Responding to Gender-Based Violence: The Role of the Medical System

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Objectives

- Describe the scope and health effects
- Outline medical setting presentations
- Make the case for a comprehensive, trauma-informed, and prevention-focused health response
- Facilitate collaboration between health care and other sectors of society
- Push the envelope (gently)

http://www.flickr.com/photos/leilarg/

Presentation Topics

I. Overview
II. Dynamics
III. Health impact
IV. Time management
V. Identification and assessment
VI. Intervention and follow-up
VII. Interprofessional collaboration and coordinated community response
VIII. On the horizon

I. Overview

1, 2, 3, 4

- One Vision
- Two Roles
- Three Concepts
- Four Principles of Care

One Vision

To end
(and ultimately to prevent)
violence in families
and in relationships

Two Roles

Private / individual

Public / advocacy

Individual Role - RADAR

R: Remember to ask

A: Ask directly

D: Document findings

A: Assess for safety

R: Review options, refer

F: *Follow up*

Public / Advocacy Role

- ❑ Respected in community
- ❑ Valued member of VIP team
- ❑ Innovator in prevention efforts
- ❑ Change agent

Three Concepts

- Safety — *Are you safe?*
- Honesty — *Help me understand*
- Respect / Empowerment — *You deserve better*

Four Guiding Principles of Intervention / Care

- ❑ Patient, self and staff safety
- ❑ Survivor autonomy / empowerment
- ❑ Offender accountability
- ❑ Transform social norms
- ❑ Work toward prevention

The Importance of Language

WHAT COMES TO MIND WHEN YOU THINK OF THE WORD "VICTIM" ?

Definition: "victim"

vic·tim

[**vik**-tim] Show IPA

–noun

1. a person who suffers from a destructive or injurious action or agency: *a victim of an automobile accident.*
2. a person who is deceived or cheated, as by his or her own emotions or ignorance, by the dishonesty of others, or by some impersonal agency: *a victim of misplaced confidence; the victim of a swindler; a victim of an optical illusion.*
3. a person or animal sacrificed or regarded as sacrificed: *war victims.*
4. a living creature sacrificed in religious rites.

http://dictionary.reference.com/browse/victim

Victim

- Helpless
- Hurt
- Weak
- Afraid
- Dependent
- Needy
- Vulnerable
- Powerless
- Isolated
- Trapped
- Violated
- Attacked, hunted
- Defeated
- Insecure
- Suffering
- Damaged goods
- Taken advantage of
- Used and abused
- Wronged
- Ashamed
- Mistreated
- Low self-worth
- Paranoid
- Devastated

WHAT COMES TO MIND WHEN YOU THINK OF THE WORD "SURVIVOR" ?

Definition: "survivor"

sur·vi·vor

[ser-**vahy**-ver] Show IPA

–noun

1. a person or thing that survives.
2. *Law* . the one of two or more designated persons, as joint tenants or others having a joint interest, who outlives the other or others.
3. a person who continues to function or prosper in spite of opposition, hardship, or setbacks.

http://dictionary.reference.com/browse/survivor

Survivor

- Alive
- Courageous
- Overcomes adversity
- Endurance
- Resilient
- Renewal
- Strong, confident
- Autonomous
- Empowered
- Perseverance
- Determination
- Has support
- Proactive
- Confident
- Hope
- Tough
- Role Model
- Lucky (possibly)
- Accomplishment
- Willing to look for help
- Moving forward
- Progress
- Liberated
- Respected

Domestic Violence: Definitions

- A purposeful pattern of coercive behaviors used by adults or adolescents against current or former dating or intimate partners
- The pervasive and methodical use of threats, intimidation, manipulation and physical or sexual violence by someone seeking power over a current or former intimate partner

Spectrum

- Physical violence
- Sexual assault
- Threats and acts of intimidation
- Emotional abuse
- Social and physical isolation
- Spiritual abuse
- Economic coercion
- Reproductive coercion
- Attacks or threats to property, pets, keepsakes
- Use, manipulation of children

What Makes IPV Different from Other Types of Violence ?

- Ongoing, evolving relationship with perpetrator
- Emotional attachment to perpetrator
- Economic dependence on perpetrator
- May share children, friends, social network
- Multiple "incidents" (rather than isolated crime)
- Measures of "incidents" don't capture patterns, context, meaning, effects of complex trauma
- Confounding, confusing societal messages
- Reluctance to report
- Shame, blame, stigma
- Danger may increase after leaving
- Health effects may worsen after seeking help

Canadian Statistics - 2010

- 99,000 victims of family violence (relationships based on 'kinship, intimacy, dependency or trust') (UCR)
- Family violence accounts for 25% of all violent crime reports to police (39% if dating violence is included)
- When dating violence is included within "family violence," FV encompasses the highest rate of violent crime among all relationship categories (higher than crimes against strangers or acquaintances*)

Source: Family Violence in Canada: A Statistical Profile, 2010. Available from Statistics Canada at:
http://www.statcan.gc.ca/pub/85-002-x/2012001/article/11643-eng.pdf

StatCan - IPV

- 102,500 victims (includes dating violence) UCR
- Territories, Saskatchewan, Manitoba highest incidence
- Ontario lowest incidence
- Women at 4 x risk of men (incidence)
- Women more likely to sustain injury
- Annual incidence is declining (police reports)

