



# **Task Force on Domestic Violence Report**

**As Required By  
H.B. 2620, 83rd Legislature, Regular Session, 2013**

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# 1. Executive Summary

House Bill 2620, 83rd Legislature, Regular Session, 2013 created the Task Force on Domestic Violence (Task Force) and charged it with examining the impact of domestic violence on mothers and children and identifying ways to improve services to this population. The legislation also directs the Task Force to identify protocols and make recommendations for the coordination of services, including improving early screening, detection, and public awareness efforts for this important issue. This report provides an update on implementation of the legislation.

The Task Force developed the following principles to provide context for its recommendations and guidance on how to implement them:

- Domestic violence is a preventable public health epidemic that adversely impacts the health and well-being of pregnant women, mothers, and their children.
- A child's health and well-being is dependent upon the health and well-being of his or her mother.
- Health care providers have an ethical duty and are uniquely positioned to improve outcomes for pregnant women, mothers, and their children affected by domestic violence.
- Effective care must be driven by individual patient needs and requires a meaningful connection between health care providers and pregnant women, mothers, and their children affected by domestic violence.
- An intentional, coordinated and comprehensive approach among health care providers, health care systems, domestic violence experts, and other community stakeholders promotes the health and safety of pregnant women, mothers, and children affected by domestic violence.

The Task Force established four committees (research, education and protocols, services, and policy) to complete the research and develop recommendations for the Legislature and state agencies. The strategies and initiatives below are a compilation of those the Task Force recommends for implementation by health care providers, state agencies, and nonprofit organizations that provide services for domestic violence victims.

- Health care leaders and local domestic violence experts should create a set of policies and practices related to domestic violence that would be available to domestic violence service providers. Below are examples of policies and practices that generally would be appropriate to include:
  - Instructions for use of signage, brochures (including legal resources), and collateral materials to create a safe environment for disclosure of abuse.
  - Procedures for domestic violence screening.
  - Protocol for response to disclosures of domestic violence.
  - Policies regarding continuing education for health care providers.
- First responders to domestic violence should coordinate services among health care professionals, social services, law enforcement, and other community supports. First responders also must ensure there is adequate and ongoing provider training and education on domestic violence regarding service coordination.
- A team of domestic violence experts should create off-the-shelf training packages for organizations providing domestic violence services. The packet should include information

on how to use the curriculum, including guidance on adult learning principles and suggestions for adapting the curricula to the services provided by that organization.

- The Texas Council on Family Violence should maintain an updated service directory for the general population as well as for health care providers, community supports, and the spectrum of health care services for pregnant and postpartum women and their babies.
- Domestic violence should be included in core education standards at medical, nursing, and midwifery schools and residency programs, and questions regarding domestic violence should be incorporated into relevant health licensing board exams. Continuing education opportunities, including grand rounds, should address domestic violence.

These recommendations should evolve as perspectives and practices change and be reviewed at fixed intervals. Rooted in its guiding principles, Task Force members stand firm in the need for implementation of the recommendations listed in this report. As Nancy Sheppard, Seton Healthcare Network Perinatal Outreach Coordinator, said, “Babies are incredible catalysts for change.”

## 2. Introduction

*Twenty-eight-year-old Breshuana Jackson was killed by Tyrone Allen at her mother's home in Dallas, on April 15, 2013. On December 3, 2013, 17-year-old Megan Hernandez was stabbed and killed by her ex-boyfriend, Eduardo Reyes, also 17.*

Over the years, domestic violence agencies have recognized and responded to domestic violence in a variety of ways. Beginning with the creation of safe spaces for victims to go in times of crisis, the movement then turned to criminal and civil justice reforms that have had a lasting effect. Although those involved in domestic violence advocacy have more work to do in these areas, advocates and policymakers have come to realize the need for further attention and innovation in settings where victims and potential victims come for one of their most basic needs: health care.

Breshauna and Megan helped drive this need home. Breshuana, who was pregnant at the time of her murder, is survived by her five children, ages two to ten. When Megan was killed, she was holding her infant daughter, who survives her today.

The Task Force on Domestic Violence (Task Force), established by H.B. 2620, 83rd Legislature, Regular Session, 2013, began with the central tenet that domestic violence is a pervasive public health problem throughout the United States, and it results in a host of negative mental and physical health problems. Nationally, one in four women has been physically and/or sexually assaulted by a current or former partner.<sup>1</sup> In Texas, a recent prevalence study found an even higher incidence of victimization with one in three women reporting being victimized by a current or former partner.<sup>2</sup> Practitioners and advocates have long identified pregnant women as particularly vulnerable to domestic violence due to heightened relationship stress and the increased physical, social, emotional, and economic demands of pregnancy.<sup>3</sup> Additionally, domestic violence during pregnancy significantly impacts pregnancy outcomes as well as the short- and long-term health of mother and baby.<sup>4</sup>

Pregnancy, childbirth, and young children all prompt increased interaction with health care providers and services. As Nancy Sheppard, perinatal outreach coordinator for Seton Healthcare Network, said, "Babies are incredible catalysts for change." Pregnant women and mothers tend to trust and look to their health care providers as sources of credible information and as a trusted

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<sup>1</sup> United States Department of Justice. *Crime in the United States, 2010*. Federal Bureau of Investigation, Uniform Crime Reports, Washington, DC, 2011.

<sup>2</sup> *Statewide Prevalence of Intimate Partner Violence in Texas*. University of Texas School of Social Work Institute on Domestic and Sexual Violence. 2011.

<sup>3</sup> *Violence against pregnant women; Prevalence, patterns, risk factors, theories, and directions for future research*. Tallieu, T.L. and Brownridge, D.A. 2010, *Aggression and Violent Behavior*, Vol. 15, pp. 14-35.

<sup>4</sup> *Intimate partner violence and adverse pregnancy outcomes: a population-based study*. Janssen PA, Holt VL, Sugg NK, Emanuel I, Critchlow CM, Henderson AD. *American Journal of Obstetrics and Gynecology*, 2003, 188(5):1341-1347.

adviser when it comes to their families' wellness. Furthermore, pregnancy and caring for a new baby is a time when women may be more receptive to ideas and options presented by their providers and motivated to make choices to improve their families' well-being.

In 2013, the Texas Vital Statistics Unit of the Department of State Health Services (DSHS) reported 387,110 births in the state. For these babies and their moms, the perinatal period offers important opportunities to provide information on the impacts of domestic violence on health. It also provides the opportunity for screening and brief interventions in health care settings for domestic violence and referral to domestic violence prevention and intervention services.

Providers need and deserve the information, tools, and partnerships necessary to effectively engage with pregnant women and new mothers around the personal safety and health concerns presented by domestic violence. With these tools, the health care community can make a significant and positive impact on the long-term health of Texas families. The clear take away from the work of this Task Force is that health care workers can save lives they may not even know are in danger by incorporating prevention and intervention strategies into their practice.

### **3. Background**

#### **3.1 Legislative**

Recognizing the immense potential the health care community could have on the safety and well-being of women, children, and families, the Texas Council on Family Violence and provider stakeholders began considering potential policy approaches related to domestic violence and the perinatal period. For some time, these stakeholders have worked at the national and state levels in a variety of areas related to health and domestic violence looking for opportunities to foster closer ties between the two fields. The Texas Legislature created a task force composed of health care providers, researchers, educators, and survivors of domestic violence to spur conversation, coordination, and ultimately meaningful, evidence-based recommendations.

House Bill 2620 established the Task Force with the following duties:

- Examine the impact of domestic violence on maternal and infant mortality, the health of mothers, and the health and development of fetuses, infants, and children.
- Identify the health care services available to children age two and younger and mothers and explore opportunities for improving the ability of those services to address domestic violence.
- Identify methods to effectively include domestic violence information and support in educational standards for educators and protocols for health care providers.
- Investigate and make recommendations relating to the coordination of health care services for children age two and younger and pregnant and postpartum women who are victims of domestic violence, including recommendations for improving early screening and detection and public awareness efforts.
- Submit a report addressing these issues to the Legislature and state agency executives by September 1, 2015.

## 3.2 Membership

House Bill 2620 dictated the membership of the Task Force (Appendix A) with an eye toward inclusion of health care providers and responders, as well as domestic violence advocates. Gloria Aguilera Terry, Chief Executive Officer of the Texas Council on Family Violence, served as presiding officer, and Dr. Jeff Temple, director of behavioral health and research in the Department of Obstetrics and Gynecology at The University of Texas Medical Branch, served as vice chair.

The Office of Health Coordination and Consumer Services within the Health and Human Services Commission (HHSC) provided staffing for the Task Force and oversaw the membership selection process. The Task Force acknowledges HHSC staff members for their contributions to this process.

## 3.3 Activities

The Task Force met six times. All meetings were in Austin, open to the public and accessible by webcast with opportunity for public comment at each meeting. The Task Force hosted presentations by researchers with the National Institutes of Health who helped illustrate many of the dynamics related to the particular vulnerabilities and opportunities for pregnant women and their children. They also met with a panel of survivors who discussed their experiences with domestic violence during pregnancy and the health care system's response to their situations. Additionally, the Task Force hosted a panel representing state agencies with work relevant to the Task Force.

