

HEALTH **eBULLETIN**

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**FUTURES
WITHOUT VIOLENCE**®



Social Determinants of Health Panel at the 2015 National Conference on Health and Domestic Violence

MESSAGE FROM DIRECTOR OF HEALTH

Here at the National Health Resource Center on Domestic Violence, we are still reveling in the immense amount of ground-breaking work featured by our colleagues at the 2015 **National Conference on Health and Domestic Violence** in Washington, DC. In this issue of the Health E-Bulletin, we are highlighting some of the latest research, policy innovation and promising practices that were presented at the National Conference.



First you will hear from one of the most innovative and exciting findings presented at the 2015 National Conference, the **IRIS Study**. This study examines the use of a computerized safety decision aid that empowers survivors of intimate partner violence to make decisions about their safety and situation based on their priorities. This tool, designed to complement professional advocacy services, is revolutionary—not just because it is easily translated into a handy app-based format. It provides an opportunity for survivors to make their own decisions about safety and utilize resources, making safety planning even more accessible and helping to put the power and control back, quite literally, into the hands of survivors.

Other innovations that promote survivor health and safety presented at the National Conference come from recent changes to federal health policy. Through the Affordable Care Act, survivors now have access to health insurance coverage in ways that they previously did not, without having to rely on their partners. These updates in health policy were critical to ensuring that “Obamacare” is safe and accessible for survivors. Because violence has such serious long-term effects on health, the implications of these changes are tremendous.

New systems policy was also a significant draw for Conference attendees. Examples of

policy and procedural change that go beyond routine screening for violence from the U.S. Veterans Affairs (VA) Administration serve as a picture of success for many health systems as they work to better respond to the needs of survivors. In research findings from a study on the VA, it is clear that the move towards patient-centered and trauma-informed care is something that survivors want from their providers and health systems.

Lastly, two brief reports highlight the necessity for the intersecting fields of violence prevention and health to focus attention on the violence experienced by adults and young people who are engaged in transactional and survival sex, or are being sexually exploited. As more research on these populations emerges, it is clear that their needs are not being met, and that often it is these unmet needs and specific vulnerabilities that put them at higher

risk for violence. A clear understanding of how individuals may become vulnerable to sexual exploitation and violence as well as possible community-based interventions are essential pieces for providers and anti-violence advocates hoping to address this issue; attendees of these Conference sessions left with more know-how of where to start.

These are just a few of the many innovative policies, programs, and research presented at the 2015 National Conference, but we feel they are exemplary of the many directions in which our field is expanding and developing. We cannot wait to see what future National Conferences have in store...look out for more information on the next National Conference on Health and Domestic Violence!

Lisa James, MA
**Director of Health
Futures Without Violence**



Vice President Joe Biden, speaking at the 2015 National Conference on Health and Domestic Violence

DEVELOPMENT OF A WEB-BASED, SAFETY DECISION AID FOR INTIMATE PARTNER VIOLENCE

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MAKING A DECISION ABOUT THE BEST OPTION FOR SAFETY MAY BE DIFFICULT FOR SURVIVORS OF INTIMATE PARTNER VIOLENCE (IPV).

Getting information on the options and the possible benefits and harms in the form of decision aids may help. Decision aids are designed to help people understand the options, consider the personal importance of possible benefits and harms, and participate in decision-making. For example, research conducted in health care settings suggests decision aids are effective in supporting informed decision-making by patients regarding screening and treatment options in a variety of situations (e.g. identification and management of chronic conditions, end-of-life choices). Decision aids provide information and help patients clarify personal values, and are intended to complement (not replace) professional services. Furthermore, decision aids have been shown to

reduce decisional conflict, which stems from feeling uninformed/unclear about personal priorities (or values) around a decision. Survivors often report feelings of decisional conflict when making decisions about their relationship and safety.

Survivors face complex safety decisions for self and family

Safety planning, a process that supports decision-making, is the cornerstone of interventions that prevent and reduce repeat IPV. Ideally, safety planning is individualized, with attention to survivor priorities for safety, relationship status, dangerousness of the relationship using risk assessment tools, and the availability of community resources. Safety planning is typically provided to survivors in formal programs such



as crisis services, advocacy, support groups, and individual counseling. However, women report that they are often unaware of IPV resources and services in their community and do not access formal services, representing missed opportunities to prevent IPV and its negative long-term health and social consequences.

Survivors access the internet for safety resources

Although abusive partners commonly isolate survivors, many have safe internet access (e.g. in home, workplace, family/friend) and actively search for IPV information and resources online. Given the reality that the majority of women experiencing IPV do not access formal domestic violence services, our team developed the first, to our knowledge, safety decision aid for IPV survivors to be accessed via a secure website. Additionally, our academic and community partners collaborated to conduct a longitudinal, randomized clinical trial to test the effectiveness of the safety decision aid compared to usual safety planning with a group of racially, ethnically, and sexual minority diverse IPV survivors in four states. Later in this article we briefly describe the Internet Resources for Intervention and Safety (IRIS) study.

