



National Advisory Committee On Rural Health and Human Services



Intimate Partner Violence in Rural America Policy Brief March 2015

Editorial Note: During its September 2014 meeting in Sioux Falls, South Dakota, the National Advisory Committee on Rural Health and Human Services discussed the impact of Intimate Partner Violence (IPV) on families and communities in rural areas. The Committee visited the Compass Center, an abuse counseling provider in Sioux Falls, and heard from stakeholders there about the challenges they face in their work. Afterwards, the Committee met with a variety of community members including law enforcement agents, non-profit organizations, Tribes, and health care providers to gain more insight into this complex issue. This policy brief continues the Committee's considerations of the issue of access and barriers to care for rural human service delivery and includes recommendations to the Secretary.

RECOMMENDATIONS

1. *The Committee recommends that the Secretary direct the Centers for Disease Control and Prevention to conduct analyses of the National Intimate Partner and Sexual Violence Survey data with a geographic variable to gain a better understanding of the unique needs of individuals in rural America of all ages and throughout the life course experiencing IPV (see page 4).*
2. *The Committee recommends that the Secretary direct the Administration for Children and Families (ACF) to work with Centers for Medicare & Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Resources and Services Administration (HRSA) to train rural health care providers on integrating IPV screening and counseling into service sites (see page 9).*
3. *The Committee recommends that the Secretary direct ACF to work with SAMHSA and HRSA to connect health care providers who have been trained in IPV screening to community organizations that help individuals in rural America experiencing IPV (see page 9).*

INTRODUCTION

More than one in three women in the United States will experience intimate partner violence (IPV), which includes rape, physical assault, stalking, emotional manipulation or a combination of these behaviors, during their lifetimes.¹ Although there is a body of research and literature on best practices for preventing and treating IPV for the general population, relatively little research has been devoted to identifying the unique needs and challenges of individuals experiencing IPV in rural communities. In the limited research that focuses on the the extent and prevalence of IPV

¹ Black, M.C., et al. "The National Intimate Partner and Sexual Violence Survey (Nisvs): 2010 Summary Report." Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2011.

in rural areas, the findings suggest that rural women who have experienced IPV face barriers to accessing the health care system, the criminal justice system, and the human services infrastructure.² Isolation, high rates of poverty, and limited access to human services all have an impact on rural women experiencing IPV,³ who are almost twice as likely to be turned away from services as urban women due to lack of capacity.⁴ Because rural individuals experiencing IPV may at times seek care in urban areas, rural IPV is an issue that touches urban parts of the health care and human services system as well. Both rural and urban providers of health and human services need to be informed on how to identify rural patients experiencing IPV and the best practices for helping those individuals who face barriers to service in rural areas.

BACKGROUND

Although violence between strangers is more commonly discussed, IPV is prevalent in communities across the country and affects women and men of all ages and throughout the life course.^{5,6} Of women who have experienced IPV, including rape, physical assault, and stalking, more than one-third have experienced more than one of these behaviors from an intimate partner. Nearly half of all women and men in the United States have experienced psychological aggression from an intimate partner at some point in their lives. Most people who experience IPV have their first experience with it before they are 25 years old.⁷

There are notable co-occurrences of IPV and child abuse; when a woman is exposed to severe physical assaults, it is likely that children in the household are also in danger of or suffering from physical harm.⁸ Research indicates that “in an estimated 30 to 60 percent of the families where either domestic violence or child maltreatment is identified, it is likely that both forms of abuse exist.”⁹

IPV can produce a rippling effect of consequences beyond the immediate injury. Women who have experienced IPV are more likely to “experience impacts such as fear, concern for their safety, need for medical care, injury, need for housing services, and missing at least one day of work or school” as a result of the IPV. IPV is also associated with a number of adverse health outcomes. For example, the Centers for Disease Control and Prevention (CDC) notes that “(m)en and women with a lifetime history of rape, physical violence, or stalking by an intimate partner were more likely to report frequent headaches, chronic pain, difficulty sleeping, activity

² Peek-Asa, C., et al. “Rural Disparity in Domestic Violence Prevalence and Access to Resources.” *J Womens Health (Larchmt)* 20.11 (2011): 1743-9.

