SAFETY CALLING: TELEHEALTH, VIRTUAL CARE, AND INTERPERSONAL VIOLENCE SCREENING

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DISCLOSURES

- Separate to these lectures, Katherine owns and operates IPV Educators, LLC, dedicated to improving healthcare providers' comfort, education, and empowerment in the areas of interpersonal violence.

OBJECTIVES

- Discuss various types of telehealth and virtual care models
- Review interpersonal violence definitions, subtypes, and statistics and evaluate various routine screening tools for interpersonal violence
- Synthesize the challenges and solutions for screening for interpersonal violence within virtual care settings

A WORD ON LANGUAGE

- Sometimes you may hear gender binary language in my presentation, particularly female pronoun victim and male pronoun perpetrator.
- This is a nod to the fact that the great majority of IPV and assaults occur along these lines, but not meant to exclude or minimize the disproportionate and understudied assaults that occur outside of these gender binary boundaries.

INTERPERSONAL VIOLENCE DEFINITIONS

- Review interpersonal violence definitions, subtypes, and statistics and evaluate various routine screening tools for interpersonal violence

INTIMATE PARTNER VIOLENCE (IPV) DEFINITIONS

- Domestic Violence: a pattern of behaviors used by one partner to maintain power and control over another partner in an intimate relationship.
- Interpersonal Violence
- Intimate Partner Violence
- Domestic Terrorism

IPV SUB-CATEGORY DEFINITIONS

- **Physical**
  - Hits, slaps, pushes, punches, pins
  - Threatens to hit or hurt people or things
  - **Prohibits access to medicines / medical care**
- **Sexual**
  - Imposes painful/uncomfortable practices/positions
  - Forced sex
  - Forced pregnancy or abortion
  - Demanding sex in front of other people
- **Psychological**
  - Threatens, berates, ridicules, intimidates, emotionally withdraws
  - Threatens to hurt or take away children, etc.
  - Isolation from friends, family, work, church, etc.
- **Economic**
  - Limits access to work, education
  - Incurs major debt
  - Controls immigration papers or insurance access
  - Accounts only in the perpetrators name

IPV STATISTICS

- 1 in 4 women, 1 in 9 men experience severe physical intimate partner violence, intimate partner contact sexual violence, and/or intimate partner stalking.
- 1 in 3 women, 1 in 4 men experience some form of physical violence from an intimate partner.
- IPV accounts for 15% of all violent crime
- 2018: U.S. spent $3.6 trillion on IPV, $2 trillion of that was healthcare related costs.

SEXUAL ASSAULT DEFINITIONS

- **Sexual Assault**: any nonconsensual sexual act proscribed by Federal, tribal, or State law, including when the victim lacks capacity to consent.
- **Rape**: The penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.
- **Sexual Violence**:
  - World Report on Violence and Health:
    - "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances or acts to traffic, or otherwise directed against a women's sexuality, using coercion (i.e. psychological intimidation, physical threat or the threats of harm) by any person regardless of relationship to the survivor, in any setting, but not limited to home and work."
      - Coerced vaginal, anal and oral penetration by a penis or other object
      - Sexual harassment
      - Sexual abuse of children
      - Forced marriage
      - Forced prostitution and trafficking

