White Paper on Improving Family Violence Prevention in Ohio

The Anthem Foundation OF OHIO
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HEALTH POLICY INSTITUTE OF OHIO

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The Ohio Family Violence Prevention Project

With the support of the Anthem Foundation of Ohio, the Ohio Family Violence Prevention Project began in January 2007. The project's goals are:

- to increase awareness of the scope and consequences of family violence in Ohio;
- to identify realistic and promising policies and programs for prevention; and
- to build support for implementing recommended policies and programs.

The main product of these efforts is the *White Paper on Improving Family Violence Prevention in Ohio*. To generate this work, the project directors convened a working group of leading academic researchers, agency personnel and practitioners (see acknowledgements). The group met quarterly in Columbus to insure that our descriptions of family violence, prevention and the related recommendations are both realistic *and* based on the most current, best available evidence.

On January 3, 2008, we completed a draft of the document which we then circulated to an external review panel of 50 researchers, administrators and practitioners throughout Ohio and across the United States. After another series of revisions, the *White Paper* publicly debuted at a conference at The Ohio State University in Columbus on February 19, 2008.

Following the conference we plan to hold a series of regional meetings throughout Ohio (including Athens, Canton, Cleveland, Cincinnati, Lima, Toledo and Youngstown and Zanesville) to solicit further feedback from local practitioners and decision-makers and build support for the vision. By June 2008, we plan to complete a detailed report that will describe our experience building support for the vision and include an expanded version of the *White Paper* with greater detail on existing family violence prevention efforts and a blueprint for moving forward.

Overview

Of the many threats to Ohio's citizens, few are as pervasive and harmful as family violence. Last year in Ohio, more than:

- 64,000 children were abused or neglected;
- 166,000 people were physically or sexually assaulted by an intimate partner;
- 29,000 elders were abused or neglected.

Not only are these figures comparable to those of other issues such as uninsured children eligible for SCHIP (105,972), mortgage foreclosures (79,072), or manufacturing jobs lost (16,248), but the consequences of family violence are every bit as devastating to community life and economic growth. Each year, family violence directly costs Ohio more than $1.1 billion in health care and social services. Moreover, considerable research now links family violence to a surprisingly wide range of outcomes, from lost worker productivity and housing instability, to smoking, obesity and chronic disease.

Given its complex causes and consequences, it is not surprising that efforts to address family violence are scattered across numerous agencies. Most funding is spent investigating suspected cases of abuse, yet state agencies are limited in their ability to identify victims and offer services. Each year, only 31% of abused or neglected children and only 8% of abused or neglected elders actually receive victims services. Such services are critical, yet are insufficient to address the problem.

To successfully address family violence, Ohio must also consider planned efforts at prevention. Research has identified several programs and practices that can strengthen families and prevent violence from beginning. Studies from three different cities, for example, found that nurses making regular, structured home visits to low-income first-time mothers may prevent many cases of child maltreatment. Economic analyses of these programs concluded that they yield $2.88 to $5.68 in cost savings for every $1 invested.

This *White Paper* aims to develop a shared vision of what family violence is and what Ohioans should do to prevent it. Our approach emphasizes that prevention should:

- Engage and coordinate multiple agencies;
- Focus on communities and perpetrators, not just individuals and victims; and
- Consider both research findings and practitioner feedback.

We also provide specific, realistic recommendations for how to move forward. Coordinated, community-level prevention is our best hope for curtailing the harm of family violence. Ohio's families deserve no less.

Introduction

Of the many threats to Ohio's citizens, few are as pervasive and harmful as family violence. Child maltreatment, intimate partner violence and elder abuse not only damage families, but also undermine communities and economic growth. The causes and consequences of family violence are so far-reaching that efforts to address the problem are scattered across numerous agencies, both public and private.

This *White Paper* aims to develop a shared vision of what family violence is and what Ohioans should do to prevent it. By disseminating the paper statewide and meeting with policy makers, practitioners, researchers and community leaders, we hope to build broad support for this shared vision. Each of the first three sections of the paper is organized around a theme:

1. Family violence causes tremendous harm in Ohio;
2. Family violence prevention can be effective and efficient; and
3. Existing efforts are critical but insufficient.

After reviewing these themes, we describe characteristics of effective prevention and provide recommendations for moving forward.

Discussion of family violence touches on many political, cultural and social issues. The extensive footnotes throughout this document attest to our efforts to base our claims on a thorough and critical appraisal of the available evidence. Towards this end, we reviewed hundreds of scientific studies from around the world. Yet because research has its own biases and limitations, we also solicited feedback from practitioners and administrators throughout Ohio. In the end, we believe this process has produced a *White Paper* that is both accurate and useful.

What is family violence?

Family violence includes acts that are physically abusive, sexually abusive and/or emotionally abusive and occur between family members. In cases where one family member is dependent on another, family violence also includes neglect. We use the term 'family' broadly, to describe relationships delineated by blood, legal status, commitment, dependency, and living arrangement. What makes family violence different from other types of violence is that it occurs in the context of a trust relationship and generally represents a pattern of behaviors occurring over time. Because of these characteristics, the consequences of such violence are especially harmful and complex. Conversely, preventing family violence can also help avoid a wide range of other problems. This document focuses on the three most common types of family violence:[1]

- **Child maltreatment**
  When a family member or caretaker neglects basic needs or inflicts physical, sexual and/or emotional abuse. Neglect is the most common type of child maltreatment, followed by physical and then sexual and emotional abuse.[2]

1 Please see Appendix A for full definitions and descriptions of each type of family violence. Other types of family violence not addressed in this paper include sibling violence and abuse of non-elderly disabled adults. While important, the paucity of research in these areas puts them outside the scope of this paper.

2 U.S. Department of Health and Human Services, Administration on Children, Youth and Families (USDHHS – ACYF). *Child Maltreatment 2005*. Washington: U.S. Government Printing Office; 2007. Accessed September 1, 2007 at: http://www.pcao.org/resources/pdfs/cm05.pdf .

- **Intimate partner violence**
  When physical, sexual and/or emotional violence occurs in the context of a current or former relationship. A perpetrator often abuses power in order to control his partner. The most serious injuries and adverse consequences of intimate partner violence are disproportionately experienced by women.[3]

- **Elder abuse**
  When a family member or caretaker neglects basic needs, financially exploits an elder, or inflicts physical, sexual and/or emotional abuse. Neglect is the most common type of elder abuse reported to adult protective services, followed by financial exploitation and then emotional, physical and sexual abuse.[4] Self-neglect is an important related issue, yet because it does not require interpersonal interaction it is beyond the scope of this paper.

Our understanding of family violence is based on a conceptual model that explains the relationships among the different types of family violence as well as their common causes and consequences. It is beyond the scope of this paper to detail such a model, so we refer readers to existing theories that highlight the developmental and ecological nature of family violence.[5] A developmental perspective recognizes that families often experience different types of violence both concurrently[6] and sequentially. For example, children who witness or experience violence may be at greater risk of involvement in partner violence as teens and adults.[7] For elder abuse, a few studies suggest that some perpetrators are motivated to neglect or abuse elderly parents who maltreated them earlier in life,[8] yet other research finds the connections between child maltreatment and elder abuse less well-established.[9] Overall, "intergenerational transmission" is a key concept in all types of family violence, but it is not an inevitable process. To understand and prevent the problem, we must also look to other explanations.

An ecological perspective emphasizes how influences at multiple levels of organization (e.g., individual, interpersonal, societal) affect family violence. Such a view extends our view from individual-level risk factors (e.g., poor impulse control, substance abuse) to those at the family (e.g., poor communication) and community (e.g., poverty, low social cohesion, gender role stereotypes) levels. This developmental-ecological model highlights the complexity of family violence and illustrates the need for a coordinated approach to prevention that engages communities and individuals as well as potential perpetrators and victims.

3 Tjaden P, Thoennes N. *Extent, Nature, and Consequences of Intimate Partner Violence: Findings From the National Violence Against Women Survey*. Washington, DC: U.S. Dept of Justice Office of Justice Programs, National Institute of Justice; 2000.

4 Teaster PB, Dugar TA, Mendiondo MS, Abner EL, Cecil KA, Otto, JM. *The 2004 Survey of State Adult Protective Services: Abuse of Vulnerable Adults 18 Years of Age and Older*. Washington: National Center on Elder Abuse; 2007. Accessed May 1, 2007 at: http://www.elderabusecenter.org/pdf/2-14-06%20FINAL%2060+REPORT.pdf .

5 Heise L. Violence against women: An integrated ecological framework. *Violence Against Women.*1998;4:262–90. Bronfenbrenner U. *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press; 1979. Cicchetti D, Rizley R. Developmental perspectives on the etiology, intergenerational transmission, and sequelae of child maltreatment. *New Directions for Child Development*. 1981;11:31-55.

6 For example, violence that occurs among an older couple could be described as both elder abuse and intimate partner violence. Also, anywhere from 30% to 70% of families with child maltreatment also experience intimate partner violence. See: Appel AE, Holden GW. The co-occurrence of spouse and physical child abuse: A review and appraisal. *J Fam Psychol.* 1998;12:578-599; Edelson JL. The overlap between child maltreatment and woman battering. *Violence Against Women.* 1999;5:134-154.

7 Foshee VA, Benefield TS, Ennett ST, Bauman KE, Suchindra C. Longitudinal predictors of serious physical and sexual dating victimization during adolescence. *Prev Med*. 2004;39:1007-16. Fang X, Corso PS. Child maltreatment, youth violence, and intimate partner violence in developmental relationships. *Am J Prev Med.* 2007; 33:281-290. Ehrensaft MK, Cohen P, Brown J, Smailes E, Chen H, Johnson JG. Intergenerational transmission of partner violence: A 20-year prospective study. *J Consult Clin Psychol*. 2003;71:741–53.

8 Walsh CA, Ploeg J, Lohfeld L, Horne J, MacMillan H, Lai D. Violence across the lifespan: Interconnections among forms of abuse as described by marginalized Canadian elders and their care-givers. *British Journal of Social Work.* 2007;37**:**491–514.

9 Korbin JE, Anetzberger G Austin C. The intergenerational cycle of violence in child and elder abuse. *J Elder Abuse Negl*. 1995;7:1–15.

Beyond our brief description of the developmental-ecological model, any introduction to family violence must acknowledge the gendered nature of the problem. Men are responsible for the overwhelmingly majority of violent crime and family violence is no exception: especially in the area of intimate partner violence, men are much more likely than women to harm their partners. While researchers and practitioners propose a range of explanations for these differences, a thoughtful consideration of gender issues must guide our understanding of family violence and our approaches to prevention.[10]

Family Violence Causes Tremendous Harm in Ohio

Because it is so common, costly and consequential, family violence causes tremendous harm to Ohio's public health and economy. Using the best available research, this section reviews the impact of family violence on our state.

How common is family violence?

Estimating the scope of family violence is very difficult, because the behaviors usually occur in private and are almost always stigmatized, illegal, and difficult to detect. Based on a review of a variety of sources, Table 1 presents the best available estimates of the incidence of different types of family violence in Ohio. In short, we estimate that currently in Ohio:

- 383,000 children under 18 have been abused or neglected;
- 1,540,000 people have been physically or sexually assaulted by an intimate partner;
- 61,000 elders have been abused or neglected.

And in the last year alone:

- 64,000 children were abused or neglected;
- 166,000 people were physically or sexually assaulted by an intimate partner;
- 29,000 elders were abused or neglected.

In general, we use two types of data to assess the scope of family violence: (1) estimated cases based on surveys of the general population and (2) investigated cases recorded by authorities. *Estimated cases* typically involve taking results from a random sample of Ohioans and extrapolating the findings to everyone in the state.[11] The strength of this approach is that it is possible to include the vast majority of cases that never come to the attention of authorities. A landmark national study, for example, concluded that child protective service agencies investigated only 28% of children seriously harmed or injured by abuse or neglect.[12] For elder abuse, estimates range from 1 in 5 cases [13] to as few as 1 in 14 cases.[14]

10 Heise, 1998.

11 Where no Ohio-specific estimates are available, we interpolate findings from national studies. When doing so, we consider how demographic differences between Ohio and the United States may bias our estimates.

12 Sedlak AJ, Hantman I, Schultz D, Broadhurst D, Thomas C. *Third National Incidence Study of Child Abuse and Neglect : Final Report Appendices, Data Collection Report, Public Use Files Manual Final Report, 3 vols.* Washington: U.S. Dept. of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, National Center on Child Abuse and Neglect; 1997.

13 The National Center on Elder Abuse. *The National Elder Abuse Incidence Study: Final Report*. Washington: Author; 1998. Accessed May 1, 2007 at: http://www.elderabusecenter.org/pdf/2-14-06%20FINAL%2060+REPORT.pdf .

