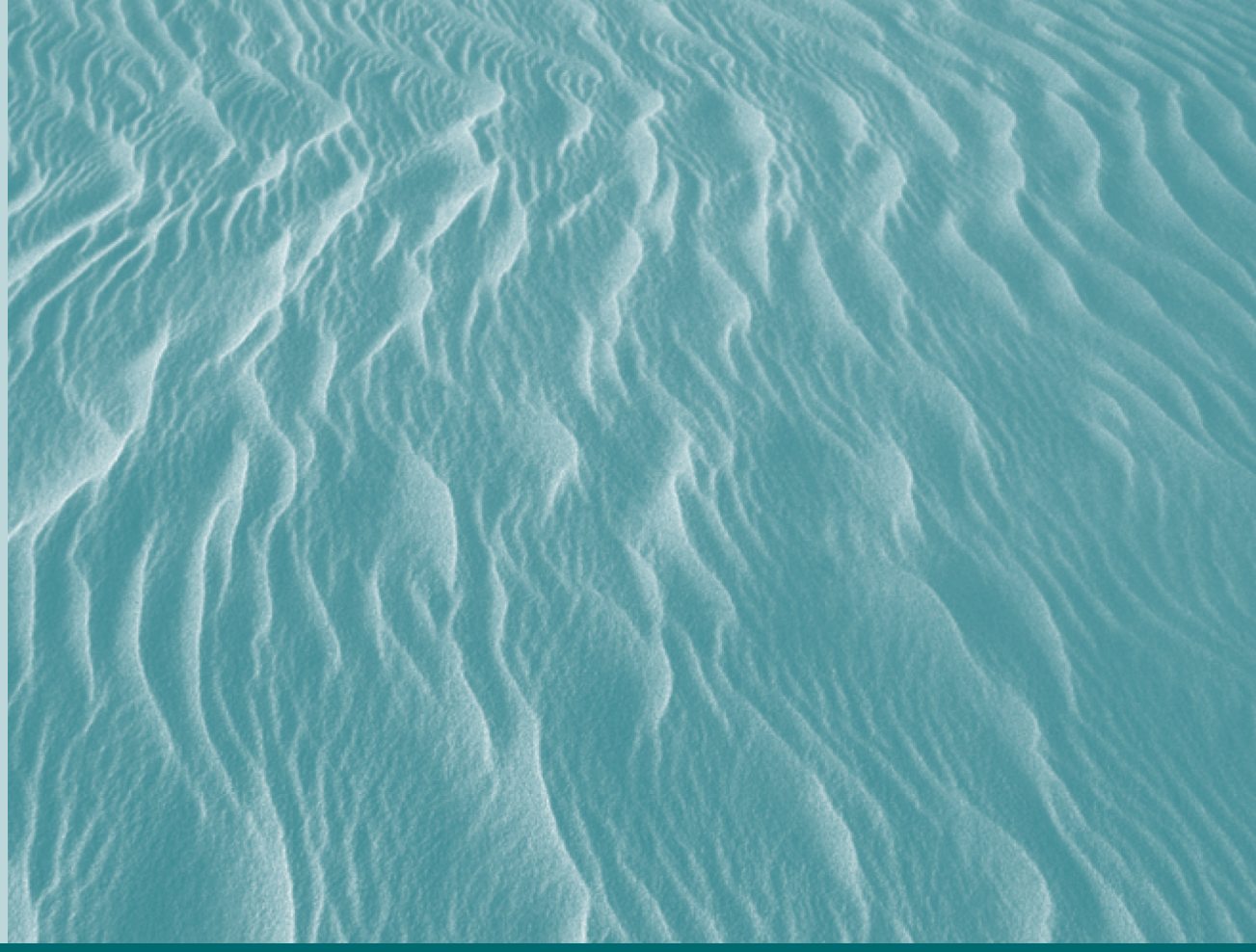

COMPETENCIES NEEDED BY HEALTH PROFESSIONALS FOR ADDRESSING EXPOSURE TO VIOLENCE AND ABUSE IN PATIENT CARE

AVA
ACADEMY ON VIOLENCE & ABUSE
ADVANCING HEALTH EDUCATION & RESEARCH

ACADEMY ON VIOLENCE & ABUSE (AVA)

MISSION

The mission of the Academy on Violence and Abuse (AVA) is to advance health education and research on the prevention, recognition, treatment, and health effects of violence and abuse.

