



# Report: Intimate Partner Violence Screening and Counseling Research Symposium

*Sponsored by the U.S. Department of Health and Human Services*

On behalf of the HHS Coordinating Committee on Women's Health (CCWH) and the IPV Research Symposium Planning Committee, we are pleased to share with you the report of the symposium held on December 9, 2013.

This report was completed by the generous contribution of NIDA's staff and input from all speakers, breakout session moderators and IPV Symposium Planning Committee members.

The National Library of Medicine and the Office of Research on Women's Health, both part of the National Institutes of Health, have created a Web Portal (<http://whr.nlm.nih.gov/ipv-symposium.html>) to serve as a central electronic resource for this research symposium. Most of the HHS agencies have provided content, as well as other federal agencies such as the Department of Justice, the Department of Labor, and the US Department of Veterans Affairs.

We hope that you find this report informative. If you have any questions or need further information on this trans-HHS effort, please contact Dr. Samia Noursi at [snoursi@mail.nih.gov](mailto:snoursi@mail.nih.gov).

On behalf of the planning committee,

Samia Noursi, PhD

IPV Symposium co-chair

(On behalf of the co-chairs, Nancy Lee, MD, Marylouise Kelley, PhD and Samia Noursi, PhD)



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*Sponsored by the U.S. Department of Health and Human Services*

**Monday, December 9, 2013, 8 a.m. – 5 p.m.**

**The National Institutes of Health Neuroscience Center, Conference Rooms C & D  
6001 Executive Blvd., Rockville, MD 20852**

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## Background

Intimate partner violence (IPV) is a serious, yet preventable public health problem that affects more than 1 in 3 women in the United States each year, regardless of age, economic status, race, ethnicity, or sexual orientation.<sup>1</sup> An extensive body of research reveals that victims of IPV often suffer lifelong health consequences, such as emotional trauma, lasting physical impairment, chronic health problems, and even death.<sup>2</sup>

As a centerpiece of the *Affordable Care Act* of 2010, Section 2713 articulates a commitment to preventive services for women. One of the key preventive services included in the guidelines is screening and counseling for interpersonal and domestic violence. The Institute of Medicine and the U.S. Preventive Services Task Force<sup>3</sup> have recommended that IPV screening and counseling become a core part of women's preventive health visits. Medical providers are in a unique position to assess and provide support for women who experience IPV in a safe, confidential environment protected by the patient–physician relationship. Improved prevention and screening guidelines are needed to aid physicians in identifying and protecting those individuals that need help and link them to the care they need.

## Goals

In an effort to develop effective guidelines for health practitioners to screen for IPV and provide patients with appropriate counseling, the Coordinating Committee for Women's Health (CCWH) at the Department of Health and Human Services (DHHS), with the support of Assistant Secretary Dr. Howard Koh, held a *Research Symposium on Monday, December 9, 2013 at the NIH Neuroscience Center* to:

- Review the current body of evidence on screening and counseling for IPV in health care settings and the context of violence across the lifespan, taking into account past and ongoing experiences of trauma.
- Encourage input from researchers, medical practitioners, federal colleagues and other stakeholders to provide insight on challenges and barriers to screening and intervention for IPV, and the paucity of research on:
  - Instruments and strategies for IPV screening and assessment;
  - Culturally-competent screening and counseling practices; and
  - The effects of screening and counseling on health, safety, and outcomes related to social and emotional well-being

The ultimate goal of this symposium was to identify gaps in research on IPV screening and counseling in primary health settings, and to shape new research priorities to address these gaps and produce tangible guidelines and services to protect individuals at risk.

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<sup>1</sup> [http://www.cdc.gov/ViolencePrevention/pdf/NISVS\\_Executive\\_Summary-a.pdf](http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Executive_Summary-a.pdf)

<sup>2</sup> <http://www.sciencedirect.com/science/article/pii/S0140673602083368>

<sup>3</sup> <http://www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderfinalrs.htm>

## Participants

### Participating Agencies

Administration for Children and Families (ACF)  
Administration on Community Living (ACL)  
Agency for Healthcare Research and Quality (AHRQ)  
Centers for Disease Control and Prevention (CDC)  
Health Resources and Services Administration (HRSA)  
Indian Health Services (IHS)  
National Institutes of Health (NIH)  
Office of the Assistant Secretary for Health (OASH)  
Office of the Assistant Secretary for Planning and Evaluation (ASPE)  
Office of Populations Affairs (OPA)  
Office on Women's Health (OWH)  
Substance Abuse and Mental Health Services Administration (SAMHSA)

### Speakers

#### Co-chairs:

- **Dr. Nancy Lee**, MD, Deputy Assistant Secretary for Health-Women's Health, Director of Office on Women's Health (OWH), OASH, DHHS
- **Dr. Marylouise Kelley**, PhD, Director, Family Violence Prevention & Services Division, Family and Youth Services Bureau, ACF, DHHS
- **Dr. Samia Noursi**, PhD, Deputy Coordinator, Women and Sex/Gender Differences Research Program, National Institute on Drug Abuse (NIDA), NIH, DHHS

*Opening Remarks:* **Dr. Janine Austin Clayton**, Director (ORWH), and Associate Director, Women's Health Research (NIH), DHHS

*Keynote Speaker:* **Dr. Jacquelyn Campbell**, Professor, Anna D. Wolf Chair, Johns Hopkins University School of Nursing.

*Administration Remarks:* **Ms. Lynn Rosenthal**, White House Advisor on Violence Against Women

Please refer to [Appendix C](#) for complete list of speakers and their biographies.

### Opening Remarks

Presenters: Dr. Samia Noursi and Dr. Janine Austin Clayton.

While IPV affects both women and men, women bear the greatest burden with 1 in 3 experiencing IPV in their lifetime, and enduring lifelong health consequences as a result. The goals of the Intimate Partner Violence (IPV) Screening and Counseling Research Symposium is to discuss what is known about the etiology of IPV, identify gaps in current IPV research and services, and devise new strategies to fill these gaps and inform future research and policy.

NIH supports research on health and violence: in fiscal year 2012, NIH spent \$36 million for 105 research projects supported predominantly by the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Mental Health (NIMH), and the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). New

research funding opportunities are available, with a particular focus on firearm violence as directed by President Obama in January 2013.

## Keynote Address

Nancy Lee, MD, Deputy Assistant Secretary for Health - Women's Health, Director of the Office on Women's Health, DHHS, thanked the members of the Coordinating Committee for Women's Health for organizing the symposium and introduced the keynote speaker, Dr. Jacquelyn Campbell.

Advances have been made in protecting victims from IPV by establishing routine screening for violence against women and brief counseling, most recently supported through the Affordable Health Care Act. The US Preventative Services Task Force now recommends screening for IPV for all women of childbearing age. Barriers exist that prevent effective implementation of IPV screening and counseling such as the lack of sufficient evidence-based interventions and exclusion of the victim's during their own screening and intervention.

It is essential to change the role of IPV screening and counseling in patient assessments by health care providers. Unless violence is explored and addressed in these visits, healthcare providers may misdiagnose or inadequately treat the health conditions of the patient. Brief counseling should be specific, in collaboration with all healthcare professionals, and should include the woman's perspective. Healthcare providers should keep in mind that a woman who presents with a history of violence experiences more than one type of abuse (emotional abuse, physical abuse, stalking). Additionally, providers should recognize and talk to women who have negative health outcomes associated with IPV:

- Forced sex – Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) intersections, Sexually Transmitted Infections (STIs), cervical cancers, other gynecological problems
- Trauma and bruising, Traumatic Brain Injury (TBI), immune system problems
- Suicide, homicide, death
- Body Mass Index (BMI) alterations, chronic pain
- Mental health: Post-Traumatic Stress Disorder (PTSD), depression, substance abuse

The research agenda also includes determining how to train providers to diagnose and counsel for IPV. Providers need to understand the best treatment to provide at a well-woman's visit, since IPV can cause secondary diseases that may not immediately or readily be associated with IPV. Several promising interventions being tested include Decision Aid, iHeal in Canada, combination HIV/IPV intervention, trauma treatment for survivors, and DOVE Intervention in home visitation. These evidence-based interventions address different aspects of IPV-related health problems, and could potentially be used conjointly. The One Love App is a danger assessment tool for use by providers to help determine how much danger the victim is in before proceeding with treatment. Ultimately, intervention should be tailored to the IPV victim's individual needs, keeping in mind her preferences, concerns, and safety.

## Panel I. Identifying Intimate Partner Violence in Clinical Settings: Client, Provider, and Systems Level Considerations

Panel Chair: Dr. Samia Noursi

Panel Experts: Dr. Connie Mitchell, Dr. Kevin Hamberger, and Dr. Elizabeth Miller.

### Panel highlights:

#### **“System Considerations for IPV Screening and Assessment.”**

Dr. Connie Mitchell reported that over 35% of women report physical violence, rape or stalking by an intimate partner at some time in the past (2011 National Intimate and Sexual Violence Survey) making intimate partner violence (IPV) a leading health problem for women, exceeding low back pain (29%), obesity (27%), arthritis (24%) and hypertension (23%) (2011 National Health Information Survey). In 2013, the US Preventive Services Task Force (USPTF) recommended health screening for IPV for all women of child-bearing age, and women who screen positive should be provided or referred to intervention services. The Affordable Care Act includes screening and brief counseling for IPV as part of required preventive services for women without cost or co-payment.

Dr. Mitchell defined “screening” as the use of a test, examination, or other procedure that is rapidly applied in an asymptomatic population to identify individuals with early disease, such as IPV-related health issues, to prevent morbidity and mortality. However, IPV is a stigmatized health problem so IPV victims may not be “asymptomatic” yet the problem continues to go unrecognized while the health impact is quite advanced. Therefore, “screening” in the traditional sense is not consistent with what actually happens in the clinical encounter. When risk or exposure to past or current IPV is assessed through “screening”, the impact can be primary prevention for patients with no history or suspicion of exposure, secondary prevention for patients with past exposure, or tertiary prevention for patients with current or acute exposure. Possible harms or unintended consequences of clinical assessment have been raised and should be considered in research trials but have thus far been unfounded.

Assessment for past or current IPV can be prompted by the clinician through direct questioning as part of a routine health survey, or through pattern recognition when signs and symptoms in the history and physical exam alert the clinician to explore the possibility of IPV in the differential diagnosis. IPV may also be disclosed by the patient without a clinical prompt or brought to the attention of the healthcare provider by reports from reliable third parties such as police or EMS personnel. Even if clinically suspected, patients may deny that IPV is a problem which complicates research protocols because in addition to the usual dichotomy of positive IPV and negative IPV cases, there is a third category of negative but suspected IPV. Each group should have a different intervention and objectives for outcomes. Additional confounders such as safety, privacy, and legal issues must be accounted for, and the duality of both perpetrator and victim means that intervention is non-linear and not isolated to the victim. While identification and intervention in the health care setting is important, IPV prevention and intervention is really more of a “quilt” with primary, secondary and tertiary prevention strategies implemented at the individual, family, community and societal level.

Dr. Mitchell described a possible IPV Intervention Algorithm that would help providers perform screening and the appropriate intervention (see Appendix F).