The Task Force used a committee process to fulfill its charge with many of the recommendations originating in committees and being vetted by the Task Force at large.

## 3.4 Terminology

After considering other commonly used terms, the Task Force agreed to use “domestic violence” for this report. In doing so, the group defined domestic violence as a pattern of behavior and tactics used to gain or maintain power and control over a current or former intimate partner that can include physical, sexual, emotional, economic, or psychological abuse or threats of abuse.

The Task Force recognizes the widely used term “intimate partner violence” (IPV), another label often used particularly in the health care arena, to describe the dynamics of domestic violence. Texas Family Code uses “family violence” to describe what advocates, law enforcement, and others typically term domestic violence. Definitions of family violence, however, generally include household members, close relatives, and certain types of child abuse, which goes beyond the scope of this Task Force.

While recognizing that any individual, regardless of race, age, gender, sexual orientation, religion, socioeconomic background, or education level, can be a victim or perpetrator of domestic violence, the Task Force focused on pregnant women and new mothers as potential victims per its legislative charge. As such, the Task Force decided that "domestic violence's"

historical and practical usage best represents the prevention and intervention efforts envisioned by H.B. 2620.

In this report, "victim" is used in conjunction with occurrences of domestic violence and corresponding response variables, whereas "survivor" refers to someone who has healed and is moving forward.

### **3.5 Guiding Principles**

After hearing from speakers, including survivors, and reflecting on their knowledge and experiences, the Task Force developed a set of principles to frame its work and provide guidance for recommendations and future collaboration. The group developed and vetted these principles through a consensus-based process and offers them to policymakers and other readers as guideposts for understanding the direction and importance of the recommendations explained below:

- Domestic violence is a preventable public health epidemic that adversely impacts the health and well-being of pregnant women, mothers and their children.
- A child's health and well-being is dependent upon the health and well-being of his or her mother.
- Health care providers have an ethical duty and are uniquely positioned to improve outcomes for pregnant women, mothers and their children affected by domestic violence.
- Effective care must be driven by individual patient needs and requires a meaningful connection between health care providers and pregnant women, mothers, and their children affected by domestic violence.
- An intentional, coordinated, and comprehensive approach among health care providers, health care systems, domestic violence experts, and other community stakeholders promotes the health and safety of pregnant women, mothers, and children affected by domestic violence.

## **4. Analysis**

The Task Force established four committees, each focused on one aspect of the Task Force's charge: research, services, education and protocols, and policy and public awareness. The work and outcomes of each committee are summarized below.

### **4.1 Research**

House Bill 2620 required the Task Force to examine the impact of domestic violence on maternal and infant mortality; the health of mothers; and the health and development of fetuses, infants, and children. To that end, the Task Force's research committee reviewed literature related to the prevalence and impact of domestic violence on women's health with a particular focus on perinatal health and domestic violence screenings. (See Appendix B for the committee's paper on intimate partner violence.)

## *Screening*

In many ways, the topic of screening for domestic violence in health care settings helped underscore the need for the Task Force. Long seen as an important opportunity to intervene, the health care sector's response has been proactive and extensive, but incomplete. The practice of offering information about available resources and inquiring about domestic violence has developed over time in response to the significant danger that domestic violence presents to the health outcomes of children and families. At the same time, inquiring about domestic violence and following through with resources requires clearly defined protocols to be effective.

The research committee evaluated the current state of screening practices in the United States. The U.S. Preventative Services Task Force, the American Congress of Obstetricians and Gynecologists<sup>5</sup>, the American Academy of Family Physicians, and the American Academy of Nursing<sup>6</sup> recommend routinely screening all women of child-bearing age for domestic violence. The research committee determined that the importance of screening has been established, but insufficient research exists to recommend a specific screening tool or approach to implement across the diverse health of care settings.

## *Evidence*

Task Force members noted that when discussing evidence, the medical field generally relies on scientifically tested and validated evidence to direct practice, while domestic violence advocates tend to prioritize expertise rooted in the experiential evidence of listening and understanding survivors' stories. Recognizing differences in terminology and approaches between disciplines proved helpful in forming productive, working relationships among Task Force members. As the domestic violence experts began to understand what resonates with health care providers and vice versa, members engaged in conversations that resulted in recommendations grounded in research with real world applications.

The research committee developed the following list of topics for researchers (and funders) to advance the design and implementation of health care-based prevention and intervention strategies for pregnant women and new mothers:

- Examples of effective information, screenings, and interventions in the perinatal period in health care settings.
- Barriers to survivors disclosing their experiences with domestic violence to health care providers.
- Why violence often escalates during pregnancy.
- The impact of parental stress on the escalation of conflict and the consequences of childhood

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<sup>5</sup> *Intimate Partner Violence. Committee Opinion No. 518.* American College of Obstetricians and Gynecologists. 2012. *Obstet Gynecol.* Vol. 119, pp. 412-417.

<sup>6</sup> *Screening and counseling for violence against women in primary care settings.* Amar, A., et al. 2013, *Nursing Outlook*, Vol. 61, pp. 187-191.

exposure to the stress.

- The effects of domestic violence on the emotional development of children.
- Long-term outcomes of domestic violence prevention and intervention strategies for perinatal women.

The Task Force recommends mixed-methods research designs, which provide a deeper understanding of the impact on participants. Domestic violence experts, as well as health care providers and representatives from domestic violence shelters, should be involved in the development of research questions and study designs, as well as the interpretation and dissemination of findings.

### *Screening for Domestic Violence in Perinatal Health Care Settings*

Domestic violence experts and service providers place a great deal of attention on health care providers' ability to detect or identify patients who are victims of domestic violence. In most cases, health care providers accomplish this by being alert to warning signs of victimization or by screening patients for victimization. Although it is important for providers to recognize and understand potential indicators of abuse, not all victims of domestic violence present outward signs of abuse. Furthermore, screening in the health care context often occurs with otherwise asymptomatic patients. This means that if a provider already suspects or learns of abuse, the situation calls for an intervention, including a referral to a local domestic violence program, rather than a screening. The Task Force recommends that practitioners combine any screening or direct inquiry with information about domestic violence, its impact on the health of mothers and babies, and other resources available. The Task Force offers the following recommendations to help health care providers incorporate domestic violence screenings into their practice:

### *Recommendations for Effective Screening in Health Care Settings*

1. Use signage and printed materials to demonstrate that the setting is a safe place to discuss domestic violence.
2. Convey in tone and approach that you, as a health care provider, care about the overall well-being of patients and their families.
3. Display and make readily available information about domestic violence and how it can impact the health of women and children. Materials should be relevant to the specific patient populations served.
4. Discuss domestic violence in private with only the patient and health care provider present. Do not discuss domestic violence in the presence of or within hearing range of family members or partners.
5. Invite domestic violence experts to join in the development of policies for screening or selection of a screening tool. Ensure the tool and approach are relevant to the setting and the patient populations served and are available in multiple languages where needed.
6. Receive training on the information and screening tool to build comfort and efficacy with both.
7. Add information about domestic violence and screenings to routine visits (e.g., prenatal visits, post-partum depression screenings, and vaccinations).

8. Stay current on research and other new developments related to screening and evaluate both patient and provider experiences with screenings.

Providers and other health care settings have a variety of screening tools to consider incorporating into their practice. Weaving information and screenings together creates a patient-centered approach, which allows victims to consider the dynamics of their situations and whether this is a safe time and setting to disclose.

## 4.2 Services

The services committee focused on identifying the health care services available to pregnant women, new mothers, and their babies and how those points of contact can be better used to address domestic violence. To illustrate the points of access and illuminate opportunities for better service coordination, the services committee envisioned an elliptical structure as in Figure 1 rather than a linear continuum.

Recognizing that women often access services for themselves and their babies at the same time, a process known as "layered care," providers should be encouraged to utilize mental health specialists as resources for patients at all points of contact. Regardless of specialization, all health care providers that encounter pregnant women, new mothers, and their babies must understand their patients' reality and have knowledge of the other providers she sees or takes her children to in order to promote greater health literacy, effective and protective parenting, and avoid giving contradictory advice.

Home visits, including Nurse-Family Partnership and other models offered through the Texas Home Visiting program at HHSC and the Prevention and Early Intervention division of the Department of Family and Protective Services (DFPS), are among the community-based supports available to women and their babies.

**Figure 1: Health Care Elliptical**



Moreover, state medical associations, including the American Congress of Obstetricians and Gynecologists (District XI), Texas Association of Obstetricians and Gynecologists, Texas Chapter of the American Academy of Pediatrics, and Texas Academy of Family Physicians, as well as other organizations represented on this Task Force, should share information on an ongoing basis with their members and peers. These agencies possess a unique ability to foster greater coordination of the care of pregnant and newly postpartum women and their babies, specifically as it relates to addressing domestic violence.

