 year span from 1939, the year the *Journal of Marriage and the Family* was first published, to 1969, the index did not include even one article with the word "violence" in the title.[2] Fortunately, the victims, survivors, activists and allies of the battered women's and domestic violence movement, who were provided a foundation paved by social movements like the civil rights, black liberation and anti-war movements of the 1950s and 1960s, helped bring the issue of domestic violence to the forefront. Along with this urgent need to uncover the magnitudte of private acts of violence happening in homes and relationships, was the need to address these acts as crimes. This "paradigm shift" in the public's view was also marked by the passing of the landmark Violence Against Women Act (VAWA) in 1994, which aimed to improve criminal justice responses and increase the availability of services to victims. Toward these efforts, VAWA also provides grants to support domestic violence coalitions (determined by the Department of Health and Human Services) in all U.S. states and territories.

Although organized before the passing of VAWA, the Delaware Coalition Against Domestic Violence (DCADV) was established as a non-profit in 1994, and continues to be Delaware's federally recognized state domestic violence coalition. As a statewide nonprofit membership and advocacy coalition, DCADV provides training and technical assistance (TA), public awareness activities, public policy advocacy, and direct support to domestic violence shelters, programs, and community partners. DCADV works to support the empowerment of victims of domestic violence and their children through access to services and legal remedies, while also seeking to change the societal conditions that support sexism, racism, homophobia, transphobia, ableism and other oppressions which fuel domestic and sexual violence. And, just as DCADV and domestic violence organizations in the 1990s struggled with how best to implement interventions, change laws, build organizations, write policies, approach training, coordinate responses, and uphold and improve the feminist and egalitarian frameworks the work was founded on, so too has DCADV and community partners grappled with how best to approach and address violence as a matter of public health.

For DCADV, the transformative journey into a public health framework officially began in 2002, when the Centers for Disease Control and Prevention (CDC) selected DCADV and eight sister coalitions to participate in their new Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) program This program later expanded to include 14 state domestic violence coalitions and funding continued through 2013. The world was also embarking on this journey to have a shared understanding of the public health approach to violence, as WHO had just published the first *World report on violence and health* in 2002. According to WHO, this document is "the first comprehensive review of the problem of violence on a global scale – what it is, whom it affects and what can be done about it" (Krug, et al., 2002).

From a public health approach, the CDC DELTA program sought to help grantees build organizational, community and state-level

"Our vision is to be a catalyst for creating empowered, transformed individuals, partnerships, communities and societies committed to respectful collaborative processes that promote a lasting legacy of equality, peace and social justice!"

— Created by the 14 DELTA State Domestic Violence Coalitions and the Centers for Disease Control, National Injury Prevention Center.

capacity around *primary prevention* , which would involve efforts to stop intimate partner violence from ever occurring, while states and communities continued their critical efforts to address *tertiary prevention/intervention* (helping *once the violence has happened* by trying to reduce the negative effects of the abuse and protect the victim from future harm), and *secondary prevention* (activities to help when early signs of risk appear). Like the Greek symbol (Δ), the DELTA project was all about change, and this change began to occur as domestic violence advocates, communities, and organizations participating in DELTA across the country increased their capacities to understand and utilize a public health framework for IPV prevention.[3] Although organizational assessments conducted during the DELTA program identified significant changes , such as primary prevention efforts in local trainings, prevention tracks at conferences, incorporating prevention into other grant applications, prevention staff job descriptions, and board, staff and member program orientation/training, DCADV's most significant early accomplishment occurred when primary prevention and capacity-building efforts appeared, for the first time in the agency's history, in a board-approved 2008 strategic plan.

"The workshop was great and very informative. I never really thought of trying to find and fix IPV problems at the very root, in addition to helping victims reduce their risk."

— Workshop Participant, 2008

A persistent challenge that was present in the early years of DELTA was around concerns from domestic violence organizations and advocates about public health approaches that initially did not appear strongly rooted in feminism, social justice or advocacy. Understanding the history of the battered women's movement provides context for this challenge. As the movement began to realize a shift from grassroots activism and consciousness-raising efforts grounded in empowerment and victim-centered strategies, to more mainstream approaches such as government funded programs, research, evaluation, and system reform, this produced some tension and trepidation that the "mainstreaming"and professionalization of these efforts would make practitioners and organizations lose sight of the social movement that had driven the work to this point. Facing these challenges, DCADV leadership and DELTA partners had to ponder the question, "Is it possible to work from both a social justice and feminist framework while incorporating tools of a public health approach?"[4] Toward that end, a significant amount of time was spent working to identify common ground/connections, "translate" public health materials, and develop innovative process tools and education materials to introduce new concepts or terminology (i.e. early evaluation trainings were called, "Working Smarter, Not Harder") that were also rooted in survivors' experiences and community wisdom, and made clear connections between public health strategies or primary prevention and grassroots advocacy and social justice. To this day, DCADV has a "Prevention and Social Change" Board Committee overseeing implementation of the strategic plan and prevention goals. Collectively, it was also critical for DELTA state and local partners to consistently demonstrate that, despite a new language and increased evaluation approach, Delaware's DELTA program would be authentic to the anti-oppression philosophy of the organization, and strongly rooted in the movement. On a national level, a similar conversation among DELTA state grantees and the CDC was playing out that resulted in "State of the Collaboration" and "Prevention Ethics" workgroups, along with the collaborative creation of a national DELTA vision, culture, and protocol.

Critical course corrections had to be made along the way, which validated the importance of adhering to the foundation and knowledge base of the domestic violence movement. For example, a post-survey of a statewide steering committee convened from 2008-2013 revealed that 45% of committee members agreed or strongly agreed that IPV is committed by people who, "have trouble managing their anger". Given that CDC's definition and widely accepted definitions of IPV point to, "a pattern of power and control used by one partner over the other," and the notable absence of the concept of anger management in any of these definitions, it was a crucial and humbling lesson learned. In a zealous attempt to build public health planning and evaluation capacity, DCADV's efforts had lost sight of the need to continuously educate members on the dynamics of IPV, and the corresponding systems of oppression that help maintain and reinforce such power dynamics.

DCADV learned a great deal about the process of institutionalizing prevention principles, concepts and practices in the context of national, state, organizational and local-level efforts. Identifying the authentic readiness and capacity levels of organizational

members, coordinated community response task forces, and state-level steering committee members so that data-driven capacity-building could be implemented was not always as straightforward as administering a measurement tool. A metaphor often used by DELTA partners was that violence prevention work is analogous to "building a plane while flying it." At times, key leaders and stakeholders also increased engagement after exposure to local DELTA-funded community strategies (i.e school/teen programs, engaging men strategies) than by capacity-building efforts tailored specifically for the organization or steering committee. Consequently, DCADV found that balancing high-level planning with action or exposure to community efforts was essential. To this day, the state action plan closely aligns with and supports local prevention efforts.

Just as DELTA programs were building capacity, so too was the broader field refining their approach and knowledge base, which shaped the next phase of DELTA. In 2012, CDC issued a new "DELTA FOCUS" funding opportunity eligible to all state and territory domestic violence coalitions. Delaware was once again fortunate to be selected as one of 10 grantees. The DELTA FOCUS program (2013-2018) puts less focus on capacity building and a stronger emphasis on implementation and evaluation to help build practice-based evidence by informing the emerging field of IPV prevention and addressing the limited evidence base of prevention strategies. As in the prior DELTA program, the application of empowerment evaluation principles, such as community ownership, inclusiveness, social justice, and democratic participation, is integral to the program[5]. Furthermore, the emphasis of the interventions are on strategies that address the social and structural determinants of health at the outer layers (societal and community) of the social-ecological model, with the expectation that state and local-level strategies aim to improve environments and conditions in which people live, work, learn and play.[6]

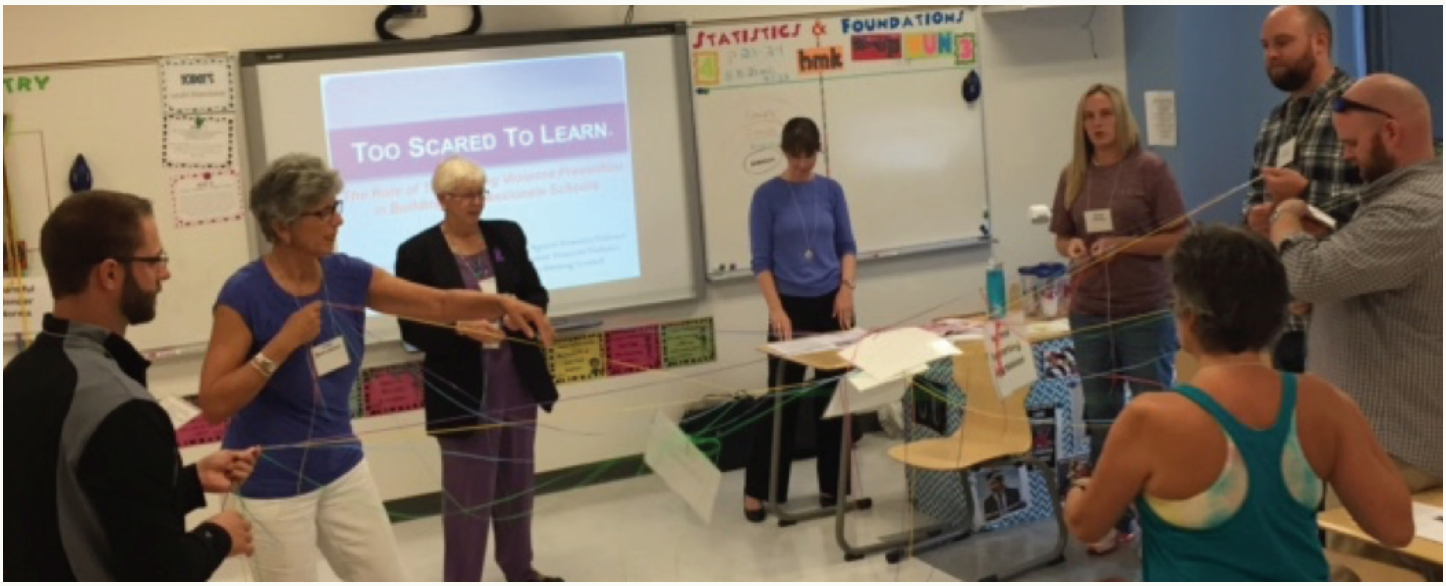
Word Cloud from Participant Feedback at 2013 DELTA FOCUS Launch Meeting

In Delaware, state-level strategies aimed at impacting system norms within the public health, healthcare, and domestic violence systems are underway, including a workforce development strategy in partnership with the University of Delaware's Domestic Violence Prevention and Services Program.[7] Indeed, preliminary evaluation findings demonstrate much buy-in by domestic violence advocates with concepts of health equity, suggesting that anti-oppression, social justice and feminist frameworks align well with the determinants approach that conditions in the physical, economic and social environment shape and impact people's health and well-being.

Innovative, strength-based strategies are also being developed and evaluated, such as *Project P.I.N. (Performing, Informing, Norming)*, a school and community-level strategy developed in partnership with Art Fusion, Inc. The project uses an interactive bystander intervention theater performance to collect data and create community-relevant messaging to promote positive social norms. Local-level strategies being implemented and evaluated, such as *Safe+Respectful* implemented by Child, Inc. on behalf of the Delaware Domestic Violence Task Force, and *REAL Relationships*, implemented by People's Place on behalf of the Delaware Victims' Rights Task Force, are described further in this issue.

DCADV utilizes logic models, theories of change, evaluability assessments, and evaluation plans to guide and inform prevention strategies and coordinates training/TA to local partners in utilizing this protocol for community-based prevention programs. Training and TA cover a wide range of topics including but not limited to: effective facilitation (participatory leadership, group consensus methods); utilizing an anti-oppression framework (power, privilege, identities, intersectionality); utilizing a public health approach (public health framework, universal vs. selected populations, social ecological model, risk and protective factors, determinants, health equity); evaluation (logic models/theories of change, collecting and analyzing data, participatory and mixed methods, SMART objectives); and, prevention strategies (evidence-based programs, engaging men, bystander intervention, social norms messaging, framing and narratives). DELTA FOCUS also represents the first time CDC violence prevention grantees are tracking data through the CDC's Chronic Disease Management Information System (CD-MIS).

DCADV has also built capacity to utilize a collective impact approach within the organization's prevention efforts, and has been further guided by the 2014 publication, *Connecting the Dots & Breaking the Silos: Understanding the Links Between Multiple Forms of Violence*[8]. This has resulted in multifaceted primary prevention efforts focused on broader community and societal-level risk factors that span multiple types of violence (i.e. dating violence, sexual violence, peer violence, child abuse/neglect, suicide, youth violence, etc.) Addressing shared risk factors, such as harmful gender norms



Educators engage in an experiential "Connecting the Dots" training

and norms that support aggression, or shared community-level protective factors such as neighborhood cohesion, school climate, or community connectedness, has positioned DCADV to engage in increased collaboration and facilitate joint action. Discussed further in this issue is DCADV's Delaware Men's Education Network (MEN), a statewide multi-sector coalition-building strategy to engage men in violence prevention and promote healthy masculinities. DCADV has also developed webinars and trainings to support community and state partners in adopting this 'Connecting the Dots' framework that is increasingly being championed by funders and policy makers.

Throughout DELTA and DELTA FOCUS, it is imperative to note that DCADV and partners were also engaged in a parallel journey to apply a trauma-informed approach to services, organizations and systems. Early consultation for this work was provided to DCADV by Dr. Sandra Bloom in 2004, and later in 2009, DCADV became one of eight sites working on trauma-informed advocacy in a project led by the National Center on Domestic Violence, Trauma and Mental Health. DCADV also became a founding member of *Trauma Matters Delaware*, a statewide steering committee made up of state and community-based agencies working to make Delaware trauma-informed across systems and services. Since that time, DCADV's understanding of trauma has expanded, now approaching it as both an individual experience (i.e. emotionally painful experiences that overwhelm an individual's ability to cope), and a collective experience for whole communities enduring chronic and pervasive adversity (i.e. poverty, discrimination, racism).[9] As trauma-informed principles have moved services and systems from asking, "What's wrong with you?" to, "What's happened to you?," understanding trauma as a collective also requires a shift from, "What is wrong with this community?" to, "What has happened to this community….. and what role has our organization and systems played in that?" In fact, implementation and process data from Delaware DELTA FOCUS prevention strategies validate the necessity for violence prevention strategies to address community trauma and support community healing, resilience and healthy resistance strategies. DCADV refers to this as "trauma-informed primary prevention."

A public health approach, primary prevention, healthy relationships, community healing and resilience, and health equity, have all been exciting and positive additions to the work of the Delaware Coalition Against Domestic Violence and are now embedded into the practice and praxis of the organization. Likewise, new partnerships and relationships have been built with state systems, organizations, healthcare, schools and community groups that were not always considered "usual suspects" in the field of domestic violence, and have resulted in increased and enhanced opportunities across both prevention and intervention efforts. As public health and health equity approaches continue to unfold in Delaware and across the country, DCADV is optimistic that the movement toward achieving optimal health for all people will remain tantamount to achieving optimal safety for all people, as being healthy and well also requires feeling safe, respected and valued where you live, work, learn, pray and play.

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DCADV Capacity-Building Timeline

• 2002- DCADV is funded to participate in CDC's National DELTA program, and assembles an advisory committee to help inform planning with representation from the Domestic Violence Coordinating Council, Division of Public Health, Wilmington Police, Abriendo Puertas, Peoples Place II, Prevent Child Abuse Delaware, DSCYF, Victims' Rights Task Force, and the Domestic Violence Task Force. Local contracts are awarded to Child, Inc., Delaware Center for Justice, and Abriendo Puertas.

• 2004- DCADV partners with Delaware's Division of Public Health and the Family Planning Council of Philadelphia to offer a "Moving Beyond Intervention to Primary Prevention of Domestic Violence" training to local DELTA Projects and Title X clinics

• 2004- A Delaware DELTA team attends a workshop hosted by the Prevent Institute of the University of North Carolina-Chapel Hill. The team develops a 3-month plan to implement upon returning to Delaware.

• 2004- Prevention Subcommittees are formed in the Domestic Violence Task Force (DVTF) and Victims Rights' Task Force (VRTF) to help Delaware's domestic violence and victim services' communities build public health prevention capacity

• 2005- DCADV' sponsors a "Call to Men" Conference, the first of its kind in Delaware to focus on engaging men in IPV prevention.

• 2005- DCADV sponsors, "Mobilizing Communities for Domestic Violence Prevention," a two-day intensive workshop presented by Donna Garske of Transforming Communities-Technical Assistance/Training.

• 2006- DCADV hosts "Advocacy Strategies for Eliminating Violence" featuring Donald Gault with The Initiative for Violence-Free Families and Communities in Ramsey County, Minnesota

• 2006- DCADV convenes a multi-sectoral statewide IPV Prevention Consortium of 22 members. Using a planning and evaluation framework, the Consortium develops *Delaware's State Plan for the Primary Prevention of Intimate Partner Violence*.

• 2007- A Delaware Team presents DELTA and a public health approach at the National Visions of Feminism Conference in D.C

• 2008- The Joint DVTF/VRTF Prevention Subcommittee, led by Child, Inc. and the Delaware Center for Justice, is presented the "Outstanding Project" Award during Delaware Victims' Rights Week.

• 2008- DCADV, the Domestic Violence Task Force and Victims' Rights Task Force co-host their first prevention conference, "Promoting Safe and Respectful Relationships: Tools for Moving Beyond Domestic Violence Intervention"

• 2008-DCADV serves as a primary prevention Mid-Atlantic regional coach to state coalitions participating in the DELTA PREP program through 2011 for primary prevention of IPV. This project was funded by the Robert Wood Johnson Foundation in collaboration with the CDC and the CDC Foundation.

• 2010- DCADV and DELTA Partners Child Inc. and Delaware Center for Justice host the full-day training, "Communities Unite: Violence is Preventable!" in Wilmington.

• 2010- Delaware's DPH hosts the conference, "Primary Prevention of Intimate Partner/Interpersonal Partner Violence" featuring trainers from the Prevention Institute, welcome remarks from DCADV's Executive Director, and a panel of DELTA partners and domestic and sexual violence advocates

• 2010- DCADV and DELTA partners Child, Inc. and Delaware Center for Justice develop a standards-based "Healthy Relationships" curricula for grades 9-12 as a Delaware DOE Model Unit of Instruction. A middle school version for grades 6-8 is later piloted in Delaware schools and launched in 2012

• 2010- Delaware MEN (Men's Education Network) is formed and later funded as a statewide coalition-building strategy in 2013 by DPH through the CDC's Rape Prevention Education Program

• 2011- DCADV, Delaware DOE, DSCYF, and DELTA partners host the "*Racing to the Top Against Media Messages: How They are Hindering the Next Generation*" statewide prevention conference for parents, teachers and youth educators.

• 2012- CDC's national DELTA Program is described in the Journal of Safety Research as a "Top 20 List of Practice Innovations in Violence and Injury Prevention" since the founding of the National Center for Violence and Injury Prevention and Control in 1992

• 2013- DCADV is selected to participate in CDC's DELTA FOCUS with local programs to be coordinated by Child, Inc. and People's Place.

• 2013- DCADV, in partnership with DPH, is awarded a 3-year "Project Connect" grant to join 11 grantees across the country in one of the only programs offering a national coordinated public health model to improve the health response to IPV and sexual violence. Local partners include Child, Inc., Peoples Place, Planned Parenthood of Delaware, La Red Health Center, and University of Delaware.

