



INTERNATIONAL ASSOCIATION OF  
**Forensic Nurses**

*Leadership. Care. Expertise.*

Intimate  
Partner  
Violence  
**EDUCATION  
GUIDELINES**



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Intimate Partner Violence  
**EDUCATION GUIDELINES**

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## INTRODUCTION

In the United States, it is estimated that more than 1 in 3 women and more than 1 in 4 men have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime (Black, et al., 2011). Based on population surveys from 48 countries, the World Health Organization (WHO) describes women's rates of physical assaults at the hands of a male partner ranging from 10-69% (Krug, et al. 2002). The Centers for Disease Control and Prevention (CDC) states that IPV is a serious, preventable public health problem that affects millions of Americans (Saltzman, et al., 2002).

The Institute of Medicine (IOM) has called for professional healthcare organizations to develop guidelines that will better inform clinicians about violence and abuse (IOM, 2002). In August 2011, the US Department of Health and Human Services (DHHS) adopted guidelines for Women's Preventive Services that not only include screening and counseling for domestic violence, but also recommend that these screening and counseling practices be covered without cost in new health plans starting in August 2012. The guidelines were recommended by the independent Institute of Medicine (IOM) and based on scientific evidence ([www.hrsa.gov/womensguidelines](http://www.hrsa.gov/womensguidelines)). The recent draft recommendation of the US Preventive Services Task Force, while still open for comment, recommends that clinicians screen women of childbearing age for IPV, and provide or refer women who screen positive to intervention services (<http://www.uspreventiveservicestaskforce.org/draftrec2.htm>).

The health consequences of IPV have been well documented. The costs of intimate partner violence exceed \$5.8 billion each year, \$4.1 billion of which is for direct medical and mental health care services (CDC, 2003). The implications of IPV for pregnant women are profound and may include homicide, significant injuries and poor fetal outcomes (Chang, 2005; Fry, 2001, Coker, 2002). Women can be subjected to reproductive coercion which involves behaviors that a partner uses to maintain power and control in a relationship. This may include: forced sex, forced impregnation and interfering with birth control.

Internationally, IPV is often discussed within the context of *gender based violence (GBV)* (Krug, Mercy, Dahlberg, & Zwi, 2002). The United Nations Population Fund defines GBV as "a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices. Any one of these abuses can leave deep psychological scars, damage the health of women and girls in general, including their reproductive and sexual health, and in some instances, results in death." (<http://www.unfpa.org/gender/violence.htm>)

IAFN's purpose for developing educational guidelines for IPV is to help inform the educational needs of forensic nurses working with patients who are victims/survivors of intimate partner violence. IPV, as used in this document, encompasses a continuum of violent and abusive experiences in which multiple variations of harm, neglect, abuse, and violence occurs *between people in intimate relationships*. Such relationships are not limited to one age group, but span the gamut from teen dating violence to abuse by intimate partners in later life.

Many patients will present with a history of experiencing or witnessing violence, whether in childhood, as an adult, or both. Regardless of when said violence occurred, there are a wide range of health care sequelae that may impact the short- and long-term health status of patients. Understanding the connection between violence exposure and health is paramount (Felliti, et al., 1998; Campbell, et al, 2002; Coker, et al., 2002; Plichta, 2004; Danese, et al., 2009):

“*In the majority of settings... women who had ever experienced physical or sexual partner violence, or both, were significantly more likely to report poor or very poor health than women who had never experienced partner violence. Ever-abused women were also more likely to have had problems with: walking and carrying out daily activities, pain, memory loss, dizziness, and vaginal discharge in the 4 weeks prior to the interview. It is particularly noteworthy that recent experiences of ill-health were associated with lifetime experiences of violence. This suggests that the physical effects of violence may last long after the actual violence has ended, or that cumulative abuse affects health most strongly (WHO, 2005, p. 15).*

As the 2010 *National Intimate Partner and Sexual Violence Survey* clearly outlines, the wide range of sequelae from victimization is well-documented, and is not specific to female patients:

