

One Department: Overview of Activities On Violence Against Women

**2008-2009
*Office on Women's
Health***

**U.S. Department of Health and
Human Services**



**ONE DEPARTMENT:
OVERVIEW of ACTIVITIES ON VIOLENCE AGAINST WOMEN**

2008-2009 UPDATE

TABLE OF CONTENTS

ADMINISTRATION FOR CHILDREN AND FAMILIES.....03

ADMINISTRATION ON AGING.....25

CENTERS FOR DISEASE CONTROL AND PREVENTION.....28

HEALTH RESOURCES AND SERVICES ADMINISTRATION.....41

INDIAN HEALTH SERVICES.....47

NATIONAL INSTITUTES OF HEALTH.....51

OFFICE OF POPULATION AFFAIRS, OFFICE OF FAMILY PLANNING.....106

OFFICE ON WOMEN’S HEALTH.....161

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.....172

ONE DEPARTMENT: OVERVIEW of ACTIVITIES ON VIOLENCE AGAINST WOMEN

ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

Family Violence Prevention and Services Program

One in every four women and one in every thirteen men have experienced domestic violence during their lifetimes, 2.3 million each year. The Family Violence Prevention and Services Act (FVPSA) provides the primary federal funding stream dedicated to the support of emergency shelter and related assistance for victims of domestic violence and their dependents.

FVPSA formula grants are awarded to every State and Territory and over 200 Tribes, which subgrant funds to more than 1,200 community-based domestic violence shelters and 300 non-residential services programs, providing both a safe haven and an array of supportive services to intervene in and prevent abuse.

FVPSA-funded programs focus on both intervention and prevention. In fiscal years (FYs) 07 and 08, FVPSA-funded programs served 593,600 victims and their children and responded to 4.7 million crisis calls. FVPSA-funded programs not only provide a wide range of protective and supportive services to victims and their children, they also work to enhance community awareness and response to domestic violence; in FY 08, programs in 22 states provided 111,200 community education presentations. On September 17, 2008, 78% of identified domestic violence programs in the United States – or 1,553 out of 2,000 programs participated in a 24-hour survey. In just one day, 60,799 victims were served, 20,658 hotline calls were answered and 30,024 professionals and community were trained by these 1,553 programs. Shelter programs have been found to be among the most effective resources for victims with abusive partners. Staying at a shelter or working with a domestic violence advocate significantly reduces the likelihood that a victim will be abused again and improves the victim's quality of life. Since opening

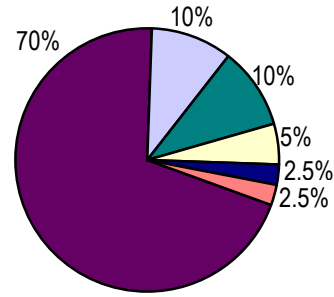
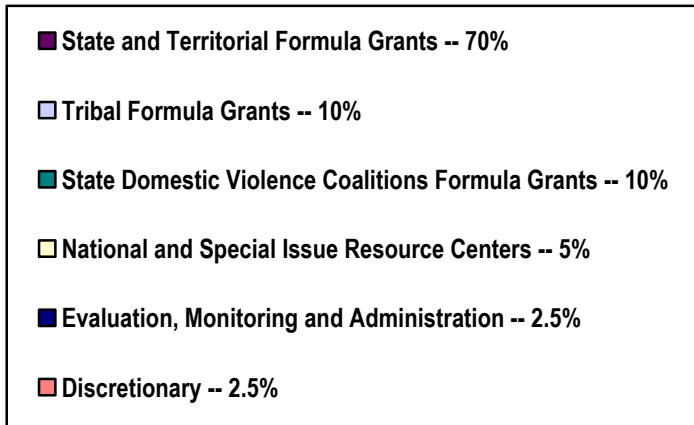
in 1996, the National Domestic Violence Hotline has received over 2 million calls and now averages 20,800 calls a month. More than 60% of callers report that this is their first call for help.

The statutory authority FVPSA (42 USC 10402 et seq.) as extended by the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, Pub. L. 110-329. FVPSA was first authorized as part of the Child Abuse Amendments of 1984 (PL 98-457) and has been subsequently amended seven times. It was most recently reauthorized for five years by the Keeping Children and Families Safe Act of 2003 (PL 108-36) and expired in 2008. The Violence Against Women and Department of Justice Reauthorization Act of 2005 (PL 109-164) made small amendments.

Program Operation

The Family Violence Prevention and Services Program (FVPSA Program) administers FVPSA formula grants to States, Territories and Tribes, State Domestic Violence Coalitions, as well as grants for national and special-issue resource centers. All grantees must apply for funds and meet the eligibility requirements. Competitive grant applications are peer-reviewed before selection.

The statute specifies how 97.5% of appropriated funds will be allocated, including three formula grants and one competitive grant program. The remaining 2.5% is discretionary, and used for competitive grants, technical assistance and special projects that respond to critical or otherwise unaddressed issues. The chart below illustrates the distribution of funds.



The FVPSA Program also administers the National Domestic Violence Hotline, which is a distinct program and receives its own line-item appropriation.

Domestic Violence Shelters

The bulk of FVPSA funds support, either directly or indirectly, local domestic violence programs. What do domestic violence shelters look like? Results from *Meeting Survivors' Needs: A Multi-State Study of Domestic Violence Shelter Experiences* and *Domestic Violence Counts 08: A 24-Hour Census of Domestic Violence Shelters and Services across the United States* help paint a picture of typical programs.

- Shelters provide immediate safety to victims and their children who are fleeing domestic violence. They also help victims heal their emotional wounds, rebuild their self-sufficiency, connect to their communities and stay safe long-term. Most programs operate shelters, hotlines, and outreach services 24 hours a day, 7 days a week.
- The average domestic violence shelter has 16 to 17 staff and 17 monthly volunteers. Seventy percent of programs have fewer than 20 paid staff, including 38% with less than 10 paid staff. The average starting salary of a full-time, salaried front-line advocate is \$24,765.
- Average capacity is 25 beds, with a range from 4 to 102, and 130 adults and 114 children sheltered in the last year.

- 98% of sampled shelters have the capacity to accommodate residents with disabilities.
- 82% have bilingual staff, including 71% who speak Spanish; sampled programs had staff/volunteers who speak 37 different languages.
- Programs offer a wide range of advocacy and services:

Type of Service or Advocacy and Percent of Programs Offering It			
Support Groups	97%	Health Advocacy	81%
Crisis Counseling	96%	TANF Advocacy	80%
Housing Advocacy	95%	Child Protection/Welfare	79%
Children’s Services	95%	Job/Job Training	78%
Individual Counseling	92%	Immigration Advocacy	76%
Civil Court Advocacy	82%	Divorce/Custody/Visitation	73%
Criminal Court Advocacy	81%		

State and Territorial Formula Grants (70%)

FVPSA State and Territorial formula grants make up 70% of FVPSA appropriations and are distributed based on a minimum award of \$600,000, with the remaining funds to be allotted to each State through a population-based formula. Grants are awarded to State, Territory and Tribal governments and subgranted to local domestic violence programs. States and Territories administer their grants in different ways, often through state health, child welfare or criminal justice agencies. Several States contract with their State Domestic Violence Coalitions to administer FVPSA funds at the state level. The Pacific Territories (Guam, American Samoa, the Northern Marianas, and the Trust Territory of the Pacific) have historically applied for and receive their funds through their consolidated social services block grants. The States and Territories each determine how to allocate FVPSA funds to local domestic violence programs. Some share funds equally among all programs and others use a competitive process. Several have complex formulas based on population and area served, while others focus on areas of need such as rural communities. If appropriations reach \$130 million, a portion of the amount above \$130 million will be reserved and made available to carry out additional projects to address the needs of children who witness domestic violence.

Tribal Formula Grants (10%)

American Indian and Alaska Native women are battered, raped and stalked at more than twice the rate of any other group of U.S. women. To address this problem, the FVPSA statute dedicates 10% of FVPSA appropriations to Tribes (including Alaska Native Villages) and Tribal Organizations. These Tribal Formula Grants are distributed based on population to all eligible Tribal governments who apply – over 200 Tribes in FY 08. These grants are primarily for the provision of immediate shelter and related assistance for victims of domestic violence and their dependents. In addition, funds may also be used in establishing, maintaining, and expanding programs and projects to prevent domestic violence. Funding is available to all Native American Tribes and Tribal Organizations that meet the definition of “Indian Tribe” or “Tribal Organization” at 25 U.S.C. 450b, and are able to demonstrate their capacity to carry out domestic violence prevention and services programs.

State Domestic Violence Coalitions Formula Grants (10%)

Each State, the District of Columbia, Puerto Rico and the U.S. Virgin Islands has a federally recognized Domestic Violence Coalition. These Coalitions serve as information clearinghouses and coordinate statewide domestic violence programs, outreach and activities. They provide technical assistance to local domestic violence programs (most of which are funded by subgrants from FVPSA State and Territorial formula grants) and ensure best practices are developed and implemented. Coalition activities are varied and may also include economic advocacy, partnerships with government agencies, and public awareness campaigns. Funds are divided equally among all Coalitions.

National and Special Issue Resource Centers (5% of total) and Culturally Specific Institutes (approximately 1.25% of total)

The FVPSA statute mandates a competitive grant program for one national and one Tribal resource center, along with three special-issue resource centers which focus on health care, civil and criminal justice, and child

protection and custody. Using FVPSA discretionary funds awarded through a competitive peer-review process, support has also been provided to five culturally specific institutes and an institute on trauma and mental health. Together, these eleven centers are national leaders, providing training and technical assistance as well as conducting research and creating evidenced-based responses to domestic violence. These programs are crucial to disseminating information to both FVPSA-funded domestic violence service providers and the broader network of professionals – including health care providers, law enforcement, court and judicial personnel, child welfare caseworkers, and educators – who reach victims and their children.

Other Discretionary Grants (approximately 1.25% of total)

The remaining half of the 2.5% of appropriated funds reserved for discretionary grants has supported collaborations within and beyond HHS, generally to respond to emerging issues. The FVPSA Program recently awarded discretionary Open Doors to Safety grants, designed to increase the capacity of State Domestic Violence Coalitions and local domestic violence programs to reach underserved populations. Five grants were awarded, three to expand accessibility of services to victims who are mentally ill, suffering from trauma or abusing substances, and two to serve incarcerated and formerly incarcerated victims. To address these hard-to-serve populations, Coalitions and local programs are building relationships with mental health providers, working closely with the FVPSA-funded resource centers and institutes, and sharing information with each other. Best practices developed through these grants will be disseminated nationally.

National and Special Issue Resource Centers and Culturally Specific Institutes

Technical Assistance (TA) and Training Statistics

	TA Request Responses ¹ FY 07	TA Request Responses ¹ FY 08	Trainings FY 07	Trainings FY 08	Training Participants FY 07	Training Participants FY 08
NRC DV	1,595	1,442	41	32	2,400	1,850
Sacred Circle	1,434	1,536	37	25	882	667
BWJP	3,168	4,925	40	73	3,295	3,798
HRC	950	1,044	40	50	2,200	1,150
RCDV	1,091	961	15	15	1,193	3,215
NCDV TMH	40	24	10	16	1,300	1,980
IDVAAC	2,500	2,500	45	52	2,150	2,535
APIIDV	163	156	21	17	939	978
Alianza	142	148	28	26	1,350	1,400
TOTALS	11,043	12,712	267	290	14,409	15,593

National Resource Center on Domestic Violence – www.nrcdv.org and www.vawnet.org

The NRC DV continues to employ three key strategies to enhance domestic violence intervention and prevention efforts – technical assistance and training, developing and disseminating specialized resource materials, and designing and implementing special projects that allow the NRC DV to focus more deeply on a particular issue or constituency group.

“We are a small rural program with a very small budget. All information we can use to overcome the many obstacles we face is beneficial and also helps staff morale.”

VAWnet, NRC DV’s online resource center supported by the Centers for Disease Control and Prevention, received an average of over 800,000 visitors annually (or over 2,000 daily visitors) during FYs 07 and 08, with an average of over 1,500 downloads. In FY 07 and 08, the NRC DV continued to develop and widely disseminate NRC DV publications and resources, as well

¹ Calls or other requests for technical assistance to which the grantee responded and provided support.

as those of our Domestic Violence Resource Network partners and others in the field.

The Women of Color Network, a project of the NRCDV, released its National Survey for Women of Color Advocates and Activists and several editions of “Women of Color Voices” Newsletter, as well as numerous facts on issues of importance to women of color activists, including dating violence, elder abuse, economic empowerment, and Lesbian, Gay, Bisexual, and Transgender (LGBT) issues.

The NRCDV developed the 2007 and 2008 Domestic Violence Awareness Month Packets and disseminated them to over 4,300 advocates and practitioners to support awareness and education activities at the community and state level.

Through the NRCDV's technical assistance, training, resource development and special projects, each year thousands of practitioners, policymakers, individuals and organizations have access to comprehensive, high quality, and free assistance, resources and support for their domestic violence intervention and prevention efforts. The NRCDV's collaborative approach allows them to extend and enhance both their efforts and those of their partners as they identify, organize and disseminate a wide range of materials and resources.

Sacred Circle: National Resource Center to End Violence Against Native Women – www.sacred-circle.com

Sacred Circle is the national resource center for all Tribal domestic violence

Tribal advocates have been very isolated from each other by geography, lack of resources, and lack of opportunity. Sacred Circle helps to de-isolate Tribal people and work. As one training participant remarked, “I never thought other people cared about us, as Indians, but I guess they really do!”

organizations. The main focus of their work is providing consultation, technical assistance, and training on domestic violence strategies and response to American Indian Tribes and Tribal organizations. Sacred Circle has particularly helped develop Tribal shelters that provide culturally appropriate services to Native victims in Indian Country.

Sacred Circle has been very successful in developing and providing information to the elected and informal Tribal leaders. This effort has created support for local Tribal domestic violence programs. Sacred Circle has

provided training, technical assistance, and consultation to 193 Indian Tribes and countless native and non-native organizations. Examples of this technical assistance include the following trainings:

- Establishing and Implementing an Effective Tribal Coordinated Community Response
- Sexual Violence in the Lives of Native Women
- Law Enforcement Response in PL 280 States (States with enforcement authority in Tribal lands)
- Response of Law Enforcement
- Batterers: Parenting, Visitation and Custody Issues
- Connections: Chemical Dependence and Battering
- Women Who Use Violence
- Probation: Tribal Systems Approach to Domestic Violence

A disabled Vietnamese victim's husband left her and took her three children three years ago. He is harassing her by phone and using her social security number. When she tried to get a new social security number, she was given a new card with the same number. We found a Vietnamese speaking advocate in her city to help her.

Battered Women's Justice Project: Criminal and Civil Justice Center – www.bwjp.org

A major focus of BWJP training efforts continues to be the enhancement of local efforts to coordinate the response of the criminal justice system to domestic violence cases. Each year BWJP sponsors a meeting of the Coalition Advocates and Attorneys Network that brings together staff from domestic violence coalitions around the country who are engaged in legal policy work in their individual states. In this way, state efforts are supported through the interchange of expertise within the group and from other national experts. Recent topics of discussion have included: trends in custody law, the overrepresentation of people of color and low income people in the Child Protection systems, and Economic Justice issues for battered mothers. During FYs 07 and 08, BWJP published several documents that addressed emerging legal issues.

Battered Women's Justice Project: National Clearinghouse for the Defense of Battered Women – www.ncdbw.org

Monica called our office collect from jail. She was terrified and didn't understand how she could be facing a murder charge when she had simply defended herself against her husband's violent attack. We supported her, spoke with her family, talked with her attorney, helped locate an expert witness and an advocate, and provided the defense team with sample motions and briefs. She was found not guilty at trial.

The NCDBW provides specialized technical assistance to defense teams (attorneys, expert witnesses, and advocates) working on cases that involve battered women charged with crimes related to their abuse. Most of these cases involve battered women who defended themselves against their

batterer's violence and were charged with assault or homicide. NCDBW is also working on developing comprehensive coordinated community responses to battered women charged with crimes.

The NCDBW has begun working intensively with five sites across the country – West Virginia, King County, WA (Seattle), Michigan, Kentucky, and Delaware – to help them develop or improve their responses to charged and incarcerated battered women, as well as to battered women returning to their communities after incarceration.

National Health Resource Center on Domestic Violence – www.endabuse.org

The HRCDV works to decrease long-term health care costs and consequences of domestic violence by educating providers on how to identify patients who are victims of abuse. The HRCDV offers model strategies and tools to health care providers and domestic violence/sexual assault programs to address and prevent the chronic health issues associated with exposure to abuse. For example, during FYs 07 and 08, the HRCDV developed patient safety cards with messages about reproductive coercion, pregnancy wheels with prompts for providers to ask about reproductive coercion, and posters for reproductive health care settings.

In Massachusetts, every family planning provider in the state has been trained on how to assess for violence and work with patients on how to prevent pregnancy in the context of an abusive relationship.

In FY 07, HRCDV reached thousands of providers through training and

technical assistance and worked to promote partnerships between health and public health professionals and domestic violence prevention advocates. In March of 2007 they convened the 4th National Conference on Health and Domestic Violence, co-sponsored by most of the major health associations in the country, and offering continuing medical education to the over 1000 providers and advocates who attended.

In FY 08, HRCDV continued their comprehensive reproductive health campaign designed to help health care providers and victim advocates reduce risk for unintended pregnancy, exposure to sexually transmitted diseases and improve reproductive health through violence prevention. They worked with major health associations to help them integrate violence prevention into efforts to promote wellness and prevention as part of any effort to decrease chronic health care costs.

Resource Center on Domestic Violence, Child Protection and Custody
– www.ncjfcj.org/dept/fvd

The RCDV provides technical assistance, training, policy development, and other resources that increase safety, promote stability, and enhance the well-being of battered parents and their children.

A specialist working in child welfare law in Hawaii requested information to help her develop her jurisdiction's juvenile dependency mediation program. The RCDV provided a copy of the Greenbook (Guidelines for Responding to Co-occurring Domestic Violence and Child Maltreatment), and walked her through tools, policies, and other resources. She developed a concrete program structure, policies and a training curriculum for new mediators.

The RCDV provides training throughout the country designed to increase the expertise and capacity of professionals in the field and improve the quality of provided services on issues relevant to child protection and

custody in the context of domestic violence. In FYs 07 and 08, RCDV staff and consultants provided training to over 4,700 participants across the nation and produced over 10 scholarly articles, resource guides, bench tools, and other publications for training purposes or for use as reference documents.

The National Center on Domestic Violence, Trauma, and Mental Health – www.nationalcenterdvtraumamh.org

The NCDVTMH develops comprehensive, accessible, and culturally-relevant responses to the range of trauma- and mental health-related issues faced by domestic violence survivors and their children. The Center offers information about current practice, model approaches and policies, and

successful collaborations as well as individualized training, capacity-building assistance, and consultation. The NCDVTMH focuses its activities in 3 main arenas: promoting dialogue among domestic violence and mental health organizations, policy-makers, and survivor/advocacy groups; helping local agencies, state coalitions, and state mental health systems increase their capacity to provide effective assistance to survivors of domestic violence who are experiencing the traumatic effects of abuse and/or living with mental illness; and improving policy affecting the complex life circumstances of domestic violence survivors and their children, particularly in relation to trauma and mental health.

A disability law center sought information for handling cases in which both a victim and a perpetrator of domestic violence are receiving mental health services at the same facility. We provided strategies for improving the mental health system's response to survivors of domestic violence with sensitivity to both victim safety and disability rights.

Key resources developed in FY 07 and 08 include tools and trainings for state and local advocates on creating welcoming, accessible, trauma-informed services, and capacity-building, a national symposium on domestic violence, trauma, and mental health, tip sheets on DV shelters and federal antidiscrimination laws, a matrix of state statutes on mental health confidentiality and state statutes on firearms and mental health, and multiple book chapters.

Alianza: The National Latino Alliance for the Elimination of Domestic Violence – www.dvalianza.org

Alianza is a national organization addressing domestic violence in the Latino population. Alianza promotes understanding, sustains dialogue, and generates solutions to move toward the elimination of domestic violence affecting Latino communities by: increasing public awareness about the devastating effects of domestic violence on Latino families and communities;

identifying and promoting research and practices that inform public policy and that lead to the development of culturally competent strategies and programs; and providing training and technical assistance to organizations and individuals that provide domestic violence related services to Latino Communities.

Alianza continues to receive and respond to requests for assistance, information, and resources from people around the country and Mexico. The requests ranged from answering questions about basic domestic violence in Latino communities and information about services provided by Alianza, to requests for referrals to domestic violence programs and educational materials in Spanish. Having materials accessible for downloading on their website has proven to be an effective way to distribute information across the nation. Though no longer an official Institute, Alianza is funded through the end of FY 09.

Alianza provided training and resources on HHS-priority issues:

- Developing strategies that build upon cultural and community strengths and eliminate barriers to services for Latino victims;*
- Working with men and boys to end domestic violence;*
- Training for HHS Office of Refugee Resettlement Healthy Marriage grantees on domestic violence;*
- Working with Latino communities on the intersection of domestic violence, mental health and trauma*

[Asian and Pacific Islander Institute on Domestic Violence – www.apiahf.org/apidvinstitute](http://www.apiahf.org/apidvinstitute)

The Hmong women’s advocates’ caucus at the National Summit provided momentum for a Midwest initiative on abusive international marriages in the Hmong community. This resulted in two forums of Hmong advocates and community leaders to develop strategies to address the issue.

Furthering the goals of strengthening advocacy and cultural competency, changing norms to prevent gender violence, and influencing systems change, APIIDV activities in this period focused on advancing work with constituents and national partners on several key issues: abusive international marriages, civil legal issues, mental health and trauma of refugees and immigrants, and sexual violence.

In November 2007, the APIIDV convened a National Summit Confronting Gender Violence: Advocacy and Activism in Asian & Pacific Islander Communities. This Summit brought together the leadership of the API

battered women’s movement with 200 advocates, researchers and policy-makers representing 70 domestic violence agencies and 20 national and state-wide organizations. Eleven ethnic specific caucuses – Arab, Chinese, Filipino, Hmong, Japanese, Korean, Muslim, Native Hawaiian and Pacific Islander, South Asian, Vietnamese, and Cambodian/Lao/Thai – met to set the national agenda for their communities.

Within their national network, there is a high demand for replicable community engagement tools and models that are effective in building awareness of domestic violence dynamics in Asian, Native Hawaiian and Pacific Islander communities. The APIIDV developed and broadly disseminated a skit, *Blanketed by Blame, Empowered by Support: Maya’s Story*, a dramatization of how a community responds when a battered woman seeks help. The skit illustrates the differences between harmful, victim-blaming responses and those that validate and support. Since they disseminated the skit, at least eight organizations have used it in their community organizing activities and adapted it for Chinese, South Asian, and Latino audiences.

[Institute on Domestic Violence in the African American Community – www.dvinstitute.org](http://www.dvinstitute.org)

Much of the work of IDVAAC during FYs 07 and 08 has been to assist communities across the country in engaging community members and expanding their awareness about how domestic violence affects the African American community broadly and certain communities specifically, as well as inform them about approaches and resources to address those effects.

IDVAAC completed a video on domestic violence – Aftermath of Katrina: Crescent House New Orleans. The video describes what we have learned regarding addressing the issue of domestic violence in the midst of a catastrophe. It was shown at the International Family Justice Center Conference (500 people) to a standing ovation.

IDVAAC has been working to develop the “African American Peace Project” in Detroit MI, Denver, CO, Los Angeles, CA, and Tacoma, WA. This project includes developing city-based newsletters, community based assessments, bringing together community leaders, and developing web-based resources including city-specific blogs. IDVAAC hopes to expand this

project across the United States. In FY 08, IDVAAC developed two newsletters with circulations of 16,000 per year. They completed two Special Issue journals and conducted webcasts on topics such as Fatherhood and Domestic Violence, Engaging the African American Community to Address Domestic Violence, and Prisoner Re-entry and Domestic Violence.

Encuentro Latino National Institute on Family Violence –
www.latinodv.org

The ELNIFV provides free technical assistance, training, and consultation informed by the recommendations of Latino survivors of domestic violence. They increase understanding of domestic violence in the Latino community through research and dissemination of culturally competent approaches, and promote best practices for Latino populations by providing information and web-based resources on promising programs, implementation and evaluation. ELNIFV helps providers and others develop capacity to effectively serve Latino clients. This new institute received funds in the last quarter of FY 08 and does not yet have training and technical assistance statistics to report.

Immigrant Family Institute – www.iistl.org

The IFI is a project-specific coalition of domestic violence and immigrant and refugee service providers in six US cities brought together to begin the process of integrating their respective practices to enhance delivery of domestic violence services to immigrants. The IFI will develop and disseminate culturally appropriate promising practices for domestic violence services to immigrant women in 18 cities around the nation. The IFI currently has a working draft of a psychosocial assessment tool, legal protocols and a culturally attuned safety plan for review and testing within six partner agencies. This new institute received funds in the last quarter of FY 08 and does not yet have training and technical assistance statistics to report.

National Domestic Violence Hotline

The Hotline is funded with its own line-item appropriation and is not part of the formula that funds all other FVPSA grants. Appropriations for the Hotline were \$3 million in FY 07 and \$2.9 million in FY 08.

The National Domestic Violence Hotline provides a live and immediate response to thousands of victims of domestic violence and their families. In FY 07, the Hotline received 235,639 calls. Call volume increased 9.6% in FY 08 to 250,119 calls. The Hotline directly connects the caller to a seamless referral system of over 5,000 community programs in response to the needs of the women, men, youth and children on the line. The Hotline operates 24 hours a day, 7 days a week and is available in 170 languages. Over 60% of callers report that this is their first call for help.

On September 30, 2008, the Hotline received its 2 millionth call. The Hotline averaged 20,800 calls per month in FY 08. Current growth rates project the Hotline will receive its 3 millionth call in 2011, which is less than half the amount of time it took to reach the first million. Demand for Hotline services continues to climb steadily due to effective outreach through mass media and community-based public awareness campaigns, and improved access for multi-lingual callers.

Not only have total calls increased, but calls have become more complex. The average length of calls increased 24 percent between FY 2007 and FY 2008 – from 6.79 minutes to 8.4 minutes. The number of calls requiring use of translation services provided through the AT&T Language Line also increased 20 percent over FY 2007. Additionally, the Hotline reported that response time was affected by call spikes experienced when the Hotline was featured on nationally syndicated television shows, such as the Oprah Winfrey Show and Spanish-language television. For example, on two days on which the Hotline number was aired on Oprah and on *Despierta America*, a popular Spanish-language morning show, call volume increased over 130 percent.

Research

The FVPSA program recently funded *Meeting Survivors' Needs: A Multi-State Study of Domestic Violence Shelter Experiences*. The study was administered by the National Institute of Justice, and conducted by the University of Connecticut's Institute for Violence Prevention and Reduction at the School of Social Work in conjunction with the National Resource

Center on Domestic Violence. The final report is available at www.vawnet.org. This unprecedented study surveyed 3,410 shelter residents in 215 programs across 8 states and was offered in 11 languages.

Nearly 99% of shelter residents described shelter as helpful, 91% reported they now have more ways to plan for and stay safe after leaving the shelter, and 85% know more community resources to help achieve that safety. These positive outcomes are associated with longer-term improved safety (less violence) and well-being in experimental, longitudinal studies. These outcome measures will be used in a new program evaluation and data collection plan beginning in FY 09.

In addition to data about the efficacy of FVPSA-funded shelter programs, the study reveals details about domestic violence shelters and the experiences of domestic violence survivors utilizing their services. Qualitative data from the study is telling; one victim replied that if shelter hadn't been available, "Probably I would have been killed. Cause I had nowhere else to go."

Collaboration

Indian Health Service (IHS) Collaboration

The FVPSA Program partnered with the Indian Health Service and two FVPSA-funded domestic violence national resource centers to improve the health care offered through tribal health clinics for those experiencing domestic violence. In 2008, the initiative expanded from 27 to 42 pilot sites.

Federal Greenbook Initiative

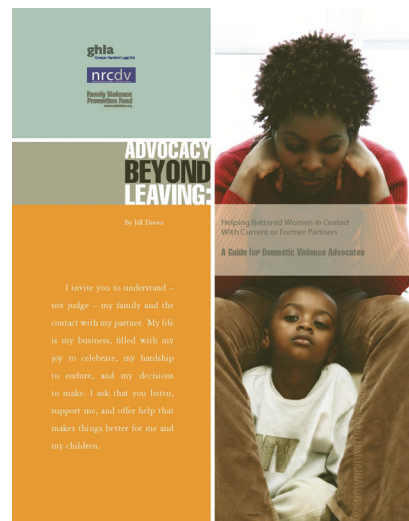
Through a collaboration of 8 offices in the Departments of Justice and Health and Human Services, this initiative supported demonstration projects, technical assistance and a national evaluation to test the effectiveness of national guidelines on addressing the co-occurrence of domestic violence and child maltreatment in the courts, child welfare agencies and domestic violence programs.

Runaway and Homeless Youth

In partnership with the Runaway and Homeless Youth Program in FYSB, the FVPSA Program funded efforts in 17 States and local communities to develop collaborative services for runaway and homeless youth experiencing or at risk of experiencing dating violence.

Building Leadership in the Domestic Violence Community: Demystifying Work with Fathers Who Batter

This meeting of domestic violence advocates, technical assistance providers, Fatherhood Program experts and federal agencies laid the groundwork for identifying strong practice in working with men with a history of violence. The focus was on promoting change, supporting safe fathering, and building the capacity of domestic violence programs to collaborate with responsible fatherhood programs. In conjunction with this effort, the FVPSA Program supported the Family Violence Prevention Fund's development of a field guide for domestic violence advocates helping battered women who are in contact with partners who have been abusive.



Child and Family Service Review Strategy Development Meeting

This meeting of child welfare and domestic violence advocates, national resource centers, the Children's Bureau and FYSB focused on developing effective strategies to address the co-occurrence of domestic violence and child maltreatment in the caseloads of child welfare agencies.

Intra-agency and Interagency Efforts to End Domestic Violence

The FVPSA Program has been an active member of and leader within five collaborative workgroups, ranging from an internal HHS network to an advisory council of expert informants from the field. These workgroups are

described in the FYSB workgroup section. In addition, in cooperation with the Department of State Office on International Women's Issues, the FVPSA Program provided training for international domestic violence programs via international Digital Video Conferences and hosted briefings for several delegations from around the world.

Office of Refugee Resettlement, Anti-Trafficking in Persons Division

The Anti-Trafficking in Persons Division (ATIP) in the Administration for Children and Families (ACF), Office of Refugee Resettlement (ORR), administers HHS' responsibilities under the Trafficking Victims Protection Act of 2000 (TVPA). The TVPA defines trafficking in persons as "sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age" or "the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery." Throughout anti-trafficking efforts there exist common threads with efforts to address domestic and gender-based violence, in particular in programs addressing the prevention and effects of sex trafficking.

The Anti-Trafficking program in ORR aims to protect victims of trafficking by providing benefits and services to help them rebuild their lives in the United States, and contributes to the prevention of trafficking by conducting a public awareness campaign; supporting the formation and work of local, multi-disciplinary anti-trafficking coalitions; and funding outreach to vulnerable populations. ATIP also funds the operation of the National Human Trafficking Resource Center (NHTRC), which hosts the national anti-trafficking hotline.

1. Certifications and Letters of Eligibility

The TVPA authorizes the "certification" of adult victims to receive certain federally funded benefits and services and ATIP issues these certifications to non-U.S. citizen, non-Lawful Permanent Resident (LPR) adult victims of

human trafficking. Though not required to receive certification, minors who are found to be victims receive “Eligibility Letters” from ATIP to obtain the same types of benefits and services.

In FY 2008, ORR issued 286 certification letters to adults and 31 Eligibility Letters to children, for a total of 317 letters issued. Of the victims certified in FY 2008, 55 percent were female, compared to 70 percent in FY 2007 and 94 percent in FY 2006. In comparison, 77 percent of minor victims who received Eligibility Letters in FY 2008 were female. Overall, 76 percent of all victims certified in FY 2008 were victims of labor trafficking, 17 percent were exploited through sex trafficking, and five percent were victims of both labor and sex trafficking. Fifty-five percent of minor victims who received Eligibility Letters were victims of sex trafficking, 26 percent were victims of labor trafficking, and six percent were victims of both labor and sex trafficking.

Certification should not be equated with victim identification. HHS grantees and contractors work with trafficking victims at every stage of the victim identification process, from initial contact with suspected victims who might not be ready to work with law enforcement to helping certified victims rebuild their lives. Other victims may elect to return to their country of origin without seeking benefits in the U.S. ATIP provides victims identified by our non-governmental partners with an array of services that will assist them in the pursuit of certification, should they so choose.

2. Per Capita Services and Case Management

ORR has a contract with the U.S. Conference of Catholic Bishops (USCCB) to provide comprehensive support services to victims of human trafficking. During FY 2008, a total of 644 clients received case management services through the Per Capita Services and Case Management contract. This number included 215 pre-certified victims, 270 certified victims, and 159 family derivatives (spouse, children, or other dependents) who received services.

3. Minor Foreign Trafficking Victims

Unaccompanied children (those without a parent or legal guardian in the U.S. who is willing or able to provide care) who are victims of trafficking may be referred to ORR's Unaccompanied Refugee Minors (URM) program. The URM program establishes legal responsibility for these children, under State law, to ensure that unaccompanied children receive the full range of assistance, care, and services available to all foster children in the State; a legal authority is designated to act in place of the child's unavailable parent(s).

ORR's Division of Unaccompanied Children's Services (DUCS) program funds a network of shelters, group homes, and foster care programs to provide services for unaccompanied alien children who are in immigration proceedings. DUCS care provider facilities, which operate under cooperative agreements and contracts, provide children with classroom education, health care, socialization/recreation, vocational training, mental health services, family reunification, access to legal services, and case management. Children referred to the DUCS program are screened for potential trafficking concerns and, where credible information is found, assessed for eligibility for benefits and referred to federal law enforcement for possible investigation of the case. Identified trafficking victims who have no family reunification options in the U.S., and are in need of safe, long-term placement, may be referred to the URM program.

4. Rescue and Restore Victims of Human Trafficking Coalitions

The Rescue and Restore coalitions consist of dedicated social service providers, local government officials, health care professionals, leaders of faith-based and ethnic organizations, and law enforcement personnel. The goal of the coalitions is to increase the number of trafficking victims who are identified, assisted in leaving the circumstances of their servitude, and connected to qualified service agencies and to the HHS certification process so that they may receive the benefits and services for which they are eligible. Along with identifying and assisting victims, coalition members use the Rescue and Restore campaign messages to educate the general public about human trafficking.

In FY 2008, HHS worked with anti-trafficking Rescue and Restore coalitions in 25 areas: Houston, Texas; Las Vegas, Nevada; New York, New York; Milwaukee, Wisconsin; Newark, New Jersey; Philadelphia, Pennsylvania; Phoenix, Arizona; Portland, Oregon; St. Louis, Missouri; San Francisco, California; Sacramento, California; Louisville, Kentucky; Nashville, Tennessee; Columbus, Ohio; Cincinnati, Ohio; San Diego, Los Angeles, and Orange Counties in California; and statewide in Colorado, Idaho, Florida, Georgia, Illinois, Minnesota, and North Carolina.

5. Building Anti-Trafficking Capacity at the Regional Level

Building capacity to identify and serve victims at the regional level is the heart of the HHS anti-trafficking program. ATIP helps build anti-trafficking infrastructure by providing financial assistance to existing programs of direct outreach and services to populations among which victims of human trafficking could be found in order to support and expand these programs' capacity to identify, serve, and seek certification for trafficking victims in their communities.

ATIP funds intermediary organizations to serve as the focal points for regional public awareness campaign activities and the intensification of local victim identification, encouraging a cohesive, collaborative approach in the fight against modern-day slavery. ATIP's street outreach grants support direct, person-to-person contact, information sharing, and counseling. Some of the vulnerable populations to whom grantees provide outreach are homeless, runaway, and at-risk youth; women and girls exploited through the commercial sex industry; and women forced to work in beauty parlors and nail salons.

6. The National Human Trafficking Resource Center (NHTRC)

Originally established in 2004 and strategically revamped in 2007, the NHTRC has emerged not only as a highly respected 24/7 trafficking victim referral crisis line, but also as the premier U.S. Government source for anti-trafficking educational materials, promising practices, and training opportunities. Under the management of the Polaris Project, the Resource Center's call volume has increased substantially and remains consistently

high—averaging, since December 2007, approximately 400 calls per month regarding trafficking tips, service needs, and training requests. NHTRC also provides 24/7 responses to email tips and inquiries. From December 2007 through the end of FY 2008, NHTRC received a total of 4,147 calls, including 553 tips regarding possible human trafficking incidents, 398 requests for victim care referrals, 949 calls seeking general human trafficking information, and 167 requests for training and technical assistance.

