Addressing Intimate Partner Violence Among Women In Maryland

August 2019

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Acknowledgements

We would like to extend our sincere gratitude to the following individuals for their contributions to the Governor’s Summer Internship program 2019. Their support and mentorship made our program experience possible.

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Executive Summary

Intimate Partner Violence (IPV) impacts thousands of women in the United States daily. Exposure to IPV can cause major mental and physical harm to individuals, which may have lasting effects over their entire lifetime. The rate of IPV among women in Maryland emphasizes the significance of this issue, and the Hogan administration’s role in reducing and preventing IPV. In order for such actions to have a lasting impact on IPV rates among women in Maryland, this paper considers IPV prevention and reduction policies and programs focused on education, mandating screening for IPV in health care settings, and abuser intervention.

Proposal One: Implementing IPV prevention and intervention programs in K-12 schools across Maryland, and the creation and implementation of informative campaigns involving the Maryland Department of Health and the Maryland Higher Education Commission.

Proposal Two: Mandating screening for IPV in emergency room and primary care settings.

Proposal Three: Adding requirements and specifications for abuser intervention programs in Maryland.

Based on specified criteria, this paper recommends mandating screening for IPV in emergency room and primary care settings as the most effective and efficient method for reducing IPV among women in Maryland. Mandating IPV screening enhances the healthcare system’s role in reducing IPV. Mandating IPV screenings improves IPV report data, leading to future funding and focused efforts to prevent and eliminate IPV. Continuing to directly acknowledge IPV among communities across Maryland enhances the safety and quality of life for all residents.
Introduction

In the United States, one in five women report having experienced IPV in their lifetime. Among women ages 15 to 44, IPV related deaths (classified under homicide) are in the top ten causes of death. These women are more than statistics; they are mothers, daughters, friends, and coworkers. Due to the young age which IPV can occur at, many women may experience and live with the consequences of IPV throughout their entire lifetime. These major consequences can involve harm to one's mental health, physical health, and lifespan. As of 2018, 51.5 percent of Maryland’s population consists of women, 20 percent of which are statistically likely to experience IPV in their lifetimes. In comparison to other states, in 2017 Maryland was considered 14th in violence related crimes, which includes IPV. It is difficult to accurately measure the amount of individuals who have been impacted by or experienced IPV due to fear of harm and mistrust. These statistics present the significance of IPV among women at a national and state level, and should be considered an important policy focus by Maryland government.

This paper will address the high rates of IPV among women in Maryland. Maryland government's current efforts have focused on implementing the STOP Violence Against Women Act (VAWA), awarding millions of dollars in grant funds to violent crime survivors and their families, providing local violent crime victim services, contributing to IPV research, approving

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numerous IPV related bills, and providing legal methods of protection for individuals experiencing IPV.

Yet, further actions should be taken to considerably decrease IPV rates. The first proposal involves implementing policies integrating IPV prevention and intervention programs in public schools. These programs could benefit all current and future students in Maryland Public Schools as a direct method for addressing and preventing IPV at a young age. Another element of this proposal involves implementation of educational campaigns; a collaboration between the Maryland Department of Health and the Maryland Higher Education Commission. Educational campaigns can prevent and decrease IPV rates among many individuals via information and focused support. The second proposal, mandating screening for IPV in health care settings, is a vital measure. Victims of IPV can face barriers to reporting or accessing services in fear of the consequences of their abuser finding out. Therefore, mandating IPV screening in health care settings could provide all women with a direct and confidential source and access to appropriate resources. Lastly, additional requirements to the “Operational Guidelines for Abuse Intervention programs in Maryland” could improve how IPV is addressed by making operational changes to abuser intervention programs. Improving and increasing participation in current abuser intervention programs could decrease IPV rates by directly acknowledging the role of abusers in IPV.

**Problem Definition**

IPV consists of any threatened or completed acts of psychological, sexual, and physical abuse, where the victim or perpetrator of IPV can be a current or former spouse, partner, or significant other. IPV can lead to serious physical injury, death and long-term mental health
problems. One of the greatest challenges in measuring the rates of IPV involves unreported cases, a number referred to as dark figure. The more this number increases the further IPV victim estimates are from reality. Worldwide, one in three women has experienced a form of physical or sexual violence by their partner or non-partner in their lifetime. In the United States, 1,140 females were murdered by an intimate partner in 2016.

