Addressing Intimate Partner Violence in the Health Care Setting: Implications for Research

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Learning objectives

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- Explain how the dynamics of intimate partner violence (IPV) and its impact on health have shaped the health care system's response to IPV
- Identify best practices for assessing and responding to intimate partner violence
- Discuss the implications and recommendations for research conducted in the health care setting

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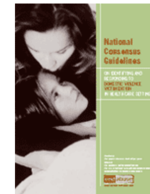
BMC DV Program- background

- BMC leadership in Health Care Response to domestic and sexual violence since early 90s



- DV Advisory Committee
  - ↳ Creation of DV Program in 2007
    - ↳ Addition of Advocacy Services in 2009

- Works across all BMC departments and disciplines to coordinate and improve the institutional response to intimate partner violence.

Internal partners

Nursing
Medicine
Pediatrics
Child Protection Team
Human Resources
Patient Advocacy
Child Witness to
Violence Project
Development
Ctr for Refugee Health

Social Work
Geriatrics
Public Safety
Pastoral Care
General Counsel
Interpreter Services
MLP|Boston
Violence Intervention
Advocacy Project
Behavioral Health

Community partners/networks

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- Boston Area Rape Crisis Center/SANE program
- Conference of Boston Teaching Hospitals (COBTH) (hospital-based DV programs)
- Jane Doe Inc. (MA Coalition of DV Programs and Rape Crisis Centers)
- MA Dept. of Public Health & Dept. of Children and Families
- Governor's Council to Address Sexual and Domestic Violence
- Multicultural Immigrant Coalition Against Violence

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What we provide

- Training and education
- Policy/Protocol development
- Consultation and technical assistance
- Community linkages
- Direct services- Safety and Support Advocates
- Intranet website for BMC staff/providers

http://internal.bmc.org/domesticviolence

Scope of partner/sexual violence in the US *Extent, nature, and consequences of intimate partner violence, National Violence Against Women (NVAW) Survey 2000*

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- 1.5 million women, 835,000 men physically assaulted or raped per year (total assaults/rapes reported-4.8 million against women, 2.9 against men per year
- Over 500,00 women; 185,000 men stalked per year
- Lifetime prevalence: 25.5% (women); 7.6% (men)

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Scope of partner/sexual violence in the US (cont) *NVAWS, CDC, WHO*

- Partner violence occurs in both heterosexual and same-sex relationships, at all ages, across all socio-demographic lines, and in all cultures.
- Women overall at significantly greater risk than men for being killed by a partner and/or sustaining serious injury.
- Most victimizations never reported to police.

Risks higher for additionally vulnerable populations such as…

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- Women of color (particularly African American and Native American women)
- Older women, pregnant women
- Children
- People with disabilities
- LGBT men and women, teens
- Poor, homeless
- Immigrants

