Chapter 6
Integrated Behavioral Health Approaches to Interpersonal Violence

6.1 An Overview of Violence and Health

Interpersonal violence is a multidimensional phenomenon that has an enormous impact on society. Intimate partner violence (IPV) is a form of interpersonal violence perpetrated by a current or former partner or spouse that includes physical and sexual assault, verbal insults and threats, manipulative behaviors, economic abuse, psychological/emotional abuse, and stalking (CDC 2018; Decker et al. 2018). Perpetrators of IPV use one or more of these forms of violence systematically to establish and maintain power and control over a current or former partner/spouse. Community violence is another form of interpersonal violence that is experienced in settings outside of the home (e.g., playgrounds, schools, residences outside the person’s home, cars, the street) by persons who are not immediate family members (e.g., strangers, acquaintances, rivals, friends, classmates). Community violence includes fights, physical assaults, and firearm-related violence (Decker et al. 2018).

Primary care settings represent a key site for screening and intervention for violence due to the high prevalence of violence in the population and the high number of injuries seen in medical settings that result from violence. Survivors of violence experience a range of comorbid health, behavioral health, and social problems and are at a higher risk for re-injury and re-experiencing violence in the future. Furthermore, different types of violence are often comorbid and intertwined with each other and share common risk and protective factors resulting in a survivor or perpetrator of one form of violence being at a much higher risk for experiencing or engaging in other forms of violence (Finkelhor et al. 2011; Hamby and Grych 2013; Wilson et al. 2014). Public health prevention strategies for various forms of violence are available and can occur at the individual, family, and community level, making the integration of screening, assessment, and intervention practices for various forms of violence in medical settings possible and imperative. In this chapter, I will explore several best practices with regard to screening and intervention for interpersonal violence in integrated behavioral health settings. Approaches that specifically address intimate partner violence (IPV) and community violence will be reviewed.
6.2 Epidemiological Impact of Violence on the Population

Data from the National Crime Victimization Survey indicated that violence victimization, after years of decline, has risen 20% from 2015 to 2018, mainly due to increases in rape and sexual and physical assaults. In 2018, there were six million violent incidents. This is a 13% rise (800,000 incidents) from 2017. The rate of rape or sexual assaults per 1,000 persons over the age of 12 almost doubled from 1.4 victimization/1,000 to 2.7/1,000 in 2018 (Morgan and Oudekerk 2019). In 2017, over 19,500 people or 6/100,000 people died from homicide and of that number, over 14,500 (4.5/100,000) were due to firearms (Kochanek et al. 2019). Violence and homicide disproportionally impact communities of color and younger persons (Sumner et al. 2015). Homicides are among the top-five leading causes of death for persons under the age of 45 and the third leading cause of death of persons between the ages of 15 and 34. For Black and Latinx persons in that age range, it is the leading and second leading cause of death, respectively (Heron 2019). Even more tragically, homicide is the second leading cause of death for Black children in the United States under the age of 10 (Heron 2019).

Men are more likely to engage in homicidal behavior (Curtin et al. 2016; Cooper and Smith 2011; Kann et al. 2018) and almost four times more likely to be victims of homicide than women (Cooper and Smith 2011). However, homicide is one of the leading causes of death for women (Heron 2019), with IPV accounting for half of all female homicides (Petrosky et al. 2017; Stöckl et al. 2013). Homicide disproportionately impacts women of color as it is the second leading cause of death for black women under the age of 20 and fourth leading cause of death for black women between the ages of 20 and 44, and it is the fifth leading cause of death for Latinx women under the age of 45 and is the sixth leading cause of death for white women between the ages of 20 and 44 (Heron 2019). Violence against the transgender and gender nonconforming (TGNC) community is increasing. Since 2013, nearly 200 TGNC persons have been murdered in the United States, the vast majority (80–90%) of whom are black transgender women (HRC 2020). In 2019, at least 27 TGNC persons were murdered. In the first half of 2020, at least 21 TGNC persons have been murdered (HRC 2020). The murder rates of TGNC persons are likely severe undercounts.

6.2.1 Ecological Factors that Impact Violence

There are several inter-related social and ecological factors that impact violence across individual, interpersonal, community, and societal levels (Decker et al. 2018; Sumner et al. 2015). Table 6.1 outlines the risk and protective factors for violence victimization and perpetration at the individual, interpersonal, and community levels. At the individual level, the experience of trauma, poverty, unemployment, substance use, and poor mental health are key factors that can increase the risk of experiencing violence (Capaldi et al. 2012; Decker et al. 2018; Sumner et al. 2015).
## Table 6.1 Risk and protective factors for experiencing violence

| Level          | Risk factors                                      | Protective factors                           |
|----------------|---------------------------------------------------|----------------------------------------------|
| Individual     | **Victimization:** Trauma, Poverty, Unemployment, Substance use, Poor mental health, Difficult temperament | **Perpetration and victimization:** Problem-solving ability, Cognitive flexibility, Flexible temperament, Emotional regulation, Prosocial behaviors and emotional competence, High self-efficacy, Positive affectivity |
|                | **Perpetration:** Unemployment, Conduct disorder or antisocial personality disorders (ASPD), History of violence, Young age, Depression, Substance use, High anger and hostility, Witnessing or experiencing IPV as a child, Unplanned pregnancy, Negative affectivity, Emotional dysregulation, Low cognitive problem-solving/ cognitive inflexibility |                                             |
| Interpersonal  | **Victimization:** Relationships marked by high conflict and tension, Perceived isolation and loneliness, Financial stress | **Both perpetration and victimization:** Positive peers, Social connectedness with positive nurturing adults, Positive marriages, Social support |
|                | **Perpetration:** Criminal behavior, association with violent or aggressive peers, Substance use and mental illness in the home, Intergenerational violence transmission through witnessing or experiencing violence, Adversity as a child, Having parents with less than a high school education |                                             |
| Community      | Schools with poor safety cohesion and efficacy, High drug and gun trafficking, Chronic poverty, High alcohol availability, Low social cohesion, High male incarceration rates | **Both perpetration and victimization:** Access to healthy schools, Neighborhood cohesion, Access to a range of comprehensive and coordinated community resources and services |

Based on CDC (2019)
Risk factors identified by the Centers for Disease Control and Prevention (CDC) for violence perpetration include low income and unemployment, conduct disorder or antisocial personality disorders (ASPD), history of violence, young age, depression, substance use, high anger and hostility, witnessing or experiencing intimate partner violence (IPV) as a child, and unplanned pregnancy (CDC 2019; Yakubovich et al. 2018). At the interpersonal level, the most common risk factors for interpersonal violence include relationships marked by high conflict and tension, perceived isolation and loneliness, financial stress, criminal behavior, association with violent or aggressive peers, substance use and mental illness in the home, intergenerational violence transmission through witnessing or experiencing violence and adversity as a child, and having parents with less than a high school education (CDC 2019; Decker et al. 2018; Capaldi et al. 2012; Sumner et al. 2015; Yakubovich et al. 2018). At the community level, risk factors for violence include schools with poor safety, cohesion, and efficacy; high drug and gun trafficking in communities; chronic poverty; high alcohol availability; low social cohesion; and high male incarceration rates (CDC 2019; Capaldi et al. 2012; Decker et al. 2018; Sumner et al. 2015; Yakubovich et al. 2018). Racist social policies play a large role in the development of these risk factors. Policies that result in housing discrimination, lack of universal health care, lack of political power due to voter suppression and discrimination, over-incarceration, racial profiling, and police violence can lead to racial inequities, concentrated economic disadvantages, segregation, and ultimately higher rates of community violence (Sumner et al. 2015).

Effectively addressing community violence is not a mystery. We know what works. While chronic toxic stress and concentrated economic disadvantage are some of the most pronounced risk factors for violence, protective factors include social connectedness with positive, nurturing adults; positive marriages; older age; social support; access to healthy schools and positive peers; neighborhood cohesion and efficacy; and access to a range of comprehensive and coordinated community resources and services. Given these protective factors, community violence can be effectively reduced or eliminated through the development of policies that reduce economic inequality through increased access to employment, good schools, affordable and safe housing, and health care (CDC 2016, 2019; Niolon et al. 2017).

### 6.2.2 Impact of Violence on Health

Exposure to violence can lead to a range of negative health and mental health outcomes. For instance, exposure to violence in childhood can lead to higher rates of psychopathology such as depression, post-traumatic stress disorder (PTSD), personality disorders such as antisocial and borderline personality disorder, conduct disorders, anxiety disorders, substance use disorders, and suicide (Sumner et al. 2015). Violence exposure can lead to higher rates of risk behaviors such as high-risk sexual behaviors leading to sexually transmitted infections (STIs) and sedentary lifestyle leading to obesity (Sumner et al. 2015). Violence exposure can also lead to later problems with employment, income, housing, and family relationships, and is
also associated with various diseases that include cancer, cardiovascular and cerebrovascular disease, and diabetes (Norman et al. 2012; Hillis et al. 2004; García-Moreno and Riecher-Rössler 2013; Felitti et al. 1998). To summarize, violence exposure is one of the most important risk factors for a range of physical health, mental health, and social outcomes, making routine screening and intervention for violence a necessary part of health and behavioral health professional practice.

### 6.3 Integrated Behavioral Health Practices to Address Violence

Given the multidimensional impact violence has on health and well-being, a variety of approaches to preventing and treating the impact of violence at the individual, family, community, and societal level are needed.

#### 6.3.1 Universal Prevention Programs

Universal prevention programs that can reduce the risk of IPV include bystander-training programs in schools and universities designed to help bystanders spot and interrupt the perpetration of violence. These programs reduce violence and violence acceptance (Coker et al. 2016, 2019). In addition, providing rape awareness and resistance training in schools can help reduce the risk of IPV and sexual violence (Senn et al. 2015). For prevention of community violence, school climates that hold students to high expectations and provide safe and healthy environments for students to learn are crucial (Niolon et al. 2017). Universal prevention approaches in elementary schools that promote safety and community, such as the “Good Behavior Game,” a classroom management strategy that teaches and reinforces emotional competence, problem-solving skills, and prosocial behaviors, can reduce aggressive behaviors (Petras et al. 2008).

#### 6.3.2 Trauma-Informed Care Approaches

Trauma-informed approaches provide comprehensive, responsive care to persons who have experienced violence and trauma while increasing safety and access to resources. These approaches can reduce re-traumatization in health settings and revictimization (SAMHSA 2014; Sumner et al. 2015). Screening, brief interventions, and treatment referrals in healthcare settings have shown good outcomes in reducing violence, and identifying and responding to IPV and child abuse and neglect in clients (Dubowitz et al. 2009, 2011; Feder et al. 2011; Sumner et al. 2015; Nelson
Trauma-focused cognitive behavioral therapy (CBT) approaches to reduce the symptoms of PTSD and depression can reduce the risk for future IPV victimization (Iverson et al. 2011). For instance, school-based approaches that use CBT and somatic approaches to help children and adolescents exposed to violence develop coping skills have been shown to be effective in reducing depression and PTSD symptoms in school children (Stein et al. 2003; Mancini 2020). CBT can also help people learn effective anger management, communication, and problem-solving skills to reduce violence perpetration and re-victimization (Lipsey et al. 2007). Family-focused interventions most effective in reducing the impact of violence include child and family counseling, multi-systemic therapy, parenting education, training, and home visitation programs. Parent training and home visitation programs have been shown to be particularly effective in reducing violence in the home (Bilukha et al. 2005; Kaminski et al. 2008, pp. 62, 63).

6.3.3 Hospital-Based Violence Intervention Programs (HVIP)

Hospital-based violence intervention programs (discussed in more detail later) provide free, longitudinal access to advocacy, case management, and counseling to survivors of community and intimate partner violence. These programs can reduce re-injury rates and are cost effective (Cooper et al. 2006). Collaborative care approaches that offer stepped care including motivational approaches, CBT, medications, and case management targeting depression, PTSD, substance use, and violence risk behavior in injured adolescents presenting to the ER showed significant positive outcomes (Zatzick et al. 2014).