As demonstrated, all women can be impacted by IPV, but it is important to recognize some of the most vulnerable populations who are at greater risk of experiencing it like, but not limited to, LGBTQ+, pregnant, and disabled women. LGBTQ+ women have difficulty accessing IPV related services due to their gender identity and/or sexual orientation. This is a result of non-LGBTQ+ inclusive definitions of domestic violence, limited LGBTQ+ specific IPV resources, and risks/fear associated with coming out in accessing services. Pregnant women also face unique barriers preventing them from reporting IPV, such as placing multiple lives at risk by reporting or having experienced IPV. In Maryland, four percent of women reported to have experienced IPV during pregnancy, which can result in miscarriages, premature deliveries, or other types of physical harm to the fetus. Research has shown that women with disabilities are also more likely to experience IPV, including rape and psychological aggression than women

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10Brown, T. N., & Herman, J. L. (2015, November). Intimate Partner Violence And Sexual Abuse Among LGBT People [PDF]. The Williams Institute
without disabilities due to impaired autonomy. By introducing our policy proposals we hope to inspire future efforts explicitly addressing IPV among all women, including vulnerable populations like LGBTQ+, pregnant, and disabled women.

IPV claims direct and indirect victims, including children. Children who witness violent acts are at risk of emotional, behavioral and educational problems as well as future violence in their own relationships as adults. Witnessing violence at home is considered an Adverse Childhood Experience that can lead to brain and health damage, and behavioral risks, such as dropping out of school and being violent towards parents.

IPV is an important and relevant issue to Maryland government and citizens. Maryland is ranked as the 10th state in the United States for female homicides by men in single victim or offender incidents. Evidence further supports this as in 2016 and 2017, Maryland experienced 15,301 domestic violence-related crimes and 46 domestic violence-related deaths, 25 of which were murdered by an intimate partner. According to the National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report, Maryland’s lifetime prevalence of sexual violence victimization for women was 38 percent. These statistics show that Maryland is not immune to the prevalence of IPV and IPV associated deaths. This also shows that decreasing the amount of IPV cases is of extreme importance for Marylanders who want to live a better quality of life.

**Origins of the Problem**

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15 Centers for Disease Control and Prevention. (2019, April 2). Adverse Childhood Experiences (ACEs).

16 Maryland Network Against Domestic Violence, 2019; Uniform Crime Reporting, 2016
In many ways, U.S. social norms and culture promotes IPV through behaviors, entertainment, and acceptance. The United States’ norms can be traced to the nation’s establishment as a patriarchal society, and has led to a culture which values and structures men over women. Research has shown that the influence of social scripts based around cultural norms of sexual behavior for males and females starts at a young age. These social scripts recognize men as “initiators or directors” whereas women are “submissive.” Research further notes that gender socialization is reinforced by observing family and peers. This shows why many partners may not have been able to reach out for help as those around them were more likely to downplay the behaviors as normal or how things were.

Another social aspect contributing to high IPV rates among women in the United States originates from norms regarding family structure. The opportunity for violence and maltreatment at home increases when intimate partners spend significant amounts of time together. As a society which originated from and strives to create this notion of a “perfect family,” many individuals forming intimate relationships expect closeness, without knowing that spending as much time as they can together increases the opportunity for incidents of violence and maltreatment.

Another aspect that plays a role in violence towards women in the United States is economic conditions. Factors such as: unemployment, low income, career-related stress, and general poverty are associated with higher rates of IPV. Populations receiving welfare benefits experience higher levels of domestic violence. It is important to note the socio-economic

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18 This research regarding gender scripts, socialization, and IPV was modified from my Persuasive Presentation for Dr. Lillian Carter’s Honors 370 seminar class at Towson University in Spring 2019 (Sophia Ross)

factors discussed here contribute to perpetration and victimization. For example, poverty is a stressor that can lead to violence in one partner and a financial dependency that prevents the other partner from leaving. Moreover, IPV and these socio-economic conditions are cyclical. In a 2003 study it was concluded that women experiencing domestic violence have difficulty finding employment, suggesting that IPV may be both a symptom and cause of unemployment and poverty.\footnote{Goodwin, S.N., S. Chandler, and J. Meisel. "Violence Against Women: The Role of Welfare Reform." Final report to the National Institute of Justice, 2003, NCJ 205792.}