StatCan Report Caveats

- Since most incidents never reported to police, police reports are underestimates
- Gross under-reporting of IPV in gay men and other traditionally marginalized groups
- What is an "acquaintance"?
- Measuring "incidents" of any kind is a poor proxy for coercion and its myriad health effects
- Many expressions of IPV are not illegal, yet have profound health and emotional effects

NISVS Study (U.S. CDC)

- Ongoing, nationally representative RDD phone survey
- Information about: SV, stalking, IPV
- Health consequences of victimization
- Women and men, English and Spanish, 18 yo or older
- New insights about rape and other forms of SV, psychological aggression/control, and reproductive coercion
- Rape defined as: completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration

Source: http://www.cdc.gov/ViolencePrevention/NISVS/

NISVS Findings

Annual U.S. incidence:

- Overall > 12 million women and men / yr (physical violence, rape, stalking by an intimate partner)
- 1% (1.3 million) women raped / yr
- 6% and 5% of women and men sexually assaulted (other than rape) / yr

Lifetime prevalence:

- 36% women, 29% men reported rape, physical violence and/or stalking by a current or former intimate partner
- Among women victims: 1 in 3 multiple types of viol.
- Among male victims: 92% physical violence alone
- Severe physical violence* by an intimate: 1 in 4 women (24.3%); 1 in 7 men (13.8%)

* e.g., hit with fist or hard object, beaten, slammed into something, burned, choked, attacked with a weapon

NISVS Sexual Violence

- Rape: 1 in 5 women, 1 in 71 men
  - First rape before age 10: 12% female, 28% male
  - Perpetrators of women victims: 51% IP, 42% acqtce
  - Perpetrators of male victims: 52% acqtce, 15% strgr
- Sexual coercion (unwanted sexual penetration after being pressured in a non-physical way):
  - 13% women, 6% men
- Unwanted sexual contact
  - 27% women, 12% men
- Forced penetration: 4.8% of men report being forced to penetrate someone else. Perpetrator: 45% IP, 45% acquaintance

NISVS: Impact of Victimization

- Women disproportionately impacted (events as well as effects)

- Common impacts:
  - Injury
  - Fear
  - Concern for safety
  - PTSD
  - Missed work or school
  - Need health care
  - Need to contact a crisis line
  - Need housing
  - Need legal services
  - Need victim advocacy services

- Significant short or long-term health impact (injury, PTSD, etc.)

  81% of victimized women

  35% of victimized men

NISVS: Health Impact

- Victimized women > likely to have asthma, diabetes, irritable bowel syndrome
- Victimized men and women > likely to have
  - frequent headaches
  - chronic pain
  - difficulty sleeping
  - activity limitations
  - poor physical health
  - poor mental health

NISVS: Who are the Perpetrators?

- For female victims, for all types of violence, majority of perpetrators are male
- For male victims, majority of perpetrators of rape and non-contact sexual assault are male. Half of stalking perpetrators are male. Other perpetrators mostly female.

Additional Studies

- 1 in 9 women seen in ED
- 1 in 2 (54%) lifetime – female ED patients
- One in four women who attempt suicide
- One in twelve women who are pregnant
- Largest cause of maternal mortality
- More than half of the mothers of abused children

Highest Prevalence

- ❑ Female
- ❑ Young
- ❑ Unmarried
- ❑ Poor

IPV: Highest Prevalence

- ❑ Alcohol or other drug abuse (survivor or partner)
- ❑ Physical symptoms
- ❑ Behavioral symptoms
- ❑ Visits to emergency facilities
- ❑ Jealous, possessive, or overly protective or involved partner

II. Dynamics

Perpetrator Dynamics

Perpetrator "Ingredients"
(do not try this at home!)

- ✓ Objectification
- ✓ Entitlement
- ✓ Power
  - ❖ Learning
  - ❖ Opportunity
  - ❖ Choice

IPV Perpetrator Dynamics

- Abuser tends to view 'partner' as an inferior adversary, not as an equal
- Abusive behavior purposefully directed to gain compliance from, or control over, another
- Abuser may seem 'healthier' than survivor
- Many perpetrators do not see their behavior as wrong in any way

SV Perpetrator Dynamics

Who is the "typical" sex offender?

SV Offender Spectrum

- Family member (biological or step-parent, uncle, sibling, cousin, other relative)
- Intimate partner (heterosexual and same-sex)
- Social acquaintance (including date)
- Clergy, therapist, scout, other "trusted" person
- Opportunist in power situation (stranger)
- Stranger-stalkers, including child predators
- Traffickers, drug dealers
- Johns and pimps
- Captors, interrogators *
- Victors, "peacekeepers" *

** Rape used as a tool of political control to inflict shame on individuals, families and communities, or to damage the cultural fabric of a people*

Survivor Dynamics

IPV Survivor Dynamics

- Fear
- Walk on eggshells
- Rules keep changing
- Erosion of independence
- World keeps getting smaller
- Attempts to improve relationship
- Feelings of failure
- Chronic and recurrent health issues

