Guidance for Domestic Violence and Sexual Assault Advocates Working in a Medical Setting

Domestic violence (DV) and sexual assault (SA) advocates may be familiar with trauma-informed care, but often find it challenging to implement supportive, effective and survivor-defined services when working in a medical setting. The pressure and pace of a medical setting may not fully allow for trauma-informed DV/SA advocacy strategies. Whenever possible, trauma-informed practices should be implemented as standard practice, which may require strategic planning with medical setting leadership in advance; other issues need to be addressed in the moment at the point of care.

The following points offer guidance in key areas in which advocates can provide the best possible trauma-informed care to DV and SA victims and survivors who are patients in a medical setting.

PATIENT SAFETY AND EXPERIENCE

CHALLENGE A: Physical safety – Many medical settings, such as hospitals and clinics, are open campuses. Abusive partners and others may come to "visit" or even seek care in an effort to gather information, locate, intimidate, and/or harm survivors.

- **STRATEGY 1 –** Work with medical staff (especially Emergency Department staff) to identify safe waiting areas and to establish protocols for placing survivors in private treatment rooms immediately or as soon as a potential threat is identified.
- **STRATEGY 2 –** Recommend best practices for screening and talking with survivors about domestic violence, sexual assault and abuse in private.[i] Suggest ways to separate survivors from companions during assessment and intervention that won't arouse suspicion in a partner or others (e.g., arranging to go for an X-Ray or urine test).
- **STRATEGY 3 –** Help with safety planning, including safety in the medical setting itself (e.g., ask each survivor if the abusive partner is in the waiting area).

- **STRATEGY 4 –** Offer appropriate referrals and resources. Provide safe print materials and/or offer to write things out for survivors. Be accommodating of survivors with low literacy levels or communication challenges. Include resources that are culturally responsive to underserved and marginalized communities. Signal your ability to assist survivors who face racism, homophobia, transphobia, ableism, ageism and other forms of discrimination.
- **STRATEGY 5 –** Arrange safe follow-up contact with each survivor.
- **STRATEGY 6 –** Suggest measures to flag or remove a survivor's name from the facility census or tracking board if the survivor requests this, so that visitors and callers can be restricted.

CHALLENGE B: Emotional safety – Many aspects of health care services can be experienced as retraumatizing to survivors, including screening and assessment, clinical exams and procedures, and the health care environment itself.

- **STRATEGY 1 –** It helps survivors if they are fully informed about who the advocate is. Introduce yourself and your role, including your hospital, clinic or agency affiliation.
- **STRATEGY 2 –** Help survivors feel more grounded and supported if the abuse, medical setting, or staff interactions produce a trauma response. Be aware of body language. Make an effort to be on the person's eye level when speaking together. Be compassionate and supportive in message and tone. Be honest and transparent. Offer perspective on the differences in focus for medical staff (diagnosis and treatment of medical conditions) and advocates (providing emotional support, assisting with safety planning and resources).
- **STRATEGY 3 –** Suggest ways to optimize safety, comfort, and privacy. Promote practices that help those who may be feeling overwhelmed or dissociating (e.g., provide a "grounding kit" with comforting items, tactile toys or items to squeeze or hold, or coloring books).
- **STRATEGY 4 –** Help staff incorporate trauma-informed practices that are appropriate to their roles in the medical setting. Offer training, consultation, and resources for staff to better understand various trauma responses. Recommend strategies for calming, focusing or connecting with those who present as distressed, withdrawn, anxious or angry. Promote trauma-informed practice training for Security Officers.
- **STRATEGY 5 –** Define duties. Promote advocacy involvement as a measure to relieve medical staff of the sole responsibility for supporting patients who are dealing with complex situations and feelings.

