NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

24-01

STATEMENT OF POLICY

Intimate Partner Violence Prevention[a]

Policy:

The National Association of County and City Health Officials (NACCHO) supports national, state, and local public health approaches which promotes collaborative relationships amongst community partners to provide safety to those experiencing intimate partner violence (IPV), coordinate access to treatment and services for those who experience and perpetrate IPV and educate communities of healthy relationship attributes.

NACCHO recommends the following evidence-based strategies to address IPV prevention:

Prevention, Intervention, and Education:

- Advocate and provide enhanced survivor-centered services, including short- and long-term shelters, crisis intervention, economic support, counseling, and other community resources to improve outcomes and overall well-being of people experiencing IPV.[1]
- Educate and raise awareness of IPV as a preventable public health issue.[2,3]
- Promote social norms that protect against IPV by mobilizing and teaching boys and men about IPV and what they can do to prevent it.[1,2,3]
- Engage influential adults and peers through family-based programs and bystander empowerment and education.[3]
- Implement prevention strategies which address risk and protective factors for IPV, while understanding systemic inequities that contribute to increased IPV risk.[1]
- Disrupt the developmental pathways toward partner violence using strategies such as early childhood home visitation, preschool enrichment with family engagement, parenting skill and family relationship programs, and treatment for at-risk children, youth, and families.[3]
- Teach skills to adolescents to prevent IPV, including empathy and social-emotional learning, healthy dating and intimacy courses, and empowerment trainings.[1,2,3]

[a] This policy statement addresses what the Centers for Disease Control and Prevention defines as intimate partner violence, which includes physical violence, sexual violence, psychological aggression (including coercive tactics), and stalking by a former or intimate partner.

- Provide opportunities to empower those at a higher risk for IPV (e.g., LGBTQ+ community, children who have been exposed to IPV, women and girls) through financial literacy courses, career planning and counseling, and leadership opportunities.[1,b]

- Create protective environments through monitoring community-level risk, implementing safe workplace policies, and creating safe spaces at schools.[1,2,3]
- Promote trauma-informed screening within healthcare settings, including stalking screenings, strangulation screenings, abuse assessment screenings, and danger assessments.[1]

Legal Protections:

- Address the systemic barriers which exist to filing a protective order and acknowledge these barriers may prevent someone from filing for a legal intervention or calling for law enforcement.[1]
- Support people experiencing IPV through the protective order process by explaining their options, helping them file, and navigating them through the protective order process.[1]
- Collaborate with local agencies to connect survivors with legal, public safety, housing, and other community resources while they await legal intervention.[1]
- Partner with law enforcement to implement risk assessments (i.e., *Lethality Assessment Program*, *Arizona Intimate Partner Risk Assessment Instrument System*) and ensure that they are able to use the assessment tool to screen for lethality when responding to an IPV call.[1,2,3]
- Advocate for supervised visitations and exchange for minors between a survivor and a non-custodial parent to mitigate violence and potential lethality.[1]
- Encourage policymakers to pass laws removing and restricting firearm ownership for people with a known (ex-parte or final) protective order against them.[4]

Housing and Other Basic Needs:

- Ensure availability of low-barrier short- and long-term housing options (emergency shelter, transitional housing, permanent housing etc.) to provide people experiencing IPV adequate shelter.[1,2]
- Reduce barriers to accessing safe and affordable housing through robust housing programs, such as the Domestic Violence Housing First Model.[5,6]
- Provide wraparound services to address immediate housing-related and basic needs such as security deposits, rental assistance, food, utility assistance, and transportation.[1,2,3]
- Ensure access and reduce barriers to affordable childcare for those who survived or are experiencing IPV.[7]

[b] Although IPV can impact all people regardless of gender, women and girls experience high gender inequality in employment, education, and income which is a risk factor for IPV. Therefore, it is important to focus on the financial literacy and security of women and girls to reduce the risk of IPV.