**Current Efforts**

Many federal and state policies pertain to IPV. The Governor’s Office of Crime Control and Prevention (GOCCP) is the main executive body with domain over IPV in Maryland. The GOCCP administers programs such as the STOP VAWA. STOP stands for “services, training, officers, prosecutors.” STOP VAWA is part of the federal Violence Against Women Act, which was reauthorized in 2013. VAWA allocates funding to services, training, law enforcement officers, and prosecutors to address violence against women. In 2019, Governor Hogan announced a total of $2.5 million in federal VAWA grants to help protect women and families from domestic violence, sexual assault, dating violence, and stalking crimes.\footnote{The State of Maryland, Office of Governor Larry Hogan. (2016, October 27). Governor Larry Hogan Announces Funding to Fight Domestic Violence, Sexual Assault, and Stalking Crimes [Press release].} VAWA requires the State to address specific needs of underserved populations and ensure that funding is distributed to linguistically and culturally specific services for those marginalized populations.\footnote{Governor's Office of Crime Control and Prevention. (n.d.). STOP (Services * Training * Officers * Prosecutors) Violence Against Women Formula Grant Program (STOP VAWA).}

STOP VAWA and other VAWA grant programs fund governmental and nongovernmental organizations alike. This includes crisis-centers and public awareness activities. Hood College
and Morgan State University also have been awarded VAWA funding in the past, receiving a grant in 2017.”

In early 2019, Governor Larry Hogan announced nearly $50 million in grants to Maryland organizations that deal with violent crime. This funding comes from the state Victims of Crime Assistance Grant Program (VOCA). The purpose of these grants is to improve services, safety, and security for violent crime survivors and their families. Notably, this funding allows all eligible funding requests received from victim service providers in Maryland to be filled. VOCA funding is awarded across the state to organizations and agencies that provide direct services to crime victims.

GOCCP also works on advocacy for victims of domestic violence. In 2015, Governor Hogan proclaimed October as Domestic Violence Awareness month. In 2018, GOCCP sponsored the first-ever Maryland Crime Victims’ Rights Conference to provide training related to a victim-centered approach to criminal justice. In addition to victim-centered approaches, the GOCCP also has policies pertaining to IPV perpetrators. The Governor’s Family Violence Council’s (FVC), housed under the GOCCP, has “Operational Guidelines for Abuse Intervention programs in Maryland.” These guidelines pertain to intake into abuse intervention prevention programs (AIP). Some of the FVC’s operational guidelines involve reporting if the abuser failed the program and creating a profile of the abuser’s actions and progress.

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23 United States Department of Justice, “FY 2018 OVW Grant Awards by Program.”
25 Ibid.
Once admitted, AIPs require the abuser to provide information such as the victim's name and contact information, assessments of substance abuse and mental health, and description of referring incident. AIPs also secure a waiver of confidentiality from the perpetrator to allow communication with the survivor and any current partners or previous partners with whom the abuser has children. This communication involves information about incidents of abuse and the abuser's participation in the program. Finally, AIPs are required to work to provide information to victims about educational, victim, and counseling services.

The Maryland Department of Health also provides services and research on IPV. One of these services is to provide a list of domestic violence resources for each jurisdiction in Maryland.\(^{28}\) These resources include crisis resource centers, shelters, and intervention programs. Additionally, the Department of Health has also created a “Guide for Providers” and sample IPV assessment tool. These are important measures, especially for pregnant women and women with disabilities, as each group had the potential to be screened during their doctor visits. However, the "Guide for Providers" has not been updated since 2013.

Before the 2018 legislative session, Governor Hogan joined with Maryland Senate President Mike Miller and House Speaker Mike Busch to enact the Rape Survivor Family Protection Act 2017.\(^{29}\) This act authorized the court system to terminate parental rights of an individual found to have committed some form of sexual assault that resulted in the conception of a child.\(^{30}\) Recently, the Governor supported several bills in the 2019 Legislative Session related to IPV. The *Local Housing Grant Program for Homeless Veterans and Survivors of Domestic Violence Bill 2019* grants funding to counties for housing for survivors of domestic violence and homeless veterans. The bill stipulates that funding will be included in future