Child Sexual Abuse

- Any sexual act directed toward a child performed by an adult or an older or more powerful child
  http://littlewarriors.ca/info/what-is-child-sexual-abuse/
- Lack of consent assumed by virtue of victim's age, as defined by law, or *statute* (statutory rape)
- CSA more often coercive than assaultive
- Most child predators work to groom and gain trust prior to first assault
- Emerging research on neurobiological and social support predictors of resilience

The "Typical" Sexual Assault

- Child or adolescent groomed, then victimized by known, trusted assailant
- Teenager or young adult on a date
  - preceded by consensual kissing
  - social alcohol use, may be underage
  - lone, known assailant
  - no weapon
  - unable to give consent (alcohol or D.R. drug)
  - verbal and physical persistence / coercion despite communication of non-consent
  - physical injury "limited" to that needed to achieve restraint, penetration
- Rape by stranger is uncommon (<15%)

IPV-Associated Sexual Violence

- Women who report being sexually assaulted by intimates also experience more severe physical violence as compared with abused women who report experiencing physical or emotional abuse alone (Coker et al, AJPH 2000;90:553–559)
- Men who sexually assault their partners during a physical attack are more likely to severely injure or kill their victims than those who perpetrate only physical abuse
(Campbell et al AJPH. 2003;93(7):1089 - 1097)

IPV Dynamics Summary

- Intentional
- Power / Control
- Intimidation / Fear
- NOT an impulse disorder
- NOT a problem of loss of control
- NOT a problem with "the relationship"
- NOT the survivor's fault

SV Dynamics Summary

- Criminal acts, not acts of passion
- Objective: assertion of power, domination, violation
- Sexual act a tool of control, not loss of control
- Women make conscious / unconscious adjustments to daily lives to avoid sexual victimization
- Rape myths widely held in society – many examples
- Feelings of guilt & shame more prevalent in sexual assault survivors than in any other crime of violence
- Long term, survivors of acquaintance rape have worse outcomes than survivors of stranger rape

Child Maltreatment / DV Overlap

- 30% to 70% of abused and neglected children live in homes in which there is DV
- Children living in violent homes are reported to be physically abused and neglected at a rate 15 times higher than the national average

Children Exposed to Domestic Violence (CEDV)

- Seeing
- Hearing
- Direct involvement
- Seeing the physical aftermath
- Experiencing the emotional aftermath
- 3.3 million children/year exposed in US

What Do Children Learn from Being Exposed to DV?

- Violent role model (perpetrator)
- Depressed, incapacitated role model (victim)
- Violence is normative in family life
- Violence an expected/appropriate way to negotiate relationships
- Violence rarely has consequences

What Do Children Learn from Being Exposed to DV?

- Child feels responsible for violence
- Child feels responsibility to protect parent, siblings
- Child craves "crumbs" of affection from offender
- Child feels violence is unavoidable
- World is not safe or secure - adults cannot protect

IPV Obstacles to Leaving

- Fear
- Lack of safe options
- Feelings of failure
- Overwhelmed by acute situation
- Economic constraints (job, home, daycare)
- Perpetrator behavior – current and past
- Concern for partner's welfare
- Promises of change, ambivalence, love
- Inadequate family / community support
- Cultural and religious pressures

IPV Barriers to Disclosure

- Fear
- Perceptions of health care system
- Language, culture and religion
- Immigration status
- Sexual orientation
- Abuser threats and control

SV Barriers to Disclosure

- Inability to recall events clearly
- Priority is survival – overwhelmed
- Not sure what happened was rape
- Denial
- Worthy *vs* unworthy victim
- Don't want friends/family to know
- Not being believed
- Shame and humiliation
- Victim blaming, self-blame
- Publicity and stigma – "the girl/guy who got raped"
- Loss of confidentiality

SV Barriers to Disclosure (cont.)

- Know perpetrator (spouse, peer group)
- Care about perpetrator and others involved
- Future relationships, fear of being shunned
- Fear of retaliation
- Fear of being 'outed'
- Process of reporting is onerous, traumatic
- Unaware of options
- Revictimization by legal system, society
- Consequences disruptive
- Sentences usually lame, even if convicted
- Time factors: time from event, statute of limitations
- Repressed memories

Health Provider Challenges

- ❑ Never learned about topic
- ❑ Lack of practical experience
- ❑ Don't know what to do
- ❑ Uncomfortable with topic
- ❑ No private space to screen or act
- ❑ Not my decision whether to screen
- ❑ Time
- ❑ Reimbursement
- ❑ Personal bias or exposure

III. Health Impact

IPV – Clinical Health Impact

- Acute injury
- Chronic sequelae of injury
- Headaches
- Gastrointestinal disorders
- Pelvic pain
- Recurrent STIs
- Eating disorders
- Musculoskeletal complaints
- "Unrelated" health effects

IPV: Mental Health Impact

- Sleep disturbances
- Drug abuse (including alcoholism)
- Chronic pain / somatization disorders
- Anxiety and panic
- Depression
- "Post"-traumatic stress disorder
- Hypervigilance
- Dissociation
- Suicidal ideation or attempts

Pathology or adaptation?