<b>Prevalence of Physical and Mental Health Outcomes Among Those With and Without a History of Rape or Stalking by any Perpetrator or Physical Violence by an Intimate Partner —U.S. Women, NISVS 2010</b>			
	Weighted %		
Health Outcome	History	No History <sup>1</sup>	p value <sup>2</sup>
Asthma	23.7	14.3	<.001
Irritable Bowel Syndrome	12.4	6.9	<.001
Diabetes	12.6	10.2	<.001
High Blood Pressure	27.3	27.5	n.s. <sup>3</sup>
Frequent Headaches	28.7	16.5	<.001
Chronic Pain	29.8	16.5	<.001
Difficulty Sleeping	37.7	21.0	<.001
Activity Limitations	35.0	19.7	<.001
Poor Physical Health	6.4	2.4	<.001
Poor Mental Health	3.4	1.1	<.001

<sup>1</sup>No history of rape, stalking, or intimate partner physical violence  
<sup>2</sup>p-value determined using chi-square test of independence in SUDANN™  
<sup>3</sup>Non-significant difference

(Black, et al., 2011)

**Prevalence of Physical and Mental Health Outcomes Among Those With and Without a History of Rape or Stalking by any Perpetrator or Physical Violence by an Intimate Partner —U.S. Men, NISVS 2010**

Health Outcome	Weighted %		p value <sup>2</sup>
	History	No History <sup>1</sup>	
Asthma	14.5	12.9	n.s. <sup>3</sup>
Irritable Bowel Syndrome	4.4	3.5	n.s. <sup>3</sup>
Diabetes	10.0	10.5	n.s. <sup>3</sup>
High Blood Pressure	30.1	29.3	n.s. <sup>3</sup>
Frequent Headaches	17.0	8.9	<.001
Chronic Pain	23.5	13.1	<.001
Difficulty Sleeping	33.0	18.4	<.001
Activity Limitations	29.7	17.9	<.001
Poor Physical Health	5.1	2.6	<.001
Poor Mental Health	2.7	1.2	<.01

<sup>1</sup>No history of rape, stalking, or intimate partner physical violence  
<sup>2</sup>p-value determined using chi-square test of independence in SUDANN™  
<sup>3</sup>Non-significant difference

(Black, et al., 2011)

While IPV is independently a serious health care issue, it may co-occur with other issues that concomitantly impact the health and well-being of patients, including human trafficking (both international and domestic), forced prostitution, and gang violence. Nurses must be aware that such factors can also be present, and seek to collaborate with community professionals who have expertise in these areas (Pan-American Health Organization, n.d.; Watts and Zimmerman, 2002; Schauer & Wheaton, 2006; Raphael & Ashley, 2008).

## DEFINING PATIENT POPULATIONS

The term “intimate partner violence,” also referred to as domestic violence, domestic abuse and gender based violence, describes physical, sexual, psychological/emotional, spiritual, and economic harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. It may be an intergenerational phenomenon that affects the patient who is abused, the offender, and members of the *extended* family and community.

The patient experiencing IPV, regardless of where she or he enters the healthcare system, is the primary focus of this document. However co-occurrence of intimate partner violence and child abuse is well-documented (Chan, 2011; Osofsky, 2003; Hartley, 2002; Edelson, 1999; Appel & Holden, 1998). For this reason, where the patient reports children in the home, the clinician must consider the potential impact on the child of witnessing IPV, or the possibility that child maltreatment may be occurring as well.

Much discussion occurs around terminology: is the correct term *patient*, *victim* or *survivor*? When describing the general healthcare encounter and the interaction between the individual seeking

care and the clinician, this document will use the term *patient*. However, clinicians should consider the broadest possible range of terms that may be used in any specific encounter as patients experiencing IPV often do not view themselves as victims.