14 Pillemer K, Finkelhor D. The prevalence of elder abuse: A random sample survey. *Gerontologist*. 1998;28:51-57.

Table 1. Estimated prevalence and annual incidence of family violence in Ohio

		Lifetime prevalence (Has ever been a victim…)		Annual incidence: (Has been a victim during the past year …)				
	Reference age group[a]	# victims	% of age group	# victims	# cases investigated	# cases receiving services	% of victims receiving services	# fatalities
Child maltreatment	0-17	383,000	14%	64,000	112,600	20,003	31%	166
Intimate partner violence [b]	15+	1,540,000	18%	166,000	-[c]-	-[c]-	-[c]-	229 [d]
Elder abuse [e]	60+	61,000	3%	29,000	8,109	2,175	8%	-[f] -

Table Notes:

All figures are estimates, except # cases investigated and # cases receiving services. For sources and methods, see http://www.healthpolicyohio.org/xtra/FamilyViolence/AFVP.html .

[a] The reference age groups of 0-17 years for child maltreatment and 60+ years for elder abuse are consistent with the legal definitions in most jurisdictions in Ohio. Dating violence definitely occurs among youth under 15 years old, but romantic relationships are less common. As such, survey estimates of dating violence below age 15 may be less reliable.

[b] Our estimates of intimate partner violence are limited to physical and sexual violence and do not include emotional abuse.

[c] Unlike child maltreatment or elder abuse, there is no single statewide agency that investigates, documents, and intervenes with suspected cases of intimate partner violence. Safety and privacy concerns understandably limit different agencies' (e.g., battered women's shelters; law enforcement; health care providers) willingness to share information on specific cases to construct a definitive tally.

[d] These fatalities do not include non-partners (e.g., other family members) who account for roughly one in five homicides related to intimate partner violence.[15]

[e] Does not include self-neglect.

[f] There exist no reliable estimates of the number of fatalities due to elder abuse. One study of 2,812 elders found that those who were abused were 3 times more likely to die over a 13-year period.[16] Interestingly, not one of the deaths was immediately attributable to injury. Also compounding the problem is that autopsies are rarely performed on the elderly, even in suspected cases of abuse. (Georgia Anetzberger, Cleveland State University, personal communication, 11/9/07).

15 Langford L, Isaac N, Kabat S. Homicides related to intimate partner violence in Massachusetts: Examining case ascertainment and validity of the SHR. *Homicide Stud*, 1998;2:353-377.

16 Lachs MS, Williams CS, O'Brien S, Pillemer KA, Charlson ME. The mortality of elder mistreatment. *JAMA*. 1998;280:428-432.

One problem of using survey data is that estimates can vary depending on the methods used (e.g., how questions are phrased; whether data are collected by phone, mail or in-person interview). Also, it can be difficult to distinguish isolated violent incidents from repeated acts of violence, (although single acts of family violence are always troubling and often occur as part of a larger pattern). For these reasons, we base our estimates on scientifically rigorous studies that employ valid measures of family violence.

Investigated cases [17] are useful indicators because they emphasize the immediate burden family violence places on government agencies such as adult or child protective services.[18] They may also provide more contextual information about the violent incidents, such as characteristics of perpetrators. One weakness of this approach is that definitions of family violence as well as data collection methods can change over time and across jurisdictions.[19] Also, inconsistent reporting mechanisms further complicate the situation. In Ohio, for instance, suspected cases of elder abuse may be reported to a variety of different agencies, including (but not limited to): local adult protective services, the local Long Term Care Ombudsman's Office, the Attorney General's Medicaid Fraud Control Unit, or the Ohio Department of Health. The location of the abuse and the relationship between perpetrator and victim generally guides where cases are reported. Still, sometime reports are filed through multiple agencies and no single office tallies the overall number of unduplicated reports.

Case totals may also be difficult to tally because local agencies differ widely in their capacity to collect data on family violence.[20] State fiscal year 2007, for example, was the first time that local adult protective service agencies serving all 88 counties reported their elder abuse case totals to the Ohio Department of Job and Family Services.[21] In the area of child maltreatment, Ohio investigates three times as many allegations per capita as Pennsylvania, but only half as many as West Virginia.[22] It is very unlikely that such large discrepancies are due to differences in the actual rate of maltreatment. Finally, our analysis of data from the Attorney General's office[23] found that only 51% (373/679) of local law enforcement agencies in Ohio submitted complete monthly reports of domestic violence, despite their being required to do so by law. Perhaps more disturbing, 9 community police agencies (i.e., not including college or metro parks forces) submitted reports each month yet recorded no incidents for the entire year.

What do these numbers mean?

The estimates presented in Table 1 are easier to understand when considered in the context of other problems. Figure 1 presents the annual incidence of selected threats to Ohio families. Last year in Ohio: 105,972 children eligible for SCHIP were uninsured,[24] 79,072 mortgage foreclosures were filed,[25] and 16,284 manufacturing

17 Not all cases reported to authorities are investigated. When a report is filed, agency officials screen the allegation to determine if it merits further investigation. Many allegations are screened out at this stage for a variety of reasons, including lack of evidence or recognition that a different agency has jurisdiction.

18 Unlike child maltreatment or elder abuse, it is usually the victim herself who notifies authorities of a case of intimate partner violence. Victims may seek help from a wide range of sources (e.g., battered women's shelters, hotlines, law enforcement), yet safety and privacy concerns understandably limit different agencies' willingness to share information on specific cases. As such it is impossible to construct a definitive tally of "investigated cases."

19 Kopels S, Charlton T, Wells SJ. Investigation laws and practices in child protective services. *Child Welfare Journal*. 2003;82:661-684

20 Daly JM, Jogerst GJ, Haigh KM, Leeney JL, Dawson JD. APS workers job requirements associated with elder abuse rates. *Social Work in Health Care*. 2005;40:89-102

21 Personal communication, Shelly Boyd, Ohio Department of Job and Family Services, 1/30/08. See also: Balaswamy S. *Evaluation of Ohio's Adult Protective Services: Structure, Operation and Cost: Phase III Final Report*. Columbus, OH: Ohio Department of Job and Family Services; 2001. Accessed July 1, 2007 at: http://jfs.ohio.gov/ocf/APSfinalReport/

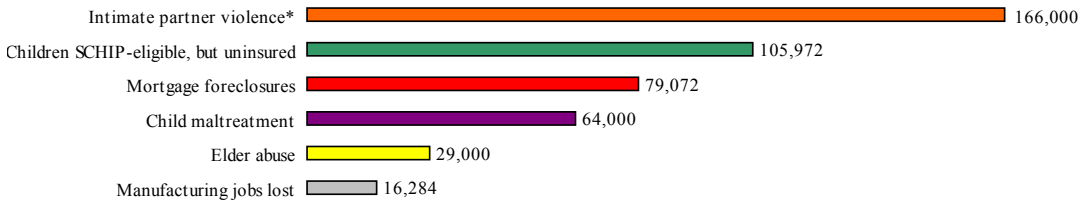
22 USDHHS – ACYF, 2007. In 2005, Ohio conducted 26.0 investigations of child maltreatment for every 1,000 children in the state, whereas in Pennsylvania the rate was 8.2 per 1,000 and in West Virginia it was 58.6 per 1,000.

23 Ohio Bureau of Criminal Identification and Investigation. *Domestic Violence Reports by County and Agency, 2006.* 2007. Accessed December 2, 2007 at: http://www.ag.state.oh.us/victim/pubs/06dvp/06DVI.pdf .

24 Unpublished data from the 2004 Ohio Family Health Survey.

25 Ohio Supreme Court. *2006 Ohio Courts Summary Report*. Columbus, OH: Author; 2007. Accessed September 1, 2007 at: http://www.sconet.state.oh.us/publications/annrep/06OCS/default.asp . The data are from 2006. From January to November, 2007, 131,025 foreclosures had been filed in Ohio. (RealtyTrac. *Ohio Foreclosures*. Accessed December 19, 2007 at: www.realtytrac.com/states/ohio.html .)

Figure 1. Selected threats to Ohio families: Estimated annual incidence



*Notes: * physical and sexual violence only; does not include emotional abuse. For sources, see footnotes in text.*

jobs were lost.[26] We do not aim to imply that one threat is more important than another, only that family violence is just as common as other problems that receive much more attention. Moreover, the consequences of family violence can be just as enduring and harmful to Ohio's families.

How accurate are these estimates?

No one knows the true scope of family violence in Ohio. Especially in the area of elder abuse, researchers are still exploring the best ways to measure the problem.[27] In preparing the estimates, we reviewed published studies and consulted with experts from around the United States and – whenever possible – from Ohio. As such, we believe they are the most accurate available and have posted online detailed descriptions of our sources and methods.[28] Nonetheless, there are several reasons why *our final estimates most likely understate the true incidence and prevalence of family violence*. First, family violence may be more common among segments of the population who are difficult to include in the types of research on which we base our estimates (e.g., persons of lower income and/or who are immigrants may be underrepresented in a survey samples).[29] Second, many types of family violence are negatively associated with a household's willingness to participate in research. Women who live in fear of an abusive partner may be more difficult to locate when conducting surveys.[30] Elders who are neglected by their family members often lack the physical or mental capacity to participate in research. In contrast, there is little reason to suspect our estimates exaggerate the scope of family violence in Ohio.

Any effort to measure the extent of family violence also involves tension between definitions of family violence and the methods used to measure them. Our definitions of child maltreatment and elder abuse (see Appendix A) describe neglect as a failure to provide basic shelter, support or other "life necessities." Yet the variation in legal definitions from county to county demonstrates the difficulty of creating a definitive case

26 We calculated this figure by comparing *Quarterly Census of Employment and Wages Data* from 2005 and 2006. Ohio Department of Job & Family Services. *Economic Development Profiles based on the North American Industry Classification System*., n.d. Accessed December 19, 2007 at: http://lmi.state.oh.us/asp/edeps/EdepsNaics.htm . Thanks to Mark Schaff, Labor Economist, Bureau of Labor Market Information, for his help preparing this estimate.

27 Thompson MP, Basile KC, Hertz MF, Sitterle D. *Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2006. Accessed March 23, 2007 at: *http://www.cdc.gov/ncipc/dvp/Compendium/IPV%20Compendium.pdf* . For examples of federal funding of elder abuse measurement, see: National Institute on Aging. *Developmental Research on Elder Mistreatment (R21), Request for Applications Number: RFA-AG-06-009*; 2006. Accessed November 1, 2007 at: http://grants.nih.gov/grants/guide/rfa-files/RFA-AG-06-009.html .

28 Steinman K. *Ohio Family Violence Prevention Project: Population, Prevalence, Incidence and Cost Estimates*. Accessed February 19, 2008 at http://www.healthpolicyohio.org/xtra/FamilyViolence/AFVP.html .

29 Tjaden, Thoennes, 2000.

30 WalterMaurer EM, Ortega CA, McNutt LA. Issues in estimating the prevalence of intimate partner violence: Assessing the impact of abuse status on participation bias. *Journal of Interpersonal Violence*, 2003;18:959-974.

definition. Similar concerns complicate measures of intimate partner violence, especially psychological/emotional abuse. Such abuse can be every bit as harmful as other types of intimate partner violence, yet it is difficult to define a "case" of emotional abuse. On surveys, the outcome is typically measured by asking a series of questions, and any respondent who answers "yes" to multiple items is clearly indicating an alarming, abusive pattern of behavior. [31] Yet in isolation many of the individual questions are distasteful but not especially troubling.[32] Thus, defining as "abuse" someone who endorses only one item will yield estimates that are simply not valid.[33] Publishing such estimates would only undermine the credibility of our other work and divert readers' attention from the very real problem of emotional abuse.

What are the costs and consequences?

In Ohio, family violence causes tremendous harm not only through its alarming frequency, but also because of the great consequences experienced by each family. Applying findings from national studies, Table 2 presents a rough approximation of the economic burden that family violence places upon Ohio. These estimates suggest that each year Ohio spends over $1.1 billion on direct costs to address only some aspects of family violence. Direct costs refer to the actual dollar expenditures that result from acts of family violence, such as medical care for victims (e.g., emergency department visits; mental health treatment) and social services (e.g., shelters for battered women; foster care for abused children). Some of these costs appear in the state budget, but most never appear as a line item. Rather they come through an uninsured woman visiting the emergency room to repair her broken jaw; or officials forced to remove a disoriented grandfather from his home because his daughter has been taking his Meals on Wheels. Even if they are not easily quantified, these costs are both real and significant.

