Frequently Asked Questions: *Domestic Violence and Health*

→What is Domestic Violence?

- Domestic violence (DV) is when one person in a relationship perpetrates a pattern of coercive or assaultive behaviors over another. It is also referred to as Intimate Partner Violence (IPV).
- DV can occur among individuals across the lifespan of every race, religion, ethnicity, culture, socioeconomic class, education level, gender and sexuality. In the U.S., more than 5 million women are abused by an intimate partner each year.[1]
- More than 1 in 3 women have experienced rape, physical violence and/or stalking by an intimate partner in her lifetime[1], making domestic violence as prevalent as or more prevalent than diabetes, cardiovascular disease, breast cancer, and cervical cancer - all health problems routinely assessed for in clinical settings.[2]

→What are the financial costs associated with domestic violence?

- Domestic violence is a public health epidemic that has largely been ignored by the healthcare sector, yet it costs the U.S. over $8.3 billion annually in lost productivity, premature death, and medical and mental health services. Additionally, the increased annual health care costs for victims of DV can persist as much as 15 years after the cessation of abuse.[3]

→Who is most at risk for domestic violence?

- According to the CDC's National Intimate Partner and Sexual Violence Survey, 7 out of 10 women who have experienced DV have first experienced it before the age 25.[4]
- Data from the CDC's National Intimate Partner and Sexual Violence Survey (administered annually since 2010) clearly shows that the burden of victimization falls on young women, women of color, women with disabilities, women who identify as lesbian or bisexual, and women who have lower household incomes or food/shelter insecurity. While DV can happen to anyone, NISVS clearly shows that women are disproportionately affected, including both the direct impact of the abuse as well as the long-term health consequences resulting from the abuse.[4]
- After having conducted a systematic review of the evidence, the U.S. Preventive Services Task Force issued a Grade B recommendation that clinicians screen women of childbearing age (including those who do not show signs or symptoms of abuse or other forms of DV), and provide or refer women who screen positive for DV to intervention services.[5]

→What do we know about the health impact of domestic violence in Delaware?

- Delaware's efforts to address domestic violence have traditionally focused on a criminal justice response, yet DV can have a chronic and long-term health impact on individuals, children and communities, and therefore also needs to be addressed through our public health and healthcare systems.
- The number of Delawareans who have experienced severe domestic violence is greater than the populations of Wilmington, Dover, Milford, Georgetown and Seaford combined.[1] This means the equivalent of entire cities of Delawareans are now also at risk for other chronic health problems as a result of their abuse and trauma, such as depression, heart disease, substance abuse, STIs, HIV/AIDS, unintended and teen pregnancies, diabetes, asthma and obesity.[4]

→What is a trauma-informed approach to domestic violence?

- A trauma-informed perspective recognizes the central impact that traumatic experiences have on emotional, mental and physical well-being. It acknowledges both the damaging effects of traumatic experiences and the amazing power of healing and resilience, while also meeting victims where they are and supporting individual choices.

→Does domestic violence impact reproductive and maternal health?

- Evidence demonstrates that violence and poor reproductive health outcomes are strongly linked, including the connection between domestic violence and the increased risk of unintended pregnancies. Delaware has the third highest rate (7.5%) in the country for the percentage of women with unintended pregnancies who experienced physical IPV 12 months prior to pregnancy. Delaware is also tied for the highest rate in the U.S. (6.8%) of women with unintended pregnancies who experienced physical IPV during pregnancy.[6] Interventions during this time are critical, as homicide is the leading cause of death for pregnant and post-partum women.[7]
- Results from Delaware's 2011 Pregnancy Assessment Monitoring System reveal that among the types of prenatal counseling provided to patients, counseling for physical abuse was the least common type received (53%) by Delaware patients, in comparison to counseling related to illegal drugs, smoking, alcohol, HIV, breastfeeding, birth defects, and medications, with rates ranging from 67-91%.[6]

→What do we know about domestic violence and mortality?

- Murder is the most extreme form of abuse. The U.S. still has the highest rate of domestic violence homicide of any industrialized country.[8] Each day on average, three women are murdered by intimate partners — husbands and ex-husbands, boyfriends and estranged lovers. Compared to men, women are far more often murdered by someone they know. In 2010, 39% of U.S. female homicide victims were killed by an intimate partner. Just 3% of men suffered the same fate.[9]
- Further study of homicides and serious injuries indicate that women often have contact with health care providers related to their injuries. Dr. Jackie Campbell, a leading femicide researcher, found that nearly 40% of murdered women had contact with a

health care provider in the year preceding their death. She refers to these contacts as having been missed opportunities.[10] Work by Campbell and others has revealed that health care providers are unsure of their skills and find it difficult to offer safety resources. A key finding from their work is for healthcare providers to improve safety planning with patients and for DV to be addressed through our public health and healthcare systems.