Gaps in research about IPV identification in the health care setting include:

- What are the best practices for identifying risk and diagnosing IPV moving beyond the choices of “best words” to use and looking more at clinical facilitation of spontaneous and prompted disclosures?
- What is the best way to train professionals to provide appropriate and ethical care for adult and child victims, and what system supports are essential to provide high quality care?
- Do screening approaches differ in different healthcare settings and for different populations?
- Considering the WHO Typology of Violence: how does IPV care compare and contrast to the care of other forms of trauma exposure and how does this impact the health care approach to identification and intervention for all victims of violence? Is trauma a collection of possible precipitating events that may be helpful when devising treatment approaches for IPV?

### **“Beyond Education: Changing Systems to Facilitate Healthcare-Based IPV Screening and Counseling.”**

Dr. Kevin Hamberger identified the need to go beyond training of healthcare providers to engage them in screening and counseling for IPV. He emphasized looking at broader system issues within clinical settings to make screening and counseling for IPV more user-friendly.

Training healthcare providers in high-risk departments for IPV screening and assessment results in increased IPV screening activity. However, to increase compliance with screening, training must be combined with system-level interventions at the department level. System level changes include intensive saturation training of selected staff in IPV and health, policy and procedure changes, increased collaboration with advocacy agencies, continuous quality improvement, and primary prevention.

Gaps in Screening for IPV:

- How can compliance in screening be maintained in high-risk departments?
- How can screening for IPV be made more user-friendly?
- Do system-wide changes go beyond screening?
- What are the most appropriate outcome variables and optimal research designs for measuring the outcome?
- What is the follow-up duration after training?
- How do we think about IPV healthcare – as an acute care model or as a chronic care model?

Challenges and barriers of compliance in screening:

- Privacy concerns,
- Time constraints,
- Patient flow,
- Professional and personal discomfort with discussing IPV, and
- Clinician knowledge and resources.

### **“Addressing Intimate Partner Violence in Clinical Settings: Provider and Client Perspectives.”**

Dr. Elizabeth Miller highlighted an important research objective - to evaluate the integration of such conversations about partner violence into clinical practice. The goal of the health care provider is not disclosure; the goal should be reducing isolation and creating safe spaces for patients.

Dr. Miller highlighted the utility and convenience of a health and safety card, which defines respect, behaviors characteristic of abusive relationships, and safety information including violence victimization services. In a high school health center setting, the safety card is also a way to give young people the tools to help reduce isolation among their peers while increasing recognition of what constitutes abusive behavior and sexual coercion. Both providers and clients find this safety card approach to be helpful.

Dr. Miller identified 4 key elements on which effective intervention relies:

1. Review limits of confidentiality
2. Conversation (normalize and provide integrated assessment during the clinical encounter)
3. Offer information, such as a safety card
4. Connect with a “warm referral” to a local domestic violence/sexual assault advocate

During intervention, consider the survivor’s needs:

- Be non-judgmental.
- Listen.
- Offer information and support.
- Do not push for disclosure.

Gaps in research and intervention:

- How can harm reduction counseling be improved?
- How can the connection between clinical sites and community resources be improved (i.e., victim service advocates).

### Question and Answer Session - Key Points:

- Screening for IPV is not an extra job, but a mandatory component of the health care provider’s primary responsibility to the patient.
- IPV should be treated as a health problem.
- Screening for history of abuse and any exposure to violence is necessary to better assess a patient’s risk for IPV and to tailor treatment to meet all the needs of the patient.

## Morning Concurrent Breakout Groups: IPV Screening and Assessment

Symposium participants were divided into groups to discuss four, strategically-selected topics on IPV screening and assessment. Each group was asked to identify goals and gaps for their assigned topic.

### I. Electronic Health Records: Meaningful Use Standards and System-wide Responses

This session focused on patient-physician communication in the context of electronic screening for IPV; electronic health record (EHR) tools that can facilitate clinical care, quality measures, and population management; and broad issues related to meaningful use of EHRs that may impact IPV screening and counseling.

Session presenters/moderators:

- **Betsy L. Humphreys**, MLS, Deputy Director, National Library of Medicine, NIH, Bethesda, MD
- **Brigid McCaw**, MD, MPH, MS, FACP, Medical Director, Northern California Family Violence Prevention Program, Kaiser Permanente, Oakland, CA
- **Karin Rhodes**, MD, MS, Director, Emergency Care Policy & Research, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA

Research Gaps:

- Research is needed to evaluate the cost and associated time required to efficiently integrate IPV services (both screening and intervention) into the workflow.
- An algorithm that matches appropriate responses, tailored to a patient's level of IPV risk as identified in EHRs needs to be developed.
- Outcome measures, utilizing patient and clinician perspectives should be identified and incorporated into evaluation of health care interventions.
- Screening and interventions for past abuse as well as current IPV need to be developed and incorporated into HER.
- Measures of effectiveness of universal education and other interventions need to be developed to assess their impact.

Research Goals:

- Increase involvement of the patient perspective in research study design to include confidentiality, safety concerns, benefits and risks of disclosure in health care setting.
- Enhance EHRs so that they can be used as a tool to educate and empower providers to address IPV through the inclusion of best practices, prompts, patient resources and links to state policies regarding reporting.
- Shift the focus from screening and identifying IPV to documentation of intervention and follow-up to treatment, and ultimately patient outcomes.
- Educationally, frame asking about abuse as a key component a for improving diagnoses and the quality of patient care

Additional discussion considerations and recommendations:

- Research Networks should standardize the data collected in EHR and Personal Health Records (PHR) to allow for de-identified analysis of population-based data and surveillance.
- Research questions should be specific to the realm of data collection:
  - EHR (provider documentation)
  - PHR (patient self-assessment; use of password protected "MyChart" options)
  - Research data (additional information captured by research personnel outside the EHR)
- Provide access to routinely collected, de-identified population-based data across the EHRs of various health systems to better understand IPV, co-morbid risks and inform the need for both provider and patient interventions.
- Add IPV to Socio-behavioral domains into Stage III of Meaningful Use Criteria -
  - NCI Grid-Enabled Measures (GEM) (Glasgow et al., 2012) – important to advocate for – inclusion of a short IPV measure. There are a number of tested validated measures to choose from.
  - Inclusion of "healthy relationship" questions as well as IPV-targeted questions.

## II. Provider Use of Screening Tools and Strategies

In this session, participants engaged in a critical dialogue on IPV screening and counseling tools and strategies and explored current research and gaps. What screening methods are providers using? What is known about provider comfort and capacity? What strategies increase provider uptake?

Session presenters/moderators were:

- **Marylouise Kelley**, PhD, Director, Family Violence Prevention & Services Program, Family & Youth Services Bureau, Administration for Children and Families (ACF), Washington, DC
- **Camille Burnett**, PhD, MPA, APHN-BC, RN, BScN, DSW, Assistant Professor and Roberts Scholar, School of Nursing, University of Virginia, Charlottesville, VA
- **Carlene Pavlos**, MTS, Director, Bureau of Community Health and Prevention, Massachusetts Department of Public Health, Boston, MA

Research Gaps:

- More research is needed to:
  - assess the burden of IPV on community services and resources.
  - determine how EHRs can be used to screen for IPV.
  - assess IPV in same-sex couples
  - how IPV risk changes across the lifespan
- Tailor different screening tools for different treatment settings.
- Determine the most effective approach for screening and interventions, i.e., personal interactions, computer based, etc.
- Identify barriers that prevent providers from screening and assessing IPV in their patients.

Research Goals:

- Screening is the end point after system change, provider education, and referrals are in place.
- To get a health care system ready to screen, much community networking and training must be put in place.
- Improve the tools and strategies used in screening and counseling.
- More clarity about what outcome we are measuring.

Considerations and Recommendations:

- It is important to establish Memoranda of Understanding between health care providers and local organizations that provide services to IPV victims and perpetrators not only to link the patients to the care they need, but also provide support for health care providers when addressing patient needs.
- A consensus must be reached that defines what types of harm IPV encompasses.
- Examine how documenting IPV in EHRs can compromise the confidentiality and safety of victims of domestic violence.
- Take advantage of virtual resources: social media, apps, tele-help, software to engage the patient and provider. Computer screening may be perceived as more private and confidential.
- Address provider discomfort as a barrier to screening and assessment and increase provider training to meet the increased need for IPV services.

### III. Culturally Competent Screening

Facilitators and participants explored the concept of “cultural humility” and its possible utility and feasibility as a framework to approach IPV screening. In addition, the importance of adopting an interdisciplinary approach to IPV screening was discussed.

Session presenters/moderators:

- **Aleisha Langhorne**, MPH, MHSA, Health Scientist Administrator, OWH, Washington, DC
- **Jennifer Numkena Downs**, LCSW, Public Health Advisor, Division of Behavioral Health, Indian Health Service, Rockville, MD
- **Kristie A. Thomas**, MSW, PhD, Assistant Professor, Simmons College School of Social Work, Boston, MA

Research Gaps:

- Culturally sensitive yet practical screening methods tailored to specific population are lacking.
- Improving screening compliance among healthcare professionals after training is acutely needed to meet patient IPV treatment needs.

Research Goals:

- Increase community based/participatory research to determine which research methods work best for recruiting, screening, and treating patients.
- Engage and expand existing training resources in communities and make sure health care providers are aware of these services.
- Normalize and reduce discomfort of screening for patients and providers.

Considerations and Recommendations:

- The cultural context and immigrant group of the patient dictates how they define IPV and must be considered during IPV screening and treatment.
- Effective delivery of IPV screening questions is important for accurately assessing a patient’s needs. Stigma and stereotypes associated with particular communities must be avoided to ensure effective treatment delivery for all vulnerable populations.
- Examine the successful trainings that incorporate cultural competence in other health fields to apply lessons learned there.
- Train and test medical professionals on how IPV, with its different physical and emotional effects, is relevant to every health issue.
- Consider training providers on the concept of cultural humility, which focuses on evaluation of self, rather than cultural competency, which focuses on evaluation of others.

### IV. Trauma-Informed Screening Methods: Lessons from Behavioral Health Settings Including Alcohol and Substance Abuse

This session focused on trauma-informed (TI) approaches to screening and assessment for IPV in health and behavioral healthcare settings. Discussions focused on creating healthcare settings that take an integrated approach to patient care having both the expertise and resources to identify and treat individuals suffering from IPV and trauma with co-occurring mental illness and substance use disorders. The session also explored existing and needed research in these areas. Topics covered included:

- Why is a trauma-informed approach critical for IPV screening and assessment?
- Why is a culturally relevant, trauma- *and* IPV-informed approach essential to screening and assessment for health, mental health, substance abuse, and other behavioral health conditions that co-occur with IPV?