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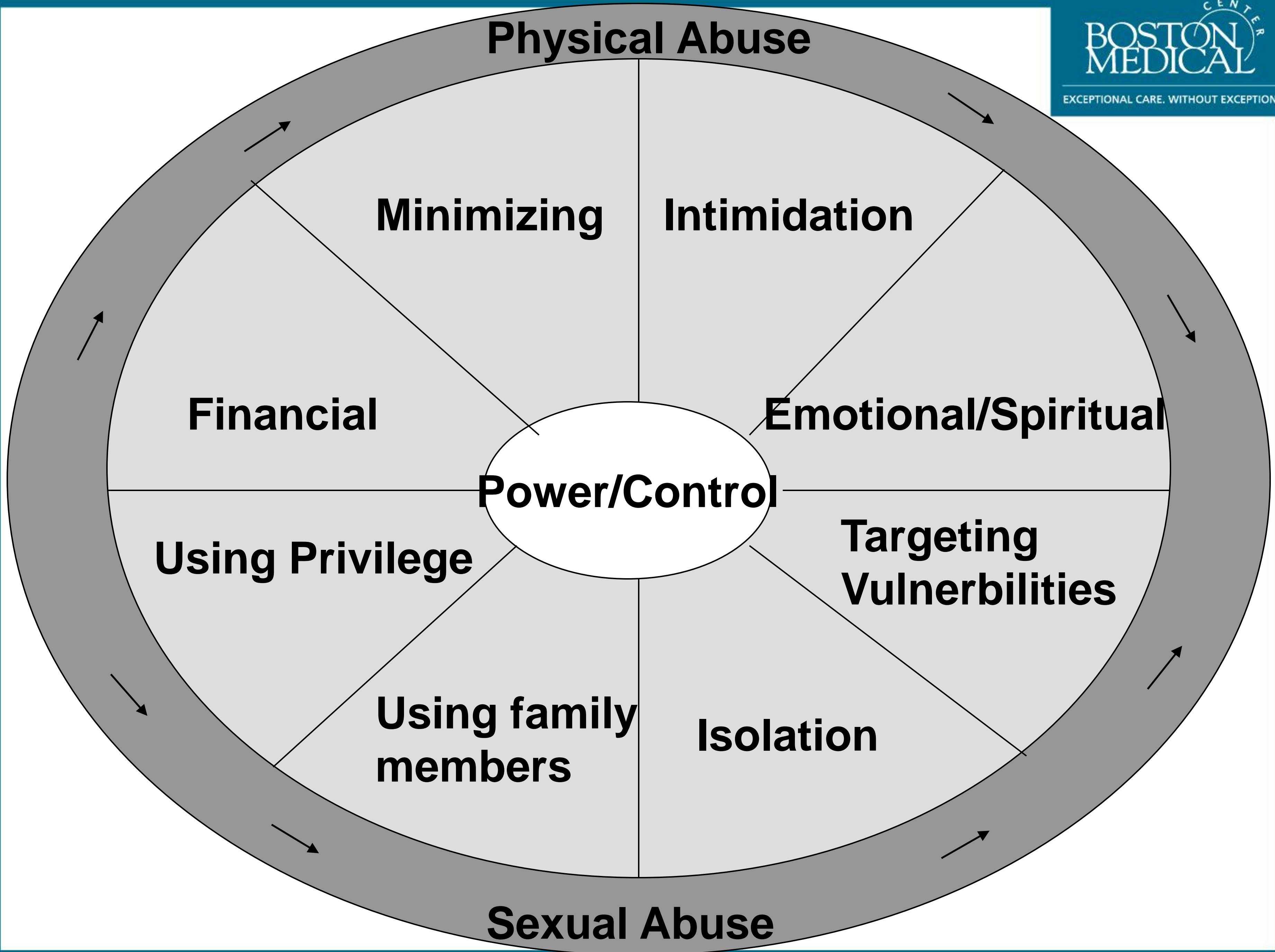
Intimate Partner Violence

Family Violence Prevention Fund, 1999

- pattern of assaultive, coercive behaviors
  - may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats
- perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship
- aimed at/resulting in power and control by one partner over the other


Physical Abuse
Minimizing
Intimidation
Financial
Emotional/Spiritual
Power/Control
Using Privilege
Targeting Vulnerbilities
Using family members
Isolation
Sexual Abuse
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Dynamics of abuse are complex

- Not all violence is abuse, and not all abuse involves violence.
- Context matters:
  - What is intent/effect of behavior?
  - Who is afraid, and of what or whom?
  - Who makes decisions/has freedom, who does not?
  - Whose health/safety are being jeopardized?
  - Who is asserting power/control over the other person?
  - What happens over time?

Tactics of abusers

- use many and varied tactics to gain and maintain dominance in the relationship.
- exploit victim's vulnerabilities.
- are strategic about their use of violence.
- may involve others in the web of control.
- escalate control tactics as needed, often at key turning points in relationship.
- retaliate when victims seek help or try to move on.

Dynamics change over time

ADAPTED from the Pattern of Abuse Graph from the American College of Nurse-Midwives

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"Why do victims stay? Why don't they leave?"

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- Many do leave, or end the relationship, or have made attempts.
- Risk/benefit decision-making process complicated by *control* and *fear*.
- "Staying" may mean survival; "leaving" may take time, planning, and lots of support.
- Question itself can lead to victim-blaming.

What might keep someone trapped? (Unique to each person, changes over time)

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- **Fear of retaliation by abuser (separation violence)**
- Loss of income, home, benefits, immigration status
- Love, hope, confusion, shame, believe abuse is their fault
- Lack of information, unaware of legal rights, other resources
- Financial, physical, or social dependence on abuser (or vice versa)
- Cultural/family pressure to keep relationship/family together
- Fears and barriers related to racism, homophobia, etc
- Compromised health or trauma-related issues
- Lack of offender accountability

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Keep in mind

- Risks are complex, different for everyone and every situation, vary over time.
- Risks could be to the victim, children, other family members, etc.
- Risks may be physical, financial, emotional, etc.
- Sometimes new risks arise when victims seek help <u>or</u> when others intervene.