Overview of the IRIS study

English or Spanish speaking adult women (18 years or older) in a currently abusive (e.g. psychological abuse and/or physical/sexual IPV) relationship with a male or female partner/ex-partner were recruited to participate in the IRIS study. Because women who experience more frequent and severe IPV are more likely to sustain serious injury and fear for their live, the current safety aid focuses on female survivors of IPV. We recruited women using web-based (e.g. Craigslist, listservs, Facebook) and community-based (e.g. health clinics, university campuses, cafes, programs serving women/adolescents) strategies in four states (Arizona, Maryland, Missouri and Oregon). To be eligible for this study, women needed to report to study staff that they had safe access to and comfort with using a computer with internet connection and had or could create a safe email address to receive study related information. Seven hundred and twenty (n=720; 180 women from each state) survivors enrolled in the study and 94% completed all four interviews, which were conducted at the start of the study and then at three, six, and twelve months during the intervention. For more details on the IRIS study protocol see ClinicalTrials.gov identifier **#NCT01312103**. <https://clinicaltrials.gov>



Internet-based safety decision aid

Women randomly selected to be in the intervention group completed the three main components of the safety decision aid when they accessed the secure, password-protected study website. The components are:

1. Safety priority-setting activity with immediate feedback;
2. Danger Assessment (DA) with immediate feedback;
3. Safety Action Plan with recommended safety strategies and resource information tailored to a woman's responses to the first two components and her previous use of safety and protective strategies.

The three components are detailed below:

Priority-Setting Activity

The safety decision aid asks the user to set priorities among five competing factors that are important drivers of women's safety decisions that were identified through literature review and validated with domestic violence advocates, survivors, and experts in IPV. The five factors to be considered are:



- » **Having resources:** *employment, housing, health insurance, legal advice, and safe childcare*
- » **Keeping my privacy:** *keeping relationship issues private from family, friends, work, and/or community resources*
- » **My feelings for my partner:** *feelings of love and concern for partner*
- » **My concern for safety:** *physical, emotional and spiritual safety for the survivor*
- » **My child's well being (for those with children living in the home):** *concern for custody of children, and for children's physical, emotional, spiritual safety and well-being*

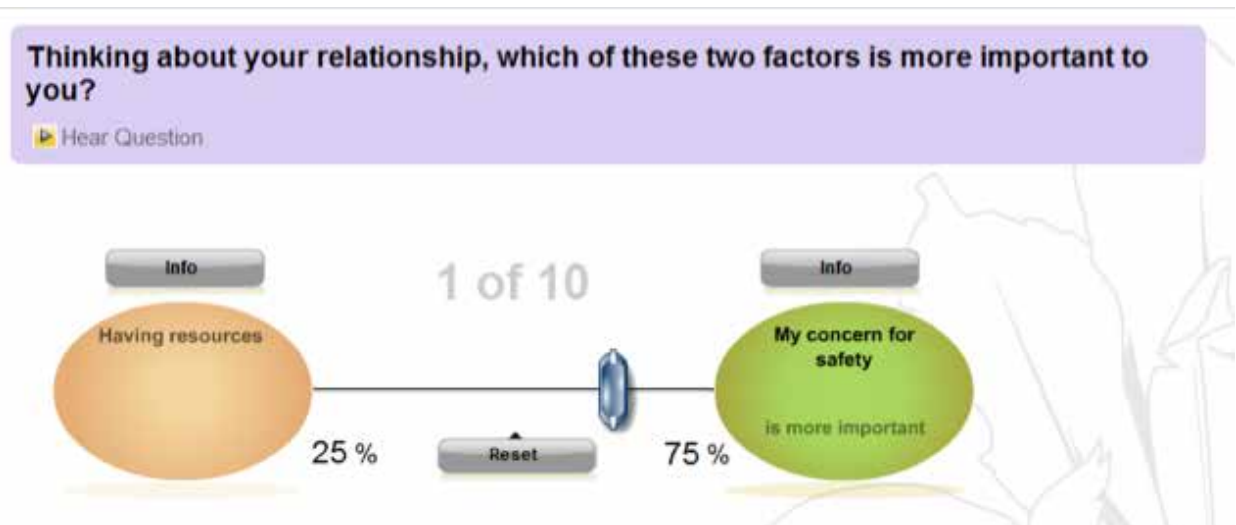
SAFETY DECISION MODEL

Figure 1



PRIORITY SETTING ACTIVITY

Figure 2



Users compare the factors for relative importance to their own safety using a sliding bar. For example, a user might compare importance of, "Having resources" against "My concern for safety." In Figure 1, the sliding bar is pushed by the user toward "My concern for safety" (75%), suggesting that for her, this factor is three times more important than having resources (e.g., home, insurance, childcare). At the end of the priority setting activity, users receive immediate feedback about their safety priorities (see Figure 2), and can review and make changes to their priorities if they desire.

