

Healing Centered Approaches to Screen and Intervene for Social Determinants of Health Including Intimate Partner Violence

Health Partners on IPV + Exploitation, a project of Futures Without Violence, serves the nation's network of 1,400 community health centers. We offer free training and resources on trauma-informed services, building partnerships, policy development, and the integration of processes designed to promote prevention and increase the identification and referral to supportive services for individuals at risk for, experiencing, or surviving intimate partner violence (IPV), human trafficking (HT), and exploitation. IPV, HT and exploitation are key social determinants of health and also significantly exacerbate other social determinants – contributing to homelessness, job and food insecurity, social connectedness and poor mental and behavioral health and as such, when health centers implement strategies to respond they can impact IPV/HT and its related health and social consequences. This paper describes evidence-based strategies for responding to IPV – and offers an approach for health care providers and decision makers that can also be applied to all efforts to address the social determinants of health.

Introduction

Intimate Partner Violence (IPV) affects 1 in 4 women; 1 in 9 men; and for men, women, and non-binary people of trans experience, rates increase to 1 in 3.^{1,2} While IPV occurs across racial, ethnic, gender, and socioeconomic groups, low-income populations (especially people living in overburdened, under-resourced communities) experience greater barriers to leaving violent relationships and may be more vulnerable to poor health outcomes related to IPV.³⁻⁵

Health and Intimate Partner Violence

Experiencing IPV is linked to long-term negative effects on the survivor's physical, reproductive, and behavioral health, and overall well-being. More than one in four women injured by an intimate partner require medical care for their injuries.⁶ In addition to acute injuries, women and men disclosing IPV are more likely to sustain chronic health impacts of IPV (e.g. asthma, chronic pain, irritable bowel syndrome, headaches, poor sleep, and activity limitations). Female survivors are also more likely to experience sexually transmitted infections, unintended pregnancy, pregnancy complications, and genitourinary problems.⁷ Behavioral health conditions (e.g. depression, anxiety, post-traumatic stress disorder, suicidal ideation, and alcohol and drug use) are significantly more common among survivors of IPV than the general population.⁸



Beyond physical and behavioral health conditions, survivors are more likely to have a range of social needs. For example, experiencing IPV is a significant contributor to homelessness among women, with about 50 percent of all women experiencing homelessness reporting IPV as the immediate cause.^{8,9} Survivors of IPV are also at high risk for food insecurity, unemployment, and lack of transportation.^{10,11} In addition, compared with non-survivors, survivors tend to have fewer social supports, such as friends and family members who can provide resources like childcare, financial assistance, or safe places to stay.¹¹

IPV does not only affect adults and adolescents; many children witness IPV, an occurrence that negatively affects their health and well-being. For example, about one in five children in the United States witness the assault of a parent before age 18.¹¹ Witnessing IPV is associated with adverse behavioral health outcomes in children, including symptoms of post-traumatic stress disorder and difficulty with regulating emotions.¹² In addition, strong evidence links experiencing or witnessing violence in childhood to increased likelihood of perpetrating or experiencing IPV later in life, thereby creating a negative multigenerational cycle.^{13,14}

Supportive Interventions

There are supportive and trauma-informed interventions that can be used by providers for patients experiencing IPV. By discussing IPV along with other health-related social needs—providers can improve health and safety for their patients. Health centers can use evidence based interventions to support adult and adolescent patients who may be experiencing IPV.¹⁵⁻¹⁸



Interrupting the cycle of IPV requires effective and meaningful interventions that provide tailored health care and social support services for survivors and their families that address root causes of violence such as economic and housing stability. Health center staff can refer families to two-generation services which aim to strengthen family bonds and treat individual symptoms in the child and primary caregiver, usually the child's mother in IPV cases. These services should be offered at critical periods in the life course and should also address root causes such as poverty, unemployment, housing instability, health inequities, racism, and gender perceptions and bias.¹⁹⁻²¹ Successful interventions require building strong, cross-sector partnerships between health care and social service providers to address the diverse challenges facing people affected by IPV.²²

