Intimate Partner Violence (IPV): A Public Health Priority for EMS Providers

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• Its contents are solely the responsibility of the presenters and do not necessarily represent the official views of the Family Violence Prevention and Services Act.
A Call to Action

“It is critical that health care providers understand how to respond to domestic violence victims, including health and safety assessments, interventions, documentation, and referrals.”

Futures Without Violence
Intimate partner violence is the “only category of crime in which the perpetrator frequently remains on the scene, expecting no negative consequences and actually perceiving intervention as a violation of their rights.”

~ EMS Response to Domestic Violence
Rationale for Healthcare Intervention

- **American College of Emergency Physicians Policy** states...”that training in the evaluation and management of victims of IPV should be incorporated into the initial and continuing education of EMS personnel. This training should include the recognition of victims and injuries, an understanding of the patterns of abuse and how this affects care, scene safety, preservation of evidence and documentation requirements.”
Why EMTs and Paramedics?

• Patient may be more candid with you than with law enforcement
• Assess and document injuries: Identification of IPV can be the first step in interrupting the progression of violence
• You may be the only witness to the home environment
• Empower the survivor with support, information, and resources
Objectives:

1. Determine the scope of the problem as it relates to EMS health care;
2. Define intimate partner violence (IPV);
3. Understand the dynamics of the IPV relationship;
4. Identify the common medical conditions associated with IPV; and
5. Discuss the guiding principles for an improved EMS response, including safety for the first responder, routine screening, intervention, documentation, and making appropriate referrals to community-based advocacy services.
Terminology & IPV Definition
A Working Definition for Intimate Partner Violence

IPV is a **PATTERN** of assaultive and coercive behaviors that may include:

– Inflicted physical injury
– Psychological/Emotional abuse
– Sexual assault
– Economic coercion
– Progressive social isolation
– Stalking
– Deprivation of medical care & medications
– Intimidation/Threats

These behaviors can be committed by an adult or adolescent with the goal to establish or maintain **POWER** and **CONTROL** by one partner over the other.
Scope of the Problem
Statistics – IPV in the U.S.

• One out of three women have experienced physical violence by an intimate partner at some point in their lives. Nearly 80% of women report verbal abuse. CDC 2010

• 84% of spouse abuse victims are female and 15% are men. Bureau of Justice Statistics 2005

• Approx. 1 in 5 women have been raped in their lifetimes & almost 50% of American women have experienced sexual assault other than rape. CDC 2010

• 1 in 6 women in the U.S. have been stalked at least once in their lifetimes. CDC 2010
Statistics - Native Americans

• Native American women suffer IPV at 50% higher rates than other ethnicities. DOJ 2004
• More than one in three (34 %) of Native American women will be raped in their lifetime.
• 86% of Native American women who report sexual violence say they were attacked by a non-Native man.

Source: National Task Force to End Domestic Violence
Statistics – IPV & Pregnancy

• 40% of pregnant women who have been exposed to abuse report that their pregnancy was unintended, compared to just 8% of non-abused women. Hathaway et al 2000

• Approximately 1 in 5 young women said they experienced pregnancy coercion & 1 in 7 experienced active interference with contraception (birth control sabotage.) National Crime Victim Survey 2005
Statistics – IPV & Fatalities

• IPV was a precipitating factor in 52.2% of female homicides. IPV was a precipitating factor in nearly one-third of suicides.

• Approximately three quarters (73.7%) of all murder-suicides involved an intimate partner.

• Homicide is a leading cause of traumatic death for pregnant and postpartum women in the U.S. Chang et al 2005

• **In 2016, NV ranked #3 in homicides connected with IPV.** Violence Policy Center, *When Men Murder Women* September 2018
Dynamics of the IPV Relationship
Demographics

Anyone can be a perpetrator or victim of IPV. They come from all groups, regardless of:

- Race/Ethnicity
- Culture
- Class
- Education
- Occupation
- Age
- Physical Ability
- Gender Identity
- Sexual Orientation (LGBTQ+)
- Personality Traits
Barriers to Leaving for Victims
“My doctor asked me why I just didn’t leave in a very irritated, demeaning way. He looked at me like I was stupid. It never occurred to him that I had left, but that my husband just tracked me down again. He doesn’t know my husband keeps threatening to kill the kids and me if I leave. I am afraid and I am scared.”
Barriers to Leaving for IPV Victims

History of having received inappropriate and victim-blaming responses from family & friends, clergy, healthcare providers, law enforcement, counselors

- “Why don’t you just leave?” “You are stupid for staying with him.” “What did you do to deserve this?”