It is important to emphasize that our direct cost estimate is quite incomplete. The chief limitation is the absence of any rigorous studies on the costs of elder abuse. With experts speaking of billions of dollars in costs nationally (see footnote in Table 2), it is likely that elder abuse costs Ohio hundreds of millions of dollars. Yet such estimates were too imprecise to include in our calculations so we simply left them out. Another limitation is that the studies we reviewed did not include criminal justice costs for intimate partner violence. Studies from other developed countries have found that direct criminal justice costs associated with intimate partner violence were similar to, or greater than

31 DeKeseredy WS. Current controversies on defining nonlethal violence against women in intimate heterosexual relationships. *Violence Against Women.* 2000;6:728-746.

32 Examples of psychological abuse from one scale ask the respondent to estimate how often during the past six months [he] has: "called her names and/or criticized her;" "put down her family and friends." Shepard MF, Campbell JA. The Abusive Behavior Inventory: a measure of psychological and physical abuse. *Journal of Interpersonal Violence* 1992;7:291–305.

33 One study reported 6-month incidence rates as high as 77% and a lifetime prevalence of 92%. Neufeld J McNamara JR, Ertl M. Incidence and prevalence of dating partner abuse and its relationship to dating practices. *Journal of Interpersonal Violence*. 1999;14(2):125-137.

Table 2. Estimated annual costs associated with family violence in Ohio

	Direct costs	Indirect costs	Total costs	Source
Child maltreatment	$920 million	$2.1 billion	$3 billion	1
Intimate partner violence	$213 million	$93 million	$306 million	2
Elder abuse	___	___	___	3
Total	$1.1 billion	$2.2 billion	$3.3 billion	

Notes:

1 *Conrad C. Measuring costs of child abuse and neglect: a mathematic model of specific cost estimations. J Health Hum Serv Adm. 2006;29:103-23. This study concluded that cases of child maltreatment on average incur direct costs of $21,649 per case. Applying this figure to the 42,483 cases of substantiated or indicated child maltreatment in Ohio in 2005 (USDHHS – ACYF [2007]) yielded our total.*

2 *National Center for Injury Prevention and Control. Costs of Intimate Partner Violence Against Women in the United States. Atlanta, GA: Centers for Disease Control and Prevention; 2003. Accessed May 1, 2007 at: http://www.cdc.gov/ncipc/pub-res/ipv_cost/IPVBook-Final-Feb18.pdf .*

3 *We were unable to locate any studies detailing the economic impact of elder abuse. In 1999, one expert estimated the cost of financial exploitation alone as ranging from $1.2 to 4 billion, (Blum B. Testimony to the U.S. Senate Committee on Commerce, Science and Transportation Hearing on "Fraud: Targeting America's Seniors." July 28, 1999. Accessed May 1, 2007 at: http://commerce.senate.gov/hearings/0804blu.pdf). A more recent White House conference estimated the costs as "tens of billions of dollars annually." (National Committee for the Prevention of Elder Abuse. 2005 White House Conference on Aging: Post Conference Summary Report. Philadelphia, PA: Author; 2005. Accessed May 1, 2007 at: http://www.preventelderabuse.org/whcoaging2005.html). We chose not to quote these estimates because the methods used to derive them are unstated and the conclusions were too imprecise.*

All figures have been converted to 2007 dollars.

National estimates were interpolated to Ohio based on census population estimates.

Cost estimates for intimate partner violence are for female victims only and do not include criminal justice costs. Indirect costs are limited to lost worker productivity and age-adjusted lifetime earnings.

For sources and methods, see: http://www.healthpolicyohio.org/xtra/FamilyViolence/AFVP.html.

health care costs.[34] Nonetheless, it is unclear how relevant those findings are to Ohio – again, these estimates were not included. Finally, our costs for intimate partner violence are limited to female victims. Because some men also experience intimate partner violence, our current estimates make no allowance for costs incurred by male victims.[35] Given all this uncounted spending, the true direct costs of family violence in Ohio are certainly much higher.

Indirect costs are also essential for understanding the impact of family violence. Indirect costs summarize the value of things that are lost as a result of violence, such as the cost of finding a new home, needing to repeat a semester of college, or lost worker productivity. When family violence is fatal, it also includes lost lifetime earnings.[36] Applying the national findings to Ohio, we estimate that the indirect costs of family violence exceed $2.2 billion annually for child maltreatment and intimate partner violence alone.

34 Economic studies of intimate partner violence from Canada, the United Kingdom, Finland and Sweden all found that direct criminal justice costs associated with were similar to, or greater than health care costs. For examples, see: Kerr R, McLean J. *Paying for Violence: Some of the Costs of Violence Against Women in British Columbia.* Vancouver, BC: Ministry of Women's Equality; 1996. Accessed November 23rd, 2007 at: http://www.eurowrc.org/06.contributions/1.contrib_en/24.contrib.en.htm. Greaves L, Hankivsky O, Kingston-Riechers J. *Selected Estimates of the Costs of Violence Against Women*. London, ON: Centre for Research on Violence against Women and Children; 1995. Accessed November 23rd, 2007 at: http://www.crvawc.ca/docs/pub_greaves1995.pdf . Stanko EA, Crisp D, Hale C, Lucraft H. *Counting the Costs: Estimating the Impact of Domestic Violence in the London Borough of Hackney.* Swindon, UK: Crime Concern; 1998. Accessed November 23rd, 2007 at: http://met.police.uk/dv/files/estimate_impact.pdf . Walby S. *The Cost of Domestic Violence.* London: Department of Trade and Industry, Government Equality Office, Women and Equality Unit; 2004. Accessed November 23rd, 2007 at: http://www.womenandequalityunit.gov.uk/research/cost_of_dv_Report_sept04.pdf. Gemzell T. *The Cost of Gender-Based Violence in Sweden.* Linköping, Sweden: Ekonomiska Institutionen, Politices Magisterprogrammet, Linköping University; 2005. Accessed November 23rd, 2007 at: www.diva-portal.org/diva/getDocument?urn_nbn_se_liu_diva-5109-1__fulltext.pdf. Piispa M, Heiskanen M. *The Price of Violence - The Costs of Men's Violence against Women in Finland.* Helsinki, Finland: Statistics Finland and Council for Equality; 2001.

35 Unfortunately, very little is known about the economic impact of male victims of intimate partner violence.

36 In Table 1, we estimate that 229 of the 525 homicides in Ohio in 2004 (among victims aged 16+) were attributable to intimate partner violence. Broken down by gender, this suggests that 18% of adult male homicides and 72% of adult female homicides in Ohio are associated with intimate partner violence.

The longer-term effects of family violence are very difficult to quantify but are no less real or enduring.[37] When people think of the consequences of family violence, they tend to focus on injury and, perhaps, mental health. These consequences are indeed enormous, but considerable research now links family violence to a surprisingly wide range of outcomes that persist throughout life. Children who experience abuse or neglect are more likely to start drinking and smoking as teenagers,[38] and to be arrested as a juvenile.[39] As adults, they are more likely to miss work,[40] develop heart disease[41] and obesity,[42] and attempt suicide.[43] Intimate partner violence also has well-documented effects on mental health, injury, chronic pain, gastrointestinal disorders and pregnancy outcomes such as low birth weight. [44] Moreover, intimate partner violence can threaten the well-being of those children who witness it. Whether or not they are directly abused, children who grow up in violent homes are at greater risk for psychological, social and academic problems.[45] Later in life, they are also more likely to develop psychiatric disorders.[46] These consequences are not evitable, as children can improve markedly if their home environment changes to one that is safe and stimulating.[47] Too often, however, such changes fail to occur.

If the consequences of family violence appear overwhelming, they also make a compelling case for prevention. Stopping violence before it begins could have a broad range of positive outcomes on everything from academic achievement to worker productivity. In the next section we review the potential of family violence prevention to achieve such effects.

Family Violence Prevention Can Work

Most people recognize the logic of the saying: "an ounce of prevention is worth a pound of cure." Yet prevention is only compelling when available approaches actually work. In this section, we define prevention and discuss it potential to be both effective and efficient.

What is prevention?

Prevention involves planned efforts to avoid specific undesirable outcomes or promote desirable ones. Researchers and practitioners often distinguish three types of prevention: universal, selective and indicated.[48]

37 Some economists quantify these longer term effects and label them "indirect costs." For the purposes of this paper, we chose to describe, but not put into dollars, these longer term effects.

38 Dube SR, Miller JW, Brown DW, Giles WH, Felitti VJ, Dong M, et al. Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence. *J Adolesc Health.* 2006;38:444.e1-444.e10. Anda RF, Croft JB, Felitti VJ, Nordenberg D, Giles WH, Williamson DF, et al. Adverse childhood experiences and smoking during adolescence and adulthood. *JAMA.*1999;282:1652–1658.

39 Maxfield MG, Widom CS. The cycle of violence: Revisited 6 years later. *Arch Pediatr Adolesc Med.* 1996;150:390-395.

40 Anda RF, Felitti VJ, Fleisher VI, Edwards VJ, Whitfield CL, Dube SR, et al. Childhood abuse, household dysfunction and indicators of impaired worker performance in adulthood. *The Permanente Journal*. 2004;8:30–38.

41 Dong M, Giles WH, Felitti VJ, Dube, SR, Williams JE, Chapman DP, et al. Insights into causal pathways for ischemic heart disease: Adverse Childhood Experiences Study. *Circulation*. 2004;110:1761–1766.

42 Williamson DF, Thompson, TJ, Anda RF, Dietz WH, Felitti VJ. Body weight, obesity, and self-reported abuse in childhood. *Int J Obes (Lond)*. 2002;26:1075–1082.

43 Dube SR, Anda RF, Felitti VJ, Chapman DP, Williamson DF, Giles WH. Childhood abuse, Household dysfunction, and the Risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *JAMA*. 2001;286:3089-96.

44 Campbell JC. Health consequences of intimate partner violence. *Lancet.* 2002;359:1331-1336.

45 Kitzmann KM, Gaylord NK, Holt AR, Kenny ED. Child witnesses to domestic violence – a meta-analytic review. *J Consult Clin Psychol*. 2003;71:339–352.

46 Kessler RC, Davis CG Kendler KS. Childhood adversity and adult psychiatric disorder in the U.S. National Comorbidity Survey. *Psychol Med.* 1997;27:1101–1119.

47 Putnam FW. The impact of trauma on child development. *Juvenile and Family Court Journal*. 2006;Winter:1-11.

48 Centers for Disease Control and Prevention. *Sexual Violence Prevention: Beginning the Dialogue*. Atlanta, GA: Centers for Disease Control and Prevention; 2004. Our use of the terms "universal," "selective," and "indicated" prevention correspond to others' use of the terms "primary," "secondary" and "tertiary" prevention. Confusingly, the CDC Division of Violence Prevention uses these same alternate terms to describe the *timing* of prevention activities: Primary prevention involves activities to prevent violence before it occurs. Secondary prevention refers to activities immediately after violence to prevent short-term adverse outcomes. Tertiary prevention occurs after violence to prevent long-term adverse outcomes.

Universal Prevention:

Strategies applied to the general population with the purpose of preventing occurrences. For example: school-based teen dating violence prevention programs targeting all tenth graders.

Selective Prevention:

Strategies targeting a particular population determined to be at-risk with the purpose of preventing occurrences. For example: nurse home visiting programs to prevent child maltreatment among low-income first-time mothers. Rather than target all mothers, these efforts focus on families at greater risk.

Indicated Prevention:

Strategies targeted to persons for whom adverse outcomes or problems have already occurred with the purpose of preventing reoccurrence. Victims services are examples of indicated prevention.

As noted earlier, most planned efforts to address family violence involve indicated prevention. That is, they focus on people who have already experienced family violence. Even with that focus, Ohio invests far too little in services such as early intervention, battered women's shelters, and adult protective services. While urging greater support for victims services, the present project aims to widen the discussion of family violence in Ohio to include universal and selective prevention as well.

Currently there is considerable debate about the merits of universal versus selective prevention. Because family violence is so widespread and is rooted in deep cultural values (e.g., gender roles, acceptable forms of discipline), many argue that prevention efforts must engage everyone. This view suggests that to focus on selected "at risk" groups only marginalizes the issue and may imply that victims are responsible for their own abuse and neglect. Others recognize these concerns, but contend that limited resources require us to focus our efforts where the need is greatest. Often, selective prevention is not only more efficient, but is more likely to demonstrate its effectiveness. Both of these perspectives are important and the consensus nature of this document precludes us from choosing sides. Nonetheless, any serious discussion of prevention must recognize this debate.