• 2013- DCADV hosts a statewide THRIVE (Toward Healthy Relationships, Individuals, and Violence-free Environments) conference featuring workshops on IPV as a health issue, gender equity, and participatory action research methods

• 2014- DCADV's 20th Anniversary Institute: Integrating Health, Prevention, and Trauma-Informed Practice into Our Work brings diverse partners from across the state together for a 3-day gathering in Dover

• 2015- DCADV sponsors Dr. Bob Prentice as the keynote for DPH's Health Equity Forum. Dr. Prentice is co-author of the National Association of County and City Health Officials (NACCHO) book, "Expanding the Boundaries: Health Equity and Public Health Practice"

• 2015- DCADV's "Resilience on the Riverfront" Trauma Conference includes violence prevention workshops and remarks from Amy Peeples, Acting Deputy Director of the National Center for Injury Prevention and Control, CDC

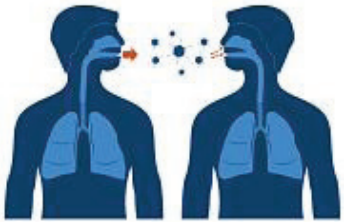
• 2016-Safe + Respectful, a Delaware DELTA program implemented by Child, Inc., is selected as a CDC case study to be disseminated nationally

The DPH Bulletin

From the Delaware Division of Public Health *Immunizations Issue - September 2016*

Vaccines protect our population against many preventable diseases

Those who have been vaccinated against vaccine preventable diseases are largely protected from these infections as long as their vaccinations are up to date. The more people who are vaccinated in a community, the less these diseases can spread.



Vaccination is considered one of the top 10 medical achievements of the 20th century. Vaccines protect us from vaccine-preventable diseases such as measles, mumps, rubella, the flu, pertussis, polio, and certain forms of cancer. Yet recently the country has seen a resurgence of some of these diseases as vaccination rates fall among certain groups. While Delaware's vaccination rates are high, we still see local outbreaks, including every year with flu and a 2014 outbreak of whooping cough, mainly in Kent County.

Free CDC Vaccine Schedules app

For iOS 6.0 or later:

Available on the App Store

For Android 4.0 or later:

ANDROID APP ON Google play

Pregnant women and vaccines

The Centers for Disease Control and Prevention (CDC) offers a quick, informative, and fun vaccination quiz for pregnant women. The CDC recommends that women receive certain immunizations before or during pregnancy. Vaccination helps prevent mothers from getting sick and passes protective antibodies to newborns through breast milk. Visit http://www.cdc.gov/vaccines/pregnancy/vaccine-quiz.html. A quiz for adolescents and adults is at https://www2.cdc.gov/nip/adultimmsched/.

Coming Soon: Special Flu edition

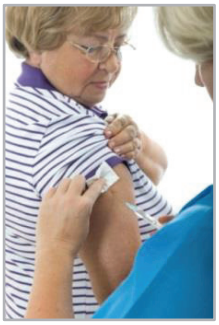
The Delaware Immunization Program

The Delaware Immunization Program within the Division of Public Health (DPH) prevents and controls the transmission of vaccine preventable diseases by increasing immunization rates.

The program is a major resource for vaccinators and provides information about vaccines and vaccine safety, vaccine preventable diseases; travel vaccination information and advisories; and storage and handling guidance. It oversees the federal Vaccine for Children program that provides vaccines at no cost to children who otherwise might not be vaccinated because of inability to pay. Visit http://www.dhss.delaware.gov/dhss/dph/dpc/immunize.html to learn more.

The Immunization Program also manages the Delaware immunization registry, DelVAX. This database collects information on all vaccinations administered in Delaware, allowing providers to quickly determine which vaccines a patient needs. The program also provides immunization records to schools and individuals. To request an immunization record, call the Immunization Program at 800-282-8672 or send a written request via email or fax to immunizedph@state.de.us.

Adults need immunizations, too



Immunizations are not only for kids! As adults age, our immune systems weaken and we become more susceptible to complications from diseases. Adults should get an annual influenza shot, and may also need a pneumococcal and shingles shot, and booster shots for diseases such as whooping cough and tetanus. Ask your provider which vaccines are right for you.

New Meningococcal vaccines offered

The Food and Drug Administration has licensed two serogroup B meningococcal vaccines for people 10 years or older at increased risk for serogroup B meningococcal infections, and anyone 16 through 23 years old for short term protection. Patients should consult with their physicians.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Office of Health and Risk Communications

PROFILES IN PREVENTION:
SAFE+RESPECTFUL

by Lauren Camphausen, Delaware Coalition Against Domestic Violence & Beth Hughes, Child, Inc.

As part of DCADV's DELTA FOCUS project, Child, Inc. receives funding and technical assistance from DCADV to plan, implement, and evaluate a locally-based violence primary prevention strategy: Safe+Respectful. The overall goal of Safe+Respectful is ***to improve physical/structural assets within the neighborhood to ultimately increase community-wide support and connectedness and decrease the potential for community violence and intimate partner violence.*** The neighborhood where Safe+Respectful is being implemented is a low-to-moderate income community of over 550 townhomes with approximately 2,000 residents and a high concentration of children and youth. Residents have experienced chronic adversity and exposure to various forms of trauma including crime, isolation, poverty, and substandard housing conditions which are known to contribute to community violence as well as many other negative health effects . In addition, this community has been the focus of multiple revitalization and development efforts throughout its history, yet few have been sustainable. With an acknowledge of this history and context, Safe+Respectful employs a multi-level approach to address community violence through adapted and enhanced implementation of the YES evidence-based violence prevention program. Core elements of the adapted YES model include:

- Youth Engagement and Education – providing youth with the knowledge and skills to make healthy relationship decisions and improve their community by increasing their sense of leadership, autonomy, and ability to plan and implement community change projects. Youth group members undergo a structured educational curriculum, but also participate in cohesion-building group activities, lead community service projects, and participate in community-wide events. Additionally, S+R is supplementing the original YES curriculum with an additional module and activities that focus specifically on healthy relationships, including concepts such as gender stereotyping and oppression.
- Community Engagement – focuses on building trust among and with residents by fostering community connectedness and raising awareness of Safe+Respectful's presence in the community. Safe+Respectful promotes active community engagement through community-wide events, and provides youth leadership opportunities by engaging them in the planning of community activities and using community events to showcase their service projects. In addition to promoting neighborhood cohesion, these events enable youth to build healthy relationships with adults in the community.
- Youth and Adult Partnerships – empowers youth to take a leadership role in their neighborhood and engage adults to serve as supportive allies. This is accomplished through building intergenerational partnerships between youth and adults through the recruitment and training of Adult Neighborhood Advocates who serve as adult allies that support youth efforts. Through youth and adult partnerships, youth lead activities to fight the stigmas of and learn how to confront adultism.

Although still in the early stages of evaluation, the strategy offers early insight into the experience of implementing and evaluating a neighborhood-based prevention strategy which addresses shared impact on multiple forms of violence (teen dating violence, intimate partner violence, sexual violence, youth violence, child maltreatment, elder abuse, suicide, etc.). Continual review of a variety of sources of process data (such as: staff implementation journals, youth group observation forms, attendance logs, and event debriefs) has validated the critical need to incorporate an acknowledgment of trauma at all levels (individual, organizational, community, and historical) and to embed a trauma-informed approach into all aspects of prevention efforts. This not only helps to ensure that strategy efforts are effective, meaningful and sustained but also that well-meaning prevention efforts do not further stigmatize, victimize, and traumatize individual participants or the community.

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Lauren Camphausen is the Empowerment Evaluator at the Delaware Coalition Against Domestic Violence and has served as the evaluator for DELTA and DELTA FOCUS since 2007. Beth Hughes is the DELTA Project Coordinator at Child, Inc. and has managed the Safe+Respectful program since 2015. For more information on the Safe+Respectful program at Child, Inc., contact the DELTA Project Coordinator at: bhughes@childinc.com

PROFILES IN PREVENTION:
REAL RELATIONSHIPS

by Lauren Camphausen, Delaware Coalition Against Domestic Violence & Melinda Dubinski, Turning Point at People's Place

Also a critical partner in DCADV's DELTA FOCUS project, Turning Point at People's Place operates the REAL Relationships program, an organization-focused strategy that seeks to build capacity within a partnering youth-serving organization around adoption of policies and practices and improvement of organizational climate to mitigate dating violence among youth. The overall goal is ***to support and facilitate review, adoption, and operationalization of organizational policies and practices that reflect best practice for establishing an organizational environment that contributes to prevention of dating violence among students***. Implementation of REAL Relationships is focused within the Delaware Adolescent Program, Inc. (DAPI), a statewide social service and education program that provides an alternative education setting for pregnant and/or parenting girls between the ages of 12-19. DAPI collaborates with the REAL Relationships program by serving as the implementation setting for piloting development, implementation, and evaluation of organizational policies and practices that are trauma-informed and address dating and domestic violence. Informed by the evidence-based Start Strong[1] prevention model, REAL Relationships' strategy efforts are comprehensive and multi-layered and include a focus on 3 core areas:

Staff Training, Capacity Building, and Technical Assistance - Program staff are often a primary point of contact for the dissemination of healthy relationship information and disclosures of teen dating violence for young adolescents. Therefore, it is crucial that staff and educators at DAPI are informed and comfortable speaking to their students about healthy relationships and dating violence. Through training and technical assistance, staff are assisted in developing an understanding of their role in prevention of teen dating violence, their ability to recognize when students may be involved in unhealthy relationships, and to make warm referrals to appropriate agencies and services. Additionally, staff are supported in building their capacity around understanding the impact of trauma and contributing to the creation of safe, respectful, inclusive, and trauma-sensitive environments.

Student Education and Support - Student groups are held weekly and cover critical topics such as: gender norms; media literacy; overcoming stereotypes; effective communication; identity and self-esteem; healthy relationship characteristics; and courageous bystanding. Providing education to students enrolled at DAPI complements efforts to build staff capacity in order to comprehensively influence a school culture that understands teen dating violence and is engaged in preventing it. The content and structure of the student education component is also incorporated into staff training and policy development so that it is holistically institutionalized into the organization's core programmatic structure and curriculum content

Organizational Policy, Procedures, and Environmental Changes – Organization Leadership are supported in identifying model policies for prevention of and response to teen dating violence as well as developing comprehensive trauma-informed procedures and physical changes to the organization environment to effectively address dating violence within the program and organization culture. Core areas of focus for development and implementation of trauma-informed policies and procedures for the response & prevention of dating violence include: universal screening for dating violence; confidentiality and mandatory reporting requirements; response protocol to disclosures of violence; ongoing required professional development for staff around dating violence; required student education on dating violence/healthy relationships; student conduct and school climate; policies and procedures to support an organizational environment that fosters health promotion and staff/student self-care; and policies that provide avenues to elicit student input and voice.

The REAL Relationships collaboration at DAPI is still in the initial stages of evaluation. However, early reviews of evaluation findings have revealed several key facilitating factors for early successes. These include: focusing implementation efforts on 'outer layer' organizational aspects (policies and procedures, program climate) rather than only focusing on more traditional individual-level aspects (student education, awareness programs); expanding the focus of policy and procedure development and technical assistance beyond dating violence to also include building organizational capacity around trauma-informed approaches; the willingness and commitment from DAPI (the implementation site) to fully share their organization's policies and procedures and engage in organizational change; and an ongoing focus on strengthening agency-to-agency relationships between DAPI and Peoples Place to expand access for DAPI to additional services and resources provided by Peoples Place and their community agency partners to help meet the needs of DAPI students.

1 Robert Wood Johnson Foundation (2015). Start Strong: Building Healthy Teen Relationships. Retrieved from: http://startstrong.futureswithoutviolence.org/4-elements-of-success/engage-influencers/

Lauren Camphausen is the Empowerment Evaluator at the Delaware Coalition Against Domestic Violence and has served as the evaluator for DELTA and DELTA FOCUS since 2007. Melinda Dubinski is the DELTA Project Coordinator with Turning Point at People's Place and has coordinated the REAL Relationships program since 2013. For more information on the REAL Relationships program at People's Place, contact the DELTA Project Coordinator at: mdubinski@peoplesplace2.com

Boys and Men as Agents of Change:

Engaging boys and men in domestic and sexual violence prevention

by Alisia D. Drew, Engaging Men Project Coordinator, Delaware Coalition Against Domestic Violence

Historically, domestic and sexual violence has been viewed as a "women's issue." While women and female identified individuals are disproportionally impacted by these crimes, there has been a growing movement in the field of violence prevention to reframe this narrative and identify domestic and sexual violence for what it is; everyone's issue- but particularly, a men's issue.

Why is Domestic and Sexual Violence a Men's Issue?

Jackson Katz, an expert in the study of masculinities, shares, what he calls, "a paradigm shifting perspective," in his famous TED Talk, "Violence Against Women: It's a Men's Issue." According to Katz, by calling domestic and sexual violence a women's issue, men may fail to recognize or choose not to acknowledge their role in the movement to end violence against women (Katz, 2012). A part of this resistance may be in part to the assumption that violence being viewed as a men's issue inadvertently insinuates that all men are violent; and that is not the case. While the overwhelming majority of violence against women (and other men, at that) is committed by those who identify as male, it is widely known and accepted that most men, indeed, are **not** violent. However, all men, in some way (intentionally or not), reinforce and support the conditions that allow violence to take place; these are called "root causes." In his TED Talk, Katz asks, "What is it about men that allow violence to take place at pandemic rates?" Rather than assuming this is an individual issue, Katz urges listeners to shift their focus towards the social systems and institutions (i.e., media, education, policy, etc.) that produce abusive men (Katz, 2012).

The Delaware Coalition Against Domestic Violence (DCADV) has championed this way of understanding men's violence against women. Since 2004, DCADV has worked to engage boys and men in promoting healthy relationships by increasing the individual and organizational capacity of others to recognize the connection between acts of domestic violence and community norms that promote hypermasculinity, violence, and inequality in relationships. The statewide "buy in" to view boys and men, not as part of the problem, but as part of the solution- agents of change- grew after DCADV hosted a special "Call to Men" Roundtable event in 2010 with long-term supporter Tony Porter, co-founder of the national A CALL TO MEN organization. At this event, participants began to identify ways to challenge harmful norms and replace them with ones that promote concepts of healthy manhood, equality, and respect. Community members enthusiastically responded to a call to action that was made during the event, and Delaware Men's Education Network (MEN) was born.

How do Harmful Gender Norms Contribute to Violence?

Delaware MEN created a safe space for thoughtful, concerned male identified citizens to begin (or for some, continue) their exploration of masculinity and how traditional notions of masculinity (i.e., don't show emotions/cry, be tough, don't ask for help, don't look weak, etc.) contributed to violence. Years later, the Center for Disease and Prevention (CDC) and Prevention Institute affirmed the work of DCADV and Delaware MEN members with their release of "*Connecting the Dots: Understanding the links between multiple forms of violence*". Backed by rigorously evaluated research,

it was now recognized that the adoption of harmful norms around masculinity is, indeed, connected to child maltreatment, teen dating violence, intimate partner violence, sexual violence, youth violence and bullying (Wilkins, et al., 2014).

One might ask if this means there is something "wrong" with masculinity and DCADV would argue that's not necessarily the case. As our dear friend, and longtime supporter, Tony Porter, said in his famous "A Call to Men" TED Talk, "Now I also want to say, without a doubt, there are some wonderful, wonderful, absolutely wonderful things about being a man. But at the same time, there's some stuff that's just straight up twisted, and we really need to begin to challenge, look at it and really get in the process of deconstructing, redefining, what we come to know as manhood, (Porter, 2010)."

Delaware MEN Partner Spotlight

"Men of Color Alliance and Men's Council, DSU student organizations, are proud to stand with DSU's partnership with Delaware MEN. We seek to create safer spaces and build communities that provide avenues for men to learn more about their role in their neighborhoods and to also feel empowered to be the change needed to end violence."

— Kyle Sheppard, President of MOCA and Men's Council, Senior at Delaware State University

Zig, a resident of the City of Wilmington, worked with members of his youth group to develop a pro-social media messaging campaign to uplift Black and Brown boys and men, combatting the negative and restrictive stereotypes placed upon them.

Delaware MEN provided a space to promote those "wonderful, wonderful, absolutely wonderful," things about being a man, while also exploring those "straight up twisted," things to which Porter referred . What are those twisted things? They are the real implications (i.e, engagement in risky behavior, decrease in health promoting behaviors, substance use and abuse, inflicting violence on self and others) of forcing boys and men into a small and narrow "man box," subsequently limiting their ability to express their manhood in ways that are healthy for themselves and others, as well as maintaining a system where violence against women, other men and marginalized groups is reinforced, encouraged and normalized.

To counter this, Delaware MEN worked toward engaging other men in the Community to recognize the implications of adopting harmful gender norms, but more importantly, identify ways to develop conditions where are all people can be healthy, happy, safe, free from violence and liberated; a world where all people, especially boys and men, can authentically be themelves.

How are We Engaging Delaware Men in Violence Prevention?

While the original Delaware MEN provided a space for individual growth and created an avenue for men to start talking to other men about masculinity and violence prevention, as time passed, it was clear that there was a need forcomprehensive, community organized efforts. With support from the Delaware Division of Public Health's Office of Women's Health, DCADV received Rape Prevention and Education (RPE) funding, allowing the Coalition to " scale up," and expand its original mission of mobilizing individuals, to mobilizing campus, military and community based groups to build sustainable initiatives.

To date, eight diverse partners from across the State of Delaware have joined together to develop and sustain best practices for engaging men in sexual and domestic violence prevention. Membership includes:

- Delaware State University
- Wilmington University
- CAMP Rehoboth
- Hilltop Lutheran Neighborhood Center
- One Village Alliance
- Delaware National Guard
- Dover Air Force Base
- University of Delaware

One unique aspect of the Men's Education Network is that very few of the Partners work directly in the domestic and sexual violence prevention field. Rather, they address:

Risk Factors *(things that increase the likelihood of violence)*	Protective Factors *(things that decrease the likelihood of violence)*
• Poverty • Community Violence • Diminished Economic Opportunities • Poor Neighborhood Cohesion • Low Academic Achievement • Witnessing Violence • Mental Health Problems	• Coordinating Resources • Access to Mental Health and Substance Abuse Services • Community Connectedness • Family Connectedness • Commitment to School • Connection to Pro-Social Peers and Caring Adults

(Wilkins, et al., 2014)

Recognizing that most social problems are interconnected and share the same root causes, Delaware MEN actualizes the CDC "Connecting the Dots" framework, bringing together partners from multi-sectors to engage in prevention across the social-ecology (individual, relationship, community and society). This allows for greater impact due to the development and implementation of strategic initiatives that mitigate risk factors and promote protective factors for, not only domestic and sexual violence, but many other public health issues too (Wilkins, et al., 2014).

By developing this safe space for dialogue, shared learning and networking, Delaware MEN partners have begun, or continue, to sustain quality, effective, and comprehensive, community-driven strategies that, not only engage men in violence prevention, but also address the trauma that can result from boys and men being exposed to traditional masculinity, as well as the trauma that men from marginalized communities may experience from chronic adversities (i.e. discrimination, poverty, racism and oppression).

In the last three years, Delaware MEN has:

- Brought in national trainers, like Men Can Stop Rape, to build organizations capacity to employ violence prevention strategies geared towards Delaware boys and men;
- Provided scholarships to Delaware MEN Partners to attend local, regional and national trainings to increase their individual capacity but also to bring their new knowledge and skills back to Delaware MEN partners, subsequently filtering into their respective communities;
- Developed pro-social, gender transformative public health media messaging / social norms campaigns to promote healthy gender norms and violence prevention;
- Worked in collaboration to host statewide screenings of *The Mask You Live In*, a film that explores America's narrow definition of masculinity and its subsequent impacts;
- Promoted community connectedness, a known protective factor (things that decrease the likelihood of violence), through events like free community dinners and discussions;
- Facilitated trainings across the state to assist others in increasing their gender analysis (the ability to identify, understand and explain gender differences and power dynamics);
- Embarked on a journey to understand and apply anti-oppression / social justice frameworks to help ensure Delaware MEN prevention efforts are inclusive, culturally relevant and community specific;
- Identified (and continues to invite) diverse community partners who are committed to working in collaboration towards a unified goal: ending violence against women and creating spaces for boys and men to live safe, healthy, authentic lives.