As Figure 1 demonstrates, each service domain blends into the other, making clear the close, influential relationship among various health care services. Thus, when one provider educates patients about the potential health implications of domestic violence for a woman, her pregnancy, and her children, that provider raises both the patient's health literacy and awareness of domestic violence. Even if the patient is not involved in an abusive situation at the time or is not ready to disclose, she will be more receptive to the next opportunity to receive information or participate in a screening. She will begin to see the health care settings as safe places and health care providers as informed supporters with whom she can discuss domestic violence. She may then be able to offer accurate information and support to other women. Every provider in the spectrum of services is part of a health care team or circle of care for pregnant women, new mothers, and babies, even if they do not practice in the same setting.

Keeping these realities in mind, providers should implement policies and procedures that take advantage of this opportunity to either introduce information regarding domestic violence and bolster patient understanding and trust around discussing these issues with health care providers. Health care leaders should create these policies and procedures in collaboration with local domestic violence experts. The Task Force believes this approach promotes better health outcomes. For example, an obstetrician/gynecologist (OB/GYN) physician who discusses domestic violence and its impact with a pregnant woman in her first trimester might connect the patient to support services that help prevent pre-term birth resulting from abuse and the costly outcomes related to early delivery. Similarly, a clinician providing postpartum care might screen for both domestic violence and postpartum depression and effectively take steps to treat both, improving the health of the mother and her baby.

Knowing and forming relationships with local domestic violence advocacy services is a critical component of coordinating health care services. In 2014, domestic violence organizations in Texas provided emergency shelter to 23,311 persons, mostly women and their children. These providers also offer a constellation of support services in addition to shelter, such as counseling, legal advocacy, and children's services. According to the HHSC Family Violence Unit, 61,119 adults and children received nonresidential services at domestic violence programs in 2014. Greater familiarity with these programs will address a top reason many providers are reluctant to discuss domestic violence—that they are not aware of resources or services for patients who are or have experienced domestic violence. To overcome this barrier, the Task Force recommends that health care providers or clinic administrators meet with their local domestic violence programs to learn about available services and how to make "warm referrals."

Together, providers and programs should develop a protocol in which local domestic violence programs provide on-call services for referrals from health care providers, develop safety plans,

and talk through specific situations and concerns. Domestic violence advocates maintain a current understanding of the resources and programs available to families and are conduits for information and connections between health care services, community supports, and the spectrum of health care services for pregnant and postpartum women and their babies. Texas Council on Family Violence's [service directory](#) lists the providers in Texas by name and city. In addition, advocates at the National Domestic Violence Hotline can provide a directory of services across the country, and they are available to talk with survivors and providers and offer safety planning assistance.

Other community supports and programs may also come into play for families at different points on the spectrum of need. Realizing this, the Task Force calls on health care practitioners to identify and connect patients with community supports that benefit the health and functioning of the whole family. For instance, the DFPS Prevention and Early Intervention division and home visiting services through the Texas Home Visiting program, both represented on this Task Force, offer valuable services to families in many communities throughout the state. In certain situations, the Office of the Attorney General's (OAG) Child Support Division, also represented on the Task Force, may have involvement with families. Trained and certified by the OAG, birth registrars operate in hospitals and work with families following a birth to complete an Acknowledgement of Paternity in the hospital. This process legally establishes paternity of the child for unmarried parents. Paternity and subsequent legal orders for support and custody of a child convey specific benefits to families and children as well as potential risks when domestic violence is a factor. [Citation: Osborne, Cynthia et al. (2014). In-Hospital Paternity Establishment: A Study of Staff, Parents, and Policy. Child and Family Research Partnership.] Certain protections exist in Texas law, such as protective orders, neutral exchange and supervised visitation features, that can be included in orders and may ameliorate some of these risks. Medical-legal partnerships have demonstrated the immense benefits of connections between health care settings and legal services for both patients and practitioners.

The Task Force also recommends that, as a matter of course, settings that serve pregnant women, new mothers, and babies should have basic legal information and referrals available, such as the [Texas Advocacy Project](#) Family Violence Legal Line, the [Texas Legal Services Center](#) Health Law Program, and [Texas Law Help](#).

### 4.3 Education and Protocols

The education and protocols committee gathered information on domestic violence trainings and protocols for medical providers. The committee surveyed 55 health care and educational agencies and teaching hospitals. From the 25 organizations that responded, the education and protocols committee learned the following:

- Fifty-eight percent of the respondents indicated that their organization offers education/training on domestic violence.
- Respondents conduct internal training through various departments, including human resources, risk management and safety, and training.
- Sixty-nine percent of respondents use published materials for domestic violence education.

- A slight majority of respondents (55 percent) indicated their organization has no protocol for when patients or clients disclose domestic violence.

Respondents listed a lack of the following as impediments to ensuring their students, staff, and members receive domestic violence training:

- Acceptance that there is a need for training.
- Readily available tools.
- Financial resources devoted to the issue.
- Knowledgeable internal trainers.

Respondents also identified the following challenges they or their community face helping survivors:

- Lack of awareness of existing services.
- Difficulties placing victims in safe facilities.
- Limited resources and capacity to respond to the demand for domestic violence services.

Based on these responses and the experiences of providers represented on the Task Force, the education and protocols committee concluded that providers need consistent, uniform information available in a variety of formats to accommodate diverse learning styles. The Task Force recommends that experts on the health impacts of domestic violence on pregnant and new mothers and their babies, as well as experts in providing services to domestic violence survivors, create training modules responsive to these findings. The Task Force also emphasizes the value of co-presentations by a medical expert and a domestic violence expert.

The Task Force also recommends that materials addressing domestic violence have standard, consistent messaging developed by subject-matter experts in state agencies, health care, academia, and direct services. Training should cover what to do following a disclosure of domestic violence by a victim, including familiarizing providers with local domestic violence advocacy services and hotlines. In addition, all education standards and protocols should be developed from a “preventable public health risk” viewpoint. Curricula should include information, activities, and examples inclusive of all Texans (e.g., gender, race, ethnicity, religion, age, physical and mental abilities, appearance, and sexual orientation).

The Task Force calls on the domestic violence services community to develop an ongoing consumer-oriented communication infrastructure that includes topic-specific websites, e-newsletters, calls-to-action, webinars, promotional materials, and awareness-building campaigns. (The [Centers for Disease Control and Prevention](#) provides a good example.) This work should be housed within a state organization so that it is readily available to all individuals and organizations.

The Task Force also recommends developing off-the-shelf training packages for organizations providing domestic violence services. A standardized approach in the form of an easy-to-use packet or toolkit would provide the framework for training that is consistent across organizations. Doing so will help organizations develop standards and protocols that are in line

with their internal needs. The toolkit should include background and descriptive information explaining why the toolkit was developed, who the target audience is, and who to contact for more information. The packet or toolkit should include instructions for how to use the curriculum, including guidance on adapting the curricula for specific audiences and learning types. An effective toolkit includes course planning forms and checklists; guidance on tailoring training to meet the needs of the organization and participants; specific, measurable, and realistic learning objectives; and methods for assessing and evaluating participants' learning and progress. Finally, domestic violence experts should develop training programs, including online education or distance learning modules, accessible to educators and health care providers.

“Grand rounds” are another valuable educational opportunity. Grand rounds provide continuing education credits required for most health care licensures. Most departments at major teaching hospitals have specialized, often weekly, grand rounds. Grand rounds are an important supplement to medical school and on-the-job resident training. With this in mind, the Task Force recommends the creation of a relevant presentation for grand rounds and a list of appropriate presenters.

The Task Force prioritizes the inclusion of domestic violence in core education standards at medical, nursing and midwifery schools and residency programs. For continuing education after residency, the Task Force calls for the incorporation of questions and standards regarding domestic violence into relevant health licensing boards (e.g., Texas Medical Board and Texas Board of Nursing) and certifying specialty boards (e.g., OB/ GYN, family medicine, pediatrics, and emergency medicine).

#### **4.4 Policy**

The policy committee reviewed the other committees' recommendations, mining them for broader policy recommendations and to further vet the practical implications of their findings. The Task Force posits that any policy directed at the diverse health care community must be grounded in evidence and generated from the expressed needs of medical practitioners for particular structure or direction. Applying prescriptive approaches broadly to disparate health care settings and providers without their input places policymakers and advocacy groups at odds with the medical community and will fail to yield intended results. The breadth of health care services involved in the care of pregnant women, mothers, and babies requires that specific health care settings, provider associations, and public programs create and implement policies relevant to their scope of services and roles to accomplish consistent practice. The Task Force recommends policymakers embrace the guidance set forth by this report and employ a process similar to this Task Force when formulating scalable policy solutions.

##### *Health Care Settings*

Because of the uniqueness of each health care setting, the Task Force recommends that health care administrators work with representatives across the health care spectrum to develop policies and practices related to domestic violence. This policy should include a plan to communicate broadly with patients using signage, brochures, or provider scripts that this setting is a safe zone for revealing that they are victims of abuse. The information could also provide information on

other resources, such as disclosing their abuse through the National Domestic Violence Hotline and local domestic violence programs. Additionally, an effective policy would include a protocol for providing universal information or screening to patients, including the response to disclosures of domestic violence and providing warm referrals to domestic violence services. Finally, the health care provider should set policies for initial and ongoing training on the identification and treatment of domestic violence in their practice.