ADMINISTRATION ON AGING (AoA)

According to the 1998 National Elder Abuse Incidence Study, women make up 71 percent of the victims of domestic elder abuse. AoA has a strong commitment to protecting seniors from elder abuse. Our community-based long-term care programs allow millions of seniors to age in place with dignity. AoA also supports a range of activities at the state and local level to raise awareness about elder abuse. These activities include training law enforcement officers and medical professionals in how to recognize and respond to elder abuse cases, conducting public awareness and education campaigns, and creating statewide and local elder abuse prevention coalitions and multi-disciplinary teams.

AoA funds the National Center on Elder Abuse (NCEA) to serve as a resource for the public and for professionals. The NCEA is a multi-disciplinary consortium of equal partners with expertise in elder abuse, neglect, and exploitation. NCEA provides elder abuse information to the public and to professionals; offers technical assistance and training to elder abuse agencies and related professionals; conducts short-term elder abuse research; and assists with elder abuse program and policy development. It manages an elder abuse list serve for professionals in the field, and it produces a monthly newsletter. NCEA's website contains many resources, including a list of the state elder abuse hotlines and information on publications, community coalitions, and upcoming conferences. For more information, please see the NCEA website at:

<http://www.elderabusecenter.org>.

Domestic Violence in Later Life

Some experts view late life domestic violence as a sub-set of the larger, elder abuse problem. Elder abuse, broadly defined, includes physical, sexual and emotional abuse, financial exploitation, neglect and self-neglect, and abandonment. The distinctive context of domestic abuse in later life is the abusive use of power and control by a spouse/partner or other person known to the victim. As the “baby boom” generation born between 1946 and 1964 ages, it is likely more victims of late life violence and abuse will seek out or be referred to the specialized services provided by domestic violence programs. This potential calls for increased collaboration between aging and domestic violence networks to assure maximum support and safety for victims and survivors of abuse in later life.

No matter what the victim's age, abusers' tactics are remarkably similar. Abusers frequently look for someone they can dominate, people believed to be weak, people unlikely or unable to retaliate. With respect specifically to abuse in later life, the aggressors include spouses and former spouses, partners, adult children, extended family, and in some cases caregivers. Domestic abuse in later life and elder abuse often go hand in hand, and the consequences on lives are very similar.

To be of greatest help to victims, members of the domestic violence community and the aging network need to know more about the support and programs each network offers for victims of late life violence in their respective states, common indicators of abuse in late life, potential victim reactions, and areas where there is potential for interagency collaboration. To begin building the bridges between the two networks, the NCEA and Wisconsin Coalition Against Domestic Violence/National Clearinghouse on Abuse in Later Life (WCADV/NCALL) developed issue briefs to encourage expanded dialogue and connections with allied partners:

- *Domestic Violence in Later Life: A guide to the Aging Network for Domestic Violence and Victim Service Programs*
(<http://elderabusecenter.org/pdf/publication/nceaissuebrief.agingnetworkguideDV.pdf>)

- *Late Life Domestic Violence: What the Aging Network Needs to Know* (<http://elderabusecenter.org/pdf/publication/nceaissuebrief.DVforagingnetwork.pdf>).

In addition, AoA and the HHS Office of Women's Health supported an effort by the WCADV/NCALL to promote collaboration and information sharing between domestic violence and elder abuse advocates and practitioners. WCADV/NCALL worked with aging advocates, including the AARP Foundation, to develop a culturally competent Domestic Violence in Later Life Curriculum, including a Trainers' Guide. WCADV/NCALL has posted a downloadable version on a newly created NCALL website <http://www.ncall.us/resources.html#NCALLPUBS>.

AoA's Long-Term Care Ombudsman Program

The Long-Term Care Ombudsman Program helps prevent abuse of the residents of nursing homes and similar facilities, the vast majority of whom are older women. Begun in 1972 as a demonstration, the program today operates in all states and in 572 regional/local areas of the country. Program representatives investigate and resolve complaints, many of which involve abuse through neglect and some of which involve outright abuse. Volunteer ombudsmen inform residents of their rights and provide a regular community presence in facilities, which helps prevent abuse. In FY 2005, ombudsmen regularly visited 82 percent of all nursing homes and 42 percent of all licensed board and care and assisted living facilities. Approximately 1300 paid and 14,000 volunteer staff (9,100 of these certified to help with complaints) investigated over 307,000 complaints made by about 194,000 people. About 80 percent of the complaints were resolved or partially resolved to the satisfaction of the complainant or resident. Ombudsmen provided information to more than 342,000 people on a myriad of topics. To support and enhance state and local efforts, AoA funds the National Long-term Care Ombudsman Resource Center (www.ltombudsman.org).

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

CDC's violence prevention activities are guided by four key principles:

- *An emphasis on the primary prevention of violence perpetration.* CDC emphasizes efforts to prevent violence before it occurs. This requires not only reducing the factors that put people at risk, but also increasing the factors that protect people from becoming perpetrators of violence.
- *A commitment to developing a rigorous science base.* CDC's approach includes defining the problem through surveillance; using research to identify risk and protective factors; developing and evaluating new prevention strategies; and ensuring widespread adoption of effective programs.
- *A cross-cutting perspective.* The public health sector encompasses many disciplines and perspectives, making its approach well suited for examining and addressing complex problems like violence against women.
- *A population approach.* Part of a broad public health view is emphasis on population health—not just an individual's health.

CDC's strategic direction for intimate partner violence prevention is promoting respectful, nonviolent intimate partner relationships through individual, community, and societal change. Additional information about CDC's programs and activities to prevent violence against women is available at www.cdc.gov/violenceprevention.

Key Partners

Preventing violence against women requires the support and contributions of many partners: federal agencies, state and local health departments, nonprofit organizations, academic institutions, international agencies, and private industry. Partners help in a variety of ways, including collecting data about violence, learning about risk factors, developing strategies for prevention,

and ensuring that effective prevention approaches reach those in need.

Monitoring, Tracking, and Researching the Problem

Measuring the Incidence and Prevalence of Intimate Partner Violence and Sexual Violence

CDC supported two optional modules on intimate partner violence and sexual violence for inclusion in the 2005, 2006, and 2007 Behavioral Risk Factor Surveillance System (BRFSS). The intimate partner violence module included seven questions and the sexual violence module included eight questions. State-level statistics on the prevalence of intimate partner violence and sexual violence enabled participating state health officials and policy makers to better understand the magnitude of the problems in their state and provided information that may be used to guide policy development and evaluation.

National Intimate Partner and Sexual Violence Surveillance System

CDC is developing the National Intimate Partner and Sexual Violence Surveillance System (NISVSS) in collaboration with the National Institute of Justice and the U.S. Department of Defense. Beginning in 2011, NISVSS will provide national and state-level data, producing frequent, consistent, and reliable information on the magnitude and nature of intimate partner violence, sexual violence and stalking. Using consistent definitions and survey methods over time, NISVSS will provide improved prevalence of lifetime and 12-month estimates to monitor trends and to guide and evaluate intervention and prevention efforts.

National Electronic Injury Surveillance System—All Injury Program

The National Electronic Injury Surveillance System – All Injury Program (NEISS-AIP) is operated by the U.S. Consumer Product Safety Commission in collaboration with the National Center for Injury Prevention and Control. It provides nationally-representative data about all types and causes of nonfatal injuries treated in U.S. hospital emergency departments. CDC uses NEISS-AIP data to generate national estimates of nonfatal injuries, including those related to intimate partner violence and sexual violence.

National Violent Death Reporting System

State and local agencies have detailed information from medical examiners, coroners, police, crime labs, and death certificates that could answer important, fundamental questions about trends and patterns in violence. However, the information is fragmented and difficult to access. Seventeen states are currently part of the National Violent Death Reporting System (NVDRS)— Alaska, California (4 counties only), Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Mexico, North Carolina, New Jersey, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, and Wisconsin. These states gather, share, and link state-level data about violence. NVDRS enables CDC and states to access vital, state-level information to gain a more accurate understanding of the problem of violence. This will enable policy makers and community leaders to make informed decisions about violence prevention strategies and programs, including those that address violence against women.

A Study of Minority Women’s Experiences of Sexual Violence

CDC is using a comprehensive sexual violence survey instrument to learn more about sexual violence victimization prevalence, characteristics, circumstances, and help-seeking behavior among English- and/or Spanish-speaking adults from different racial/ethnic minority populations. The findings from this study will provide important information about the incidence, type, frequency, characteristics, and context of sexual violence in American Indian, Hispanic, and African American communities. Currently, we know very little about sexual violence in these communities.

Assessing Links Between Various Forms of Violence

CDC is conducting a study to identify the links between different forms of interpersonal and self-directed violent behaviors among adolescents. The study will help scientists understand the prevalence and consequences of different types of aggressive behaviors; the association between dating violence and other forms of peer violence; and the manner in which these types of violent behaviors vary by sex, developmental stage, and other factors. A survey of more than 4,000 students was conducted in 2004, and data analyses have been published with more currently underway.

IPV Perpetration Study

CDC is studying how issues of power and control contribute to the development of intimate partner violence perpetration. Results of the study will help scientists determine the best way to prevent IPV perpetration. Information was collected from male batterers in a court-mandated treatment program to identify factors that lead to intimate partner violence perpetration. Data analyses are currently underway.

Understanding Risk and Protective Factors for Sexual Violence Perpetration and the Overlap with Bullying Behavior

CDC is funding a study to examine the association between bullying experiences and co-occurring and subsequent sexual violence among middle school students to inform sexual violence prevention strategies for schools. The study explores the risk and protective factors of bullying and sexual violence and examines the ways adolescent behavior is shaped by family, peers, and school environments. Approximately 3,500 middle school students in 140 classrooms across two school districts are participating.

Developing and Evaluating Prevention Strategies

Choose Respect

CDC's Choose Respect initiative is a national effort to help youth form healthy relationships to prevent dating abuse before it starts. Choose Respect provides information and educational tools to challenge harmful beliefs about unhealthy relationship behaviors and to reinforce positive attitudes about respectful relationships. The initiative targets adolescents ages 11 to 14 and also connects with parents, teachers, youth leaders and other caregivers who influence the lives of young teens.

Enhancing and Making Programs Work to End Rape (EMPOWER)

The EMPOWER project began in 2005 as a three-year prevention planning, implementation and evaluation capacity building project supporting Colorado, Massachusetts, North Carolina, North Dakota, Kentucky, and New Jersey. Using an empowerment evaluation approach, CDC works intensively with states to build individual and sexual violence prevention system capacity and to develop program planning, implementation, evaluation and sustainability tools and training. The six states are developing statewide

sexual violence prevention plans and will begin implementing and evaluating the plans in 2009.

Preventing Sexual and Intimate Partner Violence within Racial/Ethnic Minority Communities

CDC is working with the Migrant Clinicians Network and the National Indian Justice Center to build organizational capacity and develop a program model that is culturally relevant and focused on engaging men and boys in the primary prevention of Sexual Violence and Intimate Partner Violence. The aim of this initiative is to promote change in men's knowledge, attitudes, beliefs, and behaviors that support or allow violence against women. The grantees are developing, pilot testing, and evaluating prevention strategies within their communities.

Effectiveness of Screening for IPV in Primary Care

CDC is working with the Research Collaborative Unit of John H. Stroger Hospital in Chicago to conduct a randomized controlled trial to establish the impact of screening for IPV on health and quality of life. The pilot test for this study has been completed and the full study has begun enrolling participants.

Evaluation of a Workplace Program for Victims of Partner Violence

CDC is evaluating the manager training portion of a workplace program addressing intimate partner violence. The training consists of raising awareness about IPV, recognizing signs of IPV, and dealing with employees who may experience IPV.

Effectiveness and Implementation Trial of the Safe Dates Program

CDC is evaluating the intervention effectiveness, economic cost, and implementation of Safe Dates, a school-based adolescent dating violence prevention program aimed at preventing violence perpetration and victimization. Scientists are evaluating the effectiveness of Safe Dates with a diverse group of adolescents, as well as gathering information about the conditions under which the program can be implemented in new settings or with new populations most effectively and efficiently.

Supporting and Enhancing Prevention Programs Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA)

CDC is funding 14 state domestic violence coalitions to implement and evaluate prevention strategies that can be integrated into Coordinated Community Responses (CCRs) or similar community-based collaborations. The DELTA Program adds a significant primary prevention focus to the existing CCR model by funding state domestic violence coalitions that act as intermediary organizations, providing prevention-focused technical assistance, training, and funding to local communities. Funded state coalitions are Alaska, California, Delaware, Florida, Kansas, Michigan, Montana, New York, North Carolina, North Dakota, Ohio, Rhode Island, Virginia, and Wisconsin. CDC is also funding an evaluation of the DELTA project that assesses the DELTA Program's success in building capacity to implement and evaluate primary prevention strategies throughout each funded state and within funded CCRs.

DELTA-PREP Program

Building on the successes of the DELTA Program, CDC, in collaboration with the CDC Foundation and the Robert Wood Johnson Foundation, has developed the DELTA-PREP Program to provide training, technical assistance and funding to non-DELTA state domestic violence coalitions that are ready to build their capacity to prevent intimate partner violence. Through training, technical assistance, and coaching from current DELTA Program grantees, DELTA-PREP coalitions will begin integrating primary prevention concepts and principles within their daily practice and promoting primary prevention with state and local partners.

Rape Prevention and Education (RPE) Program

CDC administers and provides technical assistance for the Rape Prevention and Education (RPE) Grant program to help health departments and sexual assault coalitions more effectively use funds provided through the Violence Against Women Act. The funding—designed to enable states to educate communities about sexual violence and develop prevention programs—supports educational seminars, hotlines, training programs for professionals, the development of informational materials, and special programs for underserved communities. States and territories have strengthened their

infrastructure to address sexual violence and to implement primary prevention activities and programs.

PROVIDING PREVENTION RESOURCES

Prevention Connection

Prevention Connection: The Violence Against Women Prevention Partnership integrates web-based technology and promotes web conferences to build the capacity of local, state, national, and tribal agencies and organizations to develop, implement, and evaluate effective violence against women prevention initiatives. Prevention Connection provides a vehicle for ongoing analysis and discussion of domestic and sexual violence prevention efforts. Online forums feature a variety of prevention experts who explore and discuss approaches and comprehensive solutions to domestic and sexual violence. Prevention Connection is a project of the California Coalition Against Sexual Assault.

National Sexual Violence Resource Center

The National Sexual Violence Resource Center (NSVRC) identifies and disseminates information, resources, and research on all aspects of sexual violence prevention and intervention. Staff provides customized technical assistance, collaborate with other national and local organizations, and specialize in offering resources for underserved communities. Additional activities include coordinating national sexual assault awareness activities; identifying emerging policy issues and research needs; issuing a biannual newsletter; and recommending speakers and trainers. The NSVRC website features links to resources, including information about conferences, funding, jobs, research, and special events. The Center serves state sexual assault coalitions, rape crisis centers, government agencies, U.S. Territories and tribal entities, colleges and universities, service providers, researchers, allied organizations, policymakers, media, and the public.

Violence Against Women Electronic Network

The National Online Resource Center on Violence Against Women (VAWnet) provides support for the development, implementation, and maintenance of effective violence against women intervention and prevention efforts at national, state, and local levels. VAWnet provides a collection of

full-text, searchable electronic resources on domestic violence, sexual violence and related issues to state domestic violence and sexual assault coalitions, allied organizations, and the public. It offers useful links; monitors news coverage of violence against women issues; provides calendars of trainings, conferences and grant deadlines; presents interpretations of current research on violence against women, and provides information about Domestic Violence Awareness and Sexual Assault Awareness Months.

PUBLICATIONS

Intimate Partner Violence Compendium of Measures

Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools provides researchers and prevention specialists with a set of assessment tools with demonstrated reliability and validity for measuring the self-reported incidence and prevalence of Intimate Partner Violence victimization and perpetration. Although the compendium includes more than 20 scales, it is not intended to be an exhaustive listing of available measures. The information is presented to help researchers and practitioners make informed decisions when choosing scales to use in their work.

Screening Inventory for Use in Health Care Settings

Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings is a compilation of existing tools for assessing intimate partner violence and sexual violence victimization in clinical/healthcare settings. The compilation provides practitioners and clinicians with the most current inventory of assessment tools for determining IPV and/or SV victimization and informs decisions about which instruments are most appropriate for use with a given population.

Evaluation Guide for Sexual and Intimate Partner Violence Prevention Programs

The *Sexual and Intimate Partner Violence Prevention Programs Evaluation Guide* presents an overview of the importance of evaluation and provides evaluation approaches and strategies that can be applied to programs. Chapters provide practical guidelines for planning and conducting

evaluations; information on linking program goals, objectives, activities, outcomes, and evaluation strategies; sources and techniques for data gathering; and tips on analyzing and interpreting the data collected and sharing the results. The Guide discusses formative, process, outcome, and economic evaluation.

Preventing Intimate Partner Violence and Sexual Violence in Racial/Ethnic Minority Communities

Recognizing the need for programs that address intimate partner violence and sexual violence prevention in minority populations, CDC funded 10 demonstration projects in 2000 to develop, implement, and evaluate culturally competent intimate partner and sexual violence prevention strategies targeted for specific racial/ethnic minority groups. *Preventing Intimate Partner Violence and Sexual Violence in Racial/Ethnic Minority Communities: CDC's Demonstration Projects* summarizes the work of the funded projects. The publication describes the approaches developed by the projects and highlights challenges and lessons learned in the development, implementation, and evaluation of programs.

Uniform Definitions and Recommended Data Elements

In 1999, CDC published *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements* to improve and standardize data collected on intimate partner violence. Similar standards for sexual violence, *Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements*, were published in 2002. Uniform definitions and recommended data elements are important because they provide consistency in the use of terminology and standardization in data collection. Consistent data allow researchers to better gauge the scope of the problem, identify high-risk groups and monitor the effects of prevention programs.

CDCynergy Violence Prevention Edition

CDCynergy is designed to help violence prevention program planners conceptualize, plan, and develop health communication programs. This edition of CDCynergy is ideal for those interested in developing prevention programs on the issues of child abuse, intimate partner violence, sexual violence, and youth violence.

Preventing Child Sexual Abuse Within Organizations Serving Children and Youth

CDC has developed *Preventing Child Sexual Abuse Within Youth-serving Organizations: Getting Started on Policies and Procedures* to assist youth-serving organizations as they begin to adopt prevention strategies for child sexual abuse. The guide identifies six key components of child sexual abuse prevention for organizations and includes prevention goals and critical strategies for each component. Suggestions for addressing challenges and tools to help organizations get started are also provided.

Estimating the Incidence and Costs of Violence Against Women

Recognizing the need to better measure the scope of the problem of intimate partner violence and the resulting economic costs, Congress funded CDC to conduct a study to obtain national estimates of the occurrence of IPV-related injuries, to estimate their costs to the health care system, and to recommend strategies to prevent IPV and its consequences. The resulting report, *Costs of Intimate Partner Violence Against Women in the United States*, describes the development of the study; presents findings for the estimated incidence, prevalence, and costs of nonfatal and fatal IPV; identifies future research needs; and highlights CDC's research priorities for IPV prevention.

ENCOURAGES RESEARCH AND DEVELOPMENT

Family-based Prevention of Conduct Problems to Prevent IPV Development

Researchers from the John Jay College of Criminal Justice are examining the impact of a family-based intervention aimed at children with early conduct problems. Early conduct problems have been identified as one of the most robust risk factors for IPV. Findings from the study may inform a novel approach to preventing IPV in youth who would be most resistant to standard IPV interventions when they reach adolescence.

Dyadic, Skills-Based Primary Prevention for Partner Violence in Perinatal Parents

Researchers from the State University of New York at Stony Brook are conducting trials to determine the outcomes of *Couple CARE for*

Parents, a program that addresses interpersonal processes and promotes relationship skills. The project aims to identify factors that may reduce intimate partner violence such as communication skills, conflict behaviors, parenting expectations, and parenting stress.

PTSD-Focused Relationship Enhancement Therapy for Returning Veterans and Their Partners

CDC is funding Boston Veterans Affairs Research Institute to develop and test a couples-based, group intervention for married or partnered Operation Enduring Freedom /Operation Iraqi Freedom veterans to prevent the perpetration of intimate partner violence. The program will incorporate components of several interventions for post traumatic stress disorder and intimate partner violence.

Telephone Care Management to Prevent Further Intimate Partner Violence

Researchers from the Children's Research Institute are investigating the acceptability, safety, efficacy, and cost of Telephone Care Management (TCM) intervention to prevent further IPV. TCM provides women who have reported IPV with education about the impact of violence, referral assistance, and problem solving for common barriers to receiving advocacy services.

Roots of Sexual Abuse

CDC is funding researchers at the University of Minnesota to examine the factors that distinguish sexual abuse perpetration from delinquent behavior. The study will focus on male adolescents and their caregivers. A major obstacle to developing prevention programs for child sexual abuse is lack of information about its causes and correlates, especially in young offenders.

Preventing Violence against Women: A Web-based Approach

Researchers at Emory University are developing and testing an innovative, web-based VAW prevention program targeting male college students. The program seeks to correct misperceptions in normative beliefs, attitudes, and behaviors; increase knowledge of the elements of

informed consent for sex; improve understanding of legal definitions of assault; enhance communication skills, and increase empathy for female victims.

An Investigation of a Sexual Assault Prevention Program

Researchers from Ohio University are studying a comprehensive sexual assault prevention program for men and women administered in a single-sex format. Interventions for men will involve a program based on a social norms model of change and the women's intervention includes the teaching of self-defense and risk reduction strategies.

Is Motivational Interviewing an Effective Intervention for Women Coping with IPV?

Researchers from the University of Iowa are assessing the impact of an intimate partner violence prevention program provided to clients of a family planning clinic in the rural Midwest. The program uses motivational interviewing to guide the patient towards identifying feasible goals and steps she can take to increase self-efficacy and control over her relationship.

Raices Nuevas: Intimate Partner Violence Prevention for Latino Men

Researchers at the Community Health and Social Services Center in Michigan are testing the efficacy of a culturally-tailored, primary prevention intervention for intimate partner violence among under-served Latino men at-risk for perpetration.

Effectiveness of a Housing Intervention for Battered Women

CDC is funding the Department of County Human Services in Multnomah County, Oregon, to evaluate the effectiveness of an existing housing intervention of Volunteers of America (VOA). Methods will include in-depth interviews with survivors at regular intervals; review of case files from VOA and emergency shelters; and analysis of the costs of additional services sought and provided, including law enforcement, child welfare, health care, housing, and financial assistance.

An Enhanced Nurse Home Visitation Program to Prevent IPV

Researchers from the Criminal Justice Policy Research Institute at Portland State University are testing the efficacy of an enhanced Nurse Family

Partnership (NFP) intervention among women referred to an existing NFP program in Portland, Oregon. Prior research has shown that the standard Nurse Family Partnership (NFP) intervention is not as effective in homes that experience intimate partner violence (IPV).

Enhancing Bystander Efficacy to Prevent Sexual Violence: Extending Primary Prevention to First Year College Students

Researchers at the University of New Hampshire are implementing and evaluating a bystander approach to preventing sexual violence. The study includes a multi-session prevention program and a social marketing campaign. Approximately 700 participants from two college campuses will participate.

Perpetration of Partner Violence Among Adolescents from Violent Homes

CDC is funding researchers at Southern Methodist University to explore partner violence among adolescents exposed to violence at home. Findings will offer insight into risk and protective factors of adolescent partner violence and inform the development of targeted prevention programs for adolescents from violent homes.

Etiologic Frameworks to Prevent Gender Based Violence Among Immigrant Latinos

CDC is funding George Washington University School of Public Health and Health Services to examine the etiology of gender-related violence among immigrant Latino populations. Working with the SAFER Latinos project, researchers are assessing the community problem solving capacity in an immigrant Latino neighborhood, identifying gaps in available prevention programming, and developing an etiological model and best practices approach that can provide the basis for a community-based intervention.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Background:

Since 1991, the Health Resources and Services Administration (HRSA) has been working to address the devastating consequences of intimate partner and family violence effecting women, men, children, and elderly populations through policy development, training, technical assistance, service delivery, education, and research. From clinical domestic violence services at community-based primary healthcare sites, to demonstration grants that improve the identification and treatment of victims of domestic violence during pregnancy, to training of healthcare professionals, HRSA supports culturally competent cutting edge interventions to address this epidemic.

Education, Training, and Outreach

National Women's Health Week. HRSA Office of Women's Health coordinates activities across the agency on an annual basis for this observance to empower women to make their health a top priority. Violence prevention information is included in activities.

Intersection of Violence and HIV/AIDS. HRSA/HIV/AIDS Bureau (HAB) is currently working on a CARE Action Newsletter focused on the intersection of violence and HIV/AIDS. The Newsletter is due out early summer 2009.

Addressing Interpersonal Violence in the Wake of Disaster: Opportunities for Action in Disaster Preparedness and Response. A white paper was completed Spring 2009 to address how sex, gender, and lifespan perspectives influence disaster preparedness and system response to surges in interpersonal violence in the short- and long-term aftermath of disaster. This was a collaboration between the HRSA Office of Women's Health (OWH) and the SAMHSA Center for Mental Health Services, and CMHS' National GAINS Center.

Take A Stand. Lend A Hand. Stop Bullying Now! Campaign. HRSA launched the Stop Bullying Now (SBN) campaign in March 2004, to educate Americans about how to prevent bullying and youth violence. Print and web-based campaign materials available at www.stopbullyingnow.hrsa.gov, were designed to provide tips and strategies to stop bullying. The campaign was developed by MCHB in partnership with more than 70 health, safety, education, and faith-based organizations and a Youth Expert Panel. This campaign was also recognized and served as the foundational theme for National Child Health Day in 2005. Thirty-nine states have legislation addressing bullying up from nine when the SBN! Campaign began. The SBN! interactive web site averages over 67,000 visitors per month. SBN! DVD Tool Kits have been sent to more than 66,000 U.S. public elementary and middle schools, 17,000 libraries, all state Injury and Violence Prevention Directors, and all state Home Extension Services Offices. PSAs from the DVD Tool Kit are aired on military bases worldwide more than 70 times per week on the American Forces Network.

Grants

Geriatric Education Centers (GECS), FY07. Geriatric Education Centers (GECs) facilitate the interdisciplinary training of health professional faculty, students and practitioners in the diagnosis, treatment, prevention of disease, disability, and other health problems of the elderly, including abuse and neglect. Of the 48 FY 2007 funded Geriatric Education Centers, 29 grantees addressed preparing health care providers on elder abuse as part of their continuing education activities. These activities included implementation of evidence based protocols; a proceeding based on an Ethics in Elder Mistreatment conference; use of a Center of Excellence in Elder Abuse and Neglect as a clinical training site for the University of California, Irvine; and Grand Rounds on elder abuse. Three of the eleven Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals address elder abuse or mistreatment.

HRSA/Bureau of Health Professions is funding the California Geriatric Education Center to develop a 2-day conference on the Medical Aspects of Elder Abuse. Components of this work include:

- 1) Developing the conference content for up to 200 participants from health and social services and law enforcement;
- 2) Designing and providing a 1-day Training of the Trainer workshop on Forensic Skills in Elder Mistreatment for 60 elder abuse program leaders;
- 3) Convening up to 18 elder abuse experts for a 2-day consensus conference on ethics of elder mistreatment;
- 4) Developing a proceedings/publication based on the Ethics in Elder Mistreatment conference and evaluate training.

Advanced Nursing Education, FY08. The Advanced Education Nursing Program (AEN) provides support for primary care nurse mid-wifery and nurse practitioners, clinical nurse specialists (CNS), including psychiatric mental health CNS or nurse practitioner, administration, and community/public health nursing and other programs that prepare nurses at an advanced level to care for women's unique health care needs across the lifespan. These educational programs lead to masters or doctoral degrees or post-master's certificate. Several of the programs include content on domestic violence, rape, other traumas, child abuse, elder abuse, school violence, suicide post-traumatic stress disorder and specialized content on forensics. In FY08, 152 new and non-competing continuation grants were awarded. One AEN grantee, Boston College, specifically prepares the advanced education nurse to assess victims of violence; several other advanced education nursing programs have addressed abuse or violence in their activities related to enhancing the education or skills of the advanced practice nurse. Examples other AEN grants are below.

The *Trustees of Boston College* prepares the advanced practice nurse to assess and manage the physical and mental health needs of individuals affected by violence and crime and to provide forensic assessment, evidence collection, forensic documentation, and court testimony.

The University of Medicine and Dentistry of New Jersey prepares the advanced community health nurse to practice in urban underserved areas where there is a high level of violence and abuse.

Wayne State University prepares advanced practice psychiatric nurses (APPN) and advanced practice public health nurses (APPHN) to work

collaboratively in urban and rural federally designated and health provider shortage areas to improve public health and health care systems in efforts to meet a Healthy People 2010 objective of reducing suicide and illness resulting from alcohol and illicit drug related violence.

The University of Mississippi Medical Center prepares advanced practice nursing leaders to improve access to quality health care and reduce health disparities in rural, medically underserved, vulnerable populations, older adults and persons with mental health problems by offering courses in the curriculum that educate the advanced practice nurse on abuse and violence within the family.

The Regents of the University of California prepares graduate-level psychiatric nurses to improve clinical care for persons with depression in a variety of health care settings. Their research and experience has found that depression was a common outcome associated with traumatic experience and that there was significant co-morbidity between post-traumatic stress disorder and depression and that there is a preoccupation with suicide in trauma survivors.

Currently, 26 *HRSA/Bureau of Primary Health Care* Federally Qualified Health Center Program grantees in 20 states offer Health Center services through domestic violence shelters. In total, services are provided at 40 domestic violence shelters. Most of these grantees offer these services as a part of a Health Care for the Homeless Program. Services provided include medical, mental health, and enabling services such as eligibility assistance. The need for health services is particularly acute for women and families in domestic violence shelters, who often have been forced to sever all connections with their home communities, and sometimes with their healthcare providers.

HRSA/HIV/AIDS Bureau will be funding a new SPNS portfolio of 10 grants and 1 Technical Assistance center in FY2009 for their Women of Color Initiative. The purpose of the Initiative is to improve access and retention for women of color living with HIV/AIDS in the U.S. Violence prevention will be part of the integration of services for women served under these grants.

HRSA/Bureau of Health Professions is funding 5 awards (9/07-8/10) under the *DNP Degree Gears Grads to Put Prevention into Practice* program is to expand the availability of highly qualified, culturally competent, and diverse advanced education nurses prepared to practice at the highest level and with full accountability to respond to a wide range of preventive care needs, particularly among disadvantaged and vulnerable populations. Project period is June 2006-June 2009.

HRSA/Maternal and Child Health Bureau funded “Technical Assistance for Domestic Violence Assessment and Intervention for the Healthy Start Population” (09/2006-02/2009). The purpose of the Healthy Start Domestic Violence Technical Assistance Project, was to “develop and provide domestic and family violence technical assistance to [18] Healthy Start programs [per annum] ... tailored to the specific community and program needs of each Healthy Start site and is provided to enhance the capacity of providers to screen for and educate their clients about family violence and to improve linkages between screening sites and community-based intervention programs for women experiencing family violence during or around the time of pregnancy.”

HRSA/Office of Rural Health Policy funded District III Area Agency on Aging (5/2005-4/2008) to improve access to primary health care and social support services by using an integrated network of local providers. The project incorporated community education and outreach approaches to connect the population to a network of local health and social support services. Activities addressed include disease prevention and mental health topics, with a special emphasis on domestic violence and child abuse. The project includes outreach to seasonal migrant workers. The target audience included medically underserved and uninsured residents of Lafayette County, Missouri.

HRSA/Office of Rural Health Policy funded Butte Silver Bow Primary Health Care Clinic, Inc. (5/2005-4/2008) to address child sexual abuse through prevention education for preschool and young children, evaluating suspected victims at the Child Evaluation Center, and professional therapeutic support services for the victims and their families as well as children at risk. Partners included Butte Silver Bow Primary Health Care Clinic, St. James Healthcare,

Butte Silver-Bow Law Enforcement Detectives, Butte Silver-Bow County Attorneys Office, Butte Office of Department of Family Services, and Dr. Ken Graham (a private pediatrician)

Established in 1991, the *MCHB Healthy Start Initiative* is designed to reduce infant mortality and disparities in perinatal health in high-risk communities by improving the quality of health care for women and infants. A contract was awarded in September 2007 to provide technical assistance to a total of 18 Healthy Start grants to improve provider capacity to conduct family violence screening for all perinatal clients and to link screening sites with effective community-based intervention programs.

Other Information

A new portal on the National Maternal and Child Oral Health Resource Center (OHRC) webpage is now available with links to web resources on domestic violence and oral health. Please see <http://www.mchoralhealth.org/AZ.html> and click on "D" and look for "Domestic violence and oral health. This is a collaboration between the Health Resources and Services Administration (HRSA) Office of Women's Health, in collaboration with HRSA/Maternal and Child Health Bureau Oral Health Program staff and Indian Health Service (I.H.S.) colleagues.

INDIAN HEALTH SERVICES (IHS)

Indian Health Service (IHS)-Administration for Children and Families (ACF) Domestic Violence Pilot Project:

Overview of Health Care & Domestic Violence

Although domestic violence directly or indirectly brings millions of women to the health care system every year, health care providers often treat these women without inquiring about abuse, therefore never recognizing or addressing the underlying cause of their health problems. The health care system is positioned to play a pivotal role in domestic violence prevention and intervention. Virtually every woman interacts with the health care system at some point in her life – whether it is for routine health maintenance, pregnancy, childbirth, illness, injury or by bringing her child for health care services.

Routine screening, with its focus on early identification and its capacity to reach patients whether or not symptoms are immediately apparent, is a primary starting point for reaching women who have never talked to anyone about domestic violence in their home. When victims of domestic violence are identified in the medical setting, providers can assist them in breaking through their isolation, understanding their options, living more safely within the relationship or safely leave the relationship.

The Domestic Violence Pilot Program

Since 2002, the IHS and ACF have collaborated to fund Indian health sites to identify strategies and develop systems interventions addressing DV in the communities they serve. These I/T/U health care facilities have served as incubators for new approaches, training and resource centers, and potent advocates for DV prevention and screening within the health system. Previous partners have included the Family Violence Prevention Fund (through the HHS funded Health Resource Center on DV), Mending the Sacred Hoop Technical Assistance Project, and Sacred Circle. Project

evaluations are ongoing and include the use of the IHS DV clinical quality performance indicators.

The project was created in response to the alarming rate of domestic violence among AI/AN women; the highest of any ethnic or racial group in the United States. The project has been in place for over seven years. Currently, all 39 CCI sites, five IHS sites and 2 tribal sites 46 I/T/U are funded to integrate DV screening and education into the primary care of AI/AN women.

The purpose of the IHS/ACF Domestic Violence Pilot Program is to:

- Improve the healthcare response to domestic violence. This includes implementing policies and procedures on routine assessment, providing training to staff, and amending intake forms to more accurately document screening;
- Improve adherence to the Government Performance Results Act (GPRA) indicator goals on domestic violence and increase utilization of the IHS documentation system (RPMS Exam Code #34), to measure domestic violence screens;
- Develop and strengthen comprehensive domestic violence prevention strategies. This includes adapting public service announcements for radio and TV, holding wellness events, and educating the community about healthy relationships;
- Raise the visibility of domestic violence as a public health issue throughout American Indian/Alaska Native (AI/AN) communities. This includes creation of patient- and staff-focused educational materials, as well as participation in Health Cares About Domestic Violence Day (See discussion on page 21);
- Build stronger advocacy for domestic violence issues in the healthcare setting at the tribal, urban and national level by gaining project support from Tribal Council and Tribal Health Boards and working with advocates in those communities.

Each site maintains a domestic violence team comprised of some combination of a physician, nurse, social worker, administrator, coding specialist, dentist/dental technician, mental health provider and domestic violence advocate. The teams regularly meet to delineate tasks, and organize trainings and activities. The fifteen participating sites are a combination of new and continuing project grantees; the continuing sites serve as mentors to the new sites, sharing lessons learned, tools and expertise at project meetings. The project thus far has been in both the pilot and demonstration stages, funded by an agreement between the IHS and the ACF with funds distributed through program awards. Project coordination, technical assistance and subject matter expertise has been received through the combined efforts of project partners including IHS, the Family Violence Prevention Fund, Mending the Sacred Hoop Technical Assistance Project and Sacred Circle.

1. *What is the status of the Domestic Violence / Sexual Assault Initiative (DVSAI)?*

Note: The staff work on the DV/SA Initiative has been delayed; the IHS Women's Health Program currently has just 1 FTE and needs staff to implement this initiative.

Some of the factors involved include: 1) the change in IHS Director; 2) the need for Tribal Consultation, and; 3) the need to bring on staff for each of the 3 parts of this initiative: Domestic Violence, SANE/SART, and Data & Epidemiology.

Proposed National Programs

- 1) SANE (Sexual Assault Nurse Examiner) / SART (Sexual Assault Response Team) Initiative; 2) Domestic Violence (DV) Pilot Program; 3) DV/SA Data and Epidemiology Initiative plus the contracts and grants needed to implement each of the initiatives.
- **Technical Assistance** – Technical assistance will be needed for each of the three initiatives. The Women's Health Program currently has only one staff person, therefore the grant and contract scopes of work have not been

developed, however the scopes will include the provision of technical assistance to federal, tribal and Urban sites including educational materials, policies and protocols and policies, promotional and marketing materials, assistance with problem solving on improving clinical ‘responsiveness’ to DV and sexual assault (SA), plus site visits. .

