PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #345
INTIMATE PARTNER VIOLENCE
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Background Intimate partner violence (IPV) includes physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a spouse or intimate partner (current or former) (1). Many seriously ill patients are considered vulnerable adults, for whom there are mandatory reporting requirements in many states when IPV is suspected, *even if the patient does not wish the reporting.* Hospice & palliative interdisciplinary teams (IDTs) can play an important role in identifying and caring for seriously ill victims of IPV, as they are often embedded in the home and/or aware of family dynamics. Although there is little research on IPV near the end-of-life, this *Fast Fact* discusses best practices regarding screening for and responding to IPV in the context of patients with serious illness.

Incidence and risk factors More than 1 in 3 women and more than 1 in 4 men in the United States experience IPV in their lifetime (2). IPV can happen at any age, and may not stop just because a patient becomes seriously ill. In fact, IPV risk factors such as social isolation, depression, economic stress, and increased dependence, can be more prevalent when patients are near death (3).

Screening and Reporting The American Medical Association, American Academy of Family Physicians, and American Nurses Association recommend routine screening for IPV across healthcare settings. Though common in ambulatory, emergency, and hospital settings, IPV screening practices in hospice and ambulatory palliative settings have not been well described. Most states have laws that mandate health care professionals to report specific injuries and wounds (4), and in many states many patients near the end-of-life are considered 'vulnerable adults'. Statutory definitions of a 'vulnerable adult' vary by state, but often include people who live in licensed facilities such as nursing homes, patients receiving certain social or medical services such as personal care attendant benefits, and patients with developmental or acquired physical or cognitive disabilities (for instance, due to a progressive terminal illness). *Clinicians must be familiar with their own state statutes and institutional policies regarding mandatory reporting of IPV.*

Talking with patients
- Interview the patient **alone if possible**.
- **Normalize & ask directly:** "We've started talking to all our patients about healthy relationships and I want to go over some questions with you. Are you in a relationship where someone is hurting you?" Or, "Are you safe at home?" (5)

Challenges for patients with serious illness
- Progressive disability greatly increases patient vulnerability and dependence on the perpetrator. The abusive partner may be the patient's primary caregiver, and sometimes the only appropriate historian. Therefore, there may not be any 'natural' scenario where the patient can be evaluated alone.
- Victims of IPV may have a strong attachment to their partner, and depend on them in important ways. The only person willing/able to care for a patient in a home setting may be someone either suspected of IPV or has a history of IPV. A patient's wish to remain at home may conflict with her/his safety in that setting. 'Escaping' an IPV relationship marked may not be a patient's top priority.
- Some patients with serious illness have impaired decision-making and communication capacity. This makes the task of corroborating IPV more challenging.
- Many of the physical and emotional signs of abuse (e.g., bruises, fractures, head injuries, back or pelvic pain, headaches, mood disturbance, emotional withdrawal) can occur for other reasons with serious illness (e.g., falls or the underlying serious illness itself). *No single injury or symptom pattern indicates IPV is occurring: this is why regular screening in seriously ill patients is important.*
- In some circumstances an abusive partner may be able to legally access a patient's medical records (e.g., as a patient's health care agent/power of attorney). This needs to be considered when documenting discussions as patients often fear retaliation/ exacerbation of the abuse.

What to do when IPV is suspected or discovered
- Get help. Most health care settings have social workers available – consult with them as soon as possible. Other resources include institutional policies, ethics consults, IPV advocacy groups, institutional legal counsel, and adult protection authorities. The National Domestic Violence Hotline

can help clinicians immediately identify resources: 1-800-799-SAFE.
- If the patient is not considered a vulnerable adult, partner with the patient and advocates to determine a plan for the patient's safety. Typically, non-vulnerable adult patients get to decide whether and when to inform the police/other authorities. However, if there are children in the home where violence occurs, separate reporting requirements may apply. *It can get complicated quickly, which is why expert help needs to be accessed immediately.*
- If the patient wants immediate police assistance, offer to place the call.

Implications for IDTs IDT members may experience frustration if the patient chooses not to formally address the abuse. Clinicians should remember that the victim's preparedness to address the problem is rarely a one-time decision, but is a process that unfolds over time. Building trust, setting expectations for safety, and helping to imagine alternatives are essential steps. Most importantly, all patients must be assured of ongoing support and non-abandonment throughout their care.

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