Session presenters/moderators:

- **Jacqueline Lloyd**, PhD, Deputy Branch Chief/Health Scientist Administrator, Prevention Research Branch, NIDA, NIH, Bethesda, MD
- **Beth Glover Reed**, PhD, Associate Professor of Social Work and Women's Studies, University of Michigan, Ann Arbor, MI
- **Carole Warshaw**, MD, Director, National Center on Domestic Violence, Trauma & Mental Health, Chicago, IL

Challenges and strategies for implementing an IPV and TI approach into clinical practice and the implications for brief interventions and longer-term treatment and services were examined and include:

- Organizational changes will be required as well as changes in how individual health care providers approach patient care to effectively include IPV, TI, mental health, and substance use disorder screening and treatment into clinical practice. Thus, IPV/TI approaches must be recognized and supported at all levels within the health care system.
- The presenters provided an overview of both principles and practical strategies for conducting trauma-informed screening, assessment, brief and longer-term interventions, as well as for creating trauma-informed practices and organizations. Relevant references and resources were provided.
- Ongoing training and supervision of all staff, IPV/TI human resources policies, and attention to both the organizational culture and practice environment, as well as an approach that encompasses a deeper understanding of both survivors/patients and health care providers' experiences and responses will be needed.
- Speakers noted that trauma-informed approaches frequently challenge existing paradigms and practices, so change often involves a process which calls for buy-in at multiple levels and which is informed by regular feedback and evaluation from consumers (patients), providers, and others in the practice/system.

Research Goals:

- Develop and evaluate TI approaches to screening and assessment for IPV in health and behavioral health (BH) settings.
- Develop and evaluate tools to screen and assess for trauma, substance use/abuse, mental health, and other behavioral health problems in addition to individual and contextual risk factors that may co-occur with IPV.
- Develop and evaluate/test brief interventions to address IPV and co-occurring behavioral health problems in Health Care Systems (HCS), and also test models for referring and linking to care patients who need additional services (e.g., treatment or other more intensive services).
- Develop and test strategies and models for creating practice environments that are both IPV- and trauma-informed.
- Develop and test referral systems and strategies. This includes development and testing of models and strategies to facilitate collaboration among health care providers, behavioral health providers, and community domestic violence organizations to facilitate the development of

comprehensive, multidisciplinary TI referral networks to address the complex needs of IPV patients.

#### Research Gaps:

- Research evaluating TI practice outcomes is limited and must be expanded. The current research is preliminary and the existing tools to measure agency outcomes are not research based. Validated and meaningful IPV/TI outcome measures should address all levels of IPV/TI involvement: patient/survivor, provider, practice/health care system, funder and policy. Examples include quality of life, access to resources, long-term cost/benefits, practice efficiency, improved behavioral health, etc.
- Effective approaches need to be developed to protect IPV victims from further trauma and ensure physical and emotional safety.
- Validated, comprehensive screening tools and assessments that identify and measure the severity of mental health, substance use disorders, trauma, and behavioral problems that often co-occur with IPV need to be developed.
- Interventions need to be tailored to individual patients based on individual and contextual risk factors, co-occurring mental health, substance use/abuse and other behavioral health problems and patient identified priorities/needs. These interventions should be culturally sensitive and be offered in appropriate delivery formats, as required for specific patient populations.
- There is a need for the development, testing and use of current and state of the art methodologies that are most relevant to the current state of the field, the gaps, and future directions to move the field forward (e.g., mixed methods approaches, developmental and formative research to inform intervention development, Community Based Participatory Research (CBPR) approaches, and alternative and innovative study designs).

#### Additional discussion considerations and recommendations:

- The long-term effects of IPV on survivors, and the effects on health care providers who treat these patients (e.g., taking into account providers' own personal experience with trauma as well as secondary trauma responses) need to be identified.
- Improved strategies are needed to protect health care providers from secondary trauma reactions that result from working with survivors and responding to trauma.
- Strategies and models to effectively implement TI principles into health care settings/systems are needed.
- IPV training and technical assistance for all levels of the health care system (providers, administrative staff, leadership and others ) are needed to deliver IPV/TI care that meets the complex needs of IPV survivors.
- Effective processes that link patients to the additional services they need and a way to track referral outcomes and progress need to be developed.
- Feedback from all stakeholders in the patient-provider health care continuum (patients/survivors, providers, practice organization leadership and decision makers) should be used to inform future research on IPV/TI screening, assessment, intervention development and practice.

## Lunchtime Discussion: Survivors' Perspectives

The Lunchtime Discussion focused on the survivor's perspectives and feedback to inform healthcare providers about what approaches are most effective for screening and intervention.

## **“Keeping Survivors at the Center: Tools and Resources to Support Comprehensive Approaches to Screening and Counseling for Domestic Violence”**

Presenter: Lisa James, Futures Without Violence

Introduced by Shawndell Dawson, BA, BS, Senior Program Specialist, Family Violence Prevention & Services Program, Family & Youth Services Bureau, ACF.

Understanding that IPV impacts the overall health of victims underscores the importance of identifying, treating, and preventing IPV for overall improvement in health and well-being. Survivor Feedback indicates:

- Survivors support screening, if done respectfully and if it is followed by appropriate linkage to care.
- Survivors want privacy, confidentiality and decision-making power.
- Survivors want IPV treatment settings that are tailored to the type of organization offering services as well as to the patient population that utilizes the services.
- Survivors want “warm referrals” to community agencies that offer further support.

Future research should promote resiliency and social connectedness and explore the efficacy of home visitation programs and new resources such as patient education cards and e-learning modules to enhance the patient-provider partnership in a way that protects confidentiality.

## **“Incorporating Survivor Perspective in Research Design – Screening for Trauma and IPV in OB/GYN Settings”**

Presenter: Amina White, MD, NIH

Introduced by Mary Blake, CRE, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Effective IPV screening involves recognizing the survivor’s immediate and long-term trauma recovery needs after abuse has ended. Integrating the survivor/patient perspective into IPV screening and treatment is an essential part of providing successful care. IPV is an important health issue, and screening for both current and past abuse must be performed to identify health risks, particularly in pregnant women. When women feel safe to disclose past trauma, particularly childhood sexual abuse, physicians can better avoid known triggers and tailor trauma-informed delivery preparation to minimize the chance of re-traumatization. In an obstetrics and gynecology (OB/GYN) setting, challenges to screening include provider discomfort with the topic, time constraints within their practice, and the misconception that issues related to trauma are better classified as psychological and are not relevant to OB/GYN care.

Trauma survivor perspectives can inform research intentions and identify barriers. An all-mother trauma focus group gave recommendations for providers when screening for abuse:

- Define trauma, with examples that include childhood maltreatment.
- Explain why providers are asking about abuse and how this is helpful to the doctor as well as patient.
- Avoid making the patient feel singled-out.
- Provide more information on confidentiality and how it is maintained in electronic health records.

- List available resources before asking about IPV or past abuse.

Gaps in research for screening for trauma and IPV in an OB/GYN setting:

- Identify best practices for asking about abuse history in a clinical setting.
- Determine which interventions are most helpful once patients disclose past abuse.

## Panel II. Intervention in the Clinical Setting

Dr. Robert Freeman of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) introduced the five panelists: Pamela S. F. Glenn, Dr. Mary Ann Dutton, Dr. Nabila El-Bassel, Dr. Phyllis Sharps, and Gloria Aguilera Terry.

Panel II focused on intervention in the clinical setting. Ms. Glenn discussed screening for abuse in the healthcare setting and a need to use resources more effectively. Dr. Dutton reported on the Mindfulness-Based Stress Reduction study and its usefulness as an intervention. Dr. El-Bassel discussed a study that has a couple-based intervention approach and that linked HIV, IPV, and drug use in screening. Dr. Sharps discussed a home visitation program that provides intervention for abused pregnant women. Ms. Aguilera Terry focused on the impact of public policy in making important changes in healthcare to address violence against women.

### “Domestic Violence and Abuse Screening in the Reproductive Health Care Setting”

Pamela Glenn focused on two areas - screening for abuse in healthcare setting and identifying areas in the field that need balancing for more effective use of resources.

Practitioners should be well-versed in basic screening concepts of IPV and abuse, emphasizing that emotional abuse is abuse, for *both* female and male victims. Identifying specific emotional behaviors can be very empowering and healing for the patient. Practitioners should create a safe, non-judgmental environment where the patient is more willing to disclose IPV and abuse. A history of multiple office visits with a variety of vague complaints may be an indication to dig deeper and consider IPV and abuse, including childhood sexual abuse. Practitioners should know how to respond to IPV and abuse disclosure, keep the door open for patients, and provide resources to help in the community. For patients choosing not to leave their abuser, it is recommended that clinicians use the harm reduction approach to minimize risk and danger.

There is a need to harmonize our language, research, and services when talking about and addressing abuse, including:

- Rather than speaking of this topic as “Intimate Partner Violence” include the word “Abuse.” Limiting the term to “violence” sends a message to the public that abuse consists solely of physical violence rather than including other forms of abuse, i.e. emotional, sexual, etc. This becomes a barrier to patient understanding and awareness.
- Focus not only on what is unhealthy, but also what is healthy. Asking questions such as, “is the relationship supportive, positive, and healthy,” teaches patients what healthy behavior is.
- Males should also be screened and have equal access to services. Many statistics on this topic consistently reveal a 30% incidence of abuse happening to males.
- Include services for couples who choose to work this out and stay together.

- Educate teens about healthy and unhealthy relationships as a primary prevention effort.
- Create safe places for both males and females to openly and authentically discuss healthy and unhealthy relationships.
- Train clinicians to more effectively screen for this issue in the health care setting.

### **“Mindfulness-Based Stress Reduction (MBSR) For Trauma-Related Outcomes”**

Dr. Mary Ann Dutton discussed the usefulness of a Mindfulness-Based Stress Reduction (MBSR) study to treat trauma and its impact on a range of health outcomes. This intervention focuses on strength-building rather than illness and damage, and represents a feasible approach, that may not be appealing to everyone.

Health disparities exist for low-income women with chronic trauma exposure. There are many barriers to access to treatment for these populations, such as cost/insurance, transportation, and cultural competency. MBSR provides mindful intervention that is supportive and affordable. Sessions focus on more than the symptoms, it is a way to help increase awareness and decrease distress without the added stigma of mental health intervention groups. Participants responded positively to the MBSR intervention, describing their beneficial outcomes in the following themes: increased awareness; empowerment; non-reactivity (increased self-control); decreased distress; compassion; belonging; daily practice; and humanity.

Future steps should be for providers to consider necessary interventions and emphasize treatment options to their patients. Larger randomized controlled trials (RCTs) should be performed to examine mechanisms and moderators.

### **“Integrating Intimate Partner Violence in HIV Prevention for Women Who Use or Inject Drugs: A Couple-Based Modality”**

Dr. Nabila El-Bassel discussed how IPV and HIV are linked among women who use or inject drugs, and an HIV couple-based intervention approach that integrates IPV, HIV, and drug use.

IPV and HIV are overlapping health issues that affect many women around the world. Major links include sexual coercion, negotiation/refusal of condom use, fear of violence, and social context of drug use. There is a need for integration of HIV and IPV prevention. Current HIV intervention rarely includes male and female partners together. Dr. El-Bassel introduced Project Connect: a couple-based model approach to reduce sexual and drug risks. It emphasizes couple communication, safety planning, and linkage to care. The couple-based approach provides an opportunity to assess IPV and HIV risks in a safe environment, allows male partners to be involved in and share responsibility for prevention and couples learn to talk about reproductive issues in a healthcare setting.