Community Partnerships:

- Commit to trauma-informed systems as demonstrated through policies, practices, language, and environments in local health departments and in partner organizations.[1]
- Create a coordinated community response to IPV by partnering and supporting IPV prevention and response programs like HRDVT (High Risk Domestic Violence Team), DV/IPV Fatality Reviews, Crime Victim Compensation Funds, or Rape Crisis Centers.[1,2,8,9,10]

Justification:

"Intimate partner" refers to spouses, dating partners, domestic partners, ongoing sexual partners, or former partners. IPV is often part of a pattern of behavior used by one partner to coerce, dominate, and control the other and can take place in person, online, or through technology.[11] These behaviors can include, but are not limited to physical violence, sexual violence, stalking, and physical aggression.[11] *Physical violence* can look like hurting or trying to hurt another person by kicking, hitting, or using another type of physical force, while *sexual violence* is forcing or attempting to force a partner to take place in a sexual act, sexual touching, or a non-physical sexual event when the partner does not or cannot consent.[11] *Stalking* is a pattern of repeated, unwanted attention and contact by a person who causes fear or concern, and *psychological aggression* is the verbal and non-verbal communication with the intent to harm a partner mentally or emotionally and/or to exert control over a partner.[11] IPV is not exclusive to adult relationships. Violence in an adolescent relationship, or teen dating violence (TDV), is a form of IPV which impacts young people.[12] In fact, 25% of women and 20% of men who experience IPV in the United States (U.S.) reported their first IPV incident when they were under 18 years old.[13]

- IPV is common and affects millions of people per year. In fact, data indicates that: In total, 41% of women and 26% of men report having experienced *sexual violence, physical violence or stalking* by an intimate partner in their lifetime.[13]
- Every year, more than 12 million adults in the U.S. experience *physical assault* from an intimate partner.[14]
- According to the Centers for Disease Control and Prevention (CDC), 1 in 3 women and 1 in 4 men report having experienced *physical violence* from an intimate partner in their lifetime,[11] and 6.2 million U.S. adults experience *sexual violence* committed by an intimate partner each year.[13]
- More than 61 million women and 53 million men have-experienced *psychological aggression* (the use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally and/or to exert control over another person) in their lifetime.[3,11]
- U.S. crime reports suggest that 1 in 5 homicide victims are killed by an intimate partner, with over half of female homicide victims killed by a *current* or former male intimate partner.[11]

Many racial/ethnic and sexual minority groups as well as people with physical and mental health impairments are disproportionately affected by IPV. For example:

- Data from the 2017 National Intimate Partner and Sexual Violence Survey (NISVS) indicate the lifetime prevalence of experiencing contact sexual violence, physical violence, or stalking by an intimate partner is 57% among multi-racial women, 48% among American Indian/Alaska Native women, 45% among non-Hispanic Black women, 34% among Hispanic women, and 18% among Asian-Pacific Islander women compared to 30% among non-Hispanic White men and 37% among non-Hispanic White women .[3]
- The lifetime prevalence of experiencing contact sexual violence, physical violence, or stalking by an intimate partner is 42% among multi-racial men, 41% among American Indian/Alaska Native men, 40% among non-Hispanic Black men, 30% among Hispanic men, and 14% among Asian-Pacific Islander men.[3]
- The LGBTQIA+ community is disproportionately affected by IPV, with approximately 61% of bisexual women, 37% of bisexual men, 44% of lesbian women, and 26% of gay men having experienced rape, physical violence, and/or stalking from an intimate partner in their lifetimes in comparison to 35% of heterosexual women and 29% of heterosexual men.[3]
- Lastly, 4.3% of people with physical health impairments and 6.5% of people with mental health impairments reported IPV victimization in the past year, with studies showing people with a disability have nearly double the lifetime risk of IPV victimization.[3]

IPV profoundly impacts the quality of life for individuals, families, and communities. In addition to physical injuries, posttraumatic stress disorder (PTSD) symptoms, concern for safety, fear, needing help from law enforcement, and missing at least one day of work are common impacts reported.[11] Not only is IPV associated with a variety of negative physical and mental health outcomes, but survivors are at higher risk for engaging in behaviors such as smoking, binge drinking, and sexual risk activity.[11] The toll of IPV also has immense quantifiable, economic costs. Direct costs of medical and social services, productivity loss, law enforcement, adjudication, and incarceration are estimated at between $5.8-12.6 billion annually in the U.S.[14,15]

Persons with certain individual, relational, community, and societal risk factors are more likely to become perpetrators of IPV. Individual level factors that may contribute to perpetration of violence include low self-esteem; economic stress; emotional dependence; desire for power or control in relationships; attitudes accepting or justifying violence and aggression; mental health challenges such as depression and suicide attempts; and substance use.[16] People living in communities with high rates of poverty, unemployment, and violence or crime, as well as limited educational or economic opportunities are at a higher risk of IPV.[16] These factors can create situations of socioeconomic distress, dissatisfaction, stress and rage, which increase the likelihood of IPV.[17] Societal factors also increase the likelihood of a person becoming a perpetrator of IPV or experiencing IPV, including gender inequality, income inequality, cultural norms which support aggression toward others, and weak health, educational, economic, and social policies and laws that reinforce inequality.[16]