- **Training** – The scopes of work for the SANE/SART and DV training contracts have not been developed. The scopes will include the 5-day SANE didactic and the 5-day SANE clinical training, the 3-day SART training, and two 3-day DV conference trainings. Cost will include student travel and per diem.
- **The SANE/SART Initiative: Provisional Budget (\$3.5 M total)** – Assist federal and tribal sites to provide SANE and SART services to rape victims. Provide funding to federal and tribal sites to staff a SANE program and coordinate a SART. Until such time as an IHS SANE/SART policy and protocol is approved, sites will be accountable for implementing the DOJ SANE Protocol. Identify best practices and promote collaboration among Federal, State, national, and local community agencies and people. Bring on 1 FTE Emerging Leader as professional staff and ½ FTE Program Assistant to manage program. Contract and grants work will begin when staffing is in place. Staffing is contingent upon recommendation from tribal consultation and decision by the IHS Director.
- **The DV Pilot Initiative: Provisional Budget (\$2.5 M total)** - Assist Indian Health programs and communities in addressing domestic violence suicide utilizing community level and cultural approaches. Identify and share best and promising practices, improve behavioral health services, strengthen and enhance IHS’ epidemiological capabilities, promote collaboration with Federal, State, local and Tribal partners/agencies. Detail 1 FTE professional staff and ½ FTE Program Assistant to manage program. Contract and grants work will begin when staffing is in place. Staffing is contingent upon recommendation from tribal consultation and decision by the IHS Director.

- **DV/SA Data and Epidemiology Initiative: Proposed Budget (\$1.5 total)** - The DV/SA Data and Epidemiology Initiative includes establishing domestic violence and sexual assault epidemiologists within Tribal and Urban Epi Centers nationally to facilitate epidemiological surveillance and data enhancements related to DV and SA. 1 FTE Medical Epidemiologist is currently working on the statement of work for the Epi grant program.

National Institutes of Health (NIH) Report Violence-related Research Funding

The National Institutes of Health (NIH) supports research relating to Violence across several institutes and centers (ICs). The following report describes the research activities and brief summaries for the key projects funded by the ICs and the two key program offices residing in the Office of the NIH Director, including the National Institute on Aging, the National Institute on Alcohol Abuse and Alcoholism, the National Institute of Child Health and Human Development, the National Institute on Drug Abuse, the National Institute of Mental Health, the Office of Behavioral and Social Sciences Research, and the Office of Research on Women's Health (ORWH). The ORWH coordinates research on violence against women on behalf of the NIH, and actively works across the Department of Health and Human Services, and with the Department of Justice. . The fiscal years covered in this report include FY 2007 and FY 2008, but several ICs have described their plans for FY 2009 as well.

National Institute on Aging (NIA)

The National Institute on Aging (NIA), National Institutes of Health, and U.S. Department of Health and Human Services supports research on issues of violence, abuse and maltreatment in older Americans, including projects relating specifically to violence against older women. Research studies that were ongoing between 2007-2009 include a study of breast cancer in the context of intimate partner violence; a study of associations between prior

exposure to intimate partner violence and inflammatory markers and processes that have been implicated in a variety of conditions associated with aging (e.g., cardiovascular diseases, cognitive decline); and a survey of sexual abuse among vulnerable adults in long-term care facilities.

In FY 2005 and again in FY 2006, the NIA released Requests for Applications on “Developmental Research on Elder Mistreatment.” Between 2007-2009, grantees under these RFAs developed and tested methodologies for assessing the prevalence of elder abuse at the community level; such methodologies could later be adopted for a national study. The nine grants awarded under these RFAs include a range of approaches to identifying cases of abuse and prevalence estimation, including data linkages, identification in aging services, primary care clinics and residential long-term care as well as in community settings. One grant funded under this solicitation explores mistreatment among Native elders.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

The NIAAA grant portfolio includes a number of grants that are relevant to the issue of alcohol-related violence against women. Studies investigate the relationship between alcohol use and violence in adolescents and college age women; the effects of childhood sexual abuse on later-life re-victimization and risk behaviors among women; the psychological effects of sexual assault on women survivors; as well as the effects of intimate partner violence on women’s services utilizations. NIAAA also funds human research investigating the awareness of cues to potential violence after administration of various levels of alcohol (as well as placebo). Recently published findings from these research grants include the following:

Sexual victimization experience as a factor in subsequent heavy drinking

Testa and colleagues (2007) examined whether sexual victimization contributes to subsequent heavy drinking among a community sample of women, 18-30 years of age (n=927). Using three waves of data, 12 months apart, they examined the impact of Time 1 (T1) sexual victimization on T2 heavy drinking, and of T2 sexual victimization on T3 heavy drinking. There were significant bivariate differences between sexually victimized and non-victimized women on heavy drinking, both concurrently and prospectively.

However, after controlling for prior heavy drinking and demographic variables, most differences disappeared. The team also tested the hypothesis that Post-Traumatic Stress Disorder (PTSD) Symptoms would mediate the relationship between T2 sexual victimization and T3 heavy drinking. Although T2 sexual victimization predicted T2 PTSD symptoms, PTSD did not contribute to subsequent heavy drinking. Findings suggest that heavy drinking is relatively stable over time and that sexual victimization does not make a substantial independent contribution to heavy drinking among women in the general population. Hence, despite the substantial prevalence of sexual victimization among young women in the general population and the traumatic impact of these experiences, the prospective impact of these experiences on heavy drinking appears limited. Because of the absence of other prospective studies of the impact of sexual victimization on later heavy drinking, it is difficult to know whether these findings are an aberration or whether, indeed, there is little relationship between sexual victimization and subsequent heavy drinking within general population samples of women. Among clinical samples, the substantial comorbidity of PTSD and substance abuse, and extremely high rates of prior sexual assault among women in substance abuse treatment (e.g. Dansky, Saladin, Brady, & Kilpatrick, 1995; Miller, Downs, & Testa, 1993), have led to research aimed to understand the underlying processes and to the development of integrated treatments. The present findings do not negate the importance of these trauma processes in alcohol or drug dependent women; however, they point out the danger in extrapolating from clinical to household samples. More research is needed to determine whether sexual victimization influences heavy drinking among the general population of women.

Drinking and risk for victimization in college women

Parks et al (2008a) assessed women's risk for victimization during the first year at college, based on changes in drinking during the transition from high school to college. They compared continued abstainers with women who began drinking ("new" drinkers) and women who continued drinking but either decreased, increased, or did not change their level of weekly drinking. Data were collected using a Web-based survey each fall for the first 2 years at college with one cohort (N = 886) of incoming freshmen women at a large NY state university. Women reported on their alcohol and other drug use,

psychological symptoms, number of sexual partners, and experiences with physical and sexual victimization for the year before entering college (Year 1 survey) and for the first year at college (Year 2 survey). Abstainers were found to be significantly less likely to experience physical or sexual victimization during the first year at college, compared with drinkers. Logistic regression indicated differences in the predictors of physical and sexual victimization during the first year at college, including history of victimization, psychological symptoms, and number of sexual partners, as well as the type of change in drinking over the transition. Thus, in comparison with abstainers, having a history of physical victimization, greater psychological symptoms, and being a "new" drinker increased the odds of physical victimization, whereas having a greater number of current psychological symptoms, sexual partners, and increasing weekly drinking increased the odds of sexual victimization during the first year at college. These findings suggest that later onset of drinking may be protective against patterns of heavy episodic drinking, although additional longitudinal data are needed to determine whether new drinkers continue to drink at lower rates or whether their drinking trajectory follows that of women who increased their drinking over the transition to college. College prevention programs need to continue to stress the risks of drinking and heavy drinking in social situations for women. Women with a history of drinking before entering college are at greatest risk for escalating their drinking and experiencing more negative consequences and sexual assault. The findings of greater psychological symptoms as a predictor of physical victimization and greater number of sexual partners as a predictor of sexual victimization suggest that campus health services may provide another way in which prevention messages could be disseminated to first-year students.

Parks et al (2008b) assessed temporal relationships among alcohol use, aggression, and mood using daily data from 179 college women. Participants called an interactive voice response system over an 8-week period. The odds of experiencing verbal, sexual, and physical aggression (odd ratios = 2.25, 19.44, and 11.84, respectively) were significantly higher on heavy drinking days ($M = 7.46$ drinks) compared to nondrinking days. Both a history of victimization and greater psychological symptom severity influenced the odds of involvement in verbal aggression. The odds of alcohol consumption were 3 times higher during the 24 hr following verbal aggression compared

with days in which verbal aggression did not occur. On the day immediately following involvement in either verbal or physical aggression, positive mood decreased and negative mood increased. During the week (2-7 days) following sexual aggression, women's positive mood was decreased. These findings reinforce the need for interventions aimed at reducing heavy episodic drinking on college campuses.

Drinking and victimization in middle- and high-school students

Young et al (2008) used a Web-based, self-administered survey to collect data on 7th- through 12th-grade students (n = 1,037) in a large metropolitan area in the Midwest. A modified version of the Sexual Experiences Survey was used to ask students about their sexual victimization experiences so as to examine the involvement of alcohol within specific assault events. The sample was equally distributed by biological gender and ethnicity (white vs. black) and was, on average, 14 years of age. Findings indicate that alcohol was involved in approximately 12%-20% of the assault cases, depending on age and gender of the respondent. For females, the presence of alcohol during assault differed significantly based on the location at which the assault occurred, ranging from 6% (at the survivor's home) to 29% (at parties or someone else's home). Furthermore, alcohol-related assault among females was more likely to involve physical force than non-alcohol-related assault.

Thompson and colleagues (2008) investigated the longitudinal associations between problem alcohol use and victimization, and whether these associations varied by gender. Data from the National Longitudinal Study on Adolescent Health were used to investigate the prospective associations between alcohol use and victimization over three time points spanning 7 years. For boys, results indicated that problem alcohol use was a risk factor for subsequent violent victimization. For girls, support was found for problem alcohol use as a risk factor for, rather than a consequence of, violent victimization. Findings suggest that interventions that reduce the likelihood of problem alcohol use among adolescents can minimize the short-term risk of victimization.

Drinking and sexual aggression in young men

Noel et al (2009), in a laboratory analogue experiment, tested a disinhibition versus alcohol myopia explanation of alcohol's role by investigating effects of acute alcohol administration, expectations, and individual differences (drawn from Malamuth's Confluence Model of Sexual Aggression) on young men's acceptance of sexual aggression. Young adult heterosexual men (n=334) attended two laboratory sessions. In the first, they completed screening and individual differences measures; in the second, they were assigned randomly to consume one of four beverages: Control, Placebo, Low Dose Alcohol (0.33 ml alcohol/kg body weight) or Moderate Dose Alcohol (0.75 ml/kg), as well as view one of two video-delivered scenario conditions: "Anti-Force Cues" (scenario of a couple on a date with embedded explicit cues mitigating against forced sex) or "No Cues" (identical scenario with no anti-force cues). Participants then judged: 1) should the man continue to force the woman to have sex? 2) would they force the woman? and, 3) who was responsible for the outcome? Results supported a disinhibition versus alcohol myopia model. Consuming alcohol increased acceptance of sexual aggression. Furthermore, higher Need for Sexual Dominance and Acceptance of Interpersonal Violence scores were associated with acceptance of forced sex, but only after alcohol consumption. Overall, findings showed that key individual difference factors from Malamuth's Confluence Model enhance precision of predicting sexual aggression risk by young men under the influence of alcohol.

Davis et al (2008) assessed the frequency of sexual assault perpetration, alcohol use, and condom use during sexual assault in a community sample of young, heterosexual male social drinkers. Participants completed measures of their sexual assault perpetration. More than 50% reported sexual assault perpetration; 60% of these reported repeat perpetration. Almost one half of perpetrators reported alcohol consumption prior to every sexual assault incident. Never having used a condom during penetrative sexually aggressive acts was reported by 41.2% of perpetrators. Alcohol use and condom nonuse were positively correlated for acts of forcible rape. Findings provide information about the infrequent use of condoms during sexual assault incidents and support prior evidence of the association between alcohol and sexual assault.

Parkhill et al (2009) examined the effects of alcohol on sexual assault perpetrators' behavior in a sample of 107 Caucasian and African American men who reported perpetrating some type of sexual assault since the age of 14. The characteristics of the sexual assaults described by men who drank heavily during the incident significantly differed from those described by light drinkers and nondrinkers on a variety of measures, including their use of physical force and perceptions of the seriousness of the incident. In contrast, there were few significant differences between light drinkers and nondrinkers. This pattern of results suggests that the amount of alcohol consumed is an important factor in the characteristics and consequences of sexual assault incidents. These findings highlight the importance of sexual assault prevention programs that target men's heavy drinking.

Drinking and intimate partner violence in newlyweds

Schumacher et al (2008) examined hostility, coping, and daily hassles as moderators of the associations between excessive drinking and intimate partner violence across the first 4 years of marriage in a sample of 634 newly-married couples. Excessive drinking was a significant cross-sectional correlate, but it did not emerge as a unique longitudinal predictor of intimate partner violence perpetration in this sample. However, alcohol was longitudinally predictive of husband violence among hostile men with high levels of avoidance coping. Findings generally supported the moderation model, particularly for men. These findings implicate hostility, coping, and daily hassles--as well as alcohol use--as potentially important targets for partner violence prevention strategies for young married couples.

Drinking, child sexual abuse history, nonverbal social behavior, and sexual assault risk

Parks et al (2008c) examined the social behavior of 42 women under two alcohol conditions (high dose and low dose) in a bar laboratory. Women were videotaped interacting with a man they had just met. Women in the higher dose condition engaged in more open body position and talked, stood, and walked more than women in the lower dose condition. These behaviors are consistent with signs of intoxication or romantic interest. The women in the high-dose condition also frowned more than women in the low-dose

condition. An increase in frowning could indicate less comfort or may be considered consistent with an increase in animation during the social interaction given the concomitant increase in other behaviors. Thus, the nonverbal behavior of women in the high-dose condition could be interpreted as mixed signals. Childhood sexual abuse (CSA) victims exhibited fewer head movements (e.g., nods), were less animated, and frowned more than non-CSA victims. These behaviors convey reticence or possibly even anxiety or discomfort during the social interaction. Thus, the nonverbal behavior of women with a history of CSA may convey an unease that could be viewed by a potential perpetrator as vulnerability. These findings suggest that both acute alcohol consumption and history of CSA may influence nonverbal social behavior and may influence risk for sexual assault by sending mixed cues of romantic interest or signs of vulnerability to potential perpetrators.

Drinking, intimate partner violence and emergency department and alcohol treatment utilization

Lipsky and Caetano (2008b) examined the relationship between intimate partner violence (IPV) perpetration, risk-taking, and emergency department (ED) utilization among men in the general U.S. population. This cross-sectional study utilized data from the 2002 National Survey on Drug Use and Health, focusing on non-Hispanic white, non-Hispanic black, and Hispanic male respondents 18-49 years of age cohabiting with a spouse or partner. Approximately 38% of IPV perpetrators reported ED use in the previous year, compared to 24% of non-perpetrators. Several risk-taking factors (e.g., perception of risk-taking, transportation-related risk-taking, and aggression-related arrest), alcohol and illicit drug use and abuse or dependence, and serious mental illness were positively associated with IPV perpetration. Men reporting IPV were 1.5 times (AOR 1.47, 95% CI 1.01-2.13) more likely than non-perpetrators to utilize the ED, after taking all factors into account. Drug abuse or dependence, transportation-related risk behaviors, and serious mental illness also were independently associated with ED use. These results indicate that men who perpetrate IPV are more likely than non-perpetrators to use ED services, and suggest that screening for IPV, as well as risk-taking and mental illness, among men accessing ED services may increase opportunities for intervention and referral. Screening for IPV victimization is recommended by many professional organizations, but few, if any, policies or

programs have been instituted to address screening for IPV perpetration in the ED. Screening in a busy setting such as the ED can be problematic for providers, but innovative methods, such as computer-assisted screening, and other strategies (e.g., chart prompts) that have been implemented for routine medical problems as well as IPV victimization, may be helpful in facilitating screening for perpetration.

Lipsky and Caetano (2007) examined the relationship between intimate partner violence victimization among women in the general population and emergency department use, seeking to discern whether race/ethnicity moderates this relationship and to explore these relationships in race/ethnic-specific models. They used data on non-Hispanic White, Non-Hispanic Black, and Hispanic married or cohabiting women from the 2002 National Survey on Drug Use and Health. Results indicate that women who reported intimate partner violence victimization were 1.5 times more likely than were nonvictims to use the emergency department, after accounting for race/ethnicity and substance use. In race/ethnic-specific analyses, only Hispanic victims were more likely than their nonvictim counterparts to use the emergency department (AOR = 3.68; 95% CI = 1.89, 7.18), whereas substance use factors varied among groups. These findings suggest that the emergency department is an opportune setting to screen for intimate partner violence victimization, especially among Hispanic women. Future research should focus on why Hispanic victims are more likely to use the emergency department compared with nonvictims, with regard to socioeconomic and cultural determinants of health care utilization.

Lipsky and Caetano (2008a) examined (1) the prevalence of alcohol treatment use by intimate partner violence (IPV) type (any IPV, victimization, and perpetration) among problem drinkers and (2) the relationship between alcohol treatment use and IPV, by IPV type, in the general population. The sample was drawn from the 2002 National Survey on Drug Use and Health. Black, Hispanic, and non-Hispanic white cohabiting respondents 18-49 years of age and who reported one or more alcohol problems in the past year were included in the analysis. The prevalence of alcohol treatment use was found to be significantly greater among individuals exposed to IPV, regardless of IPV type (7.4%, 7.8%, and 6.9% among those with any IPV, victimization, and perpetration, respectively) compared with

those without reported IPV (2.8%, 2.8%, and 3.0%, respectively). Any IPV (adjusted odds ratio [AOR] = 1.97, 95% confidence interval [CI]: 1.06-3.65) and IPV victimization (AOR = 1.93, CI: 1.00-3.73), but not perpetration, were associated with alcohol treatment use. Male gender, alcohol abuse/dependence, illicit drug abuse/dependence, and serious mental illness were positively and significantly associated with alcohol treatment in all three models. The findings from this study that individuals who have experienced recent IPV are more likely than those without IPV to access treatment suggest that alcohol treatment may reduce relationship violence as well as alcohol use.

Drinking, social reactions, and sexual assault disclosure

Ullman et al (2008) explored the correlates of sexual assault disclosure and social reactions in female victims with and without drinking problems. An ethnically diverse sample of sexual assault survivors was recruited from college, community, and mental health agencies. Ethnic minority women were less likely to disclose assault, while women with a greater number of traumatic life events disclosed assault more often. Although there were no differences in disclosure likelihood by drinking status, of those disclosing, problem drinkers told more support sources and received more negative and positive social reactions than nonproblem drinkers. Correlates of receiving negative social reactions were similar for normal and problem drinkers; however, negative social reactions to assault disclosure were related to more problem drinking for women with less frequent social interaction. These results indicate that women's experiences of disclosure and receipt of negative reactions may be affected by their drinking status. Given the high prevalence of sexual victimization among female drinkers and the clear links between alcohol problems and both sexual assault and social support factors, these findings suggest that more attention be given to studying modifiable social factors that may enhance treatment and prevention of negative assault-related sequelae for all victims. Social network interventions that address negative social reactions commonly experienced by women with both of these problems may be needed to help women recover from sexual assault and problem drinking.

Predictors of different types of sexual assault perpetration in a community sample

Abbey and colleagues (2007) examined predictors of different types of sexual assault perpetration in a community sample. Computer-assisted self-interviews were conducted with a representative sample of 163 men in one large urban community. As hypothesized, many variables that are significant predictors of sexual assault perpetration in college student samples were also significant predictors in this sample, including empathy, adult attachment, attitudes about casual sex, sexual dominance, alcohol consumption in sexual situations, and peer approval of forced sex. For most measures, the strongest differences were between nonassaulters and men who committed acts that met standard legal definitions of rape. Men who committed forced sexual contact and verbal coercion tended to have scores that fell in between those of the other two groups. Almost a quarter of these men reported that they had committed an act since the age of 14 that appeared to meet standard legal definitions of attempted or completed rape. As compared to nonassaulters, rapists were lower in empathy and adult attachment. Rapists had expectations for sex at an earlier stage in a relationship and more casual attitudes about sex. Rapists also were more motivated to have sex as a means of achieving power over women, more frequently consumed alcohol in sexual situations, and reported greater peer approval of forcing sex on women.

As has been noted in past reviews, self-reports of sexual assault victimization and perpetration vary dramatically based on the precise questions asked. Providing more examples of types of forced sex may aid recall and willingness to disclose past forced sexual experiences. The use of computer-assisted interviewing may also have contributed to the high rates of self-reported perpetration.

NOTE: References for this section have been placed at the end of the document.

Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

The NICHD is dedicated to understanding the processes governing growth and development upon which the health of infants, children, youth, mothers,

and families depend. One aspect of this research seeks to understand the antecedents and developmental consequences of a range of problem behaviors, including violent behavior. To that end, the NICHD funds several ongoing studies concerning violence against women, especially in the area of women's reproductive health. These include studies of the long-term consequences of violence against pregnant mothers and children. But the NICHD's interest extends beyond a focus on reproductive health. Recognizing that violence against one family member can have far-reaching and long-term impact within the entire family unit, the NICHD's portfolio includes studies designed to improve information about family violence, increase understanding of factors underlying violence in the family, and to test the effectiveness of interventions for the prevention of family violence. For example, an NICHD funded study will increase understanding of family violence by assembling and analyzing a comprehensive database of domestic violence incidents from the National Incidence Based Reporting System (NIBRS). NIBRS includes all incidents reported to police -- not just those that result in an arrest -- in participating jurisdictions across the country. Researchers will use these data to conduct a comprehensive descriptive analysis of the 2.5 million family violence incidents reported from 1994 to 2004. Preliminary analysis indicates that NIBRS data imply a higher incidence rate of intimate partner violence against women compared to other data sources, and a much smaller trend reduction in the risk of family violence over the period 1995-2004. These data will allow us to fill many important gaps in knowledge about the situational determinants of family violence and to re-assess conclusions that have been drawn from other studies. In addition, scientists will use the NIBRS data to study the effect of unexpected emotional triggers on family violence.

The NICHD also supports research to help providers better care for the victims of family violence. For example, the NICHD is supporting a project to develop an outcome management tool for use in women's health centers and domestic violence agencies. Many victims of domestic violence who seek medical treatment do not discuss the details of their abuse, or their psychological and mental health problems, because of the brief examination time with the health care provider, or discomfort in discussing the abuse. Researchers are developing a computerized assessment that can help health care providers, social workers, and counselors determine the woman's mental

health state, personal strengths and resilience that can help with recovery, and determine if a woman needs an immediate intervention for her or her family.

Finally, the NICHD supports the development and testing of interventions targeted more directly at women at risk for intimate partner violence (IPV). One NICHD-funded study will pilot test, via a 2-armed randomized-controlled trial, a brief (10 minute) intervention to reduce risk for IPV/sexual assault among young adult women attending urban, publicly-funded family planning clinics. Another study will test the efficacy of a nurse-delivered telephone social support intervention targeted toward mothers in families with a history of intimate partner violence. By addressing the mother's individual needs as well as her needs as a caregiver, the intervention is designed to reduce stress and depression for women at risk of intimate partner violence.

National Institute on Drug Abuse (NIDA)

NIDA supports a large portfolio of quantitative and qualitative studies that aim to enhance our knowledge of the health and social consequences of drug use and violence against females. These studies address a wide range of topics, including the intergenerational effect of the co-occurrence of drug use, violence in distressed households, violence against impoverished women, intimate partner violence, and linkages among violence, drug use, and HIV risk behavior, as well as research on the neurobiology of childhood abuse. In addition, NIDA supports research focusing on treatment interventions for drug-dependent women who have experienced violence, including a large clinical trial within NIDA's Clinical Trial Network (CTN). Below is a brief description of active NIDA grants between June 1, 2007 and June 1, 2009 focusing on, or related to, violence against women and girls along with relevant recent publications, meeting activities, funding opportunity announcements and future plans.

Violence, Abuse, and Trauma as Risk Factors for Drug Abuse

Development of Substance Use in Girls (R01DA012237-07, Rolf Loeber, PI)

– This study follows and assesses the Pittsburgh Girls Study sample (N=2,451, 52% African-American, 41% Caucasian), an investigation of the

development of antisocial behavior and delinquency, in order to examine factors associated with girls' early substance use as they pass through ages 10-17. Starting at age 12, dating violence and witnessing domestic violence are assessed.

Child Abuse, Violence, and PTSD in Early Substance Use (R01DA019482-05, Cynthia Larkby, PI) – This longitudinal study on prenatal substance use and child outcomes consists of 404 low-income women, who at the start of the study were teenage mothers, and their children. This cohort has been followed since the fourth prenatal month through the age of 10 years. Data have been collected on the development of the children, the home environment, and the social and emotional status of the mother during pregnancy, at birth, and at 6 and 10 years. At the 14- and 16-year assessments, the presence, timing, and characteristics of childhood maltreatment, and the onset, rates, and patterns of substance use among the offspring, as well as the current characteristics of the children, their mothers, and their environments, including exposure to violence will be measured. Analysis of the data will facilitate identification of risk factors for adolescent substance use, and evaluate the roles that exposure to violence and PTSD may play in substance use. Data will be analyzed by gender.

Effects of Stressors on Drug Use in Young, Poor Women (R01DA20058-04, Helen Wu, PI) – The purpose of this prospective cohort study is to examine the contribution of stressors (including rape and exposure to violence) to drug abuse and dependence, as modified by coping style, among young, low-income women. The primary aims of this study are to: (1) study and report the epidemiology of stress exposure, particularly operant stressors (defined as the occurrences and accumulation of recent and ongoing stressors), in young, low-income women over time; (2) understand and examine the relationships of operant stressors with onset of DSM-IV abuse/dependence over time through theory-driven hypotheses (e.g., self-medication); and (3) examine whether an individual's coping style modify the relationships of different operant stressors with abuse/dependence.

Perception of Childhood Maltreatment: Implications for Early Adult Substance Abuse (R36 DA24778-01, Laura Elwyn, PI) – The purpose of this study is to clarify pathways that lead to adult substance use. The project uses

data from the Rochester Youth Development Study, a longitudinal study, to investigate: 1) whether an adult perception of having been maltreated in childhood is associated with early adult substance use problems over and above reported events of childhood maltreatment; 2) whether parent-adolescent attachment is associated with the relationship between childhood maltreatment, adult perception of maltreatment, and substance use problems; and 3) gender differences in the pathways from childhood maltreatment to adult substance use problems.

Long-Term Consequences of Exposure to Family Violence (R01DA20344-04, Carolyn Smith, PI) – The objective of this research is to identify the extent to which and the mechanisms through which, exposure to violence in the family might disrupt individual development in adolescence, with consequences that cascade over the life course and affect a subsequent generation. Exposure to family violence is conceptualized broadly to include domestic violence, child abuse, family conflict and exposure to multiple forms of violence. Key outcomes include public health targets of drug use, HIV/AIDS risk and violence. Guided by a developmental life-span model, the study will employ prospective data from three generations of subjects in the Rochester Youth Development Study.

Trajectories of Adverse Childhood Experiences and Adolescent Substance Abuse (K01DA21674-03, Laura Proctor, PI) – This is a five-year Mentored Career Development Award (K01) for training in the study of substance use and related problem behaviors in adolescence and emerging adulthood, and their relation to trajectories of adverse experiences in childhood (e.g., maltreatment, violence exposure, parental substance use). The primary goal of this study is to examine pathways from multiple forms of maltreatment and co-occurring childhood adversities to subsequent substance use and problem behaviors (i.e., delinquency and sexual risk behaviors) using data from the five-site Consortium of Longitudinal Studies of Child Abuse and Neglect (LONGSCAN). Child ethnicity, gender, and behavioral characteristics will be examined as potential moderators of hypothesized relations.

Intimate Partner Violence (IPV) and Drug Abuse

Informal Social Control of Partner Violence in Drug Users (K01DA020774-05, Victoria Frye, PI) – This grant is aimed at the applicant's development of expertise in ecological and stigma theories, advanced multi-level analysis, and research methods for the study of neighborhood-level factors associated with the "informal social control" ((i.e., social support of victims and social sanctions of perpetrators by community members or neighbors) a drug user) of intimate partner violence against drug-using women.

The Temporal Relationship of Partner Violence & Drug Use (K23DA019561-04, Tami P Sullivan, PI) – This award has facilitated Dr. Sullivan's development as an independent investigator of the relationships among intimate partner violence, posttraumatic stress disorder, and substance use. The broad, long-term career development objectives of the PI are: to be a leader in the field of intimate partner violence, trauma, and co-occurring substance use research; and to develop prevention and intervention programs target. Phase I of the award has focused on didactic training, mentoring, self-directed instruction, and refinement of Dr. Sullivan's research plan. Phase II has focused on the conduct of research, manuscript development, and grant writing. The research plan has focused on a feasibility study which examines three methods of data collection among a community sample of abused women. Specific aims are to gather pilot data on the temporal relationship of substance use and IPV events, and to examine the effectiveness of: 1) paper diaries; 2) monthly, retrospective, semi-structured interviews; and 3) telephone data collection methods.

Group-Based Couples Therapy for Drug Abuse (R01DA19434-03, William Fals-Stewart, PI) – The objective of this investigation is to conduct a randomized clinical trial to examine the clinical effectiveness, in terms of substance use, relationship functioning, and psychosocial adjustment, of Group Behavioral Couples Therapy (G-BCT) verses a) Standard Behavioral Couples Therapy (S-BCT), b) traditional Individual-Based Treatment (IBT), and c) multi-couple Group Psychoeducational Attention Control Treatment (G-PACT) for substance-abusing patients and their nonsubstance-abusing partners. The prevalence and frequency of intimate partner violence will be

measured prior to and after treatment. The comparative cost-benefit and cost-effectiveness of the intervention packages will also be examined.

Parent-Training and Couples Therapy for Drug Abuse (R01DA16236-03, William Fals-Stewart, PI) – The purpose of this study is to conduct a longitudinal randomized clinical trial to examine the clinical effects of a new, hybrid treatment, Parent Skills Training plus Behavioral Couples Therapy (PSBCT) compared to a) standard Behavioral Couples Therapy only, b) Parent Training only and c) Treatment-As-Usual. Married or cohabiting substance-abusing fathers and nonsubstance-abusing mothers entering outpatient treatment who live with and parent one or more preadolescent children will be recruited for the study. Participants in the treatment conditions will be compared in terms of children’s adjustment, fathers’ substance use, and family and relationship functioning. Measures of prevalence, frequency and severity of spousal violence will be included. Extensive cost, cost-benefit, and cost-effectiveness comparisons will also be conducted.

Violence, Victimization, & HIV/AIDS Risk

Impulsivity Related to Cocaine Dependence and Trauma (K23DA018718-03, Angela Waldrop, PI) – This grant it intended to prepare the grantee to independently design and conduct research on substance abuse, PTSD, and risky behaviors, with an emphasis on their relationships to impulsivity. The specific aims of the research plan are to (a) investigate impulsivity among women with and without cocaine dependence and with and without at least subthreshold PTSD related to sexual trauma, and (b) to examine the relationships among HIV risk behaviors and the laboratory and self-report measures of impulsivity. The findings of the proposed study will be used to inform future research in the area of impulsivity among women with comorbid substance use disorders and PTSD.

Drug Abuse and Risky Sex in Borderline Personality (R01DA020130-02, Ulrike Feske, PI) – This study examines the associations among borderline personality disorder (BPD), substance use disorders, and sexual risk taking and adverse reproductive outcomes in women. The investigator hypothesizes that neurocognitive competence (executive cognitive function) and risk

judgment will mediate the relationships. The study aims to recruit and assess 500 psychiatric outpatients: 300 women with BPD and 200 without, including 200 low-income African-American women. The assessments include partner violence. Modeling the association between BPD, substance use, and sexual risk taking in relation to substance use disorder and adverse reproductive outcomes will inform public health initiatives by documenting the importance of individual differences in a high-risk population (e.g., the need to screen for the presence of BPD in women presenting to substance use treatment programs).

The HIV Risk Behavior and the Urban Environment (R01DA18061-03, David Vlahov, PI) – This study examines the independent and interactive effect of features of the urban social environment (e.g., income distribution, neighborhood disadvantage, racial segregation) and the physical environment (e.g., population density, public transportation, built environment) as they relate to sexual and drug use risk factors for HIV infection and to HIV and STD prevalence.

Correlates of Sexual Risk for HIV/STI among Women Who Use Methamphetamine, (R01 DA021100-03, Kral, Alex, PI) – This study seeks to examine the individual, interpersonal (including sexual violence and abuse), structural, and cultural factors associated with high risk sexual behavior and the acquisition and transmission of HIV/STIs (gonorrhea, Chlamydia, HSV2, syphilis) among 400 methamphetamine-using women in San Francisco. The following are study's aims: 1) To determine what individual-level factors (patterns of MA use, polydrug use, psychological morbidities, and other factors) are associated with sexual risk among female MA users; 2) To determine what interpersonal-level factors (partner type, intimate relationship characteristics, dependent children) are associated with sexual risk among female MA users; 3) To determine what structural-level factors (homelessness, incarceration, venues of sex and drug use) are associated with sexual risk among female MA users; and 4) To determine what cultural-level factors (race/ethnicity, gender norms, religion) are associated with sexual risk among female MA users.

Women, Methamphetamine and Sex (K01DA017647-02, Alison H Brown, PI) – This grant is aimed at the grantee’s development as a mixed-methods researcher specializing in substance abuse and the emotional and physical health of women, with an emphasis on the interactions of methamphetamine use and histories of sexual abuse and violence on women’s sexual decision-making and HIV risk behaviors over the life course. The aims of the PI’s research are: 1) to investigate qualitatively the ways in which women MA users relate their sexual experiences to their drug use and/or their life experiences, and 2) to analyze quantitatively the longitudinal relationships between sex-risk behaviors, substance abuse, and life experiences among women MA users.

HIV Risk among Homeless Mothers (R01DA019399-03, Carol Canton, PI) – This study will utilize qualitative and quantitative components to address the gap in information on HIV risk in this fast rising subgroup of the adult homeless in the United States. HIV prevalence will be determined with the OraSure HIV test based on oral mucosal samples. STI testing for chlamydia, gonorrhea, and trichomoniasis will be based on urine and vaginal swab samples. The research team will be responsible for pre and post test counseling, test results, and treatment for positive assays. The aims of this study are to examine the relationship between HIV prevalence, STI prevalence, and HIV drug and sexual risk behaviors and homelessness, probing the extent to which risk behaviors are influenced by persistent residential instability. Guided by an integrated ecological framework, the study will investigate the relationship of multiple levels of risk and protective factors, including childhood sexual and physical abuse, mental illness, substance abuse, domestic violence, HIV knowledge and attitudes, and social support, to drug and sexual HIV risk behaviors and chronic homelessness. The study will inform the design of HIV risk behavior preventive interventions appropriate to the life circumstances of homeless mothers.

Residential Status, Drug Use, Health Among Impoverished Women (R03DA020387-01, Suzanne L Wenzel, PI) – This study blends quantitative and qualitative approaches to achieve the goal of improving our understanding of the relationship between residential status and drug use, HIV risk behaviors (i.e. risky sex), victimization by violence, and mental health among impoverished women and that will serve as a foundation for

future experimental work examining the relationship between residential status and health in this population.

Effects of Housing and HIV on Risk Behavior and Victimization of Indigent Women, (R01DA15605-05, Elise Riley, PI) – This study assesses the impact of housing type, drug use, social isolation, PTSD, dissociation, depression, manic episodes and HIV serostatus on risk behavior and victimization of poor and marginally housed women. The investigator plans to identify whether victimization and risk behavior patterns differ between women who are at risk to become HIV-infected and those who are already infected; whether predictors of victimization differ between women who do and do not report a history of childhood sexual abuse; whether the impact of PTSD and dissociation on victimization are modified by depression, manic episodes, or housing status; and whether variables that predict victimization are the same variables that predict drug use and sexual risk behavior.

Violence, Victimization, & HIV/AIDS Interventions

Multi-level HIV Prevention for Pregnant Drug Abusers (R01DA021521-02, Robert M Malow, PI) – This study targets pregnant drug abusers in treatment. It is a randomized trial of Enhanced- Behavioral Skills Training (E-BST) compared to a time- and attention-matched Health Promotion Comparison (HPC) condition. E-BST is designed to strengthen relationship-based social competency skills of the original BST were crucial in sustaining adherence to protective behavior. The E-BST emphasizes negotiation/communication skills with sexual partners/significant others and social ecological skills of help- seeking and service utilization. Participants will be 320 culturally diverse (30% Hispanic, 60% African American) pregnant drug abusers in treatment with random assignment to the E-BST and HPC. PI will seek to answer how intervention effects are mediated by theoretically relevant Individual Cognitive-Behavioral and Contextual factors and moderated by key background factors such as cognitive functioning and traumatic abuse history.