FEEDBACK ON SAFETY PRIORITIES

Figure 3



The Danger Assessment

To help survivors understand their risk for severe repeat or lethal violence, they have a choice of completing either the Danger Assessment (DA) or the DA-Revised (DA-R; for women abused by a female partner). The DA and DA-2 can be accessed at www.dangerassessment.org. Both the DA and DA-R include questions to assess: the severity and frequency of violence, controlling behavior, jealousy, threats to kill, forced sex, and other risk factors associated with severe/lethal violence in abusive relationships. Once the survivor completes the DA or DA-R questions, a score along with a level of danger (e.g. "variable danger" to "extreme danger") is shown graphically (see Figure 3), along with an interpretation of the score with safety messages about the level of danger and the importance of seeking support/resources. Users complete the priority setting activity before completing the DA/DA-R. After seeing their DA/DA-R score, they have the option to return to reset their safety priorities. For example, if a survivor's danger level is higher than expected, she might want to make changes in her safety priorities.

Safety Action Plan

Based on a user's input (e.g. safety priorities, DA/DA-R score, relationship status), an individualized action plan for both the survivor and her children (if appropriate) is provided.

The action plan includes recommended safety strategies linked to resources in their local community (based on their state and county of residence). The survivor can select among the recommended strategies and depending on her selections, she is provided with resources/services such as local domestic violence shelters, legal services, affordable housing, employment and education information, drug and alcohol treatment, child custody resources, child health, batterer intervention programs, and/or health and welfare services. In addition, if available, websites and phone/chat contacts are provided for each resource and service (local, state and national) to facilitate easy and immediate access by the survivor. Prior to completing the safety decision aid, the user is given the option to print a copy of her safety priorities, DA/DA-R score and level of danger with safety messages, and the individualized action plan if she determines it is safe to keep a copy, and/or she can access the safety decision aid 24/7 on the secure website using the password-protected login.

Promising findings from the IRIS study

A diverse group of female survivors participated in the study, with 45% of women self-identifying as African America/Black, Hispanic/Latina, or multi-racial. More than one out of ten (11%) study participants identified their abusive partner as female. The IRIS study contributes to the existing evidence on safety for survivors by





demonstrating that decisional conflict declined significantly for abused women after using the individualized, internet-based safety decision aid compared to the control group who accessed usual safety planning information online. Our findings suggest that the web-based safe decision aid supports the decision-making process of IPV survivors with no adverse events. This represents an important and promising innovation to connect survivors – who may not access safety planning through formal services – with the information and resources they need to assess their level of danger, establish priorities, and develop a safety plan tailored to their needs. More details on these findings are published elsewhere¹ and manuscripts on the main study outcomes are forthcoming. Colleagues in New Zealand, Australia and Canada have further adapted the safety decision aid for their context and are currently testing with women experiencing IPV.

The way forward

The findings from the IRIS study and the continued advances in smartphone technology have led the team to further develop and adapt the safety decision aid to reach abused women in clinical and community settings. For example, our team developed the MyPlan App in partnership with the One Love Foundation (www.joinonelove.org) for college women in abusive dating relationships. Young women are weighing multiple factors, including health, academic success, economics, and social/support/stigma, during decision-making about an abusive dating relationship. Rather than access formal systems for help on campus, abused college women most often turn to informal support networks, specifically friends, who often lack the knowledge or resources to provide effective support. Innovative strategies are needed to educate, engage and support friends of IPV survivors. Therefore, we are currently evaluating the effectiveness of the adapted interactive, personalized smart phone and web based MyPlan App with college-aged women who experience IPV and male and female friends of women experiencing IPV. We continue to collaborate to adapt and disseminate the MyPlan app with the goal of increasing survivors' safety, and ultimately preventing further IPV.

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THE AFFORDABLE CARE ACT & SURVIVORS OF DOMESTIC VIOLENCE

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THE AFFORDABLE CARE ACT (ACA) OFFERS AN UNPRECEDENTED OPPORTUNITY FOR SURVIVORS OF DOMESTIC VIOLENCE TO PURCHASE AFFORDABLE, HIGH-QUALITY HEALTH INSURANCE. The following article describes several of the mechanisms in place to help survivors of domestic violence purchase and use affordable health insurance that includes coverage of the comprehensive benefits needed to heal and thrive.