Additionally, this document will use the term *assess* versus *screen* in relation to identifying patients affected by IPV, as the clinician is not expected to simply identify the presence or absence of IPV, but rather effectively address the health implications of the IPV through planning, evaluation, intervention, and follow-up.

## PURPOSE OF THE INTIMATE PARTNER VIOLENCE EDUCATION GUIDELINES

Nurses, regardless of specialty or geographic location, will encounter patients impacted by IPV. The primary goal of these educational guidelines is to identify didactic content and supplemental clinical experiences that will prepare forensic nurses to respond effectively to patients affected by IPV. The objective of these guidelines is to assist the practitioner in meeting the needs of patients, families, communities and systems while assuring that all patients experiencing IPV receive competent nursing care in the context of culture, age, sexuality, spirituality, socioeconomic status, and geography.

These guidelines are intended to select a standardized body of scientific knowledge for the medical/forensic evaluation of the patient experiencing IPV. Upon completion of this education, the forensic nurse should be able to:

1. Identify the forensic nurse's role in the response to IPV, including but not limited to:
  - Documentation (including photography)
  - Evidence collection
  - Legal proceedings
  - Collaboration with multidisciplinary partners (within and outside of the healthcare system)
2. Prepare forensic nurses to address IPV from a Trauma Informed Model of Care. (Harris and Fallot, 2001).
3. Educate healthcare professionals, collaborating partners and the public on the dynamics of IPV.
4. Explore nursing's role in participating in prevention efforts using models such as the Spectrum of Prevention to promote healthcare participation across a variety of settings. (Cohen & Swift, 1999).
5. Participate in IPV prevention efforts, as set forth by such agencies as the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), as well as by organizations and agencies at the local and regional levels.
6. Assess (screen) for IPV across age groups, populations and practice settings, including but not limited to:
  - Acute Care (Emergency Departments, Intensive Care Units, Inpatient floors, Labor and Delivery)
  - Primary Care (Pediatrics, Adolescents (including school based-health centers) Women's Health, Gerontology)
  - Community/Public Health settings

7. Provide supportive nursing care, including validation, recognition, assessment, intervention and referral to the IPV patient.
8. Provide culturally competent referrals for services to patients, their children and other family members as appropriate.

## DIDACTIC CONTENT-TARGET COMPETENCIES

The following content has been identified as an educational framework for the forensic nurse who works with patients who have experienced IPV. These target competencies outline the minimum level of instruction required. The competencies are grounded in the nursing process, ensuring that nurses from varied backgrounds are able to provide holistic and comprehensive care for this patient population. The nursing process assumes the following steps: 1.) Assessment; 2.) Diagnosis; 3.) Outcomes/Planning; 4.) Implementation; and 5.) Evaluation<sup>1</sup>.

- I. Forensic Nursing
- II. Dynamic of Intimate Partner Violence
- III. Medical/Forensic Evaluation and Nursing Management
- IV. Program/Operational Issues
- V. Multidisciplinary Collaboration
- VI. Legal System
- VII. Ethics
- VIII. Evaluation

### **I. Forensic Nursing**

These competencies describe the role of the forensic nurse. Forensic nursing is the practice of nursing globally where health and legal systems intersect.

- a. Describes the history of forensic nursing and the role of the International Association of Forensic Nurses in establishing scope and standards of forensic nursing practice.
- b. Describes the role of the forensic nurse in his/her organization.
- c. Identifies opportunities for enhancing care to forensic patients within his/her organization.
- d. Identifies nursing resources, locally and globally, that contribute to current and competent forensic nursing practice.

### **II. Dynamics of Intimate Partner Violence**

These competencies describe the dynamics of intimate partner violence, providing context for the care of patients experiencing IPV. The forensic nurse employs this knowledge to educate patients about the connection between violence and health, and to collaborate with patients in identifying appropriate community referrals.