Adverse childhood experiences (ACEs), such as a history or physical or emotional abuse in childhood, witnessing violence between parents as a child, and unhealthy family relationships and interactions, are risk factors for IPV.[18] Witnessing or experiencing violent events as a child has been hypothesized to lead to the intergenerational transfer of violence through imitating or tolerating similar behaviors in adult relationships. ACEs may also result in increased levels of impulsivity, depression, and anxiety which are also potential mediating factors linking ACEs and adult IPV.[19] It is important to note, however, while these multilevel factors contribute to risk, they are not direct causes.

Generational Trauma:

Children exposed to IPV are at increased risk of experiencing abuse and neglect, and are more likely to develop adverse health, behavioral, psychological, and social disorders later in life.[12] The health consequences from IPV on children can range from short-term outcomes, such as difficulty sleeping and engagement in risky behaviors, to long-term outcomes like depression and anxiety.[20] In addition, IPV has the capacity to create a cyclical effect for these children as they reach adulthood. Research shows that, in a heterosexual marriage where a father perpetrates IPV against a mother, male-identifying children are 10 times more likely to perpetrate IPV when they reach adulthood, and female-identifying children are six times more likely to experience sexual abuse in adulthood than children who grow up in a home without IPV.[21]

Protective Orders:

When filed and implemented correctly in conjunction with other interventions and supports, Protective Orders (POs) are an important tool to help keep IPV survivors safe from their perpetrators. However, the effectiveness of protective orders is moderated by state laws, police enforcement of protective orders, community trust in the legal process and law enforcement, and access to legal interventions by different populations. Otherwise known as "restraining orders," POs are court-mandated protections which people use to protect themselves from a perpetrator of violence; they allow judges to impose various interventions based on state law and whether the PO is ex parte or final.[3] POs are meant to help keep people experiencing IPV safe by limiting or prohibiting contact between the person experiencing IPV and his/her/their perpetrator.[3] POs also provide law enforcement with a means to arrest and charge a perpetrator who continues to contact the person experiencing IPV and therefore violate their PO.[22] Depending on the state, final POs may also award people experiencing IPV full custody of any children they may share with perpetrators and/or require perpetrators to move out of shared homes.[22]

In terms of their effectiveness, the evidence for POs is mixed. According to one study, people who received permanent (final) POs (PPOs) were 80% less likely to experience physical abuse compared to those who did not receive a PPO.[23,24] People with PPOs also reported a significant increase in feelings of well-being, and overall reported feeling safer with their protective order.[25] Risk for sexual assault decreased by 70% for people who filed a PO after the first IPV incident.[26] Additionally, at the population level, studies suggest that people living in states with more "aggressive" PO laws, such as those that extend to people not living together were less likely to experience IPV.[27,28] Although evidence suggests that POs have some secondary prevention benefits, having a PO does not automatically ensure protection. Some studies suggest that on average 40-50% of POs are violated by perpetrators.[2] This violation of POs may be exacerbated

by lack of meaningful enforcement from law enforcement officers or lack of perceived punishment for breaking POs.[29,30] Additionally, while final POs include firearm prohibition for the guilty party, ex parte or temporary POs do not prohibit perpetrators from buying or owning firearms.[31,32] This legislative loophole combined with varied enforcement of perpetrator firearm dispossession leaves victims vulnerable to further harm from their perpetrator.[32] This type of violence, due to inability or lack of enforcement of protective orders, is all too common and can result in negative outcomes, such as continued or increased domestic violence and homicide.

Strangulation:

Strangulation is one of the most lethal forms of IPV and is a unique predictor for homicide associated with IPV.[34] In the U.S. alone, nearly 11.6 million women have reported being strangled at some point in time by an intimate partner.[11] People who have been strangled by an intimate partner are more likely to be murdered in the subsequent weeks following the attack, and it is believed that up to half of people who have experienced physical violence have been strangled at least once.[35,36] Since most of the consequences of strangulation are non-visible, it is crucial to screen patients for strangulation and other IPV-related incidents to provide the most effective care.[36] Strangulation screenings, action planning, and follow-up from healthcare professionals have the potential to decrease risk by half due to professionals' abilities to communicate with and advocate for people in their care.[36,37]

Firearms and IPV:

The presence of a firearm in a relationship where IPV is involved increases the risk of lethality, particularly for women. The presence of a gun in a house where there is a heterosexual, abusive relationship makes a woman six times more likely to be killed.[40,41] According to the CDC, about 70 women are killed nationally each month by an intimate partner through use of a firearm.[42] Abusive partners with access to firearms also pose a risk to corollary victims, including law enforcement officers, children, neighbors, and anyone else who might intervene to stop the abuse.[43,44,45] From 2009 to 2021, there were 255 mass shootings, of which about 28% of those shootings were carried out by perpetrator with a known history of domestic and/or IPV.[46] In 79% of the mass shootings where the shooter had a history of DV/IPV, the shooter killed an intimate partner or family member.[46] The intersection between firearms and IPV disproportionately affects Native American and Alaska Native women, Black women, and Latinx women.[40] In addition, although there is little data reporting on this topic, the LGBTQIA+ community and people with disabilities are particularly at risk of experiencing severe forms of abuse.[42,47,48]

The harm caused by firearms in the context of IPV is not limited to homicide. Firearms also cause nonlethal injuries, are used to threaten survivors, and are a means of maintaining power and control.[49] An estimated one million women in the U.S. have been shot at by an intimate partner and around 4.5 million have been threatened with a firearm by an intimate partner.[50] Threats with a firearm and even fear of threats with a firearm are significantly associated with PTSD.[51]

Evidence-based policies to prevent firearms from getting into the hands of people who might use them to cause harm are important for preventing injury and violence at the intersection of firearms and IPV. Examples of such approaches include: state-level policy preventing firearm access by people who are at high risk of using a firearm for harm, defining people and situations that are considered high-risk of firearm injury, and effective power to prevent people from

obtaining firearms if they are restricted from having one.[4] For these laws to be enacted, it is important to other systems such as those responsible for effective enforcement of dispossession of firearms and infrastructure to enable such restrictions.[4]

Safe Housing:

Research demonstrates a strong correlation between housing instability and IPV.[54,55,56] When an IPV survivor leaves the home he/she/they shared with a perpetrator without financial means, the perpetrator can refuse to continue to contribute to their household, prevent the survivor from paying their bills, make choices that cause the survivor's credit score to decrease, and/or stalk the survivor to prevent them from feeling safe in a home.[57] These factors, in combination with the decreasing number of affordable housing options in the U.S., lead to high rates of homelessness among IPV survivors.[57] Domestic violence agencies have focused efforts on finding safe housing options for IPV survivors;[57] however, it is vital for coalitions centered on IPV prevention to consider community-based, homelessness prevention strategies and initiatives to enhance IPV survivors' housing stability.

Role of Local Health Departments:

IPV prevention is an important matter of public health and safety as it has a profound impact on lifelong health, opportunity, and well-being. The goal of prevention efforts should be to reduce rates of IPV by promoting healthy, respectful, nonviolent relationships.[1] This can be accomplished through programs and education addressing risk and protective factors at the individual, relationship, community, and societal levels.[1] The majority of IPV work and Violence Against Women Act (VAWA) funding has been reactive, focused on intervention after IPV has been identified, such as resources are directed to law enforcement, judicial, and carceral interventions, which has had limited success.[58] The development of more prevention strategies at the local level is essential to addressing the rising rates of IPV in the U.S. IPV prevention can be approached from four different but complementary perspectives. Overall, strategies may seek to 1) provide treatment to survivors, 2) change violent and abusive behavior, 3) educate individuals about behaviors that are indicative of abuse, and/or 4) change the more broadly-based conditions which support and enable IPV. Examples of prevention strategies include healthy relationship programs for couples, bystander empowerment and education, parenting skill and family relationship programs, improving school or workplace climate and safety, strengthening household financial security, and treatment and support for survivors of IPV.[1]

It is vital to recognize signs of IPV as early as possible, including among children who may be witnessing IPV in their homes. Pediatricians have an opportunity to identify signs of abuse in the home, evaluate children who are exposed to IPV, and address it by connecting them with mental health and other wraparound services in the community.[59] LHDs can collaborate with healthcare systems to train pediatricians on how to recognize IPV in families, discuss the abuse with parents who are experiencing IPV, and create safety plans with them.[59] Furthermore, LHDs can collaborate with community partners in creating a referral-based system for these families to access community-based services and mental health treatment. Children who are exposed to IPV in their homes can be referred to community-based services that promote positive childhood experiences (PCEs) and resilience.[60,61] These systems of care can interrupt intergenerational trauma of IPV and family violence in addition to leveraging positive childhood experiences.

