

Joint Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 ▪ 800.900.9659 ▪ www.ena.org

Intimate Partner Violence

Description

Intimate partner violence (IPV) is a serious, preventable public health problem that occurs in all settings and among all age, 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 It is also important to recognize that the aging population does experience IPV, and it can be difficult to draw a clear distinction between elder abuse and IPV; the dynamics may present differently from younger populations.¹⁵ 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 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 offer interventions. Identification of patients experiencing IPV is the first step toward effective advocacy.⁷

ENA and IAFN Position

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

1. Emergency nurses and forensic nurses routinely, consistently, and privately screen all adult and adolescent patients for IPV.
2. Emergency nurses and forensic nurses consider safety, confidentiality, privacy, and compassion when caring for patients experiencing IPV.
3. Emergency nurses and forensic nurses use available resources, such as sexual assault nurse examiners (SANE), forensic nurse examiners (FNE), and other specialized care providers, to assist in identification of and/or intervention with patients experiencing IPV.

Joint Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 ▪ 800.900.9659 ▪ www.ena.org

4. Emergency nurses and forensic nurses disclose to patients the limits of confidentiality and report IPV according to their jurisdictional laws and institutional policies, understanding that adult patients may have the right to decline legal intervention.
5. Emergency nurses and forensic nurses collaborate with other community professionals and/or healthcare disciplines to develop and implement strategies, protocols, and education for improved identification, reporting, protection, and prevention when caring for individuals at risk for IPV, maltreatment, and neglect.
6. Emergency nurses and forensic 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 worldwide. 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 recommendations for routine screening of IPV vary, every patient, regardless of age, gender or sexual orientation, should be screened whenever possible due to the high prevalence of IPV in the emergency department.¹⁰ At a minimum, the USPSTF recommends “... screen 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 Academy of Medicine, formerly 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 about or

Joint Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 ▪ 800.900.9659 ▪ www.ena.org

uncomfortable 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 In addition to screening tools, utilization of risk assessment tools is helpful in safety and discharge planning for this patient population. According to the CDC, among IPV-related homicides, 79.2% and 14.3% were perpetrated by a current or former intimate partner, and approximately one in 10 victims experienced some form of violence in the month preceding their death.¹⁷ The presence of a firearm in an IPV situation increases the risk of homicide 500%¹⁸, and victims of strangulation, compared to those where strangulation was not used as means to control, have a 750% increased risk of homicide.¹⁶ Educating victims to better understand their potential for danger, in addition to the acute and long-term health consequences of IPV, completes an inclusive patient plan of care. 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 with becoming more knowledgeable about 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 by 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 patients.¹⁰

Resources

American Nurses Association; International Association of Forensic Nurses. (2009). *Forensic nursing: Scope and standards of practice*. Silver Spring, MD: Nursebooks.org

Center for Health Care Strategies, Inc. (n.d.). Resource list for trauma-informed care. Retrieved from <http://www.hmprg.org/assets/root/ACEs/Toolkit/TIC-Resource-List-September-2015.pdf>

Emergency Nurses Association. (2018). *ENA clinical practice guideline: Intimate Partner Violence*. Retrieved from <https://www.ena.org/practice-resources/resource-library/clinical-practice-guidelines/1>

Emergency Nurses Association. (2016). *ENA topic brief: An overview of strangulation injuries and nursing implications*. Retrieved from <https://www.evawintl.org/Library/DocumentLibraryHandler.ashx?id=898>

FORGE. (n.d.) *Safety planning for transgender and gender non-conforming IPV patients who are experiencing intimate partner violence*. Retrieved from <http://forge-forward.org/wp-content/docs/safety-planning-tool.pdf>

International Forensic Nurse Association. (2017). *Non-fatal strangulation documentation toolkit*. Retrieved from <http://www.forensicnurses.org/page/STOverview>

International Association of Forensic Nurses. (2012). *Forensic nurse intimate partner violence education guidelines*. Elkton, MD: Author.