Multi-tiered approaches that provide universal trauma-informed care, screening, and brief motivational interventions and longer-term, targeted case management and wraparound services that help people access resources, skills, and safe environments are important ways that hospitals and medical settings can interrupt the cycle of violence (Health Research and Educational Trust 2015). Developing collaborations with legal and justice advocacy organizations, behavioral health providers, and community-based agencies that serve survivors of violence are important ways that primary care settings can ensure that clients experiencing violence gain access to advocacy and legal services (restraining orders, protective orders), safe housing, food, medical care, and child care (Sumner et al. 2015).

6.3.4 Law Enforcement Strategies

At the community level, enactment of laws that restrict firearm possession and purchase for persons with restraining orders, mental health issues, and perpetrators of domestic violence and enactment of safe storage laws and programs can save lives and lead to reductions in violence, homicide, and suicide. Reducing the availability
of alcohol in communities and universities can also reduce violence perpetration (Decker et al. 2018). Policing strategies that reduce drug and gun trafficking in communities such as *In the Crossfire*, and programs such as *Cure Violence*, that use trained community members who have experienced violence to interrupt violent altercations and retribution before violence can spread can be very effective in reducing community violence and homicides (Webster et al. 2013; Henry et al. 2014; Butts et al. 2015; Koper and Mayo-Wilson 2006; Delgado et al. 2017).

### 6.4 Assessment and Interventions for Intimate Partner Violence

#### 6.4.1 Overview of Intimate Partner Violence

Intimate partner violence (IPV) occurs when a relationship partner engages in a pattern of behavior with the intention to establish and maintain power and control over another person. The behaviors used to maintain power and control include physical violence such as hitting, pushing, strangling, biting or inflicting injury through the use of a weapon. IPV also includes sexual violence including rape and sexual assault. IPV also include a range of controlling behaviors and tactics. Persons who engage in IPV also rely on a combination of intimidation and threats of violence to the partner or other family members including children, stalking, using mental health biases (i.e., “no one will believe you because you’re crazy”), emotional abuse (i.e., put downs, contempt), social isolation (i.e., restricting or monitoring access to friends and family), jealousy, and restricting access to resources such as social status, money, important documents, and other resources as a means to control another person (CDC 2018; Decker et al. 2018; Black et al. 2011). For persons in the immigrant and refugee community, including victims of human trafficking, tactics can include using language privilege or restricting the learning of the dominate language in a community, threatening immigration status or deportation, or preventing access to important documents such as passports, birth certificates, IDs, licenses, or green cards.

#### 6.4.1.1 Epidemiology of Intimate Partner Violence

One in four women will experience and report being impacted by intimate partner violence (IPV) in their lifetime and one in five will experience rape (Smith et al. 2018; Black et al. 2011). Nearly 45% of all women and one in five men will report lifetime sexual victimization other than rape. Over half of all reported rapes are by an intimate partner (Black et al. 2011; Smith et al. 2018). Nearly 1 in 10 women in the United States have been raped by an intimate partner and almost a quarter have experienced physical assault by an intimate partner (Black et al. 2011). One in seven
men report experiencing physical violence by an intimate partner, one in seventy-one men report being raped, and one in nineteen men report being stalked in their lifetime (Black et al. 2011). Black, Indigenous, and Persons of Color (BIPOC) experience IPV at higher rates than persons who identify as white (Breiding et al. 2014).

Approximately one in five black and non-Hispanic white women, one in seven Latinx women, and one quarter of women who identify as American Indian or Alaskan Native will experience rape in their lifetime (Black et al. 2011). IPV is also very prevalent in the LGBTQ+ communities. Approximately 60% of bisexual women and 37% of bisexual men reported lifetime experience of sexual assault, physical violence, and stalking (Walters et al. 2013). Lesbian women (44%) and gay men (26%) reported high lifetime prevalence rates for sexual assault, physical violence, and stalking (Walters et al. 2013). Rates of IPV for persons who identify as transgender are higher than in persons who identify as cisgender (Langenderfer-Magruder et al. 2016). Over half of transgender persons report experiencing IPV in their lifetime (James et al. 2016). The lifetime prevalence of physical and sexual violence for transgender persons is 35% and 47%, respectively (Landers and Gilsanz 2009; James et al. 2016).

For adolescents, approximately 12% of women and 4.5% of men reported sexual coercion, while 25% of adolescents reported emotional abuse by their partner (CDC 2012). Nearly 80% female survivors of rape experienced their first rape before age 25 and approximately 42% experienced their first rape before the age of 18.

6.4.1.2 The Impact of Intimate Partner Violence on Health and Well-Being

Assessing for IPV in healthcare settings is important because experiencing IPV places a person at a significant risk for a multitude of health problems. Injuries from assaults include bruises, broken bones, knife and gunshot wounds, burns, lacerations, and spinal cord injuries. Physical violence also results in traumatic brain injury (TBI) in over 70% of women experiencing IPV (Arias and Corso 2005; Chrisler and Ferguson 2006). More than two-thirds of persons experiencing IPV experienced strangulation at least once. Of that number, the average number of times they report strangulation is over five. Death from a strangulation incident can occur days afterward due to delayed swelling of breathing pathways injured during the event (Barker et al. 2019; Chrisler and Ferguson 2006; Coker et al. 2002; Messing et al. 2018).

Persons experiencing IPV are also at risk for a range of other serious health problems due to experiencing chronic stress. These can include chronic disease conditions such as high blood pressure, heart disease, asthma, irritable bowel syndrome, migraine headaches, joint conditions, and chronic pain (Black 2011; Coker et al. 2002). The stress of IPV can also place a person at risk for several behavioral health conditions such as suicidality, unipolar and post-partum depression, antisocial behavior, anxiety, substance use (including opioid abuse), full and partial post-traumatic stress disorder (PTSD), and smoking (Ackard and Neumark-Sztainer
Experiencing IPV also has implications for maternal and sexual health. Mothers experiencing IPV have higher rates of both miscarriages and unwanted pregnancies. They are also more likely to give birth prematurely and have low-birth-weight babies due to stress and engaging in maladaptive coping behaviors such as smoking, drinking, and drug use. Women are also more likely to have sexually transmitted infections (STIs) and urinary tract infections (UTIs) because their partners may refuse to wear protection or it is unsafe to insist on protection (Miller et al. 2010; Sarkar 2008). Over half (55%) of women with HIV have experienced IPV in their lifetimes compared to 36% of non-HIV infected women (Machtinger et al. 2012; Black 2011).

6.4.2 Implementing Approaches to Address IPV in Integrated Behavioral Healthcare Settings

IPV has a broad impact on health and well-being indicating the need for clear policies and procedures to address IPV that are trauma-informed, safe, and effective. The US Department of Health and Human Services has identified routine and universal screening and intervention as a covered preventative service. This policy was based on the 2011 recommendation by the Institute of Medicine’s Consensus report on Clinical Preventative Services for Women that universal IPV screening and counseling be provided in healthcare settings. A systematic review found screening and brief interventions at primary care sites that involved empathic listening, support, education, and referral to IPV services can lead to reduced violence, improved safety behaviors, and greater utilization of IPV resources in the community (Bair-Merritt et al. 2014). IPV interventions can also reduce risks for reproductive coercion in family planning and reproductive health sites. IPV interventions at family planning sites to address reproductive coercion that involve screening, education, empathic listening, and providing access to birth control, emergency contraception, and referrals to IPV services led to lower rates of pregnancy coercion and higher rates of patients ending abusive relationships (Miller et al. 2010, 2011).

Despite their effectiveness, implementation of universal screening and brief interventions in routine healthcare settings have proven to be a challenge (Decker et al. 2012). Effective translation requires creating a clinical environment that is supportive of addressing IPV such as: (1) having leadership and champions promoting the importance of IPV services across the organization; (2) having information pamphlets and posters in the waiting room about the effect of IPV on health and information on IPV services in the community; (3) the presence of clinical and non-clinical staff that are trained in trauma-informed practices; (4) providing routine screening procedures for IPV and brief interventions for IPV that involve universal education on healthy relationships; and (5) information/access to victim advocacy and service organizations either on-site or through warm referrals (Decker et al. 2012; IOM 2011a, b; McCaw 2011; Miller et al. 2015b).
It should be noted that the goal is not for clients and patients to disclose IPV or to leave the relationship, both of which can jeopardize the safety of the patient. Persons experiencing IPV face an increased risk of being killed when in the process of leaving a relationship (Bachman and Salzman 2000). Responding to IPV from a trauma-informed perspective means moving from disclosure and detection as the main goal, to initiating a conversation about violence that ensures patient safety and confidentiality, while also providing education, service access, and support (Miller et al. 2015a).

The common barriers to effectively initiating a conversation about IPV include low provider comfort and skill levels with discussing IPV, not having enough time or privacy in the clinical encounter to discuss IPV, and providers not knowing what to do if there is a positive disclosure due to lack of effective response procedures or IPV services available either on-site or through referral, and lack of follow-up care and monitoring. Simply screening for IPV without providing effective service provision or linkage for survivors provides little benefit and may even be harmful (Klevens et al. 2012; Wathen and MacMillan 2012). When providers have clear guidelines and skills on how to effectively respond to IPV disclosures and serve persons who screen positive for IPV, they are more comfortable with discussing IPV and more effective in their clinical encounters (McCaw et al. 2001).

Addressing these issues involves several important initiatives. First, it is important to deploy ongoing staff training on how to embed IPV screening, universal education, and information about available community resources into clinical encounters. This also includes providing safety cards to all clients in order to engage them in a conversation about universal education. Providers need to be made aware of and understand that the goal of IPV conversations is not to get clients to disclose, but to provide information and education regardless of disclosure. Training should also include opportunities for providers to discuss their concerns and experiences and give providers opportunities to practice through scripts and role-plays.

Second, it is vital to have in place a trauma-informed and integrated system of care that is responsive to health and safety of persons experiencing IPV and has clear, concrete policies regarding the provision of services to patients who disclose IPV. Provider discomfort with IPV screening and education often stems from not having clear response guidelines for when a client discloses IPV. Confusion around mandatory reporting requirements, lack of awareness of community resources, and a lack of system integration and partnership with IPV organizations, complicate this matter. The best way to ensure that providers are effective and comfortable is to have clear guidelines on what to do when someone identifies as an IPV survivor. Provision of integrated, on-site services is the best way for clients to gain access to services (Decker et al. 2012).

If services cannot be co-located on site, then warm referrals defined by clear protocols and guidelines to community IPV service organizations that provide legal advocacy and services, child care, safe housing/shelter, and food access are best. A warm referral process means having in place bi-directional partnerships with community-based IPV service organizations that include billing and referral procedures through an official Memorandum of Understanding (MOU) with outside IPV organizations that guide the referral process. During training, it is best for health
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and behavioral health providers to meet and have contact with IPV providers in the community in order to establish rapport and facilitate referral processes. Ongoing cross-training between health care and IPV partners can strengthen the relationships between these service entities, increase integration of services, and reduce fragmentation. Strong community partnerships need to be established and maintained to ensure adequate referral to services. These protocols should be tested before screening commences. This ensures an active referral process or “warm hand-off” that goes beyond just giving clients a business card and phone number. Organizations, such as Futures without Violence.org and IPVHealth.org, have evidence-based training toolkits, webinars, and resources addressing the intersection of health and violence in healthcare settings, including multilingual safety cards for multiple communities and settings (Miller et al. 2015a; Decker et al. 2012).

Third, it is vital for settings to have champions for IPV screening and intervention throughout the organization and that IPV services are integrated throughout all organizational processes, policies, and procedures. This includes having visible posters, brochures, and information about IPV in waiting rooms and restrooms. Prompts for IPV screening and brief interventions should be integrated in electronic management systems that can prompt and guide providers through the screening process. IPV procedures should also be integrated into clinical checklists, progress notes, and medical records forms and databases. Follow-up and tracking of client outcomes is important to ensure they received appropriate services and are being adequately served. IPV-related clinical goals and objectives should be integrated into all strategic planning, policy manuals, hiring guidelines, trainings, and continuous quality improvement processes (Decker et al. 2012).