As mentioned above, IPV is both a key social determinant of health and also significantly exacerbates other social determinants—contributing to homelessness, job and food insecurity, social connectedness and poor mental and behavioral health.²³⁻²⁵

Rethinking Screening for Social Determinants of Health (SDOH) – the Limits of Disclosure Driven Practice

Questions about IPV are not consistently integrated into assessments for social determinants of health although an optional question is included in the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences ([PRAPARE](#) tool). As these tools become more widely used, and as more questions about IPV are more integrated into such screening tools, it is critical to consider survivors’ perspectives on screening as well as the research that highlights the limitations of IPV screening. Relying only on patients’ disclosure of health-related social needs, including exposure to violence, means that many patients may not receive information and connection to resources. This may be because they were hesitant to disclose the challenges they are experiencing (such as housing instability) due to concerns about child welfare involvement or other undesired consequences. However, research and survivors’ perspectives can inform a more robust health care response than screening alone.

What Survivors of Intimate Partner Violence Want from Health Professionals

- **Autonomy** – Survivors want to be able to make their own decisions when it comes to health care.²⁶⁻³⁰ This includes choosing their own providers, disclosing in their own time, and having multiple pathways for potential interventions.^{26,29,30} Additionally, healthcare professionals should always explain procedures thoroughly and allow patients to ask questions or signal discomfort.²⁶ IPV can strip people of control—provider awareness can serve as a powerful tool to combat this.³⁰
- **Empathy & Compassion** – People who have been exposed to IPV want providers to validate their experiences.^{26,27,29} Providers should strive to be nonjudgmental and supportive, regardless of how survivors of IPV respond to interventions.^{29,30} A judgmental, intrusive or controlling provider may recall trauma for survivors.²⁶
- **Informed Providers** – Providers with knowledge about IPV make a significant difference in the experiences of patients. Survivors cite the value of having healthcare professionals who understand the depth and complexity of IPV. This includes the impact of trauma on health, the long-term nature of this violence, and its intersection with accessing a variety of other needs (employment, childcare, transportation, housing, etc.).^{26,29,30 1,4,5}



Limitations of Screening for Intimate Partner Violence Without Universal Education and Response

- **Non-Differential Outcomes for Screening Alone** – Outcomes for survivors are comparable between screened and non-screened patients in the absence of universal

education and warm referrals.³¹ Without an appropriate intervention in place, screening alone did not show any significant differences in quality of life, number of emergency room visits, or number of hospitalizations.³² Beyond this, no significant differences have been found in referral patterns to advocates or agency partners among screened and non-screened patients.³³

Importance of Confidentiality and Patients' Reasons for Non-Disclosure

- **Patients Concerns and Reasons for Non-Disclosure** – Among patients with a history of IPV, reasons for non-disclosure include fear of judgment, emotional distress, fear of not receiving adequate support from healthcare professionals, concern about mandated reporting procedures, religious beliefs, language barriers, and concern for children in the home.³⁴⁻³⁶ Patients who a history of IPV are also concerned about the privacy of their data, another reason for non-disclosure by survivors.³⁴⁻³⁷ Assured confidentiality of providers, as well as a clear explanation of how patient information will be used, is recommended.³⁷ These reasons for not disclosing about IPV during a clinical encounter are also similar to reasons for not disclosing health related social needs such as undocumented status, poverty, or unemployment due to fear of the consequences of carceral responses such as child welfare or ICE involvement.

Value of Universal Education & Empowerment

- **Universal Education and Empowerment** – The National Sexual Violence Resource Center encourages a trauma-informed framework that focuses on being sensitive to potential trauma in survivors, rather than responding solely to disclosure.³⁸ Comprehensive approaches including education, assessment, intervention, and prevention are recommended to empower and uplift survivors.^{39,40}
- **Outcomes for Patients**– In an intervention centered around reducing unintended pregnancies in women who experience IPV, utilization of a universal education model was associated with a 71% reduction in pregnancy pressure, and women being 60% more likely to end a relationship because it felt unsafe.^{15,39} Additional universal education models have demonstrated a threefold increase in disclosure amongst youth who experienced relationship abuse, as well as decreased self-reported isolation and reduced reproductive coercion in women with high baselines of RC.^{16,17} Patients exposed to these interventions have positive feedback, and report them to be more helpful than comparable resources.¹⁸
- **Outcomes for Providers**—Providers exposed to a universal education and empowerment curriculum report improved confidence in discussing IPV, as well as increased awareness about the complexity of issues faced by survivors.¹⁸ These outcomes are cited as reasons providers are less likely to screen.^{41,42}