- “You’ve made your own bed now lie in it.”

- “You need to pray about becoming a better wife.” “Your role as a wife is to serve your husband and your family.” “Never deny your husband.”
Barriers to Leaving

• **Without intervention, violent episodes tend to recur and escalate in intensity**

• Typically, victims may leave 7-8 times before they perceive they are safe enough and establish resources to make the break

• **DISABILITY**: fear of losing health insurance, fear of institutionalization, physically restrained when denied access to wheelchair, no access to doctor, caregiver, and/or medication. If the victim has a disability, it may take on the average 12 times before they feel safe enough and establish resources

  **The most dangerous time for a victim, is when they decide to leave the relationship!**
Common Medical Conditions & Injuries Associated with IPV
Common Medical Conditions

- Chronic back, chest, and abdominal pain
- Frequent, painful headaches – migraines
- Frequent indigestion, ulcers, diarrhea, or constipation, spastic colon – symptoms of irritable bowel syndrome
- Chronic pelvic pain--sexual discomfort, sexual dysfunction and pelvic infection
- Multiple injuries in different stages of healing
Common Medical Conditions

• Exacerbation of diabetes symptoms
• Anxiety, depression, hypertension
• Psychosomatic illnesses
• Sexually transmitted infections, HIV
• Depressed immune function
• High blood cholesterol, heart attack, heart disease and stroke
Common Injury Presentations

- Recurring or unexplained injuries; bruises
- Multiple injuries in different stages of healing
- Injuries in areas covered by clothing
- Injuries suggestive of defensive posture, such as forearm bruising
- Injuries to head (spongy scalp), neck, breasts, or abdomen
- Pattern injuries from burns or blunt trauma from fists, linear objects such as bats, belts, etc.
- Orofacial/Dental trauma
- Injury during pregnancy
At 18 weeks the baby started kicking.
At 22 weeks so did the father.
Abuse During Pregnancy Results in Complications:

- High blood pressure
- Vaginal bleeding; 1st & 2nd trimester bleeding
- Severe nausea
- Kidney & urinary track infections
- Low weight gain
- Anemia
- Maternal rates of depression
- Suicide attempts
- Tobacco, alcohol, & illicit drug use
- Miscarriage
- Pre-term delivery
Strangulation & Traumatic Brain Injury
Strangulation & TBI

- 40-92% of victims suffer physical injuries to the head; nearly half report they have experienced strangulation. Campbell, et al The Effects of IPV and Probable TBI on Central Nervous System Symptoms, 2018

- In a sample of 53 victims, 92% reported having received blows to the head in the course of their violence; 40% reported loss of consciousness. Jackson, et al TBI: A Hidden Consequence for Battered Women, 2002
Strangulation

• Manual strangulation – most common method used
• Ligature strangulation
• Hanging
More than 2/3 of IPV victims are strangled at least once! The average is 5.3 times per victim.
Petechiae located inside the eyelid.
## Documentation Chart for Attempted Strangulation

<table>
<thead>
<tr>
<th>Breathing Changes</th>
<th>Voice Changes</th>
<th>Swallowing Changes</th>
<th>Behavioral Changes</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty breathing</td>
<td>Raspy voice</td>
<td>Trouble swallowing</td>
<td>Agitation</td>
<td>Dizzy</td>
</tr>
<tr>
<td>Hyperventilation</td>
<td>Hoarse voice</td>
<td>Painful to swallow</td>
<td>Amnesia</td>
<td>Headaches</td>
</tr>
<tr>
<td>Unable to breath</td>
<td>Coughing</td>
<td>Neck pain</td>
<td>PTSD</td>
<td>Fainted</td>
</tr>
<tr>
<td>Other</td>
<td>Unable to speak</td>
<td>Nausea</td>
<td>Hallucinations</td>
<td>Urination</td>
</tr>
</tbody>
</table>

(San Diego City Attorney’s Office with Drs. George McClane and Dean Hawley)
I was strangled in Santa Monica, CA on July 24, 2007, to the point that I had blacked out. When the Santa Monica paramedics arrived on-scene, they said that my vital signs were stable. Neither the Santa Monica police nor the paramedics suggested that I go to the hospital. I did not go to the hospital. The perpetrator, the man I had been in a relationship with, was arrested for attempted murder within the hour. And then he was released sometime within the next 48 hours. I was never notified. No explanation to me. He nearly murdered me that night.