³ Logan, T. K., et al. “Qualitative Differences among Rural and Urban Intimate Violence Victimization Experiences and Consequences: A Pilot Study.” *Journal of Family Violence* 18 (2003): 83-86.

⁴ Peek-Asa et al. (2011) “Rural Disparity in Domestic Violence Prevalence and Access to Resources.”

⁵ Black et al. (2011) National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report.

⁶ The NISVS statistics for 2011 were published by the CDC after this brief was drafted. The statistics on IPV were roughly consistent from 2010 to 2011.

⁷ Black et al. (2011) National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report.

⁸ Bragg, H. Lien, and United States. Office on Child Abuse and Neglect. *Child Protection in Families Experiencing Domestic Violence*. Child Abuse and Neglect User Manual Series. Washington, D.C.: U.S. Dept. of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau, Office on Child Abuse and Neglect, 2003.

<https://www.childwelfare.gov/pubs/usermanuals/domesticviolence/domesticviolencecb.cfm>. Accessed on 9/15/2014.

⁹ *Ibid.*

limitations, and poor physical health in general compared to those without a history of IPV.” IPV is also associated with increased risk for asthma, irritable bowel syndrome, diabetes, and poor mental health. Even though IPV affects a number of health factors, only 21 percent of women experiencing IPV tell their physician about what has happened.¹⁰

INTIMATE PARTNER VIOLENCE IN RURAL AMERICA

What We Know About Rates of IPV in Rural Communities

The National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC) includes data on the national prevalence of IPV. At this time, the NISVS does collect data on respondent’s ZIP code, but the information that is published does not include a rural-urban data cut. It is important to note that when dealing with issues of self-reported IPV experiences, data must be closely protected to keep identities of the respondents confidential. It may be possible for CDC to create a geographic variable that indicates level of urbanization to better understand the prevalence of IPV in rural communities. However, that variable is not currently calculated. Data on sub-national levels (state and community) would likely not be possible for the CDC to publish out of concern for respondents’ privacy due to the small numbers in rural areas. There have been, however, several smaller studies examining prevalence of IPV in rural America.

One study found that 22.9 percent of women in small rural areas reported being victims of IPV, compared to 15.5 percent of women in urban areas. The study also found that women living in rural communities reported significantly higher severity of physical abuse than women living in urban areas.¹¹ Although the aforementioned study found higher rates of IPV in small rural communities, another recent study conducted by researchers at the CDC using data from the 2005 Behavioral Risk Factor Surveillance System (BRFSS), suggests that rates for IPV in rural areas are similar to urban areas.¹² Beginning in 2006, the CDC discontinued its policy of allowing researchers to access restricted information in the BRFSS datasets from respondents in counties with 10,000 or fewer residents that is suppressed in the publically available datasets. As a result of this change, the BRFSS data could no longer be used to analyze rural IPV. Several other smaller studies support the findings that the rates of IPV are equally high or higher in rural areas than those in urban communities.¹³

Rural persons experiencing IPV are 2.5 times more likely than those living in urban areas to have their property destroyed by an abuser.¹⁴ Additionally, women who have experienced IPV in rural America are more likely to be murdered by a partner than those living in cities. A 20-year study of murder rates by the Department of Justice concluded that, while intimate partner murder rates

¹⁰ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. “An Overview of *Intimate Partner Violence in the United States – 2010 Findings*.” Atlanta, GA: National Center for Injury Prevention and Control, Division of Violence Prevention. 2010. 1-2. <http://www.cdc.gov/violenceprevention/pdf/ipv-nisvs-factsheet-v5-a.pdf> Accessed 3/10/15.

¹¹ Peek-Asa et al. (2011) “Rural Disparity in Domestic Violence Prevalence and Access to Resources.”