- a. Defines intimate partner violence and abuse across the lifespan and describes some of the unique challenges for patients experiencing IPV within particular populations, including (but not limited to):
  - i. Teens
  - ii. GLBTIQ
  - iii. Elder

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<sup>1</sup> Please see the American Nurses' Association website for a detailed description of the Nursing Process steps: <http://www.nursingworld.org/EspeciallyForYou/What-is-Nursing/Tools-You-Need/Thenursingprocess.html>



- iv. Native/Aboriginal
- v. Immigrant/Migrant/Undocumented
- vi. Patients with disabilities
- vii. Rural populations
- b. Identifies and analyzes current scientific literature related to IPV, including:
  - i. Incidence and prevalence data - local, state, national and international
  - ii. Clinical indicators of IPV
  - iii. Associated short and long-term morbidity and mortality
  - iv. Barriers to service
    - a. Individual
    - b. Systems
  - v. Practice delivery models across healthcare settings
  - vi. Effective interventions
  - vii. Lethality, dangerousness and risk assessment
  - viii. Safety and discharge planning and appropriate referrals
  - ix. Co-occurrence of child maltreatment
  - x. Co-occurrence and spectrum of sexual violence and reproductive coercion in the context of IPV relationships

### **III. Medical/Forensic Evaluation and Nursing Management**

These competencies describe the role of the forensic nurse in caring for the patient experiencing IPV. The forensic nurse employs a patient-family centered care approach to providing comprehensive and holistic care.

- a. Uses culturally competent communication to assist patients in making decisions about the examination process (including collection of physical/biological evidence):
  - i. Patient self-determination/autonomy
  - ii. Informed consent
  - iii. Legal obligations/mandatory reporting
  - iv. Use of interpreters
- b. Identifies IPV across healthcare settings and patient populations
- c. Utilizes a trauma informed model of care<sup>2</sup> in order to minimize concerns about revictimization within the healthcare system
- d. Employs a process for comprehensive assessment, including (but not limited to):
  - i. Present health status, prior medical history, review of medications, recent hospitalizations, etc.
  - ii. Assessment of violence (acute and long-term)
  - iii. Physical assessment for trauma or signs of ill health.
  - iv. Present safety concerns and needs

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<sup>2</sup> Trauma-informed care is defined as: "...an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives". (National Center for Trauma-Informed Care: <http://www.samhsa.gov/nctic>)

- v. Safety of children/abuse of children/child witnessing (when applicable).
- vi. Dangerousness, lethality and/or risk assessment, depending on the type of tool used<sup>3</sup>
- e. Identifies physical/biological evidence collection needs and collects, packages and preserves the samples, as warranted.
- f. Analyzes the safety issues of the patient and works with the patient, and appropriate community partners to develop a safety plan
- g. Documents the care of the patient, using subjective and objective data, to provide a comprehensive clinical picture of the patient encounter
  - i. Acute history
  - ii. Long-term history
  - iii. Patient statements
  - iv. Assessment
    - 1. Injuries
    - 2. Health issues
    - 3. Written word
    - 4. Body maps/diagrams
    - 5. Danger assessment tool
    - 6. Strangulation tool
    - 7. Photography
- h. Identifies co-existing conditions that may impact both the clinical encounter and patient health outcomes
- i. Develops collaborative approaches with other professionals and community agencies, as appropriate, to address the full scope of the violence in the patient's life, including:
  - i. Child maltreatment
  - ii. Sexual assault
  - iii. Trafficking
  - iv. Gang violence

#### **IV. Program/Operational Issues**

These competencies describe the preparatory and structural aspects of providing care to the patient experiencing IPV, including those that are statutorily mandated and those specific to the individual organization or institution.

- a. Develop, appraise and regularly evaluate policies and procedures that guide care of the patient experiencing IPV
- b. Describe and demonstrate compliance with local and regional privacy regulations for all patients;
- c. Differentiate between potential confidentiality challenges and mandatory reporting laws, identifying solutions in consultation with organization risk management professionals.
- d. Develop and institute a consistent quality assurance/improvement process.