6.4.2.1 Mandated Reporting of IPV

Mandatory reporting laws require certain persons and professionals (e.g., healthcare workers, social workers, counselors, teachers) to report to state or federal authorities suspected or actual abuse of vulnerable persons (Jordan and Pritchard 2018). These laws vary by state, but reportable offenses typically involve: (1) victims of violence that involve a weapon (e.g., firearm injuries); (2) child abuse, neglect, or trafficking; (3) adult/elder abuse, neglect, or trafficking; and (4) domestic violence or sexual assault (Jordan and Pritchard 2018). While reporting laws vary, most states compel social workers, nurses, physicians, and other healthcare professionals to report offenses to state authorities (e.g., law enforcement, child or adult protective services) despite the wishes of the survivor (Durborow et al. 2013). Mandatory reporting laws for domestic violence can have significant negative consequences for victims of IPV (Lippy et al. 2020).

Many states also designate workers in domestic violence shelters as mandated reporters, which can lead to negative psychological consequences to IPV survivors parenting in these shelters (Fauci and Goodman 2020). Persons experiencing IPV may experience mandatory reporting laws if they disclose their experiences to a healthcare worker directly, if they experience an IPV-related injury from a weapon, or
they may be reported if they have children in the home exposed to domestic violence, which is often seen as a form of child harm. In 18 states, anyone over the age of 18 is mandated to report IPV, which may also include members of the survivor’s social network. Mandated reporting laws, as they pertain to IPV, have been found to have several negative consequences including lack of disclosure to medical care providers and delay of medical care for fear that a report will be filed resulting in law enforcement and social service involvement, court exposure, arrest, and removal of children from the home (Durborow et al. 2013; Jordan and Pritchard 2018; Lippy et al. 2020). BIPOC mothers who experience IPV are particularly at risk as they have been found to be more likely have their cases referred to child protective services compared to white mothers who are more likely to be referred to shelters or behavioral health services (Dosanjh et al. 2008). Lippy et al. (2020) found that fear of being reported can prevent IPV survivors from seeking support from formal and informal networks. They also found that transgender and gender nonconforming (TGNC) survivors were reluctant to disclose IPV because they were afraid law enforcement would arrest them noting the long history of police misconduct and brutality toward the TGNC population (Lippy et al. 2020); Stotzer 2014). Women were more likely to be concerned about losing their children and immigrant survivors were often concerned about being deported (Lippy et al. 2020). The experiences of persons who have been reported indicated that the experience made their situation worse due to involvement in the criminal justice and child welfare systems and subsequent loss of stability in the domains of housing, finances, and family. The experience of persons of color differed from white women. The abusers of women of color who were reported were less likely to be arrested than those who abused white women. BIPOC mothers were also more likely to lose their children after being reported (Lippy et al. 2020).

For persons experiencing IPV, help-seeking is important and potentially lifesaving. Unfortunately, evidence is emerging that suggests that the presence of mandatory reporting laws contribute to inequitable access to health care and services. Informing clients in advance that their abuse could be reported may lessen the likelihood that women will disclose abuse to healthcare providers (Jordan and Pritchard 2018). Further, mandated reporters often only need reasonable suspicion that violence has occurred in order to report an offense. A compendium is available through the Futures without Violence website that identifies mandated reporting laws for each state and the US Territory (Lizdas et al. 2019).

6.4.3 Common Screening and Assessment Practice for Intimate Partner Violence

Two factors have led to a rise in routine screening for IPV in primary care settings: (1) the decision by the Department of Health and Human Service to make IPV screening a covered preventative service; and (2) Affordable Care Act’s mandated prohibition of the discriminatory practice by insurance companies of making the experience of IPV a pre-existing condition (Decker et al. 2012; IOM 2011a, b;
Lippy et al. 2020; Lizdas et al. 2019). While screening for violence should be a universal and routine part of care, screening is not enough. It is equally important to provide both universal education to clients about IPV and health, and easy access to needed services for persons who need them.

Screening for IPV should always be done in a private setting and when the client and provider are alone. The CDC has a list of effective and easy-to-administer scales for IPV (Basile et al. 2007). A brief IPV screening instrument that has been used in a variety of settings and can be deployed as a written form or as part of a clinical interview, is the Extended Hurt, Insult, Threaten, Scream screening tool (E-HITS) (Iverson et al. 2015). This tool is an extension of the well-known Hurt, Insult, Threaten, Scream (HITS) tool for IPV (Rabin et al. 2009; Shakil et al. 2014; Sherin et al. 1998). The E-HITS tool is a five-item scale that asks clients over the last 12 months how often their partner has: (1) physically Hurt you; (2) Insulted or talked down to you; (3) Threatened you with harm; (4) Screamed or cursed at you; or (5) forced you to have Sexual activities. The scale anchors and scores are: never = 1, rarely = 2, sometimes = 3, fairly often = 4, and frequently = 5. Scores range from 5 to 25. A score of 7 or more indicates a positive screen for IPV.

Another common tool is the Partner Violence Screen (PVS) (Feldhaus et al. 1997). The PVS is a three-item “Yes” and “No” screen that asks clients: (1) Have you ever been hit, kicked, punched, or otherwise hurt by someone within the past year (if so, by whom?); (2) Do you feel safe in your current relationship?; and (3) Is there a partner from a previous relationship who is making you feel unsafe now? Any “yes” answer and recognition that the violence is from a current or past partner is a positive screen for IPV. It is also important and useful to ask clients if they have ever experienced reproductive coercion. This is particularly important in settings that provide reproductive health services.

6.4.4 Brief Interventions for IPV in Integrated Behavioral Health Settings

Providers should routinely engage in brief interventions for IPV after screening regardless of whether or not a person discloses IPV. Brief interventions usually involve providing universal education about IPV and its connection with health in a supportive and conversational manner. This often includes handing out brochures and safety cards. Practitioners also provide access to IPV services to clients either on-site or through warm referrals with trusted IPV providers in the community. Two overlapping models for brief IPV intervention will be discussed next: The CUES Approach and the Systems Approach to IPV intervention. Futures without Violence is a nonprofit organization that has promoted the CUES approach to screening and brief intervention for intimate partner violence (See: Futures without Violence.org). The CUES approach to IPV intervention has three facets: (1) Discussing Confidentiality; (2) Providing Universal Education and Empowerment; and (3) Supporting Clients through a warm referral (Miller and Anderson 2018; Miller et al. 2011, 2015a, b, 2017). Table 6.2 outlines each of the components of the CUES
Table 6.2  CUES approach to addressing intimate partner violence in health settings

| Domain          | Definition                                                                                                                                                                                                                                                                                                                                 | Script                                                                                                                                                                                                                     |
|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Confidentiality | Make patients aware of the limits of confidentiality (e.g., mandatory reporting laws) when discussing violence as early in the clinical encounter as possible through direct conversations, signage, and intake forms Use sensitive and caring language that recognizes the difficulty in talking about IPV, and detail situations that would require them to report violence to law enforcement To ensure client safety and privacy, providers should never ask about IPV or human trafficking with other people in the room If a language interpreter is used, it should be a professional that is affiliated with the setting, and not a family member or friend **Do not:** Signal that IPV-related screening questions are perfunctory and not important Violating confidentiality rules by asking about IPV with family or partners present | “Before we begin, I need to inform you that this is a safe place and that what you tell me is confidential. That means I will not share what you tell me with anyone outside of this room except if you tell me [include any limits on disclosure relevant to your state or jurisdiction]” “In my experience, clients (or patients) are sometimes going through things that may have a negative impact on their health and safety, but that they are not comfortable telling me because they are afraid for their safety or the safety of someone they love. No matter what you decide to tell me, the information and resources I share with you today can be used by you or someone else important to you” |

(continued)
### Domain Definition Script

#### Universal education and empowerment

Provide universal education about healthy and unhealthy relationships and how relationships can impact health. **Disclosure is not the goal.** The goal is initiating conversations about healthy and unhealthy relationships and educating the client about the impacts of unhealthy relationships. **Normalize the conversation.** Sit facing your client and start the conversation by letting the client know that you are interested in making sure that all of your clients are healthy and part of that is by educating clients about healthy and unhealthy relationships. **Educate** clients by introducing safety cards focused on characteristics of healthy and unhealthy relationships. Give your client a tour of the safety card by reviewing the signs of healthy and unhealthy relationships. Highlight that unhealthy or unsafe relationships do not always include physical or sexual abuse, but can also be defined by other abusive practices such as restricting contact with others, stalking, use of put-downs, threats, controlling money and resources, or using jealousy to control behavior.

Review safety information on the back of the card (e.g., safety plans, organizations, hotlines, text-lines and other resources). Review resources provided by your agency on-site or through referral. **Do not:** jeopardize safety of the client by suggesting upon disclosure that the client should leave the relationship or call law enforcement.

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| Domain | Definition | Script |
|--------|------------|--------|
| Universal education and empowerment | Provide universal education about healthy and unhealthy relationships and how relationships can impact health. **Disclosure is not the goal.** The goal is initiating conversations about healthy and unhealthy relationships and educating the client about the impacts of unhealthy relationships. **Normalize the conversation.** Sit facing your client and start the conversation by letting the client know that you are interested in making sure that all of your clients are healthy and part of that is by educating clients about healthy and unhealthy relationships. **Educate** clients by introducing safety cards focused on characteristics of healthy and unhealthy relationships. Give your client a tour of the safety card by reviewing the signs of healthy and unhealthy relationships. Highlight that unhealthy or unsafe relationships do not always include physical or sexual abuse, but can also be defined by other abusive practices such as restricting contact with others, stalking, use of put-downs, threats, controlling money and resources, or using jealousy to control behavior. Review safety information on the back of the card (e.g., safety plans, organizations, hotlines, text-lines and other resources). Review resources provided by your agency on-site or through referral. **Do not:** jeopardize safety of the client by suggesting upon disclosure that the client should leave the relationship or call law enforcement. |

"I’m going to give you two of these cards—one is for you in case you ever need it because relationships are complex and can change, and the other is for someone you care about who may be in an unhealthy relationship that you want to help.”

“On the back of the card there is information in case you or someone you care about ever needs help. There is a safety plan as well as hotlines and text-lines that are staffed 24-hours-a-day by people that understand unhealthy or complicated relationships and are ready to help.”

(continued)
| Domain                  | Definition                                                                                                                                                                                                 | Script                                                                                                                                                                                                 |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Supporting clients     | Be ready to help. Following a disclosure, be prepared to respond to clients in an effective, safe, and compassionate way  
*Validate* the client by expressing: (1) you are sorry to hear this is happening; (2) it is not their fault; (3) they are not alone; and (4) what they are experiencing is unacceptable  
Indicate that what you are hearing makes you concerned for their overall safety, health, and well-being  
*Reduce harm* by asking the client how you can be helpful and offering help in regard to safety plans, medication adherence (i.e., for partners who control access to medications), access to birth control and other forms of pregnancy prevention such as emergency contraception, and developing plans for adequate exercise, nutrition, and sleep can be very useful to the client  
Provide a menu of service options either on-site or through warm referrals to outside resources designed to support survivors of IPV such as a shelter, advocacy, counseling programs, support groups, and social service agencies  
Offer the client the option of making the phone call in your office on your phone in situations where the client’s phone is controlled by their partner  
Know the advocate you are calling and have a pre-arranged referral plan and organizational partnership to ensure a successful referral  
**Do not:**  
Engaging in victim blaming by asking: “Why do you stay?” “Why not just leave him?” “Think about your kids?”  
Re-traumatizing or triggering the client by interrogating or probing for all the sensitive details of the abuse                                                                 | “I have a range of options for you to choose from that I am happy to tell you about. These include learning about some options and resources we offer here and by our partners in the community. Some clients/patients find talking to an advocate or counselor helpful. I can connect you with a colleague that I know and who has helped many of our clients. She has lots of information about how to seek help. Would you like me to connect you to my colleague? You can call right here in the office and we can use my phone” |
approach with helpful practice suggestions and scripts. The table also identifies practices to avoid that can be harmful to clients.