Thoroughly vetted guidance for crafting these policies is available. The Task Force recommends that health care providers utilize the following publications by Futures Without Violence, formerly Family Violence Prevention Fund, to help guide the policymaking process.

- [\*National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings\*](#) by Family Violence Prevention Fund. In particular, the Task force found Appendix A: *Setting Specific Clinical Response to Domestic Violence Quick Reference Guide* on page 25 useful.
- [\*Addressing Intimate Partner Violence Reproductive Coercion and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings\*](#) by Futures Without Violence.

Several states have created protocols and policies that serve as a starting point for drafting health team policy.

- Ohio: [\*Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care\*](#), developed by the Ohio Domestic Violence Network and the National Health Care Standards Campaign Committee Ohio Chapter (2003) and revised by the Project Connect Protocol Committee (2012).
- Connecticut: [\*Model Health Care Institution Domestic Violence Policy\*](#) by the Connecticut Health Initiative for Identification and Prevention.
- Maryland: [\*Domestic Violence Policy Guidelines: A Model for Maryland's Healthcare Community\*](#) by the Maryland Health Care Coalition Against Domestic Violence.
- Washington: [\*Practice Guidelines for Working with Pregnant and Parenting Survivors: An Integrated Approach to IPV and Reproductive and Sexual Coercion\*](#), a project of the Washington State Coalition against Domestic Violence.

The Task Force calls for funding and development of similar statewide protocols or guidelines utilizing a multidisciplinary approach.

### *Professional Associations*

Each professional association represented on the Task Force should implement its own policy or guidance related to domestic violence, particularly in the perinatal period. Policy statements should include an affirmation of both the importance of screening for domestic violence and awareness among medical professionals regarding the resources available to them. Further, they should emphasize the coordination of care among health care professionals, social services, law enforcement, and other community supports, and they should make recommendations for provider education and adequate continuing education on domestic violence.

### *Public Programs and Services*

The Task Force recommends each state agency represented on the Task Force, with the approval of its executive leadership, review and integrate the recommendations of the Task Force as appropriate to their function. Further, at the discretion and direction of HHSC's Executive Commissioner, each health and human services agency should review and integrate the guiding principles and recommendations of this report. The Task Force underscores one recommendation from the [Strategic Plan to Reduce Child Abuse and Neglect Fatalities](#) produced by DFPS and DSHS in 2015: Strengthen support and screening for domestic violence during pregnancy as an important step to addressing physical abuse among infants.

Specifically the plan lays out the following actions:

- Form a DSHS-DFPS interagency workgroup to focus on domestic violence screenings and referral processes across community providers and develop a consistent, comprehensive, and evidence-based strategic plan.
- Coordinate this initiative with the Task Force for Domestic Violence, which is working with a broader group of partners to address these same issues relating to domestic violence screenings and processes.
- Identify, review, and catalog existing national materials, relevant HHSC enterprise programmatic resources, and service providers.
- Coordinate local partners to develop targeted strategies to address screening for domestic violence during prenatal and postnatal care.

Policies should reflect the Task Force's guiding principles and should be developed in collaboration with local domestic violence experts. The Texas Council on Family Violence can assist with policy development and provide introductions to local advocates. Policies should evolve as perspectives and practices change. A plan to review both patient and practitioner experiences in the implementation of policies are necessary to evaluate effectiveness and need for course corrections.

### *Public Awareness*

The policy committee discussed at length the appropriate audience for its recommendations. All Texans and society at large can benefit from greater awareness of domestic violence; shining a light on the challenges of exiting abusive relationships or ending abuse helps make the case that policymakers must prioritize prevention and intervention. That said, raising public awareness of the overall problem of domestic violence is outside the scope of the Task Force's legislative charge. As such, the policy committee narrowed the relevant audience for awareness to two distinct audiences: women who are pregnant or new mothers and health care providers.

For the first category of women who are pregnant or new moms, the Task Force recommends building on existing platforms and collateral material targeting this population. The DSHS's "Someday Starts Now" and "text4baby" sponsored by the National Healthy Mothers, Health Babies Coalition are both useful tools for increasing awareness among this population. In addition, the Task Force recognizes social media and other online events or venues can provide

additional opportunities to increase public awareness and recommends incorporating messaging about maternal and child health as it relates to domestic violence.

As previously mentioned, materials including information about domestic violence and the health of mothers and babies should be prominently displayed in health care settings in which new moms and their children seek or receive care. The National Health Resource Center on Domestic Violence, run by Futures Without Violence, provides palm cards, pregnancy wheels, and posters with specific health and domestic violence information often available free of charge. Specifically, public health settings under the purview of HHSC should display this information. High-priority settings include the following:

- Texas Women, Infants, and Children (WIC) program clinics.
- Clinics that provide services to patients under the following funding streams: Title V, DSHS Family Planning and Expanded Primary Health Care Program, and Texas Women's Health Program.
- The HHSC eligibility offices where families apply for Medicaid and Children's Health Insurance Program coverage.

Because domestic violence programs often serve pregnant women and new mothers, these offices should also include materials and signage that encourage victims to utilize available domestic violence services and information.

The Task Force encourages health care providers to continue taking steps to develop a deeper understanding of their role in preventing and intervening in cases of domestic violence. As one Task Force member said, "If they would only look in the women's eyes." The Task Force recommends a combination of public awareness campaigns and standardized education and protocols to help practitioners empathize with the women and children they serve.

The Task Force found that the best forums for promoting awareness among health care providers are those sponsored by professional associations (i.e., conferences and other events, member communications, and professional journals). Associations should make their members aware of policies and other information related to domestic violence in the perinatal period, and they should do so on an ongoing basis. Domestic Violence Awareness Month (October) and Health Cares about Domestic Violence Day (second Wednesday of October) are both important awareness-building opportunities. Furthermore, associations should include domestic violence as a common subject of discussion and inquiry among their members. Association or practitioner meetings and conferences should regularly offer sections related to domestic violence and the perinatal period, as well as invite domestic violence experts and service providers to speak or exhibit at events.

To promote a broad understanding of and normalize conversations about the health consequences of domestic violence, health-related awareness efforts must include information about the health impacts of domestic violence on pregnant women, new mothers, and their babies. Ultimately, connecting survivors to needed services and intervening to mitigate impacts of abuse are the keys to effectively addressing domestic violence.

## 5. Conclusion

The Task Force convened a dynamic group of representatives dedicated to maternal and child health and safety to chart a path forward for the Texas health care system's response to domestic violence among pregnant women and new mothers. Rooted in the guiding principles and through intentional processes of inquiry and reflection, Task Force members stand firm in the need for implementation of the recommendations listed in this report.

Any and all public health frameworks must incorporate strategies to address domestic violence within health care settings and must utilize a multidisciplinary approach to be successful. The prevalence of domestic violence and its nature as a *preventable* public health epidemic must drive a societal, professional, and individual imperative to thoughtfully address domestic violence among pregnant women and new mothers when they seek or receive health care.

Members of the Task Force call on policymakers, health care providers, and other readers of this report to take action, champion this effort, and implement the recommendations in Texas hospitals and doctors' offices and indeed in all venues where new moms and their young children come for help.

The Task Force dedicates its efforts to Brashauna and Megan and all other Texas moms and babies affected by domestic violence.

## List of Acronyms

<b>Acronym</b>	<b>Full Name</b>
AIDS	Acquired Immune Deficiency Syndrome
DFPS	Texas Department of Family and Protective Services
DSHS	Texas Department of State Health Services
H.B.	House Bill
HHSC	Texas Health and Human Services Commission
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
NVAWS	National Violence Against Women Survey
OAG	Office of the Attorney General
OB/GYN	Obstetrician/Gynecologist
STI	Sexually Transmitted Infection
Task Force	Task Force on Domestic Violence
U.S.	United States
WHO	World Health Organization
WIC	Women, Infants, and Children program at DSHS

## Appendix A

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## **Appendix B**

### **Task Force on Domestic Violence Research Committee Report on Intimate Partner Violence**

#### **Overview**

Intimate partner violence (IPV) is a serious and pervasive health problem in the United States (U.S.) and Texas. It is also known as domestic violence, interpersonal violence, battering, and spouse abuse. For this paper, we will use the term IPV. Violence between adult partners and the adolescent population occurs in all socioeconomic and ethnic groups and in heterosexual and homosexual relationships. It includes acts of physical and sexual violence and is often accompanied by emotional and verbal abuse, as well as controlling behavior. Though the incidence of male victimization by women is reported, male-to-female violence is often more repeated and is more likely than female-to-male violence to result in injury or death (1).

#### **Definitions**

While there is some discussion on crafting an exact definition of intimate partner violence (2), there is consensus in the scholarly literature regarding what behaviors comprise intimate partner violence. Intimate partner violence consists of physical abuse, sexual abuse, threats made against the self or family, and verbal abuse and often begins in adolescence (3; 2). Alhabib (2009) states that the acts involved in IPV perpetuate a violation of one's sense of self and trust. By engaging in physical, sexual, and emotional abuse, the perpetrator of IPV uses fear and intimidation to oppress another (4).

