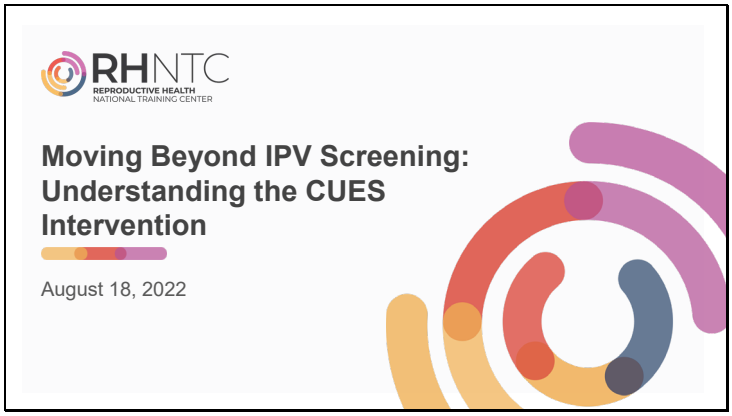
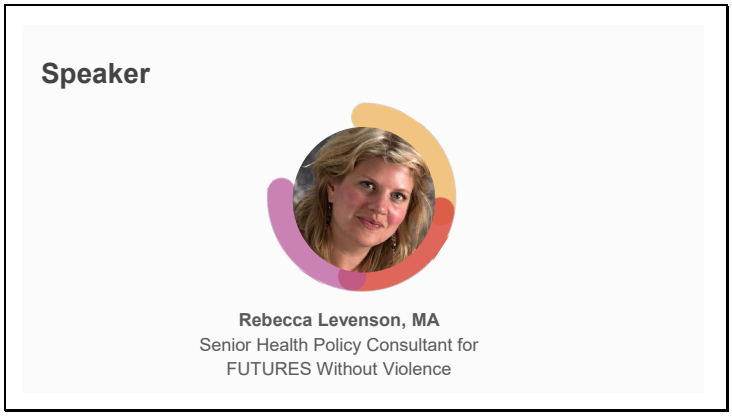
Moving Beyond Screening for IPV-Understanding the CUES Intervention
August 18, 2022
Transcript

Slide 1



- [Devon] Hello everyone. This is Devon Brown from the Title X Reproductive Health National Training Center and I'd like to welcome you all to today's webinar: Moving Beyond IPV Screening: Understanding the CUES Intervention. I have a few announcements before we begin. Everyone on the webinar today is muted, given the large number of participants. We plan to have some time for questions at the end of the webinar today. You can ask your questions using the chat at any time during the webinar. We'll also be asking for your participation at a few points during the webinar. You can respond in the "Audience Chat" pod, which is green and can be found at the bottom of your screen. A recording of today's webinar, the slide deck, and a transcript will be available on RHNTC.org within the next few days. Closed Captioning has been enabled for this webinar. To view, click on the CC icon at the bottom of your screen. Your feedback is extremely important to us and has enabled the RHNTC to make quality improvements in our work based on your comments. Please take a moment to open the evaluation link in the chat and consider completing the evaluation real-time. In order to obtain a certificate of completion for attending this webinar, you must be logged into rhntc.org when you complete the evaluation. This presentation was supported by the Office of Population Affairs (OPA) and the Office on Women's Health (OWH). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA, OWH or HHS.

Slide 2



We are excited to have as our speaker today, Rebecca Levenson. Rebecca Levenson has decades of experience helping reproductive health care systems respond to intimate partner violence (IPV). A former Planned Parenthood clinic director and Senior Health Policy Consultant for the national nonprofit FUTURES Without Violence, Rebecca is a nationally recognized researcher, educator, advocate, and speaker. Ms. Levenson is an author of numerous additional IPV training resources and publications including the FUTURES evidence-based intervention, “CUES,” which applies the power of universal education and altruism to improve providers’ ability to help clients experiencing IPV and is what we’ll be learning about today. So, with that, I will turn it over to Rebecca.

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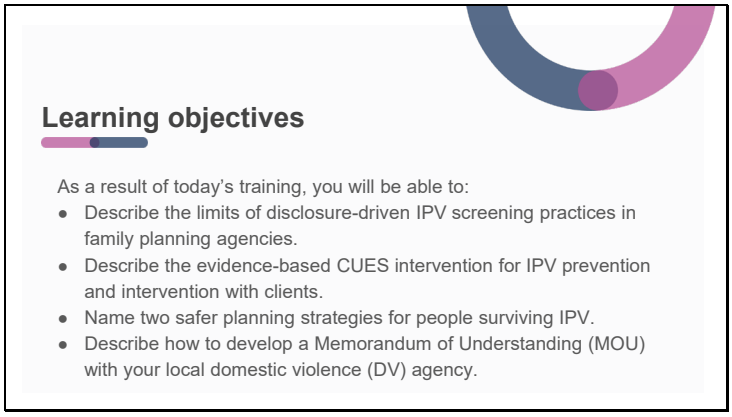

- [Rebecca] Thank you so much, Devon. And welcome everyone. I know that there are some folks who've had the opportunity to go through the series of webinars with us. So I am hoping I'm bringing you something joyful today because I believe that doubling down for what providers need and want and what helps you boots on the ground, every single client, every single patient, every single day is something I'm dedicated to. And I think that I have some tools that will be really exciting to you and new ways of approaching things. So we're going to start today by really thinking about the limits of disclosure-driven practice. Meaning I ask you a question, like, have you been hit, kicked, slapped or choked? And somebody says back to me, no. And then we tend to go on with our checklist. So we're going to talk about the limits of that. We're

going to be looking at that sort of thinking through an equity framework, and we're going to be shifting our focus as Devon mentioned to a universal education approach. So if your program is required to do screening for partner violence, I don't want you to lose your funding, but I do want you to consider a different way of segueing into a screening question in a very different kind of manner than perhaps you've done before. So we're going to talk a little bit about safer planning, partnering with domestic violence agencies and the power of the DV hotline and other tools.

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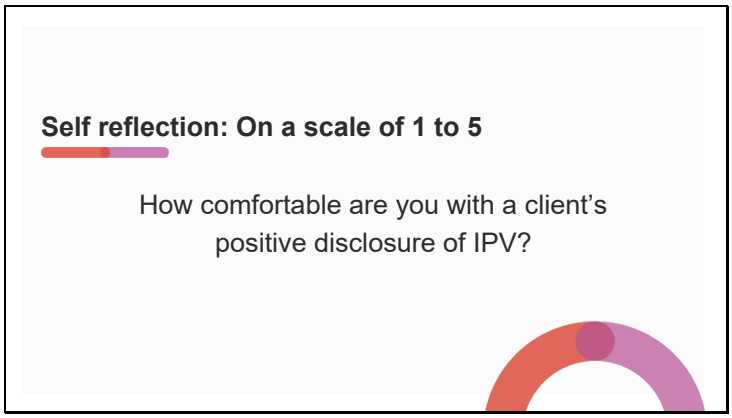

What I want you to do though, is just take a second, because I don't know where you just came from. If you're running from clinic, if you just sat down to open up your lunch or what have you, but I want to give you a little spaciousness for some self reflection. How comfortable do you think you are with a positive disclosure of IPV? Are you really comfortable? You know what to do, you've done it before, you know where to call? Are you somebody who's actually makes you really anxious to think about a positive disclosure? And if that's true, you're not alone in that. Or you'd say I haven't had much training in that. I'm not quite sure what to do. I want you to notice where you are and without judgment, if that's possible, because the goal for today is no matter where you are, if you're in the really kind of an, I'm not sure what to do, uncomfortable place, or if you're feeling pretty good about it, I think that there's something for everyone watching today that's going to help move your comfort level forward. So just notice where you're at. 'Cause I'm going to ask you the same question at the end and see if anything's shifted.

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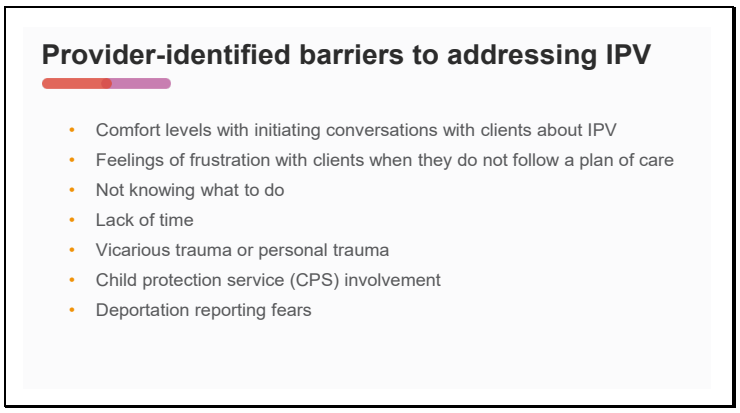

What do we know about why it's hard to talk about IPV? I think especially given the level of training you've had, if you've had a lot of opportunity to practice conversations, have conversations, that's great, but not everybody has. So people have different comfort levels and addressing these things. I think that there can be feelings of frustration as somebody who was a clinic director, I had survivors on my own staff. And I can tell you that one of the survivors who had a positive disclosure of intimate partner violence had a lot of difficulty with the fact that the client didn't follow through with the referral. And as you may remember, back from an earlier webinar we did where we talked about leaving can't be the goal, right? We really need to listen to what the client needs and let them lead. I think it's important to note that if you've had those feelings of frustrations, you're not alone. And again, we're going to give you some strategies to reframe the way that we've been holding the space as helpers in the field. And really again, think about the wisdom and the person in front of us being the expert in their own lives and how can we support them with what they need if they're experiencing intimate partner violence. Certainly I know lack of time is real. I, again, I know what it's like to have 10 charts in the rack and be behind in clinic. I think the thing that's exciting about the intervention you're going to be learning about today is you can do it in 30 seconds. I think there are very few evidence-based in some medicine that we can do in 30 seconds. So I'm pretty excited to share that with you. And then I also just want to acknowledge that there's vicarious trauma that comes with the work, or maybe you yourself have had hard experiences or your sister did, or your mom did, or you came from a home like this. So I want us all to remember back to some earlier webinars that we did, or some other, maybe trainings that you've had on how to take care of yourself. If as I'm talking today, you get triggered, I want you to know that this is being recorded so you can come back and listen to it. But if you need to catch your breath, if you yourself are in a complicated relationship and need to call the domestic violence hotline, need to take a breath outside, you can just take care of yourself as we move forward with today.