Risk Reduction for Drug Use and Sexual Revictimization (K23DA018686-02, Carla Kmetz Danielson, PI) – This grant is aimed at the grantee's development as an expert in the area of risk reduction for drug use and sexual

revictimization in adolescent sexual assault victims and at designing and executing a research project. The research project will include a) developing an early intervention, Risk Reduction through Family Therapy (RRFT) program, for adolescent sexual assault victims by adapting and integrating empirically-supported interventions that target substance abuse, trauma-related symptoms, and revictimization risk; b) testing the feasibility of the application of RRFT through a pilot feasibility trial; and c) evaluating the efficacy of RRFT by conducting a small randomized clinical trial.

HIV/AIDS & Women of Color: Roles of Drug Use, Violence & Insurance in HAART Use (R21DA022971-02, Marsha D Lillie-Blanton, PI) – This study uses data from the Women's Interagency HIV Study (WIHS) confidential data set to (1) assess whether the roles of race and drug use on HAART are moderated by the effects of health insurance coverage, and (2) examine longitudinal differences in HAART use among HIV positive female drug users and investigate the extent to which individual latent states (as defined by clusters of psycho-social or behavioral risk factors such as an individual's drug use, drug using partners, depression, and physical or sexual abuse) influence racial/ethnic disparities after controlling for other confounders. The study results will improve understanding of the roles of drug use, physical or sexual abuse, and insurance coverage in observed racial disparities of HAART use among HIV positive women and ultimately, improve interventions aimed at reducing racial and other disparities in HIV/AIDS medical care among women. The findings will also inform development of systems for monitoring quality of care among HIV positive women.

HIV Prevention Groups for AOD Using SMI Women (R01DA018916-04, Robert M Malow, PI) – This is a gender-and-culturally specific adaptation and randomized trial of a group-formatted Motivational-Enhanced, Brief Behavioral Skills Intervention (BBSI-A) for reducing HIV risk among 320 predominantly Hispanic and African American women, representing a target population of the AOD abusing, seriously mentally ill (SMI) population in community treatment in the HIV epicenter of Miami. A key focus is how group processes (e.g., group alliance, engagement, cohesion, and climate) may mediate change. The intervention to be adapted and evaluated is derived from Information-Motivation-Behavior (IMB) theory, and is evidence-based

and archived by scientific consensus for dissemination. The adaptation, BBSI-A, will be compared to a time-matched, video-based "Treatment as Usual" Educational (EDUC) condition.

Woman Focused HIV Prevention with African-Americans (R01DA11609-10, Wendee M. Wechsberg, PI) – This study will examine the long-term effects of the Women's CoOp intervention with regard to drug and sexual risk for HIV, self-sufficiency, and a woman's ability to sustain change within her social context. The study will evaluate the long-term effectiveness of a culturally specific, woman-focused intervention and the booster follow-up intervention relative to the NIDA standard intervention and NIDA booster follow-up intervention offered biannually to sustain reductions in crack use and sexual risk and improve self-sufficiency (e.g., employment, housing) at 6, 12, and 18 months post enrollment. The mediating effects of employment and housing, as well as moderators, such as age, abuse history and psychological distress, on the effectiveness of the intervention at changing HIV risk behaviors at 6, 12, and 18 months post reenrollment will also be assessed; and estimates made of the cost and cost-effectiveness of a culturally specific, woman-focused intervention relative to the NIDA standard in terms of crack use and sexual risk behaviors.

Women-Focused HIV Prevention in the Western Cape (R01DA022118-01A2, Wendee M Wechsberg, PI) – This multi-method research will conduct an extensive evaluation using qualitative and quantitative methods, repeated measures, and biological testing to determine the effectiveness of the woman-focused intervention at increasing knowledge and skills and thereby reducing substance abuse, sexual risk behaviors, and victimization. The study aims are to(1) test the effectiveness, through a randomized field experiment, of rapid HIV testing plus two woman-focused groups relative to rapid HIV testing only at increasing knowledge and skills to reduce substance abuse, sexual risk, and victimization, at 3- and 6-month follow-ups; (2) examine the moderating effects of age, race, education, employment, abuse history (i.e., sexual and physical), and HIV status, and the mediating effects of relationship power and perceived stigma on the effectiveness of the woman-focused groups at increasing positive behavior change; and (3) estimate the incremental cost and cost-effectiveness of the added woman-focused group relative to the rapid testing and counseling protocol.

Woman-Focused HIV Prevention with Pregnant African-Americans in Treatment (R01DA020852-01 Wendee M Wechsberg, PI) – This study aims to: 1) adapt the culturally specific, manualized woman-focused intervention to specifically address issues of pregnancy and substance abuse, relationships with men, social support, parenting, HIV status, living with HIV, antiretroviral (ARV) treatment, and HIV risk-reduction methods for pregnant and postpartum women; 2) Compare the relative efficacy of the woman-focused intervention for pregnant women relative to standard substance abuse treatment to sustain reductions in substance abuse and sexual risk behaviors, maintain retention in drug treatment, reduce violence, and improve prenatal care and ARV treatment adherence (as needed) at 3- and 6- month follow-ups; and 3) Explore the intervention's potential mechanisms of action (e.g., by examining the mediating effects of changes in knowledge about HIV risk behaviors, psychological distress, and readiness for change), and moderating factors (e.g., HIV status, age, stage of pregnancy, and relationships with men) that may influence response to the treatment.

HIV Prevention with Heroin Using Women Sex Workers in Tajikistan (R03DA021108-02, Anne Elizabeth Brisson, PI) –The aims of this study are to: 1) examine social-environmental risk factors (i.e., addiction, poverty, gender inequality, violence and lack of services) in Tajikistan that put these women at higher risk of HIV infection, and interfere with HIV risk behavior change efforts; and 2) design and pilot a preventive intervention that addresses these risk factors. Ethnographic methods will be used to interview/observe 30 women over 3 months to understand the impact of risk factors on both HIV risk and prevention efforts. The preventive intervention will be a small group 8-session approach which will address woman-focused HIV prevention components including social support, help seeking, and negotiation skills. Results from this study will inform HIV prevention in Tajikistan, contribute to the science related to HIV risk and prevention with woman in adverse social environmental conditions, and lead to the development of a proposal to pilot the preventive intervention.

Prevention for Impoverished Young Women in Shelters (R21DA019183-02, Suzanne L Wenzel, PI) – This is a qualitative study conducted among poor

homeless young women to understand contexts for and barriers to intervene to reduce drug abuse, HIV transmission and victimization.

Behavioral Intervention for Minority Adolescent Women (R01DA019180-05, Jane H Dimmitt Champion, PI) – The AIDS Risk Reduction Model (ARRM) was modified and piloted for minority, sexually/physically abused girls (14-18 yrs) with an STD; this group was not helped by the original ARRM. Two groups of girls are randomly assigned to either (1) workshop/support group/individual sessions program or (2) physical care/counseling only.

Reducing HIV & Domestic Violence Risk in Women Offenders (R01DA012572-05, Mike Stark, PI) – This is a randomized controlled trial to test two interventions to reduce women offenders' HIV-related risk behavior and exposures to domestic violence. Seventy HIV seronegative female offenders at risk of HIV infection (i.e. females who inject drugs, use crack, are sex partners of IDUs or trade sex for drugs, money or subsistence) will be recruited through outreach at existing county jail HIV testing sites. Subsequent to their release from jail participants will be randomly assigned to one of three study conditions: Participants in the control condition will receive the standard of care-referrals for needed services. Women in the HIV prevention condition will receive three-month case management and intensive HIV risk reduction intervention. Women in the HIV and domestic violence prevention condition will receive the same intervention as those in the second condition plus assessment and intervention for the prevention of domestic violence and coerced risk activity. All participants will complete face-to-face assessment interviews measuring their drug-related behaviors sexual risk behaviors experiences of domestic violence psychological well being behavioral self-efficacy and relationship processes.

Multimedia HIV/STI Prevention for Drug-Involved Female Offenders (R01DA025878-02, Nabila El-Bassel, PI) – This study addresses this gap in our understanding of evidence-based HIV prevention interventions among drug-involved female offenders under community supervision by conducting a randomized controlled trial (RCT) to test the efficacy of a multimedia version of 4-session, gender-specific, integrated drug use and HIV/STI prevention intervention (Multimedia WORTH) in increasing condom use and decreasing the incidence of sexually transmitted infections (STIs) among 420

drug-involved female offenders in a large Alternative-to-Incarceration(ATI) Probation Program in New York City, compared to a non-media version of the same intervention (Traditional WORTH) and to a 4-session NIDA standard HIV prevention control condition, which is not gender-specific (NIDA Control). The Traditional WORTH intervention was as a group-based, integrated drug use and HIV prevention intervention for low income, urban female offenders which addresses intimate partner violence (IPV) and other gender specific risk factors for HIV. Multimedia WORTH contains the same content as Traditional WORTH, but employs multimedia interactive tools and culturally tailored animation and video enhancements.

Prevention of Postrape Drug Abuse: Replication Study (R01DA023099-02, Heidi Resnick, PI) – This study examines the efficacy of an easily administered evidence- based preventive intervention for drug abuse and mental health problems, the Prevention of Post Rape Stress (PPRS) video. The study allows for replication at an independent site (Minneapolis) of findings from an initial NIDA funded study indicating reduced frequency of marijuana use among pre- rape recent marijuana users and reduced frequency of PTSD and depression symptoms among recent female rape victims with prior history of rape associated with the PPRS video relative to standard care.

Couples HIV Intervention Randomized Controlled Trial (R01DA015641-04, James McMahon, PI) – The broad, long-term objective of this study is to establish primary preventive interventions to reduce human immunodeficiency virus (HIV) risk behavior among drug-using minority women. Based on an integrated theory of HIV risk behavior, it is predicted that a) interventions administered to couples rather than to women only, and b) interventions that focus on relationship dynamics in the context of HIV risk, will result in a reduction of sexual risk behavior among drug-using women and their primary partners. This four-year study is employing a randomized controlled trial (RCT) 3-group design to test the efficacy of HIV intervention modality (couples versus women-only) and intervention content (relationship-focused versus standard HIV counseling and testing) on crack, cocaine and heroin (injected and noninjected) using women's sexual risk with primary partners.

Barriers to Treatment-based HIV Prevention for IDU Couples

(R21DA022960-01, Janie Simmons, PI) – This qualitative study of IDU couples and treatment providers focuses on two sets of barriers to drug treatment and treatment-based HIV risk reduction among African American and Latino heterosexual IDU couples in NYC: 1) on the relationship dynamics among partnered IDUs that deter treatment entry, retention or the maintenance of outcomes; and 2) on couples-specific structural barriers in the treatment system that further inhibit treatment entry, retention, and the maintenance of outcomes. The PI is also investigating how the above mentioned barriers interact. Findings from the proposed research will inform subsequent work to quantify these barriers and develop and evaluate programs to overcome them.

Other Prevention and Treatment Interventions

Recovery Management Checkups for Women Offenders (RMC-WO)

Experiment (R01DA021174-03, Christy K Scott, PI) – This study is designed to test the effectiveness of recovery management checkups for women offenders (RMC-WO) released from jail to provide continuity of care immediately upon release and to help them manage their long-term recovery. The specific aims of this experiment are to examine the impact of: (1) RMC-WO on accessing and staying in community-based treatment during the first 90 days after release from jail and over the course of 3 years; (2) RMC-WO and substance abuse treatment on substance use and HIV risk behaviors over 3 years; and (3) RMC-WO, substance abuse treatment, and reductions in substance use and HIV risk behaviors on psychiatric co-morbidity, interpersonal violence, illegal activity, and arrest and re-incarceration over 3 years.

Case Management Alternatives for Highly Vulnerable Women

(R01DA013131-09, James A Inciardi, PI) – This study aims at : (1) assessing the nature and extent of mental, physical, and other health service needs and barriers to service utilization among a sample of 500 drug-involved, indigent, African-American sex workers recruited from inner city Miami; (2) implementing two robust case management conditions designed to increase linkages to, and engagement with, appropriate health services by randomly assigning participants to an intervention; (3) evaluating the effectiveness of

the two conditions by conducting 3 and 6-month follow-ups with clients and providers to determine extent of service linkages and engagement, as well as changes in risk behaviors as they relate to increases in service access; (4) examining the effects demographics, violence, mental health, homelessness, current sexual behaviors and drug use, treatment experience, and other life events in predicting service linkage and engagement; and (5) estimating and compare the cost and cost-effectiveness of the case management conditions in increasing service access and utilization.

Co-occurring Disorders and Violence in Women: Moderators of Services Use and Cost (F31 DA022815-01, Allison R Gilbert, PI) – The goal of this study is to understand how different baseline symptom severity and services use profiles moderate the effect of integrated treatment versus usual care on female patients' follow-up services use and costs. The study aims to apply a set of pre-existing clusters according to baseline symptom severity, derived using a k-means cluster method, to an analysis of 12-month services use and costs. In addition, the PI aims to construct a second set of k-means clusters to reflect variations in baseline services use and costs and apply it to an analysis of 12-month services use and costs. Finally, the PI aims to compare the two clustering approaches qualitatively regarding the differences in how they moderate the effect of treatment on follow-up services use and costs (by analyzing the differences in the data distribution across the two clusters and comparing the models' respective R-squared statistics).

Jane Addams Substance Abuse Research Collaboration (R01DA013943-05, James Anthony Swartz, PI) – This program addresses the impact of drugs and the societal response to drugs on women and their children to provide a fuller understanding of the link between substance abuse, criminal justice, and women, in accordance with the agenda set forth in Healthy People 2000. The specific aims of the collaboration are: 1) Develop a community-based, multidisciplinary substance abuse research program focused on the confluence of substance abuse, criminal justice, and women; 2) Provide an organizational focus to support multi-disciplinary teams pairing senior faculty, junior faculty, and research assistants in pilot research efforts in the core area; 3) Increase active collaboration with Treatment Alternatives for Safe Communities (TASC), BRASS/HRDI, and other substance abuse providers to enhance the generation of practitioner-useful research, consistent

with the mission of the Jane Addams College of Social Work; 4) Promote culturally competent and practice-useful substance abuse research through a Minority Researcher Development Program and a Community Scholar Program; 5) Utilize an Advisory Panel consisting of providers, consumers, and senior researchers to provide conceptual guidance and specific expertise, critique research proposals, and identify applications for research; and 6) Support professional development plans, including multidisciplinary research seminars, conferences, technical assistance, and broad exposure to substance abuse research culture in order to prepare social work faculty to become fully collaborative and independent substance abuse researchers, and make pragmatic and distinguished contributions to the substance abuse field.

Computer-Based HIV/STD Prevention For High-Risk Women

(R43DA021425-03, Douglas Billings, PI) – This project will involve the initial development and feasibility testing of a computer-based HIV/STD prevention program specifically designed for women who have sex with men (WSM). The SafeSistah program will have three main foci: 1) Development of gender-specific prevention skills will be emphasized, including training in refusal skills and how to avoid physical violence; 2) The treatment and prevention of STDs will be a priority; and 3) Enhancement of empowerment and ethnic identity.

Recent NIDA-Supported Publications on Violence against Women and Girls:

Childhood Stress/Abuse/Trauma & Violence

Protective Factors Associated with Preadolescent Violence. This study explores the influences of communal values, empathy, violence avoidance self-efficacy beliefs, and classmates' fighting on violent behaviors among urban African American preadolescent boys and girls. As part of a larger intervention study, 644 low-income 5th grade students from 12 schools completed a baseline assessment that included the target constructs. Boys reported more violent behaviors, and lower levels of empathy and violence avoidance self-efficacy beliefs than girls. Path analyses revealed that, after controlling for classmates' fighting, violence avoidance self-efficacy beliefs were negatively associated with violent behavior. Communal values had a direct negative relationship with violence for boys, but not girls. Both

communal values and empathy were associated with less violent behavior through positive relationships with violence avoidance self-efficacy beliefs. For girls, classmates' fighting had an indirect positive association with violent behavior through its negative relationship with violence avoidance self-efficacy beliefs. This research identifies protective factors that can potentially be harnessed to delay the onset and/or slow the growth of violent behaviors in youth. Jagers, R.J., Sydnor, K., Mouttapa, M., & Flay, B. (2007). Protective Factors Associated with Preadolescent Violence: Preliminary Work on a Cultural Model. *Am J Community Psychol.*, 40 (1-2), 138-145.

Gender Differences in Physical and Relational Aggression as Predictors of Drug Use in High School Students. The present study investigated the longitudinal relationships between physical and relational aggression and later drug use, as moderated by gender. Self-reported data were gathered from 2064 high school students at pretest and 1-year post-test to test the hypotheses that 1) males would engage in more physical aggression than females, whereas females would engage in more relational aggression than males; and 2) physical aggression would be a stronger drug use predictor for males and relational aggression a stronger predictor for females. Results indicated that males reported engaging in more physical aggression than females at baseline; however, females and males reported engaging in similar rates of relational aggression. After controlling for relational aggression, baseline drug use, and demographic variables, physical aggression at baseline was found to predict alcohol use 1-year later for males but not for females. After controlling for physical aggression, baseline drug use, and demographic variables, relational aggression was found to predict cigarette use and marijuana use for females but not for males. However, relational aggression was found to predict later alcohol and hard drug equally across gender. These findings suggest that both physical and relational aggression are predictive of subsequent drug use and have important implications for violence and drug use prevention intervention efforts. Skara, S., Pokhrel, P., Weiner, M., Sun, P., Dent, C., and Sussman, S. (2008). Physical and Relational Aggression as Predictors of Drug Use: Gender Differences among High School Students. *Addict Behav.*, 33 (12), 1507-1515.

Childhood Maltreatment and Antisocial Behavior: Comparison of Self-Reported and Substantiated Maltreatment. Although accurate assessment of

maltreatment is critical to understanding and interrupting its impact on the life course, comparison of different measurement approaches is rare. The goal of this study is to compare maltreatment reports from official Child Protective Services (CPS) records with retrospectively self-reported measures. Research questions address the prevalence and concordance of each type of measure, their relationship to social disadvantage, and their prediction to four antisocial outcomes in adolescence and early adulthood including arrest, self-reported violence, general offending, and illegal drug use. Data to address this comparison come from the Rochester Youth Development Study (RYDS), a longitudinal panel study of 1,000 adolescents. Findings indicate that self-reported retrospective maltreatment is somewhat more prevalent (29%) than official substantiated maltreatment (21%). Among those with official reports, in young adulthood about half self-reported maltreatment, whereas 37% of those self-reporting have an official report. In general, both sources suggest that maltreatment is associated with a higher prevalence of antisocial behavior. It is not clear that combining sources of information improves prediction. Smith, C.A., Ireland, T. O., Thornberry, T. P., & Elwyn L. (2009). Childhood Maltreatment and Antisocial Behavior: Comparison of Self-reported and Substantiated Maltreatment. *American Journal of Orthopsychiatry*, 78, 173-186.

Community Violence and Youth: Affect, Behavior, Substance Use, and Academics. Community violence is recognized as a major public health problem (WHO, World Report on Violence and Health, 2002) that Americans increasingly understand has adverse implications beyond inner-cities. However, the majority of research on chronic community violence exposure focuses on ethnic minority, impoverished, and/or crime-ridden communities while treatment and prevention focuses on the perpetrators of the violence, not on the youth who are its direct or indirect victims. School-based treatment and preventive interventions are needed for children at elevated risk for exposure to community violence. In preparation, a longitudinal, community epidemiological study, The Multiple Opportunities to Reach Excellence (MORE) Project, is being fielded to address some of the methodological weaknesses presented in previous studies. This study was designed to better understand the impact of children's chronic exposure to community violence on their emotional, behavioral, substance use, and academic functioning with an overarching goal to identify malleable risk and

protective factors which can be targeted in preventive and intervention programs. This paper describes the MORE Project, its conceptual underpinnings, goals, and methodology, as well as implications for treatment and preventive interventions and future research. Cooley-Strickland, M., Quille, T.J., Griffin, R. S., Stuart, E.A., Bradshaw, C. P., & Furr-Holden, D. (2009). Community Violence and Youth: Affect, Behavior, Substance Use, and Academics. *Clinical Child and Family Psychology Review*.

Women who Experience Intimate Partner Violence (IPV)

Interpersonal Partner Violence and Women in the United States: An Overview of Prevalence Rates, Psychiatric Correlates and Consequences and Barriers to Help Seeking. In 1991, in the United States, Surgeon General Koop declared violence a public health epidemic, ushering in a surge of funding for primary and secondary prevention, as well as research to study the many faces of this social problem. For women, violence may take many forms, violence against women being the most common. Defining violence as a public health epidemic recasts problems of violence from a criminal justice framework and allowed an entrée from social science and medical health perspectives. Today, over fifteen years have passed, and we have made substantial advances in our understanding of violence as it affects women. This paper presents an overview of what we know to date on the epidemiology and treatment of intimate partner violence (IPV) in heterosexual relationships. In addition to examining known prevalence rates in the United States of IPV, the authors report on gender and ethnic differences in these rates, as well as the correlates and psychiatric consequences of IPV exposure. A discussion of treatments and social and psychological barriers to seeking and receiving help is offered in the hopes that those in a position to consider public policy may be informed about the current state of science in this field. Hien, D. & Ruglass, L. (2009). *Interpersonal partner violence and women in the United States: an overview of prevalence rates, psychiatric correlates and consequences and barriers to help seeking.* *International Journal of Law and Psychiatry*, 32, 48–55.

Violence and Substance Use among Female Partners of Men in Treatment for Intimate-Partner Violence. To improve understanding of the complex

dynamics in intimate partner violence (IPV) in heterosexual relationships, the authors explored violence and substance use among the female partners of men entering treatment for both IPV and substance-related problems. All male participants (n = 75) were alcohol dependent and had at least one domestic-violence arrest. Results showed that female partners were as likely as men to engage in substance use the week before treatment; however, according to reports by the men, the female partners were more likely than men to use substances during the last week of treatment, due to a reported increase in use during the men's treatment. Regarding violence, 59 percent of female IPV victims reported engaging in some form of mild violence against their male partners, and 55 percent reported engaging in some form of severe violence. By contrast, only 23 percent of male batterers reported that their female partners had engaged in mild violence, and only 19 percent reported that their partners had engaged in severe violence. Regardless of whether the violence was defensive in nature, the data suggest that women in relationships involving substance abuse and IPV are in need of treatment. Wupperman, P., Amble, P., Devine, S., Zonana, H., Fals-Stewart, W. & Easton, C. (2009). Violence and substance use among female partners of men in treatment for intimate-partner violence. *Journal of the American Academy of Psychiatry and Law*, 37, 75-81.

Violence against Women. This research note examines the prevalence and correlates of intimate partner violence (IPV) and other violence (OV) among women (N = 529) at risk for HIV and with histories of criminal justice system involvement. The 3-month prevalence of IPV and OV were 31.2% and 18.7%, respectively. IPV was associated with having a current main partner, substance use, sexual risk behavior, trading sex, anxiety, depression, and lower self-esteem. OV was associated with no current employment or schooling, unstable housing, drug use, trading sex, anxiety, depression, and lower self-esteem. The high prevalence of violence demonstrates the need for intervention in this population; the correlates show that effective interventions must address the complex issues in these women's lives. Weir, B.W., Bard, R.S., O'Brien, K., Casciato, C.J., Stark, M.J. (2008). Violence against Women with HIV Risk and Recent Criminal Justice System. *Violence against Women*, 14:8, 944-960.

Special Populations of Women

Correlates of HIV Testing Among South African Women with High Sexual and Substance-use Risk Behaviors. Despite its importance in raising awareness of HIV risk behavior and in linking HIV-positive individuals to care and treatment, research findings indicate that the HIV antibody testing rate in the general South African population remains relatively low, although knowledge of HIV testing services is high. The identification of important correlates of testing behavior can be used to improve HIV testing campaigns by refining messages that target individuals at highest risk for infection. This study uses data from an ongoing prevention intervention study in Pretoria, South Africa to identify factors that may have a greater influence on facilitating or hindering HIV testing among South African women who face a high risk for infection. The data for this study (n=425) are derived from the baseline interviews and HIV test results collected between June 2004 and January 2007. HIV testing for this study was significantly associated with education level, alcohol and cannabis use, sex trading, number of STI symptoms, physical abuse and number of visits to a clinic for medical treatment. Results suggest that more focused efforts need to be made to provide HIV testing to women who report substance use behavior, experience violence and report high-risk sexual behavior. Interventions also need to address denial of HIV infection and fear to test for HIV. Luseno, W. K., Wechsberg, W.M. (2009). *Correlates of HIV Testing among South African Women with High Sexual and Substance-use Risk Behaviors.* *AIDS Care*, 21:2, 178-184.

Violence and HIV Risk among Incarcerated Women. The association between history of violence and risk for HIV infection among incarcerated women was examined. Specifically, physical violence and rape were considered as they relate to unprotected sex with male primary and nonprimary (male or female) sexual partners among a sample of HIV negative female inmates (n = 1,588) housed in Connecticut's sole correctional facility for women between November 1994 and October 1996. A supplement to the mandatory Connecticut Department of Correction Inmate Medical Screening/Health History was used to collect information on each woman's background, history of violence, and unprotected sex practices. Multivariate logistic regression was used to determine the

associations between violence and unprotected sex by partner type. Experiencing any violence was found to be significantly associated with increased odds of unprotected sex with one 's primary partner, even after controlling for race, history of sex work, drug use, employment status, and having other nonprimary partners. Of particular importance was having a history of physical violence. History of violence was not significantly associated with unprotected sex with nonprimary partners. These findings demonstrate the considerable vulnerability of incarcerated women to violence and suggest that this history is associated with increased unprotected sex practices, especially with male primary partners. HIV prevention interventions among women should take experiences of violence into account. Conversely, violence prevention and interventions aimed at coping with violence can be a part of the HIV prevention agenda for incarcerated women. Future longitudinal research can confirm the relationships of violence to HIV risk in women. Ravi, A., Blankenship, K.M., & Altice, F.L. (2007). The Association between History of Violence and HIV Risk: A Cross-Sectional Study of HIV-Negative Incarcerated Women in Connecticut. *Women's Health Issues*, 17: 4, 210-216.

Gender: Post Traumatic Stress Syndrome. Patients with a chronic and severe substance use disorder who also have a history of post-traumatic stress disorder (PTSD) are thought to have a unique set of problems. The present study assessed psychiatric disorders, psychosocial problems, and traumatic events with structured interviews in 747 men and 693 women enrolling in urban opioid substitution treatment programs from 1995 to 2001. Participants with versus without a history of PTSD were more likely to have a history of many other psychiatric disorders and demonstrated more current and historical medical, employment, family/social, and psychiatric problems. PTSD was generally unrelated to substance use disorder severity or diagnoses, with the exception of an increased risk of alcohol dependence. Women were more likely than men to have experienced sexual assault, and less likely to have been physically assaulted, although these events precipitated PTSD at equivalent rates across gender. In contrast, witnessing or hearing about the death or injury of others was more likely to precipitate PTSD in women than men. Female gender, exposure to combat, sexual assault, or physical assault, and a history of major mood or anxiety disorder were the best predictors of PTSD in this group. Peirce, J.M., Kindbom, K.A.,

Waesche, M.C., Yuscavage, A.S., and Brooner, R.K. (2008). Posttraumatic Stress Disorder, Gender, and Problem Profiles in Substance Dependent Patients. *Subst. Use Misuse*, 43, 596-611.

A National Survey of Psychiatric Disorders in Pregnant and Postpartum Women. Psychiatric disorders and substance use during pregnancy are associated with adverse outcomes for mothers and their offspring, and information about the epidemiology of these conditions in this population is lacking. The objective of this study was to examine sociodemographic correlates, rates of DSM-IV Axis I psychiatric disorders, substance use, and treatment seeking among past-year pregnant and postpartum women in the United States. The study's main outcome measures include the prevalence of 12-month DSM-IV Axis I psychiatric disorders, substance use, and treatment seeking. The study relied on face-to-face interviews conducted in the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), one of the largest nationally representative surveys to date to include information on psychiatric disorders in pregnant women. A total of 43,093 respondents were interviewed, of whom 14,549 were women 18 to 50 years old with known past-year pregnancy status. The analysis found that pregnant and postpartum women had significantly lower rates of alcohol use disorders and any substance use, except illicit drug use, than non-pregnant women. In addition, currently pregnant women had a lower risk of having any mood disorder than non-pregnant women. The only exception was the significantly higher prevalence of major depressive disorder in postpartum than in non-pregnant women. Age, marital status, health status, stressful life events, and history of traumatic experiences were all significantly associated with higher risk of psychiatric disorders in pregnant and postpartum women. Lifetime and past-year treatment-seeking rates for any psychiatric disorder were significantly lower among past-year pregnant than non-pregnant women with psychiatric disorders. It was interesting to note that most women with a current psychiatric disorder did not receive any mental health care in the 12 months prior to the survey regardless of pregnancy status. The authors' concluded that pregnancy per se is not associated with increased risk of the most prevalent mental disorders, although the risk of major depressive disorder may be increased during the postpartum period. In addition, groups of pregnant women with particularly high prevalence of psychiatric disorders were identified. Low rates of maternal mental health care underscore the

need to improve recognition and delivery of treatment for mental disorders occurring during pregnancy and the postpartum period. Vesga-López, O., Blanco, C., Keyes, K., Olfson, M., Grant, B., and Hasin, D. (2008). Psychiatric Disorders in Pregnant and Postpartum Women in the United States. *Arch. Gen. Psychiatry*, 65(7), 805-815.

Male Perpetrators of Violence against Women

Drug Consumption among Sexual Offenders Against Females. This article aims to evaluate the role of drug consumption among sexual offenders against females. Three groups of participants (N =133) comprising sexual offenders against girls, pubertal females, and women were examined with reference to history of drug and/or alcohol use, impulsivity level, sexual addiction, and recidivism risk. The results of this study revealed that sexual offenders against women were found to have significantly more difficulties with drug use, higher impulsivity level, and to be younger than the sexual offenders against girls and pubertal females. The combination of drug consumption and higher level of impulsivity may contribute to sexual aggression against adult females. Baltieri, D.A., & de Andrade, A.G. (2008). Drug Consumption among Sexual Offenders against Females. *International Journal of Offender Therapy and Comparative Criminology*, 52(1): 62-80.

Concurrent Alcohol and Drug Use in Offenders of Domestic Violence. This study assesses differences between alcohol-dependent men who were arrested for intimate partner violence with and without concurrent illicit drug use. Seventy-eight participants were randomly assigned to two manual-guided group behavioral therapies and assessed across 12 weeks of treatment. The data revealed few differences between the alcohol versus the alcohol and drug using groups at baseline. With regard to treatment compliance and retention, alcohol and drug using participants attended significantly fewer sessions, had significantly fewer percent days abstinence from alcohol use, significantly more total days of positive breathalyzer results. In addition, the alcohol and drug using participants had significantly more impairments in anger management styles from pre- to post-treatment. Overall, the findings suggest that alcohol-dependent men who continue to use illicit drugs may require additional interventions to effectively control their drug use, and,

possibly their anger management problems. Easton, C.J., Mandel, D., Babuscio, T., Rounsaville, B. & Carroll, K.M. (2007). Differences in Treatment Outcome between Male Alcohol Dependent Offenders of Domestic Violence with and without Positive Drug Screens. *Addictive Behaviors*, 32, 2151-2163.

Smoking Onset among Alcohol Dependent Offenders of Domestic Violence. This study examined differences between alcohol dependent offenders of intimate partner violence (IPV) with early initiation of cigarette smoking versus alcohol dependent offenders of IPV with later initiation of cigarette smoking. Seventy-eight alcohol dependent men who were arrested for domestic violence and referred to substance abuse treatment were randomly assigned to manual-guided behavioral therapies (Cognitive Behavioral Therapy or Twelve Step Facilitation). The data show that early onset smokers had more severe problems at pre-treatment, including more anxiety, domestic violence arrests and more anger expression compared with the later smoking initiation group. Regarding treatment outcomes, there was no significant difference between groups at treatment completion. Despite more severity of substance abuse, legal and violence characteristics at baseline in the early initiation group, both smoking initiation groups responded equally well across 12 weeks of manualized behavioral treatment. Easton, C.J., Weinberger, A.H., & George, T. P. (2007). Age of Onset of Smoking among Alcohol Dependent Men Attending Substance Abuse Treatment after a Domestic Violence Arrest. *Addictive Behaviors*, 32, 2020-2031.

Cigarette Smoking and Intimate Partner Violence among Men Referred to Substance Abuse Treatment. This study examined differences between alcohol-dependent offenders of intimate partner violence (IPV) with and without current daily cigarette smoking. Eighty-five alcohol dependent men arrested for domestic and referred to substance abuse treatment were evaluated. A total of 71% of the participants reported current cigarette smoking. The groups were divided into daily smokers (n = 52) vs. non-daily smokers (n = 21). Daily smokers had significantly more days of alcohol use in the 28 days prior to starting treatment, significantly more ASI alcohol and legal severity, and significantly more participants with a diagnosis of antisocial personality disorder compared to non-daily smoking alcohol dependent offenders of IPV. Easton, C.J., Weinberger, A.H., & McKee, S.A.

(2008). Cigarette smoking and intimate partner violence among men referred to substance abuse treatment. *American Journal of Drug Alcohol Abuse*, 34, 39-46.

Neurocognitive Performance among Alcohol Dependent Men with and without Physical Violence toward their Partners. There are high rates of co-occurring alcohol dependence and intimate partner violence (IPV) among men seeking substance abuse treatment. The authors examined neurocognitive performance among treatment-seeking alcohol dependent men with (IPV+) and without reported physical violence (IPV-). Twenty-five subjects participated in this pilot study. All participants underwent a neurocognitive battery including, Continuous Performance Test (CPT), California Verbal Learning Test (CVLT), Digit Span, Iowa Gambling Test (IGT), Wisconsin Card Sort (WCST), Trail Making Test, Parts A & B, a visuospatial memory (VSWM) task and the Stroop Color Word Test (SCWT). Alcohol dependent participants with IPV (IPV+; n = 9) had more severe deficits in attention, concentration, cognitive flexibility compared to controls (n = 7). Both the alcohol dependent (IPV-; n = 9) and IPV+ groups had significantly more impairments on tasks of impulsivity than the smoking controls. The IPV- group had significantly more impairments on executive functioning compared to smoking controls, but was not significantly different than the IPV+ group. The preliminary results suggest that IPV+ males have more severe neuropsychological impairments compared to the smoking control group than did the IPV - group. Easton, C.J., Sacco, K.A., Neavins, T.M., Wupperman, P., & George, T.P. (2008). Neurocognitive performance among alcohol dependent men with and without physical violence toward their partners: a preliminary report. *American Journal of Drug Alcohol Abuse*, 34, 29-37.

Interventions

An Acute Post-Sexual Assault Video Intervention to Prevent Drug Abuse. A two-part video intervention was developed to minimize anxiety/discomfort during forensic examinations and to prevent increased substance abuse and use following sexual assault among 268 sexual assault victims participating in a forensic medical exam. The video was associated with significantly lower frequency of marijuana use at less than 3 months after the assault, 3 to 6 months post-assault, and 6 months or longer post-assault. Resnick, H.S.,

Acierno, R., Amstadter, A.B., Self-Brown, S., & Kilpatrick, D.G. (2007). An Acute Post-sexual Assault Intervention to Prevent Drug Abuse: Updated Findings. *Addictive Behaviors*, 32, 2032-2045.

An Early Video Intervention to Prevent Post-Rape Psychopathology. A randomized between-group design was utilized to evaluate the efficacy of a video intervention (designed to reduce distress during forensic examination by describing key aspects of the examination as well as depicting a model undergoing such procedure and successfully coping; length 17 minutes), to reduce post-traumatic stress disorder (PTSD), and other mental health problems, implemented prior to the forensic medical examination conducted within 72 hours post sexual assault among 140 female victims of sexual assault aged 15 years or older. After 6 weeks, the intervention was associated with lower scores on measures of PTSD and depression among women with a prior rape history relative to scores among women in the comparison group. After 6 months post assault, depression scores were also lower among women with a prior rape history who were in the video relative to the standard care condition. Resnick, H., Acierno, R., Waldrop, A.E., King, L., King, D., Danielson, C., Ruggiero, K.J., & Kilpatrick, D. (2007). Randomized Controlled Evaluation of an Early Intervention to Prevent Post-rape Psychopathology. *Behaviour Research and Therapy*, 45, 2432-2447.

Reducing HIV and Partner Violence Risk among Women with Criminal Justice System Involvement. Women with histories of incarceration show high levels of risk for HIV and intimate partner violence (IPV). This randomized controlled trial with women at risk for HIV who had recent criminal justice system involvement (n = 530) evaluated two interventions based on Motivational Interviewing to reduce either HIV risk or HIV and IPV risk. Baseline and 3, 6, and 9-month follow-up assessments measured unprotected intercourse, needle sharing, and IPV. Generalized estimating equations revealed that the intervention groups had significant decreases in unprotected intercourse and needle sharing, and significantly greater reductions in the odds and incidence rates of unprotected intercourse compared to the control group. No significant differences were found in changes in IPV over time between the HIV and IPV group and the control group. Motivational Interviewing-based HIV prevention interventions delivered by county health department staff appear helpful in reducing HIV

risk behavior for this population. Weir, B.W., O'Brien, K., Bard, R.S., Casciato, C.J., Maher, J.E., Dent, C.W., Dougherty, J.A., & Stark, M. (2009). Reducing HIV and Partner Violence Risk among Women with Criminal Justice System Involvement: A Randomized Controlled Trial of Two Motivational Interviewing-based Interventions. *AIDS Behav.*, 13(3), 1-14.