VISION

By expanding health education and research, AVA will integrate knowledge about violence and abuse into the training of health professionals, promote the health of all people, protect the most vulnerable, and advance health policy that promotes safe families, workplaces, and communities.

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Please cite this document as an organizational report or monograph in book style:
Ambuel, B, K Trent, P Lenahan, P Cronholm, D Downing, M Jelley, A Lewis-O'Connor, M McGraw, A Marjavi, L Mouden, J Wherry, M Callahan, J Humphreys, R Block, Competencies Needed by Health Professionals for Addressing Exposure to Violence and Abuse in Patient Care, Academy on Violence and Abuse, Eden Prairie, MN, April 2011

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INTRODUCTION

The health impact of violence and abuse has been recognized as a significant public health problem since the mid 1980s, but that recognition has broadened in the past decade. Current and past exposure to violence and abuse significantly increases the risk of many physical and behavioral health problems including cardiovascular, immune and reproductive health disorders, depression, alcohol, tobacco and drug abuse, and injury. Physical and behavioral health professionals are in a unique position to offer their patients and clients help in the form of education, prevention, and intervention. The following core competencies have been developed to help ensure that all health care professionals have a solid understanding of the problem, and gain the skills and confidence they will need to work with patients, clients, colleagues and health care systems to combat the epidemic of violence and abuse.

The Institute of Medicine has called for health professional organizations to develop guidelines for better training on violence and abuse.

The Institute of Medicine's (IOM) 2002 report entitled, *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence,* (Cohn, et all, 2002) called for health professional organizations to develop and provide guidance to their members, constituents, institutions, and stakeholders regarding violence and abuse education. Specifically, these recommendations emphasized the need for organizations to provide guidance in (1) competencies to be addressed in health professional curricula, (2) effective teaching strategies, and (3) approaches to achieving sustained behavior changes among health professionals. The IOM further recommended that health professional organizations identify and disseminate information on approaches for overcoming barriers to training on family violence.

Although some progress has been made, training and education about the health problems related to violence and abuse remains highly variable and often marginalized in the curricula of most health professions schools as well as within the individual practices of physical and behavioral health professionals and the U.S. health delivery system. While the governing bodies in some health disciplines have recognized the need for core competencies appropriate to practitioners in their fields, the call for an overarching set of principles remains unmet. The Academy on Violence and Abuse (AVA) was founded in 2005 to address these concerns and to support actions to achieve the IOM recommendations.

DEFINITIONS AND CONTEXT

"Violence is the intentional use of physical force or power, threatened or actual, against oneself, against another person or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (World Health Organization; 2011). Interpersonal violence is functional, intended to dominate, punish, control or eliminate an individual, a group or a community. Interpersonal violence occurs in the context of a broad range of human relationships including violence within the family—child abuse and neglect, intimate partner violence and elder abuse. Interpersonal violence also encompasses dating violence, peer violence and bullying, stalking, abuse and neglect of pets and other animals, community and school violence, gang violence, hate crimes, mob behavior, human trafficking, sexual exploitation and slavery. Also included within the scope of interpersonal violence is oppression based upon gender, race, sexual orientation, social class, national origin or religion, and state-sponsored violence such as terrorism, genocide, war, and war rape.

We use the term violence and abuse to encompass this full spectrum of harmful interactions between people including neglect, abuse, and interpersonal violence. Violence and abuse is preferred over more specific terms such as domestic violence, family violence and intimate partner violence. These terms are often associated with limited contexts or have addressed only physical, sexual, or psychological harm by a current or former partner or spouse. Using the term violence and abuse reminds us to think broadly about the complex histories and dynamics that must be considered to provide patient and client-centered care.