Sources:

- Sheila Sprague PhD, Kim Madden MSc, Nicole Simunovic MSc, Katelyn Godin BSc, Ngan K. Pham BSc, Mohit Bhandari MD PhD FRCSC & J. C. Goslings MD PhD (2012) Barriers to Screening for Intimate Partner Violence, Women & Health, 52:6, 587-605.
    - Results: The authors included a total of 22 studies in this review from all examined sources. Five categories of intimate partner violence screening barriers were identified: personal barriers, resource barriers, perceptions and attitudes, fears, and patient-related barriers. The most frequently reported barriers included personal discomfort with the

issue, lack of knowledge, and time constraints. Provider-related barriers were reported more often than patient-related barriers.

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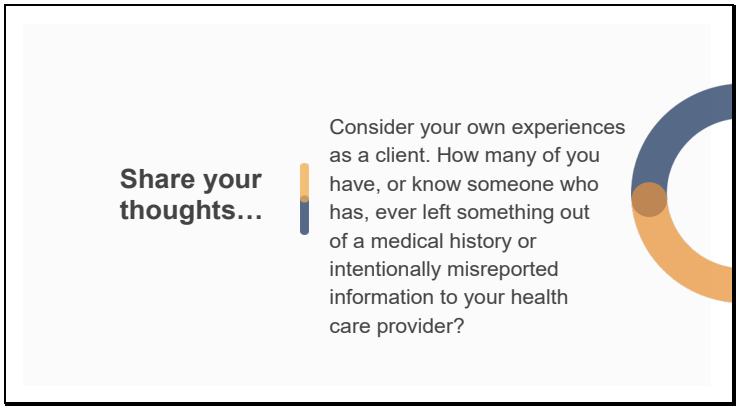

I want you to think for a second about your own experiences as a client. How many of you have or know someone who has ever left something out of a medical history or intentionally misreported information to your healthcare provider? My question to you is why? Why do people not share their stories with us? So I'm going to ask you to jump in the chat here and share with me why do you think people fear of judgment. Amisha, nice job. Why else? Why don't people shame? Shame, doesn't pertain to visit, guilt, embarrassment, trust, fear of retaliation, embarrassed. Absolutely fair, right? So not sure where that information's going to go. They distrust the provider. They distrust the whole healthcare system, 'cause they've had bad experiences in the past. So there are lots of good reasons, why people not ready to disclose. If I say it out loud, that'll make it true. And there are lots of good reasons why people can't necessarily share their stories with us.

Source:

- Annette J Browne, Colleen M Varcoe, Sabrina T Wong, Victoria L Smye, Josée Lavoie, Doreen Littlejohn, David Tu, Olive Godwin, Murry Krause, Koushambhi B Khan, Alycia Fridkin, Patricia Rodney, John O'Neil, and Scott Lennox, Closing the health equity gap: evidence-based strategies for primary health care organizations, Int J Equity Health, 2012; 11: 59. Published online 2012 Oct 13.

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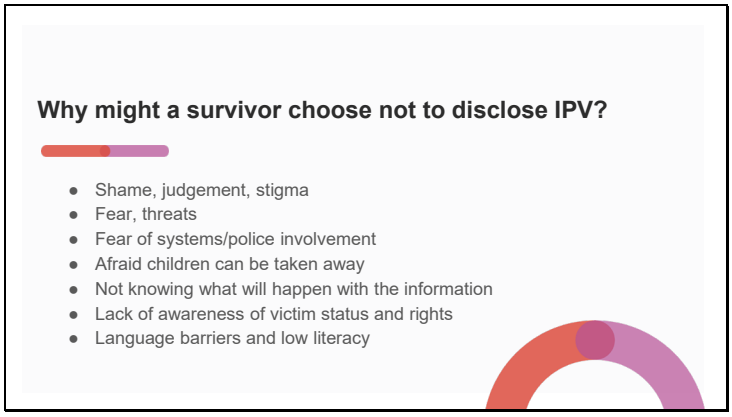

And you covered a lot of them in the chat, right? So shame and judgment, stigma. I grew up in rural Colorado on a dirt road in the middle of nowhere and we knew everyone. So if you shared something with your healthcare provider or the nurse put over here through the paper thin door, trust me, it would be throughout that little town in two seconds flat. So fears around confidentiality. I'm not knowing what will happen with the information, et cetera. Fear of child welfare, kids being taken away. So there's lots and lots of good reasons people are afraid to share their stories with us.

Sources:

- Rochelle R., Gribble A., Barrett S., Powell C.; Who Is in Your Waiting Room? Health Care Professionals as Culturally Responsive and Trauma-Informed First Responders to Human Trafficking. AMA J Ethics. 2017;19(1):63-71. https://journalofethics.ama-assn.org/article/who-your-waiting-room-health-care-professionals-culturally-responsive-and-trauma-informed-first/2017-01

- Substance Abuse and Mental Health Services Administration. SAMHSA's concept of trauma and guidance for a trauma-informed approach. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014. HHS publication (SMA) 14-4884. http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf. September 19, 2016.

- Barrows J, Finger R. Human trafficking and the healthcare professional. South Med J. 2000;101(5):521-524.

- Haynes DF. Used, abused, arrested and deported: extending immigration benefits to protect the victims of trafficking and to secure the prosecution of traffickers. Hum Rights Q. 2004;26(2):221-272.

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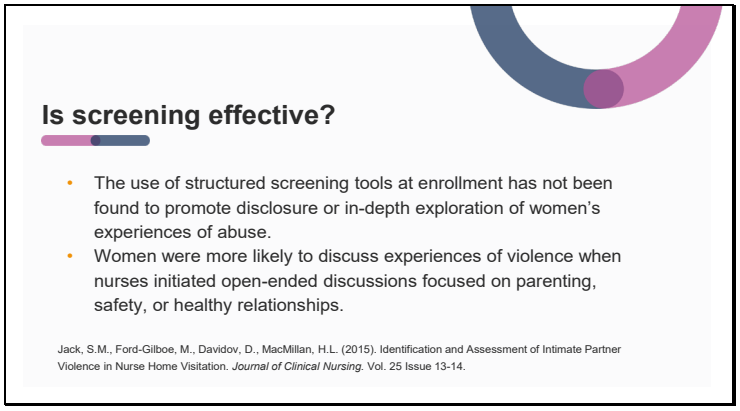
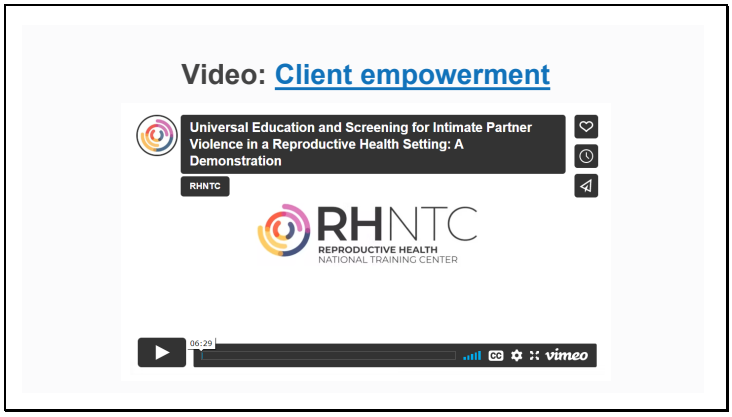


And I guess this is really the frame that we've been holding for a while. And I say this with a lot of humility because I think Futures Without Violence as the National Resource Center on Health and Domestic Violence for the whole country, 25 years ago, I was pushing to get screening for domestic violence, put on your checklist in your reproductive health clinic or in your emergency room department. And what I want to say is like any other field, just like with the Dalkon Shield, that wasn't a very good IUD, but that didn't mean we didn't go back and make other IUDs that were safe and worked really well. And I would say the same with screening. It wasn't a bad thing to do this, but I think we've grown and learned and expanded our thinking a lot since we started this work. And there's research to support this, right? So what you're looking at here is some data from Nurse-Family Partnership and no surprise, right? The use of structured screening tools at enrollment has not been found to promote disclosure or in depth exploration of women's experiences of abuse. Women are more likely to discuss experiences of violence when nurses initiated open ended discussions, focused on parenting, safety or healthy relationships. And it sort of makes sense, right? I mean, what people are looking for to get a sense of safety is a sense of a relationship with the provider, right? And if I'm having lunch in the backyard with Devon and we're eating a tuna sandwich and she likes my tuna sandwich, and I say, the secret ingredient is capers, and Devon, I'm wondering, does Jack hit kick, slap or choke you? I would never say that, right? Because in a relationship, I'd say, Hey Devon, last time we talked, things are really hard with Jack. How are things going now? Do you need anything? I've been thinking a lot about you, you've been in my heart. We would approach it in a very different way. And so putting that humanity back into just a tiny encounter with patients, I think is really rewarding, not only for the patient or client, but also for you, the provider. And I think when we have more meaning, I think it helps reduce burnout.

Source:

- Susan M. Jack, Marilyn Ford-Gilboe, Danielle Davidov and Harriet L. MacMillan, Identification and Assessment of Intimate Partner Violence in Nurse Home Visitation, Journal of Clinical Nursing Vol. 25 Issue 13-14: 2015.

Slide 9



And I'm going to stop sharing my screen because I want to share a video that's hot off the press. You'll be the first audience to see it. And it's not playing very well from my slide deck. So Devon has agreed to share her screen so you can watch this video with us, thank you.

- [Devon] And Rebecca, you just let me know if there's any sound issue coming through.

[Video dialog begins.]

- This video was produced by the Reproductive Health National Training Center, RHNTC. Universal education and screening for intimate partner violence in a reproductive health setting, a demonstration. Staff and providers often directly ask clients about intimate partner violence or IPV. But data tell us that disclosure rates tend to under-represent the true number of clients experiencing IPV. And we know their clients may have a number of different reasons why direct disclosure is hard. Using evidence-based IPV screening, has been the standard of practice in most reproductive health programs for decades. Before we learn about a different approach to IPV screening, let's take a look at two examples of how evidence-based IPV screening can look.

- So everything looks great. I was reviewing your medical history and I saw that maybe you didn't have enough time to complete all of the questions that were on the form. So I wanted to ask you, have any of your current sexual partners made you feel threatened or afraid?

- No, not at all.

- Okay, good. Have any of your current sexual partners hit, choked or physically hurt you?

- No.

- Have any of your current sexual partners forced you to do something that you didn't want to do sexually or refuse your request to use condoms?

- Not even.

- Okay, good, I'm glad. It sounds like you're in safe relationships. I did notice there were some other questions on the form that were left blank. So I just wanted to check in with you about those as well.