- In the 2013 Delaware Fetal and Infant Mortality Review Annual Report, Delaware's Maternal Mortality Review Panel recommended that DV screenings be conducted upon initial prenatal assessment/appointment for **all** pregnant women in Delaware. The recommendation was endorsed by the Delaware Chapter of ACOG (American Congress of Obstetricians and Gynecologists).[11]

→What do Delaware patients want?

- Even with efforts nationally to raise awareness of DV as a women's health issue, few providers screen for it. Yet surveys indicate that 90% of patients don't mind being asked and 71% wished that a previous healthcare provider had asked about it.[12]
- Initial results of a research project currently being conducted by Delaware's Project Connect partners have found similar results, with 67% of patients interviewed at a New Castle County clinic and 100% of patients interviewed at a Sussex County clinic reporting that, "it is helpful for providers to talk with patients about healthy and unhealthy relationships."

→Are healthcare providers prepared to address domestic violence?

- Evidence suggests that the majority of physicians do not screen for domestic violence. Even with OB/GYNs reporting, the highest screening levels are at a mere 17%.[13] Studies suggest that screening practices are influenced by lack of time and training, and physicians' comfort levels with asking women about DV. [14]
- A 2014 DV and Healthcare survey conducted in Delaware by DCADV revealed that a majority of Delaware public health officials (64%), and nearly half of respondents from Delaware healthcare systems (43%) report never being trained on DV as a health issue. Consequently, each day, doctors, nurses, and other healthcare providers interact with victims of domestic violence and may not be prepared to provide them with simple interventions that could save lives, or trauma-informed support that could facilitate the healing process.
- A major concern in the provision of services for DV is to ensure that women are not further victimized by the health sector, but are treated sensitively. Findings from the World Health Organization reveal that, initially some providers can discount patient's stories, seem uninterested, ignore the situation or focus solely on physical symptoms[15]; But with training and increased understanding of the impact of trauma, providers showed increased capacity to address the patient's needs more effectively. Therefore, efforts to integrate trauma training and expand policies and practices to ensure that trauma-informed services, organizational approaches, and trauma-informed

systems of care should be cornerstones of any healthcare response to domestic violence.

→Is training healthcare providers sufficient?

- Beyond training and education, the literature suggests that system-wide changes regarding practices will only be implemented and sustained when there are tangible changes in policies and the infrastructure to support these changes.[15] According to the American College of Obstetricians and Gynecologists, "a formalized protocol is an essential step to institutionalizing a trauma-informed, coordinated response that addresses IPV in a healthcare setting."[16]

→What is currently being done in Delaware to address domestic violence as a healthcare issue?

- The Delaware Coalition Against Domestic Violence (DCADV) has been working in partnership with Delaware's Division of Public Health to begin to change policies, build infrastructure, and formalize protocols within women's health clinics. These clinics are a critical healthcare entry point serving women of child-bearing age, who are at the most risk for DV. Specifically, DCADV has served as the project lead for Delaware's Project Connect program (2012-2015), a national initiative of Futures Without Violence and funded by the U.S. Office of Women's Health. This project aims to improve the public health response to intimate partner violence. Partners include the Delaware Division of Public Health, Planned Parenthood of Delaware, La Red Health Center, Inc., Peoples' Place, Child, Inc., and the University of Delaware.
- In the clinical setting, Delaware partners have utilized *Project Connec*t patient safety cards and training materials developed by Futures Without Violence and the American College of Obstetrics and Gynecologists (ACOG). Leading health organizations, like the U.S Preventive Services Task Force and ACOG specifically refer to *Project Connect* as a recommended evidence-based model.[16] This is a trauma-informed, evidence-based intervention which promotes universal healthy relationships education, assesses for violence/coercion, offers harm reduction strategies and assists the provider in offering a "warm" or supported referral to a community-based domestic violence program.
- In Delaware, DCADV and Project Connect partners work with clinics in advance to help prepare their setting for the introduction of this evidence based intervention. In total, 10 reproductive/sexual health clinics across the state have successfully completed the program and adopted significant changes. At the end of the trainings provided to staff in new partner clinics, participants report increased knowledge about the link between DV and health, increased comfort levels with starting and sustaining these important conversations, and increased knowledge about community resources for making victim referrals.
- Through this collaboration, this project has:
    - Distributed over 50,000 educational cards to women in Delaware
    - Trained over 1,000 providers and advocates on Project Connect
    - Increased health resources to survivors accessing emergency shelter

    - Altered and institutionalized practices at DV shelters to more effectively screen for health concerns
    - Assisted in the changes to clinical policy and practice within clinic setting, including upgrades to electronic heath records
- The Medical Committee of Delaware's Domestic Violence Coordinating Council (DVCC) – developed a DV manual for healthcare providers: *Domestic Violence Resource Manual for Healthcare Professionals*. The Resource Manual helps providers recognize domestic violence; feel comfortable in screening for domestic violence; and provides important resources and tools. In addition, the DVCC provides no-cost training to health professionals on the Resource Manual.