PREVALENCE

Reliable estimates of the overall incidence and prevalence of violence and abuse are not available in part because researchers have focused on specific types of violence and used varying methodologies and definitions. There is no comprehensive national system of public health surveillance of abuse and violence. One project that suggests the potential for national surveillance is the National Violence Against Women Survey conducted by the US Justice Department between November 1995 and May 1996. On the basis of findings from this study, researchers estimated that 1.5 million women and 834,732 men reported physical assault or rape by intimate partners in the United States. More than one-third of American women report experiences with physical and/or sexual violence by a husband, partner, or intimate friend at some point in their lives. On the international front, the WHO World Report on Violence and Health illustrates the power of basic epidemiology to understand the relationship between interpersonal violence and health. According to the report, in 2000, an estimated 1.6 million people worldwide died as a result of self-inflicted, interpersonal or collective violence, for an overall age-adjusted rate of 28.8 per 100 000 population. There is an urgent need to develop a comprehensive system of public health surveillance of all types of violence.

The term *Violence and Abuse* refers to a continuum of experiences and has been chosen to reflect the multiple variations in which harm, neglect, abuse, and interpersonal violence occur.

CORE COMPETENCIES

The AVA has worked extensively with educators and experts from a variety of disciplines who specialize in the area of violence and abuse prevention to develop the following set of interdisciplinary competencies (for information on the development process please see Appendix A). These competencies have been arranged in three different levels of responsibility: Health System Competencies, Institutional Competencies for Academic Institutions and Training Programs, and Individual Learner Competencies.

The proposed Competencies are arranged by:
1) Health System
2) Educational Institution, and
3) Individual Learner.
It is important that changes to all three levels are implemented together.

Traditionally, educational competencies in the physical and behavioral health professions have focused upon competencies of the individual learner. We have intentionally taken a more contextual, ecological approach by including the academic system and the health system. Students and trainees in the physical and behavioral health professions learn the science and art of their profession in the context of academic training programs and the larger health care system. Individual learners can only develop sophisticated clinical knowledge and skills related to violence and abuse if the academic and health systems within which they are learning and working provide a supportive environment where the system and clinicians model best practices related to violence and abuse. Defining program and system competencies will allow academic training programs and health systems to evaluate the degree to which they provide this supportive environment and will clarify what must be accomplished to improve that environment for students, employees, patients and clients.

We refer throughout the document to the "physical and behavioral health professions." The intended scope of this document includes those professions working with individuals, groups and/or populations to enhance physical and psychological health and well being. This includes, for example, medicine, dentistry, nursing, psychology, social work, family therapy, public health, pharmacy, physical and occupational therapy, and behavior health and counseling, etc. The competencies are also intended to be applicable to veterinary medicine schools and practitioners because violence and abuse between individuals can involve the animals and pets belonging to victims. The competencies are meant to be a common starting point from which academic institutions and professional societies of various health related disciplines can begin to develop profession-specific criteria regarding the skills, knowledge and attitudes that their graduates and employees should be expected to achieve.

REQUIREMENTS FOR THE HEALTH SYSTEM	
I. Health System Competency	**Health System Actions**
A. Accreditation systems embody competencies related to violence and abuse.	1. Accreditation organizations will require violence and abuse related competencies, policies and procedures.
B. Physical and behavioral health professional cultures recognize the physical and mental health consequences of violence and abuse, and value profession-specific competency on violence and abuse.	1. An understanding of physical and behavioral health consequences of violence and abuse is integrated into the professional training and practice of the various professions.
C. Physical and behavioral health professions provide specialized competencies and training programs appropriate for each profession and specialty within professions.	1. Professional societies will adapt these general competencies to the specific needs of their providers and patients/clients.
D. Physical and behavioral health care delivery systems seek and achieve sustained improvement and excellence in the identification, treatment and prevention of violence and abuse.	1. Identify individuals with interest and expertise to serve as resources. 2. Seek outside consultation. 3. Implement best practices in care management for victims of violence and abuse. 4. Implement best practices in primary prevention. 5. Implement best practices in systems for outcome measurement and continuous quality improvement.
E. Continuing education standards incorporate knowledge, attitudes and clinical skills related to the identification, prevention and treatment of violence and abuse.	1. Require Continuing Education for physical and behavioral health care professionals in all fields to build and maintain competence.