- I was reviewing your medical records and I saw that maybe you didn't have enough time to complete all the questions. Is that something you missed or something you wanted to talk to the clinician about?

- Oh, sorry. I just missed that one. So no, there's nothing going on.

- Okay, great. Then I will just check no for you on the question.

- Thanks.

- Yeah, no problem.

- We just saw two different approaches to screening for IPV both of which were based on a provider or staff member directly asking the client about IPV. As you saw, neither of these scenarios resulted in disclosure. How often do you get a disclosure of domestic violence or intimate partner violence? Daily, weekly, monthly, quarterly? Likely based on the research, most of you are seeing very low disclosure rates. We know young adult women using family planning clinics report higher rates of IPV compared to their same age peers. In some settings as high as 53%. So we know IPV is taking place on much higher rates than clients disclose in settings. Research shows that about 4% of transgender individuals report sexual assault in some point of their lives. Let's consider why disclosures may be difficult for clients. Research tells us it's a myriad of things, feelings of shame, concerns about child welfare involvement, and concerns about judgment on the part of the provider. In rural settings, clients may have concerns about who will find out or confidentiality. Lastly, longstanding issues for clients of color that have experienced racism within the health system and have a distrust of medical services, generally. Given the realities of low disclosure rates and recognition of the barriers for disclosures, how might we enhance the work we have been doing to address IPV in reproductive health? Universal education prompts providers to give information about and resources for IPV to all clients without first requiring disclosure. This approach normalizes the prevalence of IPV and how to take access help for yourself or others. Let's look at a different approach that can enhance your IPV screening.

- Before you go, I want to share these cards with you that I give to all my clients. I gave everyone too, so that you have information for yourself, and so that you can share one with a friend. We all know someone who has struggled in a relationship, and we weren't sure how to help them. So it talks about relationships and what we deserve in them, respect, kindness, no pressure to have sex. And it talks about situations with partners who may try to hurt or control you. Now on the back, there's a number for a free anonymous 24/7 text line where you can text to get information or talk about relationships. Is this something that you'd be interested in taking a look at or taking a photo on?

- Yeah, this is good. Yeah, I actually know someone who might really need this. So thanks.

- In this session, we saw the provider offer information to a client up front without needing the client to disclose first. This is what we call universal education, giving information to all clients up front without requiring disclosure since many people who could benefit from the information might not feel safe or be ready to disclose. It took about 45 seconds. Let's consider why this might be empowering for the client. What happens when we bring the intervention around two cards so we can help others? Research tells us that this approach normalizes the encounter for the client. By not having the focus solely on them, they can feel free to take the information,

even if it is for themselves. We also know that treating clients as allies who can help others is something that can be profoundly beneficial and meaningful for our clients. The client feels respected by the provider. So this approach has multiple benefits. Every client gets resources they may use for themselves or may use to help others. And providers have a sense, they may be increasing their own impact as a result. It ensures everyone leaves with resources, even if they can't or don't feel comfortable sharing their stories with us. This approach puts power in the hands of the client. Disclosure stops being the trigger for referral and universal education assures that every client has referrals. Learn more at rhntc.org.

[Video dialog ends.]

- [Rebecca] So I would love to hear in the chat what'd you think, because this, as I said, you are the first people in the entire country to have seen this video that kind of shares the difference between kind of how we've been doing it for a long time, that screening disclosure format, versus this universal education approach and bringing in the client as part of the solution to what might be happening in the community. So I just wanted to see if anybody had anything they wanted to share out. Really good video, really good video, helpful for staff training, love the universal education approach. I appreciate the representation in the staff from the clients, thank you. We really thought hard about that. It's a great way for providers to approach IPV screening, great video. It destigmatizes the issue. Yay, and yes. And you know what, given all the hard things in the world, this is like, I hope a little light in your lives because Norma, you asked if it's in Spanish. Devon, I'm going to stop and ask, is it close captioned in Spanish on the website? I don't know that answer, sorry.

- [Devon] I will go back to my team. I'm sorry, I'm getting some echo. I will go back to my team and we'll get an answer.

- [Rebecca] Okay.

- [Devon] That's a great question.

Resource:

- Video: Client Empowerment

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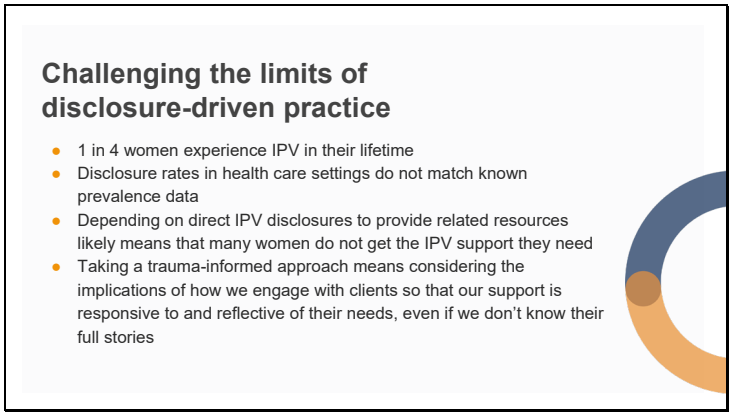

- [Rebecca] Yeah, it would be what we'd want, but I don't know exactly where things stand. So thank you for asking that. Great thing to do. And I think that she, I think the video did a nice job of summing this up. We know that a lot of people experience IPV and we know the disclosures are really small. So how can we in the name of equity and making sure we don't leave people behind shift that? And I really do think CUES is the way to do that.

Source:

- Miller E, McCauley HL Decker MR, Levenson R, Zelazny S, Jones KA, Anderson H, Silverman JG. Implementation of a Family Planning Clinic-based Partner Violence and Reproductive Coercion Intervention: Provider and Patient Perspectives. Perspectives on Sexual and Reproductive Health. 2017 Jun; 49(2); 85-93. PMID: 28272840. doi 10.1363/psrh.12021. Epub 2017 March 8

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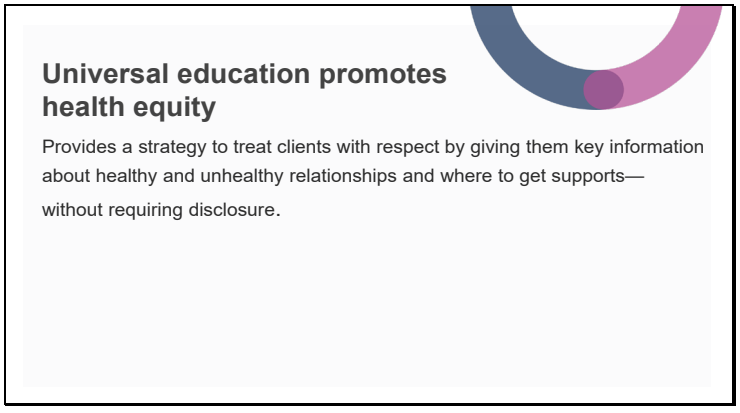

So, universal education promotes health equity. It's a strategy to treat clients with respect without requiring disclosure. And I really want you to think through the shame, the judgment, the fear of child welfare involvement, not being sure what's going to happen in their medical record if they disclose there's. So this idea that we are respecting someone and where they are in their truth and not being the gatekeeper for information anymore, I think really signals that you're somebody who cares.

Slide 12

So CUES, I'll just break it down for you. CUES stands for confidentiality. We want to see patients alone when we're having this universal education conversation. Universal education empowerment, and support. So that's the acronym, CUES. And I think somebody's going to share out, this is a copy of one of the many, many cards Futures has. This is a card that's specific to adolescents. You can use it with all adolescents in your clinic environment. I've done a lot of research on these cards with young people, with adults. So I'm excited to share a little bit more with you.

Sources:

- Adolescent Safety Card The Adolescent Safety Card and others may be viewed as PDFs and ordered as hard copies.
- www.IPVHealthPartners.org

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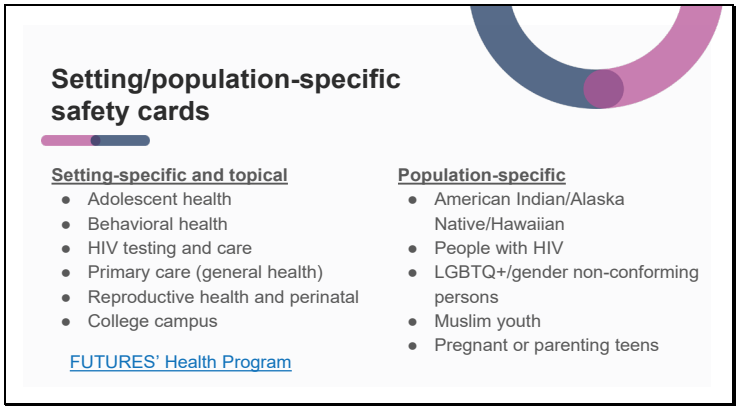


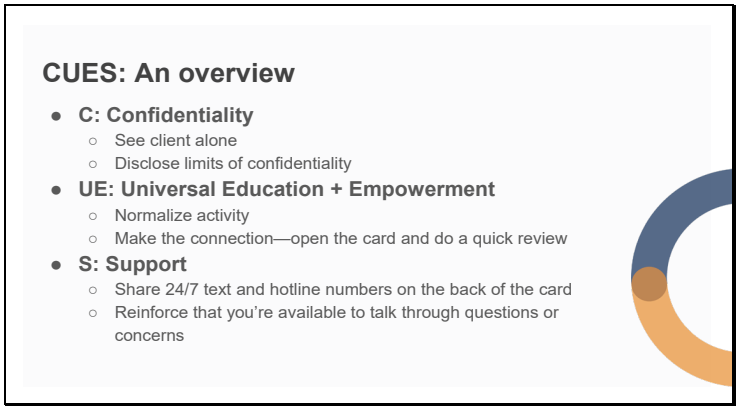
And the other thing is we've created tools that are very targeted and specific. So if you've got LGBTQ folks in your setting, we've got cards for that. If you are working with Alaska Natives or American Indians, we have tools there as well. If you're working, I know that some of you are in Title X clinics but some of you might be in broader primary care clinics. So if you're interested in stuff on behavioral health or general health, or if you're working on a college campus and

providing Title X services there, there's lots and lots of these specific hearts to help with that patient population.

Source:

- FUTURES' Health Program

Slide 14



So again, confidentiality, we want to see the client alone first. We want to make a connection. We're going to open up the card, do a quick review, just like you saw the provider do. And then the really important thing is we're going to make sure no one leaves without knowing where to go to get help. So we're going to do that S support piece and talk about the text on the back of the card part.