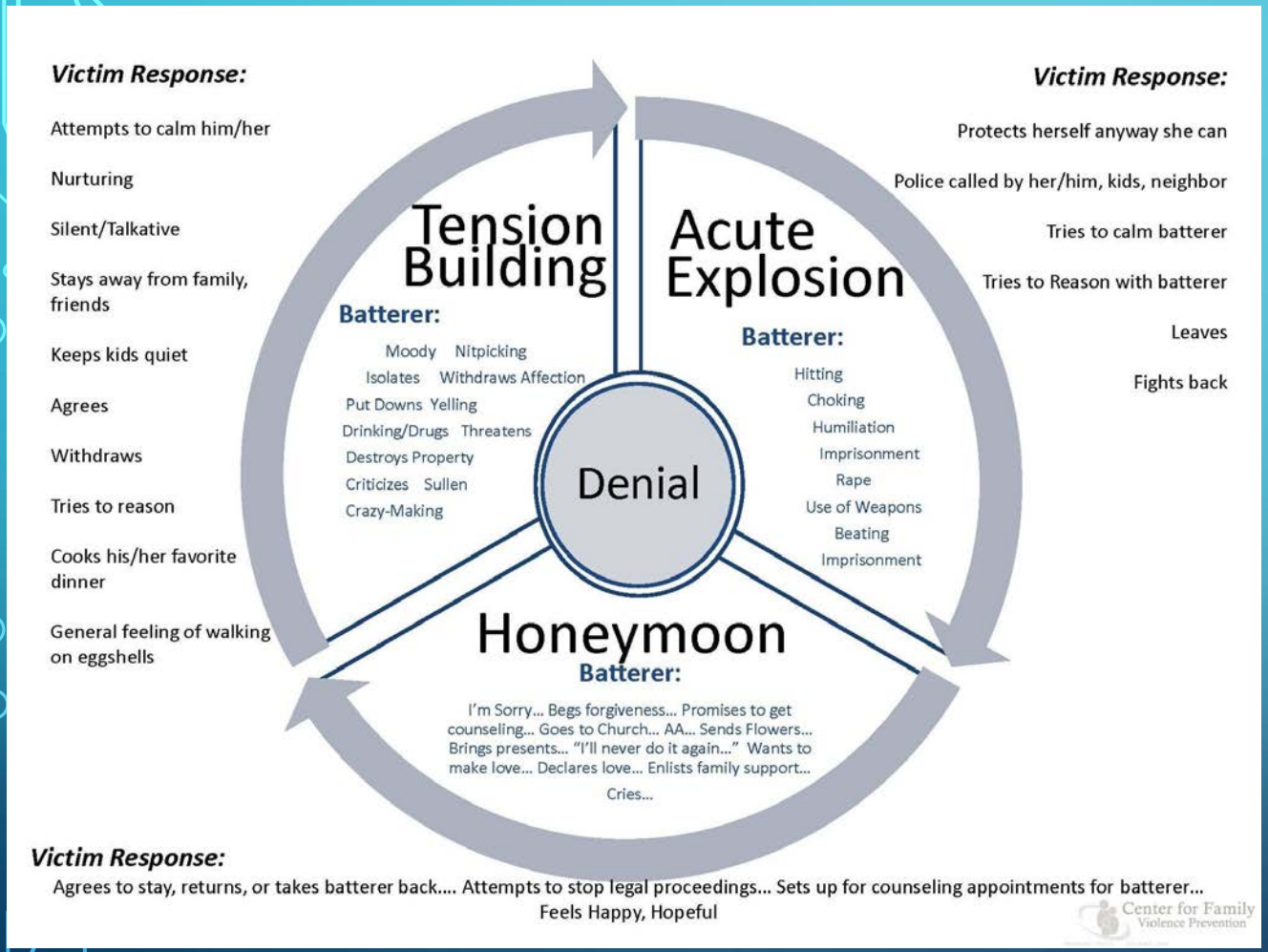
SEXUAL ASSAULT STATISTICS

- **Frequency**
  - 51% of women will experience an attempted or completed sexual assault in their lifetime.
  - 1 in 3 women (33%) will be raped.
- **Perpetrator**
  - 50-80% of perpetrators are someone the survivor knows (friends, family members, acquaintances).
  - For every 100 cases REPORTED, 7 may result in a prison sentence.
- **Under-reporting**
  - Reporting is believed to be approximately 25% of the crimes that actually occur. (In other words, 75% of sexually violent crimes go unreported.)
- **Coercion**
  - 35% of women report verbal coercion (the use of language to complete an assault)
  - 19% of women report substance coercion (the use of substances to facilitate an assault)
- **Substance Abuse**
  - More than 1/3 of survivors and more than ½ of perpetrators had been using alcohol at the time of assault.

STATISTICS DURING COVID-19

- Worldwide, rates and reporting of domestic violence rose during COVID-19
  - Some areas, United States included, saw a decrease in reporting rates, but this is believed to be attributed to the fact that victims are stuck at home with their abusers.
  - It is widely acknowledged that we are likely to see a second surge as the effects of the pandemic wind down (eventually).
- The pandemic has, in many ways, highlighted that social inequities help determine health; the effects of social isolation / shelter-at-home orders and domestic violence have not been equal during COVID-19.
- Capacity limiting measures effect shelters and other resources for IPV.
- Many factors cited in increased homicidality (loss of job, blended households, increase in drinking / drugs) are also increased during these times.

