



**RESEARCH BRIEF:**

**Identifying and Responding to Intimate Partner Violence**

**Fall 2016**

**What We Know**

- Intimate partner violence (IPV) against women<sup>1</sup> results in short- and long-term physical and psychological harm for women and their children (Stewart et al., 2013; Wathen, 2012). In Canada:
  - past 5-year prevalence of IPV is estimated at 4% and lifetime IPV at 30%, with 13% of women reporting lifetime emotional or financial abuse specifically; self and official reports underestimate IPV, and rates will vary according to where and how women are asked (e.g., rates in health settings generally higher) (Statistics Canada, 2016; Rodgers, 1994);
  - about 80% of intimate partner homicides in Canada are committed by men against women; with the rate 4 times higher in women than in men (0.44 per 100,000 females aged 15 and over versus 0.11 for males aged 15 and over) (Perreault, 2015).
- IPV is a public health issue and is associated with significant health risk behaviours, including alcohol and drug abuse, smoking, unsafe sexual behaviour and physical inactivity (Chief Public Health Officer of Canada, 2016). Exposure to trauma, including IPV, is also significantly related to health inequities.
- IPV has significant impacts on families, communities and society more broadly, including financial costs estimated at over \$7 billion dollars per year in Canada alone. While most of these costs are borne by women and families, many are paid for by government services (e.g., health care and criminal justice costs) and by the private sector, through losses to employers (e.g., lower productivity) and due to the negative impact on the expected future earnings of adolescents and children exposed to IPV (Adams et al. 2013; Zhang et al., 2012; Varcoe et al., 2011).

*Identification of IPV*

- Both universal screening and case-finding can identify women exposed to IPV, and many tools exist to identify IPV. Women generally support being asked about abuse (Nelson et al., 2012).
- RCTs indicate that screening women and providing passive referrals (information cards or print-outs) does not result in improvements in life quality and mental health (Klebens et al., 2012; MacMillan et al., 2009), or lead to reductions in violence (Koziol-McLain et al., 2010; MacMillan et al., 2009). A recent Cochrane systematic review concluded there was insufficient evidence to warrant IPV screening in health care settings (O'Doherty et al., 2015). Current practice guidelines conflict in terms of specific guidance to health care providers regarding universal screening (Wathen & MacMillan, 2012); World Health Organization recommendations (WHO, 2013; Feder et al., 2013), which include evidence from both screening trials and numerous systematic reviews, do not recommend universal screening, but suggest that all health care providers be prepared to ask women when they present with clinical signs and symptoms (see below) and provide first-line support when IPV is disclosed, including:
  - understanding, ideally through specific training, the issue of violence against women and the high prevalence of mental health conditions such as depression or post-traumatic stress disorder (PTSD) associated with IPV, and that evidence-based interventions exist for these conditions;

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<sup>1</sup> There is a lack of data regarding IPV interventions for men and gender diverse people.

- emphasizing confidentiality, but also its limits (for example, where there is mandatory reporting of children exposed to IPV); and ensuring privacy;
  - being non-judgmental, supportive and validating that it is not acceptable for anyone to experience violence; allowing women to “progress at their own therapeutic pace” (Feder et al., 2006);
  - assisting the woman to increase safety for herself and her children, where needed;
  - helping her access information about resources and provide or mobilize social support, or be able to refer her to someone who can do so;
  - ensuring, to the extent possible, that the response to an IPV does not result in harm, including avoiding attitudes and behaviors such as judging, pitying, blaming and trivializing, or pressuring women to disclose information, leave the relationship or pursue charges (Feder et al., 2006; 2013).
- Asking about IPV as part of initial assessment, and subsequently (as needed), in specific settings such as ante-natal care and mental health/substance abuse treatment settings is warranted.
  - Many studies have identified IPV indicators for use by health care providers in a process of case-finding or diagnostic assessment; these generally fall into three, sometimes overlapping, categories:
    - 1) signs and symptoms directly related to IPV exposure (e.g., injuries, depressive or post-traumatic stress symptoms, chronic pain);
    - 2) behavioural indicators or cues on the part of victim (e.g., repeatedly cancels visits, increased use of health services, defers to partner in visit) and/or indicators that suggest an abusive partner (always present, answers for partner, other controlling behaviour);
    - 3) evidence-based risk indicators (e.g., alcohol/drug misuse, financial strain, traditional gender norms).