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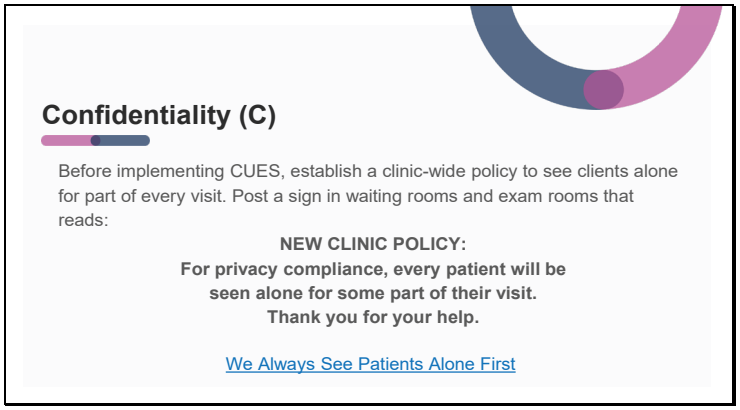


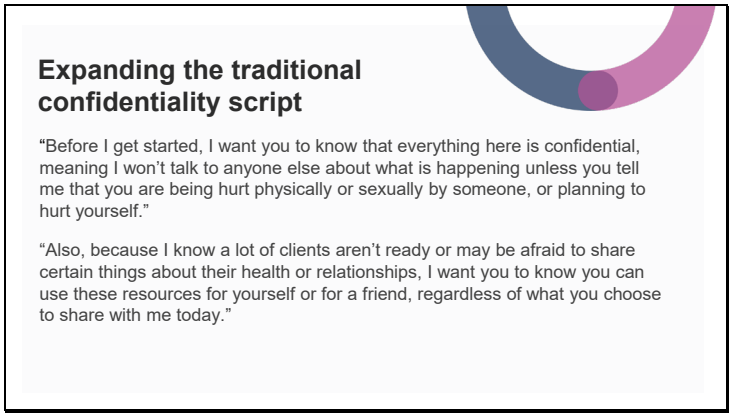
So again, confidentiality, we want to see the client alone first. We want to make a connection. We're going to open up the card, do a quick review, just like you saw the provider do. And then the really important thing is we're going to make sure no one leaves without knowing where to go to get help. So we're going to do that S support piece and talk about the text on the back of the card part. So before implementing CUES, we want you to establish a clinic-wide policy to see patients alone for every visit. Again, as somebody who had a Title X clinic was director for Planned Parenthood clinics. I can remember the adolescents that came in glued to each other,

like literally glued. Like, I didn't know that I could physically separate them because they came as like a one person. And I think that you want to get in front of that, right? So it's like, I'm so glad you brought your friend in, but you can even print this up and put it on the wall of your clinic. For privacy, we always see patients alone for a little while first, and then we can bring your friend back. Then we can bring your partner back. And it's just, I've had clinics say, it's a requirement of the federal government. It's HIPAA. I don't know what you want to do in terms of, how it's going to be if you're making a big change in your clinic most palatable. But I do think having some kind of named policy makes a big difference.

Resource:

- "We always see patients alone first"

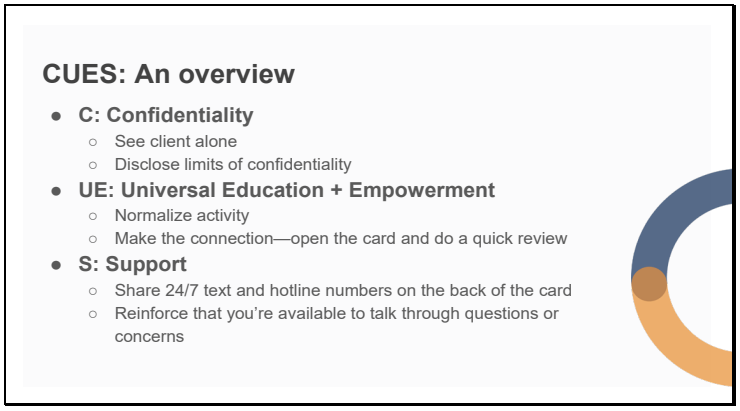
Slide 16



So here's an example of kind of how you can do this. "Before we get started, I want you to know that everything here is confidential, meaning I won't talk to anyone else about what's happening. Unless you tell me you're going to hurt yourself physically, or you're being sexually hurt by someone or planning to hurt yourself."

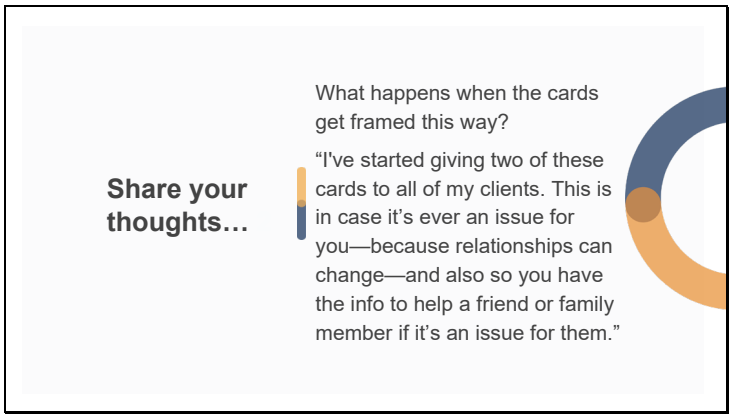
But imagine if you extended your traditional confidentiality script and included this? "Also because I know a lot of clients aren't ready or maybe afraid to share certain things about their health or relationships. I want you to know you can share these resources for yourself or a friend, regardless of what you share with me today." What a cool way to make connection with your clients?

Slide 17



So here's kind of that script you just heard from the clinician in the video, right? I've started given two of these cards to all my clients in case it's ever an issue because relationships can change. And also for you to have the info to help a friend or a family member. The card talks about healthy and safe relationships, what people deserve in relationships, as well as what to do and ones that aren't, and how those things can affect your health. It also looks at situations where youth are made to do things they don't want to do and gives you tips so you don't feel so alone. And then of course, the S, the support on the back is about the text and the national hotlines.

Slide 18



So what do you think happens? And I'm going to be curious to hear in the chat from you all here, oops. What do you think happens when we frame the card this way? I've started giving two of these cards to all of my clients in case it's ever an issue for you, because relationships can change. But also, so you have the info, so you can help a friend. Share with me in the chat. What do you think happens when we frame it? "This destigmatizes it," thanks, Brianna, exactly. Clients don't think they're being singled out, becomes a normal conversation, makes it acceptable. Awesome, exactly. Less shame. They think they're helping and you know what, they do help with these cards. That's the cool thing. Empowers them to speak up. It's a way for you to help others, exactly.

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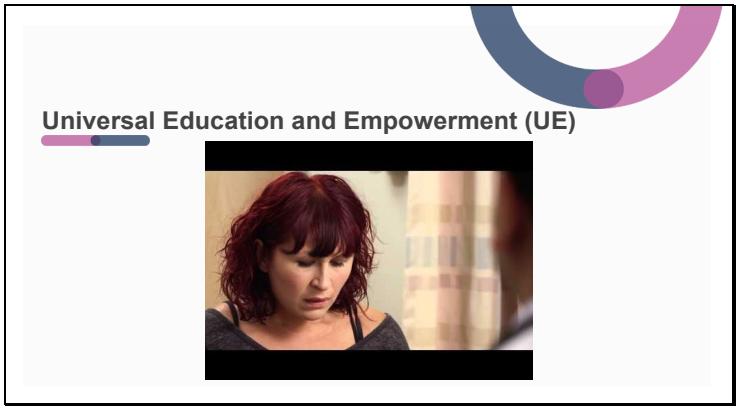

So this intervention works on a lot of different levels, and I'm going to again, stop my screen sharing, and we have another little video. And I want you to pay attention to what the client says here.

[Video dialog begins.]

- [Provider] ...have to do with all our patients is give them these safety cards. Even if they say their relationships are great, and even if they're not in a relationship.

- [Client] Why?

- Because we know that relationships change. And we also know that many women have friends and family who need help, but they don't know what to do. This card talks about what women do and do not deserve in relationships. And it has safety information and 24/7 hotlines on the back.

- [Client] Thank you for these. My sister, she's been struggling a long time, and I keep trying to figure out ways to better help her.

- I'm sorry to hear that about her.

- [Client] Yeah, me too.

- Well, I'm glad these are useful to you and possibly to her. You can call the numbers on the back for more information about how to help.

- [Client] Thank you.

[Video dialog ends.]

- [Rebecca] So my question to all of you is, was it for her or was it for her sister? Go ahead and share in the chat. Was it for her? Was it for her sister? Alan, you asked if every scenario is all women. I don't know if you noticed, but there was, it could be either. We actually had a male provider interviewing a trans woman in the very first scenario. So we definitely have mixed it up.

Resource:

- Video: Universal Education and Empowerment

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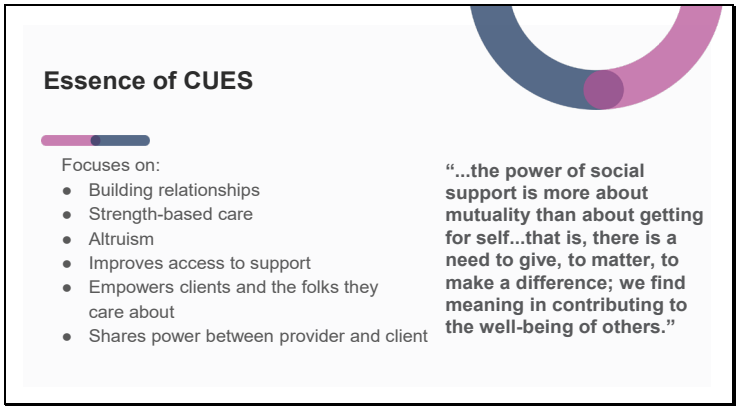

And it exactly, the whole point is it could be for her, or it could be for somebody else. And it doesn't matter because we helped either way, right? And I think that this piece around altruism and it empowers clients and the folks they care about, it improves access to support. The power of social support is more about mutuality than about getting for self. That is, there's a need to give to matter, to make a difference. We find meaning in contributing to the wellbeing of others. And that's true for all of you as clinicians, but it's really true for your clients as well. That this is a way to say, I think you're someone who can make a difference in the world, and that can be really powerful.