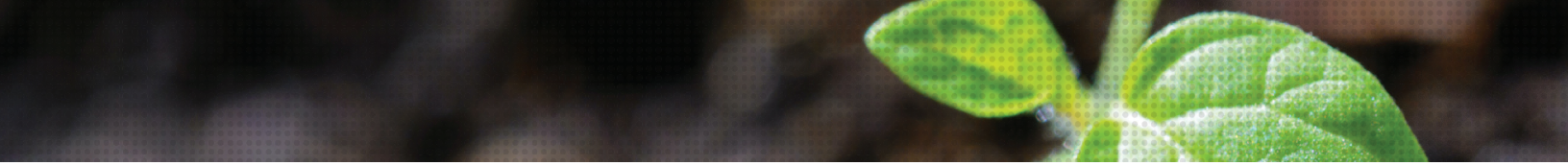
CONFIDENTIALITY

CHALLENGE A: Despite HIPAA regulations, medical staff may not adequately protect patient confidentiality and share information with family members or friends who are assumed to be supportive, law enforcement officers, or others with whom they think they should provide information.

- **STRATEGY 1 –** Clarify issues of confidentiality and mandated reporting with medical setting leadership.[ii] (Seek specific guidance for Maryland from the Maryland Health Care Coalition Against Domestic Violence.[iii]) Advocates can offer expertise in helping to update relevant policies, referencing VAWA standards and state law.[iv]
- **STRATEGY 2 –** Suggest ways that the medical staff can best protect the survivor's confidentiality. Introduce VAWA-compliant "Release of Information" forms.[v] Recommend protocols for protecting survivors from callers and visitors who may compromise safety or information. Recommend precautions to protect patient information from abusive partners who may try to gain access to patient medical records.

CHALLENGE B: Medical staff may not be clear about what they can and cannot share with advocates — and may not understand why advocates will not discuss certain information with them.

- **STRATEGY 1 –** Be clear about limits of information sharing with medical staff before talking to survivors.
- **STRATEGY 2 –** Advocates should protect the confidentiality of each survivor's information. Have release and waiver forms available for patients to sign that plainly explain confidentiality limits.



PATIENTS' ACCESS TO ADVOCATES

CHALLENGE A: Survivors may not be offered the appropriate opportunity to meet with an advocate. Some medical settings:

- Do not allow survivors time for private discussions with advocates, OR
- Do not call the advocate until right before discharge. If survivors have had lengthy and tiring Emergency Department visits, they may not be willing to stay longer to speak with an advocate.

- **STRATEGY 1 –** Advocate for adequate time to spend with survivors. Enlist support from hospital champions, local service providers and other community partners to devise protocols that ensure appropriate time for intervention.
- **STRATEGY 2 –** Work with medical staff to make the best use of downtime (e.g., when patient is waiting for treatment or test results).
- **STRATEGY 3 –** Encourage a policy of medical staff calling for the advocate as soon as DV or SA is identified, so that providers and advocates can plan for the best time for advocacy intervention to occur.

CHALLENGE B: Advocates from outside DV/SA agencies may not have the ability to move within the medical setting as their presence is questioned by staff and patients.

- **STRATEGY 1 –** Ask the medical setting facility to issue ID badges or other items that will be recognizable to staff and patients. Use discreet terms on badges, such as "Patient Advocate" rather than "Domestic Violence Advocate," and avoid listing the advocate's full name for safety reasons.
- **STRATEGY 2 –** Work with medical setting leadership towards establishing a Memorandum of Understanding (MOU) formal agreement that clarifies advocates' responsibilities and access to survivors.[vi]

CHALLENGE C: It may not be clear which, if any, records can be viewed and recorded by the advocate.

- **STRATEGY 1 –** Establish clear policies and protocols related to medical records accessed by advocates. Hospital-based and other medical setting DV/SA advocates have the advantage of being able to access and document in the patient's medical record. Outside agencies should establish parameters regarding what information they can collect and contribute.
- **STRATEGY 2 –** Advocate for the ability to include notes in the medical record. Utilize and encourage others to use documentation that is objective, does not use pejorative or judgmental language (e.g., "Patient states" is preferrable to "Victim claims or alleges"), does not include accusatory victim-blaming details, and does not record the specifics of a safety plan.