¹² Breiding, M. J., J. S. Ziembroski, and M. C. Black. “Prevalence of Rural Intimate Partner Violence in 16 Us States, 2005.” *J Rural Health* 25.3 (2009): 240-6.

¹³ Dudgeon, A., and T. A. Evanson. “Intimate Partner Violence in Rural U.S. Areas: What Every Nurse Should Know.” *Am J Nurs* 114.5 (2014): 26-35.

¹⁴ Logan et al. (2003). “Qualitative Differences among Rural and Urban Intimate Violence Victimization.”

fell in urban areas from 1980-1999, they rose in rural areas in the United States during the same time period. The study found a strong relationship between geography and intimate partner murder. Non-intimate partner murder rates over the same time period did not show a relationship with rurality.¹⁵

A pediatrician present at the Committee's meeting spoke about the considerable effects of toxic stress on children. The Centers for Disease Control and Prevention has funded the Adverse Childhood Experiences Study, a long-term longitudinal study to assess the relationship between adverse childhood experiences, health care use, and cause of death. The CDC's definition of Adverse Childhood Experiences (ACEs), defined as abuse, neglect, and exposure to other traumatic stressors, includes growing up with a battered mother as one possible ACE. The study found that growing up with a battered mother increased the likelihood of exposure to a wide variety of other ACEs during childhood, including emotional, physical, and sexual abuse as well as physical neglect. Exposure to ACEs has a strong relationship to a wide variety of health problems over the course of the lifetime.¹⁶

The incidence of IPV is not specific to a single age group or cohort. Every year, about one in ten older adults living at home experience abuse.¹⁷ The fact that rural America has a higher share of persons 65 and older than urban America makes older Americans experiencing abuse a significant concern in rural communities. Given the lack of rural-specific data about abuse and IPV in later life, the Committee urges the Secretary to raise awareness about this issue. The Committee suggests that service providers who work closely with the elderly would benefit from training in recognizing and responding to the emotional effects of IPV.

As indicated above, there are no nationally representative studies currently available on IPV in rural areas. Small-scale studies can provide some indication as to the scope of the problem, but cannot effectively inform national policy because they may be influenced by regional or state-level variation as well as variations within the populations studied. Using the NISVS data will meet the policy need of collecting nationwide information without imposing an additional data collection burden on either respondents or the government. **The Committee recommends** that the Secretary direct the Centers for Disease Control and Prevention to conduct analyses of the National Intimate Partner and Sexual Violence Survey data with a geographic variable to gain a better understanding of the unique needs of individuals in rural America of all ages and throughout the life course experiencing IPV.

Social Factors and Rural IPV

The literature suggests that social factors, including traditional gender roles and a high degree of social cohesion in rural communities, can make it difficult for women who are experiencing IPV to obtain assistance. Rural women who have experienced IPV report having less social support

¹⁵ Gallup-Black, A. *Rural and Urban Trends in Family and Intimate Partner Homicide: 1980-1999*. Rockville, MD: National Criminal Justice Reference Service, 2004. Web.

¹⁶ Anda, R.F., et al. "Insights into Intimate Partner Violence from the Adverse Childhood Experiences (ACE) Study." *The Physician's Guide to Intimate Partner Violence and Abuse: A Reference for All Health Care Professionals : How to Ask the Right Questions and Recognize Abuse Another Way to Save a Life*. Eds. Salber, PR and E Taliaferro. Volcano, CA: Volcano Press, 2006.