The ACA includes many important health insurance market changes that improve coverage and care for survivors. For example, insurance companies can no longer cancel a policy after the subscriber becomes sick. They can no longer put lifetime limits on the dollar amount of coverage. The ACA also eliminated the ability to deny coverage (or charge more for) certain pre-existing conditions including pregnancy, being of child-bearing age, and domestic violence. Young adults can now remain on their parents'

insurance until they are 26 years old. Health plans are required to provide coverage of a guaranteed benefits package that includes comprehensive medical and surgical services; expanded coverage of behavioral and mental health services and coverage of a wide range of preventive health services **including screening and brief counseling for domestic and interpersonal violence.**

Preventive health services

Health plans must cover screening and brief counseling for lifetime exposure to domestic and interpersonal violence as a core women's preventive health benefit. This benefit, available only to women, is available to most women in the country who have health insurance through their employer, through the Marketplace, or through Medicaid. It is important to note that this is not a screening requirement—



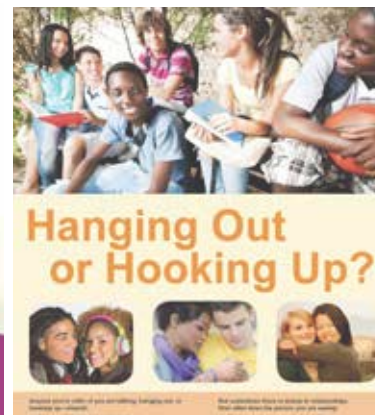
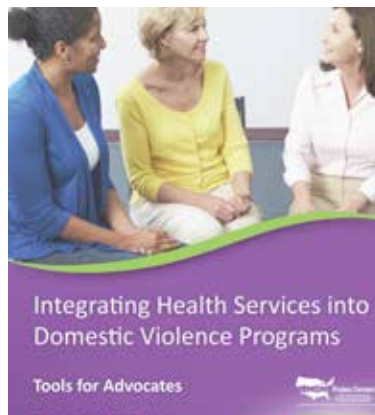
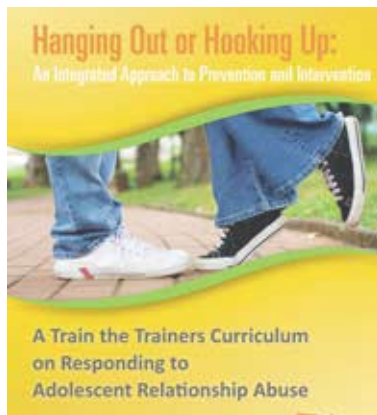
no medical provider is required to conduct a screening or provide counseling. This is a coverage requirement; insurance plans must reimburse providers who provide the service.

Each insurance plan defines what the actual benefit looks like for their plan subscribers. There may be wide variation between plans—and across states—in what plans cover. At a minimum, screening for domestic violence “may consist of a few, brief, open-ended questions” and counseling should provide basic information, referrals, tools, and safety plans. It is recommended that all women’s preventive health screenings take place during the annual “well woman visit.” But according to federal regulations, the benefit is

not restricted to once a year, and it is not limited to the well woman visit as the only setting. Futures Without Violence National Health Resource Center on Domestic Violence has many resources about how to conduct effective screening and brief counseling for domestic and sexual violence.

Impact on domestic violence and sexual assault advocacy programs

Domestic violence and sexual assault (DV/SA) programs need to be aware of this provision for many reasons. This new screening reimbursement requirement has the potential to reach more women with prevention and



www.HealthCaresAboutIPV.org

Online toolkit for intimate partner violence screening and counseling

- Information on clinical assessment, intervention and universal education
- Setting-specific tools
- Sample MOUs
- Tools for advocates
- News and policy updates

The Health Cares About IPV Online Toolkit is a project of the National Health Resource Center on Domestic Violence.



intervention messages. Over time, DV/SA programs may see an increase in referrals. These programs could benefit by developing new partnerships with providers so that the providers know where to do referrals if a patient discloses. These providers may need training on appropriate screenings and interventions and DV/SA programs should be prepared for increased training requests. It is important to acknowledge that there may be unintended consequences from the screening (e.g., poorly trained providers or reporting requirements and/or privacy concerns may put some women at risk for retaliation). Plans should work with local domestic violence programs or the National Health Resource Center on Domestic Violence for technical assistance to avoid these unintended consequences.

DV/SA programs should look for opportunities to partner with providers and better understand this screening and brief counseling reimbursement requirement and how it is being implemented locally. In time, it may result in a new and sustainable funding stream for DV/SA programs if they can partner with providers on a regular basis.

Access to health care

The ACA makes getting health insurance easier for survivors of domestic violence. Many survivors may be eligible for Medicaid coverage. Medicaid is a comprehensive health insurance plan that covers millions of women, children and families. Coverage varies dramatically by state but is based on the individual's income.

The ACA also created the health insurance marketplace. Survivors who need to purchase health insurance can go to the marketplace and compare the health plans available in their area. Significant financial help is available to make coverage affordable. Financial help is available

on a sliding scale based on income and the application is available online. There is specific special relief for some survivors of DV who want to buy coverage at the marketplace. The following guidelines apply to states that use [HealthCare.gov](https://www.healthcare.gov). Some individual state marketplaces have also adopted these policies.