### 6.4.4.1 Confidentiality

Initiating conversations about violence should be a universal practice in integrated care settings. Disclosure can happen at any point in a clinical encounter. As a result, providers of the CUES approach are directed to make patients aware of the limits of confidentiality when discussing violence as early as possible. This can be communicated in signage and on intake forms. Providers should also inform clients directly about the limits of confidentiality through sensitive and caring conversations that recognize the difficulty in talking about IPV, and detail situations that would require them to report violence to law enforcement. Clients need to know the limits of confidentiality before direct or indirect questions are asked about IPV. To ensure client safety and privacy, providers should never ask about IPV or human trafficking with other people in the room. If a language interpreter is used, it should be a professional that is affiliated with the setting, and not a family member or friend.

Mandatory reporting requirements vary by state. Every state has mandatory reporting requirements for providers in the case of child or elder abuse. Several states also have reporting requirements for bodily injury due to weapons or interpersonal or self-inflicted violence. Therefore, it is imperative that providers know the limits of confidentiality and reporting requirements in their jurisdiction around disclosure of IPV and clearly describe those limits to their client before any questions are asked about IPV. A script that can be helpful includes:

> Before we begin, I need to inform you that this is a safe place and that what you tell me is confidential. That means I will not share what you tell me with anyone outside of this room except if you tell me [include any limits on disclosure relevant to your State or jurisdiction].

> In my experience, clients (or patients) are sometimes going through things that may have a negative impact on their health and safety, but that they are not comfortable telling me because they are afraid for their safety or the safety of someone they love. No matter what you decide to tell me, the information and resources I share with you today can be used by you or someone else important to you.

Mandatory disclosure warnings are a complex issue. Issuing these warnings can often reduce the likelihood for disclosure due to fear of the consequences of being reported. These consequences can be severe, particularly for BIPOC and TGNC persons, and include criminal justice and child protective services involvement, arrest, jeopardized safety, and loss of familial and economic well-being (Lippy et al. 2020). Further research is needed on policies and procedures that allow survivors of IPV to disclose their experiences without automatically triggering a report, since mandated reporting can result in harm due to exposure to unjust systems with histories of racism and violence toward the poor, BIPOC, and TGNC communities.
6.4.4.2 Providing Universal Education About Healthy Relationships and Empowering Clients

Providing universal education to clients about healthy and unhealthy relationships and the impact of violence on health is a form of primary prevention for violence. This approach can also be a form of secondary prevention for clients with histories of IPV who are at risk for further violence, and a form of tertiary (harm reduction) prevention for those actively in relationships marked by IPV. Providers should begin by normalizing universal education about violence and how relationships can impact health in positive and negative ways. Universal education about violence should be positioned as a way of ensuring the optimal health of clients (Miller and Anderson 2018; Miller et al. 2011, 2015a, b, 2017).

The most effective way to have these conversations is by introducing safety cards focused on characteristics of healthy and unhealthy relationships. These small, discreet cards have information about the different forms of IPV, characteristics of healthy and unhealthy relationships, the negative health effects of violence, and a list of resources for those who wish to seek help. A good practice is to give two cards to clients, so they can give the card to someone they care about who may be in an unhealthy relationship. This can empower clients to help others and may also lead them to evaluate their own relationship. An example of what to say includes:

I’m going to give you two of these cards – one is for you in case you ever need it because relationships are complex and can change, and the other is for someone you care about who may be in an unhealthy relationship that you want to help.

Providers should ensure they use plain and simple language and use an agency-based interpreter when necessary. There are several common principles for initiating these conversations. First is that disclosure is not the goal. The goal is initiating conversations about healthy and unhealthy relationships and educating the client about the impacts of unhealthy relationships. The second is normalization. Sitting facing your client and start the conversation by letting the client know that you are interested in making sure that all of your clients are healthy and part of that is by educating clients about healthy and unhealthy relationships. The third principle is education. Introduce the safety card by explaining that the card is designed to provide information about the characteristics of relationships that are unsafe and can lead to health problems. Continue the conversation by giving your client a tour of the safety card, reviewing the signs of healthy and unhealthy relationships. Be sure to highlight that unhealthy or unsafe relationships do not always include physical or sexual abuse, but can also be defined by other abusive practices such as restricting contact with others; stalking; use of put-downs; threats; controlling access to family, money, children, and resources; or using jealousy to control behavior. After educating clients about healthy and unhealthy relationships, professionals should review helpful safety information on the back of the card (Miller and Anderson 2018). This information includes safety plans, organizations, hotlines, text-lines, and other resources for the client. Professionals should try these lines themselves so that they can better inform clients about what they can expect when they use these resources. A common script to guide the conversation includes:
On the back of the card there is information in case you or someone you care about ever needs help. There is a safety plan as well as hotlines and text-lines that are staffed 24-hours-a-day by people that understand unhealthy or complicated relationships and are ready to help.

### 6.4.4.3 Supporting Clients: Be Ready to Help

Professionals should have open and honest conversations about violence one-on-one with clients. During these conversations, disclosures can happen. Providers need to be prepared to respond sensitively and effectively when they do. Clients report preferring IPV assessment practices that focus on improving health and safety and are done in a private, one-on-one manner. Clients who talk with healthcare providers about IPV experiences are four times more likely to seek help and over 2.5 times more likely to leave the relationship (McCloskey et al. 2006). It should be noted that the risk of homicide increases substantially when victims are in the process of leaving a relationship, particularly when a firearm is in the home, indicating the need for a coordinated referral process that can ensure that clients receive the support, information, advocacy, and protection they need to safely leave an abusive relationship (Bachman and Salzman 2000).

Therefore, professionals need to be prepared to respond to clients in an effective, safe, and compassionate way. It is not the time to explore traumatic details of the relationship or to encourage clients to leave the relationship or call the police, as this may not be the safest option for the client at the time. Professionals should also avoid describing the relationship using alienating terms such as “violent,” “rape,” or “abusive,” and use terms like “complicated,” “unsafe,” or “unhealthy.” The primary responsibility of the provider in these encounters is to validate the client by showing concern, reduce harm, and provide education and resources to the client. Validating the experience means expressing to the client that: (1) you are sorry to hear this is happening; (2) it is not their fault; (3) they are not alone; and (4) what they are experiencing is unacceptable. Showing concern means expressing to the client that what you are hearing makes you concerned for their overall safety, health, and well-being. Reducing harm means asking the client how you can be helpful. Offering help in regard to safety plans, medication adherence (i.e., for partners who control access to medications), access to birth control and other forms of pregnancy prevention such as emergency contraception, and developing plans for adequate exercise, nutrition, and sleep can be very useful to the client. Finally, it is important for behavioral health professionals to be prepared to provide services either on-site or through referrals to outside resources designed to support survivors of IPV such as a shelter, advocacy, counseling programs, support groups, and social service agencies. Providing a warm referral to clients and a follow-up visit are the best ways to ensure that clients get the help they need and increase the likelihood of a successful referral. This will require organizational relationships and training. Warm referrals are those in which providers are able to connect the client with a professional resource they know either by phone or face-to-face. Offering the client the option of
making the phone call in the provider’s office on the provider’s phone is important in situations where the client’s phone is controlled by their partner. Knowing the advocate that the provider is calling and having a pre-arranged referral plan and organizational partnership will be essential to ensuring a successful referral (Miller and Anderson 2018; Miller et al. 2011, 2015a, b, 2017).

Offering a menu of options can be helpful in encouraging clients to choose an option that is appropriate for them. Some sample scripts to assist clients in deciding about resources include:

I have a range of options for you to choose from that I am happy to tell you about. These include learning about some options and resources we offer here and by our partners in the community. Some clients/patients find talking to an advocate or counselor helpful? I can connect you with a colleague that I know and who has helped many of our clients. She has lots of information about how to seek help. Would you like me to connect you to my colleague? You or I can call right here in the office and we can use my phone.

If services are available on-site, providers can arrange to walk the person over to the person providing IPV services. Asking clients, “How else can I be helpful to you?”, is also important to give clients an opportunity to identify ways you can help that are tailored to the specific needs of the client.

Unfortunately, providers who are untrained, unsupported, or lack comfort in IPV assessment can say and do things that are counter-productive and even dangerous. There are some practices and statements that are not helpful and can jeopardize the safety of clients. Here are some practices to avoid:

• Signaling that IPV-related screening questions are perfunctory and not important such as asking IPV screening questions in a rote manner with your back to the client, not asking the questions at all, or just listing them on an intake form and not following up.
• Violating confidentiality rules by asking about IPV with family or partners present.
• Jeopardizing safety of the client by suggesting upon disclosure that the client should leave the relationship or call law enforcement.
• Engaging in victim blaming by asking, “Why do you stay?” “Why not just leave him?” “Think about your kids?”
• Re-traumatizing or triggering the client by interrogating or probing for all the sensitive details of the abuse.

As reviewed above, IPV assessment that is empowering and effective requires active, empathic listening that involves adequate time, privacy, focus, eye contact, and concern. Documentation of IPV includes indicating if the person was assessed for IPV or the reason IPV screening and assessment did not occur. The client’s screening and assessment responses should be recorded as well as any observed health impacts if IPV is disclosed. The provider should also thoroughly document their responses regarding the provision of education, support, resources, and referrals.
6.4.4.4 A Systems Approach to IPV

A closely related approach to the CUES intervention is the Kaiser Permanente’s Systems approach to assessing and addressing IPV in health settings (Miller et al. 2015b; Decker et al. 2012; IOM 2011a, b; McCaw 2011). This approach incorporates the practices outlined in the CUES intervention above, but also includes other factors relevant for adequate implementation of IPV assessment in healthcare settings. Figure 6.1 outlines the main components to the systems approach to IPV intervention. A key component of the systems approach is for clients to access IPV services at any point in the healthcare system including primary care and ambulatory care sites, reproductive health settings, emergency settings, and hospital-based settings. The systems approach integrates IPV universal assessment and treatment services throughout the entire healthcare environment. The approach can dramatically increase the rates of IPV treatment access (Miller et al. 2015a).

The systems approach has four inter-related components. First, leadership and support of the approach throughout the system is required. Leadership support ensures that the approach can be thoroughly implemented into all aspects of patient care and sustained in the organization. Brief, ongoing training of all staff on IPV screening, assessment, education, intervention, and referral is required to ensure adequate uptake and dissemination of the approach. Second, screening and assessment procedures are integrated and supported throughout the system. Clinicians are trained to inquire directly about IPV and know how to respond to disclosure in a trauma-informed and effective manner to ensure safety and support of the client. An important aspect of the systems approach is that IPV screening, assessment,
resources, and services are integrated in the clinical encounter. This includes
prompts for IPV screening within the electronic health record (EHR) system, the
availability of IPV resources to the patient (e.g., community services, safety cards),
and posters in exam rooms and waiting areas that prompt IPV discussion. Third, a
supportive environment is established that includes trauma-informed and well-
trained staff, educational posters, and brochures available in the waiting area and
restrooms, and community education about IPV through newspapers, social media,
radio, billboard, and online resources. Fourth, linkage to community resources and
cross-training is an important aspect of the systems approach. Healthcare sites
should have active, formal relationships with IPV resources in the community such
as legal advocacy groups, domestic violence service providers, emergency and tran-
sitional housing, childcare services, crisis response teams, behavioral health
resources, support groups, and employment programs. Formal relationships ensure
warm referrals and increase the likelihood of follow-up. Further, cross-training
opportunities between healthcare and community agencies increase knowledge and
skill transfer within the service environment. Lastly, IPV service are provided
onsite. This can include risk and safety assessments, support groups, advocacy ser-
vice, peer navigators, and triage services for behavioral health. These five areas
ensure that IPV services are uniformly and universally integrated within the service
system landscape and increase access to health, advocacy, behavioral health, and
social services for IPV survivors (Decker et al. 2012; Miller et al. 2015a).

