

JAMA Insights

Responding to Intimate Partner Violence During Telehealth Clinical Encounters

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According to the Centers for Disease Control and Prevention