### **“Domestic Violence Enhanced Home Visitation Program (DOVE)”**

Dr. Phyllis Sharps highlighted the adverse outcomes for both mother and child experiencing IPV during pregnancy identified within the DOVE program. The DOVE program is a home visitation intervention for abused pregnant women utilizing screening and brochure-based counseling that is culturally relevant and is currently being examined in a randomized, controlled clinical trial. This intervention addresses the lack of interventions available to protect mothers and unborn children from IPV. Results show that IPV screening in home visitation is safe and feasible; however, several concerns still exist:

- Discomfort to pregnant women when screening occurs within the home due to lack of privacy, especially if the abuser is present.
- Lack of necessary resources available at home to treat IPV when it is discovered.
- Refusal to disclose abuse status for fear of encouraging further abuse.

## **“Health Care and Domestic Violence Programs: Critical Linkages in Violence Prevention”**

Gloria Aguilera Terry discussed how public policy on domestic violence in Texas informs changes within the healthcare system.

Training providers in IPV prevention, screening, and intervention is critical for the health of communities and reduction of IPV. When screening and providing counseling for IPV, providers should practice “warm referrals,” creating a trusting relationship that diminishes the victim’s feeling of isolation and introduces tailored options for treatment. Physicians and service providers need to better integrate patient care services to ensure that individuals receive the help they need.

### **Question and Answer Session Highlights**

- Couples-based interventions require intense and continual training to create a safe environment where couples can achieve positive outcomes
- Training of home visitors in the DOVE program was critical for positive program outcomes. The trained provider does not need to be an IPV advocate; rather he/she should recognize the signs of IPV in a patient and provide a warm referral to community resources.
- The focus of research on IPV screening and prevention has been to empower women to make decisions about how to address IPV and stay safe.

## **Administration Welcome and Remarks**

### **Administration for Children and Families, Dr. Mark Greenberg**

Dr. Marylouise Kelley delivered the Symposium remarks on behalf of Dr. Mark Greenberg, Acting Assistant Secretary of the Administration for Children and Families, emphasizing the critical need to elevate the importance of screening across a variety of settings. The Administration for Children and Families (ACF) is fully committed to the Administration’s Affordable Care Act (ACA), particularly as it pertains to IPV screening and intervention.

### **Office of Violence Against Women, The White House**

Lynn Rosenthal discussed her experience as a White House advisor on IPV. Healthcare providers need to be trained to identify IPV and signs of homicide so that they can properly treat patients suffering from multiple injuries trauma, and avoid life-threatening situations. Additionally, law enforcement personnel should also know how to identify IPV so they can properly assess situations where they and other individuals may be at risk for harm. It is also important to address the intersection between violence and HIV/AIDS and to work with men on how to curb violent behavior. Widespread training for IPV identification across disciplines can dramatically improve the care that victims receive and prevent further harm.

President Obama's administration is committed to preventing violence and improving the lives of women. Participants are encouraged to go to the <http://www.whitehouse.gov/1is2many> website to view the administration's efforts to end violence against women and decrease the domestic violence homicide rate.

## Afternoon Concurrent Breakout Groups: IPV Counseling and Intervention

Symposium participants were divided into groups to discuss five, strategically-selected topics on counseling and intervention. Each group was asked to identify goals and gaps for their assigned topic.

### I. Barriers to Conducting and Applying IPV Screening and Counseling Research

Several barriers exist within the healthcare system that prevents effective screening and treatment services from being offered to patients who need them. Barriers may include perceived versus actual risks of screening for IPV in patient populations, reluctance on the part of professionals and healthcare systems to offer IPV services, and difficulties in evaluating and tracking patients for follow-up care as needed.

Session presenters/moderators:

- **Kathleen O'Leary**, MSW, Chief, Women's Program, NIMH, NIH, Bethesda, MD
- **Annie Lewis-O'Connor**, PhD, NP-BC, MPH, Nursing Scientist and Director of the Women's CARE Clinic-Coordinated Approach to Recovery and Empowerment, Brigham and Women's Hospital, Boston, MA
- **Carla Smith Stover**, PhD, Assistant Professor and Clinical Psychologist, University of South Florida, Tampa, FL

Research Gaps:

- What is the impact of patient-informed interventions?
- What are the best methods and modes of technology for providing patient care?.
- What outcomes are researchers measuring? What outcomes are important to patients?
- What are the additional measures beyond self-report that may be needed?
- What new terminology and adaptations may be needed for immigrant populations and community-based participatory research?
- How can IPV services be effectively implemented within the overall health care system?
- How can interventions be improved to meet various patient populations? In what settings should these interventions be delivered (group vs. individual)?
- How can families or couples be effectively treated for violence and abuse in cases where there is mutual violence?

Research Goals:

- Implement IPV assessment and screening into routine care.
- Encourage practitioners to implement evidenced-based practice into policy and procedures.
- Improve communication between researchers and practitioners to build professional relationships that will help advance practice, policy and research.

- Strategize platforms to disseminate and implement research results.
- Identify best practices with robust outcomes that could be replicated in different settings.
- Research methods should be driven by the research questions using qualitative and mixed methods approaches. Randomized Controlled Trials should not be considered the only legitimate way to create evidence-based practice, since conducting an RCT in this field may pose ethical and moral issues.

## II. Complicating Co-morbidities in Physical and Sexual IPV: Substance Use, Mental Health and Medical Issues

Session presenters/moderators:

- **Sharon Amatetti**, MPH, Senior Public Health Analyst, SAMHSA Women’s Issues Coordinator, SAMHSA/CSAT, Rockville, MD
- **Niki Miller**, MS, CPS, Senior Program Associate, Advocates for Human Potential, Inc., Manchester, NH
- **Terri Weaver**, PhD, Professor, Department of Psychology, Saint Louis University, Saint Louis, MO

Research Gaps:

- What outcomes should be measured to determine the success of integrating screening for IPV into substance abuse programs and having holistic, trauma-informed services?
- Does advocacy work with tele-help, and what does a “warm referral” look like with tele-help?
- Are self-administered tools effective?
- What effective preventive measures can be applied, universally, to benefit subgroups or communities of women known to experience high levels of IPV?
- Regarding the research that suggests screening for IPV does no harm:
  - What conditions and approaches to screening are the safest?
  - Has the potential for increased distress and substance use, and the risk of re-traumatization been considered?

Research Goals:

- What is the best approach for addressing comorbid issues?
- In what way can some of the existing models for complex issues in primary care be used to inform IPV screening and referral?

Considerations and Recommendations:

- Screening and intervention practices should consider the complex needs of victims who may be using substances before, during, or after experiencing IPV, and minimize re-traumatization.
- What effective prevention and harm reduction strategies can primary care offer?
- Consider rural and tribal communities where it is difficult to make referrals.
- The role of ACASI should be considered when developing approaches to self-directed screening. These technologies can also be used to inform women about conditions, characteristics, and behaviors that are associated with high levels of violence.
- Because addiction and IPV often co-occur and the perpetrator often controls the drug supply, it is important that providers be competent in assessment of withdrawal severity, medication protocols for detoxification from a variety of substances, medication assisted treatments for

opioid or alcohol dependency, and best practices for pregnant women with substance use disorders.

### III. Screening for Abuse in Special Populations: Lessons from Elder Care, People with Disabilities, and Emergency Settings

Session presenters/moderators:

- **Jeremy Brown**, MD, Director, Office of Emergency Care Research (OECR), NIH, Bethesda, MD
- **Stephanie Eliason**, MSW, Elder Rights Team Lead, Office of Elder Rights, Administration on Aging, Administration for Community Living, DHHS, Washington, DC
- **Rosemarie Filart**, MD, MPH, MBA, Medical Officer, Office of Research on Women's Health (ORWH), NIH, Bethesda, MD
- **Mary E. Worstell**, MPH, Senior Advisor, Office on Women's Health, DHHS

Research Gaps:

- More registered clinical trials of screening and interventions are needed to determine if they are effective in elderly patients or persons with disabilities. Tools should also be framed for 3rd party responses to address the needs of patients who cannot respond for themselves.
- More data are needed to determine the incidence, prevalence, and risk factors associated with IPV against those with disabilities.
- More data are needed to better understand perpetrators of IPV in elderly and disability populations so that effective preventative measures can be taken.

Research Goals:

- Develop approaches to reduce fear and anxiety in elder populations and people with disabilities in disclosing abuse.
- Establish a universal screening instrument for these populations.
- Correct system issues that make screening for IPV in Emergency Department settings challenging.

Considerations and Recommendations:

- "Caregiver stress" needs to be defined and should not be used as an excuse for elder abuse.
- Training should be extended to increase effective screening, intervention, and referral to care.

### IV. Addressing IPV Among Women in Veterans Health Administration: Toward a Comprehensive Response

Session presenters/moderators:

- **Lisa Begg**, DrPH, Director of Research Programs, ORWH, NIH, Bethesda, MD
- **Cicely Burrows-McElwain**, LCSW-C, CSWHC, Public Health Advisor, Emergency Mental Health & Traumatic Stress Services Branch, Center for Mental Health Services, SAMHSA, Rockville, MD
- **Katherine Iverson**, PhD, Clinical Research Psychologist, Women's Health Sciences Division of the National Center for PTSD, VA Boston Healthcare System; Assistant Professor of Psychiatry, Boston University, MA
- **Rachel Latta**, PhD, Intimate Partner Violence Consultant, Mental Health Services, Department of Veteran Affairs; Research Investigator and clinical Psychologist, New England Mental Illness

Research, Education, and Clinical Center and Director, the Safing Center, Bedford VA Medical Center

Research Gaps:

- VHA patients and providers need more information about what resources are available.
- More veteran-specific IPV prevention and intervention programs need to be developed and tailored for this population, especially for women veterans.
- Research is needed to examine the role of tele-health and e-health interventions in 1) promoting patient's safety and anonymity in a close community and 2) ensuring safe and effective treatment delivery to the veterans that need it.

Research Goals:

- Increase awareness of the importance of identifying and treating IPV among VHA providers to reduce stigma and increase access to care.
- Implement training within the VA to ensure that IPV screening and response procedures are conducted in an accurate and clinically-sensitive manner and that women are provided with appropriate referral options.
- Develop and evaluate patient-centered models of brief counseling for women who screen positive for IPV.
- Need to have standardized yet flexible programs and services among VA hospitals and clinics

Considerations and Recommendations:

- Women veterans are at higher risk for IPV than civilian women and may have unique risk and resiliency factors
- Need to address childhood IPV exposure
- Training should prepare provider for adolescent and child issues

## V. Confidentiality and Mandatory Reporting

Speakers in this session discussed confidentiality and mandatory reporting in the adult and pediatric primary care settings which includes consideration of how to protect women's safety and well-being. IPV identified during pediatric visits – when the person experiencing abuse is not the patient and children's well-being may be involved – poses unique confidentiality and reporting challenges which were also explored.

Session presenters/moderators:

- **Sima Michaels Dembo**, MPH, Senior Advisor to the Deputy Assistant Secretary for Population Affairs, Office of Population Affairs (OPA), Rockville, MD
- **Megan H. Bair-Merritt**, MD, MSCE, Associate Professor of Pediatrics, Boston University School of Medicine, Boston, MA
- **Audrey Bergin**, MA, Manager, Domestic Violence (DOVE) Program, Northwest Hospital, Randallstown, MD

Research Gaps:

- Determine the impact of states' mandatory reporting laws for both domestic violence and childhood exposure to domestic violence on the safety and well-being of both the parent and child who are experiencing.