Risks are higher when abuser perceives a loss of control (e.g. victim telling someone), or is being held accountable (e.g. police called)

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Health impact of IPV *Centers for Disease Control and Prevention*

- IPV is a leading cause of death and serious injury for women, as well as numerous physical and mental health issues for both men and women.

- The costs of intimate partner rape, physical assault, and stalking exceed $5.8 billion each year, nearly **$4.1 billion of which is for direct medical and mental health care** services.

Evolution of the health care response *CDC, Commonwealth Fund, Futures Without Violence*

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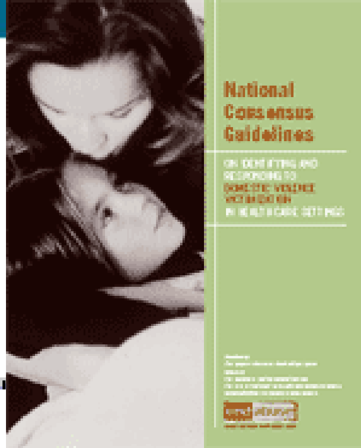
- Survivors of IPV are disproportionately represented in many medical settings and have more complex health needs.
- Medical setting is presumed to be a safe place for survivors to disclose and seek help, esp. for those who don't report elsewhere.
- Healthcare-based advocacy and strong community partnerships support/improve healthcare response to IPV.



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- Guidelines were developed supporting provider inquiry and response
  - ↳ increase screening of female patients
- Adopted by Joint Commission and most professional health care associations (ACOG, ANA, AMA, APHA, AAFP, AAP, AANP, WHO)
- 2011 Institute of Medicine recommendation that IPV assessment be integrated into routine primary care for women

Recommended health care response includes…

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- Training and Education
- Clinical Protocols for:
  - Screening and Identification
  - Validating messages (whether or not abuse is disclosed)
  - Assessment/Appropriate health care & documentation
  - Risk Assessment and Safety Planning
  - Referrals
  - Follow Up
- Support/Advocacy services

Roles and responsibilities vary by provider/setting

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Joint Commission requires that…

- Staff be able to identify abuse to be able to provide appropriate care;
- Only trained staff conduct in-depth assessment;
- When trained staff unavailable, victims be referred to appropriate outside agencies for assessment and/or other services;
- Hospitals maintain a current list of local resources to facilitate such referrals.

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What survivors want?

- Survivors think health care setting is appropriate.
- Inquiry about abuse is appreciated, even by women not currently affected.
- Countless victims and families have found help through health care intervention.

However…

- Medical model is not a perfect fit.
- Provider response makes all the difference.
- One size does not fit all!

Challenges for addressing IPV in health care setting

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- "Screening" model and tools not a perfect fit for the issue.

- Lack of training, protocols, for providers.
- Lack of knowledge in provider and general population about options and resources for survivors.
- Providers' own Hx with violence.

Challenges for addressing IPV in health care setting (cont)

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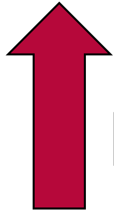
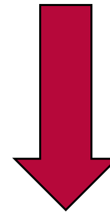
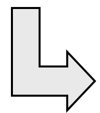

Demand/Need


$ and Services

- Changing and complex needs of survivors (trauma Hx, long term safety, economy, technology, immigration, etc).
- Complications/dangers associated with mandated reporting.
- Re-traumatization of victims by systems.

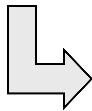
"First Do No Harm"