6.5  Hospital-Based Violence Intervention Programs
for Community-Based Violence

The experience of community-based violence is increasingly being recognized as a
disease process requiring a set of secondary and tertiary public health interventions
designed to intervene and prevent continued morbidity and early mortality. Morbidity and mortality due to firearm-related and other violent injuries are a pub-
lic health epidemic in many US cities. In the United States, there are 67,000 firearm
injuries and nearly 40,000 firearm deaths annually costing billions of dollars (CDC
Wonder Database 2020). In 2017, almost 15,000 persons were murdered with fire-
arms. Homicide is one of the top-five leading causes of death for persons under
45 years of age. Homicide is the third leading cause of death for people between the
ages of 15 and 34. It is also the leading cause of death for Black Americans and the
second leading cause of death for Latinx persons in that age range (Heron 2019).
For Black children between the ages of 1 and 9, homicide was the second leading
cause of death in the United States. (Heron 2019). The rise in youth who experience
violence in the United States has emerged as a public health crisis requiring trans-
disciplinary approaches to prevention and intervention (Cunningham et al. 2009).
Recent epidemiological data indicate that physical assault of children and youth are
common. Over half of youth under the age of 18 report experiencing a physical
assault, and nearly two-thirds of youth between the ages of 14 and 17 have experienced an assault. Approximately 10% of youth under the age of 18 report experiencing an injury from a physical assault in the last year (Finkelhor et al. 2015).

Experiencing an assault-related injury places a person at a higher risk of future re-injury. Youth who come to the ED with an assault injury are 40% more likely to experience gun violence within two years than youth who come to the ED without an assault injury. For youth with co-occurring PTSD and substance use disorders, re-injury rates were found to be substantially higher. Survivors who also have access to firearms and held positive views of retaliation were particularly at risk for re-injury and death (Carter et al. 2015; Copeland-Linder et al. 2012; Cunningham et al. 2014). Other risk factors for assault re-injury include previous fights, being injured by a weapon, and seeing someone else get shot with a firearm (Cheng et al. 2003). Experiencing a firearm-related (or other penetrating trauma) injury can increase the risk for retaliatory violence, weapon carrying, and future injuries (Kubrin and Weitzer 2003; Brooke et al. 2006; Wiebe et al. 2011). Firearm-related re-injury rates range from 25% to 44% over five years with an average of 2.6 injuries (Sims et al. 1989; McCoy et al. 2013). For a person experiencing two or more firearm-related injuries, the re-injury rate can be as high as 77%, with each subsequent injury associated with an increased risk for death (Brooke et al. 2006). Assault-injured youth who come to the emergency room are more likely to have behavioral health issues, to experience adverse childhood events, PTSD, and substance use (Corbin et al. 2013; Cunningham et al. 2014). Firearm-related injuries are also enormously expensive to treat. The cost for firearm-related injuries requiring admission to the ER in 2010 was estimated at more than $420,000 per patient, and the cost for patients discharged from the ER was $120,000 (Lee et al. 2014).

In addition to experiencing behavioral health conditions, other important risk factors for violence can largely be categorized as social determinants of health including socioeconomic (e.g., poverty), poor education, high unemployment, environment degradation, and low-quality housing (Dicker 2016). These rates have made reducing and preventing violence re-injury through addressing social determinants of health a priority for hospital-based violence prevention networks across the country. Retaliatory violence often occurs within six months of an ER visit (Wiebe et al. 2011). This suggests that the initial time during and after an ER visit is a critical time for intervention to prevent re-injury and possibly death through engagement in services (Cunningham et al. 2014; Carter et al. 2018; Copeland-Linder et al. 2012).

Hospital emergency departments are a common point of contact for persons who experience violent injuries and represent important sites for violence prevention and intervention. Hospital-based violence intervention programs (HVIPs) provide health, behavioral health, and social services to persons who have experienced injuries due to community violence such as penetrating injuries (e.g., firearm-related injuries, stabbings) and blunt force injuries (i.e., fists, club) from assaults. Providers from these programs provide outreach to assault-injured youth and their families. HVIP providers seek to engage patients while in the hospital and provide wrap-around follow-up care after discharge. There is a growing body of evidence that
shows these programs are cost-effective, improve employment and educational outcomes, and interrupt the transmission of violence by reducing re-injury rates, criminal justice involvement, and weapon carrying (Cunningham et al. 2009, 2015; Chong et al. 2015; Cooper et al. 2006; Juillard et al. 2015; Purtle et al. 2015; Smith et al. 2013; Zatzick et al. 2014).

Providers within hospital-based violence intervention programs seek to engage clients and their families in services quickly while they are in the hospital (i.e., bedside engagement). Offering services in close temporal proximity to injury can increase the likelihood survivors will engage in service because they may be more motivated and open to change. Once enrolled, service clients gain access to free, comprehensive, longitudinal, wraparound services designed to address health, behavioral health, interpersonal, and social service needs (Cheng et al. 2008a, b). For instance, many programs provide free case management services for 6 months to a year following injury. Case managers provide counseling, advocacy, mentoring, system navigation and care coordination, access to transportation and basic resources, and assistance accessing health, behavioral health, and social services in the community. Clients can also receive educational support, employment training, and job placement services (Aboutanos et al. 2011; Juillard et al. 2015, 2016; Cheng et al. 2008a, b; Lumba-Brown et al. 2017; Martin-Mollard and Becker 2009; Purtle et al. 2013; Smith et al. 2013).

Successful implementation of HVIPs may require coordination, leveraging, and integration of resources from multiple domains and levels (Bell et al. 2018; Health Research and Educational Trust 2015). Patients who experience gun and other forms of community violence are already vulnerable and face a devastating range of consequences following their injury (Juillard et al. 2016; Richardson et al. 2016). Hospital-Based Violence Intervention programs have the potential to save lives, reduce costs, and interrupt cycles of violence and the poverty that perpetuates it (Bell et al. 2018; Health Research and Educational Trust 2015). Effective implementation requires extensive coordination, a committed network of champions consisting of transdisciplinary professionals, and institutional partnerships with hospitals, universities, community providers, and funders (Bell et al. 2018; Health Research and Educational Trust 2015).

### 6.6 Summary and Conclusions

Interpersonal violence, particularly violence involving firearms, is an epidemic in the United States impacting health, home, and community. Given the prevalence of interpersonal violence in the community and its negative and generational impact on a range of health indicators, violence assessment and intervention in health and behavioral health settings must be a priority. Assessing for intimate partner violence requires health systems to create safe, welcoming spaces that promote compassionate and courageous conversations about healthy and unhealthy relationships. Survivors of IPV need to know they are in control of their story and must have easy
access to effective, comprehensive, and affordable interventions to address the broad range of health impacts resulting from violence.

Community violence, especially involving firearm-related injuries in youth, must be addressed through a broad range of policy and practice interventions. Hospitals represent important settings in which to intervene to prevent re-injury and retaliation in assault-injured youth. Homicide represents the leading cause of death for Black Americans under 40. This is directly the result of decades of racist social policies designed to segregate Black and Brown communities and limit their access to wealth and health through discrimination in the domains of housing, employment, health, and education leading to unemployment, unsafe neighborhoods, under-resourced schools, and profound poverty. Policy reforms that seek to eliminate racial wealth inequality and poverty and guarantee equitable access to employment, health care, and quality education, are the only way to reduce this epidemic of violence. Further, reducing access to unsecure firearms represents an effective means to reducing gun violence across America. Currently, rise in calls for racial justice and police reform and the realities of systemic health inequities exposed by the COVID-19 pandemic provide a unique opportunity to forge new policy priorities focused on equity and justice, both of which are vital to physical and behavioral health.

Case Study 6.1: Jessica Sanders

Jessica Sanders1 is a 31-year-old cisgendered, white woman attending her first annual physical exam at her new primary care doctor’s office. Jessica notices that the office has many wall posters that bring awareness to depression, drinking, substance use, and violence prevention. She also notices brochures in the restroom that discuss healthy and unhealthy relationships, intimate partner violence, and resources for persons who are survivors of violence and human trafficking. She also noticed on the intake form questions about her depression, anxiety, stress, and drinking levels. Jessica is married and has two children. She works in the human resources department at a medium-sized financial management company. Jessica’s doctor, Cynthia Johnson, walks in to the exam room. After the nurse leaves, Dr. Johnson begins her exam with a brief, private conversation with Jessica. She sits directly across from Jessica. She first informs Jessica about the limits of confidentiality.

Dr. Johnson: I may ask you some questions about your health and mental health, including your drinking and drug use, stress levels, and your relationships. These are routine questions I ask all my patients because they are all areas that impact health. Before we begin, I need to inform you that this is a safe place and that what you tell me is confidential. That means I will not share what you tell me with anyone outside of this room except if you tell me your children are in danger of abuse or neglect. In that situation I am a mandated reporter and must report this to State authorities. Know that your safety and the safety of your children are my priority. In my experience, patients are sometimes going through things that may have a negative impact on their health and safety, but that they are not comfortable telling me because they are afraid for their safety or the safety of someone they

1All names and other identifiers of this case have been changed to protect privacy and confidentiality.
love. No matter what you decide to tell me, the information and resources I share with you today can be used by you or someone else important to you.

Dr. Johnson begins by reviewing Jessica’s intake form and going over any significant information. Jessica’s intake form indicates that her levels of stress and anxiety are high and her depressive scores are approaching the clinical cut off for a positive score. Jessica reports that she has never abused alcohol or substances of any kind. She reports she occasionally has a beer when out with friends and has never used illegal drugs. She has no prior history of mental health or medical problems or disorders and she has no previous suicide attempts or ideation. Dr. Johnson asks Jessica open-ended questions about her stress and anxiety levels and if there are any issues at home or at work.

Dr. Johnson: Your stress levels seem pretty high and your depression levels are approaching significance. Stress can have a negative impact on health. Do you mind if we have talk about your stress?

Jessica: I guess so.

Dr. Johnson: Good. What kind of stress are you experiencing at home or at work?

Jessica discloses that has been married to Steven for 10 years. They were ‘high school sweethearts’. They have two children. Jimmy who is 7 and Matthew who is 9. They live in a single-family home in a working class neighborhood about 30 minutes from Jessica’s work. Steven works as a salesman for a local auto-parts retailer. He is on the road often and works long hours. Jessica often has to shoulder the load in terms of the children when Steven is on the road. Jessica used to be able to rely on her mother to watch Matthew and Jimmy and to help her with things around the house. Unfortunately, Jessica’s mother has Parkinson’s and suffered a recent stroke about six months ago that has exacerbated her symptoms. She is in a rehabilitation center. She will probably have to go into a nursing home after she leaves the hospital. This leaves Jessica with a tremendous burden both financially and socially. Jessica becomes tearful at this point in the interview.

Jessica: I just feel so alone and isolated with having to care for the children and my mom. I’m losing my friends and I miss my mom. You know, she is slipping away from me. Jessica also indicates that she is becoming increasingly overwhelmed at work and caring for her family. She feels lonely and isolated.

Dr. Johnson: I’m so sorry this is happening to you. You’re not alone and there is help. I’m concerned that this is having a negative impact on your health. We have resources right here at the clinic that you may find helpful. Would you like to hear about them?

Jessica indicates that she would like to learn more and Dr. Johnson tell Jessica that she is going to refer her to the social worker who works on the team who can help her get access to some help and maybe sign her up for a caregiver support group. Dr. Johnson also makes a referral for Jessica to the clinics health and wellness program to assist Jessica in learning some relaxation skills. There is also a yoga program and meditation hours each morning. Dr. Johnson then asks Jessica to describe her relationship with Steven.