PSYCHOLOGY OF IPV



POWER AND CONTROL WHEEL / BIDERMAN

ABUSE AS A PROCESS

- Abuse is not a single incident, a single moment in time, but a process, like erosion. A sand dune doesn't appear overnight, but through the patient relocation of grains of sand for years.
- As demonstrated in one case of chronic abuse:
- The first time, it was an aberration, so sudden and strange, she assumed it was just a onetime event. He was so remorseful, he cried, bought her makeup to cover the bruises.
- The abuse slowly escalated over years in a series of isolated incidents. By then, she was so beaten down, "she felt as if there was nothing left, a husk of skin and bone with no spirit, no agency of her own, only a kind of slow, painful slog toward unconsciousness".
- "The only way that I can really describe what happened to me is like part of me, like, died, and then part of me got ignited in terms of, like, my love will heal us…but I had to stop loving myself and *only* love him."

WHY DO WE NEED ROUTINE SCREENING?

- We're pretty bad at detecting IPV on our own!
- In one wide study, 1 in 35 cases of IPV was detected by the provider caring for the patient, when it was found that 1 in 4 of those women were being abused[5]

In KNOWN cases of IPV:

  - 40% received no interaction from HCPs on the subject
  - 92% received no referrals

- We ranked lower than shelters, social services, clergy, police…and lawyers at detecting and providing feedback for victims of IPV!![5]
- *"The reality is that I can't be looking for zebras every time I hear hoofbeats. Statistically, how often will I encounter a patient who is being abused?" – nurse during IPV training*

STATISTICS ON ROUTINE SCREENING

- US Preventative Services Task Force recommendations:
  - Determined that there was moderate benefit to routinely screening for IPV in clinic environments
  - Most (approximately 92% of women) remembered being screened
  - Recommended interventions on an ongoing basis (instead of brief or limited, which they determined to have limited utility without supportive overall care).
- Women also reported valuing screening / having a positive reaction to being screened, especially when done in:
  - A private environment
  - By someone they perceived cared about the answers (i.e., took their time to allow the patient to answer).

PROS / CONS OF SCREENING

Screening Method	Pros	Cons
In Person (triage)	Rapid, high yield, non-discriminatory (all patients screened)	Patients may not feel safe, may unwittingly be done in the presence of perpetrators, not as private, can feel impersonal
In Person (bedside)	More comfort / privacy, may feel more safe, may be more likely to disclose	May be more selective (fewer patients screened), takes time, excludes patients not seen in a room / bed (i.e., RME)
Paper	Allows for privacy, not age-discriminatory	Excludes patients with low reading level, language barriers, takes time to perform, may not be translated into HER
Tablets / Electronic	Appeals to a younger generation, allows for privacy	Impediments of technology (including some of the above)

SCREENING TOOL OVERVIEW

Name	Description	Sensitivity / Specificity
HITS (Hurt, Insulted, Threatened, Screamed At)	Primary care; four questions, captures emotional and physical abuse (but not past sexual abuse).	Women: sensitivity 86; specificity 99 Men: sensitivity 88; specificity 97
OVAT	EDs; Four items, measures severe physical violence, emotional abuse, threats with weapons in the past month	Sensitivity 86 Specificity 83
PVS	EDs; Three items, measures past physical violence with any perpetrator, safety with current or former partners	Sensitivity 35-71 Specificity 80-94
AAS	Prenatal clinics; five items.	Sensitivity 93-94 Specificity 55-99
WAST	Tested in primary care and EDs; Eight items, covering physical, emotional, sexual abuse	Sensitivity 47 Specificity 96

The 4-Question Ongoing Violence Assessment Tool (OVAT)

1. Within the last month my partner has threatened me with a weapon.

   True False

2. Within the last month my partner has beaten me so badly that I had to seek medical care.

   True False

3. (Circle the best response) Within the last month my partner has had no respect for my feelings.

   Never Rarely Occasionally Frequently Very Frequently

4. Within the last month my partner has acted like he or she would like to kill me.

   True False

SCREENING TOOL OPTION #1

- OVAT (Ongoing Violence Assessment Tool)
- Pros: identifies high homicide risk cases; speaks of both emotional and physical abuse
- Cons: likely fails to identify lesser physical violence.