F. Strong research programs explore issues surrounding violence and abuse.	1. Health care systems support interdisciplinary research on violence and abuse intervention and prevention. 2. Professional and advocacy organizations encourage federal and foundation funding of interdisciplinary research on violence and abuse, including: a. delineation of the biological pathways affected by exposure to violence and abuse creates adverse health outcomes, b. identification of protective factors that buffer against or mitigate adverse health effects, c. efficacy of identification and intervention programs in reducing negative health effects of violence and abuse, d. primary prevention strategies for violence and abuse, and e. cost-benefit analysis.
G. Build a common, integrated knowledge base across health care professions.	1. Research results are disseminated and readily accessible to physical and behavioral health professionals, advocates, policy makers, and the general public.
H. Implement systemic environmental change.	1. Create a safe and respectful organizational environment for employees and customers. 2. Institute policies and procedures that embody best practices regarding violence and abuse intervention and prevention, including primary prevention. 3. Assure employee's safety and provide support for those facing current or past abuse by establishing appropriate workplace policies and procedures that include education and identification of resources. 4. Promote education of patients/clients about healthy relationships, violence and abuse using diverse media (posters, safety cards and displays, newsletters, etc.), and create physically and psychologically safe spaces for disclosure. 5. Establish environmental benchmarks and implement continuous quality improvement.

REQUIREMENTS FOR ACADEMIC INSTITUTIONS AND TRAINING PROGRAMS

Institutional Competency	Program Requirement
A. Adopt an interdisciplinary approach to violence and abuse.	1. Recognize that competencies apply to all physical and behavioral health professions education. 2. Provide for multi-disciplinary instruction. 3. Develop parallel and complementary competencies for front-line workers and advocates. 4. Coordinate learning objectives across different disciplines. 5. Value inter-professional contributions.
B. Focus on prevention including healthy relationships.	1. As part of patient and client care curricula, incorporate models of healthy relationships throughout the lifespan. Include the interrelationship between relationship stress and health.
C. Partner with the community in education, intervention and prevention.	1. Establish communication and collaboration with community resources and advocates. 2. Promote activities to address populations at risk. 3. Participate in health policy activities to address family violence and abuse. 4. Promote community action to establish and enhance programs to support victims and family members and for perpetrator interventions, especially at early stages. 5. Invite community feedback on health interventions.

D. Develop curricula and provide learner-centered training opportunities regarding violence and abuse.	1. Acknowledge the scientific and ethical rationale for acquiring competencies related to violence and abuse. 2. Employ a developmental, additive, curriculum with early introduction to and continuous reinforcement of competencies. 3. Incorporate voices and perspectives of exposed patients and clients into designing and teaching the curriculum. 4. Develop varied learning methods to be used in conjunction with didactics, including multi-media tools, experiential and case-based learning, group discussion topics, service learning, clinical skills laboratories, and other forms of interactive learning. 5. Measure learners' clinical application of competencies, including knowledge, skills and attitudes, and its persistence over time. Collaborate with community programs that can provide advice on curriculum development.
E. Assure learner safety and promote self-care.	1. Recognize that many learners are survivors of interpersonal violence or know someone who is a survivor and that others may find the content personally difficult. 2. Discuss the prevalence of violence and abuse among providers and how personal experiences may shape provider behaviors during training sessions and acknowledge the impact training may have. 3. Make available accessible, non-discriminatory and profession-specific counseling and mentoring programs. 4. Offer appropriate support and mentoring.
F. Assure an institutional environment free of violence and abuse.	1. Establish policies, procedures and best practices addressing professionalism, respect, conflict resolution, and violence and abuse in the educational setting.