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<sup>3</sup> Dr. Jacqueline Campbell's Danger Assessment ([www.dangerassessment.org](http://www.dangerassessment.org)) is the recommended tool for healthcare providers. This instrument has undergone rigorous psychometric testing, has been found to be valid and reliable and is available in languages other than English, as well.

- e. Uses peer/case review as a tool for maintaining current and competent practice.
- f. Utilize an Evidence-Based Practice model of care.

## **V. Multidisciplinary Collaboration**

These competencies describe the necessary collaboration required for providing patient-family centered care to the patient experiencing IPV. The forensic nurse should continuously evaluate and strengthen collaborative relationships within the organization, as well as within the community to allow for a coordinated, patient-centered response to IPV. Although there may be professionals that are consistently represented in the coordinated response, such as victim advocates and law enforcement professionals, it is incumbent on every community to identify the full complement of appropriate resources for collaboration and consultation.

- a. Describes the role of the victim advocate and identifies differences between community-based and law enforcement (or prosecution)-based advocates.
- b. Identifies the various law enforcement agencies that may respond to patients experiencing IPV
- c. Describes parameters for involving law enforcement when caring for the patient.
- d. Compares the roles of criminal and civil attorneys in IPV cases.
- e. Outlines patient encounters that would require consulting child or adult protection professionals.
- f. Identifies other professionals who may enhance the response to IPV patients.
- g. Analyzes model team approaches to IPV, including:
  - i. Coordinated Community Response (CCR) teams;
  - ii. Family Justice Centers (FJC);
  - iii. Domestic Violence Response Teams.

## **VI. Legal System**

These competencies describe the fundamental understanding a forensic nurse should have of the criminal justice system response in IPV and how the forensic nursing role interfaces with this system.

- a. Describes the components of the criminal justice system, and the process by which a case moves through the system.
- b. Differentiates civil remedies for IPV patients, such as orders of protection, from criminal remedies.
- c. Identifies ways in which immigration status can be used as a mechanism for control in IPV situations.
- d. Recognizes potential community collaborators to assist patients facing immigration-related challenges.
- e. Constructs a foundation for the provision of evidence-based, ethical and effective testimony.

## **VII. Ethics**

These competencies describe the ethical foundation for forensic nursing practice. Because the forensic nurse integrates many aspects of nursing science into his/her practice, it is critical to consider multiple perspectives in creating a foundation for ethical practice.

- a. Describes relevant sources on ethical nursing practice, including the ANA Code of Ethics, IAFN's Vision for Ethical Practice, and ICN's Code of Ethics for Nurses.<sup>4</sup>
- b. Identifies ethical challenges that may arise in caring for the IPV patient.
- c. Engage professionals that can assist with patient decisions and process (i.e. ethicist, risk management, clergy).

## CLINICAL CONTENT-TARGET COMPETENCIES

Clinical preceptorships are an integral part of the learning process that allow for application of didactic content and skill development in a mentoring environment. Preceptorships should be with professionals that are viewed as experts in the field, ideally nurses, who can model the role of the forensic nurse with patients experiencing IPV, as well as help build competency.<sup>5</sup> Case review, peer review, education, supervision and mentoring are essential to prepare and move the clinical skills of the nurse from novice to expert.

Preceptorships may include opportunities outside the healthcare arena, so as to better understand the role of collaborating professionals and the resources available to patients (e.g. Shelters, Batterer education programs, Attorney General's Office, local police).

### **I. Demonstrates a complete medical-forensic evaluation.**

- a. Performs a comprehensive patient evaluation.
- b. Takes a focused history of the events (what happened, when did this happen, where, etc.)
- c. Identifies and interprets exam findings, including:
  - i. Injury/trauma
  - ii. Normal variants
  - iii. Disease processes
  - iv. Mechanisms of injury
- d. Formulates a differential diagnosis based on the history and exam findings.
- e. Collects, handles and packages physical evidence, as warranted.
- f. Completes photo documentation of injuries.
  - i. Demonstrates use of the camera.
  - ii. Describes appropriate image composition and use of scale.
  - iii. Photographs remarkable findings, resulting in clear images.
  - iv. Stores images securely, in accordance with organization policy and privacy regulations.
- g. Completes written documentation of the patient encounter, including body maps/diagrams.