A Change over Night

During a community dinner at a Wilmington charter school, a father (who viewed *The Mask You Live In* at a Delaware MEN event the night before), said "This knowledge doesn't matter if we don't do anything with it. So today, I found myself stopping and thinking about how I interact with my children. I'm trying to put what I learned from the film into action."

What Can I do?

While the focus of Delaware MEN is to engage boys and men as agents of change working towards ending domestic and sexual violence, DCADV recognizes that every person, regardless of their gender identity, has an important role to play. Those who wish to join Delaware MEN and DCADV on this journey of creating conditions where all people can thrive can start by doing the following:

- Visit www.dcadv.org to learn more about joining DCADV as a Supporting Member (an individual committed to ending domestic violence in the State of Delaware);
- Visit www.delawaremen.org to learn more about the Network and the great work Partners are doing in their communities;
- Explore resources to better understand healthy masculinity, violence prevention and healthy relationships. A good place to start is the "Resource" section on the Delaware MEN website: www.delawaremen.org;
- Challenge harmful norms and behaviors that promote or normalize violence against women and other marginalized groups;
- Support individuals and organizations in the State of Delaware that are committed to creating healthy, safe communities free from structural violence (things that harm people by preventing them from meeting their basic human needs);
- Align with social justice movements that are addressing the unfair conditions that keep marginalized groups from living healthy, safe, fulfilling lives; because, when one person hurts, we all hurt.

For more information about Delaware MEN, contact DCADV's Engaging Men Project Coordinator at delawaremen@dcadv.org.

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Listening *to the* Wounded

by Sandra P. Medinilla, M.D.

C.H. came out of the operating room intubated, with an open abdomen, cold and scared. His eyes were wide open and he was shaking his head vigorously with a perfect unflinching gaze into my eyes saying "no, no, no". He was shot in the chest and the pelvis and knew he was dying.

Paramedics brought him to us within the "golden hour". As the area's only Level I adult trauma, we had done this many times before. Our trauma resuscitation and surgical technique was rehearsed and precise. In order to get him out of the OR alive to the ICU for further resuscitation, we had opened his chest, performed open cardiac massage, repaired his aorta, ligated his inferior vena cava, ligated his right common iliac artery, repaired his left common iliac artery and resected devitalized portions of bowel. Our intensive care units, imaging modalities and laboratory tools are state of the art. The coordinated effort by the physicians, residents, nurses, pharmacists and techs spanning many different departments are embedded in a solid foundation of training, collegiality and respect for our patients. When it comes to caring for the traumatically injured, we have the resuscitation of our patients down to a science. Unfortunately, we still have not figured out how to prevent gun violence from occurring or what exactly must happen to facilitate the successful return of a traumatically injured patient back to the community where they were brutally violated.

Christiana Care Health System operates the only Level I trauma center that cares for both children and adults between Baltimore and Philadelphia. We see close to 5,000 trauma patients a year from the entire state of Delaware, southern Pennsylvania, northeastern Maryland, and southern New Jersey. The face of trauma is varied and can include an elderly woman who falls in her driveway, a family who is involved in a motor vehicle crash on their way home from the beach or a victim of stabbing at the hands of intimate partner violence. Twenty percent of our trauma cases are due to penetrating injury secondary to gunshot wounds (GSW) or stabbings. Since the year 2000, the number of GSW cases seen at Christiana has more than tripled from approximately 60 to 160 (CCHS Registry, 2013; Table 1). This is consistent with what the City of Wilmington has experienced from 2011 to 2013, where the number of victims injured in shootings rose 60% from 95 to 154 individuals (Sumner, et al, 2015). The American College of Surgeons' Committee of Trauma requires that trauma centers must have an organized and effective approach to injury prevention and must prioritize those efforts based on local trauma registry and epidemiologic data (ACS, 2014). Trauma surgery has lead the way in optimizing seatbelt safety laws and awareness for distracted driving nationwide. We see the end result of public health epidemics and sound the alarm for our communities to act. Gun violence is no different. The late Dr. Jonathan Mann, a prolific advocate of health and human rights, wrote, "that until a health problem is named, described and until epidemiology defines its occurrence and distribution, the problem itself does not exist" (1998).

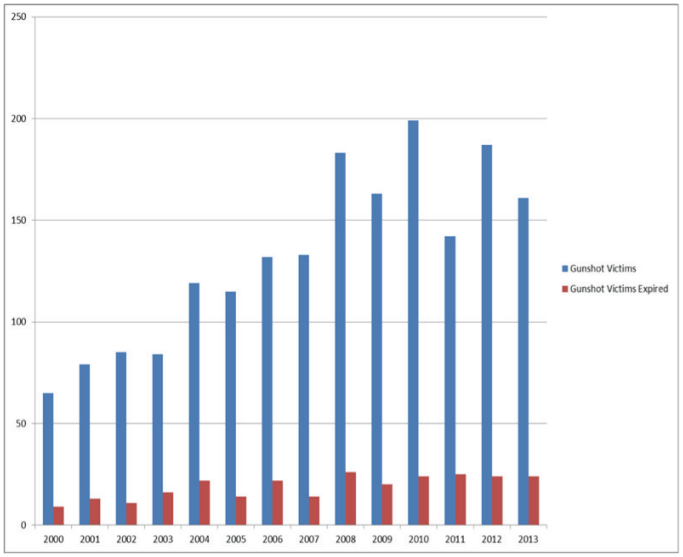
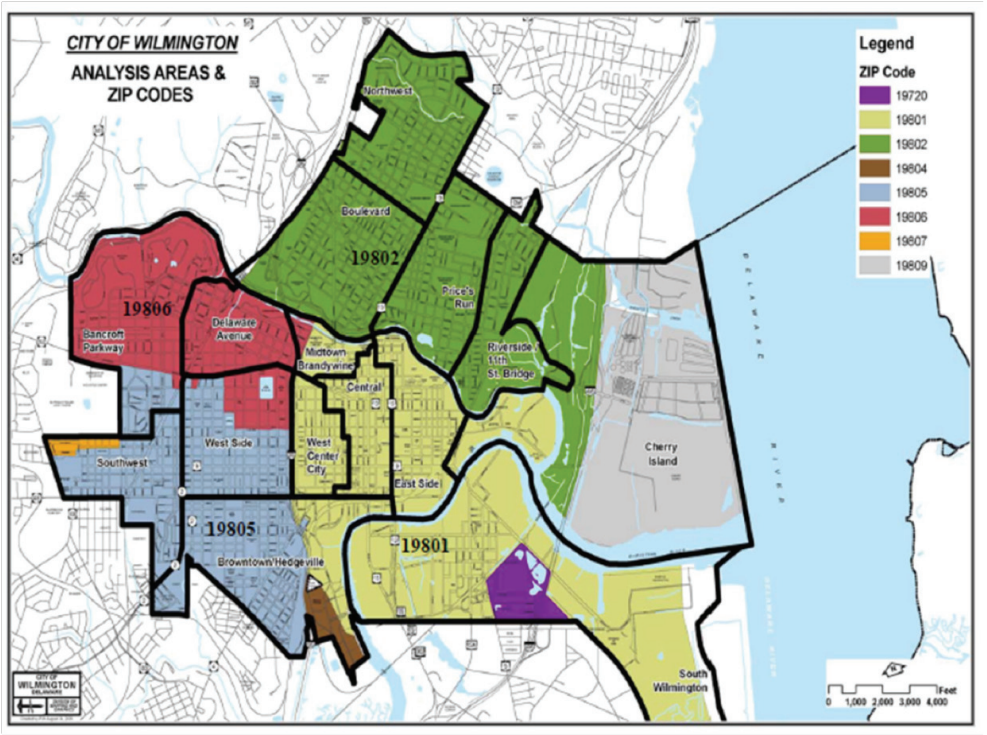


TABLE 1. *GSW total and expired. Christiana Care Trauma Registry Data 2000-2013*

This is why as trauma surgeons, we cannot ignore that this is a disease of epidemic proportions affecting our young, black males worse than any other population. We must act. CCHS is proud to be a part of the CDC Community Advisory Council to increase collaboration between social service agencies preventing gun violence. To that end, not only trauma surgeons, but also primary care physicians, pediatricians, ob-gyns and other practitioners must be ready to create change within our practice to ameliorate this disease.

Dr. Gary Slutkin, an infectious disease specialist, spent a decade fighting tuberculosis, cholera and AIDS epidemics in Africa. When he returned to the United States, he thought he'd escape brutal epidemic deaths only to identify that gun violence spread following the patterns of infectious diseases. His solution was to interrupt transmission by having credible messengers engage with the community and begin to help change the culture of violence in those areas most affected. By treating it like a disease, Cure Violence in Chicago was born and has seen reductions in affected areas by 40-70% (www.CureViolence.org). When the City of Wilmington mapped the violence in our area, it was predominantly 19801 and 19802 zip codes.

From an intervention perspective, CCHS engages our patients who have suffered an injury in the 19801 and 19802 zip codes with the City of Wilmington's Cease Violence Hospital Responder. Similar to the Cure Violence model in Chicago, They come to the bedside (with the patient's permission) and provide social and emotional support to the patient, family and friends. Our social worker works with the patient and the hospital responder to identify their needs once they are discharged. In their homes, the hospital responders, meet our patients in their homes, take them to appointments throughout the city and mediate conflicts on their behalf.



With respect to preventing gun violence, Christiana Care Health System has created and is implementing programs aimed at elementary and junior high school students. Currently, we have two prevention programs and one general educational program. The engaging session, "Choice Road," is a 45-90 minute program for adolescents in grades 6-12 which includes the showing of a 15-minute film, "Choice Road: An American Tale." The actors in the film include local students, police, emergency services, and medical professionals. In the film, a 16-year old boy decides to join a gang. He is shot and becomes a quadriplegic. A 'credible messenger' and the program coordinator engage the youth in an open discussion of friend choices and potential consequences. "YOLO" or You Only Live Once is a re-enactment of a trauma resuscitation inside Christiana Hospital. In the Virtual Education and Simulation Center at Christiana Hospital, a team of trauma nurses and physicians re-enact the resuscitation and death of Brandon Lee Brinkley. With permission from his mother, Robin White, we explore Brandon's life and dreams. During the program, students see his trauma resuscitation simulation. A re-enactment of emergency procedures with the use of a mannequin: insertion of various IVs, tubes, surgical procedures and the insertion of other emergency equipment such as breathing tubes and urinary catheters. Artificial blood. It is not the intent of this program to upset or frighten students, but rather to offer them an honest and unrestricted look at the consequences of violence. It is our hope that after participating in this program, students will be ambassadors for peace. "The Ripple Effect" is a 28 minute documentary filmed at Christiana Care. The documentary depicts scenes from the trauma bay during actual trauma resuscitations. It also includes an honest interview with a patient who talks about his injuries and how personal choices led to these injuries suffered secondary to violence. Medical professionals including physicians, trauma nurses, family support staff and mental health specialists are interviewed throughout the documentary. A medical professional concludes the program with a discussion of the documentary. This program is aimed at the broader community who may not live in high crime areas to shed light on how gun violence in the city affects all of us no matter where we live.

After multiple surgeries, CH is a survivor. We asked him later why he shook his head fervently "no, no, no" and what he was feeling at the time. He said that he had felt himself leave his body. He saw us working on him and didn't want his mother to lose him this way. He fought to stay. He fought for a second chance for a new beginning. Now 22 years old, he is a "credible messenger" and shows our YOLO kids his scars and his artificial leg replacing the limb we couldn't save. "I was just like you all - a young kid. I was running, living the fast life," Harris said. "I came out to show you it's real" (Giordano 2016). Even though our resuscitation and coordinated heroic efforts have been studied and vetted again and again, we have a long way to learn from our patients just how to prevent gun violence. If we start listening to them, maybe we can find the cure for gun violence.

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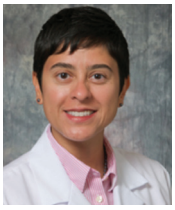


Dr. Sandra P. Medinilla, Medical Director of Violence Prevention at Christiana Care Health System.

A trauma surgeon, Sandra P. Medinilla, M.D., is medical director of community violence prevention efforts at Christiana Care Health System. Dr. Medinilla helped launch Cease Violence in Wilmington, a nationally recognized program to prevent gun violence by identifying nonviolent solutions to resolve conflict.

The majority of gun violence victims in the city of Wilmington and the state of Delaware are treated at Christiana Hospital, which sees more than 4,000 trauma patients each year and is the only Level I trauma center between Baltimore and Philadelphia that treats both adults and children.

A public health advocate, Dr. Medinilla completed her bachelor's degree in sociology at Bryn Mawr College in Pennsylvania and earned her master's degree in public health at MCP Hahnemann University School of Public Health in Philadelphia. She earned her medical degree at Temple University, where she remained for her internship and residency in general surgery, serving as chief resident. Before joining Christiana Care in 2012 Dr. Medinilla was a fellow in surgical critical care at the R. Adams Cowley Shock Trauma Center at the University of Maryland Medical Center in Baltimore.

Her career also spans pharmaceutical research, public health education, and occupational health. Dr. Medinilla is a past director of legislative affairs for the American Medical Student Association. She founded Temple University School of Medicine's chapter of Physicians for Human Rights and has worked as a homeless outreach volunteer in Philadelphia.

Dr. Medinilla has presented and published on areas of trauma and surgery including blood clotting, mustard gas exposure and chest trauma.

Dr. Medinilla lives in Wilmington, Delaware with her wife, Erin Meyer.

atTAcK addiction™

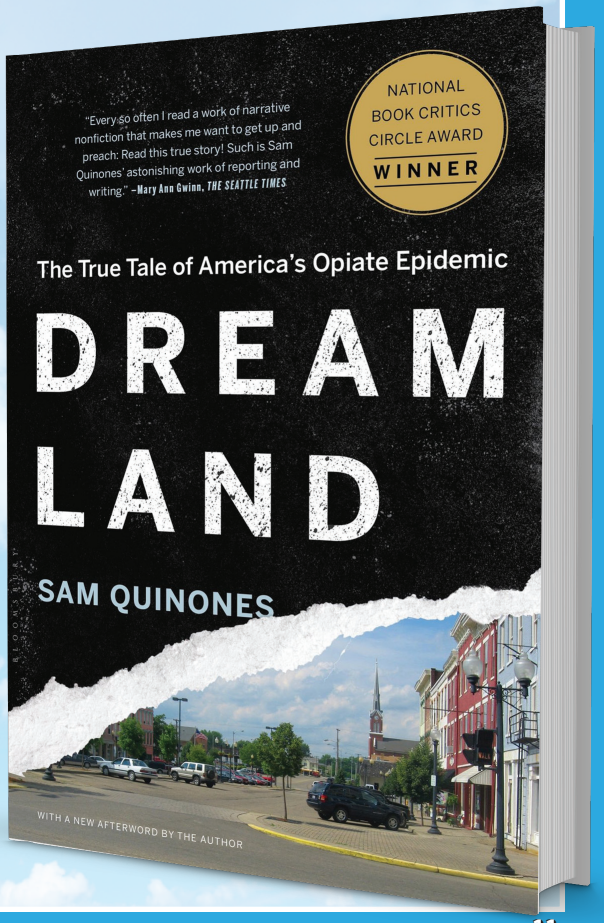
Thursday, October 27 at 7:00 p.m.

Cab Calloway School of the Arts

First Lady Carla Markell and *atTAcK addiction* are presenting a speaker and panel discussion. Our featured speaker is national known author Sam Quinones, the author of *"DREAMLAND The True Tale of America's Opiate Epidemic".*

Confirmed panelists are:

- **Sam Quinones**
- **Don Keister, Founder atTAcK addiction**
- **Matt Denn, Attorney General**
- **Rita Landgraf, Secretary of Health and Social Service**



Case Study: Delaware Shelter Programs Integrate Project Connect Statewide

by Ruth Fleury-Steiner, University of Delaware, Noël Duckworth, Delaware Coalition Against Domestic Violence and Elizabeth Miller, M.D., Ph.D., F.S.A.H.M., Chief, Division of Adolescent and Young Adult Medicine Medical Director, Ronald McDonald Care Mobile Children's Hospital of Pittsburgh, University of Pittsburgh Medical Center Professor of Pediatrics, University of Pittsburgh School of Medicine Academic Co-Director, Community PARTners (Community Engagement Core), Clinical and Translational Science Institute, University of Pittsburgh.

While reproductive and sexual coercion (i.e. birth control sabotage, pregnancy pressure) are not new tactics used by abusive partners within intimate relationships, Delaware domestic violence (DV) programs did not have shared language or definitions with which to describe it, or protocols for screening and intervention. Project Connect, aimed at improving health and safety outcomes of Delawareans at risk for domestic and sexual violence by strengthening partnerships and developing sustainable policies and practices in both reproductive/sexual health settings and domestic/sexual violence programs, hel ped bring about lasting change. Prior to the project, DV program staff had limited knowledge about reproductive and sexual health, or current practices and methods of birth control. To begin, each of Delaware's five DV shelters received reproductive coercion (RC) and Project Connect training from the Delaware Coalition Against Domestic Violence(DCADV) and Futures Without Violence, and Birth Control 101 and Healthy Sexuality training from Planned Parenthood of Delaware. As a result of these and subsequent trainings, all levels of staff are now reporting an increased comfort in talking to victims about RC, handling disclosures, providing resources and referring victims to clinics. While advocates expected to feel uncomfortable at such trainings, afterwards they reported feeling pleased and more at ease with the topic. Shelters were also provided with a Birth Control kit to keep on location to help educate victims and prepare them for discussions with their healthcare providers about the right options for them.

This work has also given advocates another way of approaching power and control dynamics in their work with victims. One advocate was able to use information from Project Connect when talking with a woman who couldn't understand why her partner, who had insisted on growing their family, was mean and distant with her once she became pregnant. Realizing that her partner's abusive behaviors had also increased during her prior pregnancies, the victim began to see this pattern as part of a broader strategy of forced financial dependence and control.

Since 2013, clinics and DV programs have forged partnerships and provided nine on-site cross-trainings to each other. DV programs remain an integral part of medical trainings to help clinicians better understand DV services and be more comfortable with providing "warm referrals". DV programs discuss the array of services they provide, role play mock hotline calls, and show photos of the shelter interior, to help clinicians get an idea of what their patients might experience when accessing such services. Public Health Nurse Practitioners have started visiting victims in shelter and implemented plans to develop a smooth referral process, provide extended appointments to assure that traumatized women are comfortable, and are offering workshops on general healthcare and reproductive health in shelter.

DV programs have changed their intake forms for shelter residents and now use model questions to assess for RC. A safety card is used in this

conversation and each victim is informed of birth control, pregnancy tests and emergency contraception available in shelter. One victim, concerned that she would have to maintain contact with an abuser whose violence had recently escalated, was able to put her mind at ease when a pregnancy test she took in shelter read negative.

As part of their trauma-informed practice, shelters have placed note cards into residents' welcome baskets of toiletries to gently and universally remind victims what health resources (i.e. pregnancy tests, emergency contraception) are available to them if they are not in a place to access the services upon intake. Hotline manuals also include reproductive coercion information and all staff, including community advocates and administrative staff, receive on-going training on the project and related protocol. Books about human sexuality for all ages (children, teens and adults) have been made available in shelter to promote education about healthy sexuality for residents.

