

Screening for GBV in formal and informal settings:

Where are we and where are we going?

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Overview

Within the last 20 years, gender-based violence (GBV) has gained increased attention globally. GBV is defined as types of violence that primarily women/girls experience, including physical violence (e.g., hitting, punching, kicked, slapped, choked, hurt with a weapon, or otherwise physically hurt), sexual violence (e.g. unprotected forced sex, coercive behaviors, including sexual slavery and coerced abortion), and psychological harm (e.g. controlling behaviors, stalking, threats of violence). These acts of violence are perpetrated by members of women/girl's family, acquaintances, and/or strangers in the home, community and/or during armed conflict. Globally, an estimated 35% of women experience physical and/or sexual

violence in their lifetime, including partner and non-partner violence.(Bott, Guedes, Goodwin, & Mendoza, 2012; WHO, 2013) Refugees fleeing conflicts and natural disasters are vulnerable to sexual violence; a recent systematic review and meta-analysis generated a pooled estimate of 21.4% (95%CI: 14.9 – 29.7%) sexual violence prevalence based on 19 studies meeting eligibility criteria and totaling 8,398 participants.(Vu et al., 2013) Global efforts often focus on GBV in recognition of the range of likely perpetrators; within the US, intimate partners are the dominant perpetrators of GBV,(Black, 2011) hence the domestic focus on IPV. Nationally an estimated one in three women experience IPV, i.e., physical or sexual violence by a current or former spouse or boyfriend, with youth and young adult women at highest risk. (Black, 2011) Gender differences persist in the nature and impact of IPV. Nationally, physical IPV prevalence is comparable for women (33%) and men (28%);(Black, 2011) however, women experience significantly more sexual IPV (9% vs. too small to report among men),(Black, 2011) more IPV with resulting fear, injury, or other health or social issues (29% vs. 10%),(Black, 2011) and IPV homicide.(Cooper & Smith, 2011; Stockl et al., 2013) There is substantial evidence indicating under-reporting of GBV both globally(Tia Palermo, Bleck, & Peterman, 2013) as well as in diverse humanitarian settings where women and girls can be particularly vulnerable.(T. Palermo & Peterman, 2011; Wirtz et al., 2013) To date, prevention and response efforts continue to be insufficient to make a significant difference in the lives of survivors and their families.

Why Screen for GBV?

Currently, the identification and care of survivors of GBV is reliant on women/girls coming forward with self-reports to health or service providers, or authorities, such as police. Significant barriers to disclosing GBV exist, including fear, stigma and discrimination, lack of recognition of abuse, lack of knowledge of, or confidence in, existing health and social services, and lack of awareness of the negative health outcomes associated with GBV. (Dienemann, Campbell, Wiederhorn, Laughon, & Jordan, 2003; Dutton, 2004; Hardesty & Campbell, 2004; Kalof, 2000;

Koss, Dinero, Seibel, Cox, & Cox, 1988) In turn, the low uptake of services for GBV coupled with limited prevention efforts likely maintains the status quo of impunity for perpetrators.

Because relying on survivors to self-identify and come forward with their needs will miss the vast majority of them, the burden for identifying and supporting survivors shifts to health and social support sectors to reach potential survivors with support and safety planning messages. Screening in the health care sector has been one of the primary means of identifying survivors for a variety of reasons. The health consequences of GBV are far-reaching, including physical, sexual and mental health as well as homicide.(J. C. Campbell, 2002; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Stockl et al., 2013) (Decker, Silverman, & Raj, 2005; Seth, Raiford, Robinson, Wingood, & Diclemente, 2010; Silverman, Decker, Saggurti, Balaiah, & Raj, 2008; Wingood, DiClemente, McCree, Harrington, & Davies, 2001; Wu, El-Bassel, Witte, Gilbert, & Chang, 2003) (Allsworth, Anand, Redding, & Peipert, 2009; J. E. Hathaway et al., 2000; Jewkes, Dunkle, Nduna, & Shai, 2010; Kouyoumdjian et al., 2013; Weiss et al., 2008) Moreover, abused women are more likely than non-abused women to seek certain forms of health services,(Decker et al., 2005; J. E. Hathaway et al., 2000; Nasrullah, Oraka, Breiding, & Chavez, 2013) making the health sector an ideal setting to identify and support survivors. In more recent years, screening efforts have begun in informal settings, beyond the formal health sector.