\(^{28}\) Maryland Department of Health, “Intimate Partner Violence.”  
\(^{29}\) Ryan, Kate “Maryland Governor Lays out Legislative Agenda to Protect Crime Victims.” *WTOP*, 2018.  
budgets for this program.\textsuperscript{31} Another bill, \textit{Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations 2019}, requires the established workgroup to study child custody court proceedings that involve either child abuse or domestic violence allegations. The workgroup is to provide a final report on findings and recommendations for how to incorporate the latest safety science into court proceedings.\textsuperscript{32}

Survivors of domestic violence can pursue Peace and Protective Orders. IPV victims can ask the court for a Protective Order, which allow victims to receive some protections and relief. These cover physical violence, mental harm, rape, and other acts.\textsuperscript{33} IPV victims can also ask the court for a Peace Order, which orders the perpetrator to refrain from contact with the victim. A Peace Order covers acts such as rape, assault, revenge porn, and other forms of violence, harassment, and control.\textsuperscript{34} Peace and Protective Orders are procedurally the same. However, Protective Orders offer additional types of relief and Peace Orders include additional types of abuse. Anyone who is not eligible for a Protective Order but experiences abuse is eligible for a Peace Order. Protective Orders typically last for seven days and Peace Orders up to six months. Although legal protections provide survivors the ability to protect themselves from abusers, they mostly only help people after they have experienced abuse.

First Lady Yumi Hogan has worked extensively on combating domestic violence. Specifically, the First Lady has worked with the Address Confidentiality Program and recently received the Medallion award for her advocacy for survivors of domestic violence and human

\textsuperscript{33} The People’s Law Library of Maryland, Protective Orders, updated 2019.
\textsuperscript{34} The People’s Law Library of Maryland, Peace Orders, updated 2019.
trafficking. This year, she delivered remarks at the annual Domestic Violence Homicide Memorial Service conducted by Maryland Network Against Domestic Violence.\textsuperscript{35}

Though Maryland Government is clearly committed to fighting violence against women, the persistence of IPV suggests there is a wider issue with these approaches. The issue may stem from the fact that many IPV policies are reactive as opposed preventative; they seek to help survivors after they have been victimized as opposed to preventing victimization in the first place. Addressing these shortcomings can further contribute to eliminating IPV.

\textbf{Policy Alternatives}

Other states (Florida, Ohio, California, and Maine) and non-profits have led various efforts to address high rates of IPV among women. These states and organizations can serve as models for Maryland. While these states have not had dramatic decreases in their IPV rates, their efforts suggest that there are additional, affordable and feasible policies Maryland can implement. Broadly, these alternatives can be broken into three main strategies: Education, abuser intervention, and health screenings.

\textit{Proposal #1 K-12 Education and Community Norms Policies}

Because societal norms and culture have been major forces in perpetuating IPV, early education about domestic and other types of violence is an important measure to prevent IPV. Maryland legislation from 2009 encouraged schools to “adopt age appropriate dating violence education into the school curricula.”\textsuperscript{36} The 2017 Domestic Violence - Education and Definition of Abuse Act, which failed to pass, was another policy measure looking to address IPV through education. This act would have required the State Board of Education to encourage county

boards of education to include domestic violence education into the curricula. The policy would have also updated definitions of abuse and harassment to be more encompassing.\textsuperscript{37}

Florida is a possible model for more effective IPV education legislation. In 2010, the Florida General Assembly passed \textit{Relating to Public K-12 Education 2010}. This act:

- “Provides that comprehensive health education taught in public schools shall include component on teen dating violence and abuse for grades 7 through 12;
- requires district school boards to adopt & implement dating violence and abuse policy; requires DOE to develop model policy;
- requires school personnel training.”\textsuperscript{38}

This policy is more forceful than previous Maryland policies and requires inclusion of violence and abuse components in health education curriculum.

It is important to note that the state can share the burden of outlining and implementing these educational programs. Organizations such as \textit{New Hope For Women} in Maine assist schools in offering prevention and intervention programs.\textsuperscript{39} \textit{New Hope For Women} has School-based Advocates to holistically implement prevention and intervention programs at K-12 schools. Although this specific group is not in Maryland, a variety of nonprofits exist throughout the state help implement the aforementioned legislated requirements.

Education reforms should extend beyond K-12 schooling as IPV is endemic to all of society. Collaborative outreach campaigns, informational campaigns, and the establishment of peer groups can all be effective in shifting this model. While each campaign cannot reach all women, different campaigns could address subpopulations and specific issues tied to IPV.