REQUIREMENTS FOR INDIVIDUAL LEARNERS

k = Knowledge based objective, s = Skill based objective, a = Attitude based objective

Individual Learner Competency	Educational Objectives Learners should be able to:
A. Demonstrate general knowledge of violence and abuse.	1. Understand the definitions of abuse and violence. (k) 2. Understand the interpersonal dynamics of violence and abuse, and the varied and changing types of violence and abuse. (k) 3. Know the epidemiology of violence and abuse in the general population and in specific clinical populations. (k) 4. Distinguish between myths and facts about violence and abuse. (k) 5. Know risk factors for continued abuse, morbidity and mortality including suicide, homicide. (k, s) 6. Understand the acute and chronic physical and behavioral health effects of violence and abuse. (k) 7. Understand the functions of violence and barriers to help-seeking (individual, social, institutional and cultural). (a) 8. Understand the social and cultural context of violence and abuse, including factors such as gender, sexual orientation, social class, ethnicity, religion, developmental stage, immigrant or refugee history, and local, regional and national variations. (k) 9. Understand individual and population based models for intervention and primary prevention of violence and abuse. (k) 10. Acknowledge pre-existing values, attitudes, beliefs and experiences related to abuse among health care professionals and how these affect interaction with patients and clients. (a)

B. Demonstrate clinical skills appropriate to one's profession and specialty including the ability to identify, assess, intervene and prevent violence and abuse.	1. Assess patients/clients via interview, questionnaire, history taking and health examination processes. Use reliable, valid and normed instruments developed for the assessment of abuse, violence and its symptoms where available. (s) 2. Intervene using evidence-based and evidence-informed treatments. (s) 3. Prevent violence using evidence-based and evidence-informed methods of primary, secondary and tertiary prevention. (s) 4. Recognize risk factors for victimization and perpetration of violence. (k) 5. Recognize physical and behavioral presentations and signs of abuse and neglect, including patterns of injury across the life span. (k) 6. Educate patients and clients regarding limits of confidentiality and reporting requirements. 7. Identify and address the problems associated with emotional, physical, and sexual abuse and neglect. (s) 8. Offer continuity of care and appropriate referrals to community resources. (s) 9. Provide thorough documentation of patient's and client's statements, clinical observations, and visual documentation of injuries, using body maps and photographs. (s) 10. Be aware of and comply with state reporting laws, collaborating with the victim of violence to make reports whenever appropriate. (s) 11. Organize and prioritize to provide an accurate, profession-specific assessment of the problem, and safe, efficient, effective care. (s) 12. Acknowledge that achieving safety is often a long-term goal that is achieved by the patient/client, requires significant preparation, and that many successful interventions can be applied during the course of this process (i.e. naming the abuse, offering support, identifying resources, safety planning, etc.). (k, a) 13. Utilize models of health behavior change, advocacy and empowerment to promote harm reduction strategies as part of an intervention. (k, s)

C. Communicate effectively with the patient/client and family.	1. Convey concern and support within appropriate professional boundaries. (s, a) 2. When responding to patients/clients exposed to violence or abuse, demonstrate self-awareness of one's emotional response, beliefs, assumptions and potential biases. 3. Demonstrate appropriate and effective ways of asking about patients'/clients' exposure to violence or abuse. (s) 4. Communicate appropriate responses to disclosure, non-disclosure and indicators of abuse despite non-disclosure.(s) 5. Acknowledge patients'/clients' responses in a non-judgmental, supportive way. (s, a) 6. Acknowledge and respect each patient's/client's right to self-determination and understand that empowerment is a primary goal of intervention. (s, a, k) 7. Review with patient/client available local resources. (s, k) 8. Discuss legal obligations on disclosure of abuse for protected categories of patients/clients. (s)
D. Communicate effectively with the physical and behavioral health care team.	1. Be able to communicate documented injuries and health effects, using forensic guidelines in obtaining and recording evidence (such as recording specific, concise and objective information utilizing body maps and photographs). (s) 2. Understand and appreciate the role and contribution of other professions in preventing and managing exposure to violence and abuse. (a) 3. Explicitly negotiate roles and responsibilities for the treatment plan. (s) 4. Maintain patient and client confidentiality in communications with health care team.