Jessica: Steven helps around the house when he can but he is always on the road. He works long hours and tries to do what he can, but when he comes home he is exhausted. He tries, he really does, and he helps with my mom, but we just can’t do it all alone.
Dr. Johnson: Sounds like a very stressful situation. I am going to ask you some questions about your safety. Unhealthy relationships can have a negative impact on health. Have you ever been afraid of Steven or feared for your safety? Do you experience any abuse from Steven? For instance, has Steven ever hit you or physically tried to harm you in any way? Does he insult you, threaten you or scream at you? Has he ever forced you to have sex or get pregnant?

Jessica (in a monotone): No. We love each other and he does the best he can. I think he wishes he could do more, but his job is very stressful.

Dr. Johnson: Are there any unsecured firearms in the home?

Jessica: Steve does have a pistol for protection. It is in a locked safe. I don't like having it around the house with the boys. We keep it locked up at all times.

Dr. Johnson then reviews the safety card that describes the characteristics of healthy and unhealthy relationships and their impact on health. She also reviews the information on the card about how to stay safe and the resources available in the community for persons who experience intimate partner violence. Dr. Johnson also states that there are resources at the clinic for persons experiencing IPV.

Dr. Johnson: “We have social workers on staff that can link you with resources directly in the community. We have a relationship with several organizations in the community that can provide a safe place to live, legal advocacy and child care. We can connect people to those resources right here in the office. I know these are difficult conversations. I’m going to give you two of these cards – one is for you in case you ever need it because relationships are complex and can change, and the other is for someone you care about who may be in an unhealthy relationship that you want to help. On the back of the card there is information in case you or someone you care about ever needs help. There is a safety plan as well as hot-lines and text-lines that are staffed 24-hours-a-day by people that understand unhealthy or complicated relationships and are ready to help. After the exam, lets go down and talk to Diane, our social worker, who can tell you about some of our resources that can help with taking care of your mom and to help reduce your stress. I’d like to see you in a few weeks just to check in and see how you’re doing. Is that OK?

One Month Later

Jessica arrives for her appointment and Dr. Johnson reviews with Jessica what has been happening. Jessica was able to secure some additional resources for her mom with the help of the social workers. She also was able to get some respite childcare help so she could visit her mom more. She has been attending the caregiver support groups and, while skeptical at first, has really found them to be helpful.

Jessica hesitates and then states that she has been thinking a lot about the resources she was given at the last meeting regarding IPV. She has reflected a lot on her relationship with Steven and how unhealthy it has been. She thinks that a lot of her stress has to do with Steven, rather than her mom. Jessica indicates that although always jealous, Steven has become increasingly suspicious of Jessica over the last five years of their marriage. He always thinks that she is having an affair. Two years ago he made her quit her previous job and forced her to work at her current job where he had a friend in the building that could ‘keep an eye’ on her. Steven became concerned about what Jessica did with her co-workers at lunch and after work and so forbade her to go out and forced her to come home every night right after work. He also forbade her to leave the house without his permission while he was away saying that he had someone watching the house. Steven said that if she disobeyed him or ever did anything to betray him he would take the kids and she would never
see them again. In the past year Steven has also increased his drinking to the point that it is interfering with his work. He has become increasingly erratic and Jessica fears for her safety and that of her children. Jessica states that she is not necessarily ready to leave Steven because she is afraid of what he may do, but she is willing to have a more detailed conversation about what options are available.

Jessica: Our conversation made me realize how messed up everything is. How mean and paranoid he is. Honestly, he’s never hit me or the kids, but he says terrible things to me, especially when he’s drunk and his jealousy has really isolated me and made me really stressed. I really can’t stand it anymore. And now his drinking? Who knows what he’s capable of. I’d like to know what my options are to keep me and my kids safe.

Dr. Johnson and Jessica call in the social worker and they get to work on developing a menu of options so Jessica can choose the right one for her and her family.

Epilogue
Eventually Jessica leaves Steven and stayed for a while in a temporary shelter with her children. She also got a restraining order and gained full custody. She is now living on her own home with her children and doing well. Her mother is recuperating and making strides. Her anxiety and panic have subsided and she found a new position at another company. She recently received a promotion. Steven eventually went to treatment for alcoholism.

Questions
What elements in the above case were important in helping Jessica improve her health?
What provider and setting characteristic were helpful?
How could the above case have been different if mandatory reporting laws required Dr. Johnson to report IPV?
What if Dr. Johnson never asked about IPV in the first place or provided resources – how could the outcome have been different?
What other services were important in helping Jessica get help?

References
Aboutanos, M. B., Jordan, A., Cohen, R., Foster, R. L., Goodman, K., Halfond, R. W., Poindexter, R., Charles, R., Smith, S. C., Wolfe, L. G., Hogue, B., & Ivatury, R. R. (2011). Brief violence interventions with community case management services are effective for high-risk trauma patients. The Journal of Trauma, 71(1), 228–237. https://doi.org/10.1097/TA.0b013e31821e0c86.
Ackard, D. M., & Neumark-Sztainer, D. (2002). Date violence and date rape among adolescents: Associations with disordered eating behaviors and psychological health. Child Abuse & Neglect, 26(5), 455–473. https://doi.org/10.1016/s0145-2134(02)00322-8.
Arias, I., & Corso, P. (2005). Average cost per person victimized by an intimate partner of the opposite gender: A comparison of men and women. Violence and Victims, 20(4), 379–391.
Bachman, R., & Salzman, L. (2000). Violence against women: Estimates from redesigned survey. Washington, DC: U.S. Bureau of Justice Statistics.
Bair-Merritt, M. H., Lewis-O’Connor, A., Goel, S., Amato, P., Ismailji, T., Jelley, M., Lenahan, P., & Cronholm, P. (2014). Primary care-based interventions for intimate partner violence:
References

A systematic review. American Journal of Preventive Medicine, 46(2), 188–194. https://doi.org/10.1016/j.amepre.2013.10.001.

Barker, L. C., Stewart, D. E., & Vigod, S. N. (2019). Intimate partner sexual violence: An often overlooked problem. Journal of Women’s Health, 28(3), 363–374. https://doi.org/10.1089/jwh.2017.6811.

Basile, K. C., Hertz, M. F., & Back, S. E. (2007). Intimate partner violence and sexual violence victimization assessment instruments for use in healthcare settings: Version I. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf. Accessed 4 May 2020.

Bell, T. M., Gilyan, D., Moore, B. A., Martin, J., Ogbeumudia, B., McLaughlin, B. E., Moore, R., Simons, C. J., & Zarzaur, B. L. (2018). Long-term evaluation of a hospital-based violence intervention program using a regional health information exchange. Journal of Trauma and Acute Care Surgery, 84(1), 175–182.

Beydoun, H. A., Beydoun, M. A., Kaufman, J. S., Lo, B., & Zonderman, A. B. (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: A systematic review and meta-analysis. Social Science & Medicine, 75(6), 959–975. https://doi.org/10.1016/j.socscimed.2012.04.025.

Bilukha, O., Hahn, R. A., Crosby, A., Fulfilove, M. T., Liberman, A., Moscicki, E., Snyder, S., Tuma, F., Corso, P., Schofield, A., Briss, P. A., & Task Force on Community Preventive Services. (2005). The effectiveness of early childhood home visitation in preventing violence: A systematic review. American Journal of Preventive Medicine, 28(2 Suppl 1), 11–39. https://doi.org/10.1016/j.amepre.2004.10.004.

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J., & Stevens, M. R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Breiding, M. J., Chen, J., & Black, M. C. (2014). Intimate partner violence in the United States – 2010. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Brooke, B. S., Efron, D. T., Chang, D. C., Haut, E. R., & Cornwell, E. E., 3rd. (2006). Patterns and outcomes among penetrating trauma recidivists: It only gets worse. The Journal of Trauma, 61(1), 16–20. https://doi.org/10.1097/01.ta.0000224143.15498.bb.

Butts, J. A., Roman, C. G., Bostwick, L., & Porter, J. R. (2015). Cure violence: A public health model to reduce gun violence. Annual Review of Public Health, 36, 39–53. https://doi.org/10.1146/annurev-publhealth-031914-122509.

Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. Partner Abuse, 3(2), 231–280. https://doi.org/10.1891/1946-6560.3.2.231.

Carter, P. M., Dora-Laskey, A. D., Goldstick, J. E., Heinze, J. E., Walton, M. A., Zimmerman, M. A., Roche, J. S., & Cunningham, R. M. (2018). Arrests among high-risk youth following emergency department treatment for an assault injury. American Journal of Preventative Medicine, 55(6), 812–821.

Carter, P. M., Walton, M. A., Roehler, D. R., Goldstick, J., Zimmerman, M. A., Blow, F. C., & Cunningham, R. M. (2015). Firearm violence among high-risk emergency department youth after an assault injury. Pediatrics, 135(5), 805–815. https://doi.org/10.1542/peds.2014-3572.

Centers for Disease Control and Prevention. (2016). Preventing multiple forms of violence: A strategic vision for connecting the dots. Atlanta: Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention. (2018). Intimate partner violence. Updated June 2018. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html. Accessed 30 Apr 2020.

Centers for Disease Control and Prevention. (2019). National Center for Injury Prevention and Control. Intimate Partner Violence: Risk and protective factors for violence perpetration.
https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html. Accessed 1 May 2020.

Centers for Disease Control and Prevention. (2020). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System, 2018. http://www.cdc.gov/injury/wisqars. Accessed 30 Apr 2020.

Cheng, T. L., Schwarz, D., Brenner, R. A., Wright, J. L., Fields, C. B., O’Donnell, R., Rhee, P., & Scheidt, P. C. (2003). Adolescent assault injury: Risk and protective factors and locations of contact for intervention. *Pediatrics, 112*(4), 931–938. https://doi.org/10.1542/peds.112.4.931.

Cheng, T. L., Haynie, D., Brenner, R., Wright, J. L., Chung, S. E., & Simons-Morton, B. (2008a). Effectiveness of a mentor implemented violence prevention intervention for assault-injured youths presenting to the emergency department: Results of a randomized trial. *Pediatrics, 122*, 938–946.

Cheng, T. L., Wright, J. L., Markakis, D., Copleand-Linder, N., & Menvielle, E. (2008b). Randomized trial of a case management program for assault-injured youth: Impact on service utilization and risk for re-injury. *Pediatric Emergency Care, 24*, 130–136.

Chong, V. E., Smith, R., Garcia, A., Lee, W. S., Ashley, L., Marks, A., Liu, T. H., & Victorino, G. P. (2015). Hospital-centered violence intervention programs: A cost-effectiveness analysis. *American Journal of Surgery, 209*(4), 597–603. https://doi.org/10.1016/j.amjsurg.2014.11.003.

Chrisler, J. C., & Ferguson, S. (2006). Violence against women as a public health issue. *Annals of the New York Academy of Sciences, 1087*, 235–249. https://doi.org/10.1196/annals.1385.009.

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*(4), 260–268. https://doi.org/10.1016/s0749-3797(02)00514-7.

Coker, A. L., Bush, H. M., Fisher, B. S., Swan, S. C., Williams, C. M., Clear, E. R., & DeGue, S. (2016). Multi-college bystander intervention evaluation for violence prevention. *American Journal of Preventive Medicine, 50*(3), 295–302. https://doi.org/10.1016/j.amepre.2015.08.034.

Coker, A. L., Bush, H. M., Brancato, C. J., Clear, E. R., & Recktenwald, E. A. (2019). Bystander program effectiveness to reduce violence acceptance: RCT in high schools. *Journal of Family Violence, 34*(3), 153–164. https://doi.org/10.1007/s10896-018-9961-8.

Cooper, A. D., & Smith, E. L. (2011). Homicide trends in the United States, 1980–2008. Washington, DC: Bureau of Justice Statistics.

Cooper, C., Eslinger, D. M., & Stolley, P. D. (2006). Hospital-based violence intervention programs work. *Journal of Trauma, 61*(3), 534–540.