Physical abuse is defined as the act of using physical force with the intent to cause harm (2). Physical acts that constitute physical abuse include hitting, kicking, shoving, slapping, punching, or using a weapon against another person (4; 2; 5). Emotional abuse, which includes verbal abuse, occurs through constant ridicule, insults, put-downs, humiliation, and criticism (4; 2). Sexual abuse is defined (2) as engaging in any forced sexual activity, including the threat of forced sexual activity. The use of technology to stalk and intimidate a partner through cell phones and social media is recognized as part of a pattern of hurtful and controlling behavior.

#### **Prevalence**

Obtaining accurate rates of prevalence is difficult because IPV is often hidden and under-reported (3; 6; 5). Nonetheless, international, national, and statewide prevalence surveys have provided an understanding of prevalence rates. In a study conducted by the World Health Organization (WHO) of 10 countries, 15 percent to 70 percent of women reported being a victim of IPV at some point in their lifetime (5). Of those surveyed, 15 percent to 30 percent indicated that they had been a victim of IPV within the previous 12 months. The WHO determined that violence against women is a worldwide phenomenon, and that women are more likely to be at risk of violence by an intimate partner than men. Men are more likely to be at risk of a violent crime by a stranger.

The National Violence Against Women Survey (NVAWS) was conducted from 1995 to 1996, and included telephone interviews with about 16,000 U.S. residents (7). This landmark study found that nearly 25 percent of women and 7.6 percent of men had been raped and/or physically assaulted during their lifetime.

The National Intimate Partner Violence and Sexual Violence Survey (8) reports that three in ten women and one in ten men in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner with and have suffered an IPV-related impact. Approximately 26 percent of women reported fear; more than 20 percent were concerned for their safety; and more than 22 percent reported post-traumatic stress disorder symptoms as a result of the violence. Nearly 15 percent were injured and 10 percent missed at least one day of school or work (8). The U.S. Department of Justice reports that females ages 18 to 24 and 25 to 34 generally experienced higher rates of IPV than females of other age categories (9).

### **Prevalence in Texas**

The Texas Council on Family Violence reports that in Texas in 2012, 188,992 family violence incidents were reported; 114 women were killed by their intimate partners; and almost 12,000 women and 14, 534 children were sheltered. More than 191,000 hotline calls were answered and more than 25 percent of adults who needed shelter was not sheltered due to lack of space.

In 2011, researchers at The University of Texas at Austin's Institute on Domestic Violence & Sexual Assault conducted a prevalence study in Texas and concluded that Texans are experiencing considerable abuse and violence at the hands of their current or former intimate partners (10). Researchers estimated prevalence using 11 items that focused on physical and sexual violence. The 11-item questions were agreed upon by an expert group of leaders and practitioners in the family violence field, and the survey instrument was developed and modeled using the NVAWS; the Health Survey of Texans: A Focus on Sexual Assault; the National Intimate Partner and Sexual Violence Surveillance System; and a previous statewide prevalence study on sexual assault (7; 11; 8; 12).

Researchers interviewed a representative random sample of adult Texans (n = 1074) and concluded that one in three adult Texans – a total of 5,353,434 adult Texans – have experienced IPV in their lifetime. An estimated 3,069,421 women and 2,284,013 men (37.7 percent of Texas women and 26.8 percent of Texas men) have experienced at least one type of abuse over the course of their lifetime. Among Texas women, 23 percent reported physical violence alone; 2 percent reported sexual violence alone; and 13 percent reported both physical and sexual violence. Among Texas men, 24 percent reported physical violence alone; 1 percent reported sexual violence alone; and 1 percent reported both types of intimate partner violence. The most frequent three types of abuse reported by women were threats of physical harm; being slammed against something; and being choked, strangled, or suffocated. For men, the most frequent three types of abuse reported were being hit with a fist or something hard; threats of physical harm; and being kicked. More than 22 percent of women who experienced IPV reported becoming pregnant as a result of forced sex. At the time of the survey, Texans who reported experiencing abuse reported an ex-spouse (25 percent), ex-girlfriend (21 percent), and ex-boyfriend (14 percent) as the perpetrator of the abuse. Of those reporting victimization, an estimated 19.5 percent (21.8 percent of women and 16.5 percent of men) reported currently being in an abusive

relationship. This equates to an estimated 1,044,514 Texans (5.9 percent of all Texans) currently in an abusive relationship. Overall, 43.8 percent of participants who reported experiencing some type of IPV had one abusive partner. More than 22 percent reported having had two abusive partners. A smaller percentage of participants (8.5 percent) reported having 3 or 4 abusive partners (10).

### **Extent in Texas**

In the survey by Busch and colleagues (10), some participants reported only one incident or type of abuse, but many participants reported multiple incidences and types. More than 25 percent of women experienced 2 or more incidents, and more than 9 percent experienced 6 or more incidents. More than 14 percent of men reported 2 or more incidents of violence, and almost 1 percent reported 6 or more incidents.

These findings help us understand the types of violence and abuse Texans report, be it psychological abuse, coercive control and entrapment, physical violence, stalking, and/or sexual violence. Through this project, we also learned that a considerable number of Texans experience multiple types of abuse and violence – as many as 43 different types. In particular, Texans report high levels of psychological abuse. Results also shed an interesting light on the relationships Texans have with abusive partners. Among Texans who reported experiencing abuse, a majority reported it happening with a former partner, with only 19.5 percent reporting abuse by their current spouse. In addition, almost one-quarter of Texans reported having had more than one abusive partner (10).

A significant number of Texans are impacted by IPV. Moreover, the impact of physical and sexual violence in the lives women is profound. Women who are victimized report severe negative consequences to their health and well-being. Findings also suggest that, contrary to popular belief, many victims leave their abusive partners; only 19.5 percent reported victimization by current spouse or partner. While most Texans report that batterer intervention is important, it is unclear how many perpetrators seek or receive those services unless it is mandated by the criminal justice system (10).

### **National Perceptions and Attitudes**

In a 2006 national survey conducted by Murphy Marketing Research on behalf of the Allstate Foundation Domestic Violence Program and the National Network to End Domestic Violence Fund, 60 percent of 1,001 participants strongly agreed that IPV is a serious social problem in the U.S. Furthermore, 83 percent strongly agreed that IPV affects people across racial, ethnic, education, social, and economic status, and 74 percent of participants personally knew someone who had been a victim of IPV. This study also determined that only 25 percent of participants were able to accurately estimate incident rates in the U.S. (13).

### **Perceptions and Attitudes in Texas**

In Texas, 57 percent of Texans (an estimated 10,314,003 Texans) know someone – a friend, family member, or coworker – who has been in an abusive relationship (10). This is equivalent to more than 62 percent of Texas women and 54 percent of Texas men who know someone who

has been in an abusive relationship. Almost one-half of women (46.8 percent) and one-quarter of men (25.6 percent) consider IPV a *very serious problem* in Texas. This equates to an estimated 6,463,985 Texans (36.2 percent of all Texans) who consider this a *very serious problem*. A majority of Texans (50.9 percent of women and 42.2 percent of men) thought that the level of help the state provides is not enough. Roughly one-third of participants were not aware of toll-free domestic violence hotlines, such as the National Domestic Violence Hotline. More than one-half of participants (62.9 percent of women and 56.4 percent of men) were aware of local services for victims and survivors of IPV. Almost all participants (97.8 percent of women and 97 percent of men) reported that all survivors of IPV should have access to support services. Additionally, a majority of participants (85.2 percent of women and 79.8 percent of men) believed that, regardless of immigration status, all survivors should have access to these services. Almost all participants (89.4 percent of women and 83.2 percent of men) agreed that services for abusers are *important* or *very important* (10).

### **Perpetrators**

While Walker (6) concludes that being a woman is the single greatest risk factor for being a victim of IPV, the aforementioned prevalence studies indicate that men are victims of IPV as well. In 95 percent of IPV incidences, men are the perpetrators (4). A batterer, or perpetrator, is a person who engages in physical, emotional, and sexual abuse and other behaviors that exert control and power over their intimate partner (4). Batterers, both male and female, are not bound by their social, economic, ethnic, professional, education, or religious group associations; most have no criminal record (4). While alcohol and substance use are often present in violent relationships, there is no evidence to indicate that use of these substances causes violence perpetration or victimization (14).

One research team, Jacobson and Gottman (15), described two basic types of batterers: Pit Bulls and Cobras. Pit Bulls, as described by Jacobson and Gottman, are most likely to have insecure attachments with their partners manifested by extreme jealousy and control. The Pit Bull abuser, usually not violent outside the intimate relationship, may appear to be a good, loving partner from the outside, but displays manipulative, possessive, and jealous behaviors that are often methods to mask feelings of inadequacy and low self-esteem. Fearful of being abandoned, Pit Bull batterers resort to forms of abuse in order to maintain control and power in a relationship (4). Pit Bull perpetrators may make comments like “If I can’t have you, no one can have you.” The partner of a Pit Bull perpetrator is at highest risk for femicide when she tries to leave the abusive relationship. The majority of male batterers, an estimated 80 percent, are thought to fit into the Pit Bulls typology. Cobras, a smaller percentage of men who batter, are equally dangerous, though different. Cobra abusers are more likely to have been sexually or physically abused as children and are typically cruel, systematic, and deliberate in their abuse of a partner. Unlike Pit Bull abusers, Cobra abusers are often violent outside the intimate relationship and are often labeled as antisocial. Cobra abusers are more likely to have substance abuse, a psychiatric diagnosis, and a criminal record than Pit Bull abusers.