SV: Health Impact

Rape Trauma Syndrome

Three predictable phases:

- acute/impact phase
- restitution/outward adjustment
- resolution/integration phase

SV: Short-Term Health Impact

- Injury (genital and non-genital)
- STIs (HIV/AIDS, Herpes, Chlamydia, Hep B, Hep C, HPV, GC, syphilis, others)
- Unintended pregnancy
- "Date rape" drug effects (alcohol, rohypnol, GHB, ketamine)
- Anxiety, sleep disturbances, flashbacks, self-injury, suicidal feelings

SV: Long-Term Health Impact

- Scarring and deformity
- HIV, STI effects
- Infertility
- Sexual dysfunction
- Risky sexual behavior
  (esp. adult survivors of CSA)
- Eating disorders, obesity
- Alcohol, tobacco and other drug abuse

Long-Term Health Impact (cont.)

- Somatization, chronic pain
- Persistent fear, anxiety
- Avoidance of medical / dental care
- Depression, PTSD
- Self-injurious behaviors
- D.I.D., other severe mental illness
- Social maladjustment, altered relationships
- Sexual identity?
- Increased risk for future victimization

SV and Self-Abusive Behaviours

- Also known as self-inflicted violence, self-mutilation, and self-injury
- Intermittent, deliberate hurting of one's own body
- May or may not escalate over time
- Examples: cutting, pinching, self-biting, trichotillomania

SV and Self-Abusive Behaviours

- Purpose: to assert control over one's own body, break through feelings of numbness ("grounding"), or make intangible pain more concrete
- Body locations often hidden
- Differs from suicidal behavior, which results from unrelenting hopelessness in which death is viewed as preferable to living on with no possibility of change

SV and Dissociation

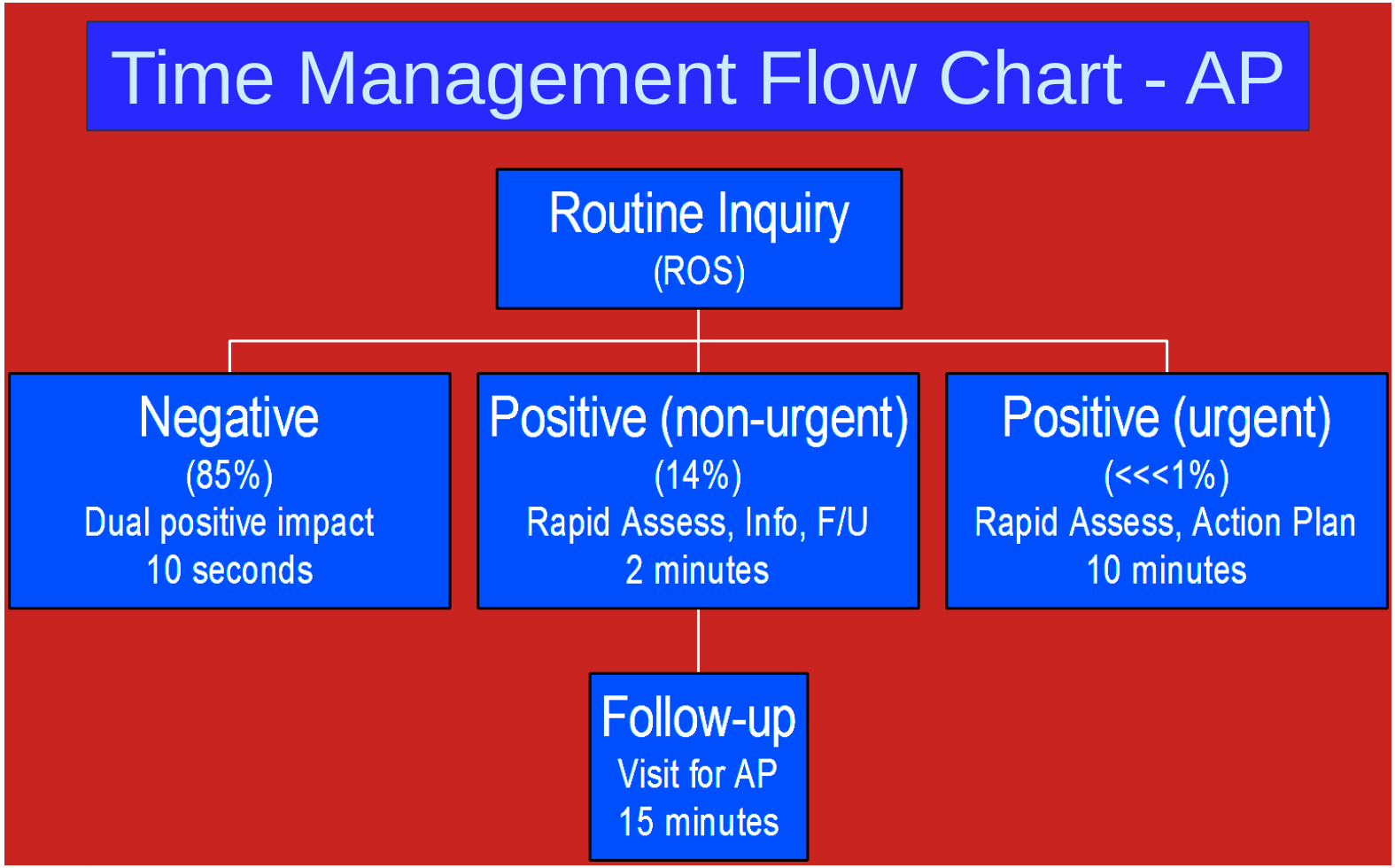
- Dissociation: alteration in thoughts, feelings, or actions. Result: some information, experiences not associated or integrated normally
- Occurs along a continuum starting with feelings such as "spacing out" or "feeling numb"
- Survivors dissociate during stressful events
- May not be able to recall event details because they were not completely present and focused and the experience was not fully appreciated and integrated