Source:

- Jordan, J. V. (2006b). Relational resilience in girls. In S. Goldstein & R. B. Brooks (Eds.), Handbook of resilience in children (pp. 79-90). New York, NY: Springer. P83-86

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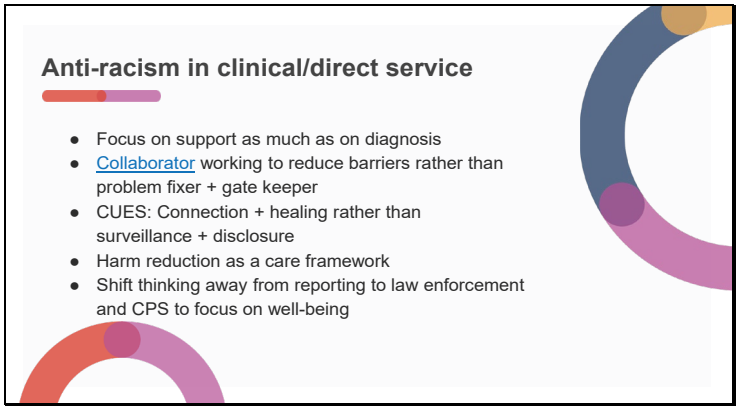

I also think there's an anti-racism and in clinical and direct service that we should be talking about. And I think historically, we haven't necessarily focused as much on support as we have on diagnosis. And I think it's important to think about being in collaboration, working to reduce barriers rather than being a problem fixture or a gatekeeper. CUES is really about making that connection with a client and healing rather than surveillance and disclosure. And that's a different framework than what we have seen historically. And it's very much a harm reduction as care framework. So we want to make sure people have this information. And I think it also gives us a chance to shift away from thinking about IPV as it's connected to reporting and law enforcement and CPS to focus on wellbeing and making sure people have key information that they might need.

Resources:

- CUES: Evidence Based Intervention
- Harm reduction principles for healthcare settings
- SAMHSA's Practices and Principles for Trauma and Resilience-Informed Values

Slide 22

And here's some research, right? So we did a lot of qualitative and quantitative research on these cards over the years. And here's what providers said. “The card made me feel empowered because you can really help somebody. Somebody that might have been afraid to say something, or didn't know how to approach the topic. This is a door for them to open, so they can feel more relaxed about talking about it.”

Source:

- Elizabeth Miller, Heather L. McCauley, Michele R. Decker, Rebecca Levenson, Sarah Zelazny, Kelley A. Jones, Heather Anderson, and Jay G. Silverman, Implementation of a Family Planning Clinic–Based Partner Violence and Reproductive Coercion Intervention, Provider and Patient Perspectives. *Perspectives on Sexual and Reproductive Health*. 2017 Jun;49(2):85-93

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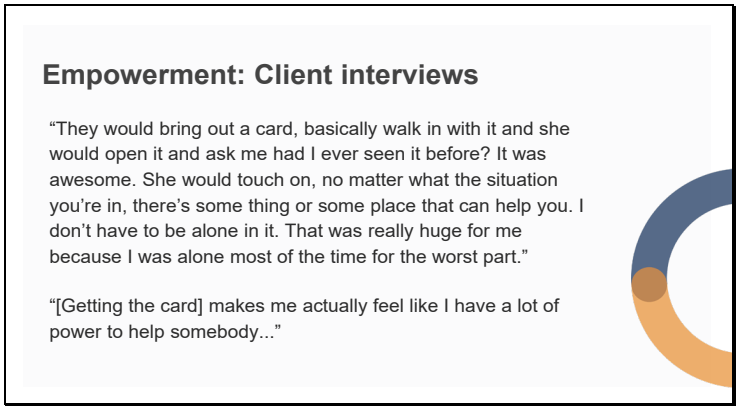

And here's what clients said. "Getting the card makes me actually feel like I have a lot of power to help somebody." And another client, "They would bring out the card and basically walk in with it, and she would open it and ask me if I'd ever seen it before. It was awesome. She would touch on no matter what the situation you're in, there's something or some place that can help you. I don't have to be alone in it." That was really huge for me because I was alone most of the time for the worst part.

Source:

- Elizabeth Miller, Heather L. McCauley, Michele R. Decker, Rebecca Levenson, Sarah Zelazny, Kelley A. Jones, Heather Anderson, and Jay G. Silverman, Implementation of a Family Planning Clinic–Based Partner Violence and Reproductive Coercion Intervention, Provider and Patient Perspectives. *Perspectives on Sexual and Reproductive Health*. 2017 Jun;49(2):85-93

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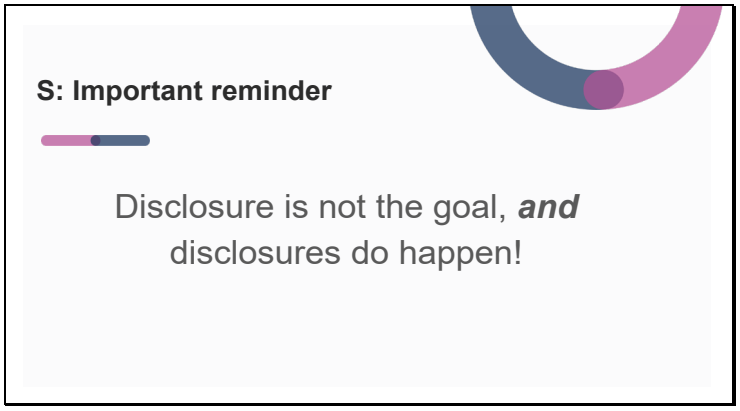

So while S and supports are incredibly important and we're moving away from this disclosure-driven practice framework. When you start to talk to people, we know that they share their stories, right? So disclosure isn't the goal anymore, but we certainly know it happens. And we want you to feel comfortable and supported when it does.

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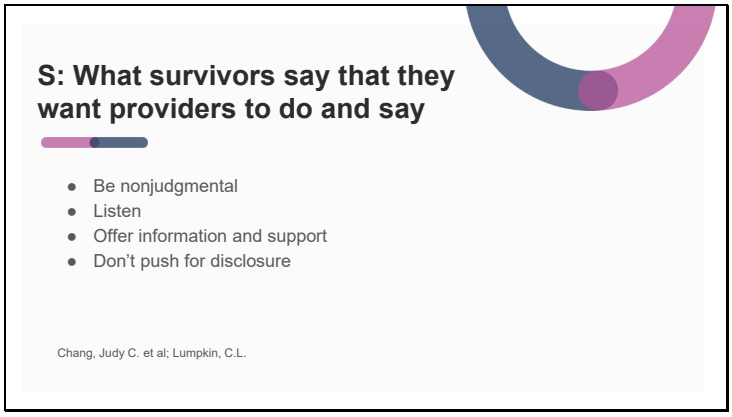

What does the research tell us? What do survivors tell us? They want you to be nonjudgmental. They want you to listen. They want you to offer information and support, and they want you to not push for disclosure.

Sources:

- Chang, Judy C. et al., *Health care interventions for intimate partner violence: What women want,* Women's Health Issues , 2005 Jan-Feb;15(1):21-30. DOI: https://doi.org/10.1016/j.whi.2004.08.007

- Carolyn Liu Lumpkin, LCSW and Adriana Taboada, MPA, “Identification and Referral for Human Trafficking Survivors in Health Care Settings: Survey Report”. Coalition to Abolish Slavery and Trafficking (2017).

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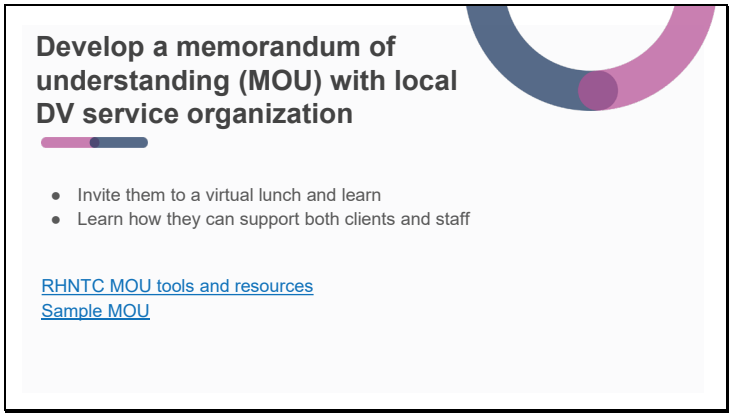

One of the things that I can tell you as a clinic director who did this in Fairfield, Vacaville and Vallejo, California, is that I developed a really strong relationship with my local domestic violence advocacy program. And it was such a deep relationship that my Title X healthcare provider would go there and provide pregnancy tests and birth control conversations and information to folks who were in shelter. And when we had what we called a hot positive, or somebody who was really struggling needed help with a report or other kinds of things, if the advocates had time, they would actually physically come to the clinic and take care of that person and support them while they were in the clinic. So I really want to underscore that if you haven't connected with your local DV agency, this is a real opportunity to do that because they're there to help you too. So if you have a complex situation that's been disclosed to you and you don't know quite what to do, their job is to not only help clients, but also to help providers as well.

Resources:

- RHNTC MOU tools and resources
- Sample MOU

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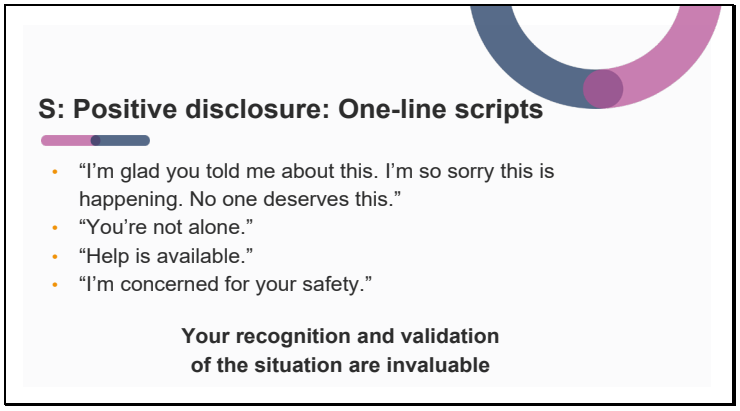

When someone shares their truth with you, I think it's really helpful to have something in your back pocket. And some of you have this in spades, but some of you maybe worry about, I'm not exactly sure what I would say if someone said they were being hurt. I'm glad you told me about this. I'm sorry, this is happening. No one deserves this. You're not alone. Health is available. These are all incredibly important things that mean a lot to a survivor when they disclose.