¹⁷ Turner, A. *Rural Domestic and Sexual Abuse Program Advocates: Making a Difference in the Lives of Older Survivors of Abuse*. Madison, WI: National Clearinghouse on Abuse in Later Life (NCALL), 2013.

and greater feelings of loneliness than their urban counterparts.¹⁸ They are also less likely to seek out help, and perceive the justice system as less helpful than urban women.¹⁹ Individuals to whom the woman might need to reach out for help, such as a member of the law enforcement team, a judge, a primary care provider, or another service provider, might have a personal relationship with her or her abuser.²⁰ In one study, fifty percent of primary care providers reported that lack of privacy in a small rural community was a barrier to care.²¹

A study on rural IPV found that, “Patriarchal views of the family and the role of women, the permanence of marriage, religious convictions, and rural cultural norms pose challenges for providing community resources in rural areas.”²² Another study of rural primary care physicians supported this view, noting that “(t)hirty-two percent of rural [primary care providers] perceived that cultural expectations common to rural communities tend to establish IPV as a normative behavior, and that beliefs of female subservience persisted.”²³

In a qualitative study in Kentucky, where both rural and urban women who had applied for orders of protection were asked about coping strategies, more urban women mentioned talking to a friend or talking to family, while rural women were more likely to be dealing with their experiences alone; rural women were more likely to report containing their feelings and trying to ignore the abuse than urban women. On the whole, urban women were more likely to suggest they were optimistic about their future and were empowered to take steps to change their situation.²⁴

Rural Poverty and IPV

Women who are affected by IPV in rural areas may have a more difficult time becoming economically independent than those in urban areas. Rural America on the whole has higher rates of poverty than other geographies. There may be fewer economic opportunities in some rural areas for women seeking to be independent from a partner. For those who can find jobs, rural women are disadvantaged by both an urban-rural wage gap and a male-female wage gap. A brief from the nonprofit Wider Opportunities for Women notes that rural women earn on average 25 percent less than their rural male counterparts and 16 percent less than their metropolitan female counterparts. In addition, rural residents are more likely to have fewer liquid assets—50 percent of rural residents are asset poor compared to approximately 30 percent of urban residents. Rural Americans are also less likely to have employer-based benefits such as paid sick days, health insurance and unemployment insurance, and they on average face higher health insurance costs.²⁵ All of these factors can make it difficult for a woman to initially leave a violent partner and also make it difficult for her to become economically secure once she has left.

¹⁸ Logan et al. (2003). “Qualitative Differences among Rural and Urban Intimate Violence Victimization.”

¹⁹ Shannon, L., et al. *Help-Seeking and Coping Strategies for Intimate Partner Violence in Rural and Urban Women*. Lexington, KY: Center on Drug and Alcohol Research, University of Kentucky, 2006.

²⁰ *Rural Survivors and Economic Security*. Washington, DC: Wider Opportunities for Women (WOW), April 2013.

²¹ McCall-Hosenfeld, J. S., et al. “I Just Keep My Antennae Out”: How Rural Primary Care Physicians Respond to Intimate Partner Violence.” *J Interpers Violence* 29.14 (2014): 2670-94.

²² Riddell, T., M. Ford-Gilboe, and B. Leipert. “Strategies Used by Rural Women to Stop, Avoid, or Escape from Intimate Partner Violence.” *Health Care Women Int* 30.1-2 (2009): 134-59.

²³ McCall-Hosenfeld et al. (2014) “I Just Keep My Antennae Out.”

²⁴ Logan et al. (2003). “Qualitative Differences among Rural and Urban Intimate Violence Victimization.”

²⁵ “Rural Survivors and Economic Security.” (April 2013).

Rural IPV service providers may have trouble accessing sources of private-sector funding to support their services. The Committee heard from executive directors at the stakeholder meeting about their concern that many rural NGOs in South Dakota cannot meet the State's matching requirement due to the fact that they have limited donors (e.g. corporations and businesses) to request unrestricted funding and limited staff to complete the paperwork for each prorated requirement.