\textsuperscript{38} H.B. 467, 2010 Reg. Sess. (Fl. 2010).
\textsuperscript{39} “New Hope for Women; School Based Prevention and Intervention.” (2019).
Proposal #2 Health Screening Policy

Social shifts can be coupled with medical ones as IPV often impacts both the physical and mental-wellbeing of women. Screening for domestic violence was first implemented in the United States healthcare system in 1992 by the Joint Commission on the Accreditation of Hospitals and Health Care Organizations (JCAHO). In 1992, to receive hospital accreditation the JCAHO mandated emergency departments to generate and expand protocols to identify and treat domestic violence victims.\textsuperscript{40} These protocols are important because they can help identify survivors and at-risk individuals for intervention. Currently, screening for IPV in health care settings occurs infrequently.\textsuperscript{41} From 2006–2009, there were 112,664 visits made to United States emergency departments that were logged as battering by a partner or spouse. The majority, or 93 percent, of these IPV patients were women.\textsuperscript{42}

The American College of Obstetricians–Gynecologists argues obstetricians and gynecologists are in a unique position to help survivors of IPV because of their relationship with patients and the opportunities for interventions during the course of a woman’s health visits.\textsuperscript{43} The United States Department of Health and Human Services has endorsed this, advocating that screening and counseling should be a central preventative measure during health visits. The American College of Obstetricians–Gynecologists suggests physicians should screen all women for IPV at periodic intervals offer ongoing support, and review available prevention and referral options.\textsuperscript{44} The Centers for Disease Control also has a comprehensive format for IPV assessment


\textsuperscript{41} Ibid.


\textsuperscript{44} Ibid.
in different health care settings. However, all of these recommendations are not mandated, and thus may be unevenly implemented throughout Maryland health care facilities.

IPV patients use more health care resources than patients who do not experience IPV. Therefore, there are significant health care costs associated with IPV. These costs can be remedied through mandated screenings, which would help those already experiencing violence and act as a preventative measure for those who have not experienced IPV. These screenings should take place in primary and urgent care settings, as these sites can offer crisis management, privacy, emotional support, and connections to social services. To implement screenings and interventions in these settings, systemic changes are necessary. This would involve incorporating on-site IPV experts, training all staff members, developing unit-based policies, and collaborating with local communities.

California can serve as a model for Maryland because of its thorough incorporation of IPV screening, treatment, and prevention in its health care system. California has required protocols for reporting and providing resources to patients, including evidence collection from individuals who have experienced some type of violence. California also requires screening protocols for victims of abuse and various health care facilities to execute those screenings. Finally, California requires and has established training for medical personnel in victim-centered care. Victims of IPV face greater risks of isolation. In light of this, health screenings at doctor

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appointments are essential to those facing IPV. Screenings can help eliminate barriers to victims receiving help, increase accuracy and number of reports, and ultimately decrease in IPV rates.

Proposal #3 Abuser Intervention Program Amendments

In order for IPV rates to decrease, policy solutions should look comprehensively at both helping victims and stopping abusers. A third policy alternative would expand the Family Violence Council (FVC) mandates for AIPs. Currently, the FVC recommendation is for abusers to enroll in AIP programs for 32 meeting hours over at least 20 weeks if in a group setting, and 16 meeting hours over at least 12 weeks if the abuser chooses to enroll in individual sessions. The recommendations outlined below are proposals to amend the existing operational guidelines within the FVC which would increase the outcomes of these AIPs in the state:

1. Establish a reasonable fee for AIPs to charge abusers who enroll in the program. These fees would account for services provided by mental health counselors and program coordinators and serve to reprimand abusers for their behavior.

2. Increase duration of enrollment to 12 months. Given this is a mental health issue which needs support over time, 20 weeks is not enough to foster sustainable change.49

3. Make attendance in AIP programs mandatory for all people identified by the courts in Maryland to be IPV perpetrators.

4. Require all organizations in Maryland who provide services to victims to include a program for perpetrators of IPV which meets the FVC’s guidelines.

Policy Analysis

In order to adapt the best fitting policy to prevent IPV among women in Maryland, these three proposals must be assessed for their effectiveness. The table below compares the cost, projected effectiveness, community impact and collaboration efforts needed.