Not long after the project started, stories across the state began to emerge about victims' experiences with RC. A sheltered client told her advocate that her abuser did not allow her to use any form of contraception. As a result, all three of her children were unplanned. Another client believed she might be pregnant as a result of a sexual assault by her partner. Shelter staff were able to offer her a pregnancy test, educate her about STIs and refer her to a partner clinic for testing and treatment. Information and services for reproductive and sexual health, such as birth control options and availability of long-acting reversible contraception (LARCs) at local clinics, are ever-changing. Consequently, DV programs recognize the importance of having staff appointed as liaisons on this project to maintain partnerships, provide effective advocacy, stay well versed in the subject, and insure that new information is consistently integrated into staff training and protocol.

Research being conducted by DCADV in Project Connect partner clinics mirrors national statistics and underscores the need to sustain these critical efforts- a key objective for Delaware's project partners moving forward. Among patients surveyed to date, 1 in 2 have experienced DV in her lifetime, 1 in 10 experienced physical on sexual domestic violence within the last 3 months, and 1 in 10 experienced reproductive coercion in the past 3 months.

Delaware's Project Connect program is a statewide partnership between the Delaware Coalition Against Domestic Violence, Delaware Division of Public Health, Planned Parenthood of Delaware, La Red Health Center, Abriendo Puertas and SAFE Program at Peoples' Place, Child, Inc., and the University of Delaware. Funding for the project was provided by Futures Without Violence through the U.S. Office of Women's Health.

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The Delaware Public Health Institute

in partnership with

The Division of Public Health

Invite you to a

Community Health Needs Discussion

The **Delaware Public Health Institute (DPHI),** a private non-profit, has been contracted by the **Delaware Division of Public Health** to compile a comprehensive health needs assessment that represents communities across the state of Delaware. As part of this process, DPHI is conducting a series of community meetings to gather input from YOU: **the resident**! We will be discussing health status and unmet health needs through the eyes of the citizens. Your feedback and opinions will be kept 100% confidential. The information you are able to provide us will help inform the strategic direction of the State Health Improvement Plan (SHIP) and beyond.

This discussion is open to community members who live, work, and play within any of the three counties listed below. Please join us and have your voice heard!

	Sussex County Residents	New Castle County Residents	Kent County Residents
WHEN	Wednesday, **October 26th**	Thursday, **October 27th**	Friday, **October 28th**
TIME	9:30 – 11:00 a.m.	9:30 – 11:00 a.m.	9:30 – 11:00 a.m.
WHERE	**The Lewes Public Library** 111 Adams Ave. Lewes, DE 19958	**The Bear-Glasgow Family YMCA** 351 George Williams Way Newark, DE 19702	**Eden Hill Medical Center** 200 Banning St. Dover, DE 19904

Please check one:

☐ Yes, I will attend the _____ County community meeting.

☐ I am unable to attend.

Name: _____

Community Affiliation: _____

(i.e., resident; civic association member; faith leader; community worker; etc.)

Phone Number: _____ **Email:** _____

To register, please email this form to Fran Schulz at fran@phmc.org **before October 21st, 2016. We look forward to seeing you there!

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

VIOLENCE IN DELAWARE:

GLOSSARY OF TERMS

VIOLENCE: The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.[1] This definition associates *intentionality* with the committing of the act itself; therefore, violence is distinguished from *unintentional* actions or incidents that result in injury.[2, 3] Violence is here defined not only as resulting in physical injury but being present where psychological harm, maldevelopment or deprivation occur; acts of omission or neglect, and not only of commission, can therefore be categorized as violent.[3]

ARMED VIOLENCE: The use or threatened use of weapons to inflict injury, death or psychosocial harm, which undermines development.[1]

BULLYING: Unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. There are three types of bullying: verbal (saying or writing hurtful things), social (hurting someone's reputation or relationships) and physical (hurting someone's body or possessions).[4]

CHILD MALTREATMENT: The abuse and neglect of children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.[1]

COLLECTIVE VIOLENCE: The instrumental use of violence by people who identify themselves as members of a group – whether this group is transitory or has a more permanent identity – against another group or set of individuals in order to achieve political, economic or social objectives.[1]

CYBERBULLYING: Bullying that takes place using electronic technology, including but not limited to devices such as cell phones, computers and tablets and communication tools such as social media sites and text messages.[5]

CYBERSTALKING: The use of electronic communications to stalk, harass or threaten another person.[6]

ELDER ABUSE: Any act of commission or omission (neglect) that may be either intentional or unintentional and involves persons aged 60–65 years or more. The abuse may be physical, sexual, psychological (involving emotional or verbal aggression), financial or involve other material maltreatment and result in unnecessary suffering, injury or pain; the loss or violation of human rights; and a decreased quality of life for the older person.[1]

FAMILY VIOLENCE: Family violence refers to child maltreatment, sibling violence, intimate partner violence and elder abuse.[3]

GANG VIOLENCE: The intentional use of violence by a person or group of persons who are members of, or identify with, any durable, street-orientated group whose identity includes involvement in illegal activity.[1]

GENDER-BASED VIOLENCE: An umbrella term for violence that is based on socially ascribed (i.e. gender) differences between males and females.[7] Although the majority of gender-based violence (GBV) victims/survivors are women and girls, the term is used by some to highlight the gendered dimensions of certain forms of violence against men and boys, as well as violence perpetrated against lesbian, gay, bisexual, transgender and intersex (LGBTI) persons who are seen as defying gender norms.[7, 8]

INTERPERSONAL VIOLENCE: The intentional use of physical force or power, threatened or actual, by a person or small group of people against another person or small group of people that either results in or has a high likelihood

of resulting in injury, death, psychological harm, maldevelopment or deprivation.[1, 2] Interpersonal violence is divided into two categories: family and intimate partner violence and community (acquaintance/stranger) violence.[2]

INTIMATE PARTNER VIOLENCE: Behavior within an intimate relationship that causes physical, sexual or psychological harm to those in the relationship, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors.[1] This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.3 "Domestic violence" is often used interchangeably with intimate partner violence.[3]

POLYVICTIMIZATION: Refers to those who have experienced multiple victimizations of different kinds, such as sexual abuse, physical abuse, bullying and exposure to family violence. This definition emphasizes different kinds of victimization, rather than just multiple episodes of the same kind of victimization, because this appears to signal a more generalized vulnerability.[9]

SELF-DIRECTED VIOLENCE: Violence a person inflicts upon himself or herself, and categorized as suicidal behavior or self-abuse.[1]

SEXUAL EXPLOITATION: The sexual abuse of children and youth through the exchange of sex or sexual acts for drugs, food, shelter, protection, other basics of life and/or money. Sexual exploitation includes involving children and youth in creating pornography and sexually explicit websites.[10]

SEXUAL HARASSMENT: Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Harassment does not have to be of a sexual nature, however, and can include offensive remarks about a person's sex. [11]

SEXUAL VIOLENCE: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic that are directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.[1,2] Three types of sexual violence are commonly distinguished: sexual violence involving intercourse (i.e. rape), contact sexual violence (e.g., unwanted touching, but excluding intercourse), and non-contact sexual violence (e.g., threatened sexual violence, exhibitionism and verbal sexual harassment).[1]

STRUCTURAL VIOLENCE: Exploitative and unjust social, political and economic systems that result in physical and psychological harm (e.g., the Apartheid system in South Africa).[3]

TERRORISM: The use of, or threat of, violence against civilians and the state, or symbols thereof, in order to create fear and achieve political, economic, religious or ideological goals.[3]

TRAUMA: An emotional response to a terrible event.[12] Trauma can result from short-lived "acute traumatic events" (e.g., accidents, shootings, natural disasters, physical or sexual assault, etc.) or longer-term, repeated "chronic traumatic situations" (e.g., long-standing abuse, domestic violence, war, etc.).[13]

VIOLENCE AGAINST WOMEN: Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether in public or in private life.[1] Gender-based violence is sometimes used interchangeably with "violence against women" although the latter is a much more limited concept.[3]

WORKPLACE BULLYING: Repeated, health-harming mistreatment of one or more persons by one or more perpetrators; abusive conduct that takes one or more of the following forms: verbal abuse; threatening, intimidating or humiliating behaviors; or work interference (sabotage).[14]

WORKPLACE VIOLENCE: Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.[15]

YOUTH VIOLENCE: Violence perpetrated by or against people between the ages of 10–29 years.[1, 2]

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REDUCING BULLYING IN DELAWARE SCHOOLS:

Progress Made, But Much Work Left to Do

by Delaware Attorney General Matt Denn

When I ran for Lieutenant Governor of Delaware in 2008, with advocacy for children being my central platform, I don't think I ever discussed the issue of school bullying. But once I began spending significant amounts of time inside our public schools as Lieutenant Governor, talking to teachers, students, and staff, it became clear to me that bullying was a significant issue in our education system that affected kids' ability to learn and teachers' ability to teach. Over the last few years, we have made real progress in combating bullying, but some of the toughest work is yet to come.

The turning point for me came in 2011, when I visited McCullough Middle School in New Castle. In 2011, McCullough was one of the best middle schools in the state; it was one of only five schools in the state – and the only middle school – to win an Academic Achievement Award, an award that I persuaded the state to create in 2009 that provided recognition and a financial grant to schools whose students were showing extraordinary progress, especially among students from lower income backgrounds. I always spent time visiting the award winners, because I wanted to learn what they were doing that was bringing such great success. When I asked the McCullough's principal Betsy Fleetwood what her greatest challenges were in overseeing the school, cyberbullying was one of the first things she mentioned – bullying that took place over Facebook, Twitter, and other social media. She was obviously handling it well; her students were excelling and I could tell from visiting them that they loved the school. But Betsy told me that dealing with cyberbullying was exhausting for teachers and administrators – a single incident could have a ripple effect inside the school that would take hours or days to unwind.

This first-hand impression I developed of bullying in our schools was borne out by both local and national statistics. As former Attorney General Biden and I indicated in our first joint report on bullying in 2014, a 2013 survey published in the national Journal of Adolescent Health suggested that bullying was a significant public health problem, affecting between 20% and 56% of young people annually; that specific sub-groups such as gay and lesbian students were far more likely to be victims; that bullying was associated with poor mental and physical health and risky behaviors; and that there was an association between bullying and depression and suicide-related behaviors. The National Center for Education Statistics developed similar numbers: it estimated that 28% of middle school aged children were bullied. Locally, a 2013 Delaware study conducted by the University of Delaware Center for Drug and Alcohol Studies indicated that 18% of high school students reported being bullied on school property in the prior twelve months, and the same study showed that 14% of high school students reported being the victims of cyberbullying in the same time period.

In 2011, I talked with Attorney General Biden about bullying, based on what we were both hearing, and we decided to focus on two areas. The first was this issue of cyberbullying, which was – in some ways – more damaging to school environments than traditional bullying: as opposed to isolated instances of physical or verbal bullying, cyberbullying incidents stayed on the internet indefinitely and often metastasized as other students

joined in. Cyberbullying was often anonymous. And most cyberbullying took place off school property, leading to real questions among school officials as to what, if anything, they could do anything about it.

The second area we decided to focus on was holding schools accountable for reporting bullying incidents to the state and to parents of both the victim and the bully. The state had laws in place that required schools to report "substantiated" bullying incidents, but the laws were unclear and rarely enforced.

CYBERBULLYING

Dealing with cyberbullying was a significant legal challenge, because around the country, First Amendment free speech challenges had been successfully raised to other school districts' efforts to combat this type of bullying. A number of courts had issued decisions saying, to one degree or another, that schools' ability to limit what students said on social media was strictly limited because the students had free speech rights and were not under the school's supervision when they engaged in their cyberbullying. Inside Delaware, we had to deal with a separate problem: school districts' fear of expensive litigation. No school district was eager to aggressively police cyberbullying, because the cost of hiring legal counsel to defend against a First Amendment lawsuit brought by a disgruntled student or their parents could easily run into the six figures.

Attorney General Biden and I decided to attack these challenges with a three-pronged strategy. First, we would hold a series of public hearings up and down the state to get a detailed, nuanced sense of the problems that cyberbullying was creating in the classroom. The case law from around the country was clear that the degree to which the state could regulate off-campus cyberbullying was tied to the level of disruption it was creating inside the school. Before crafting a cyberbullying law for Delaware, we had to have a good factual record of the problems it was creating, so we could generate a law that was tailored to deal specifically with the in-school effects of cyberbullying. Second, we would take the time to craft a model cyberbullying policy for our public schools that was based on the record from those hearings, and use the increasing body of case law from around the country to make sure that model policy was on solid legal ground. Finally, we would write our law so that schools that adopted the model cyberbullying policy would be defended by the state – not by private legal counsel – if a student challenged the policy in court.

We held our hearings, which were attended by a diverse group of parents, teachers, and school administrators, and wrote a model cyberbullying policy for the entire state. That policy was promulgated by the Delaware Department

"Statutes and rules cannot eliminate CYBERBULLYING, but at this point, Delaware has among the most robust legal frameworks in the state for its schools to minimize this very serious problem."

of Education in 2013, and took effect for all school districts and charter schools in the 2013-2014 school year. The policy made clear that school districts could punish cyberbullying – in some instances even if the bullying originated off school grounds – and gave students fair notice that posting things on particular social media platforms would be considered as broadcasting them to the entire student body – not private communications between students. At the same time, the General Assembly passed legislation in 2012 that afforded the state's legal protection to school districts that enforced this new cyberbullying policy and ended up having to defend their actions in court.

There is no statistical evidence on the efficacy of this more aggressive approach to policing cyberbullying – its frequency was not charted before these reforms took place, so it is impossible to quantify whether it is happening less frequently. However, the anecdotal response I have received from schools in the last three years is that these efforts have made a difference: that students are more aware that their activities on social media may subject them to school discipline, and that teachers and administrators are more confident directly addressing incidents of cyberbullying because they know that they have clearly written regulations allowing them to do so, and the legal backing of the state. Statutes and rules cannot eliminate cyberbullying, but at this point, Delaware has among the most robust legal frameworks in the state for its schools to minimize this very serious problem.

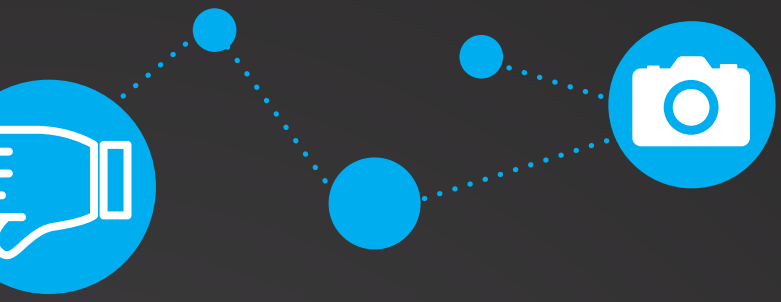
REPORTING OF BULLYING

As noted earlier, a second problem that Attorney General Biden and I identified was the underreporting of bullying in our public schools – both reporting to the state and to parents. To my mind, the underreporting to parents and guardians was a serious problem. No matter how much programming takes place in schools, the reality is that students' character and behavior in school is largely shaped at home. But if parents are not aware of what their kids are doing in school, there is no opportunity for them to address problems. The statistics we saw suggested that in some districts and schools, there was great reluctance to report bullying incidents – caused either by the school's fear of generating unfavorable statistics, or the school's reluctance to bring bad news to parents (especially involving bullying, where the facts can sometimes be subtle and contentious).

Once again, we tried to address this problem on two fronts. The first was that state law only required reporting of bullying incidents that schools "substantiated." This was a well-intentioned provision in the law, but ended up being a loophole for some schools and districts. If a school was disinclined to report bullying incidents, it could set an artificially high threshold for "substantiating" them, and thereby elude any responsibility for reporting all but the most serious incidents to the state or to parents. The second was that there was no accountability for schools with respect to reporting. It certainly appeared from reporting statistics that some schools were taking their reporting duties more seriously than others, but it was impossible for the state to prove this or do anything about it.

In 2012, Attorney General Biden and I asked the legislature to address these problems by passing new legislation that substantially changed the state's bullying reporting laws. First, schools and school districts would be required to report all alleged bullying incidents to both the state and to parents – parents both of the bullying victim and the alleged bully. The school could note whether the incident was substantiated or not, but the school was required to report the incident to the state Department of Education. This would eliminate any incentive the school had to take a hands-off approach to investigating bullying incidents, and kept parents better informed. Parents of kids who were being bullied – many of whom might be too embarrassed to tell their parents what was going on in school – would know what was happening, and parents of kids who were engaged in bad behavior would be aware of it and have the opportunity to address it at home.

The second provision of the proposed new law was that the state's Department of Education would audit a random sampling of public schools every year to ensure that bullying incidents were being reported as required. There was no penalty written into the statute for schools that were not diligently reporting, but the hope was that public reporting of the audit results would incentivize the schools to be more diligent about reporting bullying incidents.



Finally, an important addition to the proposed new law was that the state would begin to keep and report classifications of bullying victims, so the state could track whether particular groups of students were being singled out by bullies and in need of additional protection.

The legislation we proposed was passed by the General Assembly and signed by the Governor in July 2012. The first audits were conducted in 2013, and when we issued our first public report on those audits in 2014, the results were mixed: of the ten schools that were audited, about half were reporting alleged bullying incidents fairly diligently, but the other half were not. We named the schools that were not, and the report was widely publicized in the local press.

In the short term, it appears that this combination of auditing and transparency was successful. The following year, when the second round of audits was done in a second randomly selected group of schools, the rate of compliance was much higher. It appears that the message has been received by schools that they must diligently make reports of alleged bullying to both the state and to parents. It is too early to tell if this enhanced sharing of information with parents will pay dividends over the long run, but common sense tells us that it will. Parents who know what their kids are doing are better able to shape what their kids are doing. Even if not every parent will take advantage of this information, I am confident that some will.

INCREASING THE ROLE OF THE DEPARTMENT OF JUSTICE

After I became Attorney General last year, I had the opportunity to see firsthand how the Department of Justice could helpfully intervene in individual bullying incidents in our schools. The Department of Justice has, for about 5 years, had an "ombudsman" on staff to intervene with schools on issues of school violence and school bullying. On those occasions when the ombudsman has become involved in cases, he has been a very effective advocate for parents in situations where schools have not treated bullying incidents with sufficient gravity. However, very few parents or students know that the Department of Justice is available to become involved in these bullying incidents. Earlier this year, we asked the General Assembly to address this gap by requiring that schools provide every parent or guardian of a student involved in an alleged bullying incident a form generated by the Department of Justice informing the parent of the availability of the ombudsman's assistance. The requirement that this form be distributed just took effect at the beginning of the 2016-2017 school year, and we are optimistic that it will result in additional involvement by our ombudsman in bullying incidents and more satisfactory outcomes for victims and their parents.

CHANGING THE CULTURE IN OUR SCHOOLS

It is apparent that there has been a great deal of legislative and regulatory activity around the issue of bullying over the last few years. As a result of that activity, Delaware now has a much better regulatory regimen for the problem of cyberbullying, and a much more effective oversight process to ensure that schools are reporting and handling incidents of all bullying properly. That is progress. But the larger challenge is to ensure that these incidents do not occur in the first place, and Delaware – like every other state – still has work to do in that area.

After my years of firsthand involvement in this issue, I am convinced schools that create a culture among their students where diversity is valued and tolerance is expected, will see less bullying. Students know that they are not supposed to bully other students, so I do not believe that programs and campaigns designed to simply hammer home this message add a great deal of value in a vacuum. What does add value is programming that also pushes back against the tendency to ostracize or demean other students. My experience has also left me with two related impressions. The first is that these messages of valuing diversity and encouraging tolerance are most impactful at the middle school and high levels when they come from other students. And the second is that in this era of social media, smart phones, and the like, that the mechanisms by which we communicate with students about bullying must line up with the way that students receive information today.

To that end, my office is actively meeting with a wide group of experts, and we are hoping to unveil – during the coming school year – a model anti-bullying program for schools that will incorporate all of these ideas and take advantage of the expertise and experience of people who have far more knowledge in this subject area than I do. If we can effectively communicate the right messages to students in our schools, we will be able to build upon the legal and regulatory changes we have made over the last three years and make our schools even more safe and hospitable to our state's children.