Therapist Identification of Intimate Partner Violence. This study is a replication of research conducted more than a decade ago to examine mental health providers' ability to accurately perceive violence within couples presenting for therapy and to intervene in a manner that reduces risk. A decade ago, 40% of therapists sampled failed to identify the presence of intimate partner violence (IPV) and non-predicted lethality. In the current study, a list of therapists, compiled from on-line websites maintained by 15 states within the United States consisting of independently licensed psychologists, clinical social workers, and marriage and family therapists was compiled. Twenty names and addresses from each of the states' licensing websites were randomly downloaded for the three different types of mental health providers, and a mail questionnaire was sent out for completion. The questionnaire included a case vignette and a series of open ended questions. One-hundred eleven of the 900 mailed surveys were returned. Two independent raters coded all of the vignette surveys. The expectation was that today's therapists are better prepared to identify IPV within a clinical vignette. Results show that therapists did have an improved ability to identify IPV. Thirteen percent of respondents from the present study failed to identify IPV within the relationship and about 80% suggested some sort of crisis intervention as a therapeutic approach. However, only one therapist accurately predicted lethality in the present study. Implications concerning IPV training for therapists are discussed. Dudley, D. R., McCloskey, K., and Kustron, D. A. (2008). Therapist Perceptions of Intimate Partner Violence: A Replication of Harway and Hansen's Study after More than a Decade. *Journal of Aggression, Maltreatment and Trauma*, 17 (51), 80-102.

Effects of a Nurse Visiting Program with African American Mothers and Infants. This study examined the effect of prenatal and infancy home visits by nurses on mothers' fertility and children's functioning 7 years after the program ended at child age 2. A randomized, controlled trial in a public system of obstetric and pediatric care was conducted. A total of 743

primarily black women <29 weeks gestation, with previous live births and at least 2 socio-demographic risk characteristics (unmarried, <12 years of education, unemployed), were randomly assigned to receive nurse home visits or comparison services. Primary outcomes consisted of intervals between births of first and second children and number of children born per year; mothers' stability of relationships with partners and relationships with the biological father of the child; mothers' use of welfare, food stamps, and Medicaid; mothers' use of substances; mothers' arrests and incarcerations; and children's academic achievement, school conduct, and mental disorders. Secondary outcomes were the sequelae of subsequent pregnancies, women's employment, experience of domestic violence, and children's mortality. Nurse-visited women had longer intervals between births of first and second children, fewer cumulative subsequent births/year, and longer relationships with current partners. From birth through child age 9, nurse-visited women used welfare and food stamps for fewer months. Nurse-visited children born to mothers with low psychological resources, compared with control-group counterparts, had better grade-point averages and achievement test scores in math and reading in grades 1-3. Nurse-visited children, as a trend, were less likely to die from birth through age 9, an effect accounted for by deaths that were attributable to potentially preventable causes. By child age 9, the program reduced women's rates of subsequent births, increased the intervals between the births of first and second children, increased the stability of their relationships with partners, facilitated children's academic adjustment to elementary school, and seems to have reduced childhood mortality from preventable causes. Olds, D., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K. et al. Effects of Nurse Home Visiting on Maternal and Child Functioning: Age-9 Follow-up of a Randomized Trial. *Pediatrics*, 120(4), pp. e832-e845, 2008.

Individual Action and Community Context: the Health Intervention Project. HIV risk-reduction efforts have traditionally focused on the individual. The need for including the role of the social context and community is being recognized. Social capital provides social relationships and potential resources that may hinder or trigger risk or protective health behaviors, especially for individuals with limited economic means. Sixty-five adult inner-city female drug users, who were included in a woman-focused HIV risk-reduction intervention trial, participated in in-depth interviews in

Atlanta, Georgia, between 2002 and 2004. The interviews focused on the women's individual behavioral changes during the 6 months since completion of the intervention as well as on the impact of community conditions. Topics discussed were sexual and drug use behaviors, social relationships, social capital, and community physical and social infrastructure. The data were analyzed using the constant comparison methods. The respondents indicated that poor physical and social infrastructure led to alienation and negatively affected their behavioral change efforts. Social capital and social support mediated these negative influences. Drug-related violence was especially debilitating in their efforts to reduce HIV risk associated with crack cocaine or injection drug use and associated sexual behavior. Environmental conditions and opportunity structures played salient roles in the women's success. Individual actions and community context must be considered simultaneously when facilitating and assessing behavioral interventions. Sterk, C., Elifson, K., and Theall, K. (2007). Individual Action and Community Context: the Health Intervention Project. *Am. J. Prev. Med.*, 32(6 Suppl), S177-S181.

Adverse Events in an Integrated Trauma-focused Intervention for Women in Community Substance Abuse Treatment. A substantial number of women who enter substance abuse treatment have a history of trauma and meet criteria for posttraumatic stress disorder (PTSD). Fear regarding the extent to which PTSD treatment can evoke negative consequences remains a research question. This study explored adverse events related to the implementation of an integrated treatment for women with trauma and substance use disorder (Seeking Safety) compared with a nontrauma-focused intervention (Women's Health Education). Three hundred fifty-three women enrolled in community substance abuse treatment were randomized to 1 of the 2 study groups and monitored weekly for adverse events. There were no differences between the two intervention groups in the number of women reporting study-related adverse events (28 [9.6%] for the Seeking Safety group and 21[7.2%] for the Women's Health Education group). Implementing PTSD treatment in substance abuse treatment programs appears to be safe, with minimal impact on intervention-related adverse psychiatric and substance abuse symptoms. More research is needed on the efficacy of such interventions to improve outcomes of PTSD and substance use. Killeen, T., Hien, D., Campbell, A., Brown, C., Hansen, C., Jiang, H., Kristman-Valente, A., Neuenfeldt, C.,

Rocz-de la Luz, N., Sampson, R., Suarez-Morales, L., Wells, E., Brigham, G., and Nunes, E. (2008). Adverse Events in an Integrated Trauma-focused Intervention for Women in Community Substance Abuse Treatment. *J. Subst. Abuse Treat.*, 35(3): 304-11.

Cueing Prenatal Providers to Counsel Pregnant Women with Behavioral Health Risks. This study examined the impact of the Health in Pregnancy (HIP) computer program on prenatal providers' counseling about behavioral risks with patients, in particular risk for intimate partner violence (IPV) during pregnancy. English-speaking women 18 years or older, less than 26-weeks pregnant, and receiving prenatal care at one of five participating clinics in the San Francisco area, were randomized in parallel groups in a controlled trial. Participants reporting one or more risks were randomized to intervention or control in stratified blocks. Providers received summary "cueing sheets" alerting them to their patient's risk(s) and suggesting counseling statements. Thirteen percent (37/286) of the sample reported current IPV. Provider cueing resulted in 85% of the IPV-intervention group reporting discussions with their provider, compared to 23.5% of the control group ($p < 0.001$). Thus IPV discussions were influenced strongly by cueing providers. Provider cueing may be an effective and appropriate adjunct to routine risk counseling in prenatal care. Calderón, S., Gilbert, P., Jackson, R., Kohn, M., and Gerbert, B. (2008). Cueing Prenatal Providers Effects on Discussions of Intimate Partner Violence. *Am J Prev Med.*, 34 (2), 134-137.

NIDA Supported Meetings/Events.

- NIDA symposium, "Drug Abuse and Homelessness among Women At-Risk for HIV," annual meeting of the American Psychological Association, August 17-20, 2007, San Francisco, CA.
- NIDA symposium, "Family Violence and Drug Use Trajectories," annual meeting of the American Psychological Association, August 20, 2007, San Francisco, CA.
- NIDA meeting, "Intervening Early: Progress and Opportunities in Child Service Settings," September 18-19, 2007, Gaithersburg, MD.

- NIDA is a participant in the Federal Partner Teen Dating Violence Workgroup. The workgroup includes staff from NIH/ORWH, NICHD, NIMH, DOJ/NIJ, DOJ/OVW, HHS/ACF, USDA, and DOD. This workgroup organized a meeting: “Teen Dating Violence: Developing a Research Agenda to Meet Practice Needs,” December 4-5, 2007, Crystal City, VA.
- NIDA panel, “Mental Illness/Mental Health and HIV Risk: Physical/Sexual Drug Abuse, Drug Use and Depression,” the Center for Disease Control and Prevention’s National HIV Prevention Conference, December 5-7, 2007, Atlanta. GA.
- NIDA panel, the American Psychological Association Summit on Violence and Abuse in Relationships: “Connecting Agendas and Forging New Directions,” February 28-29, 2008, Bethesda, MD.
- NIDA panel, “Women in Violent Relationships: Trauma and HIV Risk,” annual meeting of the American Psychological Association, August 14-17, 2008, Boston, MA.
- NIDA is a participant in the Think Tank Committee of the National Partnership to End Interpersonal Violence across the Lifespan (NPEIV). This workgroup organized two meetings: one in September 12-13, 2008, San Diego, CA; and the second in January 13, 2009, New Orleans, LA.
- NIDA presentation at the “Translational Research on Child Neglect Consortium,” October 16-17, 2008, New York, NY.
- NIDA symposium, “Girls in the Juvenile Justice System: Health Disparities in Substance Abuse and HIV/Sexually Transmitted Infection Risk,” annual meeting of the American Academy of Child and Adolescent Psychiatry, October 29, 2008, Chicago, IL.
- NIDA presentation at the meeting, “Promoting Resiliency and Protecting Children from the Psychological Consequences of Violence:

- NIDA symposium, “Intimate Partner Violence,” annual meeting of the Society for Prevention Research, May 27, 2009, Washington DC.
- NIDA symposium, “Problematic Relationships as Shared Risk Factors for Adolescent Dating Violence and Substance Use,” annual meeting of the Society for Prevention Research, May 28, 2009, Washington DC.

Funding Opportunity Announcements (FOAs).

- On July 19, 2007, NIDA, NIMH, NIAAA, and NICHD released PA-07-409 (R01), entitled “Health Research with Diverse Populations,” calling for applications to include studies focusing on the mechanisms by which experiences of stigmatization, discrimination, and violence affect health, disease, and resiliency among LGBTI populations. This Program Announcement can be viewed at:
<http://grants.nih.gov/grants/guide/pa-files/PA-07-409.html>
- On April 17, 2009, NIDA, NIAA, and ORWH released PA-09-169 (R01) and PA-09-170 (R21), titled “Research on Teen Dating Violence” (TDV), calling for applications to facilitate the understanding the factors contribute to TDV and research to lead the understanding from TDV to its multiple adverse consequences and finally the ways to protect against TDV. The Program announcements can be viewed at: <http://grants.nih.gov/grants/guide/pa-files/PA-09-169.html> (R01), and <http://grants.nih.gov/grants/guide/pa-files/PA-09-170.html> (R21).

Future Plans:

- NIDA plans to continue to solicit and support high quality research on violence against women and girls.

- NIDA will continue to participate in the *Think Tank Committee of the National Partnership to End Interpersonal Violence across the Lifespan (NPEIV)*.
- The funding opportunities released on March 15, 2007 will continue to be in effect until September 2010.
- The funding opportunities released on April 17, 2009 will continue to be in effect until September 2012.
- NIDA plans to continue to participate in the Federal Partner Teen Dating Violence Workgroup.

National Institute of Mental Health (NIMH)

Within its larger portfolio of Violence research, NIMH funded approximately fifty research and research training grants in Fiscal Year (FY) 2008 that relate to psychiatric disorders and Violence Against Women (VAW). Much of this research is included under the broader NIMH trauma research area, since witnessing or being the victim of domestic/intimate partner violence (DV/IPV) comprises one of the most common forms of trauma experienced by women and girls. NIMH research investments related to VAW are diverse; some projects are small, pilot studies being conducted by investigators who are new to the field of research, other projects are large-scale studies, including center grants that are targeting multiple scientific and public health issues, and still other projects involve training the next generation of researchers. These research efforts can be grouped to include: 1) studies that attempt to understand the effects of trauma, including domestic violence and abuse, on physical and mental health, 2) studies that examine the relationship between interpersonal violence and HIV status, 3) studies that seek to understand the development and course of Post-Traumatic Stress Disorder (PTSD) and other mental health disorders following trauma, as well as studies on the etiology of violent behavior, and 4) studies of prevention and intervention, comprising the largest number of NIMH studies on this topic. Examples include the following:

- Among the funded studies that attempt to elucidate the effects of trauma and abuse on physical and mental health, as well as neural

circuitry, are “Spouse Aggression: Mental & Physical Health Consequences” (5R34MH076935-02), “Interpersonal trauma, posttraumatic stress and depression” (1F31MH085395-01), “Intimate Partner Violence and Mental Health Symptoms “ (5K23MH069375-05), and “Neural Circuits in Women with Abuse and PTSD” (5R01MH056120-09).

- Among the funded studies examining the relationship between interpersonal violence and HIV are “HIV Risk Among Women with a History of Childhood Sexual Abuse” (1R21MH083502-01), “PTSD and Risk Behavior in HIV + Female Adolescents” (5K01MH070278-06), and “Role of IPV, HIV and Substance Abuse in Mental Health of African American Women” (1F31MH084716-01A1).
- Not all of those who are exposed to trauma develop PTSD or other mental health disorders and, thus, not all women and children who are exposed to violence develop these disorders, so it is important to study risk factors, protective factors, personal and organizational responses to trauma, and the course of mental health disorders that follow trauma exposure. Funded research in this area includes “Domestic Violence, Child Security & Child Mental Health” (5R01MH071256-05), “Conduct Disorder & Depression in Girls: Precursors, Development and Comorbidity“ (2R01MH056630-11A2), “Genetic Determinants of PTSD in Women” (5R01MH078928-02), and “Revictimization, Emotional Regulation and PTSD” (1F31MH081629-01A2). The etiology of violent behavior is complex and multifactorial. NIMH is funding studies seeking to understand some of the early causative factors that may have relevance to future intervention and prevention planning, for example, “Uncovering and Confirming Gene-environment Interactions in Psychopathology” (5R01MH077874-02) and “Girls' Aggression: Development, Context, and Process” (7K01MH067975-06).

- Funded prevention research includes primary prevention studies such as “HIV Prevention and Partner Abuse: Developing an Intervention for Adolescent Girls” (1K01MH080649-01A1) and those aimed at higher risk populations such as “Preventing Problems for Girls in Foster Care” (5R01MH054257-10), and “Treating PTSD in Children Exposed to Domestic Violence” (5R01MH072590-05). Some intervention studies examine whether specific treatments show promise, such as “A First-Line Community-Based Mindfulness Trauma Intervention” (5R34MH077066-02), while others test specific treatments for specific populations, including “Group Interventions for Abused, Suicidal Black Women” (5R01MH078002-02), “Guided Imagery for Military Sexual Trauma-Related PTSD” (5R03MH074611-02), and “Effectiveness of Inter-Personal Therapy (IPT) Adapted for Depressed Women with Trauma Histories in a Community Mental Health Center (CMHC)” (5R01MH076928-02). Funded intervention research also includes studies focused on systems of treatment and determining an effective approach or point of entry of intervention, such as “Integration of Prevention Services into a System-Of-Care” (5R01MH074610-04), “A Stage-Based Expert System for Teen Dating Violence Prevention” (9R44MH086129-02A1), “Court-Based Mental Health Screening and Service Referrals for IPV Victims” (5K01MH075965-03), and “Age-27 Follow-up of Early Preventive Intervention” (5R01MH070761-05) to assess whether very early home visit interventions in high-risk families prevents a myriad of later life behavioral and mental health problems, including violence.

In FY2008, NIMH continued to co-fund with the National Institute of Child Health and Human Development the “Youth Violence Exposure” (5R01HD046830-05), which updates and extends the *1995 National Survey of Adolescents (NSA)* by obtaining a new national household probability sample of 12-17 year-old adolescents. This survey seeks: 1) To obtain prevalence rates and descriptive data regarding adolescents' exposure to violence (both direct and witnessed) across a range of settings (school, home, community), including sexual assault, physical assault, physically abusive

punishment, domestic violence, community violence and school violence; 2) To determine whether there have been changes among a nationally representative sample of 12-17 year olds over the 1995-2005 period with respect to the prevalence of exposure to violence, mental health problems, and risk or protective factors for a range of adverse social and mental health outcomes given exposure to violence; 3) To examine the longitudinal trajectory of exposure to violence, development of mental health and substance use and abuse problems, risky sexual behaviors, delinquency and changes in academic performance; 4)

To test the hypothesis that the relationship between adverse family environment and the outcomes of delinquency and poor academic performance are substantially mediated by exposure to violence and/or violence-related mental health problems; and 5) To test the extent to which the relationships described above are moderated by gender, race, and ethnicity.

Also, in FY2008 NIMH continued to fund a large center grant, “The Collaborative Center for Trauma and Mental Health Disparities” (5 P50 MH073453-03) at UCLA, that promotes interdisciplinary research examining the prevalence and impact of traumatic experiences on PTSD, depression and concomitant cognitive/emotional, behavioral, psychological and biological processes in ethnic minority populations. The center’s subprojects are: "Intimate Partner Violence and Mental Health Outcomes among Latinas", "Disclosure & Appraisal of Child Sexual Abuse: Relationships with PTSD, Depression, & Associated Biomarkers" among African-American and Latina women, and "Coping among Ethnic Men Sexually Abused as Children", which examines ethnic differences in coping strategies and men’s role as possible moderators or mediators of psychological distress, biological effects of childhood sexual trauma and mental health service utilization.

Since mid-2007, NIMH has participated in sponsoring/funding several large meetings that relate to Violence Against Women, including:

- “Trauma Spectrum Disorders: The Role of Gender, Race, and Other Socioeconomic Factors”, October 01, 2008 – October 02, 2008 in Bethesda, M.D., sponsored by the Department of Defense-Defense Centers of Excellence (DoD-DCoE), the NIH Office of Research on

Women's Health (ORWH), the National Institute of Neurological Diseases and Stroke (NINDS), the National Institute of Child Health and Human Development (NICHD), and the Department of Veterans Affairs (VA). This was the first such collaborative meeting among these federal agencies on this topic, and in attendance were over 400 researchers and clinicians. Staff from the NIMH Women's Program and Office for Special Populations helped plan the meeting. NIMH Director Thomas Insel, M.D. and NIMH Program Chief Farris Tuma, Sc.D., spoke on the topic of Posttraumatic Stress Disorder (PTSD), along with presentations from a number of NIMH grantees. The meeting reviewed existing science on trauma spectrum disorders related to military deployment, such as PTSD and traumatic brain injury (TBI). Speakers and discussants examined gender and other factors specific to: a) psychological health needs of populations exposed to high stress, traumatic events, and deployment; b) TBI; and, c) treatment outcomes. The conference underscored the need for improved evidence-based strategies to assess better and treat psychological health issues and TBI. Plans to continue this collaborative research effort among DoD-DCoE, NIH, and VA are underway, with a meeting on the effects of deployment upon families and children to be held in December, 2009.

- “Posttraumatic Stress Disorder (PTSD) in Women Returning from Combat”, Dec. 8, 2008 in Washington, D.C., organized by the Society for Women's Health Research (SWHR), and sponsored by the NIMH Women's Mental Health Team, Magellan Health Services, Inc., DynCorp International, and The Goodyear Tire & Rubber Company. In addition, the Department of Defense and the Department of Veterans Affairs participated in the meeting, which brought together experts in the field to review sex and gender differences in PTSD, identified gaps in research, and generated ideas for new research approaches and initiatives. Speakers discussed the neurobiology of sex and gender differences, as well as the trajectories of female and male PTSD over

time, and the latest data on the differing incidence and prevalence of PTSD in males and females, including those exposed to combat trauma and sexual trauma, and presented relevant data on both civilian and military populations. Speakers also elucidated existing systems of care, including both private sector and military systems. Participants identified strategies for advancing research as well as practical knowledge needed by clinicians in the field.

- On January 22, 2008 – January 23, 2008, NIMH joined the Department of Veterans Affairs, Office of Research and Development, and the Department of Defense, Health Affairs, in organizing a two-day working group meeting, “Design and Evaluation of Clinical Trials for PTSD: A VA, NIMH, DoD Working Group” to review, in the context of the recent IOM report, generally agreed upon standards for clinical trials in biomedical and behavioral research; discuss some of the clinical and research challenges associated with clinical trials for PTSD; and develop expert researchers’ recommendations for surmounting these challenges in future intervention trials for PTSD. The working group meeting involved academic, VA and DOD clinicians, researchers, and administrators with expertise in PTSD clinical phenomenology, clinical trial research design, statistical analyses, and health science administration. The meeting was organized around three focal areas: 1) design and analysis considerations, 2) choosing outcome measure(s), and 3) facilitating successful trial implementation. The overall goal was to enhance the foundation for developing and evaluating future PTSD interventional studies in the form of practical suggestions for researchers and expert reviewers. The proceedings of this meeting are forthcoming, to be framed as answers to questions the participants addressed during the meeting and presented as issues to be considered in the design, implementation, and analysis of clinical trials.

- Along with the HHS Office of Women’s Health, the NIH Office of Research on Women’s Health, the National Institute of Justice, and other agencies, the NIMH co-sponsored a meeting on “Teen Dating Violence: Developing a Research Agenda to Meet Practice Needs: on December 4-5, 2007. This was a product of the Federal Working Partners on Teen Dating Violence, a workgroup in which NIMH participates. The meeting included NIMH grantees as speakers, brought together researchers, policymakers and practitioners for the first time, and identified clinically relevant research findings, model pilot intervention projects and research gaps and directions for future research.

Finally, between mid-2007 and mid-2009, NIMH has sponsored several Requests for Applications and Program Announcements, soliciting research from investigators on topics relating to violence against women. These have included:

RFA-MH-08-010 & 011. Prevention of Trauma Related Adjustment and Mental Disorders in High-Risk Occupations (R01 & R34), PA-MH-09-108 & 109. Women's Mental Health and Sex/Gender Differences Research" (R01 & R21), and PA-MH-07-312, 313, 314 & 315. Mental Health Consequences of Violence and Trauma.

Office of Behavioral and Social Sciences Research (OBSSR)

OBSSR does not have grant making authority, but does support research on violence against women by providing funds to the National Institute of Child Health and Human Development (NICHD) and the National Institute of Mental Health (NIMH). Specifically, OBSSR is providing four years of co-funding (2004-2007) to support a study led by Dr. Jill Joseph (Children’s Research Institute, Washington, D.C.). The study examines the processes and mediators by which violence exposure may adversely affect young mothers of color and their children, as well as documenting the buffering or moderating effects of specific psychological resources. OBSSR is also providing two years of co-funding (2007-2008) to support a study led by Dr. Todd Herrenkohl (University of Washington). This longitudinal study examines the occurrence and consequences of family violence as well as the

enduring effects of childhood adversity and resilience in those previously exposed to violence, abuse, and other forms of child maltreatment (e.g., neglect).

Office of Research on Women's Health (ORWH)

The Office of Research on Women's Health (ORWH) is part of the Office of the NIH Director and therefore does not have "grant-making authority" to directly fund research so we partner with the NIH ICs to fund all areas of women's health, including research relating to violence against women (VAW). In addition to coordinating violence against women research across the NIH ORWH undertook a variety of VAW activities in FY 2007 and FY 2008.

In December 2007, ORWH co-sponsored along with the HHS/OWH and the Department of Justice, a trans-federal workshop, entitled, "Teen Dating Violence: Developing a Research Agenda to Meet Practice Needs." Teen Dating Violence is one of the major areas cited by Congress in the recently reauthorized Violence Against Women Act. This workshop brought together researchers, practitioners, advocates, and federal staff to identify research gaps and increase partnerships across the disciplines. Further collaborations are taking place through the Federal Working Partners on Teen Dating Violence.

In October 2008, ORWH served as the lead convener for the first annual scientific conference on Trauma Spectrum Disorders sponsored by the Department of Defense/Defense Centers of Excellence in Psychological Health and Traumatic Brain Injury, the NIH and the VA. The focus of this conference was the role of gender, race and other socioeconomic factors in these disorders. All three federal agencies continue to collaborate and will be sponsoring a 2009 conference (see below).

In April 2009, ORWH joined the program announcement led by NICHD, NIDA, and NIAAA, identified as PA-09-169 (R01) and PA-09-170 (R21),

“Research on Teen Dating Violence” (TDV), calling for applications to facilitate the understanding the factors contribute to TDV and research to lead the understanding from TDV to its multiple adverse consequences and finally the ways to protect against TDV. The Program announcements can be viewed at: <http://grants.nih.gov/grants/guide/pa-files/PA-09-169.html> (R01), and <http://grants.nih.gov/grants/guide/pa-files/PA-09-170.html> (R21).

For FY 2009, ORWH will continue to partner across the NIH to encourage VAW research. Additionally, the ORWH will again serve as the lead convener for the Second Annual Trauma Spectrum Disorders Conference: The Impact of Military Service on Family and Caregivers. This scientific conference will be held on December 10-11, 2009 at the Natcher Conference Center, NIH main campus, Bethesda, Maryland. This scientific conference is jointly sponsored by the Defense Centers of Excellence (DCoE), the National Institutes of Health (NIH), the Department of Veterans Affairs (VA), the Centers for Disease Control (CDC), and other collaborating organizations. This is the second annual collaborative research conference examining the scientific evidence on trauma spectrum disorders. This year’s conference will focus on the impact of trauma spectrum disorders on military and veteran families and caregivers throughout deployment, homecoming and reintegration. The conference will identify the needs of families and caregivers in support of military and veterans with trauma spectrum disorders, factors related to family functioning and reintegration, and effective approaches that facilitate treatment of trauma disorders and services of families and caregivers. Particular attention will be given to gender and health disparities

References from the section submitted by the National Institute on Alcohol Abuse and Alcoholism

Abbey A, Parkhill MR, Clinton-Sherrod AM, Zawacki T. A comparison of men who committed different types of sexual assault in a community sample. J Interpers Violence. 2007 Dec;22(12):1567-80.
Davis KC, Schraufnagel TJ, George WH, Norris J. The use of alcohol and condoms during sexual assault. Am J Mens Health. 2008 Sep;2(3):281-90.

Lipsky S, Caetano R. The role of race/ethnicity in the relationship between emergency department use and intimate partner violence: findings from the 2002 national survey on drug use and health. *Am J Public Health*. 2007 Dec; 97(12):2246-52.

Lipsky S, Caetano R. Is intimate partner violence associated with the use of alcohol treatment services? Results from the National Survey on Drug Use and Health. *J Stud Alcohol Drugs*. 2008a Jan;69(1):30-8.

Lipsky S, Caetano R. Intimate Partner Violence Perpetration among Men and Emergency Department Use. *J Emerg Med*. 2008b Nov 6.

Noel NE, Maisto SA, Johnson JD, Jackson LA Jr. The effects of alcohol and cue salience on young men's acceptance of sexual aggression. *Addict Behav*. 2009 Apr;34(4):386-94.

Parkhill MR, Abbey A, Jacques-Tiura AJ. How do sexual assault characteristics vary as a function of perpetrators' level of intoxication? *Addict Behav*. 2009 Mar;34(3):331-3.

Parks KA, Romosz AM, Bradizza CM, Hsieh YP. A Dangerous Transition: Women's Drinking and Related Victimization From High School to the First Year at College. *J Stud Alcohol Drugs*. 2008a Jan;69(1):65-74.

Parks KA, Hsieh YP, Bradizza CM, Romosz AM. Factors influencing the temporal relationship between alcohol consumption and experiences with aggression among college women. *Psychol Addict Behav*. 2008b 22(2):210-8.

Parks KA, Hequembourg AL, Dearing RL. Women's social behavior when meeting new men: the influence of alcohol and childhood sexual abuse. *Psychol Women Q*. 2008c 32(2):145-158.

Schumacher JA, Homish GG, Leonard KE, Quigley BM, Kearns-Bodkin JN. Longitudinal moderators of the relationship between excessive drinking and intimate partner violence in the early years of marriage. *J Fam Psychol*. 2008 Dec;22(6):894-904.

Testa M, Livingston JA, Hoffman JH. Does sexual victimization predict subsequent alcohol consumption? A prospective study among a community sample of women. *Addict Behav*. 2007 Dec;32(12):2926-39.

Thompson MP, Sims L, Kingree JB, Windle M. Longitudinal associations between problem alcohol use and violent victimization in a national sample of adolescents. *J Adolesc Health* 2008; 42:21-7.

Ullman SE, Starzynski LL, Long SM, Mason GE, Long LM. Exploring the Relationships of Women's Sexual Assault Disclosure, Social Reactions, and Problem Drinking. *J Interpers Violence*. 2008 Sep;23(9):1235-57.

Young A, Grey M, Abbey A, Boyd CJ, McCabe SE. Alcohol-related sexual assault victimization among adolescents: prevalence, characteristics, and correlates. J Stud Alcohol Drugs. 2008 Jan;69(1):39-48.

OFFICE OF POPULATION AFFAIRS (OPA), OFFICE OF FAMILY PLANNING (OFP)

OPA Prevention of VAW Activities

Office of Family Planning Title X Overview

The Title X program is the only Federal program devoted solely to the provision of family planning and reproductive health care. The program is designed to provide access to contraceptive supplies and information to all who want and need them with priority given to low-income persons. A broad range of effective and acceptable family planning methods and related preventive health services are available on a voluntary and confidential basis. In addition to contraceptive services and related counseling, Title X supported clinics also provide a number of preventive health services such as: patient education and counseling; breast and pelvic examinations; cervical cancer, STD and HIV screenings; and pregnancy diagnosis and counseling. For many clients, Title X clinics provide the only continuing source of health care and health education.

The Title X program also supports three key functions aimed at assisting clinics in responding to clients needs: (1) training for family planning clinic personnel through general training programs; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services.

The program supports a nationwide network of more than 4,500 clinics and provides reproductive health services to approximately 5 million persons each year. Title X service funds are allocated to the ten DHHS Regional Offices. The Regional Offices manage the competitive review process, make grant awards and monitor program performance. In fiscal year 2008, Title X

provided Federal funds for service delivery grants to 88 public and private organizations to support the provision of comprehensive family planning services and information. Services are delivered through a network of community-based clinics that include State and local health departments, hospitals, university health centers, Planned Parenthood affiliates, independent clinics, and public and non-profit agencies. In nearly 75 percent of U.S. counties, at least one provider of contraceptive services is funded by the Title X family planning program.

Title X funds are critical to maintaining and operating clinics which ensure the availability of family planning services to low-income and uninsured individuals in the United States. Over the last thirty years, the network of Title X family planning clinics has played a critical role in ensuring access to confidential family planning services for millions of low-income or uninsured women at no cost or at a reduced cost. Title X also provides access for many under-insured women who do not have coverage for contraceptive services, devices or drugs.

For many women, Title X serves as an entry point into the health care system, as well as a source of primary health care services. Title X-funded services, available regardless of ability to pay, help ensure access to reproductive health care for low-income and uninsured persons, a population which is disproportionately composed of racial and ethnic minorities. More than two-thirds of Title X clients have incomes at or below 100 percent of the poverty level and 91 percent have incomes at or below 200 percent of the poverty level.

The contraceptive counseling and services available in Title X-funded clinic settings help couples space births and plan intended pregnancies, an important element in ensuring positive birth outcomes and a healthy start for infants. Each year, publicly subsidized family planning services help women avoid an estimated 1.3 million unintended pregnancies. Title X services assist individuals in preventing sexually transmitted infections including HIV and concomitant complications and also play a major role in the early detection of breast and cervical cancer.

Background Information on Title X and Prevention of Intimate Partner Violence Prevention in Title X supported Clinics:

Battelle Centers for Public Health Research and Evaluation: Family and Intimate Partner Violence Prevention in Title X-supported Clinics – Summary Report

Project Summary

In 2003, the Office of Population Affairs (OPA) contracted with the Battelle Centers for Public Health Research and Evaluation to conduct a study of family and intimate partner violence (FIPV) prevention activities in Title X-supported family planning clinics. The study included several research activities including visits to nine Title X-supported clinics, key informant interviews with clinic directors and clinic health care providers, key informant interviews with state and federal staff, a literature review and an evaluation of a FIPV resource guide that was developed to help integrate FIPV prevention programs into family planning clinics. These research activities were in support of three objectives:

- To assess the extent to which strategies used to implement FIPV integration have been acceptable to program providers, and whether program staff perceive them to be effective and sustainable.
- To identify the impact of FIPV prevention activities on the implementing organizations, and arrive at implications for the program on wider integration of FIPV activities in Title X clinics, including some measures of cost of the program to the clinic.
- To identify specific strategies that the OPA and collaborating agencies can utilize to raise awareness about FIPV and to achieve better integration of FIPV prevention activities into public family planning services.

This summary provides an overview of the study including background information regarding the impetus for this study, the data collection and data analysis methods used for the study and the findings from each evaluation activity. Finally, the findings across research activities are synthesized into conclusions regarding FIPV prevention activities in Title X-supported clinics and recommendations for facilitating the further integration of FIPV

prevention into family planning clinics. The attached reports provide detailed information about each of the activities undertaken for the study.

Background

In 2001, the Centers for Disease Control and Prevention contracted with Battelle to conduct a nationally representative survey of clinic directors and clinicians at Title X-supported clinics regarding their FIPV prevention activities. The sample was stratified by Department of Health and Human Services (DHHS) region. A response rate of 93% for clinic directors and 78.4% for clinicians was obtained, with 843 clinic directors and 666 clinicians responding to the survey. Results from the clinic directors included:

- 83.3% of the clinics routinely screen for FIPV.
- 86.2% of the clinics provided brochures to clients on FIPV
- 55.5% of the clinics had written protocols about FIPV
- 45% of the clinics offered FIPV training during the previous 2 years and 36.7% provided FIPV training opportunities elsewhere

The intriguing results of this survey provided the impetus for the present study to develop a more in-depth understanding of FIPV prevention activities in selected Title X-supported clinics.

Design and Methods

To conduct a more in-depth study of FIPV prevention activities in Title-X supported clinics, OPA contracted with Battelle to undertake five research activities. These included:

- A literature review of peer-reviewed journals, published books and articles, documents produced by professional organizations, and web-based documents published from 1999 to 2005, with seminal documents published prior to 1999 included in the review. The focus was on FIPV and reproductive health, including contraception, pregnancy, sexually transmitted diseases and human immunodeficiency virus (HIV), with an emphasis on clinic considerations and documents. In particular, four types of clinical documents were sought out –

protocols and guidelines for clinicians, tools for screening and prevention, clinical training methods, and programs and evaluated interventions for FIPV prevention. In total, 166 documents were included in the literature review set.

- Open-ended, unstructured, in-person interviews with staff from Title X-supported clinics including 9 clinic directors, 17 clinicians, 2 health educators, and a vice president in charge of training. Seven of the clinic directors were also clinicians. The clinicians interviewed were primarily nurse practitioners, but also included three physicians and several registered nurses and social workers. The interviews lasted between 20 minutes and two and one-half hours. Clinician interviews were usually shorter than clinic director interviews. Though unstructured, the interviews covered four primary areas of interest: clinic policies and protocols, routine screening procedures for FIPV, health care provider and staff training programs and collaboration with community organizations. Challenges and facilitators to identifying and responding to FIPV were also discussed.
- Visits to nine Title X-supported clinics with tours of the facilities. Clinics were selected and invited to participate in the study so that the final group achieved a mix of location, organization type and community type. The clinics are located in 9 of the 10 DHHS regions and included four county health departments, three Planned Parenthood clinics, and two community health centers. Five clinics served primarily urban or suburban populations and four clinics served primarily rural populations. All of the clinics were receiving Title X funds at the time of the visit. Two members of the research team visited each clinic. The clinic director conducted a tour of the facility, and the research team observed the waiting rooms, examination rooms, consultation rooms, restrooms, laboratories, and offices. The research team noted the clinic experience from the patient's point of view, looked for information (posters, brochures, flyers) about FIPV in clinic locations, and considered the privacy of each location where clients might disclose FIPV in writing or verbally. A description of each participating clinic as well as a summary of each clinic's FIPV practices is included in the attached report.