Rural Human Services Infrastructure and IPV

Women who have experienced IPV face the same challenges in accessing human services in rural America as the rest of the rural population. Long travel times, a lack of providers, and a lack of access to certain amenities, such as transportation and telecommunications, can prevent rural women from seeking human services. A study conducted in Illinois on service use by rural and urban women who have experienced IPV indicates that rural survivors are more likely to need a range of social services, including education, transportation, and housing services than their urban counterparts.²⁶

Rural women experiencing IPV may face the additional barrier of their abuser controlling the family's transportation and communication channels, preventing them from leaving the relationship or seeking help. One study stated that "(o)ver 25 percent of women in small rural and isolated areas lived more than 40 miles from the closest [IPV] program, compared with less than 1 percent of women living in urban areas."²⁷ Without a vehicle, women may have trouble accessing health and human services providers as well as securing employment.²⁸ In one qualitative study, a woman recounted having a spouse who disabled the car by removing the keys or the spark plugs to prevent her from leaving. Transportation challenges affect advocates too; advocates present at the community stakeholder meeting in Sioux Falls mentioned that oftentimes they are not reimbursed for fuel needed to travel many miles for their

²⁶ Grossman, S.F., et al. "Rural Versus Urban Victims of Violence: The Interplay of Race and Region." *Journal of Family Violence* 20.2 (2005): 71-81.

²⁷ Peek-Asa et al. (2011) "Rural Disparity in Domestic Violence Prevalence and Access to Resources."

²⁸ "Rural Survivors and Economic Security." (April 2013).

Responding to the Needs of Culturally Diverse Rural Women in Need of IPV Services

Human services providers in rural America serve a diverse population, which is reflective of the diverse nature of rural communities. There is limited research on the experiences and needs of women of color who have experienced intimate partner violence in rural America, and additional research in this area is needed. Literature on national IPV issues suggests that hiring staff that share the backgrounds of clients, developing cultural competence for nonminority staff members, and creating culturally relevant prevention materials are several ways IPV providers can meet the needs of diverse clients.¹ The need for culturally relevant training for shelters who serve Native American women who have experienced IPV was brought up by several service providers during the Committee's visit to South Dakota. One study on rural IPV in North Dakota, South Dakota, and Minnesota noted that the service provider population was almost entirely white while the clientele came from diverse backgrounds. This study also noted a need for more diverse staff and multicultural training to enhance communication between shelter staff and women of color.²

1. Kasturirangan, A., S. Krishnan, and S. Riger. "The Impact of Culture and Minority Status on Women's Experience of Domestic Violence." *Trauma Violence Abuse* 5.4 (2004): 318-32.

2. Semler, JL, BJ Semler, and K Wetterson. "Midwest Domestic Violence Shelters: Increasing Multiculturalism Training to Improve Communication between Staff and Native American Women." *Journal of Rural Community Psychology* E13.1 (2010).

work. Additionally, limited access to telecommunications in many rural areas may create barriers to service. Qualitative studies suggest that some abusers may control phone use.²⁹ Without cell phone service or an internet connection, isolated rural women experiencing IPV may have trouble seeking help and applying for employment even after they have left violent partners.³⁰

Women who have experienced IPV may also experience homelessness or housing instability,³¹ which can have additional negative health and economic outcomes on them and their children. Without a stable address, rural women also may have trouble applying for other state and federal human services programs, as well as employment. As the Committee wrote in its April 2014 policy brief on rural homelessness, a lack of high-quality affordable housing is a persistent challenge in many rural communities. The Committee underscores its recommendation in that brief that the Department work with the Department of Housing and Urban Development and other stakeholders through the Interagency Council on Homelessness to address the unique needs of individuals and families experiencing homelessness in rural America.

HHS Programmatic Resources

IPV victimization is associated with poverty, housing insecurity, and food insecurity. As a result, multiple parts of the human services safety net are likely to have contact with women who have experienced IPV. Thirty-six percent of women who experience IPV report having a need for at least one type of human services.³² The Administration for Children and Families, Family and Youth Services Bureau, Family Violence Prevention and Services Program (FVPSA) is the primary federal funding stream dedicated to the support of emergency shelter and related assistance for victims of domestic violence and their children, including the National Domestic Violence Hotline. There are around 1,900 domestic violence service providers around the country, which are funded in part by FVPSA. At the time of the last National Census of Domestic Violence Providers, these service providers reported serving 66,531 victims in a single day. Of those victims, 36,348 were in shelters or transitional housing. Other services utilized by victims included individual support or advocacy, group support or advocacy, children's support or advocacy, court/legal accompaniment or advocacy, and transportation.