Sources:

- National Hotline on Domestic Violence: Help a Friend or Family Member
- Carolyn Liu Lumpkin, LCSW and Adriana Taboada, MPA, “Identification and Referral for Human Trafficking Survivors in Health Care Settings: Survey Report”. Coalition to Abolish Slavery and Trafficking (2017).

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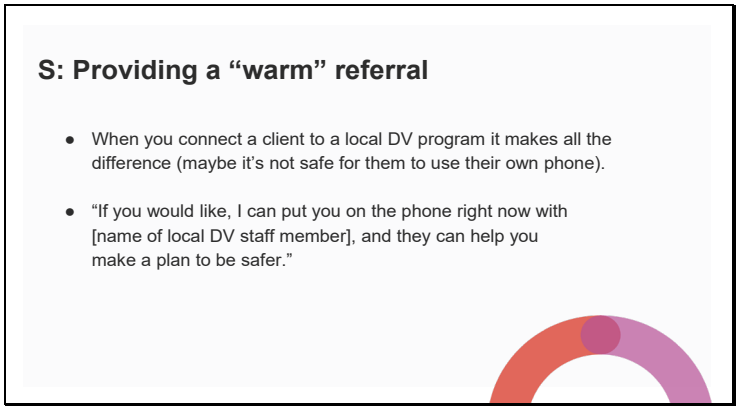
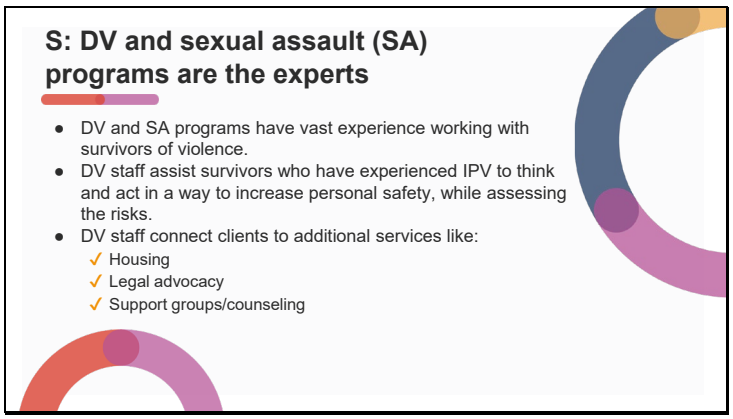


I think one of the other things that I want you all to think about is the power of your telephone and clinic or your personal cell phone. One of the things that we know happens with abusive partners is they are monitoring your text and your phone calls. So offering your clinic phone might be the first safe way the client has had to make connection with outside resources. So if you'd like, I can put you on the phone right now with Devon and she can help you with a plan to be safer.

Resource:

- Learn more about how health centers can establish or expand partnerships with DV/HT advocates as part of their care team at http://ipvhealthpartners.org/partner/

Slide 29



Domestic violence and sexual assault programs really are the experts. They have vast experience in working with survivors of violence. I know today has been pretty focused on IPV but certainly, sexual assault is something I know you also see and survivors of sexual assault is something you also see as a regular part of practice. And so knowing that what services are available, many programs either DVSA programs or SA programs offer 10 free counseling sessions, for example, for a survivor confidential counseling sessions. So learning about what's available can be really, I think, helpful to supporting your clients who disclose.

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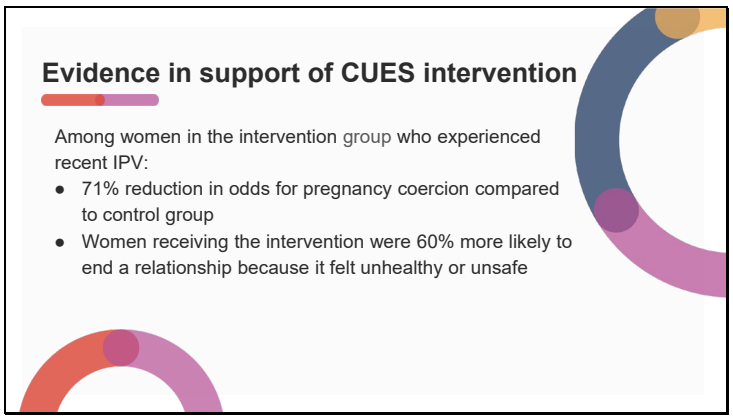


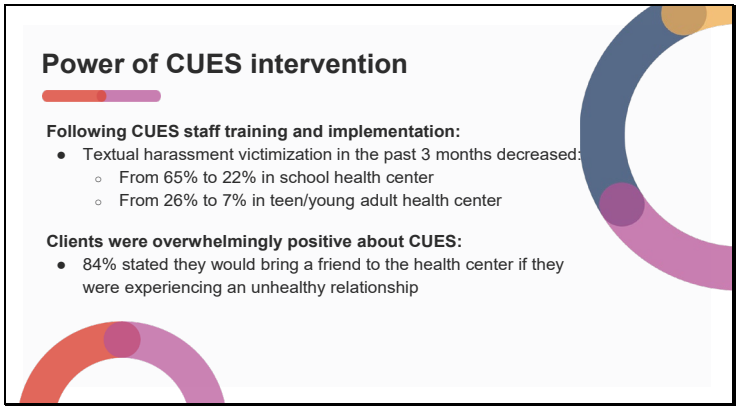
And what do we know from our original research looking at IPV and reproductive coercion? We had an intervention arm to our study and we had a control arm to our study. And in the intervention arm, they got the little card, there was the universal education. We talked about healthy and safe relationships and ones that weren't. And these are women in our study that were ages 16 to 29 years of age. And what was striking about it is that, of course these are young folks that they're moving on from one relationship to another, et cetera. But one of the

really interesting pieces in the findings was that the reasons given when they had the intervention about why they changed relationships, they were far more likely to say it felt unhealthy and unsafe as opposed to the control group who was getting sort of that standard screening question, usual kind of care. And so really remembering that not everybody has had the opportunity to see a healthy relationship. What does that look like? Maybe they had parents that thought, or their mom was in an abusive relationship. That's what they know, that's what they've come from. That's what seems normal. So the idea that taking that 40 seconds, that 35 seconds, that 45 seconds to have this conversation, to talk about what people deserve, right? Kindness, respect, all those things. And if that's not happening, and if you're afraid or uncomfortable, giving them that framework might be the first time they've ever heard it.

Source and additional notes:

- Miller E, Decker MR, McCauley H, Tancredi DJ, Levenson R, Waldman J, Schoenwald P, Silverman JG. (2011). A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. Contraception, 83: 274-80.
    - This study was conducted in a family planning clinic that was using the CUES intervention to address intimate partner violence (IPV) and reproductive coercion. Four free-standing urban family planning clinics in Northern California were randomized to intervention (trained family planning counselors) or standard of care. English-speaking and Spanish-speaking females ages 16-29 years (N = 906) completed audio computer-assisted surveys prior to a clinic visit and 12-24 weeks later (75% retention rate). Analyses included assessment of: intervention effects on recent IPV victims, awareness of IPV services, and reproductive coercion.
    - RESULTS: Among women reporting past-3-months IPV at baseline, there was a 71% reduction in the odds of pregnancy coercion among participants in intervention clinics compared to participants in the control clinics that provided the standard of care. Women in the intervention arm were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe regardless of IPV status (adjusted odds ratio = 1.63; 95% confidence interval=1.01-2.63).
    - CONCLUSIONS: Results of this pilot study suggest that this intervention may reduce the risk for reproductive coercion from abusive male partners among family planning clients and support such women to leave unsafe relationships. This contributes to the evidence base for using a safety card-based intervention.

Slide 31



I also mentioned we tested CUES in adolescent settings, and we found that textual harassment victimization decreased from 65% to 22% for young people coming into the school health center. So we were looking folks in school based health settings, but also in Title X clinics or other community health clinics. And we found there was a reduction as well in textual harassment from 26 to 7%. And clients were overwhelmingly positive about CUES. 84% stated they would bring a friend to the health center if they were experiencing an unhealthy relationship. So literally when we were doing this study, we would have teens come to the clinic with that card in hand and say, my friend gave this to me and said, this is a place that could help me.

Source:

- Miller E, Goldstein S, McCauley HL, Jones KA, Dick RN, Jetton J, Silverman JG, Blackburn S, Monasterio E, James L, Tancredi DJ. A School-health Center Intervention for abusive adolescent relationships: A cluster RCT. Pediatrics. 2015; 135(1): 76-85.

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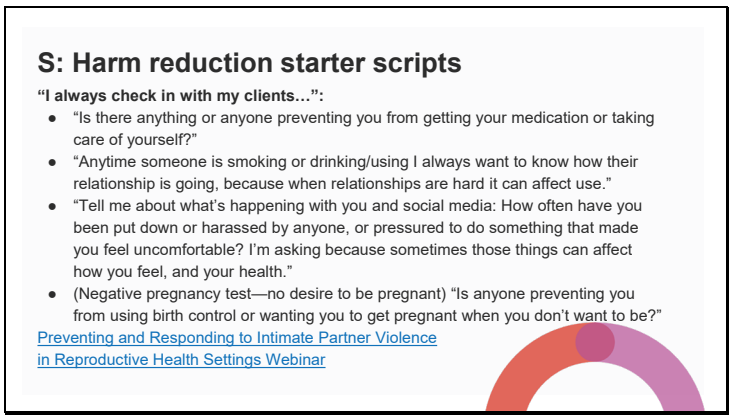


I also want to say that, in all of your wisdom as clinicians and recognizing that there are health implications associated with power and control in relationships, we want to ask other kinds of questions to get at the core of what might be going on. And here's some examples of other kinds of questions that you can build on to that universal education approach. Is there anything

or anyone preventing you from getting your medication or taking care of yourself? Here's another one. Anytime someone is smoking or drinking using, I always want to know how the relationship is going because when relationships are hard, it can affect your use. Tell me about what's happening with you in social media. How often have you been put down or harassed or pressured, or asked to do something that made you uncomfortable? I'm asking because sometimes those things affect how you feel in your health. Okay, and this one especially. If you have a negative pregnancy test, there's no desire to be pregnant on the part of the client. I think this is a great question to ask. Is anyone preventing you from using birth control or wanting you to get pregnant when you don't want to be? So you can always use this as a way to bridge other kinds of concerns that you might be having with your client.