Policy Context

The recommendation to include IPV screening in health care as routine practice is not new,("ACOG Committee Opinion No. 518: Intimate partner violence," 2012; Lee, James, & Sawires, 1999; "Physicians and domestic violence. Ethical considerations. Council on Ethical and Judicial Affairs, American Medical Association," 1992; "Position statement on physical violence against women," 1992; "Screening Tools- Domestic Violence," 2013) The Institute of

Medicine recommended in 2011 to include screening and counseling for all women and adolescent girls for interpersonal and domestic violence as part of clinical preventive services for women.(Medicine, 2011),(Gee et al., 2011) The U.S. Department of Health and Human Services then included screening and counseling for domestic violence in the “Women’s Preventive Services Guidelines,” (“Coverage of certain preventive services under the Affordable Care Act. Final rules,” 2013) and in 2013 the US Preventive Services Task Force (USPTF) recommended health screening for IPV for all women of child-bearing age and provision of, or referral to, intervention services for women who screen positive.(Moyer, 2013) Thus, IPV screening and brief counseling for women are now part of required free preventive services endorsed and expected within the Affordable Care Act. This dramatic change in U.S. health policy offers an opportunity to examine the current evidence on screening and counseling for IPV as ‘prevention’ and identify areas for research on the implementation of these screening and counseling recommendations. In 2013, the US Department of Health and Human Services hosted a Symposium on IPV screening and counseling research to guide effective practices based on the robust evidence available to date, with recommendations including trauma-informed care, integration of screening within clinical practice, and harnessing electronic medical records to enable provider consistency in screening.

Significant findings on this topic

A paradigm shift on screening for GBV

“Screening” in public health refers to the use of a test, examination, or other procedure that is rapidly applied in an asymptomatic population to identify individuals with early disease. While the idea is to identify “asymptomatic” and “early” disease to prevent morbidity and mortality, for IPV -- a stigmatized and under-recognized social problem, those who have been or are victims of IPV may not be truly “asymptomatic” when they present to the health care setting. In fact, the health impact may already be quite advanced. Thus, “screening” in the traditional sense is not

consistent with what actually transpires in the clinical encounter. When risk or exposure to past or current IPV is assessed through “screening,” the impact can be primary prevention for patients with no history or suspicion of exposure, secondary prevention for patients with past exposure, or tertiary prevention for patients with current or acute exposure.(Caralis & Musialowski, 1997; Gerbert et al., 1996; McCauley, Yurk, Jenckes, & Ford, 1998; M. Rodriguez, Quiroga, & Bauer, 1996)

What happens in practice?

Assessment for past or current IPV can occur through direct questioning as part of a routine health survey (patient or provider-delivered), or through pattern recognition when signs and symptoms in the history and physical exam alert the clinician to explore possibility of IPV. IPV may be identified in the clinical setting because either the patient or third party discloses IPV (such as police or EMS personnel) or because the health professional inquires about past or current exposure. Even when IPV is clinically suspected, patients may not disclose that IPV is a problem. Additional factors such as patient safety, privacy, legal issues (including mandatory reporting in some instances), and the impact of interventions on victims, perpetrators and children are all part of the complex context of screening and counseling interventions.

Does screening work?

Research indicates that screening and counseling for IPV can identify survivors, and in some cases increase safety, reduce abuse, and improve clinical and social outcomes.(Bair-Merritt et al., 2014; Chang et al., 2003; McCloskey et al., 2006; McFarlane, Soeken, & Wiist, 2000; Miller et al., 2011; Rhodes & Levinson, 2003; M. Rodriguez et al., 1996; M. A. Rodriguez, Bauer, McLoughlin, & Grumbach, 1999; Taft et al., 2013) Recent trials confirm limited benefit of IPV screening in the absence of systematic *intervention*.(MacMillan et al., 2009) Possible harms or unintended consequences of clinical assessment have been raised and considered in research

trials, but thus far no evidence of such harm has emerged.(Houry et al., 2008; MacMillan et al., 2006)

The value of screening without disclosure: screening as an opportunity to provide support and information to survivors who may not yet be ready to disclose.