Prevention can work

Many threats to public health seem impossible to prevent, such as natural disasters or hereditary conditions like polycystic kidney disease. Yet it was not so long ago that health officials could offer little advice for how to prevent common conditions like heart disease or injuries from motor vehicle crashes. Fortunately, research has made remarkable progress in preventing numerous cases of injury and disease that were once thought unavoidable. Since 1950, for example, prevention efforts have helped reduce rates of heart disease by 60%, infant mortality by 76% and motor vehicle accidents by 38%.[49]

In the area of family violence, a large and growing body of research has identified several promising approaches to prevention. The strength of the evidence varies according to the type of violence and the type of program, but much of the news is encouraging. The most compelling findings come from programs that have been repeatedly evaluated and yield similar outcomes in different settings. Studies from three different cities, for example, found that nurses making regular, structured home visits to low-income first-time mothers may have

49 National Center for Health Statistics. *Health, United States, 2006*. Washington: U.S. Government Printing Office; 2007. Accessed November 1, 2007 at: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=healthus06 . Even as these issues still represent major threats to public health, they are no longer seen as unavoidable. Prevention efforts seldom eliminate a threat completely, yet such successes have already saved thousands of lives and billions of dollars.

prevented many cases of child maltreatment.[50] Evidence for other types of programs is less consistent, but still promising. A meta-analysis[51] of 27 studies of school-based child sexual abuse prevention concluded that such programs have a large effect on improving children's knowledge and skills.[52] For intimate partner violence, carefully evaluated school-based programs in North Carolina and Ontario, Canada significantly reduced dating violence among teens for up to four years.[53]

Our optimism for the potential of family violence prevention also stems from the success of other prevention efforts to produce a wide range of effects over a long period of time. Beginning in 1962, for example, the High/Scope Perry Preschool project randomly assigned low-income 3 and 4 year olds to a high quality preschool environment. Followed through age 40, the project found that the high-quality preschool yielded a lifetime of benefits in everything from reduced involvement in crime and welfare, to greater likelihood of academic achievement, marriage and home ownership.[54] Still another example is the Good Behavior Game – a classroom-based program for first and second graders that markedly reduced boys' aggressive behavior[55] and smoking through age 14.[56]

At what cost?

While these examples demonstrate that prevention can improve health outcomes, it is fair to ask, "At what cost?" Social programs can be expensive and do not completely eliminate a problem, so the expected benefits should outweigh the costs.

The enormous, well-documented costs associated with family violence (see above) indicate that considerable investment in prevention may be worthwhile. Moreover, evidence for the intergenerational transmission of family violence[57] suggests that effective prevention could also yield benefits over time: preventing a case of abuse today could indirectly prevent cases of child maltreatment, intimate partner violence and elder abuse in the next generation. Such broad effects will certainly be difficult to document in practice – doing so would require investing in rigorous program evaluation for decades – yet previous examples suggest that such optimism is not unwarranted.

Unfortunately, few economic studies have conducted cost-benefit analyses of family violence prevention. One important example is the Nurse-Family Partnership, a home visitation program where nurses make regular,

50 Olds DL, Eckenrode J, Henderson CR Jr, Kitzman H, Powers J, Cole R, et al. Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial. *JAMA.* 1997;278:637-43. Olds DL, Kitzman H, Cole R, Robinson J, Sidora K, Luckey DW, et al. Effects of nurse home visiting on maternal life-course and child development: Age-six follow-up of a randomized trial. *Pediatrics*. 2004;114:1550-9. Olds DL, Robinson J, Pettitt L, Luckey DW, Holmberg J, Ng RK, et al. Effects of home visits by paraprofessionals and by nurses: Age-four follow-up of a randomized trial. *Pediatrics*. 2004;114:1560-8.

51 A meta-analysis is a set of statistical techniques that enables researchers to combine results across many studies that test related hypotheses. For a useful reference, see: Pettiti D. *Meta-Analysis, Decision Analysis, and Cost-Effectiveness Analysis: Methods for Quantitative Synthesis in Medicine, 2nd Edition.* New York: Oxford University Press; 2000.

52 Davis MK, Gidycz CA. Child sexual abuse prevention programs: A meta-analysis. *J Clin Child Psychol.* 2000;29:257-265.

53 Whitaker DJ, Morrison S, Lindquist C, Hawkins SR, O'Neil JA, Nesius AM, et al. A critical review of interventions for the primary prevention of perpetration of partner violence. *Aggression and Violent Behavior.* 2006;11:151-166.

54 Schweinhart LJ, Montie J, Xiang Z, Barnett WS, Belfield CR, Nores M. Lifetime effects: The High/Scope Perry Preschool study through age 40. *Monographs of the High/Scope Educational Research Foundation*, 2005;14.

55 Kellam SG, Rebok GW, Ialongo N, Mayer LS. The course and malleability of aggressive behavior from early first grade into middle school: Results of a developmental epidemiologically-based preventive trial. *J Child Psychol Psychiatry*. 1994;35:259-281.

56 Kellam SG, Anthony JC. Targeting early antecedents to prevent tobacco smoking: Findings from an epidemiologically based randomized field trial. *Am J Public Health*. 1998;88:1490-1495.

57 Evidence for intergenerational transmission of violence is mixed and may vary by type. See: Fergusson DM, Boden JM, Horwood LJ. Examining the intergenerational transmission of violence in a New Zealand birth cohort. *Child Abuse Negl.* 2006;30:89–108. Heise, 1998. Widom CS. Childhood victimization: Early adversity and subsequent psychopathology. In: Dohrenwend BP, editor. *Adversity, Stress, and Psychopathology.* New York: Oxford University Press; 1998. p. 81-95.

structured visits to low-income first-time mothers. Several analyses, summarized by Isaacs,[58] concluded that the program yields $2.88 to $5.68 in cost savings for every dollar invested. Evidence from other programs suggests that they may be cost effective, but no analyses have been completed. *Safe Dates*, for example, is a promising school-based program that significantly reduced physical and sexual abuse among dating teens for at least four years.[59] By relying on regular classroom teachers and an inexpensive training manual, the program has relatively modest costs compared to other school-based health programs.[60] Even as the cost-effectiveness of family violence prevention is still uncertain, this initial evidence is promising.

Realistic expectations

For all the claims of effectiveness and efficiency, we emphasize the need to have realistic expectations about the potential of family violence prevention. Too often, enthusiasm for "evidence-based" approaches to social policy is followed by frustration and defensiveness when hoped-for results fail to materialize. For this reason, it is important to recognize the challenges of translating research findings into effective practice.[61]

One challenge is the difference between how programs are tested in research versus how they are actually used in practice. When testing whether an intervention "works," researchers carefully monitor the program to ensure that it is being implemented as planned. They also spend considerable resources to accurately measure and analyze data on the outcomes they hope to change. In practice settings, however, limited resources often restrict practitioners' abilities in these areas. For example, it may be necessary to modify a school-based curriculum from 10 to 7 sessions; or to stop monitoring whether educators are implementing a program correctly. In addition, the unpredictability and brevity of funding cycles often pressures agencies to produce demonstrable outcomes in an unrealistically short period. As a result of all these factors, the program used in practice differs from the one demonstrated to be effective in research.[62]

Another major challenge involves differences between who pays the costs of prevention versus who reaps the benefits. Even as the economic and social benefits of effective programs accrue, they often are spread across multiple agencies. As such, it is difficult for any single organization to justify funding a program on the grounds that it will recover those costs in reduced expenditures within their own budgets.[63] Even within agencies, the staff responsible for universal and selective prevention may differ from those involved in indicated prevention. When family violence prevention efforts are not coordinated, it can be difficult to invest in prevention and its promise of future benefits when other programs require funding for people in immediate need.

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58 Isaacs J. *Cost Effective Investments in Children*. Washington: The Brookings Institution; 2007. Accessed March 1, 2007 at: http://www3.brookings.edu/views/papers/200701isaacs.pdf .

59 Foshee VA, Bauman KE, Ennett ST, Linder GF, Benefield T, Suchindran C. Assessing the long-term effects of the Safe Dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. *Am J Public Health*; 2004;94:619-624.

60 Substance Abuse and Mental Health Services Administration. National Registry of Evidence-Based Programs and Practices. *Intervention summary: Safe Dates*. Washington: Author; n.d. Accessed November 14, 2007 at: http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=84#description .

61 Daro D, Donnelly AC. Charting the waves of prevention: Two steps forward, one step back. *Child Abuse Negl*. 2002;26:731–742.

62 Glasgow RE, Lichtenstein E, Marcus AC**.** Why don't we see more translation of health promotion research to practice? Rethinking the efficacy-to-effectiveness transition. *Am J Public Health.* 2003;8:1261-1267.

63 Olds D, O'Brien RA, Racine D, Glazer J, Kitzman H. Increasing the policy and program relevance of randomized trials of home visitation. *Journal of Community Psychology*. 1998;26:85-100.

Existing Efforts Are Critical But Insufficient

Ohio's current approach to addressing family violence emphasizes investigating suspected cases of abuse and neglect. By law, each county must designate an agency responsible for investigating suspected cases of child maltreatment (e.g., public children service agencies) and elder abuse (e.g., adult protective services). Similarly, all law enforcement agencies should respond to incidents of intimate partner violence when probable cause indicates that a crime occurred. Complementing these efforts are scattered publicly and privately financed programs that provide everything from crisis counseling and safe shelter to legal advocacy and transportation. These programs are not optional and expendable, they may actually save lives. During the 1990's, homicides among intimate partners decreased more in cities that invested more in victims services.[64] Other scholars similarly attribute reductions in child sexual and physical abuse to improvements in the quantity and quality of child protective services.[65]

Limitations of the current approach

One major limitation of Ohio's current approach to addressing family violence is that most funding is spent trying to substantiate suspected cases. Much less is spent on victims services and even less on prevention. (The distribution of resources is somewhat different for child maltreatment, as considerable funding supports services for children who experience or who are at risk for maltreatment.) Investigating suspected cases is, of course, a legally mandated and valuable function of government; but taken alone, it is an insufficient and inefficient approach to protecting Ohio's families.

The focus on investigation is insufficient because each year the majority of cases simply never come to the attention of authorities. As reported in Table 1, last year adult protective service agencies investigated 8,109 cases of suspected elder abuse even though the actual number of new cases was closer to 29,000. Moreover, they could substantiate abuse in only 3,888 investigations (figure not reported in table). In other words, only 13% (3,888/29,000) of the elder abuse cases in Ohio were confirmed by authorities.[66] For child maltreatment, the situation is challenging in a different way. In 2005, child protective services agencies investigated 112,600 children in Ohio for suspected abuse or neglect, and identified 42,483 as victims (figure not reported in table).[67] Based on our estimate of 64,000 new cases each year, this means that authorities conducted twice as many investigations as actual cases, but still missed identifying one out of three actual cases of child maltreatment.

Identifying cases is only part of the challenge, for even after they are identified, many victims do not receive services. Based on the figures in Table 1, each year only 31% (20,003/64,000) of abused or neglected children and only 8% (2,175/29,000) of abused elders actually receive victims services. Victims of family violence experience many barriers when accessing services. People may feel the services are inappropriate, unnecessary or not culturally relevant to them.[68] Others may be afraid of retaliation from the abuser or the

64 Dugan L, Nagin D, Rosenfeld R. Exposure reduction or retaliation? The effects of domestic violence resources on intimate partner homicide. *Law & Society Review.* 2003;37:169–198.

65 Finkelhor D, Jones L. Why have child maltreatment and child victimization declined? *Journal of Social Issues*. 2006;62:685-716.

66 These estimates combine 2007 figures from Adult Protective Services [Ohio Department of Job and Family Services. *Adult Protective Services Fact Sheet for SFY 2007.* Columbus, OH: Author; 2007.] and 2006 figures from the Medicaid Fraud Control Unit [Unpublished 2006 data from Ohio Attorney General's Office, Medicaid Fraud Control Unit. Provided by Jason Helmandollar, 10/25/2007]. For complete details, visit: http://www.healthpolicyohio.org/xtra/FamilyViolence/AFVP.html..

67 USDHSS-ACF 2007, table 3-6. This total includes cases that are either "substantiated" (i.e., sufficient evidence exists under state law that maltreatment occurred or is likely to occur) or "indicated" (i.e., reason to suspect that maltreatment occurred).

68 Lee RK, Sanders Thompson VL, Mechanic MB. Intimate partner violence and women of color: A call for innovations**.** *Am J Public Health*. 2002;92(4):530-534. Tatara T. *Understanding elder abuse in minority populations*. Philadelphia, PA: Brunner/Mazel; 1999.

community if they seek help, including being forced into a long-term-care facility.[69] Even carefully planned efforts to reach victims often fall short. One project, for example, offered a range of services to women whose partners had been convicted of offenses related to intimate partner violence.[70] The vast majority of the 1,895 eligible women either could not be reached (47%) or reported that they did not want to receive services (34%). Of the one in five eligible women who accepted services, relatively few (19%) actually participated.