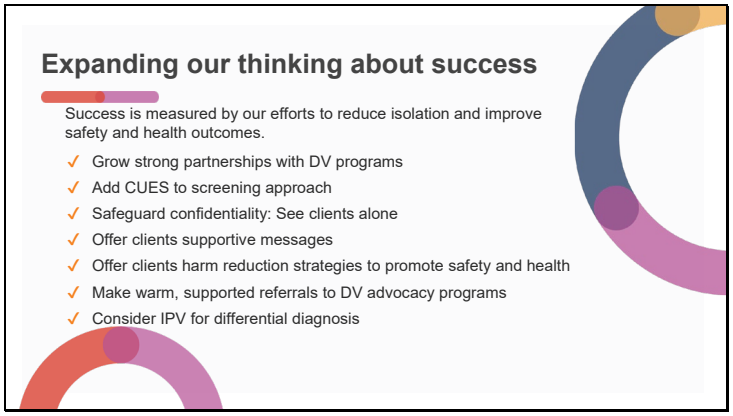
Sources:

- Rebekah E. Gee, MD, MS, MPH, Nandita Mitra, PhD, Fei Wan, MS, Diana E. Chavkin, MD, Judith A. Long, MD. Power over parity: intimate partner violence and issues of fertility control .Am J Obstet Gynecol 2009;201:148.e1-7.

- Linda Chamberlain, PhD, MPH and Rebecca Levenson, MA (Futures Without Violence) Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings Third Edition (2013).

- Preventing and Responding to Intimate Partner Violence in Reproductive Health Settings Webinar

Slide 33



So I want to expand our thinking around what success looks like. Success is measured by our efforts to reduce isolation and improve safety in health outcomes. I believe that is what CUES and universal education does in spades. I think growing that strong partnership with DV programs is so important because you deserve support. You deserve a place where you can tap into the expertise that you need to support your clinical care. I think adding CUES to any kind of screening approach is really important. We want to remember to see clients alone. We talked about supportive messages. We talked about harm reduction strategies and way to bridge that universal education into more direct conversations about things that we see or that we're worried about with our patients. We talked about how to make warm, supported referrals to DV programs. And certainly, I really want you all to keep considering your IPV as part of your differential diagnosis. If you've got somebody who's coming in with chlamydia multiple times in a

row, and you've treated them, I want you to be asking yourself, I wonder if it's safe for them to get their partner treated. Can they talk to their partner about this? Is the reason why I'm seeing them come in for chlamydia again, because they're so afraid of their partner. And we talked about pregnancy tests as well.

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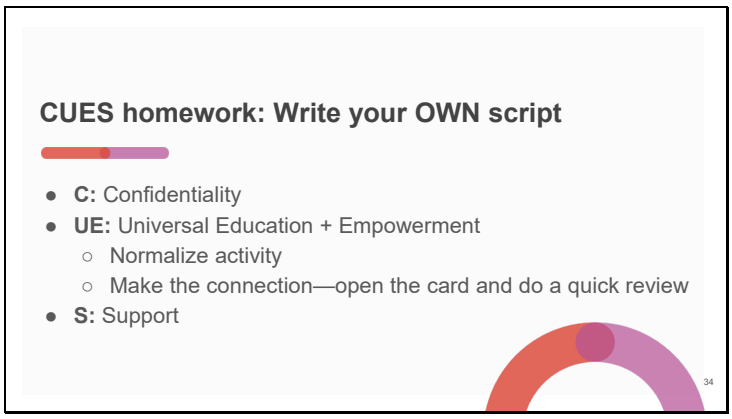

So you saw Rebecca Levenson's CUES script, all right? And here's what I can tell you. It's not perfect. I probably would change it up entirely if I was in a clinical setting with you, because if you're 16 years old or 29 years old, or if you're a mom of four kids, my conversation's going to shift depending upon the person in front of me. So one of the things that I want you all to think about is draft your own script. How would you start that conversation? What would feel right to you? And I think taking a moment to kind of write it down, saying it out loud when you're driving home, practicing it with a colleague, getting it under your skin. Once you've started doing this, it's the easiest thing in the world, but getting started can be the hardest. So for my CQI people, my manager people here, I'm hoping as part of a staff meeting, you can support your staff in writing their own scripts and getting ready to launch this. And certainly I do, I think practicing in your car while you drive home to the grocery store is a great use of time when you're trying to figure out how you'd get this started.

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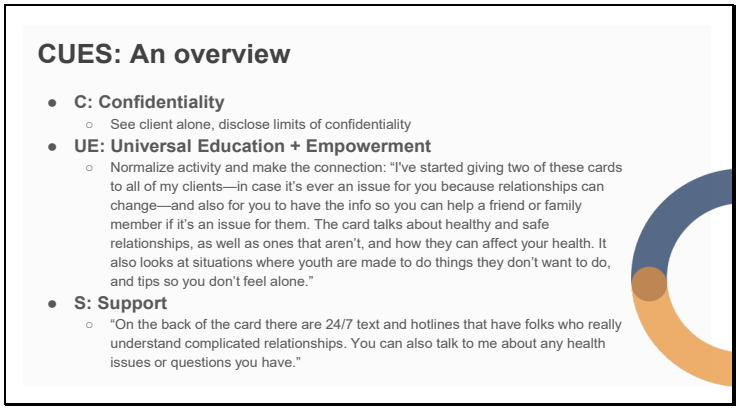

So again, here's that script, right? I've started giving two of these cards to all my clients in case it's ever an issue for you, because relationships can change. You might change this to say, I started giving two of these cards out to all my clients, because I know not everybody got to see what a healthy relationship look like, or maybe nobody ever told you, you deserve to be treated with kindness and love and respect. You're going to find you in this, right? The tools there to support your conversation, but your authentic self and the way that you would tweak this is what's going to make the magic sauce. You can certainly start with the scripts you're seeing here as a jumping off place, but I really do want to encourage you to feel like you can make this your own.

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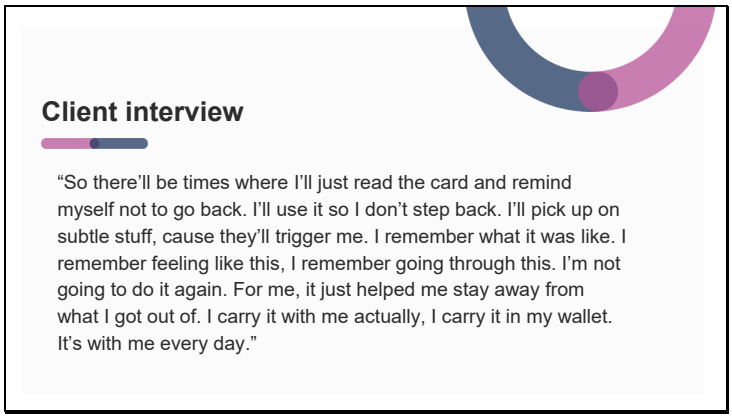

So I'm going to end with a little bit of time for Q and A, but I have the opportunity to do all these qualitative interviews. And this is a story that will stay with me forever because she got under my skin. So let me read this to you. "So there'll be times where I'll just read the card "and remind myself not to go back. "I'll use it so I don't step back. "I'll pick up on the subtle stuff, "'cause they'll trigger me. "I remember what it was like, I remember feeling like this. "I remember going through this "and I'm not going to do it again. "For me, it just helped me stay away from what I got out of. "I carry it with me, actually, "I carry it with me in my wallet. "It's with me every day." So there is so much power in this 32nd to 45th intervention. In our qualitative interviews, we'd ask, did you keep the cards? And they'd say, yeah, we kept the cards. And then say, "Where did

you put the cards?" And they said, "I put 'em in my glove compartment, "just in case I would need one for a friend." "It's in my top drawer of my dresser "next to my birth control pills "'cause that's where I put all the important things." I mean, it was really interesting hearing from folks about how they wanted to be someone who made a difference in the world. Client who shared with me. I gave it to my mom because in this client's case, the client had had her IUD pulled out by her abusive boyfriend. But when I asked her about the cards and did she use them and with whom? She said, "Well, I used them with my mom "because she's in a way worse situation than I am." And so then you just get a sense of even for the survivor, who's experiencing reproductive coercion, not in a healthy relationship. She had the wherewithal and the interest to help another person and help her mom. So I think that the ripple effect and the looking at changing cultural norms, looking at changing the ways in which we support people in the world is really important. I am going to say one thing about the cards. When we started this work, it was very gendered. We were looking at CIS women and we were not looking at men. We were not necessarily looking at trans folks or all those pieces. I'm happy to tell you, we have created, we're in the process. It's about to be printed in September, a brand new tool that is inclusive of everyone you see so you can have this conversation with any comer about what they deserve in a relationships, what unhealthy relationships look like and strategies for harm reduction. And we're really proud of it, we focus grouped the heck out of it across the country. So with teens, with adults, with all the people you can imagine. So anyway, that's coming soon and I'm very excited about it.

Source:

- Elizabeth Miller, Heather L. McCauley, Michele R. Decker, Rebecca Levenson, Sarah Zelazny, Kelley A. Jones, Heather Anderson, and Jay G. Silverman, Implementation of a Family Planning Clinic–Based Partner Violence and Reproductive Coercion Intervention, Provider and Patient Perspectives. *Perspectives on Sexual and Reproductive Health*. 2017 Jun;49(2):85-93

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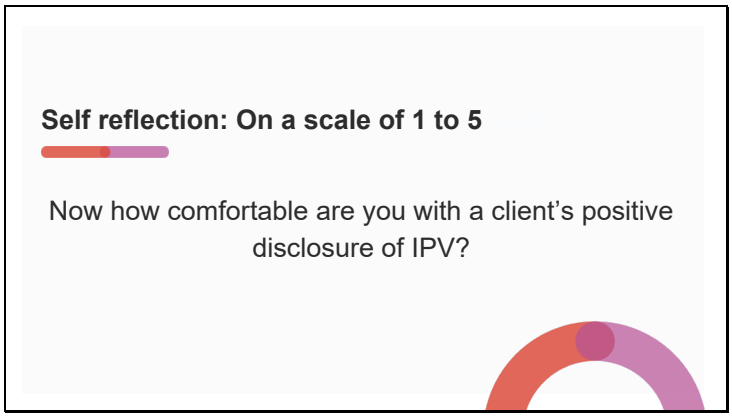
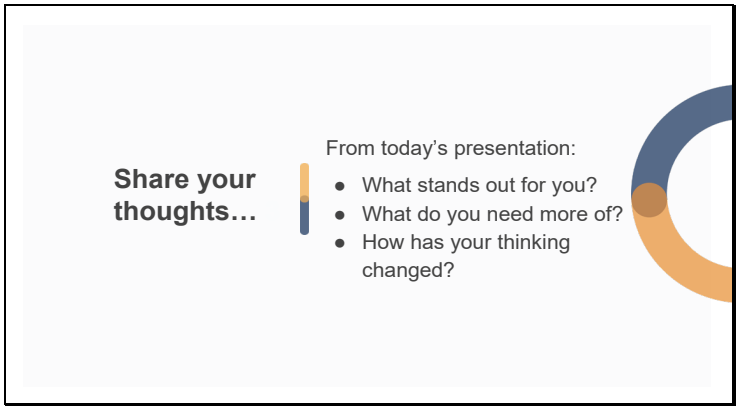


So I asked you at the outset of today, how comfortable are you with a client's disclosure of IPV? I hope the answer is a little bit more comfortable. I hope that CUES and talking about DV advocates and all of these pieces gives you more scaffolding and support and builds on what you already your own expertise.