Stereotypes and misinformation

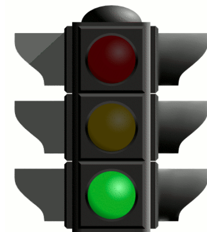


Dangerous, ineffective practices

Accurate understanding and information



Safe, effective practices



Goals of health care response

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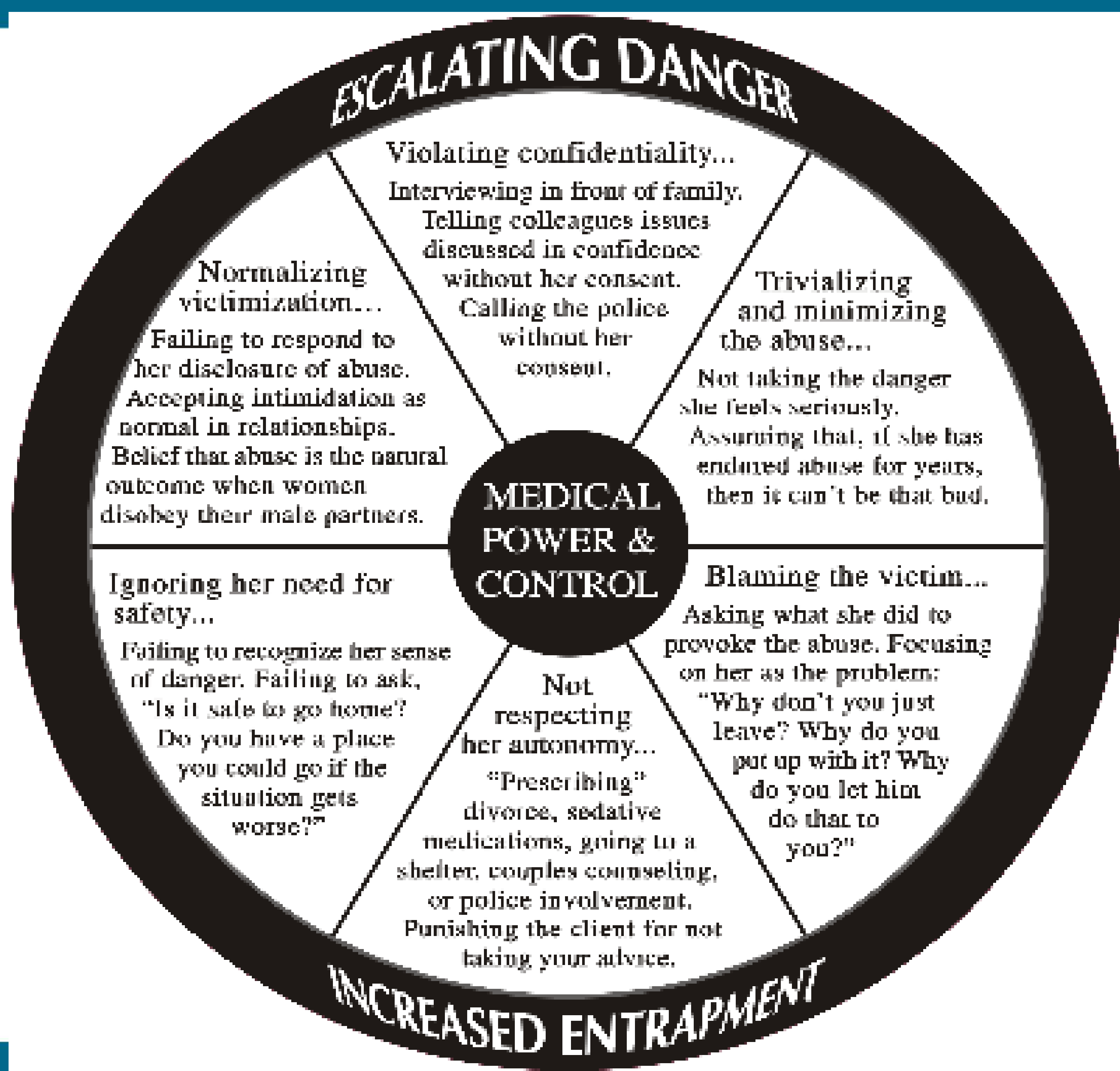
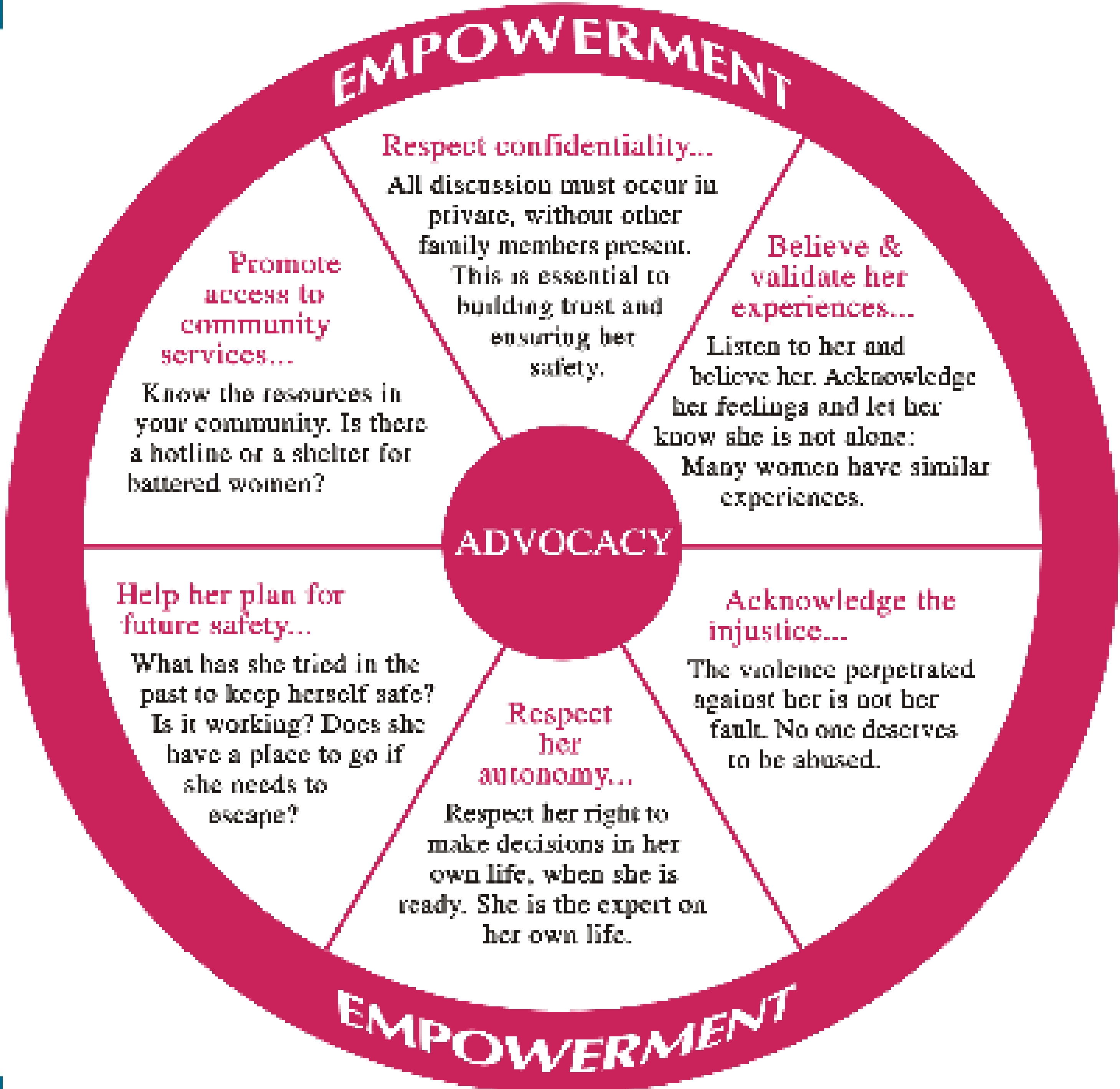
ARE