SCREENING TOOL OPTION #2

- Hurt, Insulted, Threatened with Harm, Screamed At
- Pros: sliding scale allows patients to partially identify abuse (this may be helpful for many victims who are in denial about the severity or presence of abuse
- Cons: may fail to capture severity of violence / risk of homicide

Hurt, Insulted, Threatened with Harm and Screamed (HITS) Domestic Violence Screening Tool

Please read each of the following activities and place a check mark in the box that best indicates the frequency with which your partner acts in the way depicted.

Date: _____

Age: _____

Sex: Male _____ Female _____

Ethnicity: Caucasian _____ Hispanic _____ African American _____ Asian _____ Indian _____

How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
1. Physically hurt you					
2. Insult or talk down to you					
3. Threaten you with harm					
4. Scream or curse at you					
	1	2	3	4	5
Total Score:					

Each item is scored from 1-5. Range between 4-20. A score greater than 10 signify that you are at risk of domestic violence abuse, and should seek counseling or help from a domestic violence resource center

SCREENING TOOL OPTION #3

- WAST (primary care)
- Pros: identifies various types and severities of violence
- Cons: uses "abuse" as a word choice frequently, which may fail to capture those who don't consider their partner's violence "abuse".

WOMAN ABUSE SCREENING TOOL[1] (WAST)

1. In general, how would you describe your relationship?
   - ☐ a lot of tension
   - ☐ some tension
   - ☐ no tension

2. Do you and your partner work out arguments with:
   - ☐ great difficulty
   - ☐ some difficulty
   - ☐ no difficulty

3. Do arguments ever result in you feeling down or bad about yourself?
   - ☐ often
   - ☐ sometimes
   - ☐ never

4. Do arguments ever result in hitting, kicking or pushing?
   - ☐ often
   - ☐ sometimes
   - ☐ never

5. Do you ever feel frightened by what your partner says or does?
   - ☐ often
   - ☐ sometimes
   - ☐ never

6. Has your partner ever abused you physically?
   - ☐ often
   - ☐ sometimes
   - ☐ never

7. Has your partner ever abused you emotionally?
   - ☐ often
   - ☐ sometimes
   - ☐ never

8. Has your partner ever abused you sexually?
   - ☐ often
   - ☐ sometimes
   - ☐ never

WHAT CONSTITUTES A GOOD SCREENING TOOL?

- A lot of screening success has to do with deployment (and less so the questions that are asked).
- Flexibility, graduated screening tools, trauma-informed care approach.

CHALLENGES?

- Triage screening: why doesn't it seem successful?
- How to make screening better
  - Ask questions in a specific way
  - Be comfortable with silence / waiting
  - Understand that you may be laying the groundwork for disclosure later (and that's part of the success)

VIDEO VISITS

- Primary care visits via secure video messaging
- Virtual urgent care visits / triage

TELE-TRIAGE

- Consulting nurse hotlines
- Appointment scheduling / triaging

ONLINE / CHAT MODELS

- Secure inbox messaging
- Chat / Chat Triage

PHONE VISITS

- Primary care phone visits
- Primary care phone follow-up

BASICS OF TRAUMA INFORMED CARE

ORGANIZATIONAL

- Engaging patients in organizational planning
- Training clinical as well as non-clinical staff
- Creating a safe environment from all perspectives
- Preventing secondary traumatic stress in staff
- Hiring a trauma-informed workforce

CLINICAL

- Involving patients in the treatment process
- Screening for trauma
- Training staff in trauma-specific treatment approaches
- Engaging referral sources and partnering organizations

Trauma informed approaches to care shift the focus from "***What's wrong with you?***" to "***What happened to you?***"

THERE'S NO UNIVERSAL DEFINITION OF TRAUMA!

- "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."
  - Experiencing or observing physical, sexual, or emotional abuse
  - Childhood neglect
  - Having a family member with a mental health or substance use disorder
  - Experiencing or witnessing violence in the community or while serving in the military
  - Poverty and systemic discrimination

PILLARS OF TRAUMA-INFORMED CARE

Patient Empowerment

Using individuals' strengths to empower them in the development of their treatment

Choice

Informing patients regarding treatment optiojns so they can choose the options they prefer

Collaboration

Maximizing collaboration among healthcare staff, patients, and their families in organizational and treatment planning

Trustworthiness

Creating clear expectations with patients about what proposed treatments entail, who will provide services, and how care will be provided.

Safety

Developing healthcare settings and activities that ensure patients' physical and emotional safety.