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<th>Category</th>
<th>Policy #1 - K-12 Education and Community Norms</th>
<th>Policy #2 - Health Screening Policy</th>
<th>Policy #3 - Abuser Intervention Programs</th>
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<tr>
<td>Collaboration Needed</td>
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Policy #1 Analysis

A well rounded policy on education about Maryland residents to address IPV and reduce IPV rates entails education within the classroom and beyond the classroom. Effective education is essential to IPV rates in Maryland. The multifaceted approach to education for this policy proposal makes the costs high for successful implementation. To successfully implement education among K-12 students, the state will have to train school personnel. This will also require the use of organizations who are working to prevent and reduce rates of IPV within the state. Outside of the school setting, a partnership between the Maryland Department of Health and the Maryland Higher Education Commission to run educational campaigns about IPV will also incur high costs, as new staff will have to be hired through partnerships with different organizations in Maryland working to combat IPV. The projected effectiveness of this proposal is high due to research which supports the role of education in combating IPV. 13 studies examined by De La Rue et al regarding school-based prevention programs indicated an increase
in knowledge post-test about dating violence, and a significant change in attitudes about dating violence.\textsuperscript{51} Students who were exposed to a dating violence intervention demonstrated no tolerance for dating violence.\textsuperscript{50} Educating students and the general public about the effects of IPV is of high service to the community and entails a high level of collaboration between the school system, state government and nonprofit organizations in the state.

Policy #2 Analysis

This policy recommendation will require all health care facilities within the state of Maryland to screen all women aged 18 and above for IPV during primary care and emergency room visits. It will also require all health care facilities within the state of Maryland to use one of the five screening tools recommended by the Centers for Disease Control (CDC) to screen for IPV. These tools (HITS, OVAT, STaT, HARK, WAST) have been tested by the U.S. Preventive Services Task Force (USPSTF) and have been shown to have the highest rates of specificity and sensitivity. When addressing the role of screenings in reducing or preventing IPV among women in Maryland, it is important to discuss some of the barriers which exist in effective screening for IPV. The U.S. Department of Health and Human Services notes that some of the barriers that providers face when screening for IPV include insufficient time, discomfort with the topic, fear of offending the patient, perceived lack of power to change the problem at hand and also recognizing the need for the patient’s privacy.\textsuperscript{51} In addition to the issues mentioned above, conflicting departmental protocol and a lack of concrete policies by medical facilities also


\textsuperscript{51} Intimate Partner Violence Screening. Content last reviewed May 2015. Agency for Healthcare Research and Quality, Rockville, MD.
hinders the rates of IPV screenings. Research shows that fewer than two percent of women are screened for IPV in a family practice setting. Effective system level changes and departmental protocols can increase the amount of providers who screen women during visits. Requiring primary care and emergency room physicians/nurses to screen all women during regularly scheduled visits will incur minimal cost to the health care facilities and physicians. The cost incurred from screening women will arise from creating brochures which lists resources available for women who have been a victim of IPV. Additionally, costs will be incurred as a result of physicians spending more time per patient for screening purposes which could decrease the number of patients seen by the physician in a day, thereby reducing physician productivity. Finally, training health care facilities staff (physicians and nurses) to screen for IPV among patients will also incur costs, as nonprofit organizations that have been instrumental in preventing IPV will have to be contracted by these facilities to conduct trainings.

The projected effectiveness of this proposal is high, as it will serve as a preventive measure in combating IPV. Mandating screenings for all women at primary care and urgent care/emergency room visits will ensure they receive the help they need if they have been abused, and serve as a preventive measure for women who have not been abused by making them aware of the warning signs of IPV and the services available to them. The amount of collaboration required for successful implementation is moderate, as it would entail the collaboration of health care facilities with the state health department to report data collected from screenings, and existing social workers within the health care facility to provide further assistance to women who screen positive for IPV. While data reporting is an essential part of measuring the change in IPV rates after policy implementation, it is also important to realize the need for patient privacy,

which could hinder the screening process. The data should be de-identified before reporting to the Maryland Department of Health, to ensure the protection of patient’s information.