Whitaker (16) found some differences in male and female perpetrators of IPV. Women reported engaging in proportionately more physical and less psychological IPV than males. Women tended to attribute their violence to a lost temper; to make a partner listen; to make a partner do as they wanted; or to punish their partner. Males were more likely to attribute their violence to

getting back at their partner for verbal or physical abuse; escaping their partner; showing who is the boss; and self-defense. Lee and colleagues (17) reported that females with a history of experiencing parental abuse (i.e., being hit, slapped, or forced to have sex) are more likely to engage in violence perpetration in dating relationships, while sibling violence in childhood was predictive for male perpetration of dating violence in adulthood.

### **Health Consequences**

The health consequences of IPV are significant and preventable. Intimate partner violence can result in physical injury, psychological trauma, and death. Common physical injuries sustained in IPV attacks include lacerations, broken bones, dislocated joints, head and/or spinal cord injuries, dental injury, and internal injuries. Long term health consequences of IPV include unintended pregnancy; repeated miscarriages or spontaneous abortions; repeated exposure to sexually transmitted infections, including human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS); drug and alcohol use and abuse; inadequate self-management of diseases, such as diabetes and hypertension; and post-traumatic stress disorder.

### **Intersection with HIV**

Forced sex occurs in approximately 45 percent of physically violent intimate relationships (18) and women who experience IPV or sexual violence are less likely to use condoms consistently, even with safe sex practices education (19).

Because IPV is often associated with sexual violence and sexual coercion, victims of IPV are at increased risk for HIV exposure and infection. Women in relationships with IPV have four times the risk for contracting sexually transmitted infections (STIs), including HIV, than women in relationships without violence (20). Conversely, women who are HIV-positive often experience abuse that is more frequent and more severe than their non HIV-positive counterparts (20). Teen girls abused by male partners are three times as likely to become infected with an STI/HIV (21).

### **Reproductive Coercion**

Contraception can be particularly difficult to manage for women experiencing IPV. One specific form of abuse that may partially explain the intersection of partner violence with unintended pregnancy is reproductive coercion. Reproductive coercion includes overt pregnancy coercion and direct interference with contraception (22). Interference with contraception may include birth control sabotage such as inhibiting a woman's access to contraception, destroying birth control pills, breaking condoms or diaphragms, or removing contraceptive rings or patches.

Approximately 16 percent of adult females have experienced reproductive coercion and among those women who experience it, 32 percent experience IPV in the same relationship (23). Reproductive coercion does occur in relationships in which other forms of IPV are not present (24). Single women are as likely to experience reproductive coercion as are married women (23). Teen girls in physically abusive relationships were three to six times more likely to become pregnant (25). Teen mothers who experienced physical abuse within 3 months after delivery were nearly twice as likely to have a repeat pregnancy within 24 months (26). The extent to which reproductive coercion is associated with unintended pregnancy among victims of

IPV is not fully understood, but researchers have reported a positive association between IPV and unintended pregnancy (27; 22).

### **Impact on Health of Mothers**

Pregnant women are particularly vulnerable to IPV due to an increase in their physical, social, emotional, and economic needs during pregnancy (28). The physical effects of abuse during pregnancy can be devastating for both the mother and the infant and include:

- Poor, late, or absent prenatal care.
- Uterine rupture (a potentially life-threatening condition in which the uterine wall tears open).
- Premature rupture of the membranes (the surrounding amniotic sac around the baby which necessitates immediate infant delivery).
- Placental abruption (an emergency condition where the placental lining separates from the uterus, requiring immediate delivery of the infant).
- Premature delivery of the infant.
- Hemorrhage.
- Need for blood transfusion.
- Low infant birth weight.

One-quarter of one million hospital Emergency Room visits are a result of IPV where victims present with acute injuries to the head, face, breasts, abdomen, pelvis, and genitalia. The results of blunt trauma to the abdomen can result in injury to the liver, spleen, and other adjacent organs and hemorrhage. Blunt trauma to the pregnant uterus can result in serious physical injury to the mother, miscarriage, fetal injury, and fetal death. The abused woman may present with chronic complaints of headache, gastrointestinal complaints, chronic pain symptoms, and other somatization illnesses representing her chronic stress. Health care costs, both direct and indirect, are more than \$ 8.3 billion per year (29). More than 324,000 pregnant women are abused in the U.S. each year, representing 4 percent to 8 percent of pregnant women. The number is probably much higher secondary to many women being afraid to report (29; 30; 31).

Pregnant women experiencing IPV are often of younger maternal age or adolescent. This is often an unintended pregnancy with delayed, little, or no prenatal care. She frequently lacks social support. She may be a smoker and use alcohol or drugs. As a result of IPV coercion with lack of protection, she may contract STIs, HIV, or AIDS (31).

Because IPV usually occurs in many forms including physical, emotional, financial, and sexual, the abuser in the relationship may prevent her from having prenatal care; obtaining prenatal vitamins; having proper nutrition with resultant poor weight gain; preventing STI's; or attending substance abuse recovery programs (29; 31). The psychological effects on the abused pregnant woman can lead to anxiety; depression; new or worsening substance abuse with smoking, alcohol, and drugs in efforts to cope; and suicide (29).

Violence may also escalate after birth in the post-partum period (30). As in IPV during pregnancy, younger mothers tend to be a higher risk for postpartum violence and associated

health risks, which include postpartum depression, stress, infant sleeping problems, and poor negotiation for contraception. These problems can contribute to poorly-spaced, unplanned, and unwanted pregnancies, which further exacerbate the problem of IPV.

### **Impact on Health and Development of Fetuses**

Abuse of a woman during pregnancy has both direct and indirect effects on the fetus she is carrying. Spontaneous miscarriage, fetal injury, fetal death (stillbirth), preterm delivery, and low birth weight are direct consequences of physical injury (29; 31). The indirect effects to the fetus of chronic maternal stress, maternal smoking, and alcohol or drug abuse all related to IPV during pregnancy, lead to low birth weight, intrauterine growth restriction, and fetal alcohol syndrome (29; 31).

What happens to the child later in his life may well be pre-programmed from responses to chronic stress in utero. Some children of IPV victims appear to have neurodevelopmental disorders of Attention Deficit Disorder, delayed language, and behavior problems thought to be due to maternal/fetal in-utero response to the stress hormone cortisol (32).

The severity of the stress consequences to the fetus are a combination of the nature, timing, duration, and the mother's own sense of control over the stressor itself (33). When the brain responds to stress, it activates the fight or flight response in the body. This results in release of cortisol-releasing factor which crosses the placenta entering the fetal circulation. The mother increases her cortisol level, and the fetus responds as well. The normal diurnal production of cortisol is disrupted. When stress activates this process, it is usually a temporary event, but when it is chronically activated, the immune system, growth, and tissue repair are compromised (34).

There appears to be a direct link between maternal emotional states during pregnancy and subsequent changes in the fetus' brain structure. Children born to mothers who have levels of anxiety in the early second trimester have region-specific reductions in gray matter volume and later impaired executive function in middle childhood (33). Subsequent hyperactivity, inattention, behavioral, and emotional problems by age four have been linked to prenatal anxiety (34).

Entriger and colleagues recently published the first study to show in humans that early pregnancy stress exerts a programming effect on the telomere biology system in the fetus. This system is already present at birth. The length of the leukocyte telomere (LTL) is a predictor of later age-related diseases. Cord blood was analyzed at birth, and the LTL was found to be shorter in women who had experienced stress. The results were corrected for gestational age, birth, weight, sex, and antepartum maternal obstetric complications and the results still showed a shortening of the leukocyte telomere (35).

### **Impact on the Health and Development of Children**

Intimate partner violence has a significant impact on all aspects of development in children, including both physical and emotional. These effects can have life-altering consequences on children who are exposed to IPV. An estimated 275 million children worldwide (36) and 16.3 percent of U.S. children less than 17 years of age or younger witness physical assaults between

their adult caretakers in their lifetime in 1 year (37) with children under the age of 5 years being more likely to witness adult violence (38). Children exposed to IPV are 2.6 times more likely to be physically abused and 9.6 times more likely to be psychologically abused than children without such exposure (39).

*Physical Effects.* Children of every age are physically affected by exposure to IPV with infants and preschool children demonstrating poor weight gain, poor sleep, irritability, and regressive behaviors (40). Exposure to IPV is associated with under-immunization of children (41). This, of course, can have a significant impact on the health of both the child and the public in general. There also appears to be a relationship between childhood exposure to IPV and psychological distress and delayed milestone achievement in infancy as well as early childhood (42). Children exposed to IPV and psychological stress are less likely to achieve developmental milestones, including language and gross motor skills. Fine motor and language skills are most affected in children who were exposed only to IPV (42). In children exposed to psychological stress only, language and fine motor skills were most affected. There is a growing body of evidence that IPV, whether accompanied by psychological stress or not, impacts the development of children across all aspects of developmental milestones, including the physical domain (42).