- To provide informed, holistic and appropriate care;
- To increase safety, reduce isolation, link victims and their families to additional services/support

Are NOT

- To force survivors to disclose abuse or take particular action
- To make health care providers responsible for solving the problem or to find perfect, complete solutions.


ESCALATING DANGER
Violating confidentiality...
Interviewing in front of family.
Telling colleagues issues discussed in confidence without her consent.
Calling the police without her consent.
Trivializing and minimizing the abuse...
Not taking the danger she feels seriously.
Assuming that, if she has endured abuse for years, then it can't be that bad.
Blaming the victim...
Asking what she did to provoke the abuse. Focusing on her as the problem: "Why don't you just leave? Why do you put up with it? Why do you let him do that to you?"
Not respecting her autonomy...
"Prescribing" divorce, sedative medications, going to a shelter, couples counseling, or police involvement.
Punishing the client for not taking your advice.
Ignoring her need for safety...
Failing to recognize her sense of danger. Failing to ask, "Is it safe to go home? Do you have a place you could go if the situation gets worse?"
Normalizing victimization...
Failing to respond to her disclosure of abuse.
Accepting intimidation as normal in relationships.
Belief that abuse is the natural outcome when women disobey their male partners.
MEDICAL POWER & CONTROL
INCREASED ENTRAPMENT
WITHOUT EXCEPTION.