SV & Dissociative Identity Disorder

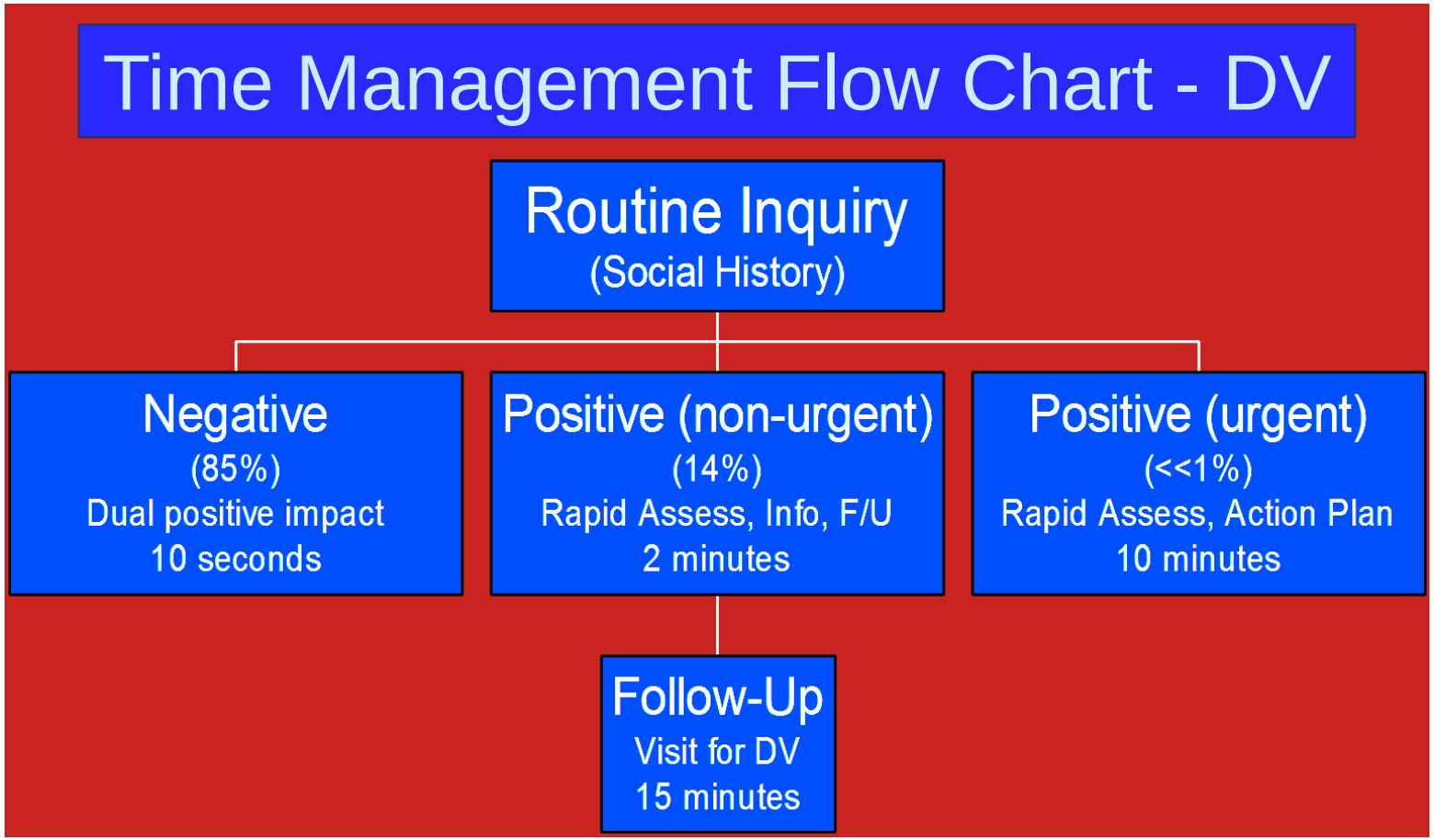
- Survivors of severe torture and abuse, esp. with onset in childhood, may dissociate to the point that they create other personalities to "cope" with abuse (D.I.D.)
- An adaptive mechanism that enables survivors to "outsource" their victimization
- Formerly called "Multiple Personality Disorder"

IV. Time Management

Time Management in Office Practice



Time Management in Office Practice



V. Identification and Assessment

(use your RADARF)

When to Suspect – IPV and SV

- ❑ Physical cues
- ❑ Social cues
- ❑ No cues

Clinical Evaluation

- ❑ Trauma-sensitive practice
- ❑ History
- ❑ Physical Examination
- ❑ Documentation
- ❑ Risk Assessment

Principles of Trauma-Sensitive Practice

- ❑ Model respect
- ❑ Establish and maintain rapport
- ❑ Share control
- ❑ Share information
- ❑ Respect boundaries
- ❑ Foster a mutual learning process
- ❑ Consider ebbs and flows
- ❑ Show compassion in response

Principles of Inquiry and Care

- Routinely seek history of current or past abuse as indicated from *all* patients
- Model trauma-sensitive practice and active, engaged listening
- Learn from patient by asking, "How has this affected your life and health?
- Validate and support patient by acknowledging her/his courage and resilience under difficult circumstances

Principles of Inquiry and Care
(cont.)