Survivors of DV are eligible to enroll in coverage through [HealthCare.gov](https://www.healthcare.gov) at any point in the year. This is called a Special Enrollment Period (SEP) and they do not need to wait for Open Enrollment. To be granted this opportunity to enroll, a survivor must call the Marketplace Call Center and ask for a SEP (they must call the Call Center and should not begin an application online). When calling, the survivor must verbally identify themselves as a “survivor of domestic violence” in order to trigger the SEP in the Call Center system. No documentation is needed to prove DV. This SEP is available to both men and women who qualify.

There is also a special provision that allows domestic violence survivors to apply for financial help in the marketplace for coverage on their own—and be found eligible for financial help based on their own income (not tied to spouse’s income). The [HealthCare.gov](https://www.healthcare.gov) application requires married couples to

report both incomes for financial assistance determinations—even if the applicant has no access to the spouse’s income. Relief from this is provided to legally married survivors who are living separately from their spouse and file taxes separately. This relief is available to both men and women who otherwise qualify. Native American survivors may use this relief at any point during the year that they apply for coverage. No documentation is needed to prove DV but if a survivor uses this relief they must attest to it on the subsequent year’s tax forms.

To access this relief, married survivors who meet the criteria should mark “unmarried” on their marketplace application. The IRS and HHS both put out this guidance; this is their formal recommendation for the marketplace application.

It is important to note that there is a significant tax penalty for being uninsured. This is to encourage all people to have health insurance—and the financial help puts coverage in reach for most people. Health insurance is critical for survivors of DV so that they can access needed medical and behavioral health services. There will be some survivors who may remain uninsured—health insurance may be out of reach for a variety of reasons. Individuals



who experience DV who are uninsured are eligible for a waiver—called a “hardship exemption”—from the tax penalty. The application for the hardship exemption can be found on HealthCare.gov or your state’s marketplace website. No documentation is needed to prove DV and the form is filed with annual tax filings (or in advance).

These important changes put critical health care coverage and care within reach for survivors and open the door to getting the comprehensive medical and behavioral health services needed to heal and thrive. The National Health Resource Center on Domestic Violence has additional information and resources on the ACA, what it means for women, and how to apply for Marketplace coverage. For more information, visit the National Health Resource Center on Domestic Violence’s online toolkit at www.HealthCaresAboutIPV.org.

RESEARCH TO ENHANCE PATIENT-CENTERED CARE FOR INTIMATE PARTNER VIOLENCE IN THE VETERANS HEALTH ADMINISTRATION

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THE GROWING POPULATION OF FEMALE MILITARY VETERANS FACES PARTICULAR RISKS OF LIFETIME EXPERIENCE OF INTIMATE PARTNER VIOLENCE (IPV) AND TRAUMA-RELATED IMPACTS.¹ Consistent with recommendations from the Institute of Medicine and the U.S. Preventive Services Task Force, and emerging practices in healthcare systems, the United States Veterans Health Administration (VHA) recently established a national program to address IPV among patients, including routine screening for past-year IPV. In preparation for implementation of this program, we conducted a series of research

studies, funded by the U.S. Department of Veterans Affairs, Health Services Research and Development, to generate knowledge about, and recommendations for implementation of patient-centered IPV screening and response procedures at the VHA. These studies have included medical records reviews, interviews, focus groups, and surveys with female VHA patients. The findings, though based on research with VHA patients and within VHA settings, are likely applicable to other health care settings and to clinical care for both veteran and non-veteran patients.



Research findings

Rates of Past-Year IPV

Among female VHA primary care patients in Pennsylvania who completed a self-administered IPV screen as part of their clinical care, 15% met scoring criteria for past-year IPV experience based on the 5-item Extended Hurt/Insult/Threaten/Scream (E-HITS) tool.² In a mail survey of female veteran VHA patients in New England also using the E-HITS scale, nearly one-third (31%) of those who were in an intimate relationship in the past 12 months reported past-year IPV.³

Physical, Mental, and Social Health Comorbidities

We found experience of IPV to be associated with patients' reports of lower self-rated overall health, increased severity of mental health symptoms, as well as higher rates of mental health diagnoses, unhealthy alcohol use, difficulty sleeping, and chronic pain.⁴⁻⁶ Patients who experience IPV are at high risk of health complications with nearly

QUESTIONS IN THE E-HITS TOOL:

In the past 12 months, how often did an intimate partner (e.g., boyfriend, girlfriend, husband, wife, sexual partner):

1. Physically hurt you?
2. Insult or talk down to you?
3. Threaten you with harm?
4. Scream or curse at you?
5. Force you to have sexual activities?

Response options are: Never, Rarely, Sometimes, Often, Frequently

Chan CC, Chan YC, Au A, Cheung GOC. Reliability and validity of the "Extended – Hurt, Insult, Threaten, Scream" (E-HITS) screening tool in detecting intimate partner violence in hospital emergency departments in Hong Kong. Hong Kong J Emerg Me. 2010; 17: 109-117.