Joint Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 ▪ 800.900.9659 ▪ www.ena.org

National Health Resource Center on Domestic Violence. (2018). Health Professionals' web page. Retrieved from <http://ipvhealth.org/health-professionals/>

National Coalition Against Domestic Violence: 1-303-839-1852. Retrieved from <http://www.ncadv.org>

The National Domestic Violence Hotline: 1-800-799-SAFE (7233). Retrieved from <http://www.thehotline.org/>

National Sexual Assault Hotline: 1-800-656-HOPE (4673). Retrieved from <http://www.rainn.org>

U.S. Department of Health and Human Services. (2018). *State domestic violence coalitions*. Retrieved from <https://www.acf.hhs.gov/fysb/programs/family-violence-prevention-services/programs/state-dv>

U.S. Department of Health and Human Services. (2018). *Health information privacy*. Retrieved from www.hhs.gov/hipaa/for-professionals

U.S. Department of Justice Office of Violence Against Women. (2013). *A national protocol for sexual assault medical forensic examinations: Adults/adolescents*. Retrieved from <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>

World Health Organization (2018). Intimate partner and sexual violence. Retrieved from http://www.who.int/violence_injury_prevention/violence/sexual/en/

World Health Organization. (n.d.). *Health care for women subjected to intimate partner violence: A clinical handbook*. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/136101/WHO_RHR_14.26_eng.pdf?sequence=1

References

1. World Health Organization. (2010). Preventing intimate partner and sexual violence against women: Taking action and generating evidence. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/44350/9789241564007_eng.pdf?sequence=1
2. Breiding, M. J., Basile, K. C., Smith, S. G., Black, M. C., & Mahendra, R. R. (2015). Intimate partner violence surveillance: Uniform definitions and recommended data elements, version 2.0. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from <https://www.cdc.gov/violenceprevention/pdf/intimatepartnerviolence.pdf>
3. Knox, B. (2018). Screening for intimate partner violence in women: Creating proper practice habits. *The Nurse Practitioner*, 43(5), 14–19. Retrieved from <https://nursing.ceconnection.com/ovidfiles/00006205-201805000-00003.pdf>
4. Centers for Disease Control and Prevention. (2018). Intimate partner violence. Retrieved from <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html>
5. Black, M. C. (2011). Intimate partner violence and adverse health consequences: Implications for clinicians. *American Journal of Lifestyle Medicine*, 5(5), 428–439. <https://doi.org/10.1177/1559827611410265>
6. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, 14(4), 245–258. [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8)

Joint Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 ▪ 800.900.9659 ▪ www.ena.org