The challenge of identifying cases and providing services is complex and many Ohio agencies do an admirable job with the resources they have. State agencies regularly explore better ways to investigate cases[71] and many local programs devise creative strategies for outreach and engagement. Nonetheless, addressing family violence through victims services will always be an insufficient response. A more comprehensive approach requires investing in efforts to prevent family violence before it begins. Prevention takes many forms, from programs that teach expectant fathers and mothers how to anticipate and handle the stress of parenting, to community initiatives that deconstruct gender role stereotypes or build social support for isolated elders. How such efforts are organized and funded has great bearing on their effectiveness.

Funding family violence prevention in Ohio

No one has ever formally calculated how much Ohio spends on family violence prevention, but it is likely a small fraction of what is spent on investigations and victims services. One analysis of expenditures in New York City found that 79% of city spending for "domestic violence" went to emergency social services and less than 1% was devoted to prevention.[72] While a complete accounting is beyond the scope of this document, this section presents a rough sketch of who funds family violence prevention in Ohio and how they do so.

As a state, Ohio spends very little directly preventing violence *before* it occurs. The only significant example of state spending is the $4.2 million for the *Ohio Children's Trust Fund.*[73] Established by the legislature in 1984, the Fund supports local advisory boards in all 88 Ohio counties to develop programs that prevent child maltreatment *before* it occurs. Other large, state-funded programs aim to address risk factors for family violence (e.g., substance abuse, low social support; parenting skills), but very few measure family violence as an outcome. As such, it is unclear if these efforts to provide parenting assistance have any effect and there is little incentive for administrators to improve their ability to prevent family violence. *Help Me Grow,* for example, is a $61 million program administered chiefly through the Ohio Department of Health's Bureau of Early Intervention.[74] Reaching all 88 counties, it provides a range of services (e.g., home visitation) to families with young children, especially those at risk for developmental delays. These efforts are valuable, yet few explicitly aim to reduce child maltreatment.[75] In summary, Ohio's direct investment in family violence prevention is very small and is limited to child maltreatment. While other state-funded programs may influence family violence indirectly, their focus on other important topics undermines their potential to address family violence.

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69 Ahmad M, Lachs MS. Elder abuse and neglect: What physicians can and should do. *Cleve Clin J Med*. 2002;69(10):801-808.

70 Gondolf E. Service contact and delivery of a shelter outreach project. *Journal of Family Violence*. 1998;13:131-145.

71 For a good example, see: Ohio Department of Job & Family Services. *Managing for Results: 2006 Performance Management Report*. Columbus, OH: Author; 2007. Accessed October 11, 2007 at: http://odjfsperformancecenter.ohio.gov/pdf%5CPerformance_Center_Yearin_Review_Final.pdf .

72 New York City Independent Budget Office. *City Spending on Domestic Violence: A Review*. New York: Author; 2007. Accessed September 30, 2007 at: www.ibo.nyc.ny.us .

73 State funding is provided through fees on birth certificates, death certificates and divorce/dissolution filings. Personal communication, Karen Minton, Program Administrator, Ohio Children's Trust Fund Ohio Department of Job & Family Services, 12/21/07.

74 Most of the budget is funded through federal programs such as Temporary Aid for Needy Families and the Individuals with Disabilities Education Act (Part C). The program also receives $8.5 million from Ohio's General Revenue Funds. Personal communication, Debbie Cheatham, Program Administrator, Ohio Department of Health, 5/1/07.

75 Some exceptions include *Nurse-Family Partnership* and *Healthy Families America*.

Among private funding sources in Ohio, the Anthem Foundation of Ohio (a supporting organization of the Greater Cincinnati Foundation)[76] is the pre-eminent supporter of family violence prevention, having spent $1 million in 2006 for state and local level capacity building as well as technical assistance. Their efforts to build infrastructure in a few counties have been essential for enabling agencies to coordinate their efforts and maintain enduring, successful programs. Unfortunately, in most areas of the state, local agencies' inability to develop or access such networks means that individual programs are isolated and temporary. Because very few other foundations in the state have any type of family violence prevention as a stated focus area, those organizations that implement programs are constantly scrambling for funding from many different sources. Our analysis of 2006 data from the Ohio Grantmakers' Forum found 22 foundations providing 60 grants totaling $1.4 million to address family violence.[77] Yet it is unclear what percentage of this work involved prevention. The inconsistency of such funding makes it very difficult to sustain programs from year to year. Instead, programs regularly stop and start, undermining their ability to retain experienced staff and establish an enduring presence in the community. In the words of one practitioner, "We spend so much time looking for funding that we have less and less time to actually implement our programs."[78]

Federal funding for family violence prevention in Ohio involves a variety of programs administered by different state agencies and organizations (see Table 3).[79] Some (e.g., the DELTA program[80]) exclusively fund prevention, but most do not distinguish the percentage of funds devoted to prevention, victims services, or other activities. Like state funding, many other federal programs address risk factors for family violence, but do not measure family violence as an outcome. Again, this currently undermines opportunities for collaboration and improving programs but also suggests the value of better coordination.

Today, there is no system for funding family violence prevention in Ohio. Instead a wide range of programs rely on scarce, diverse, and inconsistent sources of funding. Even more fragmented are the programs in these and other agencies that indirectly involve prevention by incidentally addressing factors that contribute to family violence.[81] With little funding going to coalitions and networks, the programs that do exist are too often isolated and temporary. Nonetheless, there is reason for hope. With many large programs addressing risk factors for family violence, there are many opportunities for collaboration that could greatly expand the scope of prevention in Ohio.

76 Full disclosure: the Anthem Foundation of Ohio is funding the Ohio Family Violence Prevention Project that produced this white paper.

77 Grant sizes ranged from $150 to over $200,000. By way of comparison, 2005 data found 45 foundations providing $1.6 million in funding. For a listing of all grants, please see http://www.healthpolicyohio.org/xtra/FamilyViolence/AFVP.html.

78 Personal communication, Pamela Bugara, Ohio Regional Training Center for the Child Assault Prevention (CAP) Program, Catholic Charities Community Services of the Diocese of Cleveland, 11/28/2007.

79 Table 3 actually oversimplifies the situation, as many monies are administered through multiple state agencies.

80 Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) is a program coordinated through the Centers for Disease Control and Prevention. Based on a social-ecological model, the program supports coordinated community responses to the prevention of intimate partner violence. As one of 14 states with a DELTA program, Ohio's efforts are coordinated through the Ohio Domestic Violence Network. Centers for Disease Control and Prevention. *Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA)*. Accessed June 1, 2007 at: http://www.cdc.gov/ncipc/DELTA/default.htm.

81 Examples include: Ohio Departments of Alcohol and Drug Addiction Services, Education, Mental Health, Mental Retardation and Developmental Disabilities, Rehabilitation and Corrections, Youth Services.

Table 3. Selected federal funding sources for family violence prevention in Ohio

Program title	Federal agencies/ programs	Ohio agencies	Activities	Family violence outcomes	Annual amount [a]	Contact
Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA)	CDC	ODVN	State-level capacity building; local education/prevention projects in Lucas, Knox and Warren counties	IPV	$400,000	Rebecca Cline Prevention Programs Director Ohio Domestic Violence Network 614-781-9651 rebeccac@odvn.org
Family Violence Prevention and Services Act	ACF	ODPS	Funds a range of programs statewide through a competitive application process. *(An unknown percentage of these programs focus on prevention).*	IPV, EA	$2.7 million	Walter Brown Grants Chief Office of Criminal Justice Services 614-728-5466 brown@ocjs.ohio.gov
Ohio Children's Trust Fund	ACF CBCAP	ODJFS	In SFY 2005, provided funding to 86 counties for prevention and family support services.	CM	$1.2 million[b]	Karen Minton Program Administrator Ohio Children's Trust Fund 614-466-1822 OCTF@odjfs.state.oh.us
Older Americans Act – Title VII	AOA	ODA; OAAA	Prevention efforts include education of seniors; training providers on elder abuse.	EA	$200,000	Beverly Laubert Long Term Care Ombudsman Ohio Department of Aging 614-466-1221 blaubert@age.state.oh.us

Program title	Federal agencies/ programs	Ohio agencies	Activities	Family violence outcomes	Annual amount [a]	Contact
Preventive Health and Health Services Block Grant (rape prevention program set aside)	CDC	ODH	Sexual assault prevention programs in middle schools, high schools, colleges and the community, hotlines, support and referral, and professional and public awareness.	IPV	$300,000	Debra Seltzer Sexual Assault and Domestic Violence Prevention Program Ohio Department of Health 614-728-2176 dseltzer@odh.ohio.gov
Violence Against Women Act (VAWA)	CDC	ODH	Sexual assault prevention programs in middle schools, high schools, colleges and the community, hotlines, support and referral, and professional and public awareness.	IPV	$1.4 million	Debra Seltzer Sexual Assault and Domestic Violence Prevention Program Ohio Department of Health 614-728-2176 dseltzer@odh.ohio.gov

Table Notes:

[a] Annual amounts are from the most recent available fiscal year.

[b] Competitive grant awarded annually. OCTF also gets $4.2 million in state funding.

Abbreviations:

Federal agencies: AOA=Administration on Aging; ACF=Administration for Children & Families; CBCAP=Community Based Child Abuse Prevention Program; DOJ=Dept of Justice; CDC=Centers for Disease Control & Prevention; IDEA=Individuals with Disabilities Education Act (Part C); TANF=Temporary Aid to Needy Families

Ohio agencies: OAAA=Ohio Area Agencies on Aging; ODA=Ohio Dept on Aging; ODH=Ohio Dept of Health; ODJFS=Ohio Dept of Job and Family Services; ODPS=Ohio Dept of Public Safety; ODVN=Ohio Domestic Violence Network

Family violence outcomes: CM=child maltreatment; IPV=intimate partner violence; EA=elder abuse

How to Improve Family Violence Prevention in Ohio

Having already outlined the problem of family violence, we now present three broad principles that represent our vision for family violence prevention in Ohio. Other local reports[82] have already sounded similar themes, but we need to emphasize their particular relevance to family violence. We hope that agencies and communities will employ these principles to guide their own efforts in this area. The more communities, agencies and organizations that do so, the easier it will be to work together towards broad, effective change.

Engage and coordinate multiple agencies

Of the different forms prevention can take, one of the most important is "fostering coalitions and networks."[83] Such work is critical for pooling limited resources, sharing information and coordinating community-level policies and programs. The isolation and decentralization that characterize many state-level responses to social problems are particularly true for family violence, because many programs focus on other, important outcomes and thus only address the problem incidentally. Advocates for legislation expanding substance abuse treatment, for example, may not consider how their work relates to school-based teen dating violence prevention, or caseloads for adult protective service agencies. Even within the same types of prevention, adjoining counties may separately develop similar programs. In 2003, for example, Summit County, and a group in Cuyahoga County developed programs for curtailing financial exploitation of elders. Remarkably, each team was not aware of the other's work until we interviewed them for this *White Paper.*[84]

Improving family violence prevention in Ohio should begin with better coordination at the state level. Working together will create new opportunities for innovative programming as well as new funding possibilities related to family violence prevention. Different state agencies, for example, might work together to select specific counties for implementing and carefully evaluating a range of the most promising approaches to family violence prevention. Doing so could enable more efficient use of resources and technical assistance as well as help strengthen networks for family violence prevention at the local level. Involving private foundations that support such capacity-building (e.g., the Anthem Foundation of Ohio) could also be engaged to provide technical assistance.

It's easy enough to call for coordination, but in reality many state-level officials will resist calls to attend yet another meeting. For this reason efforts in this area must aim to work through existing networks. Fortunately, numerous interagency initiatives and networks already exist to foster state-level collaboration;[85] future efforts should aim to understand and work through – rather than around – them. Moreover, every organization need not be involved. Coordinating efforts will be most effective if they begin with a clear mandate and carefully identify specific programs, units and individuals within different agencies that will be most relevant and interested.

Coordination is also essential at the local level, and involves many of the same issues: pooling resources, sharing information, avoiding duplication. We strongly encourage such work, but again, it must be developed

82 These broad themes parallel the work completed by other local task forces and groups. For examples see: Legal Aid Society of Cincinnati. *Ohio Model Protocol for Responding to Domestic Violence*. Columbus, OH: Ohio Domestic Violence Network; 1992 (revised 2003). Accessed December 10, 2007 at http://www.odvn.org/PDFs/Protocoltexonly.pdf. *Ohio's Shared State Agency Prevention Framework.* Columbus, OH: Ohio Department of Alcohol and Drug Addiction Services; 2005. Accessed December 1, 2007 at: http://www.ohiofcf.org/documents/whatsnew/Framework05.pdf . Petro J, Lawrence JW. *Ohio Elder Abuse Task Force Report*. Columbus, OH: Ohio Attorney General's Office; 2004. Accessed May 1, 2007 at: http://www.ag.state.oh.us/citizen/pubs/eatf/04eatf_rpt.pdf . Ohio Commission on the Prevention of Injury. *Injury in Ohio*. Columbus, OH: Ohio Department of Public Safety; 2003. Accessed September 1, 2007 at: http://www.ems.ohio.gov/trauma/INJ%20PREV/Injury%20Prevention%20Commission%20Report.pdf .