The National Accreditation of the Delaware Division of Public Health

by Paul Silverman, Dr.P.H. and Karyl Rattay, M.D., M.S.

Achieving accreditation is a major milestone in any organization's life. The rigorous requirements and often multi-year process forces staff to re-examine almost every aspect of the organization with the goal of continuous improvement. In spring 2016 the Delaware Division of Public Health (DPH) achieved national accreditation for the first time in its history, from the Public Health Accreditation Board (PHAB).

While such an achievement seems technical in nature, the overall outcome is that the people of Delaware will be better served by a continually improving public health agency. At this time, Delaware is the only accredited state health agency in the Mid-Atlantic region.

What is public health accreditation?

Within its 2004 Futures Initiative[1], the Centers for Disease Control and Prevention identified accreditation as a key strategy for strengthening public health infrastructure. PHAB was formed in 2007 as the non-profit entity to implement and oversee national public health department accreditation. Accreditation is voluntary and demonstrates the capacity of governmental public health agencies to deliver the Ten Essential Public Health Services.[2] PHAB standards grew from, and are organized by, these essential services that every public health agency should provide:

- Monitor health status to identify and solve community health problems;
- Diagnose and investigate health problems and health hazards in the community;
- Inform, educate, and empower people about health issues;
- Mobilize community partnerships to identify and solve health problems;
- Develop policies and plans that support individual and community health efforts;
- Enforce laws and regulations that protect health and ensure safety;
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable;
- Assure a competent public and personal healthcare workforce;
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and
- Research for new insights and innovative solutions to health problems.

Accreditation provides a means for a public health agency to identify performance improvement opportunities, enhance management, develop leadership, and strengthen relationships with community organizations. As a result of our efforts to achieve accreditation, DPH made a number of important improvements. These include the development of: a State Health Improvement Plan, a meaningful strategic plan, a performance management system, a formal quality improvement program, customer satisfaction surveys, and a workforce development plan.

Accreditation includes a site visit by three public health professionals. The site visit team that spent two days in Dover said DPH is "a state health department that is functioning at a high level of achievement as measured by the national PHAB standards. DPH is well-respected by community agencies and by other state departments and is a proven and trusted resource for the legislature. There is clear support and direction from the Department of Health and Social Services Secretary for the Division's needs and vision. Community partners praised the staff of the Division for being responsive even when requests are only peripherally related to DPH's responsibilities.[3]"

The site visit team provided these thoughts about DPH's greatest strengths:

- The strategic plan reflects the ability of the leadership team and DPH to focus limited resources for optimal impact on population health. The strategy maps utilized in the plan provide a useful visual tool for implementation and monitoring achievements.
- The administrative policies and procedures that have been developed provide excellent support for DPH to accomplish its work in an efficient manner.

Delaware is one of 19 state health departments to receive national public health agency accreditation, Governor Jack Markell, DHSS Secretary Rita Landgraf and Delaware Public Health (DPH) Director Dr. Karyl Rattay announced June 8, 2016.

- The support that DPH has created internally for developing, honing, and coordinating information and messages flowing out to the entire state appear to be a valuable and well utilized resource within the DPH.
- The culture of DPH appears to have changed over the past four to five years with a focus on evidence-based practices and the widespread involvement of senior managers in learning collaboratives, partnerships that include universities and community partners, and robust quality improvement projects.

The site visit team also provided thoughts on areas for improvement:

- There appear to be opportunities to increase involvement of the community at large to improve the health of their community through the work that DPH has begun in several local areas. Of special note is the recent finalization of the DPH health equity guidebook that is used as a training tool and resource guide to empower communities as they work to improve their health. (To learn more about the guide visit http://dhss.delaware.gov/dhss/dph/index.html.)
- DPH has an opportunity to move forward in a joint effort with community partners in the next iteration of the State Health Improvement Plan. The groundwork appears to have been laid to hone the focus of the community partners so that they commit and develop ownership for a few key areas and concentrate community-wide resources to those focus areas.
- DPH should consider including descriptions of how qualitative data is analyzed and document the process for priority selection so that as plans are made for implementing interventions, there is a clear path between priority and intervention selection and the data that supports it.
- DPH is reviewing the above recommendations and will work to continually integrate them into daily work.

Accreditation means more accountability to the people DPH serves. It should provide confidence to the public and elected officials that their public health agency strives to improve and performs at a nationally recognized standard. For DPH employees, accreditation is verification that they should be proud of the agency for which they work.

For more information on Delaware's accreditation, call DPH's Office of Health and Risk Communication at 302-744-4704. For more information about the accreditation process, visit http://www.phaboard.org.

[1] http://www.cdc.gov/futures/

[2] Core Public Health Functions Steering Committee, Fall 1994.

[3] Public Health Accreditation Board Final Report (unpublished).

Engaging Stakeholders to Develop a Patient-Centered Research Agenda for Chronic Kidney Disease in Delaware

by Sarahfaye Dolman, M.P.H., M.T.A.

More than 20 million people over the age of 20 in the U.S. have Chronic Kidney Disease (CKD). These patients have multiple comorbid conditions and see numerous healthcare providers, making it difficult to manage the condition and delay disease progression. In order to promote coordination of care and improve patient outcomes, a CKD registry in development in Delaware seeks to join electronic health records of multiple sources. To support these aims, a team of patients, clinicians, and researchers will collaborate to gather information and facilitate Patient-Centered Outcomes Research (PCOR) based on the CKD registry.

This work is supported by a Eugene Washington PCORI Engagement Award from the Patient-Centered Outcomes Research Institute (PCORI). The award will fund two conferences and a community academic workgroup. The two-year project will inform outcomes of interest and additional data needs as well as solicit feedback on research designs, privacy issues and data sharing in the context of PCOR from patients, payers, and physicians in the CKD community.

The leadership team includes one patient, one dialysis nurse, one representative of a federally qualified health center serving a vulnerable population, one representative of the Delaware Academy of Medicine and two academic researchers. Patients and other stakeholders will be engaged in each phase of conference and workgroup development and implementation. The Value Institute at Christiana Care is the lead institution for this project. Other institutions include the Delaware Academy of Medicine, Henrietta Johnson Medical Center, Dialysis Patient Citizens, and the Delaware Chapter of the American Nephrology Nurses Association.

The first conference, "Partners in Research: Developing a Patient-Centered Research Agenda for Chronic Kidney Disease (CKD)" will be held at the Christiana Care Ammon Education Center on September 16, 2016. The conference will bring together stakeholders in the registry to discuss research questions and outcomes that matter to patients and stakeholders for the ultimate goal of improving outcomes for patients with CKD. Registration for the free conference is currently open, and all stakeholders are encouraged to attend. Transportation can be arranged if needed and breakfast and lunch will be served. The day will feature both speaker presentations and interactive working groups. The morning's events include speakers highlighting the state of CKD both nationally and in Delaware, disparities in CKD, innovations in case management of chronic disease, and the importance of PCOR and community engagement in order to improve care. Working groups in the afternoon will focus on outcomes and research needs related to the registry.

For more information about the registry project, visit our website www.delaware-ckd.org.

National Violent Death Reporting System (NVDRS)

by Mathew Christensen

In August 2016, the Centers for Disease Control and Prevention awarded Delaware with funding to join the National Violent Death Reporting System (NVDRS). Beginning January 1st 2017 Delaware will collect and assemble detailed information about the circumstances of individuals killed by violence in our state. This information will provide a more complete picture of the patterns and circumstances of violence in Delaware to help guide effective violence prevention practice and policy.

One of the reasons the NVDRS is critically needed is Delaware's recent transformation in the frequency of homicide violence. Unlike any other state and the nation, Delaware has dramatically changed. While the nation's homicide rate declined from 1999 to 2014, Delaware's rate more than doubled. While most states saw a decrease in the homicide rate from 1999 to 2014, a minority of states saw an increase. In Delaware the amount of increase was more than two times larger than in any other state. Relatively quickly, Delaware went from having one of the lowest homicide rates in the nation to one of the highest. Statistically, the direction and magnitude of change in Delaware's homicide rate is an outlier from 1999 to 2014. Figure 1 shows that 2005 marked the most substantial increase in the number of Delawareans killed by homicide.

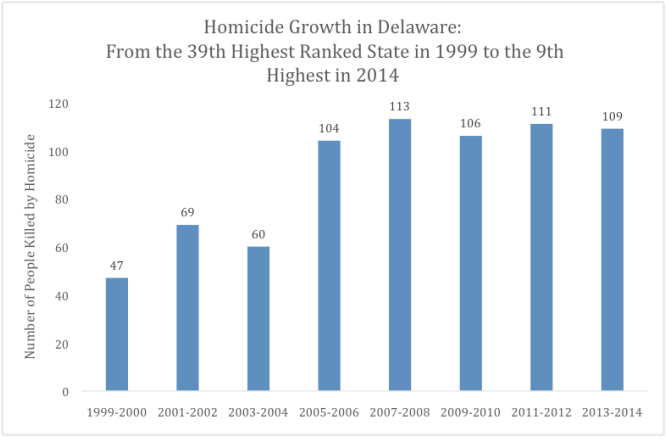


FIGURE 1. *Data source: http://wonder.cdc.gov/*

The NVDRS will allow Delaware to better understand why violence increases or decreases in our population. A clear understanding is key to effective violence prevention. Delaware is joining 32 other states already collecting and reporting information about violent death circumstances. The Delaware Department of Health and Social Services and the Department of Safety and Homeland Security are collaborating on the NVDRS. The Divisions of Public Health, Forensic Science, and State Police will collect and report the central pieces of violent death information. Additionally, Delaware received overwhelming support from numerous agencies and organizations that wrote strong letters of support encouraging CDC to select our state for NVDRS funding. For more information about the NVDRS visit the CDC website: http://www.cdc.gov/violenceprevention/nvdrs/

STEADI

Utilizing STEADI to address falls in your older adult patients

When we look at the public health model for disease prevention the first step is to identify the problem. In our older adult patients it is not difficult to identify one of the biggest problems that exist, falls. One in three adults over 65 suffers a fall every year according to the Center for Disease Control. Public health focuses on the prevention of diseases, or in this case, a fall. Our older patients may have a litany of health issues to address, but all older patients consistently have one risk factor and that is their increased risk for falling. How can the health care provider adequately address this issue of fall prevention in their daily practice with their older patients? The CDC offers a step by step program for fall prevention.

This program is specifically designed for the health care provider to use in their daily practice. The program is called STEADI (Stopping Elderly Accidents, Deaths & injuries). The STEADI website offers the materials needed to support a fall prevention program. This program includes a fall risk checklist, algorithm for assessments and interventions, brochures for patients, online training and more. The materials and training are free of charge and readily available for download order. For information on the STEADI program go to **http://www.cdc.gov/steadi/index.html**

The CDC states that for every 5,000 health care providers who adopt STEADI, over a 5-year period as many as:

6 million
more patients could be screened

1 million
more falls could be prevented; and

3.5 billion
more in direct medical costs could be saved

Funding Federal Public Health Programs

Katherine Smith, M.D., M.P.H. and Timothy Gibbs, M.P.H., N.P.Mc

In this era of the Zika virus, the increasing rate of chronic disease, and the need to adequately train our medical staff, public health agencies such as the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) are on the front line to protect the citizens of the United States. These programs are funded by an annual congressional approval of discretionary spending: the more money congress approves for their use, the safer we, as citizens of the United States, will be.

The CDC is a key source of funding for many statewide and local programs that improve the health of the population of Delaware. They are first in line when it comes to dealing with bioterrorism, virus outbreaks like the South American Zika virus, and the overall health of our nation. They support public health programs, and strive to find new ways to prevent antibiotic resistance, keep the obesity epidemic under control, and teach the public about preventing chronic diseases like heart disease and cancer. They are also charged with preventing infectious diseases like Ebola, West Nile, and SARS from taking hold within the country.

The HRSA supports medical education, and makes sure that our doctors are as well trained as they can be, and that they are prepared to care for an aging, increasingly diverse population. It increases access to primary care for women and children, strives to combat infant mortality, and increases the use of newborn screening tests for common genetic disorders. It provides programs for HIV/AIDS patients to support care, assist with obtaining the necessary anti-virals, and educate people on how to decrease the risk of HIV transmission. The HRSA also improves access to primary and preventative care for low-income and rural areas, promotes Title X programs to ensure access to preventative healthcare for women, men, and children, and helps rural hospitals and clinics stay current on new technologies and strategies for better health care.

The overall health of our nation depends on agencies and programs like these to decrease the health disparities we see every day, to respond to health threats and emergencies, and to research new and improved ways to keep the population of the United States healthy. These national programs also help to fund state and local programs, workforce, and health departments. Without the discretionary funding provided by Congress, they will be unable to do their jobs, and our communities will suffer.

There is no greater investment than in the health of the population, and investing in preventative care saves money. Without our health, we are unable to do our jobs, enjoy life, and have fun. Please, write to your congressmen and women to urge them to fund these public health programs. Let them know that the health of the nation, of the state of Delaware, of the people in your neighborhood, is important to you, and that with their help, we can keep the United States as healthy as possible.

A Quest for Safety: Helping Delaware Students Find Peace

Lanae S. Ampersand, L.C.S.W., C.P.S. and Joyce C. Persing, L.C.S.W.
Christiana Care Health System School-Based Health Centers

Students that live in homes, go to school in, and live in communities that are violent have a very difficult time focusing on their studies. Exposure to violence in almost every venue they exist in, these students need a safe place that will allow them to let their guard down long enough to let the good things in life in. The School-Based Health Centers aim to be the venue where Delaware students feel at peace; we hope to be the destination of choice for students on a quest for safety in an otherwise hostile environment.

The School-Based Health Centers in 29 high schools across the state of Delaware see many students with a wide variety of symptoms related to adverse childhood experiences or traumatic stress. Some of these experiences include physical abuse, sexual abuse, neglect, witnessing domestic violence, loss of a parent due to substance abuse, imprisonment or death, and community violence. Since many of these experiences occur in the home or community where they live, students often struggle to identify a place where they feel safe. They often struggle with symptoms of anxiety, depression and an inability to manage anger. When children are chronically exposed to traumatic stress they are in a constant state of fight or flight. They are often unable to distinguish a real threat from a perceived threat.

The fight, flight or freeze response is a physiological response to keep an individual safe when presented with a threat to emotional or physical safety. In many ways, such a response is a survival tool in neighborhoods plagued with violence or maltreatment at the hands of caregivers. However, it does not translate well in the school setting. This quest for safety presents as defiance, aggression, disrespect and apathy resulting in frequent peer conflict, noncompliance with school rules and expectations ultimately leading to out of school suspensions. Thus, the students are remanded back to the place they often feel most unsafe; home.

With the increased violence and trauma Delaware students have been exposed to this past year in their homes, neighborhoods, and in schools, treating students who live in violent neighborhoods have been an ongoing challenge and focus of the School-Based Health Centers. It is a fundamental expectation that students should be able

to come to school and feel safe but when students' homes, neighborhoods, and schools are unsafe, it makes it difficult for students to focus on their education. According to the Child & Adolescent Measurement Initiative:

[When we look specifically at] Delaware's children (age 0-17) who have been a victim/witness of neighborhood violence, 11.6% has been affected- compared to the national average of 8.6%. [Also, when we look at] Delaware's children who have witnessed domestic violence in the home, 8.0% have been affected [as] compared to the national average of 7.3%.[1]

There is a huge need to identify our students affected by violence and to help them feel understood and provide them with a safe haven.

Screening for traumatic experiences provided vital insight into a student's function. Students are often unable to make the connection between their behaviors or emotional reactions and their previous experiences. Students often identify feeling angry or on edge and not knowing why. The use of the screen tool allows providers to help students put pieces of the puzzle together. Providing psychoeducation on the impact of traumatic experiences allows students to make sense of their reactions. Providers can then help students identify triggers and how they are connected to traumatic experiences thus placing the trauma in the proper context of time so the student isn't reacting to the traumatic event, but the current experience. Teaching grounding techniques and mindfulness are also critical in helping students stay present. The goal is not to disarm the fight or flight response but help restore it to a normal level of functioning. Providing students with alternative responses allows them to become open to social-emotional learning.

Students who receive services in the School-Based Health Center are screened with a validated screening tool called the Rapid Assessment for Adolescent Preventive Services (RAAPS). Responses from students who were screened by 15 School-Based Health Centers this past year showed that:

24.0% said they often felt sad or down as though they had nothing to look forward to in the previous month. **19.2%** admitted they do things that get them in trouble when they are angry. **13.1%** said they had serious problems or worries at home or at school. **10.0%** admitted to having been threatened, teased, or hurt by someone (on the internet, by text, or in person) or to have been made to feel sad, unsafe or afraid by someone.[2]

As we continue to explore how to better identify students affected by violence and trauma to connect them with the appropriate resources in the community- as well as enhance the programming we provide in our sites- one thing is clear; we must help Delaware students to feel safe and experience peace in their lives if they are going to grow into the well-adjusted adults who contribute to society that we all know that they can become.

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[2] Rapid Assessment for Adolescent Preventive Services. Retrieved August 8, 2016, from https://www.raaps.org

Lanae Ampersand, L.C.S.W., C.P.S. is a licensed clinical social worker and a certified prevention specialist. Lanae is the Senior Program Manager for School-Based Health Centers at Christiana Care Health System. A graduate of the University of Pittsburgh, Lanae has worked in the mental health field for more than two decades in a variety of settings and has been with Christiana Care for more than 12 years, helping high school students, their families and the community.

Joyce C. Persing, L.C.S.W. is the Senior Social worker for the School-Based Health Center at Thomas McKean High School. Joyce is a graduate of the University of Maryland, in Baltimore Maryland where she received her Master of Social Work degree. She has obtained a variety of training and continuing education on trauma informed care. Joyce feels strongly about the impact trauma informed treatment can have on individuals who have endured trauma.

Editor's Note: *Early this summer I attended the annual conference of the Delaware Alliance for Nonprofit Advancement. The keynote speaker was Hildy Gottlieb. Hildy is a TEDx speaker, as well as a contributor to* The Huffington Post, *and the* Stanford Social Innovation Review. *She is also the creator and host of the Making Change podcast, where she has interviewed leaders from around the world about the factors that create powerful, positive change. Hildy presented a message that resonated with many of us in the audience at the Chase Center: We can create the future we want. What would it take to reframe how we think about change, to focus on what is possible instead of what is wrong? In addition, what can we do better together than we can do on our own independently?*

Hildy, Sheila Bravo (Executive Director of DANA) and I have continued a dialog, and the following article is one of the results of this ongoing dialog - and presents a potential road map to addressing violence in the First State. Many outside of the nonprofit sector are not familiar with the work of DANA, and I encourage you to visit their website, www.delawarenonprofit.org. It is the vision of DANA that resonates strongly with that of the Academy/DPHA:

"The quality of life for Delawareans will improve because nonprofits are delivering on their missions efficiently and effectively. The Delaware Alliance for Nonprofit Advancement will be the leader of the nonprofit sector, recognized for providing skills leadership, convening leadership, and voice leadership for the sector."

Using Causality to Create Safe, Healthy Communities | *by Hildy Gottlieb*

The lights dim, and the movie begins with the town confronting a powerful, evil force. Despite massive military efforts, the enemy is growing stronger. Finally the hero signals the turning point, declaring, "If we can't outgun them, we'll have to outsmart them." By the time the credits roll, the town is safe.

Right now communities across the U.S. often feel the desperation of that action movie scenario. The enemy isn't a single villain, but the many faces of violence itself - random acts of gun violence in movie theaters, schools and workplaces, acts of terrorism, gang violence. Whole groups of community members live in fear of violence by police officers. Police officers live in fear of violence from the very people they work to protect.