- Open-ended, unstructured telephone interviews with nine state employees who oversee the Title X program in their state and eight federal employees who are Program Consultants for DHHS regions across the United States. The state employees were chosen because they represent the same states where visits and tours of Title X-supported clinics were conducted and where the health care providers and clinic directors are employed. One state in each of 9 of the 10 DHHS regions was represented. The federal Regional Program Consultants represented 8 of the 10 DHHS regions. Clinic policies and protocols, routine screening procedures for FIPV, health care provider and staff training programs, and collaboration with community organizations were discussed with the state and federal employees. In addition, they were asked about the challenges and facilitators to identifying and responding to FIPV.
- An assessment of a Resource Guide for integrating FIPV services into family planning clinics. The Resource Guide was produced by JSI/Denver for OPA and distributed by OPA to all state Title X grantees. The grantees in turn distributed the guide to Title X-supported clinics in their states. To evaluate the Resource Guide, telephone interviews were conducted with six state grantees (drawn from states where clinic visits were conducted) and two clinicians (drawn from clinics where visits were conducted), as well as a communications expert with experience in developing FIPV products. Respondents were asked about the content and comprehensiveness of the Resource Guide and how they would use the guide. Respondents were also asked to make recommendations about improvements to the next version of the Resource Guide. The findings from this assessment do not directly relate to project objectives but are summarized because they relate to integrating FIPV prevention programs into Title X-supported clinics.

All interviews were conducted using interview guides and were recorded and later transcribed for analysis. With the exception of those conducted for the Resource Guide interviews, all transcripts were content analyzed using qualitative analysis software.

Office of Family Planning Activity from the Regions:

Region I

Domestic and Dating Violence

All Region I Grantees include assessment and counseling on intimate partner and dating violence in their approach to care for their clients. In order to do this, most of the Grantees offer regular training to their providers. Grantees also maintain up to date referral lists and referral plans to assure that women in need of help have access to providers. A number of clinics across the region are collocated with intimate partner violence programs.

The Massachusetts Department of Public Health has worked with all Title X Grantees in Massachusetts, as well as other providers who they fund, to help in revising the approaches used in asking about domestic violence and staff from family planning clinics attended two statewide training during the past year with Rebecca Levenson from the Family Violence Prevention Fund.

At Action For Boston Community Development – Boston Family Planning, in the Summer of 2006 Elizabeth Miller, MD, a pediatrician who works at a family planning delegate agency and who has significant expertise in domestic violence offered a compulsory training for family planning counselors on health relationships, intimate partner violence (IPV) and sexual coercion including birth control sabotage. The program has had a special emphasis on teens. Since then, ABCD has worked with both national and regional organizations to design and implement guidelines to assess intimate partner violence, raise awareness of local providers of IPV services and to train family planning providers, specifically on the impact of IPV on reproductive and sexual health including the ability to use a contraceptive method and avoid STD/HIV. ABCD uses materials from the Family Violence Prevention Fund and continues to work with Dr. Miller who is conducting qualitative research with young men and women. The Guidelines which ABCD developed are attached.

The Region I Training Center has developed, “**Counseling Teen Clients Experiencing Sexual Coercion.**” The video, developed for family planning providers and counselors, demonstrates client-centered approaches for

counseling teens experiencing sexual coercion. The video features two scenarios representative of the types of situations faced by Title X clients. The accompanying guide provides discussion questions and resources to enable viewers of the video to learn from one another, and to build upon their past experience working with teenage clients in difficult situations. The guide includes the complete script for each scenario, annotated to draw attention to counseling techniques, questions or statements that may be helpful in raising the issues, responding to the strong emotions that may arise, and providing support and assistance to the client. The discussion questions following each script can be used when viewing the video in a group setting such as a staff meeting or training session, or can be provided to individuals viewing the video on their own. This resource is widely used in training programs at Title X clinics in Region I.

Region II

NEW YORK STATE FAMILY PLANNING June 2009

New York State Family Planning Programs include a confidential screening for abuse, sexual coercion and dating or domestic violence as part of the initial and annual assessment for all clients. Most agencies utilize the American College of Obstetricians and Gynecologists RADAR screening guidelines when assessing clients for domestic violence. RADAR represents an approach clinicians can use to assess whether the patient has been a victim of domestic violence by:

- R:** Routinely screening about violence and victimization
- A:** Asking direct questions regarding abuse
- D:** Documenting findings in the medical record
- A:** Assessing the patient's immediate safety
- R:** Reviewing options and making appropriate referrals

If positive indicators are documented through screening or observation, a determination is made about whether or not imminent danger exists and, if so, appropriate action is taken. All agencies have referral sources for shelter,

educational materials to give to clients with the hotline number, and referral resources for counseling and follow up.

Cicatelli Associates, the Title X Region II Family Planning Training Center has developed and made available on their web site, a fact sheet manual with information for mandatory reporting in Title X funded family planning settings. This information is specific to New York State and is current as of September, 2008.

The purpose of the manual is to help program staff understand if reportable activity has occurred; whether it should be reported, to whom and how; and the consequences of reporting. The manual emphasizes that program staff must be familiar with two sets of laws: criminal and civil codes, of New York State and the federal government. The web site address to access a copy of the manual is: www.cicatelli.org/titlex/home.htm. Some of our family planning contractors have added the Cicatelli Fact Sheet on Intimate Partner Violence to their policy manual since it has specific information relevant to New York State.

Many Family Planning provider agencies have Domestic Violence Coordinators, and all post information on domestic violence, including the hotline number, in all patient care areas and, in particular, in patient rest rooms. Family Planning agencies offer innovative approaches to educating clients about domestic and dating violence. Examples from the most recent annual reports are:

- **The Chautauqua County Health Department** started a new sexual health education program called Smart Girls for females ages 8-12. The program included training on puberty, sexuality, and decision-making skills with an emphasis on refusal skills.
- **Planned Parenthood of New York City (PPNYC)** entered into a collaboration with the Columbia University, Mailman School of Public Health in 2003, to identify the prevalence and incidence of Intimate Partner Violence (IPV) with young women 15 to 24 in PPNYC's clinical setting. The aim of the project was to develop a screening instrument that would more effectively identify IPV in this

population. This project, funded by Columbia University through a CDC grant, included an anonymous survey of 625 clients, followed by a pilot of screening instruments for 700 PPNYC patients, gathering of feedback from clinicians and training of clinical staff. As a result of this project, PPNYC modified the IPV screening questions on the current medical history form and improved IPV screening protocols. This work has been published and presented at numerous scientific conferences. Through a new Robert Wood Johnson Senior Consultant Grant, PPNYC is continuing to study the impact of IPV on clients and the effectiveness of evidenced-based screening and interventions. PPNYC will use the results to continue the improvement of training, protocols and policies.

- **The LIJ Medical Center’s Family Planning Program** believes that helping young people and adults understand the qualities of healthy relationships is a key element to preventing intimate partner violence. As a result of this philosophy, the agency has developed two educational workshops that address this topic. For youth, the educational messages are centered on friendship and help young people identify the qualities of good friends. For teens and adults, the focus shifts from friendship to intimate partners. The program emphasizes that a healthy relationship - with a friend or an intimate partner - shares the same qualities, and program participants are taught to seek honesty, trust, respect, and equality in their relationships. These workshops strive to encourage individuals who feel they are in an unequal, unhealthy or abusive relationship to seek the assistance they need.
- **Yates Family Planning Services** offers a program called R.E.A.L., Responsible for Every Action in Life, a teen pregnancy prevention program. It includes curricula on healthy relationships which address intimate partner violence/domestic violence in broad terms and allow for more detailed discussion about coercion, etc. when suitable. Clients are referred to Rape & Abuse Crisis Services of the Finger Lakes when appropriate. Yates collaborates with this respected community based organization to provide staff training on domestic violence issues.

- **The Livingston County Department of Health** continues to implement activities and programs related to domestic violence. To improve the general health of women and improve birth outcomes, the Pregnancy Risk Assessment Monitoring System (PRAMS) initiative focuses on early identification of risk behaviors including the use of alcohol, tobacco and other drug use, and domestic violence risk. Objectives of the PRAMS initiative include decreasing the incidence of low birth weight, infant mortality, pregnant women who smoke, women using alcohol, tobacco and other drugs; and increasing awareness of domestic violence. All women who are entering any of the preventive health services are screened for alcohol, tobacco and other drug use, and domestic violence risk via a health assessment screening form. All clients receive counseling and educational information on risks and available assistance, and if necessary, referral to the appropriate services. Additionally, educational materials regarding domestic violence are available to clients. The Department works closely with Chances and Changes, a local domestic violence shelter, to provide educational programs in the schools. Topics include dating violence, domestic violence and rape issues.
- **Community Healthcare Network (CHN)** is committed to ensuring that that patients receive education, screening, and where indicated, intervention, support, referrals and resources. All CHN centers have trained social workers on site who are skilled in performing intimate partner violence screening; Policy mandates that all teenagers and pregnant women are seen by the social workers for this purpose. There is an annual mandated training for all clinical staff facilitated by the Social Work Department to present best practices for screening, identifying and offering interventions, especially with special populations such as immigrants and teenagers. CHN's Health Education team presents workshops on healthy relationships to teens, and provides a larger 21 workshop sexuality education curriculum that is offered free of charge to NYC schools and community-based organizations. In addition, this summer, the Health Education team

will be adding additional lessons on healthy relationships so that the agency may offer a "Healthy Relationships" mini-series.

- **Stony Brook University Hospital**-As part of Stony Brook University Hospital Cody Center's reproductive health care program and its developmental disabilities clinical program, families and patients are questioned separately regarding intimate partner violence during initial and annual exams. In addition, education about partner violence recognition and prevention for patients and their families is offered as part of the sexuality education program that all patients with disabilities attend as part of the reproductive health care program. Any cases of possible intimate partner violence are addressed with specific counseling and referrals.
- **Children's Aid Society's (CAS)** Milbank Health Center and the Bronx Family Center screen all patients for Intimate Partner Violence (IPV) as part of a structured psychosocial screening conducted during every annual health care supervision visit. All patients are interviewed about domestic violence (both IPV and family domestic violence) as well as sexual/physical abuse and assault. Additionally, any patients presenting with suspicious physical findings or chief complaints are evaluated by a health care provider for possible domestic violence or abuse. All patients admitting to IPV or suspected IPV but who are unable to disclose are referred to a primary care social worker on-site, or for evaluation, intervention and triage at time of visit. For patients requiring referrals for IPV issues, CAS is able to refer those patients (female or male), any children, and the violator (if he/she is willing) to the CAS Family Wellness Program at several locations in Manhattan and The Bronx. This program offers a wide range of counseling, case management and advocacy services for victims of domestic violence and their family members. In addition, CAS provides a group counseling intervention for men who have used abusive behavior in intimate relationships. All services are provided free-of-cost and in both English and Spanish. The Family Planning Program Health Educators also provide educational workshops for adolescents on comprehensive sexual health topics including "healthy relationships". This workshop

includes interactive, thought provoking activities that) help identify some of the early warning signs of potentially abusive relationships and) teach communication skills that help teens build healthy and safe relationships.

- **Planned Parenthood Hudson-Peconic** has a “Smart Wheels” mobile outreach van that participates with other community based organizations “Domestic Violence Awareness Month” events in October. Last year the agency co-sponsored an event at the YWCA around this issue.
- **Planned Parenthood Mid-Hudson Valley’s** Health Educators provide workshops on healthy relationships in many area schools and as part of the 20-hour peer educator training. Intimate partner violence takes on the youth-friendly name of CE teen dating violence and is addressed in the context of behaviors that constitute an unhealthy relationship. Information about sexual assault programs, resources and support are provided. PPMHV also participates in the annual Take Back The Night community events in their service area.
- **Upper Hudson Planned Parenthood’s** education, outreach, marketing and public affairs events and programs address intimate partner and dating violence in relationships in a variety of ways throughout the year. Each year UHPP participates in the area’s “Take Back the Night Rally”. UHPP also participates in college outreach, tabling and education about domestic violence with the New York State Coalition Against Sexual Assault (NYSCASA). UHPP honors and celebrates “Intimate Violence Prevention Month” with a month-long web-based presence and theme, including appropriate links and referrals. UHPP educators provide over 30 educational programs each year about the topic of relationships, decision-making and intimate partner violence (DV) in middle schools, high schools and college settings. UHPP educators are also welcome experts on domestic violence issues at youth-serving community based organizations throughout UHPP’s four-county service area. The UHPP Seriously Talking About Responsible Sex (S.T.A.R.S.) peer educators are trained on DV/intimate partner violence, and they

incorporate the topic in many diverse and creative classroom and community presentations. UHPP's "Teen Choices" after school program for Albany middle school girls includes the issue and topic in the semester's curricula at each school. UHPP educators provide educational materials on the issue at all outreach and education at health fairs, neighborhood activities and area community events. UHPP also includes information and education on healthy relationships at all weekly Teen Clinics. Finally, UHPP educates stakeholders and elected officials about the importance of supporting bills and providing funding to prevent domestic violence/intimate partner violence.

University of Puerto Rico, Title X Family Planning Program
Violence against Women (VAW) Activities 2007 – 2009
Progress Report

During the past Calendar Years (2007- 2009), the UPR - Title X Family Planning Program has focused its efforts & resources on orientation/education regarding federal regulations and protocols on VAW. The UPR-TXFPP has developed & delivered to all UPR-Delegate Agencies (DA) a culturally correct/ comprehensive sexual and reproductive health services directives regarding sexual abuse and violence.

The following is a breakdown of the activities and materials developed and delivered to DA during this period:

1- An updated Patient/Providers Educational Curriculum for adolescents and adults clientele of the UPR-TXFPP. Included topics related to prevention of VAW: Family Relationships and Healthy Partnering Relationships as a tool for the prevention of VAW, legislative mandates and legal aspects reviews directed to UPR-TXFPP providers for further management & understanding of the current laws and guidance on VAW both locally & federally. (October, 2008).

This curriculum for the patient education was revised 2008-09 and integrated in the UPR – TXFPP Clinical Manual. The program staff has been instructed to utilize a structure guide of family/social questionnaire to explore the clinic

client past experiences if any regarding sexual abuse, violence of any sort, sexual coercion or aggression ect. The Client sexual partners age is verify also the type of relationship they have (sexual coercion) if any experience of physical, verbal or psychological aggression in the past year of the clinical visit.

All patients that had an affirmative response to one of the violence predictors previously mentioned, the staff of UPR – TXFPP immediately refer the client to a social services collaborative agency, where they are assisted by a professional counselor or psychologist. Also the UPR-TXFPP DA clinic refers simultaneously to the Commonwealth of Puerto Rico “Centro de Ayuda a Víctimas de Violación” (Assist Center for sexual assault Victims or Violence survivors).

2- Work shops on the Updated guidelines for the management of women survivors of sexual aggression (ex. sexual abuse, domestic violence, etc.) Provided to all UPR – Title X Family Planning clinical Providers during CY 07,08,09.

3- Violence Prevention Related Trainings: UPR-TXFPP Grantee: The Clinical & Educational Grantee Staff has participated in:

- Updating the Clinical and Educational Manual VAW prevention (protocols and guidelines) for the UPR – Title X Family Planning Program (October 2008).
- Development & implementation of the Clinical Institute II conference for the UPR – TXFPP providers with the collaboration of Cicatelli Associates Training Center (June 11 & 12, 2009). One of the Main topics will be “Domestic Violence in Women & Its management”.

4- Establishment of collaborative agreements with specialized community based organization CBO’s and other gubernamental agencies that works with women survivors of domestic violence: Some examples are:

- Centro de la Mujer Dominicana (CMD), Inc. (Center for Dominican Women) – dedicated to the provision of legal, psychological

evaluation, health services, social Services & referrals to immigrant females of the Dominican Republic who are living in Puerto Rico with their families. This CBO devotes a special interest to women who are survivors of domestic violence, afflicted by substance abuse and / or infected with or affected by HIV / AIDS.

- Hogar Nueva Mujer, Santa María de la Merced, Inc. – organization that provides shelter and counseling to puertorrican women and their children survivors of domestic violence.
- Hogar Santa María de los Angeles en Cupey - Shelter for pregnant adolescents' single mothers that are victims of sexual aggression, sexual abuse and sexual coercion by their parents or family relatives.
- Child Protection Unit, Department of Family Services, Commonwealth of Puerto Rico (Local Offices in Rio Piedras, Ponce, Mayaguez, Aguadilla, Arecibo & Carolina)
- Family Services Adolescent Division – Adolescents (16-21 years old) who are enrolled in the Independent Live Project, these are adolescents who are remove of their home due to Violence, sexual abuse or coercion.
- Correctional Department, Drug Court Program – participants with cases of sexual abuse, domestic violence, minor's negligence and others.

The UPR-TXFPP is a member of the Puerto Rico National Planning Committee for the Prevention of Sexual Violence , Commonwealth of Puerto Rico Health Department (Centro de Ayuda a Víctimas de Violación –CAVV).

Newly accepted collaborative agreement with the UPR-TXFPP Grantee CY 2009:

Hogar Albergue Ruth- provides shelter and legal counseling for women survivors of domestic violence and her kids.

5- Educational Services related to prevention of VAW provided by the UPR-TXFPP Island wide administrative, educational & clinical staff (Current CY2009):

A total of 1,176 face to face educations were carried out in the UPR Title X Family Planning Clinics about the sexual coercion and domestic violence prevention. A total of twelve (12) educational activities related to the prevention violence were carry out in different community, primary care facilities, schools and university scenarios. The principals topics delivered were: violence prevention, co – dependence relationships and sexual coercion.

The number of directly impacted & refer clientele afflicted by any type of suspected VAW (191) persons.

NJFPL Intimate Partner Violence Information Request

League training efforts we have done targeting our provider staff as follows:

- NJ State Ambulatory Care Licensure Regulations require that all clinic staff receive training at least annually regarding identification and reporting of child abuse, sexual abuse and domestic violence.
- League delegate agencies provide educational workshop sessions on Dating Violence Prevention to adolescent and adult audiences. We partner with agencies, including high schools, alternative schools, community-based organizations, and faith-based youth groups.

The learning activities in our Dating Violence Prevention program include:

- Defining types of abuse – physical, psychological, sexual, and verbal
- Identifying signs and symptoms of abusive behaviors/situations
- Identifying strategies for avoiding abusive relationships

- Comparing characteristics of healthy relationships and unhealthy/abusive relationships
- Throughout our workshops, we employ a variety of learning strategies, including:
 - Interactive small and large group discussions
 - Values clarification activities
 - Communication skill-building activities
 - Role-play
 - Multi-media presentations
- NJFPL/NJSDH&SS – Addressing Adolescent Patients and Sexual Coercion, April, 2008 – Presenter, Angela Nuzzi, Consultant – 39 provider participants

In addition to the League Grantee efforts a description of specific delegate agency provider efforts is provided below:

- **Planned Parenthood Greater Northern New Jersey-**
- **Information on June 2007 - 2009 Intimate Partner Violence**
- **Activities**

1. In-service Sessions:

a. Center Supervisors' Meeting

(In attendance: Agency-wide representatives from the clinical setting, including the members of the Department of Medical Administration)

Date: Tuesday, February 10, 2009

In-service Provider: Morris County Assault Center
Morristown, New Jersey 07960

b. In-service Programs in Each Center

(In attendance: Center staff and clinicians)

In-service Provider: PPGNNJ Quality Assurance/Training

Coordinator, utilizing resources available within the catchment area of each center.

<u>Center:</u>	<u>Date:</u>
Dover Center	January 20, 2009
Elizabeth Center	January 23, 2009
Englewood Center	January 14, 2009
Hackensack Center	January 21, 2009
Hunterdon County Center	February 9, 2009
Morristown Center	January 12, 2009
Plainfield Center	January 26, 2009
Phillipsburg Center	January 27, 2009
Somerset County Center	January 8, 2009
Sussex County Center	February 11, 2009

2. Updated brochures and pamphlets available in all centers and posters mounted on the walls.
3. Referral manual in each center updated to include the latest resource information.
4. Screened for intimate partner abuse during clinical visit, referrals made and documented.
5. Observation checklist, used to evaluate clinical personnel, includes an intimate partner violence section.

We have presented the following educational workshops on dating/relationship violence.

2009

31 programs for 473 participants

2008

34 programs for 591 participants

June 2007-Dec 2007

9 programs for 56 participants

Grand Total since June 2007
74 programs for 1,120 participants

• **Planned Parenthood Central New Jersey-**
Summary of Dating Violence Prevention Programs- June 2007 –
June 09

Planned Parenthood of Central New Jersey provides educational workshop sessions on Dating Violence Prevention to adolescent and adult audiences. Between June 2007 and June 2009 we have delivered 77 single-session workshops to over **1,800** individuals on this topic. To reach these individuals we partnered with more than **30** agencies, including high schools, alternative schools, community-based organizations, and a faith-based youth group. Since September 2008, we have also delivered a 4-session teen dating violence prevention program to all eighth graders (approximately **100** students) in Keansburg's Bolger Middle School. The learning activities in our Dating Violence Prevention program include:

- Defining types of abuse – physical, psychological, sexual, and verbal
- Identifying signs and symptoms of abusive behaviors/situations
- Identifying strategies for avoiding abusive relationships
- Comparing characteristics of healthy relationships and unhealthy/abusive relationships

Throughout our workshops, we employ a variety of learning strategies, including:

- Interactive small and large group discussions
- Values clarification activities
- Communication skill-building activities
- Role-play
- Multi-media presentations

In addition to the educational workshops discussed above, PPCNJ delivers a professional development workshop on Intimate Partner Violence. The presentation was made to all staff (including clinicians, all health center staff, educators and administrative staff) of Planned Parenthood of Central New Jersey in March 2009. The workshop will

also be presented at the New Jersey Obstetrical and Gynecological Society Annual Meeting on June 8 2009.

The presentation includes:

- Defining Intimate Partner Violence (IPV)
- Incidence/Statistics
- Contributing Factors/Risk Factors for being a victim and a perpetrator of IPV
- Warning Signs/Indicators of IPV
- Assessing/Screening for IPV
- Treatment and Prevention of IPV

Another Group PPCNJ has been involved with is MANAVI – (MANAVI is a New Jersey-based women’s rights organization that works to end all forms of violence against South Asian women living in the U.S. South Asians are the largest ethnic minority in one PPCNJ’s congressional districts)- 37 provider participants

- **Planned Parenthood Metropolitan New Jersey**

Date/Acquaintance rape prevention programs have been utilized in FLI. On an annual basis approximately three - hundred thirty hours (330) of delivery on the topic of “Intimate Partner Violence” and fifty – six (56) hours of professional staff training. Current data demonstrates that juveniles under eighteen account for twenty (20) percent of all rapes and 30 – 50 % of child molestation committed in this country each year. Most young people who abuse in intimate settings and come to the attention of the system are found to have a history of previous sexual “acting out” behavior. The offenders have experienced some form of childhood trauma and become violent during dating encounters.

Training Sessions:

- Topic: Sexual Assault, Assault Reporting and SART Team Efforts -Presenter: Wendy Cubano –Essex County Rape Centers-Participants -43 staff
- Topic: Gay and Lesbian Client Issues- Presenter Blanche Duke, MSW- 43 Participants

- **Women's Health & Counseling Center**

The Sexual Assault Support Services program holds a 40 hour training for volunteer advocates (usually held twice a year). Part of the curriculum addresses acquaintance rape, date rape, and marital rape.

The advocates are also informed of domestic violence services available in the community as part of the referrals that they may need to make when answering the rape hotline.

Working with Adolescent Patients Presentation, Shannon Evans, MSW, LSW- Staff training session on how to work with adolescent patients who disclose sexual coercive situations/coercion and dating violence. Questions came from the Adolescent Patient Assessment form.

- **Hoboken Family Planning**

2008 update on child/elder abuse, which also included domestic violence-Presenter: Nitza Morales, RN. NPC

Region II RTC Training Programs Related to IPV for the Period of June 2007 - June 2009

In the past five years, Cicitelli Associates Inc., as the Region II Training Center for Family Planning, has delivered three onsite training programs and one audio conference on Medical Issues for Domestic Violence. These programs are aimed at helping family planning clinicians to recognize the red flags for domestic violence (DV) as well as provide the necessary referral and support to family planning patients/clients experiencing DV. Approximately 100 participants have attended the training programs including: physicians, physician assistants, nurse practitioners, nurse midwives, nurses and other clinical staff.

Additionally, CAI will deliver a one-day training program to 45 family planning clinicians (MDs and nurses) in Puerto Rico entitled, "Domestic Violence Training for Family Planning Clinicians." This program is scheduled to take place on June 11, 2009 in San Juan, Puerto Rico. The goal of this training is to provide family planning clinicians with a conceptual

framework for domestic violence, including signs to look for, as well as knowledge regarding resources and referrals. Continuing Medical Education credits will be made available for training attendees.

**New Jersey Department of Health and Senior Services (DHSS)
Reproductive and Perinatal Health Services, Family Planning
June 2007-June 2009**

In keeping with the OPA Priority to partner with CBOs, FBOs and community health in order to work with vulnerable and at risk populations and addressing the Legislative Mandate for notification of child abuse, sexual abuse, rape or incest, the DHSS delegate agencies have employed various initiatives to educate both their staff and the public they serve. Our delegate agencies have policies and referral resources regarding reporting child and sexual abuse, rape and incest which are presented during the orientation process and reviewed administratively and with staff annually. Our Planned Parenthood affiliate delegates have used a specific initiative to encourage staff awareness of the issue through prepared scripts, “mystery shopper” patients, videos and staff discussion.

All DHSS Title X agencies provide an annual in-service program for staff on the topic, often inviting speakers from community agencies who work with vulnerable populations such as sexual assault prevention and treatment agencies, and hospital social workers. Additionally, the agencies send staff to programs on various topics.

DHSS Family Planning staff meets three times yearly with our delegate agencies (clinical and education staff) to provide education through speakers on various relevant topics.

December 2007 (Clinical Services meeting) A speaker from a Monmouth County sexual abuse and assault counseling program presented a program on “Domestic and Sexual Assault-Support and Response” including domestic violence, sexual abuse & assault, different population (Latina, African descent, survivors with disabilities, Lesbian, Gay, Bisexual & Transgender) survivors, drug facilitated sexual assault, and crisis intervention

September 2008, joint meeting of clinical services staff and health educators from all agencies in collaboration with the New Jersey Family Planning League where the invited speaker presented a day long program, “Addressing the Unique Needs of Adolescents” which included social development, risk factors, sexual coercion, statutory rape and tips for working and techniques for working with sexual assault victims. We distributed information regarding domestic violence including the county rape crisis centers and web information for teens to access

October 2008 “Intimate Partner and Dating Violence” presented in by the Regional Perinatal Consortium of Monmouth and Ocean Counties. Information provided to delegate agencies, many sent staff.

Staff appointments to Boards/Councils:

Ms Renee Booze Westcott, Program Development Specialist who provides oversight of the adolescent and the education and outreach components of the Title X delegates was appointed as the Department representative to the Advisory Council Against Sexual Violence. This Council is within the Office of Prevention of Violence Against Women.

Ms Booze Westcott represents the Department at the Juvenile Justice Commission committee, “Young Women’s Action Alliance” also known as the Gender Specific Committee.

Ms. Kathleen Mackiewicz, Supervising Program Development Specialist serves as the Department representative on the New Jersey Youth Suicide Prevention Advisory Council. The Council is currently working on a statewide prevention plan across the age spectrum.

Ms. Sandra Schwarz, Program Manager, is co-chair of the steering committee for the New Jersey Maternal Mortality Review that reviews all deaths of New Jersey residents within 365 days of a pregnancy. (including homicides)

Ms. Judith Woerhle, Public Health Consultant, Nursing was recently assigned as staff to the New Jersey Maternal Mortality Case Review Team.

Public Health Solutions
June 12, 2009

Program Activities Related to Intimate Partner Violence by Delegate

The following details program activities related to intimate partner violence on behalf of Public Health Solutions' five delegates in New York City. All delegates screen for intimate partner violence and make referrals as necessary. In addition, they all provide staff training on the topic.

Public Health Solutions, as the grantee, requires that each delegate screen for intimate partner violence. The work plan and reports of all delegates are required to include benchmarks and performance measures of each agency's activities in screening all patients and making referrals for those reporting violence. Public Health Solutions also incorporates discussion of screening for intimate partner violence into grantee meetings and provides information, screening models and assistance where necessary.

Planned Parenthood of New York City (PPNYC), Bronx, NY

As a result of collaboration with Columbia University on a CDC-funded study to identify IPV for women ages 15 to 24, PPNYC developed and implemented a new standard of practice for all Planned Parenthood affiliates for assessing and screening for IPV. The results of the collaboration have been published and presented at numerous scientific conferences. In June of 2008, PPNYC received a one-year, \$50,000 grant from the Robert Wood Johnson Foundation to measure the effectiveness of the new IPV screening questions as compared to previous practice. This second phase has included an assessment of staff interest and practice with screening for IPV, as well as a meeting with community partners to discuss the issue and facilitate referrals.

The Door Adolescent Health Center, NY, NY

The Door Adolescent Health Center (The Door) provides intimate partner violence counseling and information regarding healthy relationships during a clients' psychosocial interview with health education staff and the medical history component of their clinical visit. Intimate partner violence has been a topic of interest in the Door's health education programming for the past

two years. Feedback gleaned from teachers, school social workers and the adolescent community prompted the creation of numerous workshops that focus on abusive and unhealthy relationships. Through role playing, mock decision making and group discussions, health and peer educators provide audience participants with the tools to identify relationships that are or have the potential of being abusive. Coed, male, female and LGBTQ groups are targeted; counseling and referral resources are provided to youth who disclose partner violence.

Workshop topics include the use of internet chatting and social networking sites as a means of spying in relationships; the creation of dating contracts that discuss the rights of partners in intimate relationships and the identification and classification of healthy and unhealthy characteristics of partners. Program participants are often enlisted in lively discussions regarding appropriate behavior and preferred outcomes. Staff have also conducted targeted intimate partner violence/healthy relationship programming at The Door. Visual presentations have been useful in promoting awareness. Peer educators created a large, interactive relationship decision-making wheel on a bulletin board in the lobby at The Door. Potentially viewed by over 11,000 adolescents annually, the board also identifies counseling resources and emergency telephone numbers.

MIC – Women’s Health Service, NYC (5 sites in 3 boroughs)

MIC Women’s Health Services provides routine domestic violence and teen relationship abuse screening, referrals, and social work services to all patients utilizing the Behavior Risk Factor (BRF) screen. This tool, created by Public Health Solutions through a grant from HRSA screens patients for six risk factors including exposure to violence throughout the lifespan. If a patient reports that they are currently in a violent situation whether in the home or within a relationship outside of the family system, an assessment of the situation is conducted to determine what steps should be taken in the best interest of the patient. Individual supportive counseling on site and referrals are also available for those patients who desire this service. The Social Work department participated in a teen relationship abuse and intimate partner violence training and workshop in April and May 2009. MIC Social Work staff will also be trained in the Relationship Abuse Prevention Program Curriculum to provide workshops to patients on site and in the community.

Individuals will be taught to identify warning signs of potentially violent relationships. In the community, MIC's Outreach and Education staff conduct presentations on domestic and intimate partner violence at organizations and schools. IPV information is included in the decision making and healthy relationship workshops conducted in youth based organizations, high schools, colleges, and community based organizations.

Charles B. Wang Community Health Center, NY, NY

At Charles B. Wang Community Health Center, adult users are screened for intimate partner violence by the provider through a series of verbal questions; adolescent users are given a self administered survey that include a series of questions related to sexual coercion and intimate partner violence. Patients who have been identified as high risk for possible intimate partner violence are referred for social work assessment and support. Patients can also receive individualized one-on-one counseling. Bilingual health education material related to intimate partner violence, sexual coercion, and healthy relationships is available for patients. In 2009, through an internal collaborative effort among the Teen Clinical Health Committee (composed of Pediatric medical providers), the Teen Advisory Committee (composed of adolescent community members), and the Electronic Medical Records team (composed of Health Center staff and providers), revisions to the IPV and sexual coercion screening tools for adolescents were implemented.

In 2008, the Teen Advisory Committee was asked to focus on Healthy Relationships in order for the Teen Resource Center to develop educational activities and materials about the subject matter. The committee identified topics that they thought would be relevant to their peers as well as ways of educating their peers. The Teen Resource Center also published a Healthy Relationships Newsletter in February 2008.

Program staff receive training from a variety of sources internally and externally. Annual intimate partner violence / domestic violence in-service training is provided by the Health Center to the entire clinical team ensuring that each staff member receives IPV/DV training update yearly. Staff also have the opportunity to attend external trainings ("Human Trafficking Training" or "Practicing the NYS Domestic Violence Screening Protocol")

such as those offered by Cicatelli Associates Inc., the regional training grantee.

Callen-Lorde Community Health Center, NY, NY

Callen-Lorde Community Health Center, a new Title X delegate serving the Lesbian, Gay, Bisexual and Transgender (LGBT) adolescent population, displays materials on intimate partner violence, hate-based violence and sexual violence in waiting areas and exam rooms. These materials are also distributed to LGBTQ clients who may disclose partner violence. The Health Outreach to Teens (HOTT) program providers consistently engage patients in conversations regarding the safety of their relationships with their partners. These conversations cover a range of topics from sexual coercion and negotiating safer sex to physical violence and emotional abuse. HOTT's philosophy is based on building a long term rapport with young people that ensures trusting and meaningful discussions are possible around sensitive topics such as intimate partner violence. It is the practice of the HOTT program to case conference young people who have been identified to be in unsafe relationships with their partners. Callen-Lorde works closely with the New York City Gay and Lesbian Anti-Violence Project and other anti-violence service providers to ensure smooth referrals of any patient who reports violence in their relationships. IPV is a topic included in the agency's annual employee training calendar – so staff get trained and retrained every year.

As required by Callen-Lorde's policies and procedures, all staff are required to attend annual staff training on intimate partner violence and child abuse. This training is followed by a quiz, which assesses staff knowledge post training and also identifies areas for future training needs. Additionally, when available, staff attends external trainings on intimate partner violence and intimate partner violence, especially as it relates to the LGBT population.

**USVI Department of Health
June 2009**

As part of our counseling sessions, clients are asked to answer the question, "Has your partner punched you? Are you afraid of your partner?" Have you ever been forced to have sexual intercourse or have you ever been touched against your will? These questions serve as a bases to initiate that conversation with our clients. Other than than that, there are no specific activities in this regard. We do support our local groups such as Women's Coalition. They have referred women and teens to our program and likewise we have done the same.

Region III

From Pennsylvania:

Philadelphia Area:

The Family Planning Council recently completed the development of its comprehensive policy on Intimate Partner Violence (IPV) screening and referral. This policy complements our Coercive Sex Prevention Policy as the two are closely related. In a related area, the Council participates in a 5-county coalition on Human Trafficking and has been proactive in providing training, information and referral resources on Human Trafficking to our Title X clinic staff.

Several years ago (2004), the Council received HHS 1% Evaluation Funds awarded through the Region III Office to complete a thorough examination of the barriers and opportunities for integrating screening for coercion and IPV. Since that time, FPC has used the results to guide its planning around an IPV initiative, but has not been successful with identifying resources to effectively implement the findings from the study.

The study revealed several barriers to implementing a meaningful IPV screening effort. These included resources for staff training and increased counseling and follow-up time needed to address violence issues once they are disclosed. Most importantly, the family planning provider agencies

involved in the assessment strongly felt that if family planning were to systematically screen for IPV, it is crucial that there be services readily available in the community for women to access. This is not always the case and where they exist there are often gaps in the referral agency's ability to address cultural and language needs of diverse populations.

According to the study, family planning agencies were not comfortable with or even clear on "how much" counseling or support they could provide compared with what a trained domestic violence counselor could provide. Family planning staff with IPV screening experience felt that once trust is established (and this takes repeated discussions) and the client discloses, there is an expectation and need to offer something right away. Family planning staff articulated a dilemma: They are not adequately skilled nor have the time to address in-depth counseling issues that arise with disclosure. Further, with rare exceptions, staff expressed concern that local community referral resources for IPV were not sufficient. Staff were similarly concerned that clients would be tenuous about following through on a referral to an agency that is unknown to them.

In the years since the OPA-funded study, the Council has researched referral resources and consulted with IPV experts to develop its policy. However, we know that there are interventions and collaborations between FP and domestic violence (DV) service providers that can improve the effectiveness of our IPV screening activities. The Council has past experience with two of these models and would like to see funding that replicates, expands and evaluates each.

In both these models, the DV agencies received funding directly from the PA Department of Public Welfare to establish these collaborations. The model in the FP clinic (Model 1) is still operational but has not expanded to other locations. The funds ended for the model in the school-based Health Resource Center (HRC) program (Model 2). To do either model requires funding. Either funds could flow through family planning to contract for this service, or alternatively funds could be earmarked in the domestic violence programs to provide this service for family planning delegates. The Council remains very interested in expanding these models, but has not identified resources to accomplish this collaboration.

Model 1: Partnerships in Family Planning Service Settings

A highly successful model in our family planning network is an arrangement between one of our Planned Parenthood (PP) delegates and a local DV agency in Bucks County. In this model, a staff person from the DV agency is available to come to any of PP's four clinic sites to meet with and provide in-depth counseling to family planning clients who have been or are currently exposed to IPV. These counseling sessions continue to be held at the family planning clinic until the client is comfortable with receiving services directly through the DV site. This same DV staff person routinely visits each of the four PP clinic sites to provide staff in-services, replenish materials and provide technical assistance to the family planning staff with respect to screening and disclosure issues.

In addition to expanding this model to other family planning clinics in our service area, we'd also like to see this partnership implemented in our reproductive health programs offered in youth detention facilities and county prison settings. Research has shown that the majority of incarcerated individuals have experienced personal violence in their relationships, particularly if they have also had a history of substance use.