- Identify methods and best practices for providing IPV services in the pediatric setting while protecting the confidentiality of mother and child(ren).
- Identify potential privacy breaches in the use of EHRs and how EHRs can be improved to protect confidentiality and ensure patient safety.
- Gain better understanding of issues surrounding perpetrators including:
  - Assessment/identification
  - Referral for treatment and treatment options
  - What is the duty to warn? (Where/How to report?)

#### Research Goals:

- Determine best practices for addressing IPV in the medical setting for patients while ensuring privacy and safety, and promoting well-being.
- Determine best practices for addressing IPV in the pediatric setting where the one experiencing abuse is not the patient but a parent accompanying a minor, while ensuring privacy and safety, and promoting well-being, for parent and child.
- Provide information for advocates and health providers that address confidentiality in the use of electronic health records (EHRs)

#### Considerations and Recommendations:

- Pediatric providers have tremendous reach, seeing infants an average 5-7 times during the first year of life alone. Many young women do not seek their own health care, but do seek pediatric care for their child; therefore, the pediatric setting is an important location to screen for and respond to IPV.
- It is important to disclose the limits of confidentiality to patients and their parents in the pediatric setting since some mandatory reporting laws for exposure of children to IPV may impede a woman's disclosure of IPV since women fear consequences such as losing custody of the children if a report is made.
- Advocates and providers need to work with EHR manufacturers to address confidentiality concerns faced by those experiencing IPV. Providers are not always at the table when their health system (hospital, clinic, health system) purchases an EHR system, so manufacturers need to build in appropriate privacy options. Particular concerns were raised around protecting privacy and confidentiality when EHRs are shared via patient portals and also among providers. Additional sensitive areas include IPV, behavioral health, substance abuse, some reproductive health services, and confidential teen services as permitted by law.

## Summary and Future Steps

Dr. Nancy Lee expressed gratitude from the cross-organizational planning committee to the participants and agencies for their thoughtful and informative contributions. The goal of the symposium was to identify ways to help improve the health care of victims of IPV through a re-examination of the current, evidence-based research in screening and intervention; the identification of gaps in IPV screening and counseling; and the need to set priorities to advance this critical health research agenda. It is also important to screen not just high-risk populations, but all populations at risk. Participants were urged to consider developing a research agenda for screening for IPV in locations other than clinical settings in order to reach vulnerable populations at risk.

Dr. Reem Ghandour, Senior Public Health Analyst, HRSA, outlined the preliminary synthesis of presentations and breakout groups' work in four summary areas:

### **Screening and Assessment**

What is known:

- Evidence supports routine screening; multiple brief screening tools have been tested and validated.
- IPV impacts multiple physiological, neurological, and behavioral systems, and causes varying adverse health effects.
- Provider education is necessary but not sufficient.

More research is needed on:

- Disease pathways to better inform IPV intervention, diagnosis, treatment, and management
- Patient outcomes
- Tools and processes
- Harm that results from screening
- Cultural factors and sexual minority populations
- Survivor perspectives
- How to normalize universal IPV screening and intervention
- How to link electronic health records while maintaining confidentiality and security
- How to expand IPV screening to include lifetime exposure of violence
- Ways to include men to share in the burden of prevention of harm

### **Counseling and Intervention**

What is known:

- Interventions have been tested and proven efficacious.
- IPV and history of trauma affect multiple health systems and should factor into diagnosis and treatment of chronic and acute conditions.

More research needed on:

- Disease pathways
- Survivor perspectives
- Patient outcomes
- Effective trauma interventions based on participatory research
- Multidisciplinary interventions, comorbidities, health intersections
- Use of technology to improve screening and intervention

Focus on:

- Training clinic staff
- Addressing multiple health risk behaviors
- Developing interventions that include relationship dyads where appropriate
- Improve "warm referrals" that are tailored

### **Special considerations**

- Protect patient confidentiality and safety when balancing specificity and efficiency in a health care setting

- Build relationships between provider and patient to encourage disclosure and participation during screening and treatment
- Retain focus on prevention even while promoting screening and intervention
- Access and capitalize on existing population-based network resources

**Take-away points**

- Screening and effective intervention for IPV is part of delivering high-quality care
- Research should include both survivor and provider input
- System-wide change is essential

In closing Dr. Lee outlined future steps HHS would undertake to move forward:

- Compile summary proceedings
- Develop a research agenda, prioritizing research questions
- Communicate research agenda with symposium participants and obtain comments and feedback to further prioritize research questions
- Share finalized research agenda with participants and stakeholders
- Seek public and private funding
- Tools and practices to support the well-being and mental health of providers who screen and counsel IPV patients should also be included in any future IPV research agenda.

Refer to the symposium portal for more information, including <http://whr.nlm.nih.gov/ipv-symposium.html>

## Appendix A: Meeting Agenda

TIME	ACTIVITY	ROOM NUMBER
8:00 - 8:30 a.m.	REGISTRATION	Conference Rooms C&D
8:30 -8:35 a.m.	<b>Welcome and Charge to the Group</b> Samia Noursi, PhD, Deputy Coordinator, Women and Sex/Gender Differences Research Program, National Institute on Drug Abuse (NIDA)/NIH	Conference Rooms C&D
8:35 -8:50 a.m.	<b>Opening</b> Janine Austin Clayton, MD, Director, NIH Office of Research on Women’s Health and Associate Director for NIH Research on Women’s Health	Conference Rooms C&D
8:50 - 9:30 a.m.	<b>Keynote Address</b> Jacquelyn Campbell, PhD, RN, FAAN, <i>Now That We are Screening, What Should “Brief Counseling” Look Like?</i> Introduced by Nancy Lee, MD, Deputy Assistant Secretary for Health - Women’s Health, Director of Office on Women’s Health, DHHS	Conference Rooms C&D
9:30 -10:30 a.m.	<b>Panel I. Identifying Intimate Partner Violence in Clinical Settings: Client, Provider, and Systems Level Considerations</b> Chair: Samia Noursi, PhD, NIDA Panelists: <ul style="list-style-type: none"> <li>• Connie Mitchell, MD, <i>System Considerations for IPV Screening and Assessment</i></li> <li>• Elizabeth Miller, MD, <i>Integrating Screening into Clinical Settings</i></li> <li>• Kevin Hamberger, PhD, <i>Beyond Education: Changing systems to facilitate healthcare-based IPV screening</i></li> </ul>	Conference Rooms C&D
10:30 -10:45 a.m.	Q & A: Reem Ghandour, DrPH, Senior Public Health Analyst, Health Resources and Services Administration (HRSA)	Conference Rooms C&D
10:45 -11:00 a.m.	BREAK	
11:00 a.m. –12 Noon	<b>Concurrent Breakout Groups: IPV Screening and Assessment</b> <ol style="list-style-type: none"> <li>i. Electronic Health Records: Meaningful Use Standards and System-Wide Responses</li> <li>ii. Provider Use of Screening Tools and Strategies</li> <li>iii. Culturally Competent Screening</li> <li>iv. Trauma-Informed Screening Methods: Lessons from Behavioral Health Settings including Alcohol and Substance Abuse</li> </ol>	Please refer to the Breakout Sessions Chart for room numbers, facilitators, and descriptions (Room info will be available on the day of the meeting)
12:00 – 12:20 p.m.	BREAK TO RETRIEVE BOXED LUNCH	
12:20 – 12:45 p.m.	<b>Lunchtime Discussion: Survivor’s Perspectives</b> <ul style="list-style-type: none"> <li>• Lisa James, Futures Without Violence, <i>Keeping Survivors at the Center: Tools and Resources to Support Comprehensive Approaches to Screening and Counseling for Domestic Violence</i> Introduced by Shawndell Dawson, Senior Program Specialist, Family Violence Prevention &amp; Services Program, Family &amp; Youth Services Bureau, ACF</li> </ul>	Conference Rooms C&D

TIME	ACTIVITY	ROOM NUMBER
12:45 – 1:10 p.m.	<ul style="list-style-type: none"> <li>Amina White, MD, NIH, <i>Incorporating Survivor Perspective in Research Design - Screening for Trauma and IPV in OB/GYN Settings</i> Introduced by Mary Blake, CRE, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services</li> </ul>	Conference Rooms C&D
1:10 – 1:30 p.m.	<p><b>Welcome Back Remarks</b> Acting Assistant Secretary Mark Greenberg, Administration for Children and Families (ACF) Introduced by Marylouise Kelley, Ph.D., Director, Family Violence Prevention &amp; Services Program, Family &amp; Youth Services Bureau, ACF</p> <p>Ms. Lynn Rosenthal, White House Advisor on Violence Against Women</p>	Conference Rooms C&D
1:30 – 2:30 p.m.	<p><b>Panel II. Intervention in the Clinical Setting</b> Chair: Robert Freeman, PhD, National Institute on Alcohol Abuse and Alcoholism (NIAAA)/NIH Panelists:</p> <ul style="list-style-type: none"> <li>Pamela S. F. Glenn, CNM, MS, APN, <i>Screening and Counseling for Violence and Abuse in the Reproductive Health Care Setting</i></li> <li>Mary Ann Dutton, PhD, <i>Patient Voice, Trauma and Intervention</i></li> <li>Nabila El-Bassel, PhD, <i>Integrating IPV Prevention into HIV Interventions for People Who Use Drugs: A Couple-Based Modality</i></li> <li>Phyllis Sharps, PhD, RN, FAAN, <i>DOVE Intervention: Can We Screen and Intervene in the Home Setting?</i></li> <li>Gloria Aguilera Terry, <i>Health Care and Domestic Violence Programs: Critical Linkages in Violence Prevention</i></li> </ul>	Conference Rooms C&D
2:30 – 2:45p.m.	Q & A: Reem Ghandour, DrPH, Senior Public Health Analyst, HRSA	Conference Rooms C&D
2:45 – 3:00 p.m.	BREAK	
3:00 – 4:00 p.m.	<p><b>Concurrent Breakout Groups: IPV Counseling and Intervention</b></p> <ol style="list-style-type: none"> <li>Barriers to Conducting and Applying IPV Screening and Counseling Research</li> <li>Complicating Co-morbidities in Physical and Sexual IPV: Substance Use, Mental Health and Medical Issues</li> <li>Screening for Abuse in Special Populations: Lessons from Elder Care, People with Disabilities and Emergency Settings</li> <li>Addressing IPV among Women in Veterans Health Administration: Toward a Comprehensive Response</li> <li>Confidentiality and Mandatory Reporting</li> </ol>	Please refer to the Breakout Sessions Chart for room numbers, facilitators, and descriptions (Room info will be available on the day of the meeting)
4:00 – 4:15 p.m.	TRANSITION TO PLENARY SESSION	
4:15 – 5:00 p.m.	<p><b>Summary and Future Steps</b> Reem M. Ghandour, DrPH, Health Resources and Services Administration (HRSA) Nancy Lee, MD, Deputy Assistant Secretary for Health-Women’s Health, Director of Office on Women’s Health, DHHS</p>	Conference Rooms C&D