LHDs can work with the criminal-legal system, IPV advocate groups, local lawyers, and others to help people experiencing IPV file for POs. Although obtaining a PO is free in the U.S., the realities of obtaining a PO often prove difficult for people experiencing IPV. For instance, someone may not file for a PO due to fear of future harm from a perpetrator or worry that the perpetrator may increase violence after the PO.[62] Individuals may also not apply for a PO because they are worried about negative interactions with law enforcement, are concerned over judicial bias, and/or are uncertain about how to navigate the legal system.[63] Indeed, petitioners may also have disparate success in being granted POs based on whether they have legal representation, and/or the resources to afford transportation, child care, and missed work to attend what are often multiple hearings.[62] Additionally, communities of color, people who are disabled, and LGBTQ+ individuals may experience unique barriers to obtaining POs.[63] Specifically, members of these communities cite lack of tailored/focused resources and programs, fear of stigma and discrimination, and concerns about engaging with law enforcement and the judicial branch as barriers to obtaining a PO.[63,64]

In addition, LHDs can collaborate with law enforcement to highlight high risk cases of IPV. For instance, a taskforce can be created between local government agencies, law enforcement, educational institutions, healthcare systems, and community-based domestic violence agencies to create a resource network addressing IPV within their community.[65,66] In addition, the council can create a death review team that included representatives of law enforcement, prosecutor's office, and domestic violence service providers to review family violence deaths.[66]

To disrupt cycles of IPV in the community, LHDs can collaborate with healthcare systems within their community to implement "train the trainer" models to ensure health clinicians can learn how to assess patients for strangulation. For example, the San Diego CARES (Conduct, Assess, Report, Evaluate, Safety Plan) Initiative stemmed from a collaboration between the County of San Diego Health & Human Services Agency and the San Diego County District Attorney's Office.[67] This began with the San Diego Attorney's Office being among the first in the mid-1990's to study nonfatal strangulation cases in individuals who experienced or were experiencing intimate partner violence, which led to recommendations of making strangulation screening a regular practice.[68] The initiative teaches health clinicians to conduct strangulation screenings with patients who previously experienced or are currently experiencing IPV, assess for signs of strangulation, evaluate the patient through a forensic examiner, and help the patient to develop a safety plan.[67] The initiative also implemented a "train the trainer" model for health clinicians to train their colleagues and be champions of this effort.[67] Increasing the number of LHDs offering similar training models can make this a normal practice in a greater number of healthcare settings.[67]

LHDs can also advocate for firearm policies that have demonstrated a decreased risk of intimate partner homicide. States with specific laws that restrict access to firearms for respondents of domestic violence POs were associated with a 19% reduction in the risk of intimate partner homicides and a 25% reduction in the risk of intimate partner homicides by firearms.[52] This effect is limited to states that also enable enforcement of the prohibition of purchasing firearms with a database.[54] These states had 3 to 4 times fewer intimate partner homicides a year compared to states without access to a database, and it is estimated that the majority of the lives saved are women who would have been killed with firearms.[54] Similarly, states with provisions requiring relinquishment of firearms (possession prohibition) for protection order respondents were associated with a 9.7% lower rate of intimate partner homicide and a 14% lower rate of

intimate partner homicides by firearms compared to states without statutory language regarding possession prohibitions.[4]

Finally, LHDs can collaborate with community partners and IPV advocates to establish a network that prioritizes safe housing for those who have experienced or are currently experiencing IPV. Domestic Violence Housing First (DVHF) is an intervention model that was adapted from the Housing First model, which was designed to help people who are homeless to acquire permanent housing.[5] DVHF notates that IPV survivors may need time within a domestic violence shelter or transitional housing before obtaining their own housing.[6] The model encourages IPV advocates to center their approach on working proactively within their community to find housing and to support IPV survivors by mitigating risk factors that can impact their safety.[5] Although this model is still in the process of being evaluated for its effectiveness, preliminary studies have demonstrated its positive impact for IPV survivors and their housing stability.[5,69.70]

Due to IPV becoming an increasingly urgent public health issue, it is vital to consider local partnerships and programs that can be implemented to address it through primary, secondary, and tertiary prevention measures. LHDs have a unique opportunity to organize efforts to tackle the prevention of intimate partner violence, address how it impacts families through the life cycle, and promote healthy relationships.

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Record of Action

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