Intimate Partner Violence

Description

Intimate partner violence (IPV) is a serious, preventable public health problem that occurs in all settings and among all socioeconomic, cultural, and religious groups worldwide.[1] The World Health Organization's most notable multi-country study confirmed that IPV is widespread and that overwhelmingly the global burden is borne by women.[1] This preferred term, IPV, describes physical violence, sexual violence, stalking, and/or psychological aggression by a current or former intimate partner.[2] As this term evolves, research indicates that dating violence, specifically teen dating violence, has a similar focus and elements of adult-specific IPV definitions. It is likely to be included in future description updates.[2] Intimate partners include current or former spouses (married, common-law, civil union, or domestic partners), boyfriends/girlfriends, dating partners, and ongoing sexual partners.[2] This type of violence occurs among heterosexual, transgender, and same-sex couples and does not require cohabitation or sexual intimacy.[2] According to the National Intimate Partner and Sexual Violence Survey (2010), bisexual women reported a higher lifetime prevalence of violence, stalking, or rape by an intimate partner (61.1%), compared to heterosexual (35%) and lesbian women (43.8%).[3] Seen across all cultures and populations, IPV may include physical or sexual violence, stalking, neglect, emotional or psychological abuse, financial abuse, or intimidation.[4,5]

Beyond death and injury, IPV is associated with lifelong consequences. Victims have elevated risk for a wide range of adverse health outcomes. Some of the most serious consequences of IPV are substance and alcohol abuse, depression, suicide, acute and chronic mental and physical health conditions, and miscarriage.[5] Furthermore, IPV also affects children who witness it; those who are exposed to violence, household dysfunction, and/or abuse are at increased risk for several of the leading causes of death in adulthood.[6] Patients experiencing IPV do not always report abuse, but they are often treated in emergency departments where emergency and forensic nurses can initially assess and provide assistance to them. Identification of patients experiencing IPV is the first step toward effective advocacy.[7]

ENA/IAFN Position

It is the position of the Emergency Nurses Association and the International Association of Forensic Nurses that:

1. Nurses routinely, consistently, and privately screen all adult and adolescent patients for IPV.

2. Nurses consider safety, confidentiality, privacy, and compassion when caring for patients experiencing IPV.

3. Nurses use available resources, such as sexual assault nurse examiners (SANE), forensic nurse examiners (FNE), and other specialized care providers, to assist in identification and intervention of patients experiencing IPV.

4. Nurses report IPV according to their jurisdictional laws and institutional policies, understanding that adult patients may have the right to decline legal intervention.

5. Nurses collaborate with other community professionals and/or healthcare disciplines to develop and implement strategies, protocols, and education for improved identification, reporting,

protection, and primary prevention when caring for individuals at risk for IPV, maltreatment, and neglect.

6. Nurses use evidence-based tools and educational resources to facilitate and authenticate the approach to screening and caring for the IPV patient.

7. Hospitals take a proactive role in implementing measures to promote public awareness of IPV in multiple languages – for example, with posters and/or information cards in public restrooms and waiting rooms – and develop procedures to ensure the safety of victims, patients, staff, and visitors when a victim requiring assistance presents to the facility.

8. Hospitals and healthcare systems globally provide ongoing culturally sensitive, trauma-informed education and in-service training to all staff to ensure awareness of IPV.

Background

Research has significantly improved our understanding of the immediate and long-term consequences associated with IPV.[4,5,8] Given the high prevalence of IPV and the underlying adverse health outcomes and costs of IPV, it is critical to address this public health problem. Members at the World Health Assembly (2016) endorsed a global plan of action to "strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children."[9] Major medical organizations, including the American College of Emergency Physicians (ACEP), The Joint Commission, and the US Preventative Services Task Force (USPSTF) advocate for point of contact healthcare providers to screen for IPV as part of preventative care.[10] While routine screening recommendations for IPV varies, every patient should be screened whenever possible due to the high prevalence of IPV in the emergency department.[10] At a minimum, the USPSTF recommends "screening women of childbearing age, and provide or refer women who screen positive to intervention services. The recommendation applies to women who do not have signs or symptoms of abuse."[8] The American Academy of Pediatrics (AAP) recognizes that children and their caregivers, when treated in a pediatric setting, should be screened for exposure to IPV. Abused caregivers are more likely to seek medical care for their children than for themselves, limiting contact with adult medical providers.[11] A recommendation from The Institute of Medicine (IOM) suggested that all women should be screened for IPV and sexual violence; their research found that healthcare providers working in emergency department settings only screened 20-25% of their encounters. This leads to missed opportunities for intervention, increased safety, and prevention of future violence.[12]

IPV prevention and intervention can substantially decrease the public health burden of IPV and improve the health and well-being of patients in the health care system.[5] Research indicates that in practice, screening rates are low; even with protocol implementation and training initiatives providers feel uncertain with screening questions, positive disclosures, and safety planning.[10] Screening rates have been found to be as low as 1.5% to 13% among emergency and primary care physicians.[13] Organizations that utilize more "comprehensive" approaches have been effective in increasing their screening rates by including effective screening protocols, thorough and ongoing training for staff, immediate access or referral to support services and overall institutional support for IPV.[13] Understanding victim rights becomes imperative for emergency staff in jurisdictions where privacy rights allow patients to decline legal intervention.[14] Increasing awareness assists emergency and forensic nurses to become more knowledgeable of IPV and more committed to assimilating the skills of identification, assessment, intervention, prevention, documentation, and reporting into nursing practice. This can be done safely and effectively without endangering patients, with continuous training in best practice guidelines, enabling emergency nurses to potentially identify those at risk and

improve patient-centered outcomes.[10] IPV is a cycle that may not be broken during a single emergency department visit; however, identifying and providing resources is a necessary step towards making a difference, increasing confidence and safety, and improving the overall health outcome for our patients.[10]

Resources

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