Copeland-Linder, N., Johnson, S. B., Haynie, D. L., Chung, S. E., & Cheng, T. L. (2012). Retaliatory attitudes and violent behaviors among assault-injured youth. *Journal of Adolescent Health, 50*(3), 215–220. https://doi.org/10.1016/j.jadohealth.2011.04.005.

Corbin, T. J., Purtle, J., Rich, L. J., Rich, J. A., Adams, E. J., Yee, G., & Bloom, S. L. (2013). The prevalence of trauma and childhood adversity in an urban, hospital-based violence intervention program. *Journal of Health Care for the Poor and Underserved, 24*(3), 1021–1030. https://doi.org/10.1353/hpu.2013.0120.

Cunningham, R., Knox, L., Fein, J., Harrison, S., Walton, M., Dicker, R., Calhoun, D., Becker, M., & Hargarten, S. W. (2009). Before and after the trauma bay: The prevention of violent injury among youth. *Annals of Emergency Medicine, 53*(4), 490–500.

Cunningham, R. M., Ranney, M., Newton, M., Woodhull, W., Zimmerman, M., & Walton, M. A. (2014). Characteristics of youth seeking emergency care for assault injuries. *Pediatrics, 133*(1), e96–e105. https://doi.org/10.1542/peds.2013-1864.

Cunningham, R. M., Carter, P. M., Ranney, M., Zimmerman, M. A., Blow, F. C., Booth, B. M., Goldstick, J., & Walton, M. A. (2015). Violent reinjury and mortality among youth seeking emergency department care for assault-related injury. *JAMA Pediatrics, 169*(1), 63. https://doi.org/10.1001/jamapediatrics.2014.1900.

Curtin, S. C., Warner, M., & Hedegaard, H. (2016). Increase in suicide in the United States, 1999–2014. *NCHS Data Brief, 241*, 1–8.
References

Durborow, M. A., Lizdas, K. C., O’Flaherty, A., Marjavi, A. (2013). Compendium of state and U.S. territory statutes and policies on domestic violence and health care. San Francisco, CA: Futures Without Violence.

Decker, M. R., Frattaroli, S., McCaw, B., Coker, A. L., Miller, E., Sharps, P., Lane, W. G., Mandal, M., Hirsch, K., Strobino, D. M., Bennett, W. L., Campbell, J., & Gielen, A. (2012). Transforming the healthcare response to intimate partner violence and taking best practices to scale. Journal of Women’s Health, 21(12), 1222–1229. https://doi.org/10.1089/jwh.2012.4058.

Decker, M. R., Wilcox, H. C., Holliday, C. N., & Webster, D. W. (2018). An integrated public health approach to interpersonal violence and suicide prevention and response. Public Health Reports, 133(suppl. 1), 65s–79s.

Delgado, S. A., Alsabahi, L., Wolfe, K., Alexander, N., Cobar, P., & Butts, J. A. (2017). The effects of cure violence in the South Bronx and East New York, Brooklyn. https://johnjayrec.nyc/2017/10/02/cvinsobronxeastny. Accessed 8 Sept 2018.

Dicker, R. A. (2016). Hospital-based violence intervention: An emerging practice based on public health principles. Trauma Surgery & Acute Care, 1(1), e000050. https://doi.org/10.1136/tsaco-2016-000050.

Dosanjh, S., Lewis, G., Mathews, D., & Bhandari, M. (2008). Child protection involvement and victims of intimate partner violence: Is there a bias? Violence Against Women, 14(7), 833–843. https://doi.org/10.1177/1077801208320247.

Dubowitz, H., Feigelman, S., Lane, W., & Kim, J. (2009). Pediatric primary care to help prevent child maltreatment: The Safe Environment for Every Kid (SEEK) Model. Pediatrics, 123(3), 858–864. https://doi.org/10.1542/peds.2008-1376.

Dubowitz, H., Lane, W. G., Semiatin, J. N., Magder, L. S., Venepally, M., & Jans, M. (2011). The safe environment for every kid model: Impact on pediatric primary care professionals. Pediatrics, 127(4), e962–e970. https://doi.org/10.1542/peds.2010-1845.

Fauci, J. E., & Goodman, L. A. (2020). “You don’t need nobody else knocking you down”: Survivor-mothers’ experiences of surveillance in domestic violence shelters. Journal of Family Violence, 35, 241–254. https://doi.org/10.1007/s10896-019-00090-y.

Feder, G., Davies, R. A., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., Gregory, A., Howell, A., Johnson, M., Ramsay, J., Rutterford, C., & Sharp, D. (2011). Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: A cluster randomised controlled trial. Lancet, 378(9805), 1788–1795. https://doi.org/10.1016/S0140-6736(11)61179-3.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) study. American Journal of Preventive Medicine, 14(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8.

Finkelhor, D., Turner, H., Hamby, S., & Ormrod, R. (2011). Polyvictimization: children’s exposure to multiple types of violence, crime and abuse. Office of Juvenile Justice and Delinquency Prevention and Centers for Disease Control and Prevention, Juvenile Justice Bulletin, National Survey of Children’s Exposure to Violence. NCJ 235504. https://www.ncjrs.gov/pdffiles1/ojjdp/235504.pdf. Accessed 1 Apr 2020.

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of childhood exposure to violence, crime, and abuse: Results from the National Survey of Children’s Exposure to Violence. JAMA Pediatrics, 169(8), 746–754. https://doi.org/10.1001/jamapediatrics.2015.0676.

Feldhaus, K. M., Koziol-McLain, J., Amsbury, H. L., Norton, I. M., Lowenstein, S. R., & Abbott, J. T. (1997). Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. JAMA, 277(17), 1357–1361.

García-Moreno, C., & Riecher-Rössler, A. (2013). Violence against women and mental health. Basel: Karger.

Hamby, S., & Grych, J. (2013). The web of violence: Exploring connections among different forms of interpersonal violence and abuse. New York: Springer Briefs in Sociology.
Health Research & Educational Trust. (2015, March). Hospital approaches to interrupt the cycle of violence. Chicago, IL: Health Research & Educational Trust. Accessed at www.hpoe.org

Henry, D. B., Knoblauch, S., & Sigurvinsdottir, R. (2014). The effect of intensive CeaseFire intervention on crime in four Chicago police beats: Quantitative assessment. Chicago: University of Chicago.

Heron M. (2019). Deaths: Leading causes for 2017. National vital statistics reports: from the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, 68(6), 1–77. Cooper AD, Smith EL. Homicide Trends in the United States, 1980–2008. Washington, DC.

Hillis, S. D., Anda, R. F., Dube, S. R., Felitti, V. J., Marchbanks, P. A., & Marks, J. S. (2004). The association between adverse childhood experiences and adolescent pregnancy, long-term psychosocial consequences, and fetal death. Pediatrics, 113(2), 320–327. https://doi.org/10.1542/peds.113.2.320.

Human Rights Campaign. (2020). Violence against the transgender and gender non-conforming community in 2020. https://www.hrc.org/resources/violence-against-the-trans-and-gender-non-conforming-community-in-2020. Accessed 7 July 2020.

Institute of Medicine (IOM). (2011a). Preventing violence against women and children: Workshop summary. Washington, DC: The National Academies Press.

Institute of Medicine (IOM). (2011b). Clinical preventive services for women: Closing the gaps. Washington, DC: The National Academies Press.

Iverson, K. M., Gradus, J. L., Resick, P. A., Suvak, M. K., Smith, K. F., & Monson, C. M. (2011). Cognitive-behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. Journal of Consulting and Clinical Psychology, 79(2), 193–202. https://doi.org/10.1037/a0022512.

Iverson, K. M., King, M. W., Gerber, M. R., Resick, P. A., Kimerling, R., Street, A. E., & Vogt, D. (2015). Accuracy of an intimate partner violence screening tool for female VHA patients: A replication and extension. Journal of Traumatic Stress, 28(1), 79–82. https://doi.org/10.1002/jts.21985.

Jordan, C. E., & Pritchard, A. J. (2018). Mandatory reporting of domestic violence: What do abuse survivors think and what variables influence those opinions? Journal of Interpersonal Violence, 886260518787206. Advance online publication. https://doi.org/10.1177/0886260518787206.

Juillard, C., Smith, R., Anaya, N., Garcia, A., Kahn, J. G., & Dicker, R. A. (2015). Saving lives and saving money: Hospital-based violence intervention is cost-effective. Journal of Trauma, 78(2), 252–258.

Juillard, C., Cooperman, L., Allen, I., Pirracchio, R., Henderson, T., Marquez, R., Orellana, J., Texada, M., & Dicker, R. A. (2016). A decade of hospital-based violence intervention: Benefits and shortcomings. Journal of Trauma, 81(6), 1156–1161.

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

Kann, L., McManus, M.S., Harris, W.A., Shanklin, S.L., Flint, K.H., Queen, B,… Ethier, K.A. (2018). Youth risk behavior surveillance – United States, 2017. Morbidity and Mortality Weekly Review (MMWR), 67(8), 1–114.

Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. Journal of Abnormal Child Psychology, 36(4), 567–589. https://doi.org/10.1007/s10802-007-9201-9.

Kim-Godwin, Y. S., Clements, C., McCuiston, A. M., & Fox, J. A. (2009). Dating violence among high school students in southeastern North Carolina. The Journal of School Nursing, 25(2), 141–151. https://doi.org/10.1177/1059840508330679.

Klevens, J., Kee, R., Trick, W., Garcia, D., Angulo, F. R., Jones, R., & Sadowski, L. S. (2012). Effect of screening for partner violence on women’s quality of life: A randomized controlled trial. JAMA, 308(7), 681–689.

Kochanek, K. D., Murphy, S. L., Xu, J. Q., & Arias E. (2019). Deaths: Final data for 2017. National Vital statistics reports, 68(9). Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09-508.pdf?utm_source=link_newsv9&utm_campaign=item_268094&utm_medium=copy. Accessed 1 June 2020.
Koper, C. S., & Mayo-Wilson, E. (2006). Police crackdowns on illegal gun carrying: A systematic review of their impact on gun crime. *Journal of Experimental Criminology*, 2(2), 227–261.

Kubrin, C. E., & Weitzer, R. (2003). Retaliatory homicide: Concentrated disadvantage and neighborhood culture. *Social Problems*, 50, 157–180.

Landers, S., Gilsanz, P. (2009). The health of lesbian, gay, bisexual, and transgender (LGBT) persons in Massachusetts. Massachusetts Department of Public Health. Retrieved from http://www.mass.gov/eohhs/docs/dph/commissioner/lgbt-health-report.pdf

Langenderfer-Magruder, L., Whitfield, D. L., Walls, N. E., Kattari, S. K., & Ramos, D. (2016). Experiences of intimate partner violence and subsequent police reporting among LGBTQ adults in Colorado: Comparing rates of cisgender and transgender victimization. *Journal of Interpersonal Violence, 31*(5), 855–871. https://doi.org/10.1177/0886260514556767.

Lee, J., Quraishi, S. A., Bhatnagar, S., Zafonte, R. D., & Masiakos, P. T. (2014). The economic cost of firearm-related injuries in the United States from 2006 to 2010. *Surgery, 155*(5), 894–898. https://doi.org/10.1016/j.surg.2014.02.011.

Lippy, C., Jumarali, S. N., Nnawulezi, N. A., Peyton-Williams, E., & Burk, C. (2020). The impact of mandatory reporting laws on survivors of intimate partner violence: Intersectionality, help-seeking and the need for change. *Journal of Family Violence, 35*, 255–267. https://doi.org/10.1007/s10896-019-00103-w

Lipsey, M. W., Landenberger, N. A., & Wilson, S. J. (2007). Effects of cognitive-behavioral programs for criminal offenders. *Campbell Systematic Reviews*. https://doi.org/10.4073/csr.2007.6.