- Keep safety issues (patient, children, staff, self) in forefront
- Do not try to 'rescue' patient; rather seek to empower patient to be able to make informed decisions
- Always be honest about what you can and cannot do, esp. re: confidentiality and mandatory reporting

Trauma Informed Care: SV

(Subtext: With your permission…)

- For sexual assault evidence collection, patient is fully informed of the reason each piece of evidence is collected
- Patient understands that she/he may decline any portion of the exam
- Patient controls exam, gives affirmative consent for each step
- All procedures explained fully, respectfully and patiently

RADAR

R: Remember to ask

A: Ask directly

D: Document findings

A: Assess for safety

R: Review options, refer

***F**: Follow up*

Create a Climate for Inquiry

- Practice-based efforts
  - buttons
  - posters
  - tear-off cards
  - newsletters
- Community-based efforts
  - PSAs
  - local newspaper articles, op-eds
  - participate in community activities

Inquiring about Abuse

Frame questions by normalizing inquiry:

- ✓ Abuse, either current or in the past, can be a problem in many people's lives, and so I now ask every patient I see about domestic violence, sexual assault, and other frightening or hurtful experiences that may have happened in their lifetimes.
- ✓ Many patients I see are coping with an abusive relationship, or have had one or more difficult experiences when they were younger, so I've started asking all my patients about bad or frightening experiences they have had as a child or as an adult.

Oral Inquiry (cont.)

Direct questions:

- ✓ Has a partner, family member, caregiver or anyone else ever hit, kicked, choked or otherwise hurt, threatened or frightened you?
- ✓ Has a partner, family member, caregiver or anyone else ever touched you in a sexual way when you didn't want them to, either as an adult or when you were a child?

Oral Inquiry (cont.)

Indirect questions:

- ✓ Every couple and every family has conflicts - what happens (or has happened) when you and your partner or family disagree? Do conflicts ever turn into physical fights or make you fear for your safety?
- ✓ I see patients in my practice who are being hurt or threatened by someone they love or are close to. Could this be happening to you?
- ✓ Do you ever feel afraid of your partner, caregiver or anyone else whom you know?
- ✓ Do you feel safe at home with your partner?

Written Inquiry (cont.)

Written questions:

- ✓ Have you ever been hit, kicked, choked, raped, touched in an unwanted sexual way, threatened or made to feel afraid by a partner, family member or anyone else?
- ✓ Are you currently in a relationship in which you are being hit, kicked, choked, raped, touched in an unwanted sexual way, threatened or made to feel afraid by a partner, family member or anyone else?
- ✓ When you were a child, were you ever in a situation with a family member or other person in which you recall being physically hurt, made to do sexual things, threatened or made to feel afraid?

If Abuse is Suspected

- ❑ Ask direct and indirect questions.
- ❑ Ask additional focused questions:
  - ✓ When I see a patient with an illness / condition / injury such as yours, it is sometimes because someone hurt her (him). Has someone hurt you, either recently or in the past?

Rapid (2-Minute) Assessment

Current episode:

- ✓ What happened? How were you hurt / frightened?
- ✓ Were alcohol or drugs involved? How? By whom?
- ✓ Was a weapon involved?
- ✓ Do you live with the person who hurt you?
- ✓ Do you know where the person who hurt you is?
- ✓ Do you feel you are in danger now?

Rapid Assessment, cont.

- ✓ Have your children ever seen or heard you being threatened or hurt?
- ✓ Have the children ever been threatened or hurt?
- ✓ Have you ever tried to leave? What happened?
- ✓ Do you know how you can get help for yourself if you were hurt or afraid?

Follow-Up Visit Questions

(Subtext: Please help me understand…)

Prior episodes / abuse history:

- ✓ Have you been hurt/frightened before?
- ✓ Do you recall when things were good between you and ___ (date/spouse/partner/family member/other)?
- ✓ Tell me about when things began to be not so good, when things began to turn.
- ✓ Can you tell me about the worst or scariest time?
- ✓ Can you tell me about the most recent time?
- ✓ Have you needed medical care because of abuse?
- ✓ Have you ever needed to get away for your safety?

Follow-up Visit Questions (cont.)

Current or ongoing abuse:

- ✓ Does your partner threaten to hurt you, others close to you, or a pet or other animal?
- ✓ Does your partner belittle, insult, or blame you?
- ✓ Has your partner ever tried to restrict your freedom?
- ✓ Are you able to talk to or see your friends and family whenever you want to?
- ✓ Is your partner a jealous person?
  - -- Does he/she accuse you of having affairs?
- ✓ Has your partner made you have sex when you didn't want to?