83 Cohen L, Swift S. The spectrum of prevention: Developing a comprehensive approach to injury prevention. *Inj Prev* 1999;5:203-7.

84 Personal communication, Jan Bohinc, (formerly of) Benjamin Rose Institute, 12/11/07. Personal communication, Lorrie Warren, Summit County Court of Common Pleas, Probate Division. 12/11/07.

85 Examples include: the Interagency Prevention Partnership, Ohio Domestic Violence Network, Ohio Family and Children First, Healthy Ohio,

thoughtfully. Community-level interventions often have trouble demonstrating their effectiveness[86] and it is important that we learn from previous successes as well as failures. Fortunately, Ohio has existing programs like *Partnerships for Success* that have considerable experience developing and measuring this type of capacity-building at the local level.[87]

Focus on communities and perpetrators, not just individuals and victims

Most current prevention efforts address individual-level risk factors, such as increasing knowledge (e.g., how an elder can make herself less vulnerable to financial exploitation), changing beliefs (e.g., "abuse can happen to me") and building skills (e.g., how to resolve conflicts without violence). Such programs can be useful and effective, but may also be inefficient. Because family violence affects all segments of society, relying on education alone is impractical given the enormous resources it would require to teach all relevant individuals. In contrast, community-level interventions aim to create social environments that reflect both an awareness of and lower tolerance for family violence.

Focusing on communities also helps agencies consider the cultural, historical, and social diversity that characterizes Ohio. Whereas family violence affects everyone, the problem can assume different forms that require tailored approaches in different communities. Prevention of partner violence among gay and lesbian couples, for example, must consider legal issues particular to that community.[88] Women with disabilities experience similar forms of abuse as other women but also their own unique types as well. Removing a battery from a wheelchair is akin to locking someone in a closet; insisting on a kiss before helping someone out of a bath is a type of sexual abuse.[89] Cultural differences can also shape individuals' views of healthy relationships and their willingness to work with social service agencies.[90] Even when implementing the most promising prevention practices, tailored, culturally competent program delivery will be essential for success.

It is beyond the scope of this *White Paper* to review the numerous, complex issues involved in tailoring prevention for each significant community in Ohio. Attempting to do so here would be presumptuous and duplicate the useful resources already available. Instead, we highlight the need for each agency to continually examine whether their work is culturally competent and relevant to each community they serve. This means that both program selection and delivery must be evaluated for all service populations in a given community. Because cross-cultural research finds as many similarities as differences in family violence across diverse communities,[91] attention to both will be essential for effective prevention.

Improving family violence prevention in Ohio will also require directing efforts towards potential perpetrators. Because perpetrators, not victims, are responsible for abusive behavior, prevention efforts must engage them as well. We recognize that strategies for each group can differ markedly: in the case of intimate partner

86 Merzel C, D'Afflitti J. Reconsidering community-based health promotion: Promise, performance, and potential. *Am J Public Health.* 2003;93:557–574.

87 Ohio State University Center for Learning Excellence. Partnerships for Success. 2007. Accessed December 21, 2007 at: http://www.pfsacademy.org/ .

88 Renzetti CM, Miley CH. *Violence in Gay and Lesbian Domestic Partnerships*. Binghamton, NY: The Haworth Press; 1996.

89 Hassouneh-Phillips, D. Curry MA. Abuse of women with disabilities: State of the science. *Rehabil Couns Bull*. 2002;45:96-104.

90 Tatara, 1999. Lee et al., 2002. Borrego J, Terao SY. The consideration of cultural factors in the context of child maltreatment. Talley PF (Ed). *Handbook for the treatment of abused and neglected children. Binghamton, NY: Haworth Social Work Practice Press; 2005, pp. 341-357.* See also the two special issues on "Transnational and Cross-Cultural Research on Family Violence" *Violence Against Women*, 2004;7&8.

91 Malley-Morrison K. (Ed). *International Perspectives on Family Violence and Abuse: A Cognitive Ecological Approach*. Mahwah, NJ, Lawrence Erlbaum; 2004. Hyman I, Forte T, Mont JD, Romans S, Cohen MM. The association between length of stay in Canada and intimate partner violence among immigrant women. *Am J Public Health*. 2006;96(4):654-659. Strumpf NE, Glicksman A, Goldberg-Glen RS, Fox RC, Logue EH. Caregiver and elder experiences of Cambodian, Vietnamese, Soviet Jewish, and Ukrainian refugees. *Int J Aging Hum Dev*. 2001;53(3):233-252.

violence, consider the difference between anger-management and self-defense training. For elder abuse, it might be substance abuse treatment for caregivers versus educating seniors about recognizing their vulnerability. Other approaches, however, are relevant for both perpetrators and victims. Broader, community-level interventions to shift relevant cultural norms (e.g., appropriate forms of parental discipline, gender role stereotypes) could reduce potential perpetrators' willingness to abuse as well as potential victims' vulnerability to it. Similarly, planned efforts to improve neighborhood cohesion could reduce the social isolation that influences both perpetration and victimization. Employing this broader focus on prevention is consistent with models of family violence, yet the evidence of their effectiveness remains incomplete. So while we encourage such efforts, we also recognize the need for careful evaluation.

Consider both research findings and practitioner feedback

In many areas of social policy, decision-makers now emphasize "evidence-based" practice – that is, employing programs and practices that have been found to be effective in research studies.[92] Yet few approaches to family violence prevention have been so well-studied that one can conclusively label them as "evidence-based" or not.[93] In fact, this dichotomy is itself misleading, for assessing research evidence is a complicated process that yields conclusions along a continuum. Instead, it is more useful to think in terms of "the strength of the evidence" by reviewing multiple studies, which typically vary in their quality, relevance and conclusions.

Unfortunately, reports and grant applications for family violence prevention often overlook such ambiguity. Practitioners preparing these documents usually have little time and limited access to research databases. Also, the research itself is often incomplete with few, if any, directly relevant evaluations of a proposed program. Because of these limitations, agencies often focus on extending the number of sites for a promising program, before considering whether that program can be effective once it is replicated.[94] For example, one well-designed prevention study in Elmira, NY yielded positive results, but the authors issued a clear warning that their approach was not yet ready for dissemination.[95] Nonetheless, numerous panels and boards soon advocated for such a program for all parents nationwide.[96] More recently, the authors of a successful teen dating violence program in rural North Carolina issued similar warnings, yet reported receiving over 700 requests for their curriculum from across the country.[97]

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92 For examples, see: Centers for Disease Control and Prevention. *Community Guide to Preventive Services*. Atlanta, GA: Author; 2007. Accessed November 1, 2007 at: http://www.thecommunityguide.org . The Council for Excellence in Government. (2007). *The Coalition for Evidence-Based Policy*. Accessed September 12, 2007 at http://coexgov.securesites.net/index.php?keyword=a432fbc34d71c7 . Substance Abuse and Mental Health Services Administration. *National Registry of Evidence-Based Programs and Practices*. Washington: Substance Abuse and Mental Health Services Administration: Author; n.d. Accessed November 14, 2007 at: http://www.nrepp.samhsa.gov . Rand Corporation. *Promising Practices Network on Children, Families and Communities*. Santa Monica, CA: Author; 2007. Accessed December 1, 2007 at: www.promisingpractices.net .

93 The Centers for Disease Control and Prevention's *Community Guide to Preventive Services*, lists 23 common practices and programs related to violence. Of these, 5 are recommended, 1 is not recommended and 17 have insufficient evidence.

94 Daro, Donnelly, 2002.

95 Olds DL, Henderson CR, Chamberlin R, Tatelbaum R. Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics*. 1986;78:65–78.

96 U.S. Department of Health and Human Services Administration for Children and Families and U.S. Advisory Board on Child Abuse and Neglect. *Creating Caring Communities: Blueprint for an Effective Federal Policy on Child Abuse and Neglect*. Washington: U.S. Dept of Health and Human Services and U.S. Advisory Board on Child Abuse and Neglect; 1991.

97 Foshee et al., 2004.

Because the evidence for family violence prevention is often inconclusive, improving work in this area will require a willingness to carefully and consistently engage with research. While many agencies already are adept at identifying promising programs, there is less understanding of the organizational factors that facilitate successful and sustainable replication of programs.[98] Because finding, critiquing and summarizing research studies requires special skills, there is a great need for practitioners to connect with professionals who have such expertise. Coordinating organizations like Ohio Family and Children First, and the Ohio Domestic Violence Network can play a vital role in this regard.

While the translation of research to practice is an essential component of effective prevention, it is equally important that practice should inform research – that is, practitioners should help guide what types of research is funded.[99] When asked about prevention, many practitioners have passionate, if divergent views on "what works." Still others are unsure whether any universal or selective prevention can be effective.[100] Nonetheless, their collective experience is invaluable in determining what approaches to prevention might work and how they may work. Soliciting feedback from front-line experts not only leads to valuable insights but is critical for any coordinated approach to prevention.

Specific Recommendations

However convincing the rationale, improving family violence prevention in Ohio won't just happen. To build momentum and focus attention, we have identified the four specific recommendations below. These are not the only things Ohio should be doing, nor do they completely reflect the principles already discussed. Instead, they represent some concrete "next steps" that research finds compelling and practitioners find realistic.

Recommendation #1:
Increase the quality of Ohio's home visitation programs.

Numerous home visitation programs[101] operate in Ohio and address a wide range of outcomes, from reducing low birth weight to improving school readiness.[102] Many programs are funded through a state initiative, *Help Me Grow*,[103] which focuses on children with, or at risk for developmental delays. Unfortunately few programs measure how their work is reducing, or is being undermined by, family violence.[104]

98 Mihalic SF, Irwin K. Blueprints for violence prevention: From research to real-world settings—Factors influencing the successful replication of model programs. *Youth Violence & Juvenile Justice*. 2003;1: 307-329.

99 Ross S, Lavis J, Rodrigues C., Woodside J., Denis JL. Partnership experiences: Involving decision-makers in the research process. *J Health Serv Res Policy*. 2003;8:26-34.

100 Daro, Donnelly, 2002.

101 Home visitation programs typically involve a nurse, social worker or trained paraprofessional regularly visiting a mother and child during pregnancy and/or up to three years after birth. The home visitor provides education, advice and emotional support.

102 Home Instruction for Parents of Preschool Youngsters (http://www.hippyusa.org/) and Parents as Teachers (http://www.parentsasteachers.org) focus primarily on school readiness; Healthy Families America (http://www.healthyfamiliesamerica.org) focuses on positive parenting, child health and development and preventing maltreatment. Healthy Start (http://www.healthystartassoc.org/) is a federally-funded program that focuses primarily on birth outcomes. It currently funds programs in Cleveland and Columbus. Nurse Family Partnership (http://www.nursefamilypartnership.org) focuses on a variety of birth outcomes using funds from diverse sources. Ohio has four NFP sites in Cincinnati, Columbus, Dayton, and Hamilton.

103 Ohio Department of Health. *About Help Me Grow*. Columbus, OH: Author; n.d. Accessed September 1, 2007 at: http://www.ohiohelpmegrow.org/aboutus/AboutHelpMeGrow.aspx .

104 Personal communication, Pat Lyons, Executive Director, Prevent Child Abuse Ohio, 11/16/07.

This state of practice represents an important missed opportunity because:

- About one third of home-visited mothers experience intimate partner violence;[105]
- Intimate partner violence limits program effectiveness on other maternal and child outcomes;[106] and
- High-quality home visitation programs can produce impressive reductions in child maltreatment.[107]

Ohio's home visitation programs are a compelling approach to improving family violence prevention because of the existing infrastructure established by the Bureau of Early Intervention at the Ohio Department of Health. Moreover, a large number of studies have identified best practices for home visitation, and some exemplary programs are already being implemented in Ohio.[108]That said, it will be neither practical nor desirable to force all *Help Me Grow* partners to explicitly address family violence. Rather we recommend creating the capacity and incentives for them to do so.

Detailed suggestions:

A. Develop a unified approach for recording suspected child maltreatment.

We encourage programs to employ a common definition of child maltreatment and a uniform approach to recording suspected cases. Virtually all home visitors already report suspected cases of child maltreatment to the appropriate authorities, but few programs keep their own records of how many allegations have been filed. Creating a common form and reporting such information to a central office *(e.g., Help Me Grow)* would help identify those programs whose clients disproportionately experience family violence, and assess whether it interferes with program success in other areas. These data would also be a valuable resource and could serve as a proxy "comparison group" when evaluating those home visitation programs that aim to prevent child maltreatment.

