Guidance for Recognizing and Responding Safely to Intimate Partner Violence

VEGA
FAMILY VIOLENCE
EDUCATION RESOURCES

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The guidance in this document summarizes the evidence about interventions for identifying and responding to intimate partner violence (IPV). Use of these strategies will be influenced by variations in provincial/territorial and local context, culture, and resources/service availability. For more information about the processes used to create this guidance, see here.

1. Ask questions about IPV when potential indicators are present.

Healthcare and social service providers should ask about IPV when potential indicators are present, including: 1) signs and symptoms related to IPV exposure (injuries, mental health issues such as depressive or post-traumatic stress symptoms, chronic pain); 2) behavioural indicators or cues (e.g., repeatedly cancelling visits, increased use of health services, deferring to partner in visit) and/or indicators suggestive of an abusive partner (partner is always present, answers for partner, exhibits other controlling behaviour, etc.); and 3) specific risk indicators based on epidemiological data (e.g., alcohol/drug misuse, recent separation, financial strain/recent job loss, expressing traditional gender norms). Particularly in the context of perinatal care, mental health and addictions care, healthcare and social service providers should consider asking about IPV at assessment and subsequently as needed. Universal screening for IPV victimization is not recommended based on current evidence.

2. Offer immediate support to those who disclose IPV, including sexual violence in the context of an intimate relationship.

If healthcare and social service providers suspect or confirm that someone is experiencing IPV or its consequences, immediate support should be provided. This can be within their typical work setting or another that is accessible. Immediate support characterized by the following should be offered: active listening, respectful, compassionate and nonjudgmental interactions, assessment of immediate safety and discussion of potential referral options.

3. Caution is warranted when considering discussions with potential IPV perpetrators.

Healthcare and social service providers may encounter cases where IPV perpetration is suspected, confirmed or disclosed. Based on existing best practice evidence, when safe to do so, a provider may ask the abusive (ex-)partner about their use of violence, being careful not to indicate inquiry was prompted by anything the abused partner said.[1] If disclosure occurs, providers should acknowledge it while reinforcing the unacceptability of violence, and offer ongoing support (details regarding referrals for perpetrators are described below). Providers should assess the abusive (ex-) partner's suicide risk and the family's safety. At any point, if providers feel conflicted or compromised, they should refer the (ex-)partner to another provider.

4. Women's shelters provide safety for women at immediate risk, and their children.

Women's shelters are residential facilities for women exposed to IPV, and their children. Shelters generally provide: 1) safe refuge in a time of crisis; 2) material support (e.g., food and clothing, as needed); 3) informational and system navigation support/ advocacy; and 4) education and counselling. They may also provide transitional or "second-stage" housing. Many of these services are often available on an outreach basis for women not residing in the shelter.

5. Offer referrals to advocacy services to women who disclose IPV, especially those experiencing IPV during the perinatal period.

Advocacy is an intervention that seeks to help current or past IPV victims (and their children) by providing them with IPV-specific advice (on safety planning and legal, housing or financial matters) and/or support to facilitate access to community resources (e.g., shelters, emergency housing, IPV outreach services, psychological interventions, social or other appropriate services). Structured, brief advocacy interventions have been shown to be effective for women experiencing IPV, whether or not they are in a shelter at the time. The evidence for intensive advocacy interventions remains uncertain; therefore, no recommendation for or against is made here.

6. Consider cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR) interventions for IPV-exposed adults with post-traumatic stress symptoms.

CBT is a type of psychological intervention that generally attempts to challenge distorted, negative thinking patterns to help people develop more adaptive cognitions and behaviours. EMDR is a type of psychological intervention with standardized procedures for simultaneously focusing on 1) spontaneous associations of traumatic images, thoughts, emotions and bodily sensations, and 2) bilateral stimulation, most often in the form of repetitive eye movements. These interventions, if available, should be delivered by professionals with specific expertise who have a good understanding of IPV. More information is available in the World Health Organization (WHO) guidelines for the management of conditions specifically related to stress.

7. Consider brief to medium-duration counselling and advocacy/support for pregnant women who disclose IPV.

IPV during pregnancy is of particular concern due to the risks to fetal health and because IPV that continues during pregnancy is often severe. The extent to which this guidance, and the related guidance in #5, above, applies to settings outside of antenatal care is uncertain. For details on managing of mental health issues in this group, please see the mhGAP guidelines.

8. Consider referrals to other evidence-based interventions.

Following an assessment by a qualified provider, adults exposed to IPV may need to be referred to evidence-based treatments for specific symptoms or conditions (e.g., depression) or other concerns (e.g., substance use). At this time, there is insufficient evidence to refer adults exposed to IPV to any other interventions simply based on this exposure; referrals to interventions should be based on an assessment of the needs of the individual.

9. Couples' interventions are not recommended.

Couples' interventions may take various forms, including multi-couple or individual couple sessions and interventions where partners participate together in the same session(s) or separately, as is the case in 'sex-specific group' interventions. These interventions are often referred to as "couples' therapy." Available evidence does not show benefits for couples' interventions; there are concerns about potential harms, especially to women. The type of violence present in a relationship (conflict vs. coercive control) is crucial when considering therapeutic options involving both partners.

There is insufficient evidence for or against the following intervention types:

- Peer support interventions for adults exposed to IPV
- Perpetrator interventions

How this guidance was created

VEGA developed this guidance by engaging expert IPV clinicians and researchers, who formed an IPV evidence review group (IPV-ERG). The IPV-ERG set the scope of evidence to be collected, analyzed and evaluated in coordination with the mandate set by the Public Health Agency of Canada (PHAC): safe and effective strategies to identify, relate to and support those who have experienced family violence. Most systematic reviews were conducted and analyzed by an independent team of experts, the McMaster Evidence Review and Synthesis Team (MERST), in consultation with an expert from the MacGRADE team. The GRADE (Grading of Recommendations, Assessment, Development and Evaluations) methodology was then applied to create the above guidance statements. In some cases, when consistent with the evidence, recommendations were adapted from the WHO guidelines for responding to IPV and sexual violence against women. These guidance statements were reviewed by VEGA's National Guidance Implementation Committee (NGIC), which is composed of representatives from 22 key Canadian healthcare and social service professional organizations invited to participate in VEGA by the federal minister of health.

For further information

Please refer to VEGA's online education resources about IPV, including the Recognizing and Responding Safely to Intimate Partner Violence Module and the Handbook Section on IPV (https://vegaeducation.mcmaster.ca/).

Sources

1. The Royal Australian College of General Practitioners (RACGP). (2014). Abuse and violence: Working with our patients in general practice (4th ed.). Melbourne: RACGP.

2. World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva, Switzerland: World Health Organization.

3. World Health Organization. (2010). mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental Health Gap Action Programme (mhGAP). Geneva, Switzerland: World Health Organization.

4. World Health Organization. (2013). Guidelines for the management of conditions specifically related to stress. Geneva, Switzerland: World Health Organization.