Follow-Up Visit Questions (cont.)

- ✓ How do you cope with bad feelings that arise because of what has happened? Have you ever:
  - Cut yourself?
  - Burned yourself?
  - Pulled out your hair or ground your teeth?
  - Ate a lot, stopped eating, or vomited on purpose?
  - What else?
- ✓ Have you ever had thoughts of harming yourself, made a plan, or actually made an attempt to hurt or kill yourself?

Physical Examination: Suspicious Findings

(Subtext: With your permission…)

- ❑ Any injury
- ❑ Bilateral or multiple injuries
- ❑ Delay between injury and presentation
- ❑ Explanation inconsistent with injury
- ❑ Prior use of emergency services

Suspicious Findings (cont.)

- Chronic pain symptoms without apparent etiology
- Signs of psychological distress
- Pregnant woman with any injury
- Partner who is overly protective, controlling or refuses to leave

Drug-Facilitated SV: Historical Clues

- Drunkenness that does not correlate with amount consumed
- Gaps in memory
- Inability to supply history
- Unexplained trauma (vaginal, anal, other)
- Awoke undressed or in unfamiliar environment

SV-Facilitating Drugs

- Ethanol
- Marijuana
- GHB / GBL / Butanediol
- Flunitrazepam (Rohypnol)
- MDMA (Ecstasy)
- Ketamine
- Other sedative-hypnotics
- Cocaine
- Miscellaneous amphetamines

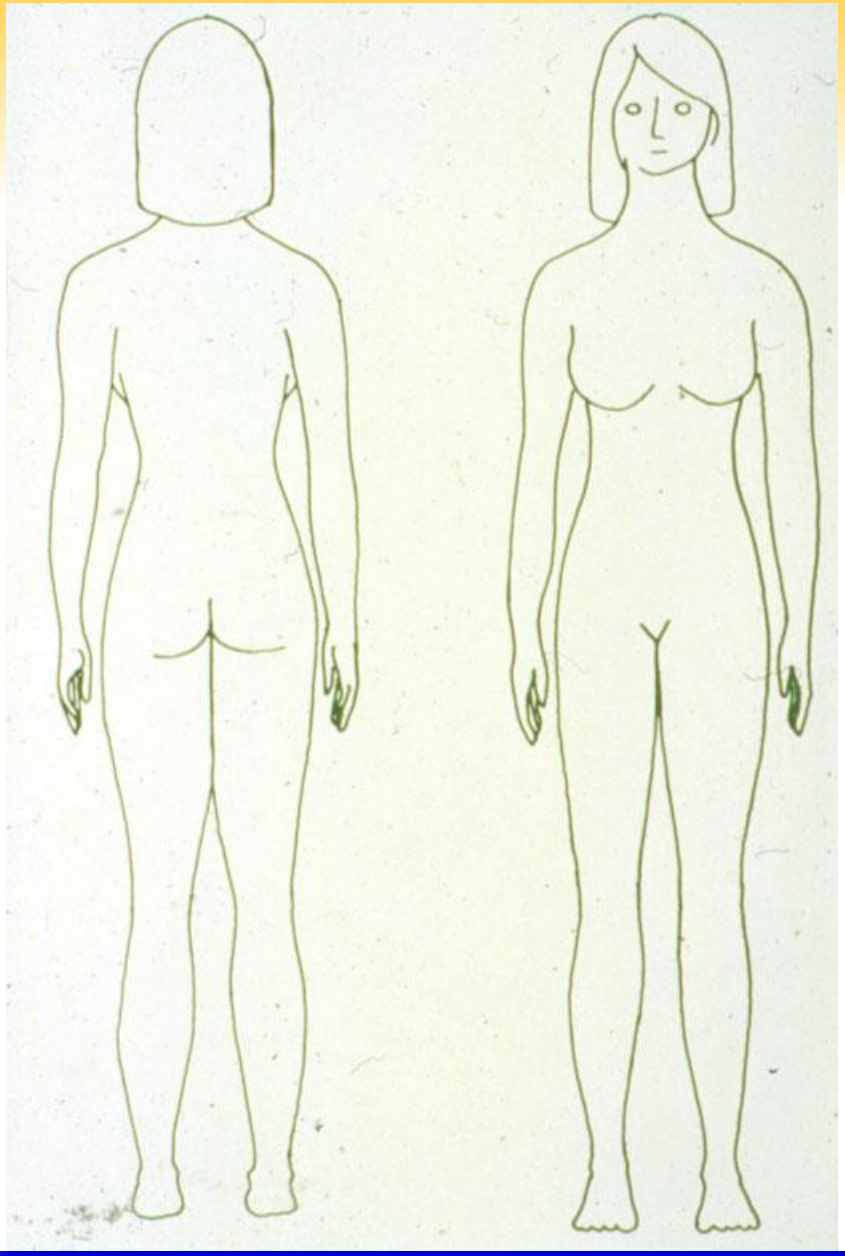
Documentation

Reasons to document:

- ❑ Medically right
- ❑ Morally right
- ❑ May keep provider out of court - criminal or custody case
- ❑ May keep provider out of court - standard of care

Documentation (cont.)