6 KEY COMPONENTS OF TIC

1. Safety (physical and emotional)
2. Trustworthiness and transparency (no secrets, no surprises)
3. Peer support (therapy / support groups, trained trauma survivors who can provide realistic peer support)
4. Collaboration and mutuality (between clinicians and patients, staff and clinicians, area organizations)
5. Empowerment, voice, and choice (the patient is empowered to their voice and take control of their individual needs and treatment options; there are no right or wrong answers)
6. Cultural, historical, and gender issues (the organization and the individual is educated and informed on the historical framework that patients are likely approaching care from).

PSYCHOLOGICAL FIRST AID

- Answer questions about what survivors may be experiencing.
- Normalize their distress by affirming that what they are experiencing is normal.
- Help them learn to use effective coping strategies.
- Help them be aware of possible symptoms that may require additional assistance.
- Provide a positive experience that will increase their chances of seeking help if they need it in the future.

THAT'S GREAT, BUT HOW DO I DO THIS??

- Using trauma sensitive language:
  - No labels
  - No judgement
  - No jargon

- TALK to them:
  - Thank them for telling you: "Thank you for telling me about your experience. That sounds really difficult"
  - Ask them how you can help: "I want to know what would feel most helpful for you right now. I can give you some options and help you decide, or you can tell me yourself what would be helpful."
  - Listen without judgment
  - Keep supporting (especially important for IPV).

OTHER RECOMMENDED / AVOIDED LANGUAGE

RECOMMENDED

That sounds…

That feels like…

How did that feel?

How did that make you feel?

Tell me more about…

Tell me everything about…

Can you tell me more about…

RECOMMENDED

Don't assume, ask openly
How can I support you?
What would feel good to you right now?
Would you like to hear about some of our resources?
No matter what happens, I'm here to support you however I can.

AVOIDED

That must have…
You must be / feel…
Here's what we should do next…
We need to / You need to
We must / You must
He/she must be a really terrible person
That's not a good way to treat anybody

ENSURING SAFETY

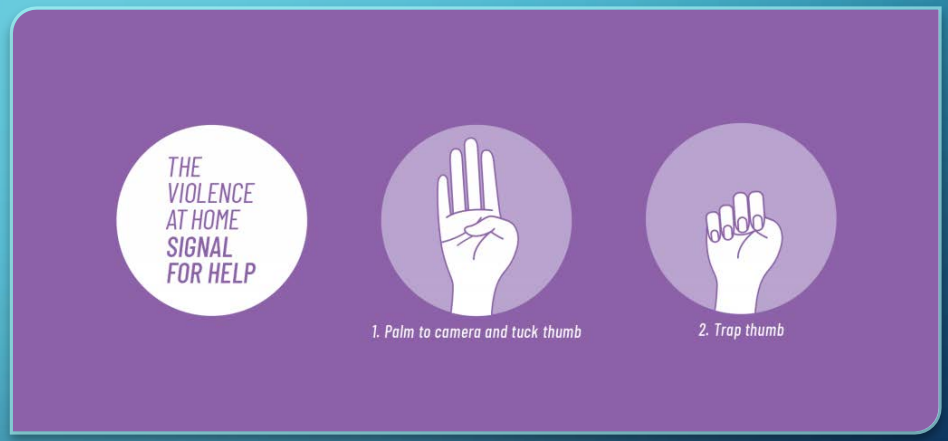
- Privacy and safety concerns during virtual care:
  - Are they alone in the room?
  - Are they within earshot of others?
  - Is the chat transcript or screening form saved to the computer or is there a virtual footprint of the patient's answers?
  - Does anybody else have access to their online chart / patient resources?

HOW DO WE SCREEN VIRTUALLY?

- We must:
  - Ensure safety
  - Employ alternative measures
  - Screen privately (i.e., using fillable forms, mail-in forms, etc.)
- Ensuring safety
  - Verbal or non-verbal cues
  - Routine safety statements
- Employ alternative measures
  - Coded responses
  - Patient isolation and screening

INNOVATIVE IDEAS

- Beth Israel Deaconess Medical Center (Boston, MA): poster with instructions in top spoken languages and QR code with no virtual footprint.
- UK: IRIS (Identification and Referral to Improve Safety) program is rolling out universal screening in care environments, sexual health clinics, and pharmacies.
- Safe Word and Signal for Help: public education campaigns to provide non-verbal or hidden queues for healthcare providers conducting virtual visits.



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THANK YOU!

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