## Appendix B: Breakout Session Charts

### Morning Concurrent Breakout Groups: IPV Screening and Assessment (11:00am – Noon)

BREAKOUT GROUP	FACILITATORS	ROOM NUMBER
<b>I. Electronic Health Records: Meaningful Use Standards and System-wide Responses</b>	Betsy L. Humphreys, MLS, Deputy Director, National Library of Medicine, NIH, Bethesda, MD	5 <sup>th</sup> Floor NIDA Director's Conference Room (Room 5274)
	Brigid McCaw, MD, MPH, MS, FACP, Medical Director, Northern California Family Violence Prevention Program, Kaiser Permanente, San Francisco, CA	
	Karin Rhodes, MD, MS, Director, Emergency Care Policy & Research, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA	
<b>II. Provider Use of Screening Tools and Strategies</b>	Marylouise Kelley, PhD, Director, Family Violence Prevention & Services Program, Family & Youth Services Bureau, Administration for Children and Families (ACF), Washington DC	Conference Room D
	Camille Burnett, PhD, MPA, APHN-BC, RN, BScN, DSW, Assistant Professor and Roberts Scholar, School of Nursing, University of Virginia, Charlottesville, VA	
	Carlene Pavlos, MTS, Director, Bureau of Community Health and Prevention, Massachusetts Department of Public Health, Boston, MA	
<b>III. Culturally Competent Screening</b>	Aleisha Langhorne, MPH, MHSA, Health Scientist Administrator, Office on Women's Health, Washington DC	3 <sup>rd</sup> Floor NIDA Main Conference Room (Room 3103)
	Jennifer Numkena Downs, LCSW, Public Health Advisor, Division of Behavioral Health, Indian Health Service, Rockville, MD	
	Kristie A. Thomas, MSW, PhD, Assistant Professor, Simmons College School of Social Work, Boston, MA	
<b>IV. Trauma-Informed Screening Methods: Lessons from Behavioral Health Settings Including Alcohol and Substance Abuse</b>	Jacqueline Lloyd, PhD, Deputy Branch Chief/Program Officer, Prevention Research Branch, National Institute on Drug Abuse, NIH, Bethesda, MD	Conference Room C
	Beth Glover Reed, PhD, Associate Professor of Social Work and Women's Studies, University of Michigan, Ann Arbor, MI	
	Carole Warshaw, MD, Director, National Center on Domestic Violence, Trauma & Mental Health, Chicago, IL	

**Afternoon concurrent Breakout Groups: IPV Counseling and Intervention  
(3:00 – 4:00pm)**

BREAKOUT GROUP	FACILITATORS	ROOM NUMBER
<b>I. Barriers to Conducting and Applying IPV Screening and Counseling Research</b>	Kathleen O’Leary, MSW, Chief, Women’s Program, National Institute of Mental Health, NIH, Bethesda, MD	3 <sup>rd</sup> Floor NIDA Main Conference Room (Room 3103)
	Annie Lewis-O’Connor, PhD, NP-BC, MPH, Nursing Scientist and Director of the Women’s CARE Clinic-Coordinated Approach to Recovery and Empowerment , Brigham and Women’s Hospital, Boston, MA	
	Carla Smith Stover, PhD, Assistant Professor and Clinical Psychologist, University of South Florida, Tampa, FL	
<b>II. Complicating Co-morbidities in Physical and Sexual IPV: Substance Use, Mental Health and Medical Issues</b>	Sharon Amatetti, MPH, Senior Public Health Analyst, SAMHSA Women’s Issues Coordinator, SAMHSA/CSAT, Rockville, MD	Conference Room C
	Niki Miller, MS, CPS, Senior Program Associate, Advocates for Human Potential, Inc., Manchester, NH	
	Terri Weaver, PhD, Professor, Department of Psychology, Saint Louis University, Saint Louis, MO	
<b>III. Screening for Abuse in Special Populations: Lessons from Elder Care, People with Disabilities and Emergency Settings</b>	Jeremy Brown, MD, Director, Office of Emergency Care Research (OECR), NIH, Bethesda, MD	NIMH Conference Room (8120)
	Rosemarie Filart, MD, MPH, MBA, Medical Officer, Office of Research on Women’s Health (ORWH), NIH, Bethesda, MD	
	Stephanie Eliason, MSW, Elder Rights Team Lead, Office of Elder Rights, Administration on Aging, Administration for Community Living, HHS, Washington DC	

BREAKOUT GROUP	FACILITATORS	ROOM NUMBER
<b>IV. Addressing IPV among Women in Veterans Health Administration: Toward a Comprehensive Response</b>	Lisa Begg, DrPH, Director of Research Programs, Office of Research on Women’s Health (ORWH), NIH, Bethesda, MD	NIDA 5 <sup>th</sup> Floor OD Conference Room  (Room 5274)
	Katherine Iverson, PhD, Clinical Research Psychologist, Women’s Health Sciences Division of the National Center for PTSD, VA Boston Healthcare System; Assistant Professor of Psychiatry, Boston University, MA	
	Rachel Latta, PhD, Intimate Partner Violence Consultant, Mental Health Services, Department of Veteran Affairs; Research Investigator and Clinical Psychologist, New England Mental Illness Research, Education, and Clinical Center and Director, the Safing Center, Bedford VA Medical Center	
	Cicely Burrows-McElwain LCSW-C, CSWHC, Public Health Advisor, Emergency Mental Health & Traumatic Stress Services Branch, Center for Mental Health Services, SAMHSA, Rockville, MD	
<b>V. Confidentiality and Mandatory Reporting</b>	Sima Michaels Dembo, MPH, Senior Advisor to the Deputy Assistant Secretary for Population Affairs, Office of Population Affairs (OPA), Rockville, MD	Conference Room D
	Megan H. Bair-Merritt , MD, MSCE, Associate Professor of Pediatrics, Boston University School of Medicine, Boston, MA	
	Audrey Bergin, MA, Manager, Domestic Violence(DOVE) Program, Northwest Hospital, Randallstown, MD	

## Appendix C: Speaker Biographies

### **Mary Blake, CRE**

#### **Public Health Advisor, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration**

Mary Blake is a Public Health Advisor for SAMHSA's Center for Mental Health Services (CMHS) in the Community Support Programs Branch in the Division of Service and Systems Improvement. Serving as CMHS lead for adult trauma and trauma-informed care, she is the Contract Officer Representative for SAMHSA's National Center for Trauma Informed Care (NCTIC) and the National Center Promoting Alternatives to Seclusion and Restraint Through Trauma-Informed Practices. Ms. Blake brings her expertise in trauma and trauma-informed care to a number of SAMHSA and broader federal committees and workgroups, including the Women and Trauma Federal Partners Committee, where she serves as Committee Co-Lead. She has taken a leadership role in promoting and integrating consumer/survivor participation in the context of broader systems change. Ms. Blake is a noted speaker on trauma recovery, trauma-informed care, recovery support, evidence-based and promising practices in recovery-oriented services and systems change, and peer leadership.

### **Jacquelyn C. Campbell, PhD, RN, FAAN**

#### **Anna D. Wolf Chair and Professor, Johns Hopkins University School of Nursing**

Dr. Jacquelyn C. Campbell is the Anna D. Wolf Endowed Chair and a Professor in the Johns Hopkins University School of Nursing with a joint appointment in the Bloomberg School of Public Health as well as the National Program Director of the Robert Wood Johnson Foundation Nurse Faculty Scholars Program. Her BSN, MSN and PhD are from Duke University, Wright State University and the University of Rochester Schools of Nursing. She has been conducting advocacy policy work and research in the area of domestic violence since 1980. Dr. Campbell has been the PI of 12 major NIH, NIJ or CDC research grants and published more than 220 articles and seven books on this subject, including the textbook *Family Violence and Nursing Practice* with Janice Humphreys. She has received numerous awards including elected membership in the Institute of Medicine and the American Academy of Nursing, three honorary doctorates, the Pathfinder Award from FNINR, and is Co-Chair of the IOM Forum on Global Violence Prevention. Dr. Campbell proudly is Chair of the Board of Directors of Futures Without Violence, was a member of the congressionally appointed US Department of Defense Task Force on Domestic Violence, and has been a board member at 3 shelters.

### **Janine Austin Clayton, MD**

#### **Director, Office of Research on Women's Health, National Institutes of Health**

Janine Austin Clayton, MD, is the Director of the Office of Research on Women's Health, National Institutes of Health (NIH), and Associate Director for Research on Women's Health, NIH, in the NIH Office of the Director.

She is the author of over 80 scientific publications, journal articles, and book chapters. Prior to joining the Office of Research on Women's Health, she was the Deputy Clinical Director of the National Eye Institute (NEI), NIH. A board certified ophthalmologist, Dr. Clayton's research interests include

autoimmune ocular diseases and the role of sex and gender in health and disease. Dr. Clayton has a particular interest in ocular surface disease and discovered a novel form of disease associated with premature ovarian insufficiency which affects young women.

A native Washingtonian, Dr. Clayton received her undergraduate degree with Honors from the Johns Hopkins University, and her medical degree from Howard University College of Medicine. She completed a residency in ophthalmology at the Medical College of Virginia and fellowship training in Cornea and External Disease at the Wilmer Eye Institute at Johns Hopkins Hospital, and in Uveitis and Ocular Immunology at NEI. Dr. Clayton has been an attending physician and clinical investigator in cornea and uveitis at the NEI since 1996, conducting research on inflammatory diseases of the anterior segment. Her clinical research has ranged from randomized controlled trials of novel therapies for immune mediated ocular diseases to studies on the development of digital imaging techniques for the anterior segment.

Dr. Clayton is a Fellow of the New York Academy of Medicine. She currently serves on the FDA Advisory Panel for Ophthalmic Devices; the medical and scientific advisory board of Tissue Banks International; and the editorial board of *The Ocular Surface*. She was selected as a Silver Fellow by the Association for Research in Vision and Ophthalmology and a recipient of the Senior Achievement Award from the American Academy of Ophthalmology. Dr. Clayton has received several awards from her NIH peers in recognition of her leadership. She co-chairs the NIH Working Group on Women in Biomedical Careers with the NIH Director.

**Shawndell Dawson, BA, BS**

**Senior Program Specialist, Division of Family Violence Prevention, Family Youth Services Bureau, Administration for Children, Youth and Families, Administration for Children and Families**

Shawndell Dawson has been an advocate providing support to domestic violence survivors, advocates, and service providers for over 15 years working on local, state, and national levels. Shawndell is currently a Senior Program Specialist with the Department of Health and Human Services' Family Violence Prevention and Services Program, managing discretionary grant programs focused domestic violence related training and technical assistance. She works directly with FVPSA funded Culturally Specific Institutes, Special Issue Resource Centers, and National Resource Centers including the National Health Resource Center on Domestic Violence.

Before working with the Federal Government Ms. Dawson worked for several national and state specific domestic violence organizations, coordinating the development of curriculums, training tools, and leading training and technical assistance on issues related to financial safety planning, economic empowerment, technology safety, and legal advocacy.