- ❑ Written descriptions
- ❑ Diagrams or sketches
- ❑ Photographs



VI. Intervention and Follow-Up

Danger Assessment

- Important determinants:
  - Patient's appraisal
  - Clinician's appraisal
- Risk factors for serious or lethal injury:
  - Increase in frequency or severity of abuse
  - Threats of homicide or suicide by partner
  - Presence or availability of a firearm
  - Abuser knowledge of survivor's plans to leave or take other action

Clinician's Role

- ❑ Communicate concern
- ❑ Provide information
- ❑ Review options, refer as necessary
- ❑ Refer for safety planning
- ❑ Medical treatment

Communicate Concern

Validate, communicate empathy

- ✓ I believe what you are telling me
- ✓ You are not crazy
- ✓ You are not alone
- ✓ You are not at fault or to blame
- ✓ You deserve better
- ✓ The must be so difficult for you
- ✓ You have tremendous courage and stamina
- ✓ Your symptoms may subside once you are safe
- ✓ Your symptoms might actually worsen, temporarily, once you are safe

Communicate Concern (cont.)

- ❑ Convey concern for safety
  - ✓ I care about your safety and well-being
  - ✓ Help is available
- ❑ Leave the door open
  - ✓ You have choices
  - ✓ As your situation changes, I (or my office, hospital) will help you by providing information and support

Provide Information

- **Offer basic information:**
  - ✓ What has happened to you is not uncommon, and it is not your fault
  - ✓ Physical violence is only one part of IPV
  - ✓ Abuse often increases in frequency and severity over time
  - ✓ Children can be affected by being
    - -- physically hurt
    - -- witnessing or hearing abuse

Offer Resource Referrals

- ❑ Safety planning
- ❑ Support groups
- ❑ Legal services
- ❑ Social welfare services
- ❑ Services for children, others exposed
- ❑ Short and long-term counseling
- ❑ Shelter services
- ❑ SANE, forensic eval. for sex assault (≤120 hrs)
- ❑ Rape crisis, medical advocacy services
- ❑ Other

Safety Plan

- First guiding principal of intervention
- Best done with / by an advocate
- Process, not a "thing"
- Individualized for each patient
  - Dynamic, evolves as situation changes
  - Current danger
  - Resources needed
  - Involve survivor, respect her/his choices and autonomy
- Assure follow-up

Safety Plan Components

- ❑ Crisis / "disaster" plan
- ❑ Place to go, way to get there
- ❑ Logistics - if survivor stays and abuser leaves
- ❑ Logistics - if both stay
- ❑ Logistics - if survivor leaves

Value of Assuring Follow-up

- Support, credibility for survivor
- Time management for self and staff
- Strengthens therapeutic relationship
- Clinician learns more about what works
- Reinforces team concept
- Gets easier and more rewarding

VII. Interprofessional Collaboration and the Comprehensive Coordinated Community Response

Cooperation, Coordination and Collaboration

- Cooperation: requires a minimum of interaction and communication.
- Coordination: requires more complex interaction and communication .
- Collaboration: requires working together with others towards a common outcome. Requires the highest levels of interaction and most complex communication.

Comprehensive Coordinated Community Response

- Task forces
- Coordinating councils
- Provincial commissions
- Partnerships and collaborations

Many ways to bring like minded people together, especially to tackle community and policy-level issues. May benefit individuals but not designed to assist individual cases on an immediate basis.

What is IP Collaboration?

- The provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver the best quality of care in every health care setting (traditional health care definition)
- *The provision of comprehensive, coordinated services to individual survivors by a team that works collaboratively to deliver the best possible services in a survivor-centered and trauma-informed manner.*

Interprofessional Collaboration

- Multiple disciplines
- Flexible and nimble
- Survivor / patient / client-centred
- Not rigidly hierarchical
- Results (outcome) focused
- Different disciplines work (co-labor) together for goals that are jointly defined, may change, *and include the survivor / patient / client*
- More efficient
- Improved outcomes

Barriers to Collaborative Practice**

- Interpersonal differences - age, gender, culture…
- Fear of change from status quo
- Language - gender, profession, social class, jargon…
- Models of Practice - medicine, nursing, social work…
- Structures - acute care, community care…
- Management Priorities – money, space, personnel
- Traditions - historical ways of doing, training…
- Historical Rivalry - me, him/her, them
- Stereotypical Views – "Social workers are…."

*** Address proactively if possible*

Make Sure you Have a Shared Understanding

Though we use the same language, it will not automatically lead all to the same conclusion.

We Won't Get Very Far if we Don't Collaborate

VIII.

On the Horizon

Next Steps – on the Horizon

- **Lifespan issues**
  - adult effects of child victimization
  - intergenerational effects
  - indirect economic and social effects
- **Focus on men**
  - as survivors
  - as allies and partners

More Next Steps

- Focus on prevention, esp. primary prevention
- Help for providers
  - expert consultation in practice
  - guidance and support for personal issues
  - continuing education
  - leadership opportunities

Leadership Opportunities

- Focus on collaboration and partnership
- Healthcare provider as change agent
  - Local or provincial coordinating councils
  - Teaching, training opportunities
  - Research and evaluation opportunities
  - Continuing education opportunities
  - Media contacts – expert voice
  - Volunteer activities
  - IPV/SA hotline
  - SANE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