- **Peer-to-Peer Education** – Patients who receive universal education do not only directly benefit from the information and resources; they also share the information with their peers. Studies have demonstrated that participants who received universal education were almost twice as likely to share the number for the domestic violence hotline with someone.¹⁶ Additionally, patients who receive palm-sized cards have cited the empowerment they feel when sharing concrete resources with their peers.¹⁵

Cross-Sector Partnerships & Women’s Health and Safety

- **Coordinating Care and Collaborative Learning** – Systems approaches, rooted in strong cross-sector networks, show important outcomes for survivors who have experienced IPV. Community partnerships create an easier “warm referral” process, allowing providers to facilitate the connection between survivors and resources. These warm referrals increase the likelihood of survivors utilizing interventions.⁴³ Network models and cross-sectoral curricula demonstrate an improved knowledge base for all participants. Collaborative groups successfully challenge misconceptions around IPV, build meaningful relationships, and improve culturally affirming care.^{44–46}
- **Connecting to Resources is the Goal**- Assessment tools should be built to promote understanding of the impact of IPV and other adversities on health and to connect patients to resources, rather than existing independently. Screening for SDOH, like IPV, may be perceived as judgmental, and patients/families may have fears related to disclosure. Screening should occur within a comprehensive systems approach and should prioritize increasing access to community-based resources.^{47–49} The [CUES](#) approach, while not yet evaluated specifically for addressing SDOH beyond partner and sexual violence, may be particularly relevant for patients from marginalized and underserved communities who may be facing multiple challenges including food insecurity, housing instability, and transportation barriers.

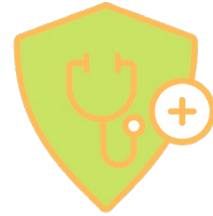


Patient and Family Focus - Many screening tools were initially created for research purposes and may not be tailored for use in clinical settings. It is crucial for health professionals to consider the patient and family context. As noted above, disclosure should not be the goal. This means avoiding risk-stratification. Recognizing that violence occurs across all racial, ethnic, gender, and socioeconomic groups, providers should screen all people, regardless of their perceived status or history.⁴⁸ Interventions where patients/families are asked for permission to be contacted by a community resource (such as a worker from a food bank) tend to have much higher uptake and successful connection to resources.



Integrating a Healing Centered Approach in SDOH Screening, Including IPV Universal Education and Trauma Informed Interventions

Because of the serious and long-term health impacts that IPV can have on survivors, it is crucial that healthcare professionals integrate strategies for supporting patients who may be experiencing abuse. Though screening questions may elicit conversations around abuse with some survivors, many do not feel safe disclosing violence to their health care provider. Like other stigmatized health conditions and life experiences, disclosure rates of IPV in health settings are very low relative to how frequently we know abuse is happening in our communities. Fear of being judged, mandatory reporting, child welfare involvement, loss of privacy, and the abusive partner finding out about disclosure are just some of the reasons that survivors may not feel safe sharing their experiences of IPV with providers.