**Mary Ann Dutton, PhD**

**Professor, Georgetown University Medical Center**

Mary Ann Dutton, PhD is Professor of Psychiatry, Georgetown University Medical Center and Co-Director of the Community Engagement and Research component of the Georgetown Howard Universities Center for Clinical and Translational Science (GHUCCTS). She is also Associate Director of the Georgetown Center for Trauma and the Community. Dr. Dutton's research focuses on trauma, health and mental health among low-income minority women and veterans. She has received

numerous federal grants, including for longitudinal studies, randomized behavioral clinical trials involving both mindfulness and tele-health interventions. Dr. Dutton has also been involved in research involving immigrant women's use civil protection orders and in training immigration advocates to provide trauma-informed legal advocacy. Dr. Dutton has also worked to help organizations to evaluate their trauma-focused interventions. Dr. Dutton is the author of numerous scientific journal articles and books.

**Nabila El-Bassel, PhD**

**Professor, Columbia University, School of Social Work, Director of the Global Health Research Center of Central Asia, Director of the Social Intervention Group**

Dr. El-Bassel is a Professor at the Columbia University School of Social Work and Director of the Social Intervention Group (SIG), which was established in 1990 as a multi-disciplinary organization focusing on developing and testing effective behavioral prevention and interventions. Dr. El-Bassel is also the Director of the Columbia University Global Health Research Center of Central Asia (GHRCCA), a team of faculty, scientists, researchers, and students in both New York and Central Asia committed to advancing solutions to health and social issues in Central Asia.

She has designed and tested HIV intervention and prevention models for women, men, and couples, which have been disseminated nationally and internationally. Dr. El-Bassel has been studying the intersecting epidemics of HIV, drug abuse and violence against women and has designed HIV interventions that address these co-occurring problems with significant scientific contributions in gender-based HIV prevention for women. Dr. El-Bassel has been funded extensively by the National Institute of Mental Health and the National Institute on Drug Abuse.

**Robert Freeman, PhD**

**Health Scientist Administrator, National Institute on Alcohol Abuse and Alcoholism**

Since 2002, Robert C. Freeman, PhD, has been a Program Official in the Division of Epidemiology and Prevention Research at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), U.S. National Institutes of Health (NIH). At NIAAA, he oversees the research portfolios in the epidemiology and prevention of alcohol-related violence as well as HIV/AIDS risk. He has been affiliated with a number of U.S. federal panels devoted to prevention of youth violence, teen dating violence, bullying, and child maltreatment, as well as intimate partner violence involving HIV-positive and at-risk women.

Dr. Freeman received his PhD (Urban Sociology) from Fordham University in 1994. He is the author (with Yvonne Lewis and Hector Colon) of *Handbook for Conducting Drug Abuse Research with Hispanic Populations* (Praeger Publishers, 2002), has authored or co-authored over two dozen scientific papers in the fields of HIV/AIDS, substance abuse, and sexual violence, and has been a reviewer for the *Journal of Urban Health*, *AIDS Care*, *International Journal of STD & AIDS*, the International AIDS Society, the U.K. National Institute for Health Research Health Technology Assessment Programme, the Society for Prevention Research, and the U.S. National HIV Prevention Conference.

**Reem Ghandour, DrPH, MPA**

**Senior Public Health Analyst, Office of Epidemiology and Research, Maternal and Child Health Bureau, Health Resources and Services Administration**

Dr. Reem M. Ghandour is a Senior Public Health Analyst with the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) in the Office of Epidemiology and Research. Her current research focuses on children with special health care needs and pediatric mental health conditions. In addition, Reem serves as the MCHB-lead for Healthy People 2020, managing editor for the annual *Child Health USA databook*, contributing author to the *annual Women's Health USA*, and original coordinator for the Collaborative Improvement & Innovation Network (CoIIN) to reduce infant mortality. Dr. Ghandour began her career in MCH and women's health as a hotline counselor and companion advocate for survivors of domestic violence and sexual assault. She holds a Masters of Public Administration from Syracuse University and a Doctorate in Public Health from the Johns Hopkins Bloomberg School of Public Health where she was the recipient of an Interdisciplinary Research Training Grant on Violence supported through the National Institute of Mental Health and the John and Alice Chenoweth-Pate Fellowship in Maternal and Child Health. In 2011, she was awarded the Maternal and Child Health Young Professional Achievement award by The Coalition for Excellence in MCH Epidemiology for her work on Healthy People 2020.

**Pam Glenn, BSN, MS**

**Certified Nurse-Midwife, Planned Parenthood of Minnesota, North Dakota, South Dakota**

Pam Glenn has been a Certified Nurse-Midwife for nearly 30 years, a graduate of Georgetown University. She has worked in a variety of settings providing both full-scope midwife services as well as focused reproductive care. More recently, Pam was the Director of the Advanced Practice Nurses for Planned Parenthood of Minnesota, North Dakota, South Dakota, supervising 40-50 clinicians for the past 8 years. Recently she has chosen to return to full-time clinical care while also working as an Accreditation Surveyor Consultant for Planned Parenthood Federation of America.

Throughout her career, Ms. Glenn has focused on screening for domestic violence and abuse. Her work has included providing clinical services at a battered women's shelter. She has also presented the topic of dating violence and abuse to high school students. For over 10 years Pam has taught "Screening for Domestic Violence and Abuse in the Health Care Settings" to RN and APN student as well as other health care clinicians.

**L. Kevin Hamberger, PhD**

**Professor of Family and Community Medicine, Medical College of Wisconsin**

Kevin Hamberger holds a PhD in clinical psychology and is a Professor in the Department of Family and Community Medicine, and an affiliate of the Injury Research Center at the Medical College of Wisconsin. Since 1982, he has conducted treatment and research programs with domestically violent men and women, and developed and evaluated health care provider training programs to deliver violence prevention and intervention services to patients. He was P.I. on a recently completed CDC-funded project to evaluate the impact of a health systems change model of intervention to prevent and end intimate partner violence in primary care settings.

He has served as a consultant to the National Institutes of Health, National Institute of Mental Health, National Institute of Justice, Department of Defense, Centers for Disease Control, and the Family Violence Prevention Fund. More recently, he has lectured in China and Norway on how doctors and nurses can talk to their patients about intimate partner violence. He is on the editorial boards of 6 scholarly journals, and has published over 100 articles and chapters and 6 books, including *Violence Issues for Health Care Educators and Providers* (The Haworth Press) and *Domestic Violence Screening in Medical and Mental Healthcare Settings* (Springer).

### **Lisa James**

#### **Director of Health, Futures Without Violence**

Lisa James is Director of Health at Futures Without Violence (formerly the Family Violence Prevention Fund). As part of a National Health Initiative on Domestic Violence, Ms. James has collaborated with health care providers, domestic violence experts and health policy makers in over 20 states across the U.S. to develop statewide health care responses to domestic violence through training, health policy reform and public education. She currently helps coordinate Project Connect: A multi-state initiative to educate public health professionals on violence prevention and response. She collaborates with national medical and nursing associations to enact effective health policy and programmatic health care responses to abuse and was the recipient of the American Medical Associations' Citation for Distinguished Service for her efforts to train health care providers on domestic violence. Ms. James coordinates the biennial National Conference on Health Care and Domestic Violence (attended by over 1000 participants).

During her 17 years Futures without Violence, Ms. James has also worked with the international program, collaborating with leaders from non-governmental and health care organizations in Russia, Mexico, India and China to build the capacity of health systems, providers and community members to identify and help victims in reproductive health settings. Ms. James has developed educational materials for healthcare professionals on domestic violence, and is editor of the FVPF's manuals, such as: *The National Health Care Standards Campaign on Family Violence: Model Practices from 15 states* (2004). Ms. James serves as a past Chair of the National Health Collaborative on Violence and Abuse a group of health professional associations dedicated to violence prevention.

### **Marylouise Kelley, PhD**

#### **Director, Family Violence Prevention & Services Division, Administration for Children and Families, U.S. Department of Health and Human Services**

Dr. Marylouise Kelley administers the Family Violence Prevention & Services Act (FVPSA) Program, the primary federal funding source for States, Territories and Tribes dedicated to the support of shelter and supportive services for victims of domestic violence and their children. Dr. Kelley began working in the field of domestic violence and sexual assault services in 1983. Her career spans working as a victim advocate in a community based shelter and rape crisis center to managing national programs addressing sexual assault, domestic violence and child abuse. She has over 20 years of experience managing diverse programs including domestic violence, sexual assault, foster care, legal services, health care, substance abuse services, immigration and refugee services, and a network of family centers. Dr. Kelley earned her doctorate in Social Work at the Catholic University School of Social Service where she

conducted research on the effects of children on the decision-making patterns of domestic violence survivors. She has participated in and managed numerous research and evaluation projects and conducted professional training for multi-disciplinary professionals who respond to sexual assault, domestic violence, and child abuse. As an Adjunct Professor in Social Work at Catholic University she developed and taught a graduate course on Family Violence Across the Lifespan.

**Nancy Lee, MD**

**Deputy Assistant Secretary for Health, Women’s Health, Office on Women’s Health, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services**

Dr. Nancy C. Lee is the Deputy Assistant Secretary of Women’s Health, and Director, of the Office on Women’s Health at the Department of Health and Human Services, a position she has held since April 2011. For most of her career, she was employed at the CDC where her research and public health efforts focused on cancer screening, the epidemiology of reproductive system cancers, safety of contraceptive methods, and HIV infection among American women. She has extensive experience in women’s health, cancer prevention and control, and surveillance systems and has published over 95 articles in scientific journals. Dr. Lee has consulted with the National Cancer Institute, the Food and Drug Administration, the American Cancer Society, the Institute of Medicine, Planned Parenthood Federation of America, the World Health Organization, and the Agency for International Development. She participated in research projects in Africa, China, Central America, and Southeast Asia. From 1999-2004, she was Director of CDC’s Division of Cancer Prevention and Control, a division with more than 130 staff and an annual budget of \$280 million. She left that position in 2004 to work as a private consultant. Dr. Lee is board-certified in internal medicine. She has two children, Jesse and Chloe, who are navigating their college years with success.

**Elizabeth Miller, MD, PhD**

**Chief, Division of Adolescent Medicine, Children’s Hospital of Pittsburgh of UPMC, University of Pittsburgh School of Medicine**

Dr. Elizabeth Miller is Chief of Adolescent Medicine at Children’s Hospital Pittsburgh, the University of Pittsburgh Medical Center and Associate Professor in Pediatrics at the University of Pittsburgh, School of Medicine. Trained in medical anthropology as well as Internal Medicine and Pediatrics, Dr. Miller’s doctoral research focused on sex trafficking of adolescent females into Japan’s sex industry and HIV risk associated with gender-based violence. Her current community-partnered research examines the nexus of adolescent and women’s health with gender-based violence, with a focus on underserved youth populations including pregnant and parenting teens, foster, homeless, and gang-affiliated youth. Her research includes evaluations of community and clinic-based interventions to promote healthy relationships, prevent adolescent relationship abuse, and reduce health risks associated with partner violence and reproductive coercion.

**Connie Mitchell, MD, MPH**

**Chief, Policy Unit, Office of Health Equity, California Department of Public Health**

Dr. Connie Mitchell is board certified in Emergency Medicine with over 20 years of level 1 trauma hospital experience. Her academic focus for much of that time has been family violence and she has contributed to advances in health education, research and clinical practice changes in this field. While serving as faculty at the University of California Davis, she was the Director of Domestic Violence Education and under state contract she developed and delivered standardized professional education on domestic violence medical and forensic care to over 8,000 California health professionals. She has performed or supervised forensic exams on maltreated or sexually assaulted children, adults and elders and provided courtroom testimony regarding perpetrator and victim exam findings.