Anonymous; August 2, 2010
"Power and Control Wheel"
Sexual

- Makes demeaning remarks about intimate body parts
- Looks or touches the partner sexually in ways that make them feel uncomfortable
- Bruises around breasts or genital area, vaginal/anal bleeding, torn or bloody underwear
- Takes advantage of physical or mental illness to engage in sex
- Sexual contact that is forced (rape/sodomy)
- Coerced nudity; exhibitionism (masturbation/indecent exposure)
- Forces partner to watch pornography on television and/or the computer – taking photos of sexual acts that are explicit & exploitative
- Not using protection from STIs
- Using spiritual practices such as doctoring & sweat lodges to take advantage of closed surroundings to commit sexual acts. Uses their status as spiritual advisors or traditional healer to engage in sex to “heal” the woman or they will use “bad” medicine against them
The IPV Relationship and the Role of EMS
They didn’t say it was an IPV call...

- Many of these calls are not identified as IPV
- Evaluate EVERY call, EVERY patient, and where there is a need for law enforcement involvement
  - Scene Safety Assessment
  - Patient Safety Assessment
- Police officers state that IPV calls are one of the most dangerous
- EMS should treat these calls the same way...dangerous and volatile
- Do not hesitate to return to the ambulance to discuss options and/or notify the police to secure the scene
Responding to IPV Calls

• **Know yourself well** when it comes to responding to these calls: What are my limitations, my strengths, my own history? Will I be triggered by observing, screening, and caring for this patient? Access care for vicarious trauma.

• Upon approach, and entry look for:
  – Obvious dangers in approaching the residence
  – Condition of yard/outside the building for position of lawn furniture/tools/chemicals
  – Presence and condition of children and pets
  – Number of adults at the scene, where are they located?
  – Weapons on the scene
  – Evidence of substance abuse
Responding to IPV Calls

- Previous calls to this address
- History of suspicious calls
- Stay alert. Wait & listen as you approach: Do you hear yelling or sounds of a struggle?
- Upon arrival, make sure you identify yourself as EMS providers
- Were you met at the door or denied entry by someone who says the victim is fine & does not need medical care? Other attempts to conceal information?
- Keep your partner/crew members in sight at all times and never split the team
- Consider using cell phone vs. radio that could be monitored
Scene and Patient Safety

- Identify all possible exits for escape; let occupants lead the way & maintain a safe distance
- Potential problem areas:
  - Kitchen: variety of potential weapons (knives, glass, pots & pans)
  - Bedrooms: may contain concealed weapons and fewer escape routes
  - Bathrooms: no escape route
- Do NOT ask questions regarding possible violence and no display of sympathy should be made until after the victim is in the ambulance and away from the abuser
- No safety in numbers, no scene is ever “secure” and removal of the victim is the surest ways to provide safety for all
EMS Response

Recognizing IPV & Speaking with the Patient
Recognizing IPV

• Key component → patient interview & their medical care
• What if you can’t get the victim alone to assess injuries? Suspected abuser (partner or caregiver) is “hovering” over the victim or answering on behalf of the victim
  – Ask them to retrieve something like a towel or blanket
  – Ask them to step into another room due to HIPAA law. Medical information cannot be heard by anyone else and you cannot treat the patient because of their proximity
  – Be aware that the abuser may be eavesdropping even if they are in another room
  – Abuser may refuse transport & attempt to control the patient’s interaction with EMS
  – Family members should NOT be used to interpret!
Speaking with the IPV Patient

• While you assessment is routine, it can be traumatic, degrading and may become a life changing event for the victim

• Set the tone for your evaluation:
  – The victim will assess your body language, demeanor and verbal language for your reaction and understanding
  – Ask questions in a non-judgmental, non-threatening way
  – Trauma can affect the way a patient recalls and responds to medical questions
Routinely Screen & Ask...