EMPOWERMENT
Respect confidentiality...
All discussion must occur in private, without other family members present. This is essential to building trust and ensuring her safety.
Believe & validate her experiences...
Listen to her and believe her. Acknowledge her feelings and let her know she is not alone: Many women have similar experiences.
Promote access to community services...
Know the resources in your community. Is there a hotline or a shelter for battered women?
ADVOCACY
Help her plan for future safety...
What has she tried in the past to keep herself safe? Is it working? Does she have a place to go if she needs to escape?
Acknowledge the injustice...
The violence perpetrated against her is not her fault. No one deserves to be abused.
Respect her autonomy...
Respect her right to make decisions in her own life, when she is ready. She is the expert on her own life.
EMPOWERMENT
CARE. WITHOUT EXCEPTION.

Trauma-informed practice

- Maximizes patient safety by:
  - Acknowledging prevalence of IPV, likelihood that a patient may have a current or past history of abuse or trauma whether patient discloses or not, whether someone “appears/acts” like a victim or an abuser or not.
  - Minimizing physical and emotional risks associated with inquiry and disclosure.
- Unlikely to cause harm when followed, but may cause harm when not followed

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What do you see?

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Abuse Inquiry and Response Guide for Clinicians

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Ask direct questions about abuse/violence ONLY WHEN:

- Patient is in a **private space and alone** or w/ appropriate interpreter.
- You are **prepared to respond** and **have resources to offer** (e.g., advocate/hotline #, brochure, palm card, etc.)
- Whenever possible, patient is **aware of any limits to confidentiality**, such as mandated reporting requirements.

Frame/set context, then

Ask direct question(s)

- No abuse reported

If you do not suspect abuse

Remind patient that:

- abuse is very common, but people sometimes feel unsafe or uncomfortable talking about it,
- if this ever does happen, s/he can tell you, and **there is help available**.

Ask again at next visit.

If you suspect abuse due to indicators or Hx

Respect patient decision not to talk about it,

Express concern w/o blaming or judging patient

+ Current/past abuse reported

Listen, Acknowledge that talking about this can be hard**, Thank** patient for trusting you.

Further Assessment varies by role and setting; may include:

- **Abuse Hx, impact on health status/access**
- **Coping strategies/strengths**
- **Immediate safety concerns-** (consider Lethality assessment if appropriate)

KEY MESSAGES: "You are not alone, you are not to blame, you do/did not deserve this, there is help available if/when you would like it."

Document all above steps objectively and according to departmental protocol, and **Refer to appropriate resources**- visit **http://internal.bmc.org/domesticviolence** to learn more. *(The National DV Hotline can offer guidance to providers as well as direct victim support 800-799-7233)*

Red flags to be prepared for

- Certain types/locations of injuries or other conditions;
- Substance use, depression, eating/sleep disorders;
- Frequent missed appts./need for refills, delays in seeking care, pregnancy related issues;
- Overbearing, ever-present partner/family member;
- Lethality risk indicators including:
  - Recent increase in severity/frequency of violence (esp. sexual assault)
  - Abuser has used or threatened with a weapon
  - Woman believes abuser is capable of killing her

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When offering referrals

- Include at least one 24 hour hotline, stressing importance of connecting with a DV expert who can assist with further risk assessment and safety planning.
- Materials/numbers may be unsafe to take; be creative about giving information discreetly (e.g., generic business card or resource list with hotline # one of many)
- Consider giving basic DV resources to all

DV experts provide or link to both immediate and long-term support/resources

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- Hotlines
- DV Programs
- Rape Crisis Ctrs

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- Safety planning & Advocacy
- Restraining orders
- Shelter, housing
- Counseling
- Legal services
- Financial assistance
- Child/elder care
- Education/training
- ??

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Referrals NOT recommended…

- Couples/family counseling (only AFTER abuse stops and victim feels safe)
- Anger management for abuser
- Individual counseling/therapy only
- ANY intervention or professional involvement without patient knowledge or consent (within limits of the law)

Mandated Reporting and IPV

In MA, IPV is not reportable except where it overlaps with and fits the criteria for other reportable forms of abuse:

- Abuse of a child under 18 (witnessing is not automatically reportable, see DCF handout for guidance)
- Abuse of a person age 60 or older
- Abuse of a person with disabilities

Safety planning with victim is critical when reporting abuse!