Policy #3 Analysis

Bodea & Cluss (2011) in their literature review of the effectiveness of AIPs, discuss the many difficulties faced in the implementation of AIPs. They define an effective program as one which significantly reduce aggressive behaviors among abusers as a result of enrollment in the program. To measure if there has been any changes to aggressive behaviors of participants, Bodea & Cluss suggest the use of official reports of abuse such as arrests and complains of abuse. It is however noted in this literature review that official reports are never an accurate measure of IPV, as many instances of IPV are not reported. Costs incurred from these recommendations are high due to the fact that extending the length of attendance in the program to one year would also increase the amount of enrollees, oversight, staff, facilities and utilities needed to sustain these programs. It is however important to consider the fees which will be charged to enrollees in the program, as fees charged to enrollees will supplement additional costs for staffing and program implementation as needed. The implementation of this approach is projected to be high in return, as it does not entail any mandatory expenses from the state and gives room for local organizations to be fully involved, while being accountable to the courts and the Governor’s FVC. The projected effectiveness of this approach is high, as it ensures that people found guilty by the courts for IPV are not only punished by the legal system for violence, but are also get the necessary mental help needed to prevent future incidents of IPV. Bearing in mind that although IPV exists in Maryland, the majority of residents are not perpetrators of IPV, the service to community is moderate, as the policy would mainly those identified by the courts.

as perpetrators of IPV. A moderate level of collaboration is needed: collaboration between the Governor’s FVC, the courts, and various organizations across the state.

**Policy Recommendation**

It is in the best interest of the Maryland State Government and Governor Larry Hogan to effectively and efficiently address the rate of IPV among women in Maryland. Therefore, we recommend mandating IPV screenings in emergency room and primary care settings. This would fill the present gap in screening for IPV in all health care settings, most importantly those visited by women who have or are experiencing IPV. Many abusers physically and psychologically control and maintain power over their victims, isolating many women experiencing IPV from vital support systems. By being trained to screen for IPV health care professionals would be able to fill this role and connect women who are or have experienced IPV to appropriate resources. IPV screening can be considered the most efficient preventive tool, as they require training of staff and takes minutes to complete. While other proposals require more time to implement and lack immediate effects to prevent/eliminate IPV.

IPV screenings are also the most cost effective method as they can prevent future costs associated with IPV related medical care/hospital visits, which will reduce the overall cost of healthcare in a year for the state and individuals. The costs associated with mandating IPV screenings are minimal, as they would be a part of the normal routine follow up for every woman who visits her primary care provider. Whereas, educational intervention programs/outreach campaigns and AIP’s are considerably costly due to the length of time required and staffing needs. IPV screenings can be considered the most effective method for immediately addressing IPV among women. Requiring screenings in emergency room and primary care settings, a total of 438 locations across Maryland, would directly impact any patients at risk for experiencing or
who have experienced IPV. \(^\text{54}\)\(^\text{55}\) Whereas educational intervention programs only focus on addressing and preventing IPV among K-12 students, outreach campaigns are more selective about whom they serve, and AIP’s only focus on impacting abusers denoted by the legal system.

**Implementation Issues**

While the above proposed policy will be instrumental in combating and eventually reducing/eliminating IPV in the state of Maryland, it is important to note the various issues which could hinder the success of this policy if implemented. Medical professionals, especially in settings where IPV victims are more likely to receive care, can play a role in directly preventing and stopping IPV. Because many women facing IPV are usually isolated and living in fear, having access to a trusted health care professional who can provide assistance to women facing IPV is of great assistance.

Victims of IPV can face barriers to reporting or accessing services in fear of the consequences of their abuser finding out. Implementation issues which could arise from screenings for women at primary and emergency care visits can include women who are at risk of IPV declining an IPV screening due to fear of their abuser. While making screening available to all women by physicians can be mandatory, it is not possible to mandate that all women get these screenings, as patients have the right to decline any medical service.

**Conclusion**

IPV impacts all women, regardless of gender, sexual orientation, age, or other characteristics. Addressing IPV in Maryland will eliminate unnecessary deaths, ensure safe and healthy relationships, unify families, and sustain a greater quality of life for all Marylanders today and in the future. We proposed building upon Maryland’s current efforts to address high


IPV rates among women by implementing IPV educational programs and outreach campaigns, mandating screening for IPV in health care settings, and adding abuser intervention program requirements. Based on specified criteria, we recommended mandating IPV screenings in emergency room and primary care settings, as it is the most efficient, effective, and least costly proposal. Successfully doing so can make Maryland an example for all states in reducing IPV among women.