One strategy to ensure that as many survivors as possible are getting access to support regardless of their ability to disclose abuse is to employ a **Universal Education** approach. Universal education normalizes the conversation around how relationships can impact our health and ensures that patients leave the visit with information about local IPV resources, for themselves or a friend or family member, without having to answer “yes” to screening questions. While screening for IPV is focused on *identifying* survivors, Universal Education is focused on *supporting* survivors and fostering trusting relationships between providers and patients. When this approach is used – we see an increase in connection to services and supports including increase in disclosure rates, increase in knowledge of and use of community-based resources. **Universal education on IPV and other stigmatized life and health experiences should be offered before using an SDOH screening tool such as PRAPARE.**

Elements of Universal Education

- Always meet with your patient privately for some part of the visit.
- Establish your limits of confidentiality with your patients. What would you have to report or share outside of the care team if your patients spoke with you about? Make sure patients know what those things are so they can decide what they want to share with you.
- Ensure that all patients understand that they do not have to answer “yes” to screening questions to receive information about supportive community-based services.
- Discuss why these questions are central to your patient’s health and explain why all patients are being asked.
- If a patient does disclose that they have experienced abuse from a partner (or disclose other needs asked about on the [PRAPARE](#) tool), health providers should respond with validating and supportive messages, thank the patient for sharing it with them, and ask if they would like to be connected to a local community-based resources - in this case - a domestic violence advocate or the [national DV hotline](#).

Before the Visit

- Set up a [protocol or practice](#) to see patient alone for some part of the visit to discuss IPV and PRAPARE.
- [Order safety card tools about IPV](#) to offer all patients as part of your PRAPARE practice (Health Partners on IPV + Exploitation, a project of Futures Without Violence offers these resources free of charge)
- Access [tailored resources for different settings and patient populations](#) (multi-lingual, LGBTQ, Trans, Muslim youth etc.)
- Prepare a “script” for introducing the PRAPARE tool and integrating information about IPV and available survivor support resources for people to give to their family and friends into the visit.
- Connect with community-based agencies and hotlines to understand what services they provide so that you will be able to offer information to patient

Every state and territory maintain a DV coalition, visit nedv.org/content/state-u-s-territory-coalitions/ to identify your coalition; or www.niwrc.org/tribal-coalitions to identify tribal coalitions and reach out to identify local DV program(s). Approach your local program and ask them to consider partnering to increase health enrollment for clients and staff, or to provide mobile health, or other supportive services onsite for clients. Where a local program is not available, the National Domestic Violence Hotline is available 24/7, call 1-800-799-SAFE (7233), for 24/7, free and confidential support. For Native American clients contact [Stronghearts Native Helpline](#) 1-844-7-NATIVE (762-8483). DV programs in turn can support the health center’s response to patients, as well as serving as a primary referral for staff needing personal support, as they have vast experiences working with survivors of violence and expertise in identifying ways to increase personal safety while assessing the risks.

Sample Script

“At least once a year, we like to have a conversation with all of our patients about what is going on in their lives and how it might be impacting their health. I am going to be giving you a questionnaire asking you questions that may not feel directly related to your health and maybe you have not talked with a health provider about these things in the past. The reason we have started talking with all patients about these things, such as food access and housing, is that they really impact our health and understanding your needs will help us provide the best care possible. It is your choice about what questions you want to answer and no matter how you answer these questions today, I will be providing you with a list of resources in our community that you can take with you to share with friends or family. [\(If you’ve ordered the IPV resource card:](#) I’m also offering all my patients this resource – for yourself or for you to share with friends or family members – they talk about healthy relationships and where to get help if you need it). As always, anything that we talk about does not get shared outside of your care team unless you tell me you [\(fill in based on any state](#)

Social Interventions: Responding to Social Needs Including IPV During the Patient Visit

While a growing number of tools are being developed and implemented to address SDOH and help providers refer patients to the supports and services in their local communities, many of these efforts miss the critical opportunity to support providers in creating tailored healing centered interventions during the visit. This is particularly clear when thinking about the opportunities presented in a visit to help survivors of IPV. Providers can offer brief interventions that can help with the immediate safety and well-being of the patient in addition to discussing a care plan - that takes partner interference into consideration - and then referring to a local DV program or hotline.

If a patient does disclose a need on the PRAPARE tool such as responding “yes” to the IPV question, it’s important to respond in a supportive manner and to create a care plan that reflects the patient’s experiences.