Other relevant reporting laws

Providers/researchers should be familiar with other relevant reporting laws depending on nature and setting of the practice/study, e.g.,

- Duty to warn (Tarasoff rule)
- Sexual assault (anonymous PSCR form)
- Reportable injuries (gunshots, serious burns, etc.)

Where best practices for clinical care and research meet

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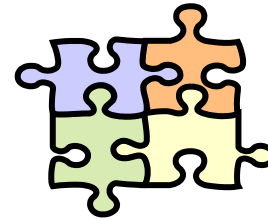

- TRAINING by experts in dynamics of IPV, resources for victims, relevant laws and scenarios depending on population and health issues involved.
- COLLABORATION with clinical and DV staff, compliance with clinical and IPV-related protocols in study area.
- SAFETY and CONFIDENTIALITY!! Private space for both recruitment and study activities, safe contact, correspondence, documentation, etc.
- SURVIVOR control and decision-making at every step.

Important considerations for IPV researchers in health care settings

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- What are the salient research questions and how do we answer them in ways that will truly benefit victims and advance the work?
- How will the study…
  - Ensure existing information and resources for victims are offered when appropriate?
  - Ensure medical care is not impeded?
  - Minimize inherent power imbalances that may put undue pressure on patients to participate?
  - Involve experts in IPV at all stages?

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BMC DV Program

- To make referrals for DV Advocacy services M-F 9-5, please use main Intake line **4-5457 or pager 2590**.
- After hours, leave a message on Intake line or call a hotline listed on our website page http://internal.bmc.org/domesticviolence
  click "Where To Find Help" in left hand column

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Additional Resources at BMC

- **Inpatient Social Workers** available by unit, 8AM-7PM
- **Emergency Room Social Workers**
  - Mon-Fri, 10:30AM-7PM Adult SW **8-7147, pager 5569**
    Ped SW **4-5007, pager 4543**
  - Sat-Sun, 7AM-7PM SW coverage by **pager 3119**

- **Child Protection Team** to consult on child abuse response/reporting- 4-3663 pager 7336
- **Public Safety- "Code Green"** 4-4444 to report violent incident
- **General Counsel's office** 8-7901
  (after hours or emergencies call page operater 8-7243 and page the lawyer on call)

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Key Resources in MA

- **SafeLink DV Hotline 1-877-785-2020** *(TTY: 1-877-521-2601* http://www.casamyrna.org/safelink.html
- **Boston Area Rape Crisis Center 1-800-841-8371** http://www.barcc.org
- Jane Doe Inc. (State Coalition) http://www.janedoe.org
- MA Dept. of Public Health Violence Prevention and Intervention http://www.mass.gov/dph/violence
- Multicultural Immigrant Coalition Against Violence http://www.micav.org/home

National/International Resources

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National DV Hotline 1-800-799-7233
(TTY: 1-800-787-3224)
http://www.ndvh.org

National Teen Dating Abuse Helpline 1-866-331-9474
(TTY 1-866-331-8453) http://www.loveisrespect.org/

National Sexual Assault Hotline 1-800-656-4673
http://www.rainn.org/

International Directory of Domestic Violence Agencies
http://www.hotpeachpages.net/

Recommended reading re: IPV research and evaluation

- "Ethical conduct in intimate partner violence research: Challenges and strategies". *Btoush and Campbell, 2009 (handout)*
- *"Evaluating domestic violence support service programs: Waste of time necessary evil, or opportunity for growth?" Sullivan, 2011 (handout)*
- "Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women" *Dept. of Gender and Women's Health, Family and Community Health-World Health Organization*

http://www.who.int/gender/violence/womenfirtseng.pdf

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For more information on IPV and health

- WHO Multi-country Study on Women's Health and Domestic Violence against Women

http://www.who.int/gender/violence/who_multicountry_study/en/

- “Population Reports: Ending Violence Against Women” http://www.infoforhealth.org/pr/l11/violence.pdf
- “Extent, Nature and Consequences of IPV”- Findings from Nat’l Violence Against Women Survey

https://www.ncjrs.gov/pdffiles1/nij/181867.pdf

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Additional health care resources

- Conference of Boston Teaching Hospitals DV Council
  http://www.cobth.org/dom_violence.html
- National Health Resource Center on DV
  http://www.futureswithoutviolence.org/health

888-Rx-ABUSE (888-792-2873) *TTY: 800-595-4889*

- Centers for Disease Control and Prevention

http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html

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For more information

http://www.internal.bmc.org/domesticviolence

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