Model #2. Partnerships in School-based Programs

Another successful model was piloted in our Title X funded high school-based Health Resource Center program. The HRCs are staffed by family planning delegates and provide counseling on abstinence, safe sex behaviors and distribute condoms to students whose parents have not opted them out of receiving condoms. Some of the HRCs also provide urine screening for Chlamydia and Gonorrhea following Title X and the IPP Region III guidelines. A few years ago, the HRCs experimented with a co-sited service model similar to the one described above. A staff person from a local DV agency gave "assembly programs" in the HRC schools, exposing large groups of high school students to IPV prevention strategies. The assemblies addressed the topic of IPV and stressed prevention strategies and available resources for both the victim and the abuser. That same DV staff person also spent time in the HRC where he/she would counsel students one-on-one to address personal IPV situations. This service was a successful complement to the HRC program in the fact that students were more comfortable with disclosing IPV or seeking advice on preventing IPV in their relationships in a

setting that already provided a confidential service. We also learned that in some schools, particularly those with large Latino populations, IPV was not an easy topic to address and students required greater time to build trust in order to voluntarily disclose. We also learned that students will seek advice to assist a “friend” who might be in a difficult relationship.

Other Initiatives

The Council has also addressed the issue of IPV in two of its publications, one for younger teens and the other for parents of teens. Both publications were funded by Title V block grant funds from the PA Department of Health. “Puberty’s Wild Ride” is a book designed for younger teens. In addition to addressing physical and social changes that occur during puberty, the book covers many other issues of concern to young teens including safety issues. Under safety issues, “Puberty’s Wild Ride” explains different types of abuse (physical, emotional, sexual); how to recognize an abusive situation; and what to do about it. The book contains referral resources for national and local hotlines. The second publication for parents is called “Parent Probe” and includes an article called “Love Should not Hurt” about how violence that can occur in adolescent relationships. It provides parents with information about how to determine if their child is being abused in a relationship and how to determine if their child is an abuser in a relationship. Hotline referral resources for both parents and adolescents are included. As an added resource, the Council’s Web site www.familyplanning.org includes links to other Web sites that provide additional information and referral sources on intimate partner violence and other abusive relationships.

In the past, the Council’s Regional Training Center, TRAINING 3, has provided cross-training throughout DHHS Region III to staff from community-based organizations on reproductive health issues, particularly addressing HIV risks among their service populations. Under this activity, funded by the Centers for Disease Control and Prevention, TRAINING 3 worked to educate and raise awareness of the reproductive health needs and HIV risk of abused women who seek services in domestic violence shelters. For the most part, DV provider agencies do not integrate information about family planning and reproductive health services with their services. This effort to train DV staff received national attention and an informational brochure was developed for IPV staff by TRAINING 3.

Child abuse prevention is another focus for training and for the Title X service providers. This year the Council used Title X funding to train 135 family planning staff on the topic of “Working with Minors.” The trainings produced by TRAINING 3 address sexual coercion, legal reporting requirements, and family involvement.

Resources needed

The Council would like to see initiatives by OPA and the Office on Women’s Health to support IPV prevention and screening activities that cement programmatic linkages and expand funding for partnerships between FP grantees and DV service providers.

Programmatically, the Council would like to see funding be made available to:

- Replicate the clinic-based program as described above and evaluate this model in comparison to the traditional screening/referral model.
- Restart the HRC program collaboration with DV agencies and evaluate its effectiveness.
- Obtain supplies of attractive materials in diverse languages for family planning clinics to publicize the issue in family planning clinics, provide hotline options and safety cards, and normalize the clinic as a place where IPV can be discussed and identified.
- In order to facilitate routine IPV screening and referral practices in the family planning program, the following components are desirable:
 - On-going training for family planning staff that not only provides the information and skills needed to do screening, but also clarifies and supports the counseling expectations/protocols for family planning staff when IPV is disclosed. These trainings also need to address cultural practices and norms so family planning staff know and understand how to elicit information in a sensitive and non-judgmental manner.

- A video or panel presentation that could be part of staff training. The presentation would show survivors telling their story of what motivates disclosure and what it takes to leave an abusive situation. Ideally, these survivors will have disclosed to a medical professional or have an experience where a medical professional was instrumental in motivating and supporting disclosure. In that manner, the information will be directly relevant to the family planning audience. Through the video, survivors will share their experience, describing who or what circumstance was instrumental in their decision to take action, and what they expected from others at the time of disclosure.
- Better integration of the issue and repetition of skills-development into related training programs such as Contraceptive Counseling, Options Counseling, STD/HIV Counseling
- Job aids that family planning staff can use to remind themselves of critical elements covered in the trainings
- Materials to post in the clinics and “safety planning” cards to use one-on-one with clients
- Funds to revise and reprint history forms to include screening questions
- Compensation in recognition of the screening activities. Delegates are asked to do more with fewer resources; there is no funding stream for which to invoice screening, education and counseling services related to IPV.
- Better linkages between family planning and DV agencies such as staff visiting each other’s programs and sharing information.
- Increased capacity of the DV agencies in the community (particularly in our suburban counties) to provide services in various languages and visit/provide in-service to family planning delegates
- Data systems to track and monitor screening activities and outcomes

Central PA Area:

Family Health Council of Central PA does not have any HHS-funded projects on domestic violence that target health care providers. In the last five years FHCCP offered training sessions at quarterly provider forums on Sexual Assault exams and counseling around domestic violence. FHCCP also collaborated with the Pennsylvania Coalition Against Domestic Violence (PCADV) on the provision of emergency contraception, but the emphasis of

this collaboration was to ensure that EC remain over-the-counter (it was not targeting HCP).

From Maryland:

The Maryland State Family Planning Program is one of the funding sources for the Rape Crisis Program of the Maryland Department of Human Resources, Office of Victim Services. The Office of Victim Services focuses on the special needs of individuals in crisis to address domestic violence, rape and sexual assault, and to provide general assistance to crime victims. The Office of Victim Services, an agency within the Community Services Administration, is aligned with the Department's objectives of caring, prevention and self-sufficiency. This funding in part supports local efforts to counsel and educate young people who are at-risk of sexual coercion. By forming partnerships with community-based organizations and county governments throughout Maryland, the Office of Victim Services is able to use crisis intervention and preventive measures to reduce risky behaviors and promote self-sufficiency. Activities are also carried out through collaboration with DHMH's Center for Health Promotion. This office provides community and health provider education on the topics, informational materials, and provides consultation to training programs for Sexual Assault Forensic Examiner nurses.

The 27th Annual Reproductive Health Update (conference)

- statewide conference attended by approximately 300-320 health care professionals providing family planning/reproductive health care in Maryland and the region (physicians, nurse clinicians, nurses, social workers, counselors)
- To be held May 8, 2009 in Clarksville, MD – this year featuring, as one of 5 presentations, an hour long segment, “*Intimate Partner Violence: The Silent Epidemic*” presented by Jacquelyn Campbell, PhD, RN of Johns Hopkins University (lecture, PowerPoint, discussion)
- Goal of this presentation: Discuss effective techniques to identify victims of intimate partner violence and appropriate interventions
- Sponsored by MD Department of Health and Mental Hygiene/Center for Maternal and Child Health, Howard Community College, TRAINING 3

- Presented through a \$25,000 Memorandum of Understanding with Howard Community College and CMCH/DHMH, registration charge is \$35 for the all-day conference with nursing, nurse-midwife, and social work continuing education credits provided
- In addition, invited exhibitors include representatives from local Maryland domestic violence and sexual assault prevention centers

Virginia:

Virginia Department of Health: Initiatives for HCP and Domestic and/or Dating Violence

Initiative	Date	Target Audience	Geographic Location	Program Goals and Objectives	Methodology	Funding Source	Program Status
Statewide regional training offerings on: "Violence Against Women"	2001	VDH Family Planning Staff, Community Health Care Providers	Richmond	Raising the awareness among health care workers to understand the dynamics of violence against women. Discuss the social implications of violence against women Describe the cycle of violence Discuss assessment techniques Identify health care interventions Identify local resources	Didactic Sessions held in five geographical locations in Virginia	Joint Partnership initiative between the VDH Family Planning Program , VDH Department of Injury and Violence Prevention (DIVP), and the University of Virginia Contracted with the University of Virginia	Trainings completed during calendar year 2002
			Norfolk				
			Winchester				
			Fairfax				
			Wytheville				

Development of the training video “A Single Moment of Decision – Preventing Sexual Coercion” and curriculum	2001	VDH Family Planning Staff	34 Health Districts Statewide	Identifying sexual coercion among minors in the family planning clinic setting Techniques for counseling minors on resisting sexual coercion	Train the Trainer	Joint Partnership with VDH Family Planning and the VDH DIVP Contracted with local media company	Video distributed statewide – Video Updated in 2004 and remains in use “Crossing the Line- When a Sexual Relationship is Coerced”
Statewide training on Mandated Reporting and Sexual Coercion	2004	VDH Family Planning Providers	Charlottesville	Development of a training DVD for health districts	Didactic Sessions and Train the Trainer	Joint Partnership with Training 3 VDH Family Planning and VDH DIVP Contracted with local media company	Live trainings completed
	2008		Norfolk	Identify state laws and regulations			DVD distributed to all 34 health districts. Annual update required of all VDH family planning staff.
			Wytheville	Identify resources Developing a plan for integrating sexual coercion counseling in the clinic setting			
Live Satellite Training on the Project Radar Intimate Partner Violence Initiative	10/2007	VDH Family Planning Providers	34 Health District Statewide	Define intimate partner violence Perform specific screening, assessment and intervention	Didactic Session Presentation via polycom satellite to all 34	Collaboration with VDH Family Planning and VDH DIVP	Virginia Department of Health providers and other health care workers have access to Program materials at: http://www.project

strategies for clients

health
districts

RadarVA.com

Identify and
formulate responses
to challenges specific
to the OB/GYN
setting

Direct victims of
Intimate Partner
Violence to
appropriate
resources

Region III

ADAGIO HEALTH, INC. - Initiatives on Domestic Violence and IPV

I. Domestic Violence Screening Project

In 1999, Adagio Health, Inc. received \$95,000 in funding from the FISA (Federation of Independent School Alumnae) Foundation to conduct a two-year pilot project to train clinical staff to screen clients for domestic violence and to provide appropriate referrals for victims of domestic violence. This project took place in four family planning offices in rural western PA—Uniontown (Fayette County), New Castle (Lawrence County), Seneca (Venango County), and Indiana (Indiana County).

RADAR was selected as the model for intervention. RADAR was developed by the Massachusetts Medical Society (1992) in response to the Joint Commission on Accreditation of Healthcare Organizations requirement that emergency rooms and hospital ambulatory care services have written procedures and staff training for identification and referral of victims of violence. RADAR stands for:

- R – Routinely screen female patients
- A – Ask direct questions
- D – Document your findings
- A – Assess patient safety
- R – Review patient options and referrals

Staff in the four project sites participated in a five-hour workshop on the cycle of violence, power and control in a relationship, why women stay in abusive relationships and how to screen for domestic violence. One staff member also received training to serve as a Domestic Violence Coordinator. Additionally, in Venango and Lawrence Counties, the local domestic violence shelters provided medical advocacy services to victims of domestic violence at the Adagio Health medical offices.

This project had two objectives:

- a. To provide basic training for all staff at the four project sites in order to implement RADAR and to create a climate of awareness for all Adagio Health staff in western PA;
- b. To provide ongoing support and training for nurse practitioners, registered nurses and domestic violence coordinators in the four project sites about the identification and management of domestic violence in the clinic setting for two years.

The target audience was low-income women living within these rural counties receiving both family planning services and prenatal services. In contrast to the comparison period in 1999, there was documentation in 86.1% of the medical records showing clients had been screened for domestic violence, indicating that use of RADAR was a useful tool for identifying family planning patients who were experiencing abuse. This project was included in a study of domestic screening projects in health care settings across the county by the Centers for Disease Control and Prevention. The primary investigator, Patricia M. Ulbrich, Ph.D., was a member of the panel of the experts to help the CDC develop their research agenda on *Violence and Reproductive Health: Health Care Practice*. While funding for this evaluation project ceased in 2000, its interventions continue. In 2001, Adagio Health implemented a network-wide policy on screening for intimate partner violence and providing appropriate referrals and interventions. A copy of the Adagio Health policy on IPV screening is attached.

INTIMATE PARTNER VIOLENCE POLICY

It is the policy of Adagio Health to screen all patients for potential violence, abuse, or neglect and to provide appropriate intervention.

GENERAL INFORMATION

Intimate Partner Violence is a pattern of assaultive and coercive behaviors, including physical violence, sexual violence, threat of physical or sexual violence, and psychological or emotional abuse against a woman by her family members or other intimates. Commonly referenced behaviors included within the broad category of violence against women include: homicide, domestic violence, partner abuse, psychological abuse, dating violence, spousal abuse, woman battering, elder abuse, courtship violence, sexual assault, date rape, acquaintance rape, and marital rape, as well as economic coercion that adults or adolescents use against their intimate partners. Key elements of domestic violence:

1. Occurs in the context of a current or former intimate relationship.
2. A pattern of assaultive and coercive behaviors, including physical, sexual, psychological, or economical abuse.
3. A pattern of purposeful behavior, directed at achieving compliance from, or control over a person.

Intimate Partner Violence presents unique challenges and requires specialized responses from health care providers.

- I. Identification of and intervention with the victim of Intimate Partner Violence are guided by the following principles:
 - a. Safety of the victim (and any children) is a priority.
 - b. Respecting the integrity and authority of each battered woman over her own life choices.
 - c. Recognizing that perpetrators are responsible for their abusive relationships and for stopping the behaviors.
 - d. Advocating on behalf of the victim.
 - e. Acknowledging the need to improve the health care response to Intimate Partner Violence.

STAFF TRAINING

Intimate Partner Violence is a national health priority but health care providers need education and experience in detection, evaluation, treatment, and prevention of this type of violence. A clinician's attitudes, knowledge, and skills in evaluating violence may influence whether a woman discloses abuse and is subsequently treated. In order to facilitate the Adagio Health response, education and training needs are assessed and implemented at the following levels:

1. Non-professional staff: Awareness Level. Raising awareness of the issue of Intimate Partner Violence and how to access services.
2. Professional staff: Professional level. This targets licensed professional staff and provides training in both the concepts and techniques used to provide intervention.
3. Resource staff: Expert level. This targets licensed professional staff whose roles require expertise in specialized areas of Intimate Partner Violence

Licensed and allied health professionals will receive ongoing training on the dynamics of intimate partner violence protocol and procedures with an emphasis on staff roles and the coordination of the care of the patient.

Region V

Indiana Family Health Council

Johnson Nichols Health Center in Greencastle, Indiana:

“I have attended a program initiated by the ISDH on sexual assault. I also attended two evening meetings on Sexual Assault that was facilitated by Family Support Services in Putnam County. They essentially provided education on the issue surrounding Sexual Assault and want to create a task force in our community to deal with sexual assault issues. I do not know who funded either of these initiatives.”

Ruth Ralph/Johnson Nichols Health Clinic

IFHC requires that all sites have a referral for sexual assault. Each site also has information on domestic violence posted in the patient rest room.

Title X Project Director, Gayla Winston serves on the Sexual Violence Primary Prevention Advisory Committee of the Indiana Office of Women’s Health. The group is developing the plan for Indiana in response to a CDC grant. I’m having mixed results in having them accept family planning’s role in this.

Michigan Department of Community Health:

All MDCH delegate agencies are required to screen for, assess, provide education, counseling and referral to clients of Title X clinics regarding sexual coercion and sexual violence. All delegate agencies have referral relationships with community agencies that provide services to women who are victims of sexual or domestic violence. All teen clients are provided with education and counseling regarding sexual coercion. Clinic staff are trained in sexual violence and domestic violence. Most agencies incorporate sexual violence into their community education programming. Many collaborate closely with community agencies and coalitions that focus on violence against women. Several programs have developed a business size card that provides resources and escape plan information made available to women in the clinics. Many agencies have representation on community Domestic Violence/Sexual Assault prevention and Support services coalitions

Several delegate agencies supplied information on additional their activities:

- Planned Parenthood of West and Northern Michigan has developed brochures, incorporated skill training in it's peer education program

- Planned Parenthood of East Central Michigan does the following programming in the community which includes a section on domestic/dating violence: a program for incarcerated males in Genesee County, a wellness class on relationships for HIV positive adults, A sexuality class for homeless youth, and for chemically dependent women in a long term residential treatment facility.

- Luce, Mackinac, Alger and Schoolcraft County District Health Department program works closely with other health department units on a project for Sex Offender Group services funded through Michigan Prisoner Re-Entry Initiative. LMAS has provided a 26 week program "Batter's Intervention" group in the past, not currently funded.

- The Benzie-Leelanau DHD is having an Intimate Partner Violence training this week for all staff

- Saginaw County incorporates Dating violence and sexual coercion information in it's community trainings in the youth correctional facility, and to Middle and High school students at Saginaw Public schools.

- Allegan Family Planning Program includes training on sexual violence and coercion in the Allegan County Schools called "Health Relationships" these activities are funded by private foundation.

- Health Department of Northwest Michigan has worked with a local Women's Resource Center to develop a brochure on dating violence and sexual Coercion. Brochure is attached:

- Genesee County Health Department Family Planning program in collaboration with their local coalition has developed funding and is holding a conference which includes as a focus domestic violence sessions. Brochure is attached.

Planned Parenthood of Northeast Ohio

444 W. Exchange Street

Akron, OH 44302

(330) 535-2674

www.ppneo.org

Violence Against Women Steering Committee – Query HCP

- **Date:** 1/11/09
Number of Participants: 25
Title of Program: Healthy vs. Unhealthy Romantic Relationships”
Target audience: teen girls and their mothers/guardians – TACKLE (Teaching Accountability Changes Kids Lives Everyday) group program participants are from North High School in Akron, OH 44310. The TACKLE program is a teen pregnancy prevention group. Planned Parenthood outreach educators meet weekly with the girls at their high school.
Methodology: Direct service
Goal: To teach teens how to recognize the signs of an unhealthy relationship
Objective: Assess current/future romantic relationships by applying relationship smart scale to your love life
Expected Outcomes and Organizations: At the end of the single session, the teens will complete a Relationship Check scale to assess a relationship in their life. The expectation is that each girl will discuss her score with her mother/guardian present and they will continue to talk at home about the assessment tool and use it any kind of relationships.
Planned Parenthood of Northeast Ohio collaborated with the Rape Crisis Center of Medina & Summit Counties. Jennifer Jeter, community educator from the Rape Crisis Center provided the keynote speech on domestic violence.
- **Date:** 5/16/09 and 10/09 – (the exact date has not been determined for the second event later in the Fall)
Number of Participants: 60
Title of Program: Personal Power for Girls conference

Target audience: Pre-teen girls (middle school ages 11-13 yrs.) living in Summit County, OH

Methodology: Direct service – education activities centered on women’s health concerns. The conference will feature sessions facilitated by Planned Parenthood of Northeast Ohio, the Rape Crisis Center of Summit and Medina Counties and the Girl Scouts of Northeast Ohio. The conference will include sessions about puberty, reproductive health, and reproductive anatomy, violence against women, self-defense, and self-care/hygiene.

Organizations: Planned Parenthood of Northeast Ohio in partnership with Area Health Education Center and the Ohio Department of Health, Bureau of Health Promotion and Risk Reduction, Sexual Assault and Domestic Violence Prevention Program

Goal: To provide a comfortable environment for pre- and early-adolescent girls to explore feelings about their changing bodies, improve decision-making skills, learn self-defense techniques, and discover knowledge about their cultural heritage.

Objective: Recognize constructive and destructive elements in relationships

Describe self-care activities for female reproductive health
Practice self-defense techniques

Expected Outcomes: Each girl will increase her knowledge and decision making skills. Each girl will develop insights concerning relationships and responsibilities to others.

Hosted a teleconference, "Teen Relationships, Pregnancy and Marriage: Making a Love Connection sponsored by the Title X Region V Family Planning Training Program. The date for this teleconference was 8/17/06. Other training include "Breaking the Cycle of Domestic Violence sponsored by Akron Children's Hospital Adolescent Health Department on 11/7/05.

Office of Family Planning Region V

CCADV Brown Bag Schedule for 2009
Held in Methodist Conference Room DG 422 B
Thursdays 11:30am – 1:30pm

Domestic Violence is a serious problem that affects people from all walks of life. Domestic Violence is recognized as both a criminal and public health concern of women, men and children presenting for healthcare. Recognition and intervention by health care providers can reinforce that abuse is not acceptable and provide resources to assist patients or fellow employees identified as victims of domestic violence. Clarian Coalition Against Domestic Violence (CCADV) provides training and education on domestic violence to staff and the public in an effort to provide resources and enlightenment with the monthly brown bag lunch series, quarterly manager trainings, and computer-based training modules.

SAVE THE DATES:

- **January 22 – Changing Paradigms of DV**
- **February 26 – Human Trafficking**
- **March 19 – Men’s Perspective**
- **April 23 – Legal Options**
- **May 21 – Parent/Teen Panel**
- **June 16 – Health Impact**
- **July 9 – Policies & Procedures**
- **August 13 – Elder Abuse**
- **September 10**
- **October 15—DG 422 A & B—Day Long Conference**
- **November 19 – Suicide Prevention**
- **December 15**

*Contact Hours (CEUs)
will be offered.
All Clarian staff and the
public are welcome.
Light refreshments will be provided.*

Methodist Hospital is at 1701 Senate Blvd, Indianapolis, IN 46202--located right off Exit 115 (21st St.) and I-65. Please park in Parking Garage 2. From the first floor entrance go straight and take a left towards the Library. By the library there is a staircase which leads directly to the Conference Rooms in the basement.

If you have any questions, please call Kira Hudson at 317-962-6100.

Region VIII

Family Planning Program
Upper Missouri District Health Unit

June 10, 2009

Char R. Reiswig, Director
North Dakota Family Planning Program

Title X activities related to intimate partner violence

State wide the program had twenty-one referrals to a rape crisis center and eight referrals to a domestic abuse center.

The delegates reported activities:

1. We are involved with Domestic Rape Crisis Violence Center, Dickinson Clinic, Great Plains Clinic, SW Dist. Health Unit and the Healthy 8 network, Stark Co. Social Services, DSU Student Health.

Carrie Decker, Nurse Educator
Community Action Family Planning

2. Staff are on the Sexual violence prevention committee; meets 6 x a year.

Diane Ruhland, RN
Fargo Cass Family Planning Program

3. I am part of the Board of Directors for Three Rivers Crisis Center since 1999. Shannon, RN is an advocate for Abuse Resource Network since September 2009.

Betty Zimmerman, RN CNM
Richland County Family Planning Program

4. UMDHU is involved on child protection teams in the four counties. I was involved for a year on a rape prevention coalition. We work with the domestic violence center when they need services for women.

Evonne Hickok, RN
Family Planning Program
Upper Missouri District Health Unit

Planned Parenthood Association of Utah

In Utah during 2008 and 2009 the following activities took place related to the prevention of violence against women.

- PPAU's Community Educator participated in the Teen Dating Violence Task Force, coauthored a lesson for UT High School students on Healthy Relationships that will be part of the Utah State Office of Education Prevention Dimensions Curriculum for all high school students. She trained over hundred teachers, police officers and other professionals on presenting the lesson in Spring of 09
- PPAU partnered with the Utah Coalition Against Sexual Assault to conduct primary prevention activities in the area of sexual violence. These included presenting a Healthy Girls Strong Women Conference in a Salt Lake City Elementary School that reached 47 girls age 9-13 and over 20 caregivers. Presentations covered the rights girls have in different aspects of their lives, Parent Child Communication around sex and sexuality, Boundaries: Discovering Yours, Respecting Others and Sticking Up for Everyone's, as well as Body Respect and Media Awareness
- PPAU updated our Healthy Relationship Lesson and it is one of four lessons in the Be Smart Be Safe Be You Teen Sexuality Education Program. This lesson has been presented to adolescents in four high schools, two middle schools, and five community agencies regularly multiple times in 2008-2009 reaching over 200 youth.

- Adult Healthy Sexuality Education in Women's Jail and Women's Treatment programs includes Healthy Relationship Lessons. During 2008-2009 over 200 women received these classes from PPAU Educators.
- PPAU presents the male sexual responsibility curriculum Wise Guys as an 8 series class. This includes lessons on consent and healthy relationships in addition to sexual health. In August of 2008 PPAU was awarded a Rape Prevention Education Grant from Utah Department of Violence and Injury Prevention to offer Wise Guys in Spanish to teen males. With the funds come an opportunity to work more closely with the state coordinating agency, Utah Coalition Against Sexual Assault, local shelters and community agencies focused on the prevention of sexual violence through biannual network meetings.
- PPAU is participating in a community effort to educate the Latino community in UT about the Age of Consent. This is a partnership with the Children's Justice Centers, Salt Lake County Government, state legislators, and other Latino Agencies.

Annabel Sheinberg, MM
 Education Director
 Planned Parenthood Association of Utah

Montana's Title X Family Planning Clinics

Following are some activities--we don't have the information compiled in this format going back to 2007, so this is just for this FY. Hope this is what you wanted--let me know!

During SFY 2009, the health educators in Montana's Title X Family Planning clinics completed educational trainings with various audiences on topics relating to the prevention of intimate partner violence. During the months of October through December 2008, the health educators conducted 8 presentations regarding communicating with your partner. They also instructed on healthy relationships in 17 different presentations across the

State. Education and conversations regarding values were discussed at 10 presentations.

During the months of January through March 2009, the family planning health educators presented 26 times on the topic of healthy relationships. Communication with your partner was addressed in 20 different presentations, and values were discussed during 14 separate educational trainings that occurred across Montana.

The Montana Title X family planning clinics also participated in Sexual Health Awareness Month during February 2009. This educational campaign promoted discussing healthy sexual relationships between parents and teens, and between intimate sexual partners.

Many family planning clinicians received sexual coercion counseling training at the Spring 2009 Family Planning Training Conference that took place in Helena, Montana on May 14-15, 2009.

Wyoming Health Council

Wyoming Health Council has conducted the following activities targeted toward education/raising awareness of intimate partner violence and providing resource materials to agencies. The majority of this work has been done by Susie Markus, Project Manager, Education and Outreach.

- Title X Service Delivery Meeting presentation in January 2009 using online Ahler's intake numbers that demonstrated that some clients were reporting they were in relationships that harm them.
- Distributed Handouts of Wyoming Coalition Against Domestic Violence community clinic brochures at the January meeting.
- Served on Sexual Violence Prevention Strategic Planning Committee of Attorney General's Office, Division of Victim Services; developed a needs assessment and a statewide strategic plan for sexual violence prevention.
- Invited to present at Wyoming Sexual Assault Conference on April 22, 2009 – Presented on "Empowering the Disempowered: Frameworks for

Understanding Marginalized Populations and Providing High Quality Care” – 3 hour workshop for 160 people

- Purchased several materials for lending library using Healthy Mothers/Healthy Babies grant money and speaker honorarium for Sexual Assault Conference. These will be available on WHC website for lending.
 - Expressing Anger: Healthy vs. Unhealthy
 - NO! The Rape Video
 - The Ten Signs of Relationship Abuse
 - Open Arms? Open Eyes! Power, Control, and Abuse in Teen Relationships
- “Can We Talk?” workshops statewide – prevention of violence and bullying at early age

At the delegate agency level, all clinics have solid working/referral relationships with

REGION X

State of Oregon Dept of Human Services (DHS) grantee

1) State of Oregon SAFE (Sexual Assault Forensic Evidence) Project, \$50,000 supplemental award in 2007 to train nurses at six family planning delegate clinics to be certified in the Sexual Assault Nurse Examiner (SANE) program. Each delegate established pilot SANE programs. A workgroup among the initial six and the remaining 31 delegates increased awareness and participation in SANE training.

2) DHS’ Adolescent Sexual Coercion Initiative in 2005 provided technical assistance for Title X clinics’ development of mandatory reporting policies and protocols, developed and distributed educational materials for health care providers’ use at family planning clinics, and developed and provided staff training on adolescent coercion (Identification, Prevention and Response). Updated in 2008, training programs continue and education materials are available for all grantee and delegate staff.

Curriculum was developed for adolescent sexual coercion screening and counseling, and training was provided to family planning agency and school staff, domestic violence agencies, state child protective services, probation and police officers, and therapists in 15 Oregon counties and video conference training for 10 counties. I developed Adolescent Sexual Coercion: Identification, Prevention and Response guidelines for family planning agencies.

State of Washington Dept of Health grantee

Pertinent trainings were reported from Planned Parenthood of Western Washington/Planned Parenthood of the Great NorthWest (PPGNW).

2008 PPWW/PPGNW LICENSED STAFF PRESENTATIONS REGARDING

DOMESTIC VIOLENCE OR DATING VIOLENCE

Date	Organization	Location	Target Audience	Participants	Hours
Dec 2007	Planned Parenthood	Seattle	Clinicians	90	2
Nov 2008	PPFA	Audio Conference	Clinicians	unknown	2
10/21/2008	Planned Parenthood	Seattle	All new Staff	7	2.5

2008 PPWW/PPGNW ALL STAFF PRESENTATIONS REGARDING MANDATORY REPORTING AS IT RELATES TO DOMESTIC VIOLENCE AND SEXUAL VIOLENCE

Date	Organization/School	Location	Target Audience	Participants	Hours
6 Times per year	Planned Parenthood	Seattle	All new staff	90	1 per session

Additional Information:

1. A WA DOH grantee member sits on the Washington State Department of Health’s Family Violence Workgroup. It meets once a quarter.

2. WA DOH nurse practitioner sends out information to delegate staff about domestic violence and dating violence when available, e.g., Intimate Partner Violence and Sexual Violence screening.

3. Grays Harbor County Public Health and Social Services Department (WA delegate) Beyond Survival and Domestic Violence Center Presentation

-target audience: Entire Public Health and Social Services Staff, 40 participants

-site/location: Grays Harbor County Public Health and Social Services Department

- Date: Completed on 1/6/08

- Amount of HHS funds (if known): No specific amount of funds needed because part of routine staff training at delegate site.

This presentation was an informational presentation about services that are available in our community for DV victims, and ways to communicate with clients.

Office of Adolescent Pregnancy Title XX Overview:

The AFL program supports demonstration projects to develop, implement and evaluate program interventions to promote abstinence from sexual activity among adolescents and to provide comprehensive health care, education and social services to pregnant and parenting adolescents. The program supports two basic types of demonstration projects: (1) prevention demonstration projects to develop, test, and use curricula that provide education and activities designed to encourage adolescents to postpone sexual activity until marriage, and (2) care demonstration projects to develop interventions with pregnant and parenting teens, their infants, male partners, and family members in an effort to ameliorate the effects of too-early-childbearing for teen parents, their babies and their families. The AFL program also funds grants to support research on the causes and

consequences of adolescent premarital sexual relations, adolescent pregnancy and parenting.

The Title XX funds not only help the teens and families they serve directly, but also provide valuable information and evaluation findings that can serve as a basis for future strategies. Every program that receives AFL grant funds is required to include an independent evaluation component. This ensures that the lessons learned by each community will benefit others in the future.

Office of Adolescent Pregnancy Title XX Overview of Activities:

During 2007-2008, the Office of Adolescent Pregnancy Programs (OAPP) coordinated a series of technical assistance workshops for all AFL Care and Prevention grant recipients, specifically the program staff. Two net-conferences were held on the sexuality in the media. The first net-conference examined the ways young girls are exploited through various media and identified strategies health practitioners could use to address the issue within the AFL projects. This net-conference was held on March 12, 2008. The second workshop held on July 10, 2008 discussed how boys receive sexual images in the media and provided program strategies to successfully address the issue. In addition to the net-conferences, a face-to-face workshop was provided to enhance the understanding of healthy relationships and relationship exercises to use with teens. This training was held on May 29-30, 2008 in Denver, CO.

In addition to the regional training, the National Prevention Grantee Conference held on December 8-11, 2008 in Vienna, VA. This conference was for program directors and program evaluators. A workshop session on adolescent intimate partner violence was offered. The workshop increased the awareness of adolescent intimate partner violence (IPV) and provided skills on how to talk about IPV with youth.

By introducing the topic to both program directors and their staff, they are more informed about the healthy and unhealthy behaviors. In consecutive years, OAPP is committed to sharing information with AFL Care and Prevention grantees about combating the abuse of women and exploitation through the regional training series and/or the national annual conference.

DHHS OFFICE ON WOMEN'S HEALTH (OWH)

Violence against Women is a major public health problem for American women. More than 2.5 million women are victims of violence each year. We serve as the point of contact for the Department on violence against women issues and in that role we direct citizens, colleagues, and organizations to the appropriate office or agency to respond to inquiries and provide resource information.

To address this major public health problem, the OWH is involved in the following activities:

- **National Advisory Committee on Violence Against Women (VAW)**

OWH collaborates with the Department of Justice-Violence Against Women's Office in working with the National Advisory Committee on VAW.

The National Advisory Committee on Violence against Women ("the Committee") is a joint effort between the United States Departments of Justice and Health and Human Services, which was chartered by Attorney General Gonzales on January 31, 2006 to provide policy advice to the Attorney General and Secretary of Health and Human Services concerning the implementation of the Violence Against Women Act, raising public awareness regarding violence against women, and facilitating cooperation among members of the criminal justice system and our communities. This committee has been charged by the Attorney General to address the following issues: children exposed to violence, dating violence, expanding the reach of victim services and outreach to faith based and community services.

- **DHHS Violence Against Women Act (VAWA) Steering Committee**

The DHHS Violence against Women (VAWA) steering committee is chaired by Office on Women's Health (OWH). The Committee has the responsibility for coordinating the Health and Human Services (HHS) response to issues related to violence against women and their children

and also coordinates HHS violence related activities with those of other Federal agencies.

Selected departmental initiatives include:

- Maintaining the national domestic violence hotline.
- Funding grants for coordinated community responses to domestic violence.
- Studying the economic and personal costs of violence against women.
- Establishing links with professional societies in the health and social service fields to increase attention to women's health and violence issues, and coordinating programming with the Department of Justice.
- Developing joint HHS-DOJ grant announcement on family violence.

The members of the DHHS Steering committee serve as resource experts for the National Advisory Committee on VAW.

- **NWHIC's Violence Against Women Web Site**

The Office on Women's Health in the Department of Health and Human Services (HHS) announced the addition of a special section on Violence against Women as part of the expanding National Women's Health Information Center (NWHIC). The violence section was launched to offer information and resources to women concerning domestic violence, intimate partner violence, sexual assault, and elder abuse.

- **FY 2008-2009 Contracts**

Currently we have funded two programs entitled "End Violence Against Women on College/University Campuses" and "HIV/AIDS-Related Prevention Education Services for Survivors of Domestic Violence." The End Violence Against Women on College/University Campuses develop projects that target campus female students of all ages and also trains/educates faculty, staff and campus security/police

concerning critical issues associated with VAW. Under the latter program, organizations will develop and implement programs to address the risks of contracting HIV/AIDS. The program is specifically designed to serve female survivors of domestic violence. It was also designed to train their counselors to incorporate HIV/AIDS prevention and intervention strategies when working with their clients. The contractors are:

1. B Squared Enterprises, LLC
Mandrell Birks
P.O. Box 3262
Laurel, MD 20709
Phone: (301) 685-3539
E-mail: B2Ent@verizon.net
Target School: Bowie State University, Bowie, MD
2. ENSYNC Diversified Management Services, Inc.
Christine McMillon
225 Waymont Court, Suite 111
Lake Mary, Florida 32746
Phone: (407) 936-1515
Email: ensyncdms@aol.com
Target School: Bethune-Cookman University, Daytona Beach, FL
3. Hermes, LLC
Danielle Laborde
409 Clearbrook Drive
Wilmington, NC 28409
Phone: (910) 375-5454
Email: dlaborde@hermesllc.com
Target School: North Carolina Central University, Durham, NC
4. Institute for Successful Leadership
Dorothy Triplett
1619 Bardmoor Hill Circle
Orlando, FL 32835
Phone: (407) 521-1364
Email: THEISL4U@aol.com
Website: <http://www.theisl4uonline.com>
Target School: Edward Waters College, Jacksonville, FL

5. Social Solutions International, Inc.
Susanna Nemes
8070 Georgia Avenue, Suite 201
Silver Spring, MD 20910
Phone: (866) 901-6583
Email: snemes@socialsolutions.biz
Target School: George Washington University, Washington, DC
6. The Wright Group
Amelia J. Cobb
1001 Pennsylvania Avenue, NW
Suite 600
Washington, DC 20004
Phone: (202) 904-6824
email: acobb@twgstrategies.com
Target School: Howard University, Washington, DC
7. Messages of Empowerment Productions
Quinn M.Gentry
280 Highland Lake Trace
Atlanta, GA 30349-3916
Phone: (404) 494-9370
E-mail: QuinnGP@aol.com
Target Location: Georgia
8. Susan B. Spencer
8016 Flourtown Avenue
Wyndmoor, PA 19038-7920
Phone: (215) 233-5373
E-mail: sbspencer@comcast.net
Target Location: Philadelphia, PA and surrounding suburban counties

- **OWH Regional Domestic Violence Activities**

The 10 HHS regional women's health offices have had an impact on domestic violence, sexual assault, and violence against girls throughout the country. The Regional Women's Health Coordinators (RWHC) have done ground breaking work on the issues faced by incarcerated women, tribal women, and women in the territories.