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1 in 5 female VHA patients who reported past-year IPV also reporting current homelessness or concerns about housing instability and 28% reporting current unhealthy alcohol use.² In a survey of VHA patients in New England, 19% of women reported indicators of possible IPV-related traumatic brain injury in their lifetimes.⁷

Patient Perspectives on Screening and Response

We conducted interviews and focus groups with female VHA patients in Philadelphia and Boston to identify patients' perspectives on IPV screening and response in VHA.^{8,9} The importance of routine screening was highlighted by patients indicating that they were unlikely to tell their providers about their IPV experiences without being asked directly: "No one ever asked me about it... I may have talked about it if I had been given the chance, but I wasn't going to bring it up on my own." Patients expressed that they did not always feel comfortable disclosing their IPV experiences, even when directly asked, and noted that comfort with the provider and with talking about their experiences may develop over time.

Patients emphasized the importance of healthcare providers' responding to disclosure in a sensitive and supportive manner, offering validation as well as concrete resources and information to assist patients in navigating steps towards safety and recovery. A patient noted the potential harm in not adequately responding to a disclosure: "If [a patient] tells you [about her IPV experience] and you don't follow up, then in the back of her mind, she's saying, 'Well, I told them and they don't seem to care...I guess it's just like he says: I deserve it'."

Patients expressed concerns about privacy and confidentiality with documentation of their IPV experiences, especially given an electronic medical records system that may be accessible to a wide network of providers and staff. Furthermore, there may be safety considerations if abusive partners gain information about patients'



A patient noted the potential harm in not adequately responding to a disclosure: "If [a patient] tells you [about her IPV experience] and you don't follow up, then in the back of her mind, she's saying, 'Well, I told them and they don't seem to care...I guess it's just like he says: I deserve it'."

disclosure or safety planning through documentation in the medical records. While we know that specific documentation of IPV experiences can be helpful, especially for ongoing or subsequent legal cases, and could be useful for continuity and coordination of clinical care, women indicated that documentation must be balanced with patients' desire for confidentiality. Women appreciate having the opportunity to make informed decisions about what is documented in the medical records.

Women appreciate having the opportunity to make informed decisions about what is documented in the medical records.

Next steps – future work

In conjunction with routine screening for experience of IPV, the VHA plan includes having on-site domestic violence coordinators at each VHA medical center to provide follow-up assessment and ongoing care to patients with IPV-related needs, consultation and support for providers, and collaboration with community-based programs offering support to patients who have experienced IPV. In the next stage of research, we will further examine the process and impact of, and patient preferences regarding, healthcare-based clinical interventions for patients with IPV-related needs. The continued efforts of healthcare systems to implement patient-centered IPV detection, assessment, and response programs are essential for improving patients' empowerment and safety.

The views expressed here do not necessarily represent those of the Department of Veterans Affairs or United States Government.

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SEX WORK AND SEX TRAFFICKING: DEVELOPING AND PILOTING A GENDER-BASED VIOLENCE INTERVENTION FOR WOMEN “IN THE GAME”

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WOMEN WHO TRADE SEX ARE TYPICALLY KNOWN AS “FEMALE SEX WORKERS” OR FSWS.

The Joint United National Programme on HIV/AIDS (UNAIDS) defines sex work broadly and behaviorally, as adults who trade sex for money or other goods, including occasional transactions, and notes that many who engage in sex work do not identify as sex workers.¹ The term “FSW” can be uncomfortable for those who believe that sex work is inherently exploitative. The reality is that those involved in the sex industry, regardless of how that experience is described, are at substantial risk of violence. Moreover, their violence-related needs are going unmet – in part due to the discomfort in how to address sex work and sexual exploitation. It is time for the violence prevention field to be part of the solution.

First, it is important to recognize that not all sex workers are trafficked. Public health evidence since 2008

shows clearly that some portion of those involved in the sex industry enter as minors or under conditions of exploitation, while others enter as adults under other circumstances, many with early experiences of violence.^{2,3,4} Some enter as minors but age out and still risk violence, harassment and harm as adults. This evidence forces us to address the complex reality that sex trafficking victims need and deserve support for violence and a host of other health issues, as do those who are trading sex who are not trafficked. When we consider violence prevention and supporting survivors, we must widen our lens to include both those who are exploited and those who trade sex as adults and under a wider range of circumstances. We cannot let the debate about how to characterize these experiences continue to undermine our response to their violence-related needs. Regardless of what brings people to trade sex, those people deserve to live free of violence.



Figure 1

Emergent global data documents pervasive physical and sexual violence against female sex workers.⁵ For example, our study in Moscow, Russia found that 75% of FSWs had experienced physical violence from a client in the past year alone.⁶ Yet women in the sex industry slip through the cracks of violence prevention and support programs. The criminal justice system often fails to protect FSWs, obstructs their access to justice for crimes perpetrated against them and, in some cases, perpetrates harm. The culmination of social stigma, added layers of self-blame for abuse, isolation and criminalization of sex work fuels violence against FSWs with impunity.⁷ Marginalization and risk of violence can be greater still for sex workers who are people of color, transgender, lesbian, bisexual and/or gay, due to racism, transphobia, homophobia and other intersecting systems of oppression.