7. Family Violence Prevention Fund. (2004). Part II: Guidelines for responding to intimate partner violence victimization in health settings. In *National consensus guidelines on identifying and responding to domestic violence victimization in health care settings* (pp. 11–20). San Francisco, CA: Author. Retrieved from <https://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf>
8. Agency for Healthcare Research and Quality, US Preventative Task Force. (2013). Intimate partner violence and abuse of elderly and vulnerable adults: Screening. Retrieved from <http://www.uspreventiveservicestaskforce.org/uspstf/uspstf.htm>
9. World Health Organization. (2017). Violence against women. Retrieved from <http://www.who.int/news-room/fact-sheets/detail/violence-against-women>
10. Choo, E., & Houry, D. (2015). Managing intimate partner violence in the emergency department. *Annals of Emergency Medicine*, 65(4), 447–451. <https://doi.org/10.1016/j.annemergmed.2014.11.004>
11. Bressler, C., Brink, F., & Crichton, K. (2016). Screening for intimate partner violence in the pediatric emergency department. *Clinical Pediatric Emergency Medicine*, 17(4), 249–254. <https://doi.org/10.1016/j.cped.2016.10.002>
12. Sutherland, M., & Hutchinson, K. (2018). Intimate partner and sexual violence screening practices of college health care providers. *Applied Nursing Research*, 39, 217–219. <https://doi.org/10.1016/j.apnr.2017.11.031>
13. Williams, J., Halstead, V., Salani, D., & Koermer, V. (2015). Intimate partner violence screening and response: Policies and procedures across the health care facilities. *Women's Health Issues Journal*, 26(4), 377–383. <https://doi.org/10.1016/j.whi.2016.03.006>
14. Department of Health and Human Services, Office for Civil Rights. (2004). When does the privacy rule allow covered entities to disclose protected health information to law enforcement officials? Retrieved from <https://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html>
15. McGarry, J., Ali, P., & Hinchliff, S. (2016). Older women, intimate partner violence and mental health: A consideration of the particular issues for health and healthcare practice. *Journal of Clinical Nursing*, 26(15–16), 2177–2191. <https://doi.org/10.1111/jocn.13490>
16. Mack, M. (2013). States with strangulation legislation. A product of the Training Institute on Strangulation Prevention. Retrieved from <https://www.strangulationtraininginstitute.com/>
17. Petrosky, E., Blair, J., Betz, C., Fowler, K., Jack, S., & Lyons, B. (2017). Racial and ethnic differences of homicides of adult women and the role of intimate partner violence – United States, 2003–2014. *Morbidity and Mortality Weekly Report*, 66(28), 741–746. <https://doi.org/10.15585/mmwr.mm6628a1>
18. Campbell, J., Webster, D. & Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., . . . Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health*, 93(7), 1089–1097. <https://doi.org/10.2105/AJPH.93.7.1089>

Authors

Authored by

Katie Bush, MSN, APRN, FNP-C, CEN, SANE-A
Kim Nash, BSN, RN, SANE-A, SANE-P

Contributors

2018 ENA Position Statement Committee
G. J. Breuer, RN, CEN, CCRN, FAEN
Judith Carol Gentry, MHA, BSN, RN, CEN, CPEN, CFRN, CTRN, CNML, NE-BC, RN-BC
Kimberly Johnson, PhD, RN
Sherry Leviner, PhD, RN, CEN, FNP-C

Joint Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 ▪ 800.900.9659 ▪ www.ena.org

Cheryl Riwitis, MSN, RN, FNP, EMT-B, CEN, CFRN, FNP-BC, TCRN, FAEN
Jennifer Schieferle Uhlenbrock, DNP, MBA, RN, TCRN
Sally K. Snow, BSN, RN, CPEN, FAEN
Elizabeth Stone, MSN, RN, CPEN
Justin Winger, PhD, MA, BSN, RN, Chairperson
Mary Ellen Zaleski, DNP, RN, CEN, RN-BC, FAEN

2018 ENA Board of Directors Liaison
Ellen Encapera, RN, CEN

2018 ENA Staff Liaison
Monica Escalante Kolbuk, MSN, RN, CEN

Developed: 2014.

Approved by the ENA Board of Directors: February 2015.
Approved by the IAFN Board of Directors: December 2018.
Approved by the ENA Board of Directors: December 2018.

©Emergency Nurses Association, 2018.

This position statement, including the information and recommendations set forth herein, reflects ENA and IAFN's current position with respect to the subject matter discussed herein based on current knowledge at the time of publication. This position statement is only current as of its publication date and is subject to change without notice as new information and advances emerge. The positions, information and recommendations discussed herein are not codified into law or regulations. In addition, variations in practice, which take into account the needs of the individual patient and the resources and limitations unique to the institution, may warrant approaches, treatments and/or procedures that differ from the recommendations outlined in this position statement. Therefore, this position statement should not be construed as dictating an exclusive course of management, treatment or care, nor does adherence to this position statement guarantee a particular outcome. ENA and IAFN's position statements are never intended to replace a practitioner's best nursing judgment based on the clinical circumstances of a particular patient or patient population. Position statements are published by ENA and IAFN for educational and informational purposes only, and ENA and IAFN do not "approve" or "endorse" any specific sources of information referenced herein. ENA and IAFN assume no liability for any injury and/or damage to persons or property arising out of or related to the use of or reliance on any position statement.