The artillery lobbed at this enemy has included the War on Terror, the War on Poverty, the War on Drugs. Local task forces and national task forces have tried idea after idea, rooted in different scenarios of who or what is to blame. Yet the problems persist.

With our very lives at stake, where is that movie hero with the answer to save the day?

Outsmarting vs. Outgunning

That sense of frustration and hopelessness has been a steady conversation for decades in the social change arena. In quiet whispers and in loud political proclamations, people who thought they had the answers wonder why, after all that effort, our problems still feel so overwhelming.

On the other side of that equation, though, the past hundred years has witnessed some of history's biggest leaps toward our human potential. The Civil Rights Movement, the Indian Independence Movement, and the South African Freedom Movement are evidence that the good guys can win in very big ways.

That simple fact has inspired my own research for the past 20 years: to identify what is at the root of those huge leaps of social progress, and to see what would happen if those success factors were applied to other large scale problems – poverty, climate change, violence.

My research has included the fields of sociology and history (the study of group behaviors), as well as the fields of behavioral psychology and neuroscience (the study of individual behaviors). My findings have been curiously similar to that movie plot: the solution to our problems lies not in our actions, but in the thinking that goes into those actions – outsmarting vs. outgunning the problem.

That thinking is rooted in the basic scientific principle of cause-and-effect. Simply put, social progress happens when causality is employed to create the future we want vs. react to our problems.

To see what that looks like in action, this article will first define causality. We'll explore what it looks like to use causality to create the future we want. Then we will compare that to how policy has been created in the past, using a variety of scientific disciplines to explain why those approaches have not produced significant results. We will then share steps you can take to apply causality to create the future you want, with an example rooted in the issue of community violence.

Causality

According to Merriam-Webster's online dictionary, causality is "the relationship between something that happens or exists and the thing that causes it." It is the simple fact that today's reality is both the result of yesterday and the cause of tomorrow.

We know that arguing with our kids at breakfast can set off a chain of causality that might include their being late to school and forgetting their lunches, as well as our being late to work and being grumpy when we arrive. Causality can turn a tiny snowball at the top of a hill into a growing mass that becomes an avalanche as it rolls downward.

That same principle of causality is both creating and perpetuating problems such as poverty and violence.

Our efforts to cure those problems do not begin with the social policies and programs we create, however, because those programs and policies have causes as well – the thoughts, assumptions and beliefs of the people building those programs.

If we want to create a future different from our present, that chain of causality will therefore begin not in our actions, but in our thinking.

Using Causality to Create the Future We Want

Aiming at a positive future means asking, "What do we really want? What would success look like? What is the highest potential outcome of our efforts?" and then determining the cause-and-effect conditions that will lead to that result. Those two steps – aiming and creating conditions – render that positive result as inevitable as the snowball gaining mass and momentum as it rolls downhill.

> Our power to create significant change in our communities lies in the power to aim at what we want, and to create favorable conditions for a chain of causality that will lead to that future.

We want a world filled with healthy, humane communities, where everyday life brings out the best in our uniquely human potential. We want the world Dr. Martin Luther King imagined in his "I Have a Dream" speech.

But having a dream is not enough. Leaders of the Civil Rights movement reached for that dream by determining the conditions under which it was likely to happen. In his Letter from a Birmingham Jail (1), Dr. King noted, "[Nonviolent resistance] seeks to so dramatize the issue that it can no longer be ignored." Night after night on the evening news, politicians and average citizens watched peaceful adults and children being set upon by fire hoses and dogs, until finally they demanded change. That strategy exemplifies what it means to aim for what is possible and place cause-and-effect stepping stones towards that future.

The Norm in Social Policy

Social change agents want to think their work is aimed at creating a healthy, humane world. In truth, though, almost all current social policy is reactive, not creative. A "war" on anything is, by definition, reactive – poverty, drugs, terror. Anti-violence campaigns, anti-hunger campaigns, programs to reduce drop-out rates, law-and-order platforms, and mass incarceration efforts are all reactive programs, aiming to eliminate what we do not like about our current situation.

Reactivity shows itself in problem-solving programs (reacting to the problem), root cause programs (laying blame for and then reacting to those deeper issues), and proactive prevention programs (reacting by ensuring bad things don't happen in the future).

In analyzing the difference between movements that create social progress vs. this plethora of reactive efforts, it becomes clear that programs and policies rooted in reactive thinking are almost guaranteed to result in a lot of work for very little reward.

Reactive programs are almost guaranteed to result in a lot of work for very little reward.

It feels counterintuitive. How could the very act of problem-solving be perpetuating our problems? Again, the answer can be found in cause-and-effect, and specifically the kinds of chain reactions that happen when cause-and-effect gains momentum.

The situations we face today, from poverty to terrorism to gun violence, are the result of chain reactions that were sparked years ago. All these years later, our current efforts to solve those problems are like standing in front of that giant snowball as it careens downhill. At best, our tiny body may slow that snowball down a bit; at worst we will be pummeled into the snow, feeling like we did our best to stop it, but that we were up against unwinnable odds.

Sometimes reactivity is absolutely necessary. When the chain of cause-and-effect from the past is resulting in harm today, intervention can be a critical first step. Whether that harm is a family member stuck in a cycle of substance abuse or a community stuck in a cycle of poverty, sometimes we need to do our best to either stop that downhill-racing snowball from careening into the village or move people out of the way.

Unfortunately, social policy to date has, for the most part, exclusively focused on that reactive intervention. To create a future where such interventions are no longer needed, the only approaches that are scientifically more likely to create that reality are those, like the Civil Rights movement, that use causality to create an unstoppable chain reaction in the direction of our dreams.

What Science Teaches Us about Reactivity

A variety of scientific disciplines confirm that creating causality is the only effective approach to moving beyond our problems, to create the kinds of communities we all want.

Physics and Chemistry

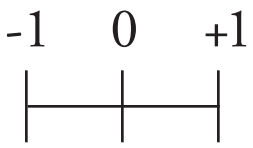
According to the Columbia Electronic Encyclopedia, "a chain reaction is a self-sustaining reaction that, once started, continues without further outside influence."

Picture that snowball, or a forest fire, a line of dominoes, a nuclear reaction, the viral spread of a disease. Once a chain reaction starts, the longer it has been gaining momentum, the more energy it takes to stop it.

The violence facing many communities today is the result of a chain reaction that has been building momentum for decades. It should therefore be no surprise that programs designed to reverse or slow that chain reaction often feel so inadequate. Those programs are the equivalent of sitting in a lone backhoe at the bottom of a hill, trying to stop an avalanche.

Math

From physics and chemistry we turn to simple grade school math, which teaches that eliminating a negative cannot create a positive state; it can only get us to zero.



Applying that mathematical truth to social change programs, the best possible outcome from policies aimed at reducing or eliminating a problem is zero – stasis. This applies to intervention programs just as it applies to programs aimed at ending negative circumstances - ending racism, ending poverty, slowing or reversing global warming.

Sadly many policy makers even consider stasis to be too optimistic a goal. With the admonishment to "get real," the prevailing culture warns that it is not realistic for programs to aim at completely eliminating poverty (or racism, or global warming, or terrorism, or drug abuse). For those programs, the goal becomes reduction, not elimination, defining 100% success as *less bad*.

The frustration change leaders face is therefore predictable. They are hoping to create something positive by reducing something negative, a mathematic impossibility.

Brain Science

It is hard to imagine that the simple question, "What should we do to solve this problem?" could cause its own chain reaction of negative forces. But that is what happens when people spend hours talking about what's wrong, ascribing blame (root causes) for the problem, struggling in frustration to find new solutions because old ones have not produced results. The unconscious level of stress in these negative conversations triggers the brain's fight-or-flight center, the amygdala, to release chemicals such as adrenaline (2).

Those chemicals then create their own chain reaction, a condition psychologist Daniel Goleman refers to as Amygdala Hijack (3). The more time people spend in reactive circumstances, the more prolonged their stress, the more argumentative and suspicious they become, staking a claim in being right and challenging others who propose different ideas. Those behaviors are a predictable part of the chain reaction kicked into play by that simple question. We may suggest that people "leave their baggage at the door," but those reactive questions are, in fact, inviting that baggage into the room.

Just like any chemical chain reaction, once fear has entered the room, it takes considerable energy to stop that reaction, to bring a discussion back to what is possible. People often leave such meetings feeling frustrated or hopeless.

On the other hand, when conversations begin with +1 questions such as, "What do we want life to feel like in our community?" agreement happens quickly, because virtually everyone wants a healthy environment, a safe community where people are kind and caring. That spirit of agreement has the potential to ignite a different chain reaction, bypassing the brain's fear center, releasing chemicals associated with feelings of well-being, and activating the parts of the brain where reason and creativity reside[4].

Science in General

There is one more scientific truth that drives scientists and mathematicians to discover new formulas and thought processes: Unless something is physically impossible, it is possible.

Unless something is physically impossible, it is possible.

Science is constantly discovering that what they thought was impossible yesterday is actually possible – that all it took was asking different questions, looking at things differently.

The implications for social programs is clear: Humanity can be everything our human potential suggests, simply because that is not physically impossible. As it is with scientists discovering new realities, what it takes to turn that possibility into reality is asking different questions.

Unless something is physically *impossible*, it is possible.

Creating Causality towards the Future We All Want

If reactive approaches are physically incapable of creating the world we all want, and may actually lead our brains in the opposite direction of creativity and cooperation, what would it take for actions to start a chain reaction ***towards*** the future we want for our communities?

The answers to that question have become a critical component of a set of practices called Catalytic Thinking[5]. Catalytic Thinking pulls together approaches that have brought out the best in people and situations throughout time and across disciplines. Those practices are rooted in questions, because the act of asking and answering questions can catalyze its own chain of cause and effect[6]. Change the questions we ask, and we can change the world.

The chart below shows the difference between questions that can catalyze potential vs. reactive questions.

Questions that react to what we do not like about the present	Questions that create the future we do want
What is the problem, and what will we do to solve it?	What is the future we want to create, and what would it take for that future to be reality?
What obstacles could stop us?	What would people need to have / know / believe, for our goals to be realized?
How can we ensure people follow the rules? What will we do when they don't?	What systems would bring out the best in people?

Catalytic Thinking practices are rooted in two interrelated observations about the cause-and-effect of positive change:

1) Our power to create powerful results lies in our power to create favorable cause-and-effect conditions towards our dreams.

2) The most favorable conditions begin and end with bringing out the best in people vs. focusing on stuff (money, food, education).

Focusing on People vs. Stuff

It would seem obvious that the most effective social policies are rooted in the strengths and potential of people (7). Unfortunately, most social policy overlooks that proven truth. This article has already noted vast areas of social policy that focus on suspecting and preventing the worst in humanity vs. building on people's strengths, with the prison system in the U.S. being perhaps the worst offender.

In addition, because those policies tend to be intervention-based, they tend to focus on things - food to address hunger, homes to address homelessness, prisons to address crime. And as we've seen, intervention alone falls short of even getting us to zero.

Therefore, to create favorable conditions for a new chain reaction, the most powerful conditions will aim at bringing out the best in people, creating systems for sustaining that "best."

Creating a Path to the Future

To activate our power to create a path towards our dreams, first we need to be able to identify those dreams. Having been told for so long that even the zero-sum of "ending violence" is a pipe dream, most people do not have practice in identifying and reaching for what they really want. Towards that end, Catalytic Thinking's strategy framework employs questions that help to first identify what we really want for our communities, and to then create the cause-and-effect path that will create that future.

Question 1 - If we were to end violence in our communities, what would that make possible for the people who live and work there? For whom in particular?

If violence begets violence, what are the good conditions we want in our communities instead? That picture of what good would look like is where we will aim our chain reaction of causality.

Causality is actually embedded in the question itself. The phrase "make possible" suggests that ending violence is actually a precondition for something greater. Through the lens of causality, our "problems" are actually just unmet conditions for something amazing. So this first question aims beyond the problem, to the +1 vision on the other side of its resolution. When that problem no longer exists, what will be possible?

You can also see the focus on people in the question: "People who live and work there" and "for whom?"

- What could life look like for children? For the elderly?
- For school teachers? For school kids? For that relationship?
- What would ending violence make possible for the police? For people of color? For the relationship between police and people of color?
- And so on.

The answers to these questions will be rich with words like "compassion" and "safety" and "health" and "vibrant." The more you ask the question, "And what would that make possible?" the richer those images will become.

Question 2 – What cause-and-effect conditions would render that healthy, humane future inevitable?

Our uniquely human potential to envision a future different from our present means that we also have the power to identify the pre-requisite conditions that will create that future. Those conditions are the dominoes that will create our chain reaction.

Many planning processes begin by creating a vision, and then leap to today's reality, asking, "What will we do in the next few years, to aim at that vision?" Tethered to today's reality, the only future such a question can create will be an extension of today. Today-forward planning is like standing on the sidewalk, staring at the roof of a 30 story building, wondering how far up we could jump.

Causality-driven conversations create the ladder to get to the roof. Those conversations begin with your future vision, then step backwards from that vision one step at a time, until they eventually land at today. In causality-driven strategy discussions, "today" is the last thing you'll discuss.

For policy-makers, the good news about this reverse engineering process (sometimes called back-casting) is that we all learn this approach at a very young age and use it all the time without realizing it.

If you need to be at the airport for a 9am flight, how would you determine what time to wake up? You would start with that 9am flight and work backwards:

- For a 9am flight, you'll need to be at the airport by 7am.
- To be at the airport by 7am, you'll need to leave the house by 6:30.
- You may still have some packing to do, plus taking a shower and feeding the dog – that's another hour.
- You'll set your alarm for 5:30.

Each of us uses this approach for everything in our lives, from getting to work on time to planning an elaborate dinner party. We can do the same for creating a safe, healthy community.

Just like the question of where to aim was about possibility for people, Catalytic Thinking's questions about cause-and-effect conditions will be about the people as well. For every aspect of the beautiful picture of your vision, what would people need to have? What would they need to know and understand? What would people need to value and believe? What would they need to be assured of?

Taking the next step backwards, you will look at the answers to those questions, and then ask that same set of question again, this time about that first group of answers. "What would it take for THAT to be in place? What would people need to know? What would they need to feel?" and then backwards again, "And what would it take for THAT to be in place?"

When you are done, you will have laid a path of stepping stones between today's reality and your desired future. You will have done so by describing the intricate web of conditions that will naturally fall into place if you kick-start that first domino – a step by step, cause-and-effect map to the future you want. And that web will all be rooted in bringing out the best in the people who are both the cause and the result of your plans.

Using Causality to Outsmart Community Violence

From the theoretical to the practical, let's apply Catalytic Thinking's strategy framework to the issue of community violence, specifically to the relationship between police and people of color. What could an end to violence make possible for that relationship, and for the parties individually?

Question 1: If we were to end violence in our communities, what would that make possible for people of color? For the police? For the relationships between those parties?

Answers to that question might include…

- Safety for all parties. Trusting that they will be safe when they encounter each other.
- The community overall would be safer.

- Resources currently devoted to safety could be focused on education, recreation, health and overall quality of life, increasing security in all meanings of the word.
- For the relationship between the parties, a feeling that we're all on the same side. Relationships of trust, support, and friendship.
- Those specific relationships of trust and support will ripple out to everyone in the community – a community culture of trust, support, and friendship.
- Those relationships of trust will lead to true equality in everything, among people of all races, ethnicities, sexual orientations, income levels.
- And so on.

As these conversations evolve, the ripples of possibility often lead to places that feel surprising, touching on every aspect of what it is like to live in a healthy, humane community. For example, someone might suggest, "If we build relationships of trust and support, our community would be filled with art." Why art? "Because graffiti could be seen as an opportunity to channel artistic talent into positive outlets." And so on, all fueled by the question, "And what would that make possible? For whom?"

These questions have the opposite effect of asking Root Cause questions. Instead of spiraling deeper into negativity, the energy in the room increases every time you ask, "And what would that make possible?"

From here, you will begin to consider what conditions need to be in place for your community to become the vibrant, humane place you have envisioned. For purposes of this example, let's focus on the last bullet item above – a community where people trust each other in a spirit of true equality.

Question 2: What would it take for community members to trust each other in a spirit of true equality? What would people in the community need to feel? What would they need to know? What would they need to value?

In general, the answers might include…

- To trust each other, people from all walks of life would need to know each other.
- They would need to feel how each other experiences life.
- People would need to find the things they have in common vs. the things that separate them.
- People would need to value each other as fellow humans vs. labels and positions.
- And so on.

You might also ask about specific groups. In this scenario, those questions might include, "What would people of color need to have and be assured of? What would public safety officers and people working in the criminal justice system need to believe and know? What would policy makers need to value, understand, be assured of?"

The answers might include…

- People of color would need to feel heard. They would need to know that their experience is taken seriously, that their lives and their experience genuinely matter. And so on.
- Public safety officers would need to feel safe on the job. They would need to feel supported. They would need to feel they can be compassionate at work vs. having to hide their humanity behind their fear. And so on.
- Individuals working in the criminal justice system would need to know how to create conditions for the success of a person who has been arrested. They would need to have encouragement to explore restorative alternatives to incarceration. And so on.
- Community leaders and policy makers would need to emphasize the development and maintenance of trust relationships in their communities as much as they emphasize the development and maintenance of roads, financial infrastructure, and sewer systems. They would need to understand that their investment in public safety (fire, police) would go a lot farther if they invested in building trust (+1) vs. investing solely in reacting / intervening when there is no trust (-1). And so on.

With these and many other conditions in place, you will be creating the chain reaction towards the trusting community you envisioned. Without these conditions, there is no snow for the snowball, no dominoes to tumble.

From here, you'll take another step backwards, to create the pre-conditions for the conditions you just listed. What would it take for people to know each other and share stories and experiences openly, valuing each other and finding commonalities? What would the people need to have, to know, to feel, to be assured of?

For people to know each other…

- They would need to have gathering places. They would need to be assured that they were stepping into a safe space for such conversations. There would need to be fun! And food! And laughter!
- There would need to be ongoing, honest conversations between groups who experience power disparities - communities of color and the police, communities of different income levels, citizens and policy makers.
    - For those trust conversations to occur regularly, there might need to be structures such as facilitation, guidance, ongoing nurturing of relationships so they sustain and so that people don't revert to prior assumptions and behaviors.
    - For structures to be maintained, there would need to be investment of sufficient resources – especially human capital – to ensure that these efforts are sustained over not just one or two years, but decades.
- And so on.

For policy makers to invest in human interaction as the backbone of everything else in the community…

- They would need to understand the types of infrastructure that could support those trust relationships, with detailed, budgetable blueprints, just as they receive detailed blueprints for expansion of the sewer system.
- They would need to have mechanisms for working with the community to co-develop the infrastructure, to ensure they are building trust relationships with citizens in the very development of the mechanisms.
- And so on.

Even in this brief example, you can see the path we have created from our lofty vision to today's actions. It is at this point that groups begin to recognize actions they might take – perhaps expanding an existing program, or perhaps listing assets that can be shared to create safe spaces for conversation. Perhaps the words "people" and "policy makers" and "police" are being replaced in your mind by names of real individuals and real organizations. Perhaps you might see a first step as simply having coffee with those individuals.

By changing the questions we ask in our day-to-day lives, Catalytic Thinking practices instantly reframe our focus from what's wrong to what's possible, and from a reactive focus on "things" to a supportive and creative focus on our human potential.

We are creating the future every day, whether we do so consciously or not.

Coming back to our movie scenario, this is where the hero steps in and lays out his plan. And the townspeople proclaim, "This might just work!"

Social policies and programs can create healthy, humane communities, because we are creating the future every day, whether we do so consciously or not. Using causality to bring out the best in ourselves and the situations we face, we can absolutely create the future we want.