#### *Interventions for IPV (health care and community-based services)*

- A number of systematic reviews (Wathen & MacMillan, 2003; Rivas et al., 2015; Nelson et al., 2012; Jahanfar et al., 2013; O’Doherty et al., 2015, Van Parys et al., 2014) have concluded that the evidence supporting specific interventions for abused women is generally lacking, especially interventions provided in health care settings, or those to which health care providers could refer women.
- There is emerging evidence regarding specific types of personal counseling, including ante-natal, to reduce IPV and improve outcomes such as safety planning (Tiwari et al., 2005; 2012; McFarlane et al., 2006; Kiely et al., 2010), however findings are mixed (Bair-Merritt et al., 2014; Van Parys et al., 2014) and do not extend to all outcomes (Tiwari et al., 2010) or all kinds of settings (Hegarty et al., 2013).
- Intensive advocacy may improve everyday life for women in domestic violence shelters/refuges in the short term and reduce physical abuse one to two years after the intervention. There is no clear evidence that intensive advocacy reduces sexual, emotional, or overall abuse, or that it benefits women’s mental health. It is unclear whether brief advocacy (mostly given in health care settings) is effective, although it may provide short-term mental health benefits and reduce abuse, particularly in pregnant women and those suffering less severe abuse (Rivas et al., 2015).
- Systematic reviews of treatment for men who use violence in relationships (“batterer” or “perpetrator” interventions) reveal small improvements associated with such approaches at best, and in some cases, small harmful effects (i.e., increased recidivism); they generally conclude the evidence to be mixed and inconclusive (Arias et al., 2013; Babcock et al., 2004; Feder & Wilson, 2005; Smedslund et al., 2011). Current evidence is generally weak, however therapies for perpetrators based on motivational interviewing approaches may be emerging as promising.
- The evidence for couple therapy is mixed and of varied quality, with RCT level evidence indicating little to no benefit overall (Bradley & Gottman, 2012; Brannen & Rubin, 1996; Dunford, 2000; Fals-Stewart et al., 2006, 2009; Stith et al., 2004). Most authors caution that these types of approaches are not safe for many abused women, particularly those experiencing coercive control.



- Permanent, but not temporary, civil protection orders may be effective in reducing future violence (Holt et al., 2002). These are older US data; Canadian data are required.
- While a vital service for women and children at risk, the effectiveness of shelter services in reducing violence and improving other outcomes for women remains understudied. The existing literature is characterized by methodological weaknesses (Wathen et al., 2014).
- There is emerging evidence regarding the importance of culturally safe and specific interventions, and trauma- (and violence) informed care (TVIC) more generally (Ponic et al., 2016).

### **Practice & Policy Implications of Current Best Evidence**

- Based on currently available evidence, health care providers and settings should:
  - Be alert to the signs and symptoms associated with intimate partner violence exposure and ask questions about abuse when these indicators are present (case finding, see above);
  - Develop and implement protocols to refer abused women, per their needs, to local services;
  - Ensure that women are asked about violence in sensitive, safe and appropriate ways that lead to discussion to determine their needs, safety concerns, etc.
- Education of health care providers and settings is urgently required in both key health and social service university and college-level programs as well as in continuing professional education modules for health care providers already in practice (WHO, 2013; Wathen et al., 2009).
- Those providing service to abused women should be aware of the significant mental health co-morbidities associated with current and past violence exposures.

### **What We Don't Know – Research Gaps**

- Research on the effectiveness of existing IPV services and new interventions is a priority (Wathen et al., 2012). It should take intersectional, gender and sex-based analytic approaches, and a lifespan perspective, as there is evidence that violence earlier in life is related to exposure and outcomes later on (Cook et al., 2011; 2013). The role of gender norms and beliefs is key, and men and women in intimate relationships use violence for different reasons and with different results (Bair-Merritt et al., 2010).
- Promising interventions include those based on advocacy models, including coordinated services, case management and “system navigation”. Two systematic reviews indicate promising evidence regarding IPV primary prevention initiatives for youth (DeKoker et al., 2014; Leen et al., 2013).
- Further research is required on treatment for those who commit abuse (mainly men), as well as couples’ therapy for specific types of IPV. Perpetrator programs should focus on reducing attrition through integration of factors related to non-completion (Olver et al., 2011). Primary prevention research should focus on known and modifiable abuse risk factors (Capaldi et al., 2012).
- Further research regarding identification of violence exposure in health care settings (including routine screening) should only be conducted when explicitly linked to a specific intervention or intervention(s), and this should form part of the evaluation.
- There remain large research gaps in understanding how best to address and ameliorate community-level factors related to IPV, especially outside of urban, developed areas (VanderEnde et al., 2012), and in all forms of IPV research in developing countries.

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