Slide 38



So Devon, I think this is our Q and A period, and I have not been paying attention to the chat. So if there are questions there that you want to start with or want to catch me up on anything, please do.

- [Devon] Sure. So I do want to encourage folks to please feel free to go ahead and answer these questions in the chat as you feel inspired. So we'd love to hear what stands out to you, what you need more of, how's your thinking changed, feel free to kind of marinate in that and share as you would like.

Slide 39

- [Devon] And we do have a couple questions. The first one is more of a request, Rebecca, and it's, I hate to go away from the slide, but it was a request to share the privacy language again, that kind of overall, that suggested language that clinics could put in their waiting.

- [Rebecca] Let's do it. Now, I think it's such a sweet way to, here we go. So imagine if this is what you got to hear when you walked into your provider's office. Also, because I know a lot of clients aren't ready or maybe afraid to share certain things about their health or relationships. I want you to know you can use these resources for yourself or a friend, regardless of what you choose to share with me today. And you can see how beautiful that is. It leaves the door open for them to share something at another visit to say, I'm feeling like I'm ready to talk about it. It doesn't require them to disclose and it meets them where they might be, which is afraid to

share. Not comfortable, not ready, not yet trusting. So is that, do I get it Devon? Is that what they were asking for?

- [Devon] I'm want to see who asked it and if they could just put in the chat, if that was the right, I think it was Angela.

- [Rebecca] Did I get it right?

- [Devon] I'm wondering too, if they were thinking or requesting for that. You had some language about, we only see people one at a time.

- [Rebecca] Oh, sure. I can go back to that one too. This one.

- [Devon] I think maybe that's it.

- And honestly, when the change got made, we had it on the wall, we had it on the clipboard. We had it on the back of exam room door. And I think that helping the staff universally say, you know it's a change. I get it, it's a pain and a no. Or they have words if they have people who are upset about not being able to come back right away and anticipating that and really coming at it from a nonchalant, not a rules perspective, but really from like this is just what we do. It's just part of HIPAA. It's part of what we're required to do. And I'm so glad you came in today. I'm so glad that you care so much and we are totally going to get you back there, I promise. It's just going to take me a minute. So you can see how the way that you hold that space can make all the difference.

- [Devon] Yeah, and we do have a couple other questions, Rebecca. So one is, is there one question that you would put on the social history in place of some of the standard IPV questions we have now? Like the, have you been hit, kicked, slapped, et cetera.

- [Rebecca] In my magical thinking world, on every EHR, and on every screening, every tool that you're using in a medical facility, the question I would like to have on there is did you review CUES with the client? Yes or no? That's what I'd like. Did you do universal education with this framework? And that would be the replacement if I had, and again, if you have to screen, that's part of your funding, I don't want you to be in trouble. But what we're doing right now nationally is asking in EHRs to have these kinds of prompts put in so that you can be reminded, oh, did I do CUES yet? And have the tools available. And obviously with virtual reality, if you're doing a Zoom visit, you can send these electronically and have that conversation. So that's what I would change. I would really shift it away from that screening thinking to, we are going to make sure no one ever leaves again, without having key information to help themselves or others.

- [Devon] Yeah. Someone else has asked, you had a great question asking a female patient if they were being prevented from using birth control, if they don't want to get pregnant. If the patient says yes, that they were being prevented from using birth control, what would be the next best response to this disclosure?

- [Rebecca] Yeah, so one of the things that we know is that abusive partners are often monitoring menstrual cycles, right? 'Cause if they want you to be pregnant, they want to know if you're pregnant or not. So the morning after pill obviously is a great potential answer. We recommend even taking it out of its packaging. I don't know if it's still in a bright pink box that says Plan B. But if you've got an abusive partner going through your person, they're trying to get

you pregnant. You don't want them to find that. So giving them multiple doses of plan B, I think can be a good idea. I also really think the copper T IUD is an important thing to know about, because of course they can get their period at the same time every month, but you can actually cut the strings off in the ass. And for somebody, from a harm reduction perspective, if you've got somebody who's not able to shift that relationship, but they know their partner's trying to get them pregnant and they don't want to be, they can't feel those strings and they can't pull them out if they're all trimmed up way inside of the ass. And so that is one of the interventions that is been really effective.

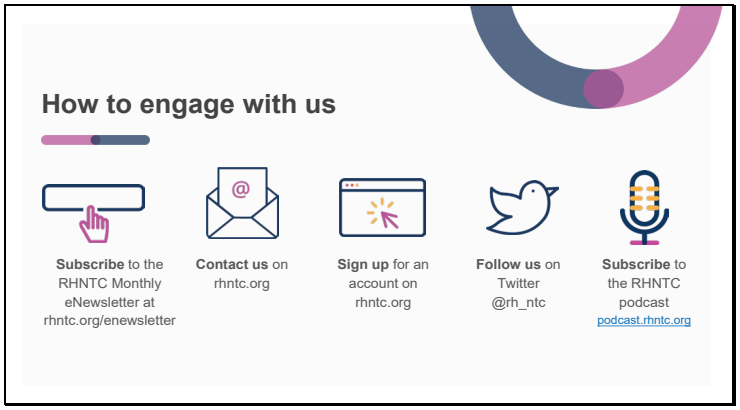
- [Devon] And then I think we're coming up to the end of the hour. So I'm going to ask one more question. For clients who we know or suspect or experiencing IPV, is there another way to practice CUES or share this information with them that doesn't involve the information card? I could be worried to send them back to an environment where the presence of the card might be dangerous for them.

- [Rebecca] So I really trust people. And you saw on the clinician video, she said, so is this something you can take with you today? Do you want to take a picture of it? Checking in with them, not assuming, but you saw the patient say, actually I have a friend and I'm going to give her this card. So I think you can read your client's CUES. One thing I will tell you, my brilliant friend, Dr. Elizabeth Miller does, is she says, you can put that hotline number under my name, and you can say, this is Dr. Liz's number. You know what I mean? Like there are other strategies to kind of cover for what that is.

- [Devon] Yeah.

- [Rebecca] So I think that can be a helpful thing to think about. And no, everyone doesn't have to take the cards, but in my experience, people are pretty excited unless... and I see people slipping into things like the back of a cell phone case. Perfect place to put it. Nobody can see that it's there. The inside secret part of your wallet. And you know you all have some secret compartment somewhere in that purse, that wallet, wherever you're. So I see people do all kinds of things with it, including not take it that day would too.

Slide 40



- [Devon] Just getting the information from it and, yeah. All right, well, I think I'm going to move us into the end of our time together today. So we want to thank you all so much for joining us today. And I hope that you will thank me and thanking Rebecca for being with us and presenting

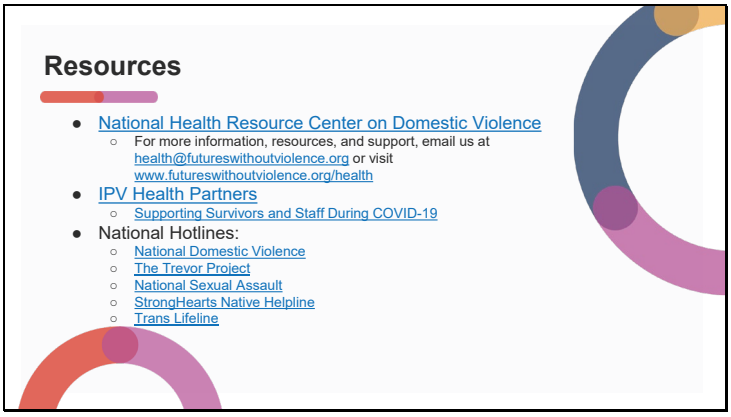
all of this fabulous information. As a reminder, we will have the materials from today's session available within the next few days. To stay in touch with RHNTC, you can subscribe to our monthly eNewsletter by visiting rhntc.org/enewsletter. You can contact us through our website, which is rhntc.org. You can sign up for an account on our website. You can follow us on Twitter, find us at RH_NTC. And finally, you can subscribe to our podcast through podcast.rhntc.org, or using your favorite podcast app. And if you have any additional questions for RHNTC on this topic, please don't hesitate to email us. The email address is on the slide here, and that's rhntc@jsi.com. And our final ask is that you please complete the evaluation today. I believe the link is in the chat, and it will also appear when you leave the webinar. The evaluation link will also be emailed to you after the webinar. So lots of opportunities to complete that. We really love getting your feedback and we use it to inform future sessions. And just a reminder, in order to obtain a certificate of completion for attending the webinar, you must be logged into rhntc.org when you complete the evaluation. So we thank you once again for joining us. And that concludes today's webinar.

- [Rebecca] Thank you so much. And thank you for all you do to make the lives of your clients and patients better every single day. So you're deeply and thanks for listening to new strategy that I hope was going to be helpful to a lot of folks that you serve.

- [Devon] Thank you all.

Slide 41

Slide 42



- National Health Resource Center on Domestic Violence
- IPV Health Partners
    - Supporting Survivors and Staff During COVID-19
- National Hotlines:
    - National Domestic Violence
    - The Trevor Project
    - National Sexual Assault
    - StrongHearts Native Helpline
    - Trans Lifeline

The National Health Resource Center on Domestic Violence is a project of Futures Without Violence and supports health care practitioners, administrators and systems, advocates, policy makers, and others at all levels as they improve health care's response to domestic and sexual violence.

- For more information, resources and support:
    - E-mail: health@futureswithoutviolence.org
    - Visit: www.futureswithoutviolence.org/health

The IPV Health Partners is an online toolkit and is the go-to resource to learn more and find related tools and resources related to today's training. www.ipvhealthpartners.org was developed by Futures Without Violence in an earlier Project Catalyst phase of work informed by twenty participating community health centers and domestic violence advocacy programs. They also have a page dedicated to supporting survivors and staff during COVID-19.