### **II. Demonstrates comprehensive psychosocial assessment for all patients, including:**

- Crisis intervention
- Lethality/danger assessments
- Safety and discharge planning, including referrals and follow-up recommendations

<sup>4</sup> [http://www.icn.ch/images/stories/documents/about/icncode\\_english.pdf](http://www.icn.ch/images/stories/documents/about/icncode_english.pdf); also available in French, German, Spanish, Slovakian, Swedish, Dutch, Polish, Japanese, Russian, Italian and Norwegian at <http://www.icn.ch/about-icn/code-of-ethics-for-nurses/>

<sup>5</sup> Competency is determined by the professional assessing the required clinical skills.

# RECOMMENDATIONS FOR TRAINERS/CORE FACULTY MEMBERS

It is highly recommended that core faculty members include registered nurses who:

1. Have completed IPV-specific coursework;
2. Currently practice in an arena where they care for patients affected by IPV;
3. Attend and/or provide routine continuing education for maintained currency of knowledge; and
4. Actively collaborate with multidisciplinary representatives.

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## ADDITIONAL PUBLICATIONS

- Assessment Instruments for Use in Healthcare Settings* (2007). Centers for Disease Control and Prevention, National Center for Injury Prevention and Control: [http://www.cdc.gov/ncipc/pub-res/ipv\\_and\\_sv\\_screening.htm](http://www.cdc.gov/ncipc/pub-res/ipv_and_sv_screening.htm)
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- Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender and Queer Victims of Hate Violence and Intimate Partner Violence* (2010). The National Center for Victims of Crime and the National Coalition of Anti-Violence Programs: <http://www.ncvc.org/ncvc/AGP.Net/Components/documentViewer/Download.aspxnz?DocumentID=47632>

## WEB RESOURCES

### North America:

- Compendium of State Statutes and Policies on Domestic Violence and Health Care<sup>6</sup>:  
<http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf>
- Language Line Interpreter Services:  
[http://www.language.com/page/interp\\_prods/](http://www.language.com/page/interp_prods/)
- National Aboriginal Circle Against Family Violence (Canada):  
<http://nacafv.ca/en/mandate>
- National Clearinghouse on Family Violence Canada:  
<http://www.phac-aspc.gc.ca/ncfv-cnivf/index-eng.php>
- National Coalition Against Domestic Violence State Coalition Listing:  
<http://www.ncadv.org/resources/StateCoalitionList.php>
- National Dating Abuse Helpline (US):  
<http://www.loveisrespect.org/about-national-dating-abuse-helpline>
- National Domestic Violence Hotline (US):  
<http://www.thehotline.org/>

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<sup>6</sup> Clinicians may contact AEquitas, which maintains current statutes regarding IPV reporting. However, they should consult with legal counsel for an interpretation of those statutes.

National Network to End Domestic Violence:

<http://www.nnedv.org>

National Sexual Violence Resource Center (US):

<http://www.nsvrc.org>

Shelternet.ca (Canada):

<http://www.shelternet.ca/splashPage.htm>

The Provider's Guide to Quality and Culture

<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English&ggrou>  
[up=&mgroup=](http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English&ggrou)

### **International:**

1800RESPECT: National Sexual Assault, Domestic Family Violence Counseling Service  
(Australia):

<http://www.1800respect.org.au/>

Americans Overseas Domestic Violence Crisis Center:

<http://www.866uswomen.org/>

Hot Peach Pages (International Directory of Domestic Violence Agencies):

<http://www.hotpeachpages.net/>

International Rescue Committee:

<http://www.rescue.org/>

Women's Aid (United Kingdom):

<http://www.womensaid.org.uk/>



# NOTES



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