• “Domestic violence is so common I ask all of our patients about abuse in the home.”
• “We often see people with injuries such as yours, which are caused by someone they know. Could this be happening to you?”
• “You seem frightened and anxious. Has someone hit you or tried to injure you in any way?”
• “Do you ever feel unsafe at home?” “I am concerned for your safety.”
• Is there a partner from a previous relationship who is making you feel unsafe?”
If the patient says “yes”

Validate and Educate:

- “You are not alone.”
- “You don’t deserve to be treated like this.”
- “You are not to blame.”
- “Help is available to you.”
- Inform patients that they may be a victim of crime (like assault, battery, rape, stalking, threats, property, destruction, false imprisonment, fraud, etc.)
- Inform patient of option to call police, Elder Protective Services, Advocacy Programs--and respect the patient’s assessment of whether this is appropriate or safe
Important Tips

- Remember to assess patients in confidential settings
- DO NOT make a promise you cannot keep. “The police department will protect you…”
- Assess lethality and escalating danger
- DO NOT tell them to leave & everything will be fine. Victims are at much higher risk of being killed (75%) after they leave. Leaving has to be very carefully planned.
Additional Considerations

• **If the patient answers “no”**
  – Be aware of physical and behavioral clues
  – Provide first aid
  – Document any inconsistencies
  – Make referrals discreetly

• **Transport vs. Non-Transport**
  – If patient accepts, consider advising hospital security
  – Explain medical consequences to the patient for not receiving medical care
Additional Considerations

• Crime Scene
  – Minimize your effect on potential evidence including all personnel use same entrance
  – Advise police of injuries discovered during patient assessment
  – Provide police with your contact information
  – Discuss with police ahead of time regarding appropriate protocols for evidence collection
NEXT STEPS: Scenarios for EMS Providers

HANDOUT: Minimal Elements of Domestic Violence Protocol
Road to Success
Defining Success

• Don’t judge the success of your intervention by the patient’s action or lack of action to stay or leave – it is their decision

• Did the patient...
  – Have a safe, confidential environment for assessment and possible disclosure?
  – Receive educational material about IPV? FWV Safety Cards, brochures
  – Receive information about community-based domestic and sexual violence advocacy resources?
Making Appropriate Referrals to Community-based Domestic and Sexual Violence Programs
Domestic & Sexual Violence Programs

- All services are free and confidential
- All services are focused on safety
- Requests for services must come from the victim
- All services are premised on support, empowerment, & options
National Resources for Survivors & Professionals

http://
Helping Survivors

Hotlines/Helplines:

• National Domestic Violence Hotline
  1.800.799.7233 www.thehotline.org

• National Sexual Assault Hotline
  1.800.656.4873 www.rainn.org

• National Dating Abuse Helpline
  1.866.331.9474 Call, chat, & text services

• GLBT National Help Center 1.800.246.7743
National Health Resource Center

A Project of Futures Without Violence
www.futureswithoutviolence.org/health

1.888.Rx.ABUSE (888.792.2873) toll-free;
TTY: 800.595.4889
Monday-Friday 9:00AM-5:00PM PDT
National Health Resource Center

• Provides specialized materials & technical assistance
  – Consensus Guidelines on Routine Assessment for DV
  – Pediatric Guidelines on Routine Assessment for DV
  – National Health Care Standards Campaign on Family Violence: Model Practices from 15 States
  – Multilingual Public Educational Materials
  – Training Videos
  – Multi-disciplinary Policies and Procedures
  – Online e-Journal: *Family Violence Prevention and Health Practice*

• Order educational tools: patient safety cards, posters, provider buttons, training videos, and more...
Presentation Acknowledgements

• *Improving EMS Response to Domestic Violence*, adapted from the New Hampshire Bureau of EMS, the National Health Initiative on Domestic Violence, and Futures Without Violence, 2005

• *Domestic Violence Awareness for EMS & Paramedic Providers, Identifying and Responding to Domestic Violence Victimization*, prepared by Kimberly Phillips, Deputy City Attorney-Criminal Division, et al, City of North Las Vegas, 2011

• *EMS Response to Domestic Violence: A Curriculum and Resource Manual*, Community Health & EMS, Division of Public Health, Department of Health and Social Services, Juneau Alaska
Reviewing the Presentation
Objectives
Reviewing the Objectives

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Questions?

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