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Hildy Gottlieb is co-founder of Creating the Future, a 10-year experiment to create a healthy, humane world by bringing out the best in people. A TEDx speaker and author, Hildy's work combines research with practical experience, built upon her decades as a social scientist and a leader in social change efforts, including founding the first diaper bank in the U.S.

PARTNERS *in* RESEARCH:

Developing a Patient-Centered Research Agenda for Chronic Kidney Disease (CKD)

Friday, September 16, 2016 | 8:00 a.m. - 3:00 p.m.

John H. Ammon Medical Education Center

Christiana Hospital

(there is no cost to attend this educational activity)

About this conference

The goal of this conference is to educate and engage a broad range of stakeholders (patients, providers, payors, and researchers) on:

- The CKD registry project
- The state of CKD in Delaware and nationally
- The issue of disparity in CKD

We will begin a discussion about:

- Which outcomes are of most interest to patients, payers and physicians
- How the registry can be useful
- Interest in other data sources (geographic, technological, database)
- Other vital useful information

Target Audience

- Patients and their caregivers
- Payors (representatives from insurance companies, Medicare/Medicaid, and similar groups)
- Providers including, but not limited to, primary care physicians, nephrologists, nurses, physician assistants, social work and public health professionals
- Researchers
- Policy makers

Please visit our website at www.delamed.org/CKD

This program is partially funded through a Patient-Centered Outcomes Research Institute (PCORI) Eugene Washington PCORI Engagement Award 3426.

DELAWARE-CTR ACCEL ACCELERATING CLINICAL AND TRANSLATIONAL RESEARCH

CHRISTIANA CARE HEALTH SYSTEM Value Institute

DELAWARE ACADEMY of MEDICINE

DPHA DELAWARE PUBLIC HEALTH ASSOCIATION

VIOLENCE IN DELAWARE: STAKEHOLDERS DIRECTORY

The following organizations and their contact information comprise a foundational listing of the many groups that work to prevent violence and/or address the effects of violence through social, legal, criminal justice, educational and health care resources. We have made every attempt to be inclusive; however, this is **not** an exhaustive list.

Abriendo Puertas

http://peoplesplace2.com/programs-services/abriendo-puertas/

Hotline: (302) 745-9874

Abriendo Puertas, operated by People's Place, is an emergency shelter program for Latina women and children in domestic violence situations in Sussex County. Abriendo Puertas also offers family therapy, case management and transition services.

Adult Protective Services; Delaware Health and Social Services

http://dhss.delaware.gov/dsaapd/aps.html

1 (800) 223-9074

The Adult Protective Service (APS) Program responds to cases of suspected abuse, neglect or exploitation of impaired adults.

American Civil Liberties Union of Delaware

https://www.aclu-de.org/

(302) 654-5326

Local affiliate of the national ACLU, this group plays an important role in protecting the rights and liberties of Delawareans.

Brandon Lee Brinkley Foundation, Inc.

https://blbfinc.wordpress.com/

(302) 588-7454

The Brandon Lee Brinkley Foundation, Inc. works to prevent violence among Delaware youth through conflict management and education and career assistance.

Catholic Charities of the Diocese of Wilmington

http://www.ccwilm.org/

New Castle County *(Main Office):* (302) 655-9624

Kent County: (302) 674-1600
Sussex County: (302) 856-9578
Eastern Shore of Maryland: (410) 651-9608

Catholic Charities of the Diocese of Wilmington is a faith-based social services organization, delivering critical direct care human services regardless of religion, race or ability to pay. Catholic Charities offers domestic violence intervention, anger management services, behavioral health services, housing assistance and more.

Center for Community Justice

http://peoplesplace2.com/programs-services/center-for-community-justice/

(302) 424-0890

In partnership with the State of Delaware, the Center for Community Justice (CCJ), operated by People's Place, provides victim-offender mediation for misdemeanor offenses referred by the justice system. The CCJ also offers community mediations and conflict resolution classes.

CHILD, Inc.

https://www.childinc.com/

Domestic Violence Hotline: (302) 762-6110

Office: (302) 762-8989

Kent/Sussex Counties: 1 (800) 874-2070

CHILD, Inc., a private, nonprofit organization dedicated to advocating for and serving the needs of Delaware's children, provides creative prevention and treatment programs that meet the changing needs of families. The organization serves dependent, neglected and abused children and their parents, and provides programs for those involved in domestic violence situations, especially children. CHILD, Inc. protects the victims and treats those responsible for acts of domestic violence in order to help children heal. Programming includes a 24-hour domestic violence hotline; counseling and treatment services; support groups; the Safe + Respectful program, which promotes healthy relationships among teens; and a shelter system and two family visitation centers in New Castle County.

Children's Advocacy Center of Delaware

http://www.cacofde.org/

New Castle County: (302) 651-4566

Kent County: (302) 741-2123

Sussex County: (302) 854-0323

The Children's Advocacy Center of Delaware provides services in a child-friendly setting in order to expedite the investigation and prosecution of child abuse cases while ensuring the victims receive immediate, effective and sensitive support.

Christiana Care Trauma Department

http://www.christianacare.org/violenceprevention

(302) 733-4996

The Christiana Care Trauma Department seeks to treat violence in the community by helping people better understand the consequences of violence. Free prevention programming includes "Choice Road," a 45-90 minute program for adolescents in grades 6-12 which includes the showing of a 15-minute film; "The Ripple Effect," a 28-minute documentary filmed at Christiana Care depicting scenes from the trauma bay and interviews with medical professionals; and "You Only Live Once," a re-enactment of a trauma resuscitation inside Christiana Hospital.

Community Legal Aid Society, Inc.

http://www.declasi.org/

New Castle County: (302) 575-0660

Kent County: (302) 674-8500

Sussex County: (302) 856-0038

The Community Legal Aid Society, Inc. provides free legal services to: People with disabilities, older citizens (60 and over), victims of housing discrimination, people living in poverty, victims of domestic violence and immigrant victims of crime, abuse and neglect.

ContactLifeline, Inc.

http://www.contactlifeline.org/

Crisis Helpline: 1 (302) 761-9100

New Castle County Office: (302) 761-9800

Kent/Sussex County Office: 1 (800) 262-9800

ContactLifeline, Inc. provides telephone counseling, crisis intervention, information and referral, education and prevention services for persons in crisis and for persons in need of listening services.

Delaware 2-1-1

www.delaware211.org/

Dial 2-1-1 (Monday – Friday, 8 a.m. – 9 p.m.)

Office: (800) 560-3372

Delaware 2-1-1 provides one central resource for access to the health and human service organizations that offer the support to make a difference.

Delaware Academy of Medicine

http://www.delamed.org/

(302) 733-3900

The Delaware Academy of Medicine is a nonprofit organization striving to enhance the well-being of the community through education and the promotion of public health.

Delaware Attorney General's Office

http://attorneygeneral.delaware.gov/index.shtml

Wilmington: (302) 577-8500
Dover: (302) 739-4211
Georgetown: (302) 856-5353

Delaware's Attorney General, the State's chief law enforcement officer, has broad responsibility to combat crime, safeguard families, fight fraud and protect consumers in the First State.

Delaware Center for Justice, Inc.

http://www.dcjustice.org/

(302) 658-7174

The Delaware Center for Justice, Inc. is the leading nonprofit organization in Delaware committed to transforming the quality of justice through advocacy, policy and practice.

Delaware Coalition Against Domestic Violence

www.dcadv.org

(302) 658-2958
New Castle County Hotline: (302) 762-6110 (bilingual)
Kent/Sussex Counties Hotline: (302) 422-8058 or (302) 745-9874 (bilingual)

The Delaware Coalition Against Domestic Violence (DCADV) is a statewide nonprofit organization of domestic violence agencies and individuals working to prevent and eliminate domestic violence by serving as an educational and informational resource to member agencies and the community; advocating for domestic violence concerns in the community; and providing a statewide voice for victims of domestic violence. DCADV understands domestic violence as both a criminal justice issue and a public health concern. The organization engages with community partners on violence prevention efforts, connecting the dots between sexism, racism and family violence.

Delaware Coalition Against Gun Violence

http://decagv.org/

(302) 653-2435

The Delaware Coalition Against Gun Violence works to prevent gun violence in Delaware by promoting sensible gun laws and addressing the root causes of gun violence.

Delaware Criminal Justice Council

http://cjc.delaware.gov/

(302) 577-5030

The Delaware Criminal Justice Council is the State Administering Agency of multiple federal grant programs that will enhance the criminal justice system in Delaware.

Delaware Health and Social Services

http://dhss.delaware.gov/dhss/

(302) 255-9040

The mission of Delaware Health and Social Services is to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency and protecting vulnerable populations.

Delaware State Police Victim Services Center

http://dsp.delaware.gov/victim_services.shtml

Toll-Free Hotline: 1-800-VICTIM-1 (1-800-842-846-1)
Headquarters: (302) 739-3711

The Delaware State Police Victim Services Center addresses the needs of crime victims, witnesses and survivors of sudden deaths by providing crisis intervention, information and referrals.

Delaware Volunteer Legal Services, Inc.

http://www.dvls.org/

Wilmington: (302) 478-8850
Kent/Sussex Counties: (888) 225-0582

Delaware Volunteer Legal Services, Inc. serves indigent residents throughout the State of Delaware by providing quality, pro bono legal services.

Department of Correction

http://www.doc.delaware.gov/

(302) 739-5601

The Department of Correction's mission is to protect the public by supervising adult offenders through safe and humane services, programs and facilities.

Division of Family Services; Department of Services for Children, Youth and Their Families

http://kids.delaware.gov/fs/fs.shtml

Child Abuse and Neglect Report Line: 1 (800) 292-9582

General Information: (302) 633-2657

The Division of Family Services (DFS) investigates child abuse, neglect and dependency and offers treatment services, foster care, adoption, independent living and child care licensing services.

Division of Long-Term Care Residents Protection; Delaware Health and Social Services

http://www.dhss.delaware.gov/dltcrp/

24/7 Hotline: 1 (877) 453-0012

New Castle County: (302) 421-7400

Kent/Sussex Counties: (302) 424-8600

The Division's mission is to protect residents in Delaware long-term care facilities through promotion of quality of care, quality of life, safety and security, and enforcement of compliance with State and Federal laws and regulations.

Division of Public Health; Delaware Health and Social Services

http://dhss.delaware.gov/dhss/dph/index.html

(302) 744-4700

The Division of Public Health's mission is to protect and promote the health of all people in Delaware. The Division's Office of Women's Health works with partner organizations to offer rape prevention and education services.

Division of Youth Rehabilitative Services; Department of Services for Children, Youth and Their Families

http://kids.delaware.gov/yrs/yrs.shtml

(302) 633-2620

The Division of Youth Rehabilitative Services (DYRS) provides services including detention, treatment, probation and aftercare services to youth in the State of Delaware who are ordered to its care by Family Court.

Domestic Violence Advocacy Program

https://www.childinc.com/domestic-violence-services.html

New Castle County: (302) 255-0420

Kent County: (302) 672-1075

Sussex County: (302) 856-5843

The program, operated by CHILD, Inc., helps to empower victims of domestic violence by guiding them through the Family Court system as they seek protection from their abusive partners. CHILD, Inc. staff and volunteers are based in each of the Family Court buildings.

Domestic Violence Coordinating Council

http://dvcc.delaware.gov/

Wilmington: (302) 255-0405

Milford: (302) 424-7238

The Domestic Violence Coordinating Council (DVCC) is a state agency legislatively created to improve Delaware's response to domestic violence and sexual assault. The DVCC brings together all stakeholders including service providers, policy-level officials and community partners to eradicate domestic violence. The DVCC is committed to leading the nation through innovative legislative action, community education and an outstanding coordinated system response to violence in families and the community.

Dover Police Department Victim Services

https://doverpolice.org/victim-services/

(302) 736-7134

The Dover Police Department Victim Services Unit provides emotional support, practical support and assistance to victims of crime in the city.

Family Advocacy Program; Dover Air Force Base

http://www.dover.af.mil/Units/Family-Advocacy

(302) 677-2711

The Family Advocacy Program develops, implements and evaluates programs and policies to prevent and treat family maltreatment.

Family Court of the State of Delaware

http://courts.delaware.gov/family/

Administrative Office: (302) 255-0050

New Castle County: (302) 255-0300

Kent County: (302) 672-1000

Sussex County: (302) 855-7400

The Family Court has extensive jurisdiction over all domestic matters and provides information and resources for guidance through the legal process.

Family Visitation Centers

https://www.childinc.com/domestic-violence-services.html

(302) 283-7518

The Family Visitation Centers, operated by CHILD, Inc., provide supervised exchange for off-site visitation or monitored on-site visitation for children from homes where there has been domestic violence or sexual abuse. Currently there are two visitation centers in New Castle County.

La Esperanza

http://laesperanzacenter.org/

(302) 854-9262

La Esperanza is the only bicultural and bilingual multi-service agency in Sussex County that provides programs and services in the areas of family empowerment, immigration and victim services for Hispanic adults, children and families. Programs include: Hope for Tomorrow, which provides holistic support and advocacy for the rights, protection and safety of victims of crime and abuse; the Family Law Program, which addresses the legal needs of victims of domestic violence, sexual assault, dating violence and stalking; and Seeds of Hope, which offers mental health counseling and supportive services to Latina survivors of sexual assault.

Latin American Community Center

http://www.thelatincenter.org/

(302) 655-7338

The Latin American Community Center works to empower the Latino community through education, advocacy, partnerships and exceptional services. The Center provides a full range of bilingual/bicultural services at no cost for victims of domestic violence, including case management, therapy and immigration services. The Center also provides guidance to crime victims on police reporting and judicial processes.

Mental Health Association in Delaware

http://mhainde.org/wp/

Office: (302) 654-6833 or (800) 287-6423

New Castle County Support Groups: (302) 654-6833

Kent/Sussex Counties Support Groups: (800) 287-6423

The Mental Health Association in Delaware (MHA) promotes improved mental well-being for all individuals and families in Delaware through education, support and advocacy. MHA offers support groups for Survivors of Suicide (SOS) and Survivors of Accidents and Murders (SAM).

New Castle County Police Community Services Unit

http://www.nccde.org/266/Community-Services-Unit

(302) 395-8050

The Unit has specialists trained in a variety of safety and security concerns and offers 37 programs covering safety and prevention.

New Castle County Police Victim Services Unit

http://www.nccde.org/1104/Victim-Services-Unit

Victim Service Specialist: (302) 395-8193 or (302) 395-8135

Bilingual Assistance: (302) 395-8117

The New Castle County Division of Police, Victim Services Unit, provides information and support to victims of domestic violence and sexual assault. Additional support is provided to children and elderly victims, as well as family members of homicide victims or surviving members of suicide.

Newark Police Victim/Witness Services

http://cityofnewarkde.us/index.aspx?NID=341

(302) 366-7100

The Newark Police Department, Victim/Witness Services Unit, provides social work services to victims/witnesses of violent crime including crisis intervention, information and support.

Office of the Child Advocate

http://courts.delaware.gov/childadvocate/

Wilmington: (302) 255-1730
Georgetown: (302) 856-5720

The Office of the Child Advocate (OCA) is a non-judicial state agency charged with safeguarding the welfare of Delaware's children.

Prevent Child Abuse Delaware

http://pcadelaware.org/

(302) 425-7490

Prevent Child Abuse Delaware provides resources and training to make sure every child has a safe and nurturing childhood, one free of abuse and neglect.

REAL Relationships

http://www.realrelationshipsde.org/

Phone: (302) 424-2420

REAL Relationships, the violence prevention program at Turning Point, engages with youth to promote healthy relationships with respect, equality, acceptance and love throughout Kent and Sussex Counties.

SAFE (Shelter Advocacy Freedom & Empowerment)

http://peoplesplace2.com/programs-services/safe/

Hotline/Office: (302) 422-8058

The SAFE program, operated by People's Place, provides a 24/7 hotline offering safety planning, support and community resources to victims of intimate partner and family violence. SAFE operates two emergency domestic violence shelters in Kent and Sussex Counties.

SAND (Sexual Assault Network of Delaware)

http://www.contactlifeline.org/sand/

Administrative Office: 1 (302) 761-9800

The Sexual Assault Network of Delaware (SAND), run by ContactLifeline, Inc., represents a multi-disciplinary group of professionals working to raise awareness of the problem of sexual assault in all its forms. SAND facilitates sexual assault community service coordination and takes part in legislation tracking, policy recommendations, education, training and prevention.

SOAR (Survivors of Abuse in Recovery)

http://www.survivorsofabuse.org/

Wilmington & Newark: (302) 655-3953
Dover: (302) 422-3811
Georgetown: (302) 645-4903

SOAR provides professional mental health services to victims of sexual trauma and their families regardless of their ability to pay. A leader in the field, SOAR also provides education, advocacy and professional development.

Turning Point

http://peoplesplace2.com/programs-services/turning-point/

(302) 424-2420

Turning Point, operated by People's Place, offers a variety of services throughout Kent and Sussex Counties for people impacted by domestic violence, including counseling for victims and children and groups for domestic violence offenders. Turning Point is also actively engaged in prevention programming with schools and community organizations.

University of Delaware Sexual Offense Support (S.O.S.)

www.udel.edu/sos

UD Helpline 24/7/365 (S.O.S. advocates): (302) 831-1001
Business Hours – Professional advocate/crisis counselor: (302) 831-3457

S.O.S. offers year-round crisis intervention and victim advocacy 24 hours/day for members of the campus community who are survivors of sexual assault, dating/domestic violence, sexual harassment and stalking. The service is also for anyone supporting a survivor – family, friends, significant others, parents, UD faculty and staff. An S.O.S. advocate can provide information and support, accompaniment to other resources, referral and an appointment with a professional advocate/crisis counselor for ongoing assistance.

University of Delaware Students for the Second Amendment

https://studentcentral.udel.edu/organization/studentsforthe2ndamendment

Email: https://udel.collegiatelink.net/organization/studentsforthe2ndamendment/about/contact

The organization works to teach responsible firearm ownership, knowledge and laws and bring positive firearm awareness to the University of Delaware.

Victims' Compensation Assistance Program

http://attorneygeneral.delaware.gov/vcap/

(302) 255-1770

Administered by the Delaware Department of Justice, the Victims' Compensation Assistance Program (VCAP) provides financial assistance to crime victims and their families.

Victims' Voices Heard

http://www.victimsvoicesheard.org/

(302) 697-7005

Victims'Voices Heard works to strengthen, improve and transform the lives of crime victims and survivors by offering programs that will open dialogue between victims and offenders, and provide offenders with insight into the aftermath of trauma their victims/survivors have experienced.

VINE (Victim Information and Notification Everyday)

https://vinelink.com/#/home

1-877-DE8-VINE

This service allows crime victims to obtain timely and reliable information about criminal cases and the custody status of offenders 24 hours a day.

Wilmington HOPE Commission

http://wilmhope.org/

(302) 407-3397

The Wilmington HOPE Commission works with community partners in the transformation of Wilmington's most underserved communities. The Commission operates the Achievement Center, a hub for evidence-based reentry services for formerly incarcerated men.

Wilmington PeaceKeepers Association

http://wilmingtonpeacekeepers.weebly.com/

Email: Wilmington.Peacekeepers@yahoo.com

The Wilmington Peacekeepers Association, a not-for-profit 501c3 organization, is a multi-denominational, God-centered, ethnically diverse group of men and women concerned with gun violence and the educational development of young people.

Wilmington Police Victim Services

http://www.wilmingtonde.gov/government/city-departments/department-of-police/victim-services

Victim Services Coordinator: (302) 576-3622
Victim Services Specialist: (302) 576-3975
Bilingual Victims Case Coordinator: (302) 576-3665
Domestic Violence Coordinator: (302) 576-3648
Youth Victim Advocate: (302) 576-3652

The Wilmington Police Victim Service Unit provides support, crisis counseling, information and referrals to victims. The unit works closely with police officers to provide safety and court information specifically for victims of domestic violence and for Spanish-speaking victims.