*Psychosocial Effects.* The emotional effects of IPV on children are widely accepted by researchers as harmful to the emotional development of children (41; 36; 34; 42; 40; 43; 44; 45). Children's responses to witnessing IPV are generally described as internalizing or externalizing. Internalizing behaviors direct problematic energy inward and include depression, eating disorders, substance abuse, cutting, or other self-harm. Externalizing behaviors direct problematic energy outward and include antisocial behaviors, aggression, bullying, defiance, theft, and vandalism. Children exposed to IPV exhibit significantly more internalizing, externalizing, and total behavioral problems when compared to their counterparts who are not exposed to IPV. McFarlane and colleagues (40) compared the reporting of female caregiver's experience of IPV and behavior problems in children. Children whose caregivers were exposed to IPV exhibited both internalizing and externalizing behavior problems. Severity of the violence witnessed was associated with internalizing and externalizing behaviors. When witnessed violence was less severe, the relationship to child's behavior was less clear. When exposed to inter-parental violence as a child, girls tend to report more self-blame than boys (36).

Childhood exposure to IPV is related to an increase in risk-taking behaviors among children that continue into adolescence and adulthood. Parents who have difficulty parenting constitute the greatest at risk population and that exposure to witnessing violence has a known relationship between social and scholastic problems (42; 44; 45). Reducing parental stress may mitigate the development of IPV and prevent the development of resulting behavioral problems in children. The intersection of witnessing parental IPV and social and behavioral problems, particularly suicidal behaviors, urgently require evidence-based interventions to enhance the safety and well-being of children exposed to parental IPV (40). Children's exposure to IPV is associated with victimization and perpetration of relationship abuse in adolescence. Greater attention to the interrelatedness of children's exposure to violence and its impact on their relationship behavior is key to reducing and preventing IPV in adulthood (46).

## **Prevention and Intervention Programs for Pregnant and Postnatal Mothers**

Over the last four decades, prevention and intervention programs have been used to counteract the effects of IPV on women and their young children. These programs occur in several different settings. Three of the most common arenas for these programs are within clinics or medical facilities, through community-based organizations, and during home visitations (see Attachment A).

There are many community-based intervention and prevention programs for domestic violence, although very few target pregnant or postnatal women in particular. The programs that do target this population tend to be local in scope and focus on specific populations (i.e. particular demographic groups). Although there are significant differences between many of these programs, their goals are similar. These goals include providing emotional and social support to mothers experiencing IPV; increasing knowledge around parenting; reducing depression and other negative health impacts of IPV; and mitigating the negative impacts of IPV for children. Of programs that have been evaluated, successes include increases in positive parenting skills (47); development of positive coping mechanisms for children (48); increases in the knowledge base of parents and children around domestic violence and healthy relationships (47; 48); and reduction of health outcomes such as depression and post-traumatic stress disorder (49).

Home visitation programs are another arena where IPV prevention and intervention programs have seen some successes. Like the community-based programs, there is considerable variation between many of these programs. Nurses that participate in these programs execute prevention across the spectrum. In terms of primary prevention, they may provide parenting support (50; 51). In terms of secondary prevention, they may conduct screening for IPV or choose to visit homes identified as high risk (51; 52). In terms of tertiary prevention, they may provide targeted services to women already experiencing considerable violence in hopes of mitigating the negative effects to mother and child (53; 51). Some of the successful outcomes from these kinds of programs include increases in positive parenting skills; avoidance of child protective services; and decreases in the effects of post-partum depression and other health related issues in young mothers (51; 52). Some findings also show that maternal participation in home visitation programs can also help in reducing incidences and severity of IPV in those homes (54; 55; 51; 56).

Prevention and intervention programs can also take place within medical or health care settings. Within these settings the people trained to provide the interventions include nurses, physicians, and counselors. These programs include screening for IPV (57), either providing information about or connecting clients directly to community resources (58; 59); individualized case management (57; 55); and counseling support (55; 59). Successes of these kinds of programs include decreases in depressive symptoms; women's empowerment to leave abusive relationships; and reduction in incidences and severity of IPV.

One major gap in the literature is the lack of research regarding the long term impacts of many of these programs. One exception is a group of studies conducted by a group of researchers who evaluated the outcomes of home visiting nurse prevention programs in the short term (60) and then 15 years later (61). They found that of the families that received services through home visitation until the child reached two years of age, there were fewer reports of child

maltreatment. Eckenrode, et al, (62) utilized the same dataset and further clarified that the higher the number of reported DV incidents, the less likely there was a decrease in child maltreatment over the time period. The researchers suggested that this particular finding shows the importance of recognizing how interventions may be more or less effective depending on the group.

### **The LGBTQ Community**

There are limited statistics available related to the prevalence of IPV in the lesbian, gay, bisexual, transsexual, and queer (LGBTQ) population. The Texas Council of Family Violence does not specify sexual orientation when reporting rates of IPV. In an analysis of national data, 4 in 10 (43.8 percent) lesbian women and 6 in 10 (61.1 percent) bisexual women experienced rape, physical violence, and/or stalking by an intimate partner, while 1 in 3 (35.0 percent) heterosexual women were affected by IPV (63). These results reported from the National Intimate Partner and Sexual Violence Survey (63) take into account only IPV experienced by lesbian, gay, and bisexual individuals who responded to the survey and disclosed their sexual orientation. The survey does not include the rates of IPV among those who identify as transgender or queer. Overall, women who identified as LGBTQ experienced IPV at higher rates than women who identified as heterosexual (63; 64; 65; 66; 67).

As in heterosexual IPV, instances of LGBTQ IPV are under reported (68). Heterosexism leading to marginalization of LGBTQ individuals may contribute to under reporting (69; 70). The assumption that a person is heterosexual may prevent health care providers from asking for the person's sexual orientation masking incidences of IPV that are assumed to be heterosexual in nature (68). The discomfort of health care providers may prevent screening and appropriate interventions for same sex IPV. Reasons for underreporting are similar to underreporting of heterosexual IPV; however, there are specific issues that influence reporting for LGBTQ women. There is a mistrust of the criminal justice system and a belief that the police will not take reports of same sex IPV seriously (68; 71). Tradition gender role stereotyping that assumes women are nonviolent may contribute to a lack of recognition of same sex IPV by women in the relationship, criminal justice personnel, and social services (72; 73). In some cases fear of disclosure of sexual orientation and concerns about the custody of children prevent reporting (68; 71). The socio-cultural stigma associated with same sex couples can influence a person's ability to identify as part of the LGBTQ community and inhibit reporting IPV or misrepresenting same sex IPV as heterosexual IPV (68). Formal community resources may not be sought due to potential marginalization and discriminating responses or a lack of visible resources (68).

Health care providers need education on providing a supportive environment; validation of women's experience of IPV in same sex relationships; and information to provide patient-specific interventions for women in same sex relationships who experience IPV (68). Safe shelter and community resources should be available to women in same sex relationships and women should be encouraged to utilize informal support systems for help (68; 70). Research is needed in all areas of LGBTQ IPV to effectively meet the needs of this population.

### **Screening and Support**

Intimate partner violence is so prevalent that there is virtually no health care setting in which it might be reasonable to assume that patients would not be at risk for it. Stated another way, it is

reasonable and realistic to assume that victims of relationship violence will be encountered in all health care settings, particularly women's health and pediatric care settings. While men are increasingly victimized in intimate relationships, IPV disproportionately affects women in terms of incidence and health care consequences (74). Both the Institutes of Medicine and the American Academy of Nursing have endorsed routine screening and counseling of women regarding IPV (74).

Currently, only four states require screening of all patients for IPV (i.e., California, New York, Pennsylvania, and West Virginia). Texas does not mandate screening of all patients for IPV, but does require medical professionals who treat a person for injuries that they have reason to believe were caused by family violence to immediately provide them with information regarding the nearest family violence shelter; document in their file that they have been given such information and the reason for the health care professionals belief that the injuries were caused by family violence; and give them written notice regarding their rights, provided in Texas Family Code, Section 91.003. Mandatory reporting is most often not helpful to victims of IPV (75). Quality health care responses from providers include ongoing and supportive access to medical care, addressing safety issues, and guiding patients through available options. These actions are more likely when a victim of IPV believes that it is safe to confide in their health care provider without fear of repercussions that may result from mandatory reporting (75).

Routine screening and counseling means asking every patient at every visit about past and current experiences with stalking; physical, emotional, and sexual violence; and discussing safety options, including referral to sources of support for IPV (76). Combining screening with brief counseling and safety planning can increase women's safety behaviors (77).