To begin to respond to this confluence of unmet needs, and the structural forces that enable risk for violence, we undertook a community-based, participatory process in Baltimore, Maryland. We convened providers from domestic violence and sexual assault support organizations, and sex work outreach and anti-trafficking programs (Figure 1), together with women currently and recently involved in sex trade including, but not limited to, survivors of exploitation. Through coalition meetings and individual discussions, we reviewed local and global data on the prevalence and nature of violence against women in the sex industry, and gaps in their ability to access violence-related support and justice. We reviewed the few existing interventions addressing violence for this population as well as models that have been developed for more general populations. We considered feasibility, safety, and acceptability of approaches from the perspectives of multiple stakeholders including providers and survivors themselves. Program and individual participants felt strongly about language on how to characterize the population, and collectively agreed to phrasing that specifies “women who trade sex, are sexually exploited,

and/or trafficked” to reflect the underlying range of experiences. Individual participants recommended the shorthand “in the game.” We discussed how to convey information about trafficking and available support in the context of the wider umbrella of violence-related support. We developed a safety card to summarize the key messages of the intervention and provide information on accessing support services for violence, sex work, and trafficking. Check out our survivor-informed safety tips at

<https://inspiresafety.wordpress.com/>

Through this process, we developed a brief, trauma-informed intervention that harnesses existing HIV outreach services to raise the topic of violence, discuss harm-reduction strategies for violence and HIV, and provides information on violence-related and sex work support services. In doing so, interventionists also provide information about trafficking-related support for those who are underage or experiencing exploitation. The intervention is being evaluated for acceptability, feasibility and impact. Early anecdotal reports suggest that this brief support intervention is highly acceptable. Many of our participants indicate that they have never been asked about abuse, often despite physical evidence of harm. The burden of violence against women who trade sex demands an evidence-based response.

The evaluation will determine the effectiveness of this brief intervention in providing support, promoting harm reduction and connecting women to services while providing insights on how this approach may need to be strengthened to achieve their goals of safety and well-being. Our participatory intervention development process may serve as a model for other communities seeking to strengthen the system of care for women “in the game.”

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“I’LL DO WHATEVER AS LONG AS YOU KEEP TELLING ME THAT I’M IMPORTANT”: DATING VIOLENCE VICTIMIZATION AND COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN

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HUMAN TRAFFICKING, COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN (CSEC), DOMESTIC MINOR SEX TRAFFICKING (DMST)... While the terminology continues to evolve and expand, advocates, researchers and practitioners are increasingly being asked about the link between these topics and sexual and domestic violence. Providing training to health professionals, teachers, parents and youth can be challenging without research-based evidence on the intersection of these topics.

As many advocates know, researchers have been studying the prevalence and consequences of dating

violence since the 1980s. Numerous consequences have been documented and are often addressed during trainings and prevention programs—these include depression, suicidality, eating disorders, school problems, unwanted pregnancy, sexually transmitted infections, injuries and death.^{1,2,3,4,5,6} However, people are increasingly aware of and interested in commercial sexual exploitation as another possible consequence of unhealthy dating. Conversely, those who provide education about CSEC are now starting to add “having a relationship with a coercive or abusive partner” to the list of other possible risk factors for CSEC victimization—which include a childhood history



of abuse victimization, having other family members sexually exploited or trading sex, being unemployed, living in area of concentrated poverty or high in crime, having dating relationships with older men, being a runaway, throwaway or homeless youth, being gay, lesbian, bisexual or transgender, living somewhere with a transient adult male population (such as a military base) or living somewhere with political instability and/or where natural disasters have occurred.^{7,8} Therefore, new information about dating violence victimization as a risk factor for CSEC can inform our approaches to each of these two important topics and help build bridges between activists who may be working exclusively on one or the other.

In 2014, a Boston-based research team interviewed four survivors of CSEC. All were sexually exploited by dating partners at one time in their lives, and for three of them, their first experience of a commercial sexual encounter was arranged by their intimate partners and occurred when they were younger than 18 years old.⁹ Details about the methodology of the study and the full results—which include quotations from the survivors—are available here: <http://digitalcommons.library.tmc.edu/childrenatrisk/vol6/iss1/8/>.

Several themes emerged from the survivors' stories about when they were first exploited by dating partners. We organized these themes chronologically; each reflected precursors to dating, the early phase of dating or later phase of dating.