Human services providers also staff hotlines and carry out prevention and education trainings and campaigns. At the time of the last National Census, local and state hotlines answered 20, 267 calls in one day and the National Domestic Violence Hotline fielded 550 calls. Nationally, there is a shortage of IPV services. Last year, in just one day, there were 9,641 requests for services that were unmet due to lack of funding, shelter space, and staffing; 60 percent of the unmet requests were for shelter.³³ In FY 2011 and FY 2012, the FVPSA Program reported that over 349,800 victims and their children were turned away because shelters were full or programs lacked resources, such as not enough beds in shelter or not enough staff to provide services.³⁴

²⁹ Riddell et al. (2009) "Strategies Used by Rural Women."

³⁰ "Rural Survivors and Economic Security." (April 2013).

³¹ Dudgeon and Evanson. (2014) "Intimate Partner Violence in Rural U.S. Areas."

³² Centers for Disease Control and Prevention. (2010) "An Overview of *Intimate Partner Violence*."

³³ National Network to End Domestic Violence, *Domestic Violence Counts*. (Washington, DC. 2013). http://nnedv.org/downloads/Census/DVCounts2013/DVCounts13_NatlSummary.pdf Accessed 9/17/2014.

³⁴ This reference to "victims" refers to all victims (women, men, and those who did not identify as either sex/gender).

The Rural Health Care System and IPV

In rural communities where barriers to care such as travel time, lack of providers, and higher rates of uninsurance can keep women from seeing providers, women who have experienced IPV may have trouble accessing health care. Exposure to violence results in higher rates of health care utilization and costs nationally.³⁵ In addition to the social and economic costs for women who have experienced IPV, these health costs in aggregate may put a strain on an already financially weak health infrastructure in rural communities.

As noted above, survivors of IPV are more likely to experience adverse health outcomes and may have difficulty having their health care needs met due to a shortage of providers. Rural women who have experienced IPV report more severe physical and mental health problems than urban women who have experienced IPV.³⁶ For example, women who have experienced IPV also have higher rates and severity of depression, anxiety, post-traumatic stress disorder, low self-esteem, and suicidal thoughts.³⁷ Women who have experienced IPV report much higher rates of substance abuse than women who have not, although urban women who have experienced IPV are more likely to report abusing alcohol than rural women.³⁸ Given that there is limited access to mental health care services in rural areas due to a shortage of providers,³⁹ many women experiencing IPV in rural are unlikely to have their needs met by the existing mental health system.

In small rural organizations where one provider plays many roles, the provider may have less specific training to address the needs of women with mental health and/or substance abuse conditions. Leaders of non-profit organizations at the South Dakota community stakeholder meeting highlighted that human service providers need more education on how to deal with those who have mental health and substance abuse issues.

To mitigate these shortages, there has been growing momentum behind the integration of behavioral and mental health into primary care practices to ensure access to mental health services. Most models that have received national policy attention; however, typically focus on integrating screening, counseling and treatment for depression and substance abuse into primary care centers rather than specific services to address the needs of women who have experienced IPV.⁴⁰ Integration of screening and counseling for IPV into rural primary care delivery services would effectively leverage the existing workforce available in rural areas.

³⁵ Dolezal, T, D McCollum, and M Callahan. *Hidden Costs in Health Care: The Economic Impact of Violence and Abuse*. Eden Prairie, MN: Academy on Violence and Abuse, 2009.

³⁶ Logan et al. (2003). "Qualitative Differences among Rural and Urban Intimate Violence Victimization."

³⁷ Pico-Alfonso, M. A., et al. "The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide." *J Womens Health (Larchmt)* 15.5 (2006): 599-611.