B. Improve coordination of home visiting programs.

As a central source of funding, *Help Me Grow* plays an important role in supporting a diverse array of home visitation programs across Ohio. We recommend strengthening their coordinating role to pool resources for training and technical assistance, and standardize program evaluation procedures. Additional training, for instance, could improve home visitors' ability to recognize and respond to family violence even among those programs that do not focus on it as an outcome.[109] Developing expertise in this way will be critical to enable more programs to address it explicitly.

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105 See Duggan A, Windham A. Hawaii's Health Start Program of home visiting at-risk families: Evaluation of family identification, family engagement, and service delivery. *Pediatrics*. 2000;105:250-259; El-Kamary SS, Higman SM, Fuddy L, McFarlane E, Sia C, Duggan AK. Hawaii's Healthy Start Home Visiting Program: Determinants and impact of rapid repeat birth. *Pediatrics*. 2004;114:317-326; Fergusson DM, Hildegard GL, Horwood J, Ridder EM. Randomized trial of the early start program of home visitation. *Pediatrics.* 2005;116:803-809; Olds DL, Kitzman H, Cole R, Robinson J, Sidora K, Luckey DW, et al. Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial. *Pediatrics*. 2004;114:1550-1559.

106 Eckenrode J, Ganzel B, Henderson CR, Smith E, Olds DL, Powers J. Preventing child abuse and neglect with a program of nurse home visitation. The limiting effects of domestic partner violence. *JAMA*. 2000;284:1385-1391. Stevens J, Ammerman RT, Putnam FG, Van Ginkel JB. Depression and trauma history in first-time mothers receiving home visitation. *Journal of Community Psychology.* 2002;30(5): 551 – 564.

107 Karoly LA, Kilburn MR, Cannon JS. *Early Childhood Interventions: Proven Results, Future Promise*. Santa Monica, CA: Rand; 2005. Accessed September 1, 2007 at: http://www.rand.org/pubs/monographs/2005/RAND_MG341.pdf .

108 Two examples include*: Every Child Succeeds(* http://www.cincinnatichildrens.org/svc/alpha/e/every-child/) and *Nurse-Family Partnership* (http://www.nationwidechildrens.org/GD/Templates/Pages/Childrens/CCFA/CCFALong.aspx?page=5616) .

109 A recent assessment of 32 federally-funded home visitation programs found that staff regularly encountered family violence yet feel ill-prepared to address it. (Chamberlin LW, Levenson R. Addressing domestic violence within the context of home visitation. *Family Violence Prevention & Practice.* 2007;6:1-10.) For a useful training resource, see: Chamberlin LW. *Family violence home visitation assessment tool*. San Francisco, CA: Family Violence Prevention Fund; 2007. Accessed November 10, 2007 at: http://www.endabuse.org/health/ejournal/archive/1-6/files/home_visitation_tool.doc .

C. Support demonstration projects that expand home visitation programs to include prevention of intimate partner violence.

While an evidence base has not yet been built demonstrating the effectiveness of home visitation programs in prevention intimate partner violence,[110] we believe this approach is worth exploring on a trial basis. Most previous programs were not designed to address intimate partner violence and evaluations usually have not assessed whether programs prevent the onset of abuse; instead only focusing on reductions in abuse that were already occurring. The Domestic Violence Enhanced Home Visitation (DOVE) Program in Baltimore and Kansas City[111] is one recent example of a home visitation program that specifically aims to address intimate partner violence. Based on an empowerment model, the DOVE program uses strict guidelines for safely documenting and addressing intimate partner violence. Any data collection efforts developed or expanded in Ohio should ensure confidentiality of identifying information and utilize aggregate data to protect victims.

Expanding home visitation programs to address intimate partner violence must be done carefully, for its potential to cause harm.[112] For instance, a nurse who raises the issue during a home visit may anger the abusive partner, and thus put herself and her client at risk of harm. There is also the ethical concern of screening people when effective victims services are not easily available.[113] If victims cannot access services, the potential for harm may greatly outweigh the potential benefits. As such, special approaches will be necessary in rural areas where the dearth of services is especially acute.

Recommendation #2:
Create school environments that promote healthy relationships.

Schools represent an especially promising setting for prevention, as they afford access to a wide range of young people, including potential perpetrators as well as victims. Many schools provide an environment – distinct from the family – that is relatively stable, safe and offers regular contact with adults who genuinely care about them. Especially for young people who experience violence within their families, schools are a critical domain for developing healthy social relationships.

Some evidence supports the ability of school-based programs to help prevent certain aspects of family violence. Programs for preschoolers and kindergartners can build knowledge and skills that reduce the likelihood of child sexual abuse victimization[114] and may even increase rates of disclosure.[115] In the area of intimate partner violence, the *Youth Relationships Project*[116] in Ontario and *Safe Dates*[117] in North Carolina have produced impressive reductions in teen dating violence. Given the enormous consequences and costs

110 Chamberlin, Levenson, 2007.

111 Johns Hopkins University School of Nursing. *Domestic Violence Enhanced Home Visitation Intervention (DOVE) Project*. Baltimore, MD: Johns Hopkins University School of Nursing: Author; n.d. Accessed March 1, 2007 from: www.son.jhmi.edu/research/dove . Also, Harriet MacMillan (McMaster University) has a pending grant with the Centers for Disease Control and Prevention to implement and home visitation in 10 sites that employs a similarly "enhanced" version of the Nurse Family Partnership.

112 An elder abuse prevention program involving public education and home visitation by police and domestic violence counselors actually *increased* physical abuse of elders. See: Davis RC, Medina-Ariza J. Results from an elder abuse prevention experiment in New York City. Washington: National Institute of Justice # NCJ 188675; 2001. Accessed December 19, 2007 at: http://www.ncjrs.gov/pdffiles1/nij/188675.pdf .

113 Wilson JMG, Jungner F. Principles and practice of screening for disease. In Public Health Papers No. 34. Geneva: World Health Organization; 1968. .

114 Davis, Gidycz, 2000.

115 Finkelhor D, Strapko N. Sexual abuse prevention education: A review of evaluation studies. In Willis DJ, Holden EW, Rosenberg M (Eds.) Prevention of Child Maltreatment: Developmental and Ecological Perspectives. New York: John Wiley & Sons; 1992. p. 150-167.

116 Wolfe DA, Wekerle C, Scott K, Straatman A, Grasley C, Reitzel-Jaffe D. Dating violence prevention with at-risk youth: A controlled outcome evaluation. *J Consult Clin Psychol.* 2003;71:279-291.

117 Foshee et al., 2004.

of family violence and the relatively low per-child costs of such school-based programs,[118] this approach can be cost effective even with only modest reductions of violence.

Currently, however, such promising programs benefit relatively few youths in Ohio. One limitation is that many schools do not provide any such programming because they lack the time and other resources. Administrators already are busy with standardized testing, higher academic standards and numerous mandates to teach about physical activity, substance abuse, sexual behavior and so on. Nonetheless, a recent national study found that 49% of middle schools and 69% of high schools reported teaching about dating violence.[119] A greater challenge may be the uneven quality of the programs offered. For instance, those schools that implemented violence prevention programs devoted an average of only 2.5 hours per semester to addressing the topic (of which dating violence is only a part). In comparison, the best examples of programs typically require 10 to 20 hours of classroom instruction.[120] Not surprisingly, a US Department of Education report on school-based prevention summed up its conclusions in its title, "*Wide Scope, Questionable Quality*."[121]

There is reason to hope for improvement in school-based violence prevention programming. Most schools have already established programs to address violence; the challenge is to provide them with the resources and support to do a better job.

Detailed suggestions:

Encouraging as it is, the evidence base for these school-based programs is still too thin for us to recommend statewide adoption of specific practices. Even were such programs predictably effective, it's unclear whether they can be successfully disseminated and replicated across numerous schools districts. For these reasons, we suggest they be operationalized as demonstration projects that are carefully evaluated to assess their effectiveness and potential for dissemination.

A. Develop and integrate promising school-based curriculum on healthy relationships.

Too often, school-based health promotion is limited by a lack of coordination across different topics and different grades. Within a single school district, first grade programs on anti-social behavior often have little connection with sixth grade programs on bullying or tenth grade programs on dating violence. This approach relies on discrete programs to alter students' belief structure and "inoculate" them against future exposure to social ills.[122] Afterwards, they move on to a different grade and a different program for a different problem.

Rather than addressing these issues separately, we recommend integrating programs that address aspects of family (and non-family) violence at different grades. Under the rubric of "Healthy Relationships," it is

118 A cost-effectiveness analysis in Michigan found that school-based sexual abuse prevention cost $2.14 per child, compared to $324 per family for home visitation programs and $253 per family for parent education programs. Caldwell RA. *The Costs of Child Abuse vs. Child Abuse Prevention: Michigan's Experience*. Lansing, MI: Michigan State University; 1992. Accessed March 1, 2007 at: http://www.msu.edu/user/bob/cost.html.

119 Kann L, Telljohann SK, Wooley SF. Health education: Results from the School Health Policies and Programs Study 2006. *J Sch Health*. 2007;77:408-434.

120 Hahn R, Fuqua-Whitley D, Wethington H, Lowy J, Crosby A, Fullilove M, et al. Effectiveness of universal school-based programs to prevent violent and aggressive behavior: A systematic review. *Am J Prev Med*. 2007;33:S114–S129.

121 Crosse S, Burr M, Cantor D, Hagen CA, Hantman I. *Wide Scope Questionable Quality: Drug and Violence Prevention Efforts in American Schools.* Washington: U.S. Department of Education, Planning and Evaluation Service; 2001. Accessed November 22, 2007 at: http://www.ed.gov/offices/OUS/PES/studies-school-violence/wide-scope.pdf .

122 McGuire WJ. The nature of attitudes and attitude change. In Lindzey G, Aronson E, editors. *Handbook of Social Psychology, Vol. 1*. Reading, MA: Addison-Wesley; 1968. p. 136-314.

possible to incorporate a wide range of topics and open up a range of new funding opportunities as well.[123] Rather than developing a new curriculum from scratch, we encourage faithful implementation of existing practices and programs that have shown the most promise in research. In some topics, there is a relatively extensive literature on best practices (e.g., child sexual abuse prevention[124]; bullying[125]). For teen dating violence, some programs in some settings have shown tremendous promise, but others have not.[126] We strongly encourage such work, but recognize that the need for careful evaluation will be greatest for those programs with a smaller evidence base.

B. Support efforts to change the school environment.

Traditional health education curricula can be effective, but should be only one part of a broader effort to promote healthy relationships. Equally important are efforts to change the culture of the school environment. The movement for "health promoting schools"[127] is consistent with this approach. Rather than limit efforts to educational programming, a theme of healthy relationships could also be incorporated into school policies on bullying, professional development for staff, and efforts to build school unity characterized by mutual respect among all members of the school community.[128]

Employing such an ecological approach also broadens our perspective: instead of the traditional focus on potential victims and the (somewhat newer) focus on potential perpetrators, such programs recognize that the entire community has a role in reducing family violence. These broader efforts could also address issues related to the gendered nature of violence that may go unaddressed in educational curricula.[129] If successful, fellow students would be more likely to challenge hateful banter that demeans women; staff would be better able to identify students at risk of family violence and create opportunities for safe disclosure.

C. Evaluate the process of implementing a curriculum, not just the outcomes.

One major challenge for disseminating school-based health promotion programs is maintaining program fidelity. The uncertainties of the real world – staff changes, insufficient teacher training, changing school schedules – dilute the effectiveness of even the best programs. For this reason, demonstration projects of an integrated "Healthy Relationships" curriculum should include careful process evaluation – that is, *how* the programs are implemented. Doing so will provide valuable information on the potential to successfully

123 For example, grant programs through the U.S. Department of Education (e.g., Safe and Drug Free Schools, Character Education, and Safe Schools/Healthy Students) devote few dollars to dating violence prevention alone, but have been interested in broader violence prevention efforts. In FY2007, the Ohio Department of Alcohol and Drug Addiction Services received $2.5 million to support drug and violence prevention programs for school-age youth. The Ohio Department of Education received $9.9 million.

124 Davis, Gidycz, 2000. Hébert M, Tourigny M. Child sexual abuse prevention: A review of evaluative studies and recommendations for program development. *Advances in Psychology Research.* 2004;32:111-143.

125 Whitted KS, Dupper DR. Best practices for preventing or reducing bullying in schools. *Children and Schools.* 2005;27:167-175. Elinoff MJ, Chafouleas SM, Sassu, KA. Bullying: Considerations for defining and intervening in school settings. *Psychology in the Schools*. 2004;41:887-897. Baldry AC, Farrington DP. Effectiveness of programs to prevent school bullying. *Victims & Offenders*. 2007;2:183-204.