Dr. Mitchell wrote California's Clinical Guidelines for the Health Care of Intimate Partner Violence. She served as the Chair of California's State Leadership Team on Health and Domestic Violence that resulted in critical legislation and policy change to improve victim access to services. She is Editor-in-Chief of a major textbook, *Intimate Partner Violence: A Health-Based Perspective*, published by Oxford University Press which was recognized as the best textbook of 2010 by the American Medical Writers Association. She chaired the AMA National Advisory Council on Violence and Abuse representing the California Medical Association and is on the advisory board to the National Health Resource Center on Domestic Violence. She is consulting on a national web-based curriculum to educate health care practitioners on domestic violence screening and counseling interventions which are now required as part of preventive services in health care reform. In 2008, after completing a Master's Degree in Public Health, Dr. Mitchell wanted to have a more active role in prevention of violence. She now serves as Chief of the Policy Unit in the Office of Health Equity in the California Department of Public Health and oversees policies to promote the health and well-being of all Californians.

**Samia Dawud Noursi, PhD**

**Deputy Coordinator, Women and Sex/Gender Differences Research, National Institute on Drug Abuse, National Institutes of Health**

Dr. Samia Noursi is the Deputy Coordinator for the Women and Sex/Gender Differences Research Program at the National Institute on Drug Abuse (NIDA), National Institutes of Health (NIH). Dr. Noursi completed and received her Ph.D. in Applied Developmental Psychology from the University of Maryland in 1995 while holding a graduate study and pre-doctoral training award at the Section on Social and Emotional Development at the National Institute on Child Health and Human Development (NICHD). Upon graduation, Dr. Noursi was awarded an IRTA Post-Doctoral fellowship at NICHD during which she led a longitudinal study on the effects of domestic violence on children's development. Upon completion of her post-doctoral training, Dr. Noursi worked on several projects focused on children's development among them directing research for the National Child Welfare Resource Center on Legal and Judicial Issues at the American Bar Association Center on Children and the Law. In 2006, Dr. Noursi joined NIDA and is currently the Women and Sex/Gender Differences Research Deputy Coordinator and Health Scientist Administrator. At NIDA, together with the Coordinator, Dr. Noursi provides leadership for NIDA's Women and Sex/Gender Differences Research Program and co-chairs the NIDA Women and Sex/Gender Differences Research Group. Dr. Noursi is a member of several NIH and HHS committees among them the Coordinating Committee on Research on Women's Health, the HHS Women and Trauma Committee and is a Board Member of the National partnership to End Interpersonal Violence

(NPEIV). Dr. Noursi has presented numerous papers at national professional conferences and authored a number of articles in both peer-reviewed journals and books in three different languages (Arabic, Hebrew, and English).

**Lynn Rosenthal**

**White House Advisor on Violence against Women, The White House**

Lynn Rosenthal is the first-ever White House Advisor on Violence Against Women. She works with Vice President Biden and the White House Council on Women and Girls to coordinate efforts across federal agencies to address domestic violence and sexual assault. In 2010 President Obama announced unprecedented coordination across the federal government to address violence against women. Ms. Rosenthal staffs this effort and works with federal agencies to improve their response to domestic violence, dating violence, sexual assault, and stalking. From 2000-2006, Ms. Rosenthal served as the Executive Director of the National Network to End Domestic Violence (NNEDV) where she worked on the reauthorization of the Violence Against Women Act and assisted states and local communities with implementation of this groundbreaking federal legislation. She also worked closely with corporate partners to bring funding to local communities to respond to domestic violence. Ms. Rosenthal has been widely recognized for her efforts to address domestic violence at the national, state and local levels. She has been a shelter director and leader of state domestic violence coalitions in Florida and New Mexico. In 2006, she was the first recipient of the Sheila Wellstone Institute National Advocacy Award.

**Phyllis W. Sharps, PhD, RN, FAAN**

**Associate Dean for Community and Global Programs, Johns Hopkins University School of Nursing**

Dr. Phyllis W. Sharps is the Associate Dean for Community and Global Programs and Professor at the Johns Hopkins University School of Nursing, with a joint appointment in the Johns Hopkins Bloomberg School of Public Health. She is a maternal child health clinical nurse specialist, a researcher, and a mentor to the next generations of nurses local to global. She is also the director of the School of Nursing's three health and wellness centers, and provides care in a Baltimore shelter for homeless battered women and their children, and conducts community - based research. The overarching focus of her work is on the effects of intimate partner violence on the physical and emotional health of pregnant women, infants, and very young children. Currently implementing a second \$4 million grant from the National Institutes of Health, Dr. Sharps is testing the use of computer tablets for screening and implementing the Domestic Violence Enhanced Visitation Program (DOVE), a promising intervention to keep abused women and babies safe from intimate partner violence. She is an active participant in the Sigma Theta Tau, the American Public Health Association, the Nursing Research Consortium on Violence & Abuse, and the Nursing on Network on Violence & Abuse International. She is a Fellow in the American Academy of Nursing and was a 2013 inductee into Sigma Theta Tau International Nurse Researcher Hall of Fame.

**Gloria Aguilera Terry, BBA**  
**Chief Executive Officer, Texas Council on Family Violence**

Gloria Aguilera Terry joined the Texas Council on Family Violence 2008. In her role as CEO, Gloria guides and directs the statewide activities of TCFV, such as the Texas Legislative Session, establishing and fostering tactical partnerships, provide outstanding services to programs and strategically positioning TCFV to create the influence necessary to continue serving the needs of victims and their families.

Ms. Terry came to the Texas Council from El Paso, Texas where she served as Executive Director of the Center against Family Violence (CAFV), a significant border community domestic violence program with a 100 bed shelter, robust non-residential program and a Battering Intervention & Prevention program. Major accomplishments at CAFV, include positioning the Center as Organizing Agency for a \$5 million health prevention initiative, strengthened and prioritized education and workforce development initiatives and obtaining the agency's first transitional living center.

Ms. Terry holds a BBA from the UT El Paso and offers time to the Judicial Commission for Children, Youth and Families with the Texas Supreme Court, VAWA Planning Committee with the Governor's Office, Diversity Committee of the National Council of Juvenile and Family Court Judges, and current Board member of the National Network to End Domestic Violence.

**Amina White, MD, MA**  
**Assistant Professor/Bioethics Fellow, Howard University College of Medicine in the Department of Obstetrics and Gynecology/ NIH Clinical Center Department of Bioethics**

Dr. Amina White is an obstetrician and gynecologist who completed her undergraduate education at Yale University, obtained her medical degree from Harvard Medical School, and completed her OB/GYN residency training at Georgetown University Hospital prior to becoming a faculty member of the Howard University College of Medicine in the Department of Obstetrics and Gynecology since 2008. Her experiences with ethical dilemmas in patient care led her to pursue formal training in ethics while maintaining her clinical practice, and in the spring of 2013 she obtained a Master's Degree in Liberal Studies with a concentration in Ethics and the Professions from Georgetown University. She also serves as Associate Editor in Bioethics for MedEdPORTAL, an online peer-reviewed publication service of the Association of American Medical Colleges that provides access to medical school and residency teaching materials in the areas of bioethics and medical ethics. Currently, she is completing a bioethics fellowship at the NIH where she is focusing on issues related to medical professionalism and ethical challenges that physicians face when caring for vulnerable patient populations, particularly trauma survivors in pregnancy.

## Appendix D: List of Attendees

**Sara Afayee, MSW**

Public Health Advisor  
Substance Abuse and Mental  
Health Services Administration  
sara.afayee@samhsa.hhs.gov

**Chizara Ahuama-Jonas**

Graduate Student  
University of Cincinnati  
ahuamacu@mail.uc.edu

**Sharon Amatetti, MPH**

Women's Issue Coordinator  
Substance Abuse and Mental  
Health Services Administration  
sharon.amatetti@samhsa.hhs.gov

**Deirdre Anglin, MD, MPH**

Professor of Emergency Medicine  
Keck School of Medicine of USC  
anglin@usc.edu

**Carolyn Aoyama, CNM, MPH**

Senior Consultant for Women's  
Health  
Indian Health Service  
carolyn.aoyama@ihs.gov

**Shavon Artis, DrPH, MPH**

Public Health Analyst  
National Institute of Child Health  
and Development  
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**Frances Ashe-Goins, RN, MPH**

Associate Director  
Office on Women's Health  
US Department of Health and  
Human Services  
frances.ashegoins@hhs.gov

**Jane Atkinson, DDS**

Director, Center for Clinical  
Research  
National Institute of Dental and  
Craniofacial Research  
National Institutes of Health  
jatkinso@mail.nih.gov

**Bernard Auchter, MSW**

Consultant  
Retired - National Institute of  
Justice  
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**Loraine Bacchus, PhD**

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**Megan Bair-Merritt, MD**

Associate Professor of Pediatrics  
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**Laura Bartlett**

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**Andrea Baruchin, PhD**

Senior Advisor to the President  
Foundation for the National  
Institutes of Health  
abaruchin@fnih.org

**Tamara Bavendam, MD**

Senior Scientific Officer  
National Institute of Diabetes and  
Digestive and Kidney Diseases  
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**Lisa Begg, DrPH, RN**

Director of Research Programs  
National Institutes of Health, Office  
of Director  
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**Megan Bell**

Genetic counseling student  
National Human Genome Research  
Institute  
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**Audrey Bergin**

Program Manager  
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**Dara Blachman-Demner, PhD**

Social Science Analyst  
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**Mary Blake, CRE**

Public Health Advisor  
Center for Mental Health Services  
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Health Services Administration  
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**Diane Bohn, PhD, RN, CNM**

Director, DVPI  
Cass Lake Indian Health Service  
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## Appendix E: Short Summary

**2013 Trans-HHS Intimate Partner Violence Screening and Counseling: Research Symposium Portal:**  
<http://whr.nlm.nih.gov/ipv-symposium.html>

The Coordinating Committee on Women's Health represents Health and Human Services (HHS) agencies and offices throughout the Department. It has identified the prevention and intervention of domestic/intimate partner violence (IPV) as a priority focus for its cross-federal work. There is a critical need for guidelines for health practitioners to effectively screen patients for IPV and provide appropriate counseling, and HHS convened a research symposium at the National Institutes of Health (NIH) on Monday December 9, 2013 to discuss it. The purpose of the Symposium was to identify gaps in research in screening and counseling for IPV in primary health care settings and to shape priorities in the national research agenda moving forward. Ultimately, the Department's goal is to promote effective strategies for health care practitioners for screening and counseling.

The specific areas covered during the symposium were:

- Culturally-competent, comprehensive screening and counseling practices
- Barriers to screening for IPV
- Past and ongoing experiences of trauma
- The intersection of IPV and substance abuse
- Integrating screening into clinical settings
- The effects of screening and counseling on health, safety, and outcomes related to social and emotional well-being

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## Appendix F: Possible Intervention Algorithm