Prior to dating

There were several commonalities in the survivors' descriptions of their lives and emotional states prior to meeting their dating partners. Each one said that she felt deeply insecure about her physical attractiveness, like she didn't fit in with peers—two were bullied— and each one had experienced sexual abuse during childhood or early adolescence. Perhaps like most adolescents, they wrestled with feelings of anxiety, but more atypically each experienced depression and a sense that they fundamentally did not fit into their families. They each had conflicts with parents (and in one case, siblings as well), that made them want to spend time away from home. None had experience with a healthy dating relationship before entering into a relationship with the person who ultimately exploited them.

Early phase dating

Having been sexually abused previously meant that two of the four survivors had severe trauma responses when they first had sex—dissociating, freezing up, and subsequently wondered if that meant they were sexually abnormal. Wanting to prove that they could be “good at sex” and/or wanting to keep their

relationships meant they pushed themselves to have sex even when they didn't want to. When they met their partners who ultimately became exploitive, they each felt charmed by romantic gestures, or felt proud to be “chosen” by a popular, well-dressed, handsome, older, or powerful male. When they began dating the people who ultimately exploited them, they also felt special and trusted when they were asked to hold weapons, cash, or drugs, or shoplift for them. Each one of their abusive dating partners encouraged them to use alcohol, marijuana and other drugs.

Late phase dating

These survivors remained with their partners after being exploited for several reasons, including loving them, believing in the idea that they would one day own a house together, they had children together, they were physically and sexually assaulted by those partners and prevented from leaving, they were financially dependent on them, and being kept vulnerable due to sleep deprivation, alcohol and drug use, stress, and fear. However, the survivors explained that once they were exploited, their fear of returning to their parents or guardians intensified (because they would have been punished for engaging

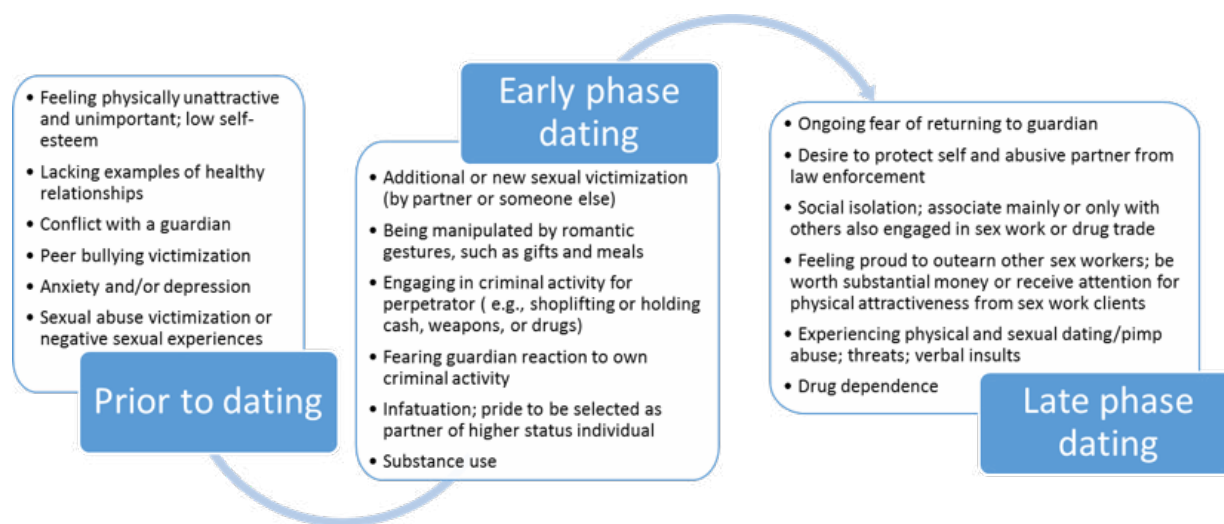


Figure 1. A proposed framework for conceptualizing risk for dating abuse victimization and subsequent sexual exploitation by an intimate partner

in criminal activity). They were also scared of law enforcement —both for themselves and for the partners whom they felt they loved. Consequently, they did not view law enforcement as a resource or source of safety. They each mentioned that they became socially isolated from people who were not also involved in commercial sex or drug trade, which normalized what was happening to them. Each survivor talked about feeling proud at various times during the time when she was being exploited about out-earning other women as strippers or as sex workers, or receiving more attention from customers than other women. Feeling in-demand as a sex worker made some feel more attractive than they had in high school, even though those feelings were temporary and conflicted. For each survivor in this sample, maintaining an illegal drug dependence took over as one of the primary reasons for remaining with their abusive partners and for remaining exploited. For two of these survivors, the realization that they wanted to exit the commercial sex industry came as a result of realizing that their substance dependence had taken over their lives.

Framework and future directions

The framework depicted in **Figure 1** is proposed as one conceptualization of how dating abuse victimization can lead to sexual exploitation by a dating partner, drawn from the results of this study.

This study, a case series involving four women, provides insights for future research that can test the proposed framework and ask more in-depth questions with diverse groups of survivors of dating abuse and CSEC to learn more about what they need from service providers and communities to live lives free from violence.¹⁰

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