E. Intervene to promote safety and reduce vulnerability.	1. Perform focused assessment of immediate risk/safety including routine inquiry, screening and case-finding. (s) 2. Assess for immediate danger. (s) 3. Promote safety planning with victims and families. (k) 4. Consult with and refer to specialists and community resources for safety, education, caretaking, and support services (such as protective services, social work, shelter, child abuse hotlines, legal, mental health, substance abuse, and criminal justice) as appropriate. (k) 5. Maintain appropriate clinical follow-up. (s)
F. Recognize the individual and cultural variation in relationships and distinguish healthy from abusive patterns.	1. Demonstrate awareness of cross-cultural health issues. (a) 2. Recognize that cultural factors influence the responses communities have to family violence. (k) 3. Provide culturally competent assessment and care to victims and perpetrators of violence and abuse. (s) 4. Recognize potential barriers to providing care and accessing resources that may arise from cultural differences. (a, k) 5. Utilize professional translation services effectively. (s) 6. Know how to assess cultural explanatory models for causation and acceptance/non-acceptance of violence and abuse. (s) 7. Recognize the potential for complex legal and cultural issues related to a refugee's or immigrant's exposure to violence in their country of origin. (a)
G. Identify and assess relationship health.	1. Explain that a person's relationship health has a significant impact on their physical and mental health. (s) 2. Understand that relationships are dynamic processes that impact people differently. (k) 3. Recognize that healthy relationship dynamics are the standard on which an assessment of the status of relationship health should be based. (a) 4. Demonstrate effective communication strategies with patients and clients regarding elements of healthy and unhealthy relationships in the context of health and wellness. (s) 5. Demonstrate the ability to refer patients and clients to the appropriate resources depending on their relationship health needs. (s)

H. Know legal issues in treating and reporting family violence that apply to one's profession in the jurisdiction of practice.	1. Know state reporting laws and mandates, local and state reporting agencies, and their procedures and regulations, including potential liability for failure to report. (k) 2. Be able to interact effectively with law enforcement and protective services agencies when appropriate. (s) 3. Understand what happens when a report is made to law enforcement and protective services. (k) 4. Understand the need to balance respect for individual autonomy with concerns for safety of vulnerable persons when making reporting decisions. (a) 5. Understand the health professional's role in working with the legal system including law enforcement and the courts. (k) 6. Be able to effectively introduce evidence-informed, ethically-defensible, expert testimony in courts. 7. Know and utilize appropriate steps for thorough documentation of abuse in patient/client charts. (s, k) 8. Be able to support patient/client safety when making a report. (s, k)
I. Know the ethical requirements of one's profession regarding violence and abuse.	1. Know ethical principles that apply to patient and client confidentiality for patients/clients exposed to violence and abuse as well as the limits of that confidentiality. (k) 2. Be able to explain the limits of confidentiality. (k) 3. Be aware of the formal ethical positions of the learner's discipline. (k) 4. Incorporate these ethical requirements in the learner's personal ethical system regarding care. (a)