Lizdas, K. C., O’Flaherty, A., Durborow, N., & Marjavi, A. (2019). *Compendium of state and U.S. territory statutes and policies on domestic violence and health care* (4th ed.). Futures Without Violence. http://fvfp.convio.net/site/EcommerceDownload/Compendium%204th%20Edition%202019%20Final-1793.pdf?dnl=111966-1793-W11qlxwQAk8UYXM4. Accessed 4 May 2020.

Ludermir, A. B., Lewis, G., Valoungeiro, S. A., de Araújo, T. V., & Araya, R. (2010). Violence against women by their intimate partner during pregnancy and postnatal depression: A prospective cohort study. *Lancet, 376*(9744), 903–910. https://doi.org/10.1016/S0140-6736(10)60887-2.

Lumba-Brown, A., Batek, M., Choi, P., Keller, M., & Kennedy, R. (2017). Mentoring pediatric victims of interpersonal violence reduces recidivism. *Journal of Interpersonal Violence, 886260517705662*. Advance online publication. https://doi.org/10.1177/0886260517705662.

Machtinger, E. L., Wilson, T. C., Haberer, J. E., & Weiss, D. S. (2012). Psychological trauma and PTSD in HIV-positive women: A meta-analysis. *AIDS and Behavior, 16*(8), 2091–2100. https://doi.org/10.1007/s10461-011-0127-4.

Mancini, M. A. (2020). A pilot study evaluating a school-based, trauma-focused intervention for immigrant and refugee youth. *Children and Adolescent Social Work Journal, 37*, 287–300. https://doi.org/10.1007/s10560-019-00641-8.

Martin-Mollard, M., & Becker, M. (2009). Key components of hospital-based violence intervention programs. http://nnhvip.org/wp-content/uploads/2010/09/key.pdf. Accessed 1 June 2020.

McCaw, B. (2011). Using a systems-model approach to improving IPV services in a large health care organization. In *The Institute of Medicine (IOM) preventing violence against women and children: Workshop summary* (pp. 169–184). Washington, DC: The National Academies Press.

McCaw, B., Berman, W. H., Syme, S. L., & Hunkeler, E. F. (2001). Beyond screening for domestic violence: A systems model approach in a managed care setting. *American Journal of Preventative Medicine, 21*(3), 170–176.

McCloskey, L. A., Lichter, E., Williams, C., Gerber, M., Wittenberg, E., & Ganz, M. (2006). Assessing intimate partner violence in health care settings leads to women’s receipt of interventions and improved health. *Public Health Reports, 121*(4), 435–444. https://doi.org/10.1177/003335490612100412.

McCoy, A. M., Como, J. J., Greene, G., Laskey, S. L., & Claridge, J. A. (2013). A novel prospective approach to evaluate trauma recidivism: The concept of past trauma history. *The Journal of Trauma and Acute Care Surgery, 75*, 116–121.
Messing, J. T., Patch, M., Wilson, J. S., Kelen, G. D., & Campbell, J. (2018). Differentiating among attempted, completed, and multiple nonfatal strangulation in women experiencing intimate partner violence. *Women's Health Issues, 28*(1), 104–111. https://doi.org/10.1016/j.whi.2017.10.002.

Miller, E. & Anderson, J. (2018). The “CUES” approach to Address IPV/Human Trafficking and intersections with HIV in Primary Care: what’s the evidence?. Webinar sponsored by Futures without Violence. Downloaded at: https://www.futureswithoutviolence.org/wp-content/uploads/Demo-Site-Webinar-3-Final.pdf

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., & Silverman, J. G. (2011). A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception, 83*(3), 274–280. https://doi.org/10.1016/j.contraception.2010.07.013.

Miller, E., Goldstein, S., McCauley, H. L., Jones, K. A., Dick, R. N., Jetton, J., et al. (2015a). A school health center intervention for abusive adolescent relationships: A cluster RCT. *Pediatrics, 135*, 76–85. https://doi.org/10.1542/peds.2014-2471.

Miller, E., McCaw, B., Humphreys, B. L., & Mitchell, C. (2015b). Integrating intimate partner violence assessment and intervention into healthcare in the United States: A systems approach. *Journal of Women’s Health, 24*(1), 92–99. https://doi.org/10.1089/jwh.2014.4870.

Miller, E., McCauley, H. L., Decker, M. R., Levenson, R., Zelazny, S., Jones, K. A., Anderson, H., & Silverman, J. G. (2017). Implementation of a family planning clinic-based partner violence and reproductive coercion intervention: Provider and patient perspectives. *Perspectives on Sexual and Reproductive Health, 49*(2), 85–93. https://doi.org/10.1363/psrh.12021.

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., & Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception, 81*(4), 316–322. https://doi.org/10.1016/j.contraception.2009.12.004.

Morgan, R. E. & Oudekerk, B. A. (2019, September). Criminal victimizations, 2018. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. https://www.bjs.gov/content/pub/pdf/cv18.pdf. Accessed 4 May 2020.

Nelson, H. D., Bougatsos, C., & Blazina, I. (2012). Screening women for intimate partner violence: A systematic review to update the U.S. Preventive Services Task Force recommendation. *Annals of Internal Medicine, 156*(11), 796–282. https://doi.org/10.7326/0003-4819-156-11-201206050-00447.

Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). *Preventing intimate partner violence across the lifespan: A technical package of programs, policies, and practices*. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLoS Medicine, 9*(11), e1001349. https://doi.org/10.1371/journal.pmed.1001349.

Petras, H., Kellam, S. G., Brown, C. H., Muthén, B. O., Ialongo, N. S., & Poduska, J. M. (2008). Developmental epidemiological courses leading to antisocial personality disorder and violent and criminal behavior: Effects by young adulthood of a universal preventive intervention in first- and second-grade classrooms. *Drug and Alcohol Dependence, 95*(Suppl 1), S45–S59. https://doi.org/10.1016/j.drugalcdep.2007.10.015.

Petrosky, E., Blair, J. M., Betz, C. J., Fowler, K. A., Jack, S., & Lyons, B. H. (2017). Racial and ethnic differences in homicides of adult women and the role of intimate partner violence – United States, 2003-2014. *MMWR. Morbidity and Mortality Weekly Report, 66*(28), 741–746. https://doi.org/10.15585/mmwr.mm6628a1.

Purtle, J., Rich, L. J., Bloom, S. L., Rich, J. A., & Corbin, T. J. (2015). Cost-benefit analysis simulation of a hospital-based violence intervention program. *American journal of preventive medicine, 48*(2), 162–169. https://doi.org/10.1016/j.amepre.2014.08.030
Purtle, J., Dicker, R., Cooper, C., Corbin, T., Greene, M. B., Marks, A., Creaser, D., Topp, D., & Moreland, D. (2013). Hospital-based violence intervention programs save lives and money. *Journal of Trauma, 75*(2), 331–333.

Rabin, R. F., Jennings, J. M., Campbell, J. C., & Bair-Merritt, M. H. (2009). Intimate partner violence screening tools: A systematic review. *American Journal of Preventive Medicine, 36*(5), 439–445.e4. https://doi.org/10.1016/j.amepre.2009.01.024.

Richardson, J. B., St. Vil, C., Sharpe, T., Wagner, M., & Cooper, C. (2016). Risk factors for recurrent violent injury among black men. *Journal of Surgical Research, 204*, 261–266.

Sarkar, N. N. (2008). The impact of intimate partner violence on women’s reproductive health and pregnancy outcome. *Journal of Obstetrics and Gynaecology, 28*(3), 266–271. https://doi.org/10.1080/01443610802042415.

Senn, C. Y., Eliasziw, M., Barata, P. C., Thurston, W. E., Newby-Clark, I. R., Radtke, H. L., & Hobden, K. L. (2015). Efficacy of a sexual assault resistance program for university women. *The New England Journal of Medicine, 372*(24), 2326–2335. https://doi.org/10.1056/NEJMsa1411131.

Shakil, A., Bardwell, J., Sherin, K., Sinacore, J. M., Zitter, R., & Kindratt, T. B. (2014). Development of verbal HITS for intimate partner violence screening in family medicine. *Family Medicine, 46*(3), 180–185.

Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: A short domestic violence screening tool for use in a family practice setting. *Family Medicine, 30*(7), 508–512.

Sims, D. W., Bivins, B. A., Obeid, F. N., Horst, H. M., Sorensen, V. J., & Fath, J. J. (1989). Urban trauma: A chronic recurrent disease. *The Journal of Trauma, 29*, 940–947.

Smith, R., Dobkins, S., Evans, A., Balhotra, K., & Dicker, R. A. (2013). Hospital-based violence intervention: Risk reduction resources that are essential for success. *The Journal of Trauma and Acute Care Surgery, 74*, 976–982.

Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M., & Chen, J. (2018). The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 data brief – Updated release. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. *JAMA, 290*(5), 603–611. https://doi.org/10.1001/jama.290.5.603.

Stöckl, H., Devries, K., Rotstein, A., Abrahams, N., Campbell, J., Watts, C., & Moreno, C. G. (2013). The global prevalence of intimate partner homicide: A systematic review. *Lancet, 382*(9895), 859–865. https://doi.org/10.1016/S0140-6736(13)61030-2.

Stotzer, R. L. (2014). Law enforcement and criminal justice personnel interactions with transgender people in the United States: A literature review. *Aggression and Violence Behavior, 19*(3), 263–277. https://doi.org/10.1016/j.avb.2014.04.012.

Strong, B. L., Shipper, A. G., Downton, K. D., & Lane, W. G. (2016). The effects of health care-based violence intervention programs on injury recidivism and costs: A systematic review. *The Journal of Trauma and Acute Care Surgery, 81*(5), 961–970. https://doi.org/10.1097/TA.0000000000001222.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *Trauma-informed care in behavioral health services*. Rockville: Substance Abuse and Mental Health Services Administration.

Sumner, S. A., Mercy, J. A., Dahlberg, L. L., Hillis, S. D., Kleven, J., & Houry, D. (2015). Violence in the United States: Status, challenges, and opportunities. *JAMA, 314*(5), 478–488.

Walters, M. L., Chen, J., & Breiding, M. J. (2013). *The national intimate partner and sexual violence survey (NISVS): 2010 findings on victimization by sexual orientation*. Atlanta: National Center for Injury Prevention and Control, CDC.

Wathen, C. N., & MacMillan, H. L. (2012). Health care’s response to women exposed to partner violence: Moving beyond universal screening. *JAMA, 308*(7), 712–713.
Webster, D. W., Whitehill, J. M., Vernick, J. S., & Curriero, F. C. (2013). Effects of Baltimore’s Safe Streets Program on gun violence: A replication of Chicago’s CeaseFire Program. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 90*(1), 27–40. https://doi.org/10.1007/s11524-012-9731-5.

Wiebe, D. J., Blackstone, M. M., Mollen, C. J., Culyba, A. J., & Fein, J. A. (2011). Self-reported violence-related outcomes for adolescents within eight weeks of emergency department treatment for assault injury. *The Journal of Adolescent Health, 49*(4), 440–442. https://doi.org/10.1016/j.jadohealth.2011.01.009.

Wilson, N., Tsao, B., Hertz, M., Davis, R., & Klevens, J. (2014). *Connecting the dots: An overview of the links among multiple forms of violence*. Oakland: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (Atlanta, GA) and Prevention Institute.

Yakubovich, A. R., Stöckl, H., Murray, J., Melendez-Torres, G. J., Steinert, J. L., Glavin, C., & Humphreys, D. K. (2018). Risk and protective factors for intimate partner violence against women: Systematic review and meta-analyses of prospective-longitudinal studies. *American Journal of Public Health, 108*(7), e1–e11. https://doi.org/10.2105/AJPH.2018.304428.

Zatzick, D., Russo, J., Lord, S. P., Varley, C., Wang, J., Jurkovich, G., et al. (2014). Collaborative care intervention targeting violence risk behaviors, substance use, and post-traumatic stress and depressive symptoms in injured adolescents: A randomize clinical trial. *JAMA Pediatrics, 168*(6), 532–539. https://doi.org/10.1001/jamapediatrics.2013.4784.