126 Whitaker et al., 2006.

127 Lister-Sharp D, Chapman S, Stewart-Brown S, Sowden A. Health promoting schools and health promotion in schools: Two systematic reviews. *Health Technol Assess.* 1999;3:1–207.

128 Sprague JR, Walker HM. *Safe and Healthy Schools: Practical Prevention Strategies*. New York: Guilford; 2005.

129 Some researchers critique school-based violence prevention efforts for ignoring the role of gender. (Brown L, Chesney-Lind M, Stein N. Patriarchy matters: Toward a gendered theory of teen violence and victimization. *Violence Against Women*, 2007;13:1249-1273.) Unfortunately planned efforts to change sex role attitudes have been largely unsuccessful (Bigler RS. Psychological interventions designed to counter sexism in children: Empirical limitations and theoretical foundations. In Swann WB, Langlois JH, Gilbert LA (Eds) *Sexism and Stereotypes in Modern Society: The Gender Science of Janet Taylor Spence.* Washington, DC: American Psychological Association; 1999. p. 129-151.) Rather than revise existing curricula (and risk undermining their effectiveness), we encourage schools to consider developing supplemental approaches to addressing issues of gender and power. For an example of such work, see: Matthews NA. Generic violence prevention and gendered violence: Getting the message to mainstream audiences. *Violence Against Women*. 2000;6(3): 311-331.

disseminate this approach to other schools. Arizona[130] and Massachusetts[131] have developed multi-site process and outcome evaluations of teen dating violence programs that can serve as useful examples.

Evaluations must also consider these programs' potential ability to cause harm. Some sexual abuse prevention programs may increase children's worries about being abused.[132] In addition, increasing disclosures of abuse is not without risk: for the few accusations of abuse that are unfounded, investigations can be enormously painful and disruptive to families and worsen rather than improve children's well-being.[133] As such, it is critical that school districts that implement such programs first establish careful mechanisms for handling disclosures.

Recommendation #3:

Support county-level demonstration projects of inter-agency elder abuse "I-Teams" to coordinate prevention, investigation, treatment services. [134]

[The paucity of research on elder abuse prevention means we have little evidence to guide our recommendations. As such, we recognize that this recommendation tends more towards indicated prevention that towards our focus on universal and selective prevention. Even so, we believe that such teams will be very helpful for devising prevention strategies.]

Cases of elder abuse usually involve multiple public agencies that too often have trouble working together. A memorandum of understanding (MOU) brings local individuals and agencies together that are essential to achieving the objective of elder protection. The MOU is a cost efficient initiative that brings these offices together to determine roles and responsibilities of each agency. The MOU is a tool that provides direction to all agencies involved. It confirms a commitment to address the issues and educates all departments on the roles of others. It is effective in reducing and eliminating issues that may overlap. The MOU essentially formulates a plan, requires participation of key agencies and provides a reference for interested and responsible parties.

Since the Ohio Elder Abuse Task Force recommended the creation of interagency "I-Teams" in 2004, relatively few counties have actually followed through and no statewide legislation has mandated their creation. Whereas Wisconsin and other states are developing similar approaches, we recommend providing support to a select number of counties to develop "I-Teams" and document the best processes for their development.

Children service agencies have developed MOU's that appear effective. The MRDD Victims of Crime task force adopted this mandate for counties regarding individuals with MRDD. Providing a similar structure for elder abuse would provide consistency for Ohio's vulnerable populations — children, individuals with MRDD and the elderly.

The I-Team will be comprised of a group of professionals from a variety of disciplines who will meet regularly to discuss and provide consultation on specific cases of elder abuse. These individuals will work together to determine the best service plans for each case and will serve as a critical forum for planning prevention efforts. Implementation of I–Teams will be drafted within the language of the MOU. Appendix B of the Ohio Elder Abuse Task Force Report contains an I-Team Manual that describes this process in greater detail.[135]

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130 University of Arizona. *Promoting Healthy Relationships Project*. Phoenix, AZ: University of Arizona: Author; n.d. Accessed June 4, 2007 at: http://ag.arizona.edu/fcs/azyfc/phr/index.html

131 Massachusetts Department of Education. *Guidelines for Schools on Addressing Teen Dating Violence*. Boston, MA: Massachusetts Department of Education: Author; n.d. Accessed March 1, 2007 at: http://www.doe.mass.edu/ssce/tdv/guidelines/

132 Finkelhor D, Dziuba-Leatherman J. Victimization prevention programs: A national survey of children's exposure and reactions. Child Abuse Negl. 1995;19:129-39.

133 Daro D. *Confronting child abuse: Research for effective program design*. New York: Free Press; 1988.

134 This recommendation is adapted from Petro, Lawrence, 2004.

135 *Ohio elder abuse interdisciplinary team (I-Team) manual*. Columbus, OH: Ohio Attorney General and Ohio Department on Aging; 2004. Accessed July 1, 2007 at: http://www.odvn.org/PDFs/Ohio%20I-Team%20report.pdf

Recommendation #4:

Expand training of elder abuse among banking professionals.

Unlike other forms of elder abuse, financial exploitation unavoidably involves contact with an institution or trained professional (e.g., bank, attorney). In response to the growing recognition of elder abuse, many professional organizations have developed and sometimes mandated training on the topic. Health care providers,[136] law enforcement and attorneys[137] have been especially active in this regard. In contrast, banking professionals often are unaware of elder abuse or are ill-equipped to respond to it. Some individual banks offer staff training,[138] but in Ohio there has been no statewide effort to train banking professionals.[139] Without adequate training, we miss many opportunities to identify vulnerable elderly clients and curtail financial exploitation – one of the most common forms of elder abuse.[140]

Towards this end, we recommend developing a campaign to train Ohio's banking and financial service professionals in the area of elder financial abuse. Both the Ohio Banking League and the Community Bankers Association of Ohio have indicated their interest in participating in such an effort. In addition, past statewide efforts in Massachusetts,[141] California,[142] and Oregon[143] provide useful models for adaptation and experience with dissemination.

Detailed suggestions:

Development of such a training program should:

A. Involve leading banking and financial service institutions and organizations.

Other states' experience suggests that the success of such campaigns requires developing collaborative relationships among such institutions and relevant governmental and community agencies.[144] Government-initiated efforts should understand the industry's concerns in aggressively pursuing suspected cases of exploitation.[145]

B. Increase professionals' ability to detect financial exploitation.

Provide training to different levels of staff, including both tellers and managers. National City Bank[146] and The Summit County Elder Abuse Prevention Coalition[147] have experience providing such trainings in Ohio.

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136 Heath JM, Dyer CB, Kerzner LJ, Mosqueda CL. Four models of medical education about elder mistreatment. *Acad Med. 2002;77:*1101-1106. Pillemer K. Abuse prevention 101. Strategies for hiring, training, and supervision. *Contemp Long-term Care*. 2002;25*:*28-30.

137 Kemp BJ, Mosqueda LA. Elder financial abuse: An evaluation framework and supporting evidence. *J Am Geriatr Soc. 2005;*53:1123-1127.

138 Personal communication, Scott Blashford, Loss Avoidance and Investigations, National City Bank, 1/3/08.

139 Personal communication, Melea Wachtman, Communications Director, Ohio Banking League, 6/4/07. Personal communication, Dawn Hoover, Community Bankers Association of Ohio, 6/4/07.

140 The National Center on Elder Abuse, 1998.

141 Price G, Fox C. The Massachusetts Bank Reporting Project: An edge against elder financial exploitation. *J Elder Abuse Negl.* 1997;8:59-71.

142 California Bankers' Association (n.d.). *The Elder Abuse Training Materials*. Accessed May 1, 2007 at: http://www.calbankers.com/content/governmentandlegalaffairs_elderabusetrainingmaterials.asp#C .

143 Kaye AP, Darling G. Oregon's efforts to reduce elder financial exploitation. *J Elder Abuse Negl.* 2000;12:99-102.

144 Price, Fox, 1997.

145 Hughes SL. *Can bank tellers tell? Legal issues related to bank reporting of suspected elder abuse.* Washington, DC: American Bar Association Commission on Law & Aging; 2003. Accessed May 30, 2007 at: http://www.elderabusecenter.org/pdf/publication/bank_reporting_long_final_52703.pdf .

146 Personal communication, Scott Blashford, Loss Avoidance and Investigations, National City Bank, 1/3/08.

147 The Summit County Elder Abuse Prevention Coalition developed the CHECKS program (Coalition Helping Elder Clients Keep their Savings). Personal communication, Lorrie Warren, Summit County Court of Common Pleas, Probate Division. 12/11/07.

C. Increase professionals' knowledge of when and how to report suspected exploitation.

Successful systems require a clear protocol for referral within each institution, and, when necessary, to appropriate authorities. Employees should know what information they need to collect in order to file a useful report and what will happen once their report is filed.

D. Ensure that state and local law protects employees from liability.

When they suspect exploitation and make "good faith" disclosures of financial records to the proper authorities.

E. Educate consumers as well.

Including consumers in an educational campaign can facilitate the identification of cases and allay consumers concerns about privacy. Moreover, such an approach demonstrates that the campaign does not solely rely on banking and financial institutions to reduce financial exploitation.

F. Build a network.

Built a network to support further policy changes to curtail financial exploitation. Currently states and institutions around the nation are exploring ways to reduce financial exploitation (e.g., statutes that encourage or mandate that bank employees report suspected instances of financial abuse[148]). While evidence of their effectiveness remains uncertain, such networks will be essential for successfully evaluating and disseminating these practices.

148 California State Senate. Senate Bill 2005-1018, *The Financial Abuse Reporting Act.*

Appendix A

Family violence definitions

These definitions were prepared by the *Ohio Family Violence Prevention Project Working Group* based on the references listed below. Following these definitions, we present three vignettes to illustrate a few of the ways family violence occurs.

CHILD MALTREATMENT includes the following categories:

- **Child abuse** is the inflicting, by a family member or other caretaker, of physical injury to individuals under the age of 18 through malicious, cruel, or inhumane treatment. Physical punishment that results in injuries that leave marks, break the skin or bones, or involve real or perceived threats to life or health are regarded as abusive.

- **Child sexual abuse** includes the intentional exposure of individuals under the age of 18 to sexual acts and materials, the passive use of children as sexual stimuli for adults (child pornography), and actual sexual contact of children with older individuals. Children are assumed not to be able to consent to these sexual activities. A child's apparent "consent" to participate in sexual activity does not reduce the older individual's responsibility or alter the diagnosis of child sexual abuse.

- **Child neglect** may take many forms, but the common feature is the failure of a parent or other caretaker to provide an individual under the age of 18 with basic shelter, supervision, or support. This failure can be passive, such as failing to provide education or to obtain needed health care. Child neglect can also be active, such as knowingly exposing a child to a hazardous situation.

INTIMATE PARTNER VIOLENCE is when physical, sexual and/or emotional violence occurs in the context of a current or former relationship. This violence is often characterized by the abuse of power by one partner to control another. It includes four main types:

- **Physical violence** is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; strangling; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person.

- **Sexual violence** is divided into three categories: 1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and 3) abusive sexual contact.

- **Threats of physical or sexual violence** use words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.

- **Psychological/emotional violence** involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence.

ELDER ABUSE includes three basic categories: (1) domestic elder abuse; (2) institutional elder abuse; and (3) self-neglect or self-abuse. In most cases, state statutes addressing elder abuse provide the definitions of these different categories of elder abuse, with varying degrees of specificity. Because we chose not to include self-neglect or self-abuse in our definition of elder abuse for this White Paper, we focus instead on types of domestic and institutional elder abuse that may be further categorized as follows:

- **Physical abuse** is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. It may include, but is not limited to, such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, it may also include the inappropriate use of drugs and physical restraints, force-feeding, and physical punishment.

- **Sexual abuse** is defined as non-consensual sexual contact of any kind with a person who is elderly, with a person who has a disability or with any person incapable of giving consent. It includes but is not limited to unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.

- **Emotional or psychological abuse** is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from his/her family, friends, or regular activities; giving an older person the "silent treatment;" and enforced social isolation are examples of emotional/psychological abuse.

- **Neglect** is defined as the refusal or failure to fulfill any part of a person's obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care. Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed-upon responsibility to an elder.

- **Exploitation** is defined as misusing, for personal or monetary benefit, the resources of person who is elderly or who has a disability. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

In preparing these definitions, we relied on the following references.

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Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2002. Accessed January 27, 2007 at: http://www.cdc.gov/ncipc/pub-res/ipv_surveillance/Intimate%20Partner%20Violence.pdf .

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