- Offer Supportive Messages
“Thank you for sharing this with me. I am sorry this happened to you. Experiences like this are very common and there are resources that can help. I want to be of help to you.”
- Assess for Immediate Safety and Health Needs
“What you are telling me makes me worried about your health and safety in other ways...”
- Discuss Harm Reduction and Health Promotion Strategies
Work with patient to discuss a care plan that takes partner interference (and/or other social needs and systemic/structural challenges) into consideration. This could include managing or anticipating interference with medication plans, recovery or reentry programs or other health promotion goals; directly limiting access to food, or preventing the patient from working, exercising, seeing friends or engaging in social activities; preventing or limiting access to transportation or health care or destabilizing the patient’s housing options.

If the patient needs help right away-

- Offer resources and make a warm referral to a local and/or national IPV prevention and response organization.
“If you are interested, I can put you in touch with the folks at [local domestic violence agency]. They know a lot about how to support people going through tough relationships.” Provide the National DV Hotline: 1-800-799-7233, and offer use of phone in a private place in clinic to call a hotline, or meet with an advocate.
- Create meaningful partnerships with your local programs and develop a memorandum of understanding to clarify roles and responsibilities for any referral. For a sample MOU and partnering worksheet, visit: ipvhealthpartners.org/partner
- Offer additional referrals to other behavioral health/social services

- Offer referrals to legal support, if patient is interested

Discuss documentation with patient and document

- Discuss with the patient what you plan to document in the medical record
- Code IPV/HT disclosure and report on UDS under line 20f: using ICD10 codes such as: (T74.11, T74.21, T74.31, Z69.11, Y07.0 etc. see link below for full list)
- Document and code that education was offered using preventive service codes: <http://ipvhealth.org/wp-content/uploads/2017/02/Preventive-Medicine-Service-Codes-and-privacy-principles>
- Document and code that social intervention including referrals were offered (USE Social intervention codes)



If patient does not need immediate help or does not want the immediate referral-

- Offer Resources: Provide the National DV Hotline, contact information for local DV advocacy, and offer educational resources
- Offer Follow-Up with Behavioral Health/Social Services

Ensure plan for follow-up—with those with emergent needs and those not needing immediate help.

Privacy Principles and CURES Act

For survivors of IPV, the importance of keeping medical records confidential is not only about privacy, it is also about safety – as a breach in privacy could put patients at risk of retaliation. It is important to have robust, informed patient consent about sharing of healthcare data, patient control over how health data is shared and with whom, and transparency over who has access to the patient’s health data and when, and urgency in having sensitive information de-identified whenever possible. It is also important to be aware of what information is shared on plan/billing documents. For more information:

<https://healthpartnersipve.org/futures-resources/privacyprinciples/>

The CURES Act does not override other health information privacy laws (Health Insurance Portability and Accountability Act - HIPAA). It is important to understand that HHS created eight categories of exceptions, which if you meet them, you are not information blocking (safe harbors). Preventing Harm is one of those exemption and keeping documentation of IPV in a private part of the record can be considered reasonably necessary practices to prevent harm to a patient or another person.

Measure Impact on Health Outcomes and/or Patient/Provider Satisfaction with Your Social Intervention

Change takes time and you can monitor your response and measure impact of your intervention with our QAQI tools: <https://ipvhealthpartners.org/wp-content/uploads/2020/10/QAQI-Tools-2020.pdf>

For more information about these approaches please see our comprehensive online toolkit that offers guidance on: enhancing patient privacy, disclosing limits of confidentiality, universal education scripts, disclosures + supportive messages, warm referrals to local DV programs, safely sharing resources, tech privacy tips etc.: <https://ipvhealthpartners.org/>

For more information about Health Partners on IPV + Exploitation: free learning opportunities and technical assistance please reach out! <https://healthpartnersipve.org/>

About Health Partners on IPV + Exploitation

Health Partners on IPV + Exploitation offers health centers training on trauma-informed services, building partnerships, policy development, and the integration of processes designed to promote prevention and increase the identification and referral to supportive services for individuals at risk for, experiencing, or surviving IPV, human trafficking and exploitation.

Email: healthpartners@futureswithoutviolence.org

Website: <https://healthpartnersipve.org/>

Toolkit: www.IPVHealthPartners.org



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