Of the many routine screening tests required during pregnancy, IPV is more common than the maternal complications of diabetes, neural tube defects, and pre-eclampsia (extremely high blood pressure and high levels of protein in the urine) (31; 78). Kady noted that 85 percent of assaulted women in her large study (described above) had presented for at least one visit and might have been targeted for preventive IPV care (79). All women should be screened for IPV. The American Congress of Obstetricians and Gynecologists recommend routine screening (29), and routine screening during pregnancy is required in the Texas entitlement programs.

Health care providers may not screen for IPV for a number of reasons, but most often report that they fear offending a patient; are unsure about the best way to ask; or do not know how to respond to an affirmative response (80). There many screening instruments available for use by health care providers in general care settings or specific care settings. Most of these are described in detail in a document titled "*Intimate Partner Violence and Sexual Violence Victimization Instruments for Use in Healthcare Settings*" available on the Centers for Disease Control and Prevention website (81).

A comprehensive discussion about best practices for screening and supporting victims of IPV is beyond the scope of this paper. However, the body of literature about screening in cases of IPV (76; 74; 82; 83; 84; 80) can be summarized as follows:

- Every adolescent and adult woman should be screened during most health visits, even in the absence of physical indicators of abuse.

- Screening should be done when the patient is alone with the health care provider, not in the presence of or within hearing of family members or partners.
- Screening questions should be direct and kind and refrain from using words like victim, domestic violence, and IPV. An example might be, “Because violence is so common, I ask all of my patients about it. Are you afraid of anyone right now?” and “Have you been forced to engage in sexual activities when you didn’t want to?”
- Use nonjudgmental language that does not blame the victim and refrain from using language that is blaming (i.e., asking if she did something to provoke the abuse or why she does not leave).

### **Conclusion**

Intimate partner violence among adults and adolescents is a serious and pervasive health problem in the U.S. and Texas and necessitates further research (see Attachment B). The health consequences of IPV for victims, their unborn infants, and children who witness it can be devastating. Women in violent relationships may experience unwanted pregnancies or closely spaced pregnancies due to reproductive coercion, increased risk for HIV, and a number of other chronic health conditions. Miscarriage or premature birth often results from violence against a woman during pregnancy. A woman is very vulnerable to violence during and after pregnancy as violence often begins or escalates when a woman becomes pregnant. Infants born to victims of IPV may be small for gestational age; develop physical illness; or progress toward developmental problems initially or at a later date. Children who witness IPV are often victims of abuse themselves. Witnessing inter-parental violence can lead to behavioral, cognitive, social, and developmental problems in children with lifelong implications.

Victims of IPV have increased risk for HIV, and other chronic health conditions. Victims of IPV and their children often seek more health services than others (85) and are seen in a variety of settings. Because there is no health care setting in which victims of IPV might reasonably be expected to seek care, health care providers are well positioned to intervene with victims of IPV and to prevent some of the complications to victims and their children. Thus, a deliberate, evidence-based, and consistent approach by health care providers is needed to facilitate the best possible care and the best outcomes for victims and their children.

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### Attachment A: Summary of Current IPV Prevention Programs

Initiative	Initiative Focus	Brief Description	Supporting Research	Notes
Fourth R	School-based primary prevention	Evidence-based program that uses best practice approaches to target multiple forms of violence, including bullying, dating violence, peer violence, and group violence. By building healthy school environments we provide opportunities to engage students in developing healthy relationships and decision-making to provide a solid foundation for their learning experiences.	<a href="http://www.youthrelationships.org">www.youthrelationships.org</a> ; Reduced dating violence among boys.	
Did You Know Your Relationship Affects Your Health? (86)	Safety card intervention	A safety card can be used by health care providers to conduct a brief evidence-based assessment and intervention with adult women in health care settings. The wallet-sized card includes questions about IPV and reproductive coercion, as well as safety planning strategies and help resources.	(58) Positive outcomes were found for women in a randomized, controlled trial at four family planning clinics. Women who received the intervention showed a 71 percent reduction in experiencing pregnancy pressure and coercion 12-24 weeks later. They were also more likely to report ending a relationship because it was unhealthy or because they felt unsafe regardless of	<a href="http://www.futureswithoutviolence.org">www.futureswithoutviolence.org</a> <a href="http://www.healthcaresabotipv.org/wpcontent/blogs.dir/3/files/2013/04/Reproductive-HealthGuidelines.pdf">http://www.healthcaresabotipv.org/wpcontent/blogs.dir/3/files/2013/04/Reproductive-HealthGuidelines.pdf</a>

Initiative	Initiative Focus	Brief Description	Supporting Research	Notes
Hanging Out or Hooking Up	Safety card for adolescents	Health care providers are encouraged to use the wallet-sized brochure to educate youth annually, during health appointments, when the patient is by him/herself without parents, partners, or friends present (87).	whether they had disclosed a history of IPV.	<a href="http://www.futureswithoutviolence.org">www.futureswithoutviolence.org</a>
Connected Kids: Safe, Strong, Secure	Offers child healthcare providers a comprehensive, logical approach to integrating violence prevention efforts in practice and the community. The program takes an asset-based approach to anticipatory guidance, focusing on helping parents and families raise	The AAP recommends that discussion about dating and relationships should begin at the 11-12 year old well child visit, before patients start dating.  Connected Kids includes a Clinical Guide and 21 handouts for parents and teens topics such as bullying, discipline, interpersonal skills, parenting, suicide, and television violence.	(88) Connected Kids was well received by practices participating in the case studies, and all practices made significant progress in planning to implement and/or implementing Connected Kids during the project timeframe. The following were identified as characteristics of successful implementation: the program is being used, families are being helped, counseling is improved, residents are educated on the program (where applicable), there is increased awareness of	<a href="http://www.aap.org/connectedkids">www.aap.org/connectedkids</a>

<b>Initiative</b>	<b>Initiative Focus</b>	<b>Brief Description</b>	<b>Supporting Research</b>	<b>Notes</b>
	resilient children.		violence, provider-patient relationships are enhanced, connections are made with the community, and both patients and staff are satisfied with implementation.	
Home Visitation Programs	<p>Early childhood home visitation programs began in earnest almost 30 years ago. All programs operate under the belief that appropriate, early intervention is critical in preventing health, social, and economic problems before they become a family or societal crisis.</p>	<p>Supports families at increased risk for IPV including young, first-time parents, low-income households, parents with low education, and families in isolated areas who may lack access to other sources of social support.</p> <p>There are a number of models that have been successful nationally. Home visitation programs are encouraged to work collaboratively with a local domestic violence program to develop a Domestic Violence Protocol (89).</p>	<p>These programs are successful in improving child and family outcomes in child and family safety and stability, maternal and child health, and early childhood development</p>	<p><a href="http://www.futureswithoutviolence.org">www.futureswithoutviolence.org</a></p> <p><a href="http://www.nursefamilypartnership.org">www.nursefamilypartnership.org</a></p> <p><a href="http://www.tcfv.org/protocol-for-home-visiting-visitiation-guidelines">http://www.tcfv.org/protocol-for-home-visiting-visitiation-guidelines</a></p>

<b>Initiative</b>	<b>Initiative Focus</b>	<b>Brief Description</b>	<b>Supporting Research</b>	<b>Notes</b>
Mom's Empowerment Program	Supports mothers to discuss the impacts of violence on their child's development	The program has three goals 1. Reduce the level of mothers' traumatic stress and violence exposure. 2. Enhance mothers' safety and ability to parent under stress. 3. Provide support and resources in a group setting.	Supporting research: Howell, et al., (47) evaluated the program and found that there was a positive change in the mother's positive parenting score, but there was no finding that negative parenting behaviors decreased.	<a href="http://injurycenter.umich.edu/programs/moms-empowerment-program">http://injurycenter.umich.edu/programs/moms-empowerment-program</a>
Promundo	Education with men during the pregnancy of their wife or partner.	Trains health care providers to educate all men during prenatal visits on how to communicate better with wives and partners, raise children in nonviolent ways and understand their roles in maternal and child health.		<a href="http://www.promundo.org">www.promundo.org</a>
SafePlace	Skills for healthy, nonviolent relationships	Works in schools with adolescent boys who have been exposed to violence.		<a href="http://www.safeplace.org/expectrespect">www.safeplace.org/expectrespect</a>

## **Attachment B: Recommendations for Further Research**

1. Cultural and social influences on non-reporting.
2. Better understanding of why violence escalates during pregnancy.
3. The impact on IPV with regard to general health of children and utilization of health resources.
4. The impact of reducing parental stress on the development of violent arguments and subsequent childhood exposure.
5. The effect of the specific form of IPV and the impact on the emotional development of a child.
6. Reporting of internalizing behavior among adolescents and the discrepancies among adult reporting.
7. The relationship between dating violence and STI/HIV testing and diagnosis as well as potential areas for intervention.
8. The association of IPV on suicide attempt/completion.
9. The dynamics of reciprocal violence in same sex relationships including the willingness of partners to talk openly about the use of reciprocal violence.
10. Needs of LGBTQ victims of IPV regarding safe shelter. The availability of community resources and what type of community resources are accessed.
11. Acceptance of LGBTQ victims of IPV and their children in existing shelters.
12. Attitudes of health care providers who screen and care for LGBT victims of IPV.
13. Factors that influence the occurrence of IPV in same sex relationships.