YWCA Sexual Assault Resource Center

http://www.ywcade.org/site/c.ahKKIZMHIlI4E/b.9285749/k.3AA2/Sexual_Assault_Response_Center.htm

Hotline: (800) 773-8570
Director: (302) 273-1301

The Sexual Assault Response Center (SARC) is a rape crisis center in Delaware that provides comprehensive, free and confidential rape crisis services to all sexual assault survivors aged 12 and older and their non-offending family members, friends and partners in New Castle County and Sussex County (starting October 2016).

ORGANIZATION RESOURCE STRUCTURE

Several organizations have separate divisions or programs that address different facets of violence in Delaware. When applicable, some of these divisions and programs, and their unique contact information, were listed separately in order to create the most comprehensive directory. Please refer to the following organization resource structure.

American Civil Liberties Union of Delaware

Brandon Lee Brinkley Foundation, Inc.

Catholic Charities of the Diocese of Wilmington

CHILD, Inc.

- Domestic Violence Advocacy Program
- Family Visitation Centers
- Safe + Respectful

Children's Advocacy Center of Delaware

Christiana Care Trauma Department

Community Legal Aid Society, Inc.

Contact Lifeline, Inc.

- SAND (Sexual Assault Network of Delaware)

Delaware 2-1-1

Delaware Academy of Medicine

Delaware Attorney General's Office

- Victims' Compensation Assistance Program

Delaware Center for Justice, Inc.

Delaware Coalition Against Domestic Violence

Delaware Coalition Against Gun Violence

Delaware Criminal Justice Council

Delaware Health and Social Services

- Adult Protective Services
- Division of Long-Term Care Residents' Protection
- Division of Public Health

Delaware State Police Victim Services Center

Delaware Volunteer Legal Services, Inc.

Department of Correction

Department of Services for Children, Youth and Their Families

- Division of Family Services
- Division of Youth Rehabilitative Services

Domestic Violence Coordinating Council

Dover Air Force Base

- Family Advocacy Program

Dover Police Department Victim Services

Family Court of the State of Delaware

La Esperanza

Latin American Community Center

Mental Health Association in Delaware

- Survivors of Accident and Murder (SAM) Support Group
- Survivors of Suicide (SOS) Support Group

New Castle County Police Community Services Unit

New Castle County Victim Services Unit

Newark Police Victim/Witness Services

Office of the Child Advocate

People's Place

- Abriendo Puertas
- Center for Community Justice
- SAFE (Shelter Advocacy Freedom and Empowerment)
- Turning Point
  - REAL Relationships (a program of Turning Point)

Prevent Child Abuse Delaware

SOAR (Survivors of Assault in Recovery)

University of Delaware Sexual Offense Support (SOS)

University of Delaware Students for the Second Amendment

Victims' Voices Heard

VINE (Victim Information and Notification Everyday)

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VIOLENCE AND Children

by David Chen M.D., M.P.H. and Iman Sharif M.D., M.P.H., M.S.

The guy who taught me how to read, he was shot and killed in his car and I think that's the earliest remembrance of someone getting shot, and then a friend of mine who lived behind me, his brother was shot and killed in front of him... Just recently, one of my old students, he was shot and killed. It's just like... it's kinda like a piece of you is missing, even if you didn't hang with this person every day, you don't consider him a close friend, it's still somebody you're used to seeing as part of your neighborhood. They're no longer there anymore so it takes away whatever blessing God had that person being in that neighborhood, and it... it takes away a piece of someone else, cause that was someone's child, someone's family member, brother. It's just somebody gone from your neighborhood. (Chen & Lloyd, 2014, para. 26).

There are few issues in healthcare as viscerally disturbing as that of violence and children, especially when the injuries are visible. Cigarette burns, broken bones, bruises and scars; these are the readily identifiable stigmata of child abuse and represent the most common context in which providers encounter violence in children. In such settings, we describe risk factors and etiologies in terms of specific relationships and environments. We imagine them to be modifiable through secondary and tertiary prevention: by removing the child from an abusive household or a violent environment while providing medical and psychological therapies to mitigate and heal the harm. But what does it mean to think of violence as a public health issue? Is it necessary or even possible to address violence in terms of primary prevention? In the past year alone, Delaware has experienced a number of high profile teenage violence-related deaths, including the beating and death of a high school girl by other students (Horn & Parra, 2016).

The opening quote comes from an informal interview with Donovan, a young man who grew up in Wilmington. He describes a variety of violent encounters during childhood and adolescence ranging from whiffleball bat fights with neighborhood kids to being robbed at gunpoint. Though he was never seriously injured and never exhibited signs of post-traumatic stress disorder, the already normative frequency of violent deaths experienced by Donovan and his neighbors has only increased since their childhood.

THE LOCAL DATA

The escalation in firearm related injuries in Wilmington prompted an epidemiologic investigation by the Centers for Disease Control and Prevention (CDC), the first firearm related research by the institution in nearly twenty years (Bidgood, 2015). Between 2011 and 2013, the number of shooting victims in Delaware has risen by 45% and since 1999 the overall rate of increase in homicides has outstripped that of every other state (Centers for Disease Control [CDC], 2015, p. 1). In its analysis of 569 individuals arrested for involvement with violent firearm crime from 2009 to 2014, the CDC found that 15.1% were under the age of 18 with the majority (54.5%) under age 25 (p. 4-5).

The report also developed an analytical tool based on aggregated data from administrative sources such as criminal justice systems, health systems, and the department of education to highlight individual risk factors for firearm violence. Notably, in this study population 48% had had a prior Emergency Department visit for physical harm/suicidal ideation/police encounter; 29% had a child welfare investigation as a victim of child maltreatment or out of home placement; 54% were involved with state juvenile services; 86% were currently unemployed; 73% had received social assistance programs related to schools; 42% had been suspended or expelled from school; and 58% had 10 or more school absences in the year preceding crime (p. 6).

The People's Report, an ethnographic participatory action research study conducted in Southbridge and Eastside communities and published in 2013, found that 60% of participants had "seen a seriously injured person after an incident of violence," that 55% had at least one relative killed with a gun, and nearly 60% lost a friend to gun violence; the average age in which loss of a friend occurred was 18 years old (Payne, 2013, p. 40-42).

INTERPRETATIONS

What is notable beyond the novel roots in community research done by these studies is their description of the sheer volume of exposure to both violence and to concomitant risk factors before the age of 18. While it is easier in the clinical setting to characterize the impact of discrete violent episodes, the cumulative impact of chronic violence on childhood development and wellbeing can be difficult to extract from other chronic stressors such as poverty, food insecurity, housing insecurity, mood disorders, substance abuse, as well as the exposure to all of the above in the lives of other family members. Consequently, it can be challenging to discern exactly what the relevant relationships are between exposure to violence & risk factors and the subsequent development of violent behavior. Is violence the consequence of poverty or a contributor? Which elements are correlative and which are causative? How much do age and degree of exposure matter? If violence is related to other broad and complex socioeconomic factors, what explains the recent trends towards escalation in gun violence in particular, and if that has increased rapidly can it be similarly reduced?

Some public health approaches treat violence as a contagious disease. The Institute of Medicine Forum on Global Violence Prevention held a workshop to explore this concept: that exposure to interpersonal violence is a risk factor for perpetration of violence, that there appears to be a dose-response effect, that incidents cluster, and that different individuals have risk factors to make them more susceptible or resilient (Patel, Simon, & Taylor, 2013). Key contributor Dr. Gary Slutkin founded Cure Violence, an organization in Chicago that used these concepts to develop a "violence interrupter" program that employs those formerly affected by violence as community health workers to actively mediate local and ongoing conflicts and change community norms ("The Cure," n.d.).

Most other approaches have characterized negative effects on childhood wellbeing more comprehensively through the impact of Adverse Childhood Events (ACEs) on lifelong health. The original ACE study in 1998 was a retrospective analysis of over 17,000 participants in San Diego and examined exposure to abuse (psychological, physical, and sexual) and household dysfunction (substance abuse, mental illness, mother treated violently,

and criminal behavior); it determined a graded dose-response relationship between the number of adverse events experienced and negative health outcomes in adulthood[1] (Felleti et al., 1998).

The hypothesis behind the contribution of ACEs to these negative outcomes is complex and extends beyond simply behavioral conditioning or socioeconomic factors. The American Academy of Pediatrics (AAP) issued a technical report in 2012 detailing the mounting evidence suggesting that "toxic levels" of environmental stress may impact neurodevelopment and the hypothalamic-pituitary-adrenocortical axis in such a way that fundamentally changes, in a biologic fashion, perceptions and responses to stress, fear, mood regulation, executive function, and impulse control (Shonkoff et al., 2012). In other words, children exposed to high levels of chronic stress are vulnerable to dysregulation, the phenomenon in which they develop impaired coping mechanisms to stressful situations while simultaneously becoming more likely to behave in risky and impulsive ways.

Subsequent studies on ACEs and children have not only confirmed associations between ACEs and negative health outcomes for both children and adults (Kelly-Irving et al., 2013) but specifically for adolescent violence perpetration as well. A large cross-sectional study in 2010 of high school students found significant correlation between ACEs and actions such as bullying, physical fighting, dating violence, weapon carrying, self-harm, and suicidal ideation and attempts (Duke, Pettingell, McMorris, & Borowsky, 2010). Moreover, it found a *dose-dependent* effect with each additional ACE increasing risk of violence perpetration by 35% - 144% (Duke et al., 2010).

This is significant in its determination that even risk factors that are not inherently or necessarily violent can still create vulnerabilities to violence and that this risk is both cumulative and potentially modifiable. Consequently, the AAP has taken the strong stance that:

The growing availability of evidence based interventions that have been shown to improve outcomes for children in the child welfare system underscores the compelling need to transform "child protection" from its traditional concern with physical safety and custody to a broader focus on the emotional, social, and cognitive costs of maltreatment. The Centers for Disease Control and Prevention has taken an important step forward by promoting the prevention of child maltreatment as a public health concern. (Shonkoff et al., 2012, p. e241).

THE TRAUMA INFORMED APPROACH

But even if exposure to ACEs over the course of a lifetime is both cumulative and measurable, it is still challenging to develop effective and responsive models of care. How can a provider begin to engage a statistical entity describing a myriad of deeply disruptive and often shame-filled events that span the life spectrum?

The response to this question parallels the development of the Patient Centered Medical Home (PCMH), which was initially developed for pediatric primary care to address health disparities in children with complex and special health care needs. The PCMH suggested that though this subpopulation was selectively disadvantaged, disparities were reduced when a comprehensive set of interventions restructured the way care was delivered throughout the entire practice or health system rather than as interventions limited to specific vulnerable individuals alone (Starfield & Shi, 2004). By developing ways to improve access and coordination of care for all patients, practices provided "better effectiveness of services as well as fewer disparities and more equity in health across population subgroups" (Starfield & Shi, 2004, p. 1497). The success of this model within pediatrics prompted expansion, inclusion, and standardization of the model in other fields of primary care.

Likewise, addressing ACEs implies a fundamental alteration to our methods of care delivery will be necessary. One popular model is the "Trauma Informed Approach". As operationalized by

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SAMHSA[2], the Trauma Informed Approach to care refers to "a program, organization, or system that…

- Realizes the widespread impact of trauma and understands potential paths for recovery;
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively resist re-traumatization." ("Trauma-informed Approach," 2015, para. 2)

Like the PCMH, a Trauma Informed Approach relies on a change in the way care is delivered. While specific interventions, such as using trauma-oriented screening tools and assessments, can highlight vulnerable individuals & families, the success of this model depends on sensitizing staff and operations at all levels to detecting and responding to traumatic narratives such as those caused by ACEs. Most toolkits recommend training of all personnel, from the reception desk to the provider and administrators, in methods for harm reduction as well as care. For example, nursing assessments can proceed beyond Airway, Breathing, and Circulation (ABCs) to include Distress, Emotional support, and Family circumstances (DEFs) (*D-E-F Nursing*, n.d.). Interviewers can change the clinical approach from "What's wrong with you?" to "What happened to you?" ("Trauma Informed Care," n.d.) Patient autonomy can be expanded in ways as simple as allowing greater privacy and choices regarding physical exam clothing/gowns and maneuvers (Trauma Informed Practice Strategies, n.d.). Narrative Exposure Therapy, a structured set of eight therapy sessions developed for those in conflict zones and refugee populations, can be used in modified form (KIDNET) by clinical psychologists for children and adolescents to reduce PTSD symptoms (Neuner et al., 2008).The concepts of the Trauma Informed Approach and Adverse Childhood Events are still in the process of dissemination throughout practice communities, but are gaining popularity in a variety of contexts: school systems, health care systems, correctional facilities, and other points of human services and contact.

29%

had a child welfare investigation as a victim of child maltreatment or out of home placement

55%

had at least one relative killed with a gun

42%

had been suspended or expelled from school

NEXT STEPS

Based on the available evidence, the primary prevention of violence in children, adolescents, and adults is possible but will only be successfully optimized with multiple tiers of intervention: ones that operate at both the verge of violence as well as the early childhood roots. Delaware has already begun to mobilize resources on multiple levels, many of which implement a Trauma Informed Approach.

Targeted interventions for firearm-related violence:

- CDC Community Advisory Board: Created following the report to operationalize the risk-assessment tool by coordinating services across healthcare, social services, education departments, and the justice system to continuously identify and connect high risk individuals with services (Pizzi, 2016).
- You Only Live Once: Re-enactment in a simulated trauma bay of care for a shooting victim at Christiana Hospital, demonstrated for school and youth groups (Giordano, 2016). The Trauma Department also sponsors other programs as part of its Violence Prevention initiative (http://www.christianacare.org/violenceprevention).
- Cease Violence: Founded by the City of Wilmington (based on Chicago's Cure Violence program) to employ violence interrupters as community based workers to prevent retaliatory attacks when firearm injuries do occur (Horn, 2015).

Global interventions:

- Trauma Matters Workgroup: Meetings sponsored by Children's Department of Delaware's Division of Prevention and Behavioral Health Services for facilitation of public and private partnerships in addressing ACEs through Trauma Informed Care.
- Building Community Resilience: Established by Nemours, Building Community Resilience is a collaborative funded by the Kresge Foundation in 5 communities across the country, including Delaware. Participants develop, share, and test strategies to address toxic stress across health care institutions and community partners.
- Change in Mind Initiative: Children & Families First (Wilmington, DE) is one of 10 members of the Alliance for Strong Families and Communities chosen as a site to use advances in brain science to impact practice and policy.
- Delaware Project LAUNCH: Funded by SAMHSA, aims to promote the wellness of young children from birth to 8 years by coordinating child-serving systems and the integration of behavioral and physical health services for school readiness.

As we proceed, the work around the Trauma Informed Approach must also align with the work of the Delaware State Innovation Models Initiatives, particularly "Healthy Neighborhoods" which is the implementation of national grants via the Center for Medicare & Medicaid Innovation (CMMI) for specific value-based payment models and population health goals (Delaware State Innovation Models, 2016). These interventions represent some of the many efforts to improve the safety and wellbeing of children in Delaware. Collaborative efforts to dovetail and connect the separate efforts over the past couple of years have been and will continue to be vigorous.

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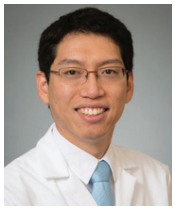
BIOGRAPHIES



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From the History & Archives Collection

Elizabeth E. Healy, M.P.H.

Ambroise Paré: Father of Modern Surgery

Many historians and health care professionals regard Ambroise Paré as the father of modern surgery. He gained increasing popularity while serving as a barber-surgeon in Paris; his reputation became so well acclaimed, that he became the surgeon for many monarchs including Henry II, Francis II, Charles IX, and Henry III. Paré was a pioneer in surgical techniques, battlefield medicine, and was an expert in forensic pathology.

The following excerpt is taken from "*The Case Reports and Autopsy Records of Ambroise Paré*". This collection of notes and observations originally published in 1575 in Paré's native French, details his work and discoveries in treating battle and gun shot wounds. Also pictured, is a bronze statue of Paré, both part of the collection housed by the Delaware Academy of Medicine and Delaware Public Health Association.

In this particular segment, readers are afforded a small window into Paré's skill and inventiveness in wound treatment. Here, he recalls his first experience joining a military expedition, and his subsequent first attempt at treating gunshot wounds. Heeding the advice of an earlier surgeon, Jean de Vigo, Paré applied a boiling mixture of oils prior to cauterization, which he noted would cause excruciating pain to his patient. Once he ran out this oil solution, he resolved to use his own mixture of egg yolk, rose oil, and turpentine. The next day, the initial patients treated with the boiling oil we feverish, swollen, and in discomfort. The patients treated with his alternative mixture, had rested well through the night and had little inflammation. Paré vowed from then on never to inflict the same pain on future patients through use of the burning oil.

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pulsive bandage. My reasons were that the oil and brandy could penetrate to the depths of the puncture, dry the moisture from the nerve and by their actual and potential warmth, calm the pain. The diachalciteos plaster had equal virture of resolving the humor coursing the arm and prohibit the descent of other humors. As for the bandage, it served to strengthen and sustain the muscles, express and remove to the upper parts the humors that descend and prevent their new flow. The Physicians agreed to this and concluded such remedies to be useful and necessary. Thus the pain ceased. And to better resolve and slow the humors contained in the part, we used resolving and drying remedies.

The King remained three months and more without power to flex or extend the arm, nevertheless, thanks to God, he was perfectly healed without being deprived of any motion.

Gangrene of Arm after Bleeding Accident (MII,116)

Of recent memory was Mademoiselle Courtin, living in rue St. Croix, near the Bretonnerie in Paris, who being badly bled, the arm fell into gangrene and total mortification, of which she died, since she was not so treated.

First Experience with Gunshot Wounds (MII,127)

(1536, Paré's first military expedition under M. de Montejan to Piedmont and Turin, with the army commanded by the Connestable Montmorency and accompanied by the Dauphin, later Henri II.—Ed.)

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I was at that time a fresh-water surgeon, since I had not yet seen treated wounds made by firearms. It is true I had read in Jean de Vigo,[48] first book of *Wounds in General*, Chapter 8 that wounds made by firearms are poisoned because of the powder. For their cure he advised their cauterization with oil of elders mixed with a little theriac. To not fail, this oil must be applied boiling, even though this would cause the wounded extreme pain. I wished to know first how to apply it, how the other Surgeons did their first dressings, which was to apply the oil as boiling as possible with the tents and setons. So I took heart to do as they did. Finally my oil was exhausted and I was forced to apply instead a digestive made of egg yolk, rose oil and turpentine. That night I could not sleep easily, thinking that by failure of cauterizing, I would find the wounded in whom I had failed to put the oil, dead of poisoning. This made me get up early in the morning to visit them. There, beyond my hope, I found those on whom I had used the digestive medication feeling little pain in their wounds, without inflammation and swelling, having rested well through the night. The others on whom I had used the oil I found feverish, with great pain, swelling and inflammation around their wounds. Then I resolved never again to so cruelly burn the poor wounded by gunshot. (See also pg. 162—Ed.)

[48] Giovanne da Vigo was born in Rapello in 1460. When Julian I became Pope in 1503 he brought da Vigo as his Surgeon to Rome, where he developed a large practice. Following the Pope to the Wars, he worked for ten years on a series of books on Medicine and Surgery. It was published in Rome in 1514 in nine volumes, *Practica Copiosa in arte Chirurgica* and went through 21 (Malgaigne) or 40 (Castiglione) editions including translations into several foreign languages. Malgaigne listed its contents and noted that he originated no single new idea, method or process; it was the work of a compiler and copyist. The man himself passed from sight and his place and time of death is unknown; 15[illegible] the approximate date (Malgaigne, Intro. CLXXV).