Given the documented barriers (e.g. fear of partner, lack of trust and confidence in the formal systems) to patient disclosure of GBV,(Dienemann et al., 2003; Dutton, 2004; Hardesty & Campbell, 2004) recommendations for health sector screening increasingly emphasize the use of screening as an opportunity to provide information and support to all female patients rather than focusing on disclosure.(American College of & Gynecologists, 2013) That is, screening is recognized as an awareness/educational opportunity that normalizes and contextualizes the health setting as a safe place to discuss GBV and its consequences and to be connected to support services within the facility or larger community. The process of recognizing coercive behaviors as GBV is complex; e.g., women often do not define sexual assault experiences meeting the definition of rape as rape,(Kalof, 2000; Koss et al., 1988) particularly when their perpetrator is known.(Koss et al., 1988) In turn, screening efforts increasingly seek to provide universal education about what constitutes GBV, particularly elements of coercion and control that survivors may have difficulty recognizing as abusive.

Meeting the Health and Safety Needs of Survivors

Survivors face complex, dangerous, and difficult safety decisions.(J. C. Campbell & Glass, 2009; J. C. Campbell, Sharps, P., Glass, N. E., 2001) The cornerstone for interventions to reduce exposure to GBV is safety planning, a dialogic process that supports women/girl's decision-making. Safety planning should be individualized, with attention to women's priorities for safety decisions, plans (e.g., leaving or remaining in the abusive intimate relationship), available resources, and the dangerousness of the relationship or situation, using evidence-

based risk assessment of the likelihood of severe and/or lethal violence.(J. C. Campbell & Glass, 2009) Safety planning is typically accessed from formal services such as crisis services, advocacy (in health, social service and legal settings), support groups, and individual counseling.(Macy, Nurius, Kernic, & Holt, 2005) However, survivors are often unaware of IPV resources, how to find them, or what services they offer,(L. Westbrook, 2009) and the majority do not access formal services, representing missed opportunities to prevent and respond to ongoing exposure to GBV and its negative health consequences.(Ansara & Hindin, 2010; Coker, Derrick, Lumpkin, Aldrich, & Oldendick, 2000; Shannon, Logan, & Cole, 2006) Screening represents an opportunity to begin the safety planning process for women, either through connection with formal services, or by initiating safety planning through other means.

Discoveries & Innovations

Screening paired with brief intervention

GBV screening paired with brief intervention demonstrates success in improving health and reducing coercion. For example, a universal education and brief counseling intervention for female clients seeking care in family planning (FP) clinics incorporates an introduction to local advocates as part of the clinician and staff training at each clinical site. The intervention evaluation followed women for 4 months and identified a 71% reduction in pregnancy pressure (a key element of reproductive coercion) among women experiencing recent IPV. Moreover, women receiving the intervention were also 60% more likely to end a relationship because it felt unhealthy or unsafe.(Miller et al., 2011) The intervention provides universal assessment for all female FP clients about IPV and reproductive coercion that provides both screening and education, discussion of harm reduction strategies to reduce risk for unintended pregnancy and IPV, and lets women know the clinic can help make referrals to IPV support services (supported referrals). All women are offered a safety card (or several to share with their friends) with information about harm reduction strategies and national hotline numbers. During intervention

training, providers meet with designated advocates from local support services to enhance the referral system. Finally, the emphasis on harm reduction and connection of FP clinics with IPV services underscores that the FP clinic is a safe place for all women to seek care for unhealthy relationships. Patients who disclose abuse can receive immediate support. As each site is introduced to their local domestic and sexual violence advocates through formal and informal staff meetings, clinician comfort appears to increase related to implementing this IPV assessment. Further study is needed to identify best practices to scale these kinds of cross-sector partnerships.

Harnessing eHealth to support GBV screening, risk assessment & safety planning

The past decade has seen an explosion of information and communication technology (ICT) applications that aim to improve health and well-being. In 2005 the World Health Assembly adopted an eHealth resolution calling on countries to use eHealth solutions to address their health needs. They defined eHealth as the “cost-effective and secure use of information and communications technologies in support of health and health-related fields, including health-care services, health surveillance, health literature, and health education, knowledge and research.”(558th World Health Assembly., 2006) Opportunities exist within resource rich and limited settings to integrate eHealth initiatives for improved identification, assessment and safety planning with survivors. For example, given the new requirements in the ACA that GBV screening and brief counseling is a component of preventative care – clinicians needs efficient tools for implementation. For example, validated screening questions can be integrated into the electronic medical records that will trigger providers to ask the questions to all patients as the protocol directs for the setting. Further, clinical decision aids can support informed decision-making by patients related to safety once screened positive for GBV.(Stacey et al., 2014) They provide information and help patients clarify personal values, and are intended to complement (not replace) professional services.(Ottawa Hospital Research Institute, 2013)

One innovative approach in meeting the needs of survivors who lack access to formal services is the creation of a safety decision aid (SDA) for IPV survivors, that can be adapted for survivors of other forms of GBV including with survivors in low-resource settings, based on existing evidence in violence prevention and decisional conflict research. The safety decision aid is individualized and helps abused women understand their risk of repeat and near-lethal violence, set safety priorities and plan for safety. (Glass, Eden, Bloom, & Perrin, 2010) IPV survivors in shelters (N=90) who tested the SDA via laptop had significantly reduced decisional conflict after just one use. (Glass et al., 2010) eHealth interventions such as the SDA hold promise in meeting the needs of survivors; although abused women are commonly isolated by their partners, many have safe Internet access and actively search for IPV help and information online. (L. Westbrook, 2008) The individualized internet-based SDA reduced conflict significantly for abused women, with greater reduction in overall decisional conflict compared to the control group who accessed usual safety planning information online. These findings support the underlying premise that providing usual safety planning information (emergency safety plans, phone numbers and websites) is not as useful at reducing decisional conflict about safety for IPV survivors as providing a personalized safety plan based on her own assessment of safety priorities and level of danger in the relationship, as well as relationship characteristics and previous protective actions. Just one session using an Internet based safety decision aid was effective at reducing decision conflict and thereby supporting the decision-making process of IPV survivors, with no adverse events. This represents an important and promising innovation to connect abused women – who most often do not access safety planning through formal services -- with the information and resources they need to assess their level of danger, establish priorities, and develop a safety plan tailored to their needs. While facility based GBV screening is best done in an environment that enables immediate access to established support services, tremendous GBV support needs exist in resource-poor settings where health and social program infrastructure is frequently absent; thus, innovation is needed in safety planning

post-screening for survivors. Implementing eHealth technology through a SDA application (App) can increase survivors access to survivor centered health and safety messages with an individualized safety plan for self and family when leaving or remaining in the home or setting.

Translation of research into practice

In 2009, Futures Without Violence, a national non-profit organization dedicated to ending violence against women and children, was funded by the federal Office on Women's Health (OWH) to launch *Project Connect: A Coordinated Public Health Initiative to Prevent Violence Against Women* to provide technical assistance to selected states as part of the Violence Against Women's Act health title funds. *Project Connect* involves developing, implementing and evaluating new ways to identify, respond to and prevent domestic and sexual violence, and promote a coordinated public health response to GBV. Funds in the initial phases of the project were directed to geographically and ethnically diverse sites to create comprehensive models of public health prevention and intervention to improve health and safety for women and children. Each *Project Connect* site identified family planning, adolescent health, home visitation, or other maternal child health or perinatal programs to develop policy and public health responses to domestic and sexual violence, with an emphasis on training health care providers in these settings to implement screening and brief counseling interventions described above. *Project Connect* sites also worked to provide basic health and reproductive health services in domestic and sexual violence programs. Coordinated state-level teams of public health and domestic and sexual violence partners were formed, with the goal of creating sustained policy changes and coordinated responses for victims. Examples of policy changes included adding assessment of domestic and sexual violence into statewide nursing guidelines and clinical assessment forms, requiring training on reproductive coercion in state-funded teen pregnancy prevention programs, and improving data collection by adding new questions about domestic and sexual violence to statewide surveillance systems.

A major emphasis of *Project Connect*, now in the second round of funding (grantees are six states and five Native communities), has been on the development of coordinated state-level Leadership Teams (LTs) which include representatives from public health programs and domestic violence and sexual assault coalitions for each of the sites involved to ensure implementation of best practices. These teams are expected to guide the development of project planning and implementation, create practice and policy change, and sustain collaborations beyond the funded project period. *Project Connect* is a promising strategy for creating coordinated systems within public health to implement best practices and evidence-informed clinical screening and counseling interventions to prevent domestic and sexual violence.

Major barriers to translating research findings into practice

There are multiple individual and system level barriers to implementing evidence into practice. Identifying and supporting survivors remains difficult, (Acierno, Resnick, & Kilpatrick, 1997; Cohen, De Vos, & Newberger, 1997; Eisenstat & Bancroft, 1999; Erickson, Hill, & Siegel, 2001; Friedman, Samet, Roberts, Hudlin, & Hans, 1992; McCauley et al., 1998; McNutt, Carlson, Gagen, & Winterbauer, 1999; M. A. Rodriguez et al., 1999; Siegel, Hill, Henderson, Ernst, & Boat, 1999; Sugg, Thompson, Thompson, Maiuro, & Rivara, 1999) in part due to provider discomfort (Elliott, Nerney, Jones, & Friedmann, 2002; Parsons, Zaccaro, Wells, & Stovall, 1995; Sprague et al., 2012; Sugg et al., 1999) and lack of training (Deboer, Kothari, Kothari, Koestner, & Rohs, 2013) Barriers for implementation of routine GPV screening and counseling in the health system are myriad including clinician concerns about time, limited incentives by facility and community program administration for screening, (Colarossi, Breitbart, & Betancourt, 2010) either non-existent or poorly implemented policies to guide practitioners and clinical practices in conducting such screening, lack of knowledge and confidence about how to support

a patient who discloses GPV,(Cha & Masho, 2014; Jaffee, Epling, Grant, Ghandour, & Callendar, 2005; Tower, McMurray, Rowe, & Wallis, 2006; Weeks, Ellis, Lichstein, & Bonds, 2008; Yonaka, Yoder, Darrow, & Sherck, 2007) which may reflect lack of reliable intervention services,(Minsky-Kelly, Hamberger, Pape, & Wolff, 2005) and inadequate cross-sector collaborations with victim service advocates.(O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011; Rhodes et al., 2007) For impact and sustainability, a clear, efficient and limited clinician role is key: ask validate GBV screening questions in private setting, provide information about relationship of GBV to health, facilitate GBV discussion with advocate or community agency, and validate survivors' experiences with message such as "you are not to alone", "you deserve to live free of violence", with concrete direction to the provider on responding to GBV disclosure including connection to advocacy services and safety planning for survivor when leaving the facility.(Decker et al., 2012; McCaw, Berman, Syme, & Hunkeler, 2001)

Critical gaps in knowledge & recommendations for study design

The advances over the past three decades have positioned the field for innovation and impact in reaching survivors and improving their health and well-being. We prioritize several critical gaps in knowledge that will continue to push the field forward, and allow us to realize the promise of harnessing the health and other sectors to create safe environments to identify and support those in need. Given the evidence accumulated to date via randomized controlled trials, our recommendations emphasize translation of evidence to best practices and focus heavily on implementation science to determine where, how, what are the appropriate settings for screening and intervention, and what are the health and social outcomes we can reasonably expect to see at a population level.

What do survivors do after they are screened?

While screening interventions have demonstrated success in improving health and mitigating abuse, the process by which these interventions create impact is less clear. Implementation science can help us understand how the health and violence support sectors operate in systems, and where they can be strengthened, including understanding if and where women go for services (formal and informal) after they are screened and receive brief counseling in the health setting, or whether the support and resources provided in a screening encounter with a skilled provider is sufficient to meet their needs for safety. Further, implementation research can inform providers in challenging settings where advocacy and community based supports are limited as what the minimum package of GBV services that are required from the perspective of the survivors, providers and community leaders to safely integrate GBV screening and brief counseling in health programs. Additionally, the use of mixed methods research (triangulation of qualitative and quantitative techniques) from multiple key stakeholders on harm reduction strategies and safety trajectories after GBV screening and brief counseling can help researchers, advocates and policymakers to better understand how screening and brief interventions improve health and social outcomes and for whom.

What are most meaningful and feasible outcomes that can result from screening?

To date, the research base on GBV screening has focused heavily on health improvements and reductions in violence, yet demonstrating impact on these endpoints is challenging within the constraints of most study designs, e.g., short follow-up periods. Further these endpoints are not always aligned with the multiple complex influences priorities (e.g. economic and resource needs, feelings for abusive partner, privacy, safety and well-being of children) of survivors themselves. Clarity and consensus on outcomes that are both feasible and meaningful, e.g., clarity of decisions related to safety, aware of options for safety within formal (e.g. hotlines, shelters, supervised visitation for children) and informal (e.g. trusted friends/family members) reducing economic and emotional dependence on the abusive partner, is needed to ensure we

are truly meeting the primary safety needs of survivors, and positioning our interventions and evaluation designs for impact on health, such as reduce depression/anxiety and chronic pain which is often a more distal outcome. Meaningful engagement by researchers and funders with survivors and advocates through a consensus meeting that includes their voices is recommended to fill this gap in the evidence for appropriate and meaningful outcomes when implementing interventions in the formal health system and in informal settings.

What is the minimum package needed to implement screening?

Recommendations that GBV screening and brief intervention only be implemented in health settings where sufficient training and support services exist are well intended, but can prompt communities to continue to accept the consequence of inaction, especially in resource-limited settings. With the availability of eHealth interventions and resources globally that provide evidence based screening tools with guidance on confidentiality and implementation, as well as support diverse facility and community based health providers in collaborating with women/girls on safety planning in the absence of formal services, the frequent excuse of the lack of formal services in the community is somewhat less relevant. Yet to date, few standards and little empirical evidence have emerged on the minimum standards necessary for initiating GBV screening and brief safety interventions in health and informal sectors. Again, implementation science with input from survivors and key stakeholders is essential here.

Harm reduction strategies

The emphasis on screening implementation and health outcomes in GBV screening research to date, coupled with connecting women to formal support services, has created critical gaps in our knowledge of women's own harm reduction strategies. Qualitatively and quantitatively understanding patterns of safety behavior and harm reduction from women themselves, particularly those who have not sought formal services, will help interventionists to craft harm

reduction and safety messages that can be meaningfully integrated into clinic-based screening as well as that in other sectors.

Combination Prevention/Intervention

Structural interventions, i.e., those that change the broader social-structural climate that gives rise to perpetration of GBV, are increasingly recommended for primary and secondary prevention. Given these needs, coupled with evidence of efficacy of GBV screening and intervention, there exists a need to understand optimal packages of interventions, i.e., combination prevention/intervention, including that which pairs GBV screening with larger-scale structural interventions, such as safe and affordable housing, employment with a living wage, trauma informed and survivor centered services. This type of research typically requires collaborations among multiple partners from diverse disciplines, governmental and non-governmental organizations and survivor groups in distinct geographic communities to avoid issues of contamination and are thus more resource-intensive.

Evidence-based Best Practices on Screening Implementation

Addressing barriers, developing protocols and improving screening practices requires attention to multiple levels within the health care delivery system to create a safe, trusting environment for clients/patients.(McCaw et al., 2001) Strategies include provider education,(K.L. Hamberger et al., 2004; K.L. Hamberger & Phelan, 2006; McNulty, Andrews, & Bonner, 2005; O'Campo et al., 2011) client support and engagement, policies and protocols with tools for clinical settings,(Coker et al., 2007; K.L. Hamberger & Phelan, 2006; Scholle et al., 2003; Thurston et al., 2007) collaboration with GVV advocates, as well as environmental cues, reminders within the electronic health record, and quality incentives integrated into clinic flow.(K.L. Hamberger & Phelan, 2006; Sprague et al., 2013) Studies are needed on how to implement clinical guidelines

for GBV screening and assessment with attention to barriers and testing strategies to increase screening and counseling efficiency, effectiveness and sustainability.

Evidence-based Best Practices on Systems Strengthening

When the goal for GBV screening and brief safety interventions shifts from a sole focus on identification to creating safer spaces for survivors within the health care delivery system, the clinical space transforms into a place to build connections to supports, services, and protection. Evidence suggests that when health care providers facilitate the connection for their patients to an advocate (i.e., assist with making a phone call or connecting to an advocate) – called a ‘warm referral’ in practice – patients are more likely to use an intervention. (J.E. Hathaway, Willis, & Zimmer, 2002; McCloskey et al., 2006) Health providers report, however, that they often are unfamiliar with local resources and do not know what to do if a patient discloses IPV to them. (Erickson et al., 2001; Friedman et al., 1992; McCauley et al., 1998; Minsky-Kelly et al., 2005; M. A. Rodriguez et al., 1999; Siegel et al., 1999; Sugg & Inui, 1992) To date, little guidance exists on how to build these connections with victim advocacy services, how to strengthen the local connections, and to nurture a collaborative relationship, and how to evaluate systems as they strengthen and evolve to meet the needs of survivors.

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