³⁸ Logan et al. (2003). "Qualitative Differences among Rural and Urban Intimate Violence Victimization."

³⁹ Fordyce, M.A., et al. *2005 Physician Supply and Distribution in Rural Areas of the United States*. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, 2007.

⁴⁰ These different models include : Consumers as Partners in Health, IMPACT, Cherokee Health Systems, DIAMOND, Vermont Blueprint for Health, The Integrated Behavioral Health Project, ICARE Partnership in North Carolina Project, The Massachusetts child Psychiatry Access Project (MCPAP), and the Macarthur Initiative. SAMHSA-HRSA Center for Integrated Health Solutions has this list of project profiles accessible online at <http://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care> .

The US Preventive Services Task Force recommends providers screen women of child-bearing age for IPV. Many health associations, including the American Medical Association and the American College of Obstetrics and Gynecologists, also recommend routine screening.⁴¹ Additionally, under the Affordable Care Act, IPV screening and counseling is one of the preventive services for women that is now offered for free by most health coverage plans. Yet, a recent study comparing rural and urban primary care physicians in Pennsylvania showed that most rural primary care doctors “...did not practice routine screening for IPV due to competing time demands, lack of training, limited access to referral services, as well as low confidence in their effectiveness, and concern that inquiry would harm the patient-doctor relationship.”⁴² **The Committee recommends** that the Secretary direct ACF to work with CMS, SAMHSA, and HRSA to train rural healthcare providers on integrating IPV screening and counseling into service sites and deepen formal ties between health care providers and IPV service providers in rural communities.

A recent article on the importance of nurses screening for IPV notes that since rural women may present in rural or urban settings, it is important that providers in all geographies have tools to address the unique needs of rural individuals experiencing IPV. The authors suggest specifically that patients should “...be asked how far away she is from the closest neighbor, if she has access to a telephone or a means of transportation, if she has a social support system...if she knows of shelters or other survivor services near her home, and whether she has used or would consider using those services.” If the rural woman is assessed to be in danger, the article suggests that the provider “help the survivor identify whom she might turn to in her home community.”⁴³ The Committee suggests that providers serving a rural population be trained on the available domestic and sexual violence resources available for survivors in local communities so that warm referrals to expert providers can be made easily and safely for survivors.

The Committee also suggests that consideration must be given to the close social ties in rural communities so that a victim’s need for anonymity is taken into account and that appropriate service referrals and protection is afforded rural victims. **The Committee recommends** that the Secretary direct ACF to work with SAMHSA and HRSA to connect healthcare providers who have been trained in IPV screening to community-level organizations that help individuals in rural America experiencing IPV.

CONCLUSION

The Committee emphasizes that, although more research needs to be conducted to assess the prevalence and severity of IPV nationally, the existing evidence base and the testimony they heard in South Dakota from service providers suggests that the prevalence of IPV in rural America is at least comparable to that in urban areas. While rural women experience IPV at similar rates to urban women, they are more likely to experience greater severity of violence, less

⁴¹ de Boinville, M. “Screening for Domestic Violence in Health Care Settings.” *ASPE Policy Brief*. Washington, DC: U.S. Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), August 2013.

⁴² McCall-Hosenfeld et al. (2014) “I Just Keep My Antennae Out.”

⁴³ Dudgeon and Evanson. (2014) “Intimate Partner Violence in Rural U.S. Areas.”

likely to reach out for help as a result of the high degree of social interconnectedness in rural communities, and less likely to be screened for IPV by their health care providers. Due to high rates of poverty, transportation barriers, a lack of affordable housing, and telecommunications barriers in rural America, rural women may face both significant barriers to leaving an abusive situation and establishing a new life once they have left. For these reasons, rural women experiencing IPV are an especially vulnerable population. The Committee encourages the Department to work together with the Departments of Justice and Housing and Urban Development to collect and analyze additional data and use that data to inform policies targeted to addressing the unique needs of rural women of all ages experiencing IPV.