HEALTH CARE PROVIDER PERSPECTIVES

CHALLENGE A: Medical staff who may not feel competent or comfortable in providing care to DV or SA survivors or providers who do not understand the impact of psychological trauma may become frustrated working with DV or SA patients.

- **STRATEGY 1 –** Model a trauma-informed, person-centered approach for others.
- **STRATEGY 2 –** Understand that medical staff may have experienced trauma themselves. Use professional but trauma-informed and compassionate communication in dealing with staff.
- **STRATEGY 3 –** Seek out opportunities to provide training for medical staff to broaden the understanding of dynamics of abuse, barriers to leaving, impacts of past and/or complex trauma on an individual's experience, helpful responses to various trauma responses and other topics.
- **STRATEGY 4 –** Provide medical staff with training and support in working to mitigate the effects of discrimination and oppression on all patients. Work with medical staff to better understand an individual's experience of abuse through the lens of intersectionality, acknowledging that facing racism, poverty, ableism, ageism, homophobia, transphobia and other forms of oppression affect a person's experience of trauma and access to assistance.

CHALLENGE B: Medical staff may be suspicious or dismissive of advocates.

- **STRATEGY 1 –** Establish regular channels of communication with leadership. Be professional, direct and approachable. Providing helpful and effective services is the best way to be seen as an important part of the team.
- **STRATEGY 2 –** When possible, educate medical setting staff (such as social workers, chaplains, and care managers) who might also be helpful, to be sure that they are knowledgeable about DV/SA services that advocates provide.
- **STRATEGY 3 –** When disagreements with medical staff occur, it is usually best that advocates ask to speak to the staff member separately from survivors and, if needed, bring issues back to leadership at a later time. Advocates should be direct and supportive, being careful not to adversely affect the patient/provider relationship or proper patient care.

PRIMACY OF MEDICAL NEEDS

CHALLENGE A: Addressing medical needs is the top priority in medical settings. It can be challenging for advocates to have a discussion with survivors who may have acute medical needs (such as pain or injury) or to ensure that the advocates are not in the way of medical staff.

- **STRATEGY 1 –** Defer to medical staff attending to medical issues, while advocating for the importance of emotional support, safety planning and resource linkage.
- **STRATEGY 2 –** Advocates should plan to provide follow-up contact when each survivor will have more time and attention to focus.

Survivors of abuse who seek health care are best served when advocates and medical staff work together to meet their needs. Hospital-based advocates and advocates from DV/SA agencies can employ many strategies to address challenges to patient-centered care in the health care setting. Additionally, advocates can work to foster solid relationships with health care professionals and medical staff by encouraging regular meetings to discuss DV/SA services and collaborative participation in DV/SA service councils, workgroups and community initiatives that benefit survivors and raise awareness.

List of References

[i] De Boinville, M. (2013). Policy Brief: Screening for Domestic Violence in Health Care Settings. Office of the Assistant Secretary for Planning and Evaluation. [PDF file]. Retrieved September 27, 2021 from https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//44281/pb_screeningDomestic.pdf

[ii] Futures Without Violence. (2019). Compendium of State and U.S. Territory Statutes and Policies on Domestic Violence and Health Care. [PDF file]. Retrieved September 27, 2021 from https://store.futureswithoutviolence.org/index.php/product/us-state-and-territory-compendium/

[iii] Maryland Health Care Coalition Against Domestic Violence. (2018). Confidentiality and Mandated Reporting Requirements in Maryland. [PDF file]. Retrieved from https://secureservercdn.net/50.62.174.113/f7m.2d8.myftpupload.com/wp-content/uploads/2019/06/ConfidentalityReporting.pdf

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[v] Network to End Domestic Violence. Confidentiality Templates: Templates for Agencies Working With Survivors. Retrieved September 27, 2021 from https://www.techsafety.org/confidentiality-templates

[vi] IPV Health of Futures Without Violence. (2021). Sample Memorandum of Understanding. [PDF file]. Retrieved September 27, 2021 from https://ipvhealth.org/wp-content/uploads/2021/07/MOU-Template-Final-2021.pdf