→Is there buy-in from Delaware healthcare providers to sustain and expand these efforts?

- Survey respondents from all 3 systems (public health, healthcare, and domestic violence) who participated in DCADV's 2014 DV and Health survey indicated they agree/strongly agree that IPV should be a health area of focus for Delaware's public health and healthcare system.

References

1. Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walter, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Centers for Disease Control and Prevention.
2. Center for Disease Control and Prevention. *Trends in lifetime risk and years of life lost due to diabetes in the USA, 1985–2011*. The Lancet Diabetes & Endocrinology. Accessed at: http://www.cdc.gov/diabetes/pdfs/newsroom/now-2-out-of-every-5-americans-expected-to-develop-type-2-diabetes-during-their-lifetime.pdf
   American Heart Association, Inc. (2015). *Statistical Fact Sheet 2015 Update Women & Cardiovascular Diseases. Available at:* http://www.heart.org/idc/groups/heart-public/@wcm/@sop/@smd/documents/downloadable/ucm_472913.pdf
   Howlader N, Noone AM, Krapcho M, et. al. (eds). (2012). *SEER Cancer Statistics Review, 1975–2009 (Vintage 2009 Populations)*, National Cancer Institute. Bethesda, MD. Summary available at: http://www.cancer.gov/types/breast/risk-fact-sheet#r1
3. Centers for Disease Control and Prevention. (2013). *Injury Prevention & Control: Data & Statistics (WISQARS)*. Atlanta, GA: Centers for Disease Control and Prevention. Accessed at: www.cdc.gov/injury/wisqars/index.html on 20 August 2013.
4. Breiding, M.J., Chen J., & Black, M.C. (2014). *Intimate Partner Violence in the United States — 2010*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
5. Moyer, VA on behalf of the U.S. Preventive Services Task Force (2013). "Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: U.S. Preventive Services Task Force Recommendation Statement." Ann Intern Med. 2013;158:478-486.

6. Centers for Disease Control and Prevention. (2011). *Pregnancy Risk Assessment Monitoring System 2011 Data.* Atlanta, GA: Centers for Disease Control and Prevention. Accessed at: http://www.cdc.gov/prams/pramstat/index.html June 2015.
7. Chang J, Berg CJ, Saltzman, LE, Herndon J. "Homicide: a leading cause of injury deaths among pregnant and postpartum women in the United States, 1991–1999." American Journal of Public Health. 2005; 95: 471–477
8. Krug EG et al., eds. (2002). *World report on violence and health*. Geneva, World Health Organization.
9. Catalano, Shannan. (2013). *Intimate Partner Violence: Attributes of Victimization, 1993-2011*. Ed. Vanessa Curto and Morgan Young. Rept. No. NCJ 243300: U.S. Department of Justice. Print.
10. Campbell, J. C., Webster, D., Koziol-McLain, J., Block CR, Campbell, D., Curry, MA, Gary, F, Sachs, C. Sharps, PW, Wilt, S., Manganello, J., Xu, X. (2003). Risk factors for femicide in abusive relationships: Results from a multi-site case control study. American Journal of Public Health, 93, 1089-1097
11. Child Death, Near Death and Stillborn Commission. (2013). Child Death, Near Death and Stillborn Commission Annual Report. Wilmington, DE. Accessed at: http://courts.delaware.gov/childdeath/docs/AnnualReport2013.pdf
12. Weinsheimer, RL, CR Schermer, LH Malcoe, LM Balduf, and LA Bloomfield. (2005). "Severe Intimate Partner Violence and Alcohol Use Among Female Trauma Patients." *The Journal of Trauma*. 58.1: 22-9. Print.
13. Rodriguez, M., Bauer, H., McLoughlin, E., & Grumbach, K. (1999). Screening and intervention of intimate partner abuse: practice and attitudes of primary care physicians. *Journal of American Medical Association*, *282*, 468-474
14. Beynon, C. E., Gutmanis, I. A., Tutty, L, M., Wathen, C. N., & MacMillian,H. L. (2012). Why physicians and nurses ask (or don't) about partner violence: A qualitative analysis. *BMC Public Health*, *12*, 473.
15. Bott S, Guedes A, Guezmes A. The health service response to sexual violence: lessons from IPPF/WHR member associations in Latin America. In: Jejeebhoy S, Shah I, Thapa S, eds. Non-consensual sex and young people: perspectives from the developing world. New York: Zed Books; 2005. pp. 251-268.
16. Reproductive and sexual coercion. Committee Opinion No. 554. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013; 121:411-5. Accessed at: http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co554.pdf?dmc=1&ts=20150311T1613530784