For 2008-2009, regional activities have focused on training health professionals and faith-based organizations on identifying and address domestic violence as well as the health needs of women impacted by violence.

Region I has funded a project with Sojourner House, in Rhode Island. The project, titled “Still I Rise Outreach” empowers homeless women and girls in Rhode Island to identify and reduce their risk for violence through culturally reinforced, peer-led targeted outreach, individual and group level interventions. The Region also has a project with the Maine Coalition Against Sexual Assault. The goal is to increase the awareness of sexual violence issues among physicians and other medical professionals throughout Maine and improve their ability to screen patients for sexual assault and abuse. This project will also help create a safe and more secure environment within the doctor’s office for victims/survivors to talk about their experiences. Another project is with the Connecticut Coalition against Domestic Violence. The goal is to influence the public’s perception of domestic violence within the Latino community by developing culturally sensitive public service announcements to be aired on Connecticut’s Latino radio stations. The state contact for the program will be working with DV and SA coalitions, Physicians for Social Responsibility, Eastern Maine Medical Center, Boys to Men, Attorney General's office, Maine DHHS offices of Integrated Services and Child and Family Services, ME OMH, Office of Rural Health and Primary Care and Maine Women's Health Campaign (a partnership with over 15 community partners across the state of Maine). Expansion of the AMCHP Safe Families Initiative to support 2nd year of training for Healthy Maine Partnership.

For fiscal year 2008 and 2009 the region has funded, Jane Doe, Inc to support education and awareness to providers State-wide domestic violence homicide prevention efforts in response to the Governor’s initiative on DV as a Public Health Emergency. Association of Haitian Women in Boston, which supports organizations that use education and community outreach to help prevent and heal domestic violence through community organizing and advocacy for self-empowerment. New Beginnings-A Women’s Crisis Center, Safe Havens Interfaith

Partnership Against Domestic Violence/Third Sector New England, Safeline, Inc. and finally, Women and Families Center which mitigates the harmful behaviors and attitudes that contributes to the acceptance and normalization of sexual violence, as related to the lives and experiences of young women.

Region II established “Training Institute on Mental Health and Trauma Affecting Women and Children”, which provides training to state and local government agencies and community-based organizations working in the fields of trauma, mental health, domestic violence and sexual assault, child abuse and neglect, suicide prevention, primary health care, and emergency preparedness and response to develop and foster systems of trauma-informed care.

Region III is funding two projects: West VA Foundation for Rape Information and Services, and the Fairmont WV, which is conducting a prevention of sexual violence that targets middle school students, named, “Taking the Second Step”. The project goals are: Present Second Step curriculum on violence prevention to middle school students; to train rape crisis staff to implement the curriculum; and to develop 9 county prevention plans to implement the curriculum. Implementation will begin in the 2009-2010 school year and they expect to reach a minimum of 4500 youth. Secondly, the Fairfax County Dept. of Community and Recreation Services in Fairfax, VA is conducting a girls violence mentoring project for middle school girls to strengthen self-image and resilience to resist initiation into gangs and the subsequent violence that is part of the initiation rites as well as receive training on domestic violence, sexual assault, and other forms of abuse used in gang activity. The project name is “Road DAWG” (Don’t Associate With Gangs). The project goals are to educate, introduce girls to services, provide mentorship to 45 at risk middle school girls and facilitate on-going prevention programming on violence against women and girls. The target race/ethnic population is African American and Hispanic girls. Finally, “Addressing Intimate Partner Violence Through Peer Educators in a College Campus” raises awareness about Intimate Partner Violence (IPV) among women and

men on a college campus through peer educators. Each of the workshops will provide information in a culturally appropriate mode using principles of health literacy.

Region IV based in Atlanta, Georgia, the region collaborates with HBCU Tennessee State University to raise awareness regarding issues affecting the health and wellness of women. Awareness was raised through the incorporation of a week long series of workshops and lectures. Partnerships were inclusive of on campus student organizations such as Tennessee State University Health Center and Tennessee State University's Department of Residence Life. A total target population of 259 individuals served. Following, programs/campaigns in Region IV included: The Black Church and Domestic Violence Institute National Women's Health Week, Tennessee Coalition Against Domestic and Sexual Violence Poster Campaign, Mental Health Association of East Tennessee, Mental Health in the Workplace initiative, O.R.A.N.E. Prevention and Relationship Conference, OPA/Family Planning Clinics, which is currently in the planning period to pilot a screening for domestic violence programs.

Following, Region IV has funded 48 projects this year through the JSI mega contract and will fund an additional 9 projects through PSC, including Prevention Violence, and has supported a Women's Winter Series at Tennessee State University. Other programs awarded that aims to stop violence against women are: D.I.V.A., Inc., Gateway House, Inc., Girls Incorporated of Chattanooga (Project BOLD) and Hanging Moss Road Church of Christ and New Hearts Encouragements Ministries which provides a space for intergenerational bonding between women and girls through the creation of an "empowerment quilt", and finally South Brevard Women's Center, Inc. and Women's Center of Jacksonville, Inc.

Region V participated in a kick-off media event for the Chicago Foundation for Women's Illinois Safe State Initiative. They also collaborated with the Administration for Children and Families,

Housing and Urban Development, the Warrenville Correctional Center, and the Health and Medicine Policy Research Group (HMPRG) to conduct three trainings in April 2008 on the impact of trauma on women; and received a presentation from Dr. Stephanie Covington of the Center for Gender and Justice. The region hosted training for service providers in the anti-violence community in Chicago, and collaborated with the Chicago Foundation for Women (CFW) to host an event called “Bringing the Violence Prevention Community Together for Change.” A total of 47 individuals representing a large array of violence prevention as well as domestic violence and sexual assault crisis centers participated in this half-day training presented by Dr. Sujata Warrior.

The Region’s contract with Health and Medicine Policy Research Group (HMPRG) to implementing the Anti-Violence Health Project for Court Involved Girls, a unique collaboration of organizations convened by HMPRG, to engage court-involved girls, health professionals that provide services to girls, and health and anti-violence advocates in directly addressing the cycle of violence experienced by the girls, to create and advocate for more successful health policy, practice and access to care. This effort will bring together the broad array of advocates, researchers, policy makers, and educators working on these issues to create a common agenda, conduct policy research to facilitate policy change within the criminal justice system, and educate an array of working and emerging health professionals on issues of violence, health and court involvement.

Current projects include the Cleveland UMADAOP, that targets girls ages 13-18 and their adult care givers’ in understanding teen dating violence/abuse in the Greater Cleveland intercity neighborhoods. Other Region V projects include: Cream City Medical Society (Milwaukee Metropolitan area), Family Recovery Center, Heartland Recover Center (Children Exposed to Violence), The Board of Trustees of the University of Illinois for Cook County Extension, and finally Wisconsin Coalition Against Sexual Assault (WCASA), focused on tribal and county community awareness of child sexual assault.

Region VI, in 2008, worked with several service organizations to stop violence against women, which included: Harris County Hospital District, Family Abuse Center, Esperanza Shelter, and Counseling Services of Eastern Arkansas that held a program called “Respect the Legacy: Taking a Stand Against Domestic Violence”, increased public awareness about domestic violence toward African American women. The project also worked with African American adult and teen victims of domestic violence on building self-esteem.

The region also worked with Enlace Comunitario which raised awareness and changed personal perceptions about domestic violence amongst Spanish speaking adolescent girls aged 12-17 through a domestic violence primary prevention media outreach campaign. Alongside this program other such as Guiding Right, Inc., Migrant Health Promotion and Safe Places, this is the “Violence No More! An Awareness and Education Program for Preventing Violence against Women and Girls”, the project targeted women and girls in the general population, as well as those whose primary language is Spanish.

Region VII in 2008 the region hosted the Regional Domestic Violence Conference title “Fabric of the Family: the Effects of Domestic Violence”, while supporting other conferences such as: “Latina Women’s Summit to educate Latina women across the lifespan on domestic violence and mental health issues”, and “Child Abuse/Domestic Violence Conference to increase awareness of abuse and violence”. On April 25, 2008, Region VII OWH along with FOH, CMS, and other federal partners hosted the Denim Day, lunch and learn. Denim Day is about increasing awareness of domestic violence and sexual assault. Seven federal agencies and 35 employees participated including OPHS, FOH, CMS, HRSA, OCR, ACF, the RD office.

On April 3, 2008, Region VII OWH hosted the Regional Domestic Violence planning committee meeting in Kansas City, MO. The conference will be held on September 25, 2008 in Kansas City, MO, 300 participants are expected to attend the event.

Region VII continues to collaborate with community groups such as The S.A.F.E. Center, Inc to provide a theater group from Omaha presented at five area high schools in order to increase awareness of dating violence and available resources while educating on positive strategies to use when faced with relationship violence. These presentations also engaged bystanders in the prevention of violence while education students on personal boundaries and healthy relationships. Also, University of Missouri, Sinclair School of Nursing, provided a full day conference on Violence against Women: Prevention, Assessment, Intervention and Management. Specific content related to adolescents and women at-risk for, or who currently experience, several health-related issues including actual or threatened domestic violence and sexual abuse was included in the full-day conference. Advanced practice nurses from both inpatient and primary care settings attended. Specific content included: physical, mental, and emotional impact of violence against women across the life cycle; screening methods; and formulating an escape plan.

Region VIII has worked on several fronts to address violence against women from a public health perspective. Engaging health care providers in prevention and intervention was the focus of the Center on Domestic Violence of the University of Colorado Denver School of Public Affairs conference titled “The Colorado Regional Conference on the Health Care Response to Domestic Violence” co-sponsored by OWH Region VIII. In 2008-09 our regional office additionally sponsored a “Teen Summit” in Riverton, WY at the Wind River Indian Reservation, focusing in part on violence and sexual assault prevention. Culturally competent violence prevention classes for Latina teens were developed and implemented by RAAP (Rape Assistance and Awareness Program -Denver) and funded by the regional office. Other funded projects included: the development and implementation of a teen violence prevention program in Jamestown, North Dakota; through the non-profit “Courage is Change” the implementation of Red Tent Clubs in 2 Boulder Valley School District High Schools to empower and inform young women about domestic and dating violence; to implement the program “Love is Not Abuse” via the Latin American Research and Service Agency (LARASA) online Learning Centers; and

to implement the Sexual Assault Resource Team (SART) Peers Program to provide sexual violence prevention education to middle and high school students, parents and staff within the Poudre School District in Northern Colorado.

Region IX has partnered with six community based organizations and district leaders to put an end to violence against women. The region has participated in the Peace over violence campaign, Denim Day that has been in order since 1997, and continues every year in April for Sexual Assault Awareness Month. Other partnerships include: Resident Council Coalition - Remedial Reading Resource Centers, The Shade Tree, Inc., and The Rape Crisis Center, which works to increase awareness in the Clark County area on dating violence and sexual assault among teens.

Also, the American Indian Prevention Council hosted a Violence Against Women Prevention and Education Seminar for staff of community and faith-based organizations whose client population is primarily Native American. The seminar focused on Native American values including the circle of life, the definition of violence/abuse, legal issues and alternatives, and how to talk with Native American women and girls about abuse. Fifty (50) staff members attended the seminar.

Region X has worked on many projects to prevent violence against women. In 2008 and 2009 regional projects have been carried out by several organizations. These organizations include: Standing Together Against Rape (STAR) in Anchorage, AK; Domestic Violence and Sexual Assault Services of Whatcom County in Bellingham, WA; and Asian Counseling and Referral Service in Seattle, WA, which piloted the project "Speak Up and Be Safe" for Asian women. As a part of the National Women's Health Week, the regional office provided support to May Day, Inc. to hold a self defense seminar. Region X has also worked with the Deschutes County Health Department in Oregon to support the implementation of DV screening protocol in the county health department clinic.

In addition, the regional staff regularly attends meetings of the Community Partnership Against Sexual and Domestic Violence (CPASDV). CPASDV is a group of state and local organizations in western Washington that shares information and collaborates on projects related to educating health professionals and DV advocates on working together.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES (SAMHSA)

Center for Mental Health Services (CMHS)

During the past decade, it has become widely recognized that trauma plays a major role in the lives of people served by mental health and human services. Research shows that anywhere from 85-95% of people served have experienced severe trauma in their lives, that childhood trauma causes neurological damage and the adoption of health risk behaviors, and that trauma contributes to health problems in adulthood and early mortality. Disasters such as hurricane Katrina take a huge toll on people with histories of abuse, causing retraumatization, the re-emergence of severe symptoms and dysfunctional behaviors, and relapse from recovery. Trauma causes untold personal, financial and social costs.

Recognizing and responding effectively to trauma can provide solutions to some of the most challenging issues facing mental health and human services today. Addressing trauma is therefore one of the most effective strategies a state can use in transforming their systems of care. Trauma provides a unifying framework for transformation, and it represents a fundamental shift in beliefs and attitudes – a shift from hopelessness to hope, from consumer passivity to consumer voice, from custodial care to individualized planning and goals.

Women and Violence and Trauma

It has become clear at CMHS over the past ten years that the production and application of knowledge on the topic of women and violence and trauma in the mental health, substance abuse, and criminal justice system – indeed, across the public health system - cuts in many directions that cross many sites, systems and moral boundaries.

Women who have been abused in childhood may later appear in the criminal justice system as offenders. Women who are abused as children by family members may experience continuing abuse as adults from others in her environment. These same women may be the mothers of children who are currently experiencing abuse, and who also may also enter the juvenile or criminal justice system. Women offenders with histories of abuse are most likely to be diverted from the criminal justice system into the community corrections system that refers them to the same community-based services that exist for women with abuse histories who have never appeared in the criminal justice system.

Furthermore, all abuse is not equal or equally deserving of support or compensation in the eyes of society. Victims of rape and domestic violence have established some dominion, victims of incest have not. Victims of reported crime merit compensation, but victims of unreported crime do not. “Innocent” victims of crime deserve our sympathy and succor; victims who are viewed as having somehow precipitated the crime do not. Victim compensation exists only to redress immediate and damaging impacts of the act of violence itself, and does not exist for those whose prior histories have yielded a host of problems needing treatment (such as co-occurring disorders), and treatment for these disorders typically is not be supported through crime victim compensation counseling.

Interventions designed to address the impacts of violence are often experienced as revictimizing by the victims they are intended to help. Coercive institutional practices are most frequently identified as significant carriers and multipliers of the original violence and its impacts. Practices of seclusion and restraint in jails, prisons, and mental hospitals, and echoes of these practices in community programs are often experienced as profound setbacks. The “second injury” dealt to a victim of crime through the trained detached professionalism of their helpers, which is an emblem of good

professional practice, is often felt by the victim to be as, or more, traumatizing than the original crime.

Given this diversity of statuses, experiences, and responses to different types of women experiencing trauma, a broad range of technical assistance opportunities have been established by the Center for Mental Health Services in the area of gender-specific adult violence and trauma across the spectrum of public health and multiple human service systems. These include the following:

Programs and projects:

I.CMHS's National Center for Trauma-Informed Care (NCTIC), CMHS/SAMHSA, 2004 Present, Scheduled to 2013). This technical assistance program is designed to address the issue that, unlike traditional mental health services or public health services, trauma-informed care (TIC) recognizes trauma as a central issue in the lives of those seeking services. Knowledge about the prevalence and impact of trauma has grown to the point that it is now universally understood that almost all of the women and a majority of the men seeking services in the public health system have trauma histories. The percentage for women is estimated to be close to 100%. **TIC provides a new paradigm under which the basic premise for organizing services is transformed from “what is wrong with you?” to “what happened to you?”**

TIC is initiated through an organizational shift from a traditional “top down” environment to one that is based on collaboration with consumers and survivors. Incorporating TIC values and gender-specific services into existing organizations is therefore central to improving program efficacy and supporting the healing and recovery process. Since a wide range of programs and systems have a felt need to integrate trauma-informed practices, NCTIC provides extensive and intensive technical assistance and education and consultation toward agency transitions to help these programs and services to incorporate gender specificity while they take this revolutionary step forward. NCTIC undertakes the following:

- 1) **Organizes facilitated learning opportunities** (i.e. education, training, and consultation) for candidate organizations and systems

interested in implementing TIC, and provide follow-through implementation assistance;

2) **Establishes TIC implementation “mentor” sites to demonstrate TIC in action**, and to stimulate and broker implementation by potential users; and

3) **Engages in TIC alliance building through the purposeful cultivation of various types of potential user and user networks** of program and consumer experts, organizations, and systems –

4) **Formation of leadership cadres of program and consumer “trauma champions”** to sustain TIC change and implementation at all levels of service systems.

5) **Develops and supports a series of “TIC Organizational Change Practicum”** are planned for representative public health teams demonstrating readiness for change at the state and local level.

To date, requests for NCTIC consultation have far outstripped response capacity. In the past year, over 250 programs have been served directly. Currently, over 45 State Mental Health Authorities have established TIC within their state systems. Interest in trauma-informed care in the consumer/survivor communities has grown rapidly, not only in the service delivery end of peer support, but also in the role of peers in effecting trauma-informed systems change. Numerous requests for consultation also come, not only from mental health services, but from human service organizations across the public health spectrum. Current plans involve testing and further refining of knowledge about effective gender specific models for implementing trauma-informed care and integrating perspectives and voices of consumers/survivors in the organizational implementation process across the range of public health and human services delivery systems.

The core focus for NCTIC FY09 activities are: (1) provision of strategic TA support to all State mental health authorities/systems (including executive, regulatory, advisory) in implementation of TIC; and (2) provision of TA support to consumer/survivors and peer groups (coalition-building, strategic partnership, planning, and peer support) to establish leadership toward developing, monitoring, and evaluating TIC implementation into each state’s transformation goals and objectives. At present, a number of Mental Health Transformation State Incentive Grantees have initiated TIC implementation.

To meet this challenge, TIC knowledge is organized in a variety of ways, at different levels of complexity, to meet different needs of various target audiences and mesh with different learning styles and capabilities of stakeholders using the most cost effective approaches that yield the most successful results. TIC concepts and organizational change practice learning will be systematically presented in a **TIC Video Training Series** that will be based upon **NCTIC's Trauma Informed Systems of Care Resource Center Toolkit For Training Mental Health Administrators and Providers**.

This Toolkit, developed under contract to CMHS by NASMHPD's NTAC Program is designed as a one day training for state mental health system administrators and providers. It has been used in trainings for groups as small as 25 and as large as 4000. It can be adapted for many types of settings, and a self-study version of this is under development. An Outline of the Curriculum is as follows:

- **Pretest – *Focusing on Trauma***
Prior to the start of this training participants will be presented with a tool to record their thoughts. A series of PowerPoint slides will be shown and participants will then be asked to write down and then talk about what trauma impact and meaning these slides have for them. At least 20 minutes should be given for this activity and then the didactic part of the training starts.
- **Module I: *Setting the Stage for Trauma Informed Care***
Introduction to Trauma Curriculum and Training Event emphasizing facilitating culture change in Programs serving mental health consumers, and development of a curriculum to implement Trauma Informed Systems of Care.
- **Module II: *Experiences of Trauma in Residential Settings***
Given the high prevalence of trauma it could be assumed that staff members and clinicians should be very knowledgeable about trauma. This module will portray the reality of what currently characterizes many if not most shelters serving consumers who

are homeless. Vignettes from consumers, staff members and the media are included to portray examples of such factors as coercion, loss of hope, disempowerment, rules, hierarchical levels, lack of inclusion in treatment, lack of effective treatment activities, lack of relationships, gender insensitivity, retraumatization, etc of PTSD and trauma histories, inadequate assessment, lack of effective treatment

- **Module III: *Understanding the Bio-psychosocial Impact of Trauma***

This module will provide an overview of the neurobiological and psychological effects of trauma on human beings. Individualized experiences and reactions to traumatic life events are described in examples that clearly demonstrate trauma's impact on daily life and responses to stressors. Biological changes that occur from trauma, especially in childhood are linked with growth and development throughout the age span. Current research on trauma and its effects support the content in this module and core concepts linked to healthy human development are discussed. The prevalence of trauma in the lives of consumers who are homeless is higher than any other population.

- **Module IV: *Trauma-Informed Care: An Overview of Fundamental Concepts***

This module will introduce the principles and characteristics of systems of care that are trauma informed as compared to those that are not trauma informed. It includes definitions, statistics on traumatic experiences in a variety of populations, implications for care settings, descriptions, guidelines, and the organizational commitment that is required to implement.

- **Module V: *Leadership in Organizational Change***

The core strategy in creating sustainable culture change in any organization is leadership. Without leadership there is no vision, plan or accountability. Leadership staff must take effective and thoughtful action to change historical practices and implement a

new philosophy and values in daily operations. Leadership must be organized when seeking culture change and one way to do this is do develop a culture change plan that describes the goals, objectives, activities and the person(s) responsible person for each step. Then they, and others, must be willing to be held accountable to that plan. There are emerging core principles of effective leaders that are being researched and discussed on the national level. This module introduces some of these key core principles and include strategies specific to implementing trauma informed care in a mental health setting.

- **Module VI: *Identifying and Managing Risk Factors Associate with Conflict and Violence in Various Settings***
This strategy suggests the creation of an environment whose policy, procedures, and practice is based on knowledge of risk factors for violence. The purpose of this strategy is to create a living environment that is more able to prevent violence, conflict and injuries resulting from violence. In this sense it is a prevention of trauma intervention. This strategy is implemented primarily through staff training and education and policy and assessment procedures changes. It includes the training of staff in assessing risk for violence and covers the expected and required knowledge, skills and abilities of staff and an organization with regards to risk assessment characteristics.
- **Module VII: *Trauma Sensitive Tools: Part One***
This first module on the same topic presents specific strategies that are trauma informed and assist the organization to become trauma informed in terms of policy, procedure and staff activities. These tools and assessments are integrated into facility policy and procedures and each individual consumer's recovery plan. This strategy relies heavily on the concept of individualized treatment. It includes the use of assessment tools to identify risk for violence and the use of a universal trauma assessment; tools to identify persons with high risk factors and the use of de-escalation surveys or safety plans.

- **Module VIII: *Trauma Sensitive Tools-Part Two***

This first module on the same topic presents specific strategies that are trauma informed and assist the organization to become trauma informed in terms of policy, procedure and staff activities. These tools and assessments are integrated into facility policy and procedures and each individual consumer's recovery plan. This strategy relies heavily on the concept of individualized treatment. It includes the use of use of person-first language, environmental changes to include comfort and sensory rooms; sensory modulation experiences and other meaningful treatment activities designed to teach people emotional self management skills.

II. After the Crisis: Retraumatization from Disasters Technical Assistance Initiative (CMHS/NCTIC/GAINS) 2004 until 2013

Considerable work has been done over the past thirty years concerning the role of mental health systems in disaster response. State and federal governments and national disaster response organizations have provided leadership in addressing mental health needs in both disaster preparedness and response. Some attention has been paid to the needs of people diagnosed with mental illnesses, who may be at higher risk for distress following disasters, and whose stress symptoms may manifest in ways that mimic exacerbation of psychiatric illness. In particular, they may be at risk for developing post-traumatic stress symptoms over time. This increased risk may be due in part to lack of resources or to characteristics associated with the diagnosis, e.g., an increased sensitivity to stress.

A growing body of evidence suggests that increased vulnerability probably reflects the high rates of previous forms of trauma, especially childhood physical and sexual abuse, which can range up to 90% or more among this population. Higher rates of post-disaster distress among people with psychiatric diagnoses may also be related to the increased risk of victimization (particularly interpersonal violence) following a disaster. In addition, disasters pose unique problems for people with mental health problems and abuse histories residing in psychiatric facilities and in

correctional settings, and those who experience violent crimes in the aftermath of a disaster.

Despite this evidence of increased vulnerability, people with mental health problems and abuse histories often rise above the immediate distress of a disaster to provide leadership and support to others. In the past few years, some of the most exciting and innovative approaches to mental health disaster response have been peer-run and peer-delivered services. Peer-run programs are inherently consistent with established principles of disaster response, since they emphasize outreach, occur in natural community settings, emphasize people's strengths, avoid mental health labels, and are likely to be culturally sensitive because they are delivered by people who are themselves community members. However, information about peer-run programs is not widely available and is only beginning to be integrated into mainstream disaster response.

The significant retraumatizing impact of terrorism and natural disasters has recently come to public attention. Since trauma has a cumulative and repeating impact across the lifespan, it can be anticipated that people with prior trauma histories will be especially vulnerable to the impact of a disaster and that they will be more likely than others to be revictimized in the aftermath. It can also be anticipated that responding to people with prior trauma histories may pose special difficulties. NCTIC working collaboratively with the GAINS Center synthesized emerging knowledge about this issue into a series of written issue briefs, brochures and other materials. NCTIC will collaborate with GAINS and work with states, consumer and advocacy groups, and disaster response systems to respond to the retraumatization of hurricane Katrina and Rita and others to better prepare for similar disasters in the future.

III. Trauma Champions Institute Peer Training Advocacy Resource Center Program (CMHS/NCTIC through 2013)

The "Trauma Champions Institute" day-long training program, developed by a consumer owned and operated trauma informed peer work group, carries the message and frames the strategies for trauma survivors to be at the core of

all systems change such as policy, financing, training and services. Trauma Champion Institute staff members share the experience of SAMHSA's Women, Co-Occurring Disorders and Violence Study, and serve as consultants for NCTIC. They are grounded in knowledge of trauma as a central experience and unifying theme for a wide variety of peer/consumer/survivor and disability issues, including self-injury, retraumatization, and misuse of power and coercion in public systems of care. This training program underscores the importance of voice for marginalized people through the personal stories of participants, and moves planning for "recovery" to transformation for self, families, and communities. Advocacy and community and organizational change strategies are advanced

IV Integrating Services for Female Victims of Crime: Bringing Together Mental Health, Criminal Justice, and Victims Services CMHS/Council of State Governments (CSG) /Office of Violence Against Women (OVW), DOJ through 2010

Women with mental illness are over 40% more likely to be victims of violent crime than other women. Mental health service providers, victim advocates, and other policymakers and practitioners generally know little about women with mental illness who have experienced violence. Furthermore, state and local government officials and advocates have few, if any, resources available to them—resources that can be tapped to help protect, inform, serve, and treat this population and minimize the likelihood that they are victimized again.

In order to improve response to women diagnosed with mental illnesses who have been victims of crime, CMHS and CSG is coordinating a multi-year project focused on this population of women. CSG developed an Issue Brief that summarizes the latest research regarding this issue, identifies some programs and resources that serve women with mental illness who are recent victims of crime, and recommends an action agenda for the federal government. Based on the issue brief and input from mental health and victim services experts, CSG has drafted policy and practice recommendations to serve this population of crime victims, and recently coordinated a meeting of key leaders in the fields of mental health and victim services to respond to these recommendations. These recommendations will

serve as a foundation from which mental health and victim service providers can build new, collaborative responses to women with mental illness who have been victims of crime.

V. The Role of Religion and Spirituality in Trauma-Informed Care (NCTIC and CMHS's Office of Refugee Mental Health) through 2013

The role of religion and spirituality in trauma healing has long been recognized. The experience of violence may raise fundamental questions about good and evil, and the transformation of self and relationships that trauma survivors undergo is frequently experienced as a deep spiritual or religious journey. Many treatment programs work to include faith, prayer and religious practices in their interventions and/or develop relationships with organized religions.

Religious institutions can be a resource for trauma survivors, but they need education about mental health and trauma issues in order to respond effectively. In addition, there are significant concerns about how to address this important component of people's lives while honoring separation of church and state, and while maintaining a commitment to evidence-based practices. The mental health system has a great deal to learn from other countries and other cultures regarding new approaches to healing from trauma and violence – and many of these approaches include a religious dimension. When under stress, people often revert to the most basic aspect of their identity, their religion, and mental health workers will increasingly need to know how to respond to suffering in religiously appropriate ways. Trauma-informed systems recognize that there are multiple and complex paths to healing, are sensitive to cultural context, and display an ability to learn from the experience of the people they serve. Religion and spirituality form an important and growing aspect of cultural context.

This project will convene stakeholders who represent a wide variety of roles, cultures and religions in an effort to take a broad and systemic look at the issues. Participants will be drawn from state, federal and local government, faith-based offices and initiatives, refugee and immigrant communities, religious and spiritual institutions, trauma treatment programs, advocacy groups, and the scientific community. The project will have a public health

framework, using a strengths-based approach and focusing on prevention, resilience and community interventions as well as individual treatment.

VI. Special Panel Series: Trauma Informed Care for Female Genital Circumcision (Office of Women's Health, HHS/CMHS/NCTIC) through 2013

CMHS's National Center for Trauma Informed Care (NCTIC), under leadership from the DHHS Office of Women's Health (OWH), sponsored an expert panel meeting in February 2008 focused **on trauma-related issues with regard to female genital circumcision (FGC)**. Objectives for the meeting included : 1) review scope of problem and history of legislation and activities that address FGC work in US; 2) develop initial guiding principles to in support of societal and cultural values and familial principles to address FGC trauma challenges that may vary from community to community; 3) develop strategic plan to address FGC healthcare issues for women and girls in their communities based a human rights and trauma-informed approach; and 4) develop template for trauma-informed TA plans to respond to FGC needs of a community through actionable consultation strategies

VII. Cross-Generational Trauma-Informed Peer Leadership/Mentoring Initiative (CMHS/NCTIC) through 2013

This is a new initiative to develop sustained leadership for trauma-informed systems change and collaboration among older and younger women to address issues of trauma and women, and to enhance strategic planning for the prevention of violence and abuse and the promotion mental health and wellness. The objectives are to address the particular concerns of women, especially young women and transition-aged youth, as related to trauma's impact on their spiritual, social, mental, and physical wellness. A mentoring model that allows for partnering of older and younger women to provide for leadership development and transition planning. Goals are to create empowerment strategies for consumers/survivors in integrating their perspectives within TIC systems/organizational changes activities; to provide a forum for professionals and peers to share dynamically in leadership

activities and mentoring relationships; and to promote concepts of healing and recovery for women.

To accomplish the above, the establishment of a Women's Leadership Sub-Council under NCTIC will be implemented which will provide recommendations specific to engaging youth and young women in trauma-informed systems change and develop a framework for a guide to developing a national leadership institute.

VIII. Creating New Ethical Standards for Promoting the Integration of Trauma Informed Care in Healthcare Reform

The CMHS National Center for Trauma-Informed Care (NCTIC) is launching an effort to develop ethical standards for engaging trauma-informed approach across systems of care. These standards will promote self-determination, hope and commitment to change that can be applied to any setting, system and level of health and human services. Trauma-informed ethics will further the course of peer leadership and empowerment, while creating a culture of practice committed to change. Ethical standards yield opportunities for improvement and establish new ways of thinking that move beyond complacency with the *status quo* and challenge providers to stretch to a new standard that supports wellness. Using a public health approach, these standards will serve to prevent trauma and retraumatization, while supporting the healing process for trauma survivors and communities.

Ambassadors for change must be engaged in the development of ethical standards that are responsive to diverse community needs. **NCTIC anticipates establishing pathways to hope and healing for trauma survivors.** A commitment to change involves engaging in dialogues with resource experts from public, private and non-profit sectors of local, state and federal agencies. This will also include all levels of healthcare providers, from local outpatient physical health, behavioral health and substance abuse providers, to inpatient hospital, residential and rehabilitation services providers who treat individuals that have survived trauma.

IX. Under Development: Key Issues Regarding Gender Specific Men's Trauma Services

(CMHS/NCTIC/Community Connections) through 2013

Recent federal initiatives have highlighted the pervasiveness and widespread impact of *women's* experiences of trauma, especially of women who have mental health and/or substance use problems. When trauma studies have focused on the experiences of *men*, military-related trauma has often been the primary area of interest, resulting in a considerable research and clinical literature as well as a broad range of interventions for combat-related PTSD.

However, both research studies and gender-specific trauma recovery services have much less frequently addressed other forms of interpersonal violence involving boys and men, including childhood physical and sexual abuse and community or institutional violence. Further, the attention paid to such experiences as male sexual abuse has usually neglected men who receive publicly funded mental health, substance abuse, or other community-based services. Finally, male gender role stereotypes and expectations often constitute barriers to recognizing the prevalence and impact of trauma among men.

Involving men with lived experiences of trauma in all activities, some key goals in this domain are: 1) to expand, consolidate, and disseminate our understanding of the unique needs and resources of men who are trauma survivors; 2) to enhance gender-sensitivity in both trauma-informed and trauma-specific services; and 3) to assist in making trauma recovery services both accessible and engaging for men.

Key Issues:

- Many of the sequelae of trauma are similar for men and women. However, differences in gender role expectations often affect both the experience of trauma and survivors' responses.
- Because "being a man" and "being a victim" are so frequently seen as incompatible, men who are trauma survivors face a dilemma, disconnecting from either a sense of masculinity (and strength) or one of victimization (and weakness).

- Service providers may have a similar, culturally-shaped difficulty recognizing victimization among men.
- For these and other reasons, it is often difficult for men to seek out and engage in trauma recovery services.
- When men do seek services, there is a relative paucity of gender-specific approaches for male survivors.
- There is a need to raise awareness of the prevalence of trauma among men as a step toward reducing the stigma of male victimization.
- There is a current need to develop models that take into account the experiences of male trauma survivors, both in trauma-informed and trauma-specific arenas.
- There is also a need for services that address frequently marginalized men with multiple vulnerabilities, reflected in mental health problems, substance abuse, homelessness, and/or criminal justice involvement.

Publications

[“The Damaging Consequences of Violence and Trauma.”](#) Jennings, A. (2004).

This document is a collection of evidence compiled to help inform state mental health officials and the federal government’s Substance Abuse and Mental Health Services Administration (SAMHSA) about trauma and to generate interest in this daunting public health and public policy issue. A uniquely valuable publication that combines elements of a technical report, literature review, and a de facto call-to-action under one cover.

[“The Story of a Child's Path to Mental Illness and Suicide.”](#) Jennings, A. (2006).

[“It’s My Time to Live – journeys to healing and recovery.”](#) Heckman, J. and Veysey, B., with Markoff, L., Mazelis, R., Russell, L., (2006), SAMHSA, CMHS.

This monograph is a groundbreaking, in-depth look at recovery from trauma and co-occurring disorders from the perspective of women who are themselves trauma survivors. Based on interviews with ten women who were participants in the *Women, Co-occurring Disorders and Violence Study* (WCDVS), the first large-scale research study to address the effects of trauma in a comprehensive fashion, the monograph presents an emerging model of recovery that goes well beyond current formulations. The conceptual framework presented stresses the inner nature of the journey, difficulties and set-backs faced along the way, and the importance of three components of healing: the moment when the woman first *believes* that recovery is possible; some external event that gives her a *reason* to recover; and concrete changes in *behavior* that help to sustain her recovery. Everyone who has ever worked in the mental health or substance abuse fields, anyone who has ever confronted interpersonal violence and its sometimes devastating aftereffects – in fact, anyone who cares about the strength and dignity of the human spirit – will be moved and changed by this monograph. *DRAFT for review and comment only.*

[“Creating Trauma Services for Women with Co-occurring Disorders.”](#) Moses, D. J., Reed, B. G., Mazelis, R., and D’Ambrosio, B. (August 2003), SAMHSA, CMHS

Creación de Servicios de Trauma para Mujeres con Trastornos Concurrentes

Moses, D., Reed, B.G., Mazelis, R., D’Ambrosio, B. (Spanish translation: Amaro, H. and Cabrera, M.) (2003). Spanish translation of one of the key documents coming out of the *Women, Co-occurring Disorders and Violence Study, Creating Trauma Services for Women with Co-Occurring Disorders*. This monograph describes how systems and services can be redesigned to be appropriate and effective for women who have experienced violence and outlines the challenges and lessons learned by project sites as they implemented their trauma-specific and trauma-informed service

interventions. The final section offers a list of resources for the interested reader. *Now available for the first time for Spanish-speaking audiences.*

[“Understanding and Responding to People in the Criminal Justice System Who Live with Self-Inflicted Violence.”](#) Mazelis, R. (April 2007), SAMHSA, CMHS.

Developing Trauma-Informed Behavioral Health Systems: Report from NTAC's National Experts Meeting on Trauma and Violence, August 5-6, 2002, Alexandria, VA ([pdf](#)) Responding to Childhood Trauma: The Premise and Practice of Trauma Informed Care ([pdf](#)) Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation ([pdf](#)) To obtain an electronic version of these documents, and others go to:

www.mentalhealth.samhsa.gov/nctic

Publications from GAINS Center (www.prainc.com)

[And So I Began to Listen to Their Stories . . . Working With Women in the Criminal Justice System](#) *

[Addressing the Needs of Women in Mental Illness/Substance Use Disorder Jail Diversion Programs](#)

[The Special Needs of Women with Co-Occurring Disorders Diverted From the Criminal Justice System](#) (Training Material)