J. Engage in multi-disciplinary collaboration and outreach in response to violence and abuse.	1. Know how to identify resources in a state and local community and build collaborative relationships with these resources. (k) 2. Understand the impact of community outreach programs on the prevention of physical, emotional and sexual abuse and neglect. (a) 3. Understand the principles of prevention of interpersonal violence. (k) 4. Demonstrate the ability to collaborate with other disciplines to create a comprehensive response within a clinic, organization, hospital, or emergency department; including prevention, identification, intervention and follow-up. (s, a) 5. Demonstrate understanding and ability to collaborate with individuals, disciplines, professions, and agencies that may be directly and indirectly involved with advocacy to end violence. (a)
K. Practice effective self-care.	1. Acknowledge how one's own experiences with violence and abuse may influence one's ability to respond appropriately to situations, to ask for assistance resolving biases, and developing competencies. (k, a) 2. Be aware of the potential effects on providers of caring for patients and clients exposed to violence and abuse. (a, k) 3. Know how to access support for effective self-care. (k)
L. Obtain the training and skills necessary to advance the field.	1. Understand how to acquire additional teaching skills, research and advocacy skills. (k) 2. Take responsibility for personal and professional development and identify appropriate learning activities. (a)
M. Apply the concept of systems-based practice.	1. Understand how to develop a patient-centered, systems-based, inter-professional intervention in an outpatient office, emergency department, or health care system. (k) 2. Be able to describe the prevention, recognition, treatment and management of exposure to violence and abuse in terms of organized systems of care. (s)

AVA COMPETENCIES BIBLIOGRAPHY

American College of Graduate Medical Education (2007). *Program requirements for graduate medical education in pediatrics effective: July 1.* Chicago, Illinois: Author, February. http://www.acgme.org/acWebsite/downloads/RRC_progReq/320pediatrics07012007.pdf

American Medical Association National Advisory Council on Violence and Abuse (2006). *Competencies necessary for physicians to provide quality care to victims of family and intimate partner violence and abuse.* Chicago, IL: American Medical Association, unpublished manuscript.

Block, R.W., Ismailji, T., Schneider, F., & Dolezal, T. (2009). *Creating core competencies for health education on violence and abuse.* Preconference Institute, Family Violence Prevention Fund Conference on Violence and Health, New Orleans, Louisiana, October 8.

Block, R.W. (2005). Medical student exposure to family violence issues: A model curriculum. *Family Violence Prevention and Health Practice*, 01, 2. http://endabuse.org/health/ejournal/archive/1-2/Block.pdf

Brandt, E. (1997). Curricular principles for health professions education about family violence. *Acad Med*, 72 (1 Suppl), S51-8.

Cohn, F., Salmon, M.E., & Stobo, J.D. (Eds) (2002). *Confronting chronic neglect: The education and training of health professionals on family violence*. Washington, DC: National Academy Press, Institute of Medicine.

Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B., & Lozano, R. (Eds.) (2002). *World report on violence and health*. Geneva, Switzerland: World Health Organization.

Tjaden, P.G., & Thoennes, N. (2000). *Full report of the prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey*. Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice.

World Health Organization (2011). Violence. Geneva, Switzerland: Author. http://www.who.int/topics/violence/en/, accessed 3 March 2011; adapted from World Health Organization (1996). *Violence: A public health priority*. WHO Global Consultation on Violence and Health. Geneva, Switzerland: Author (document WHO/EHA/SPI.POA.2).

APPENDIX A: METHODS

The set of competencies reflected here derives from several sources including: 1.Appendix H of the IOM report Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence, entitled Core Competencies for Family Violence 2. *Medical Student Exposure to Family Violence Issues: a Model Curriculum, Block R.W., Family Violence Prevention and Health Practice; 1(2):www.jfvphp.org. 200*, 3. Requirements for Residency Training in Pediatrics, Pediatrics Review Committee of the ACGME 4. "Tentative Curriculum" adapted from a presentation by Dr. Ed Brandt at the Family Violence and Health Professions Education Conference, in Oklahoma City, OK March, 1994, and 5. *Competencies Necessary for Physicians to Provide Quality Care to Victims of Family and Intimate Partner Violence and Abuse*, developed by the AMA National Advisory Council on Violence and Abuse.

A summary of these sources was used at a Family Violence Prevention Fund pre-conference institute hosted by the AVA and the Family Violence Prevention Fund, October 8, 2009 entitled "Creating Core Competencies for Health Education on Violence and Abuse." The results of this pre-conference institute were compiled and posted to an online discussion site where participants in the pre-conference institute and invited experts provided comments in a Wikipedia style online environment. Final development and editing of the document was conducted by the Education Committee of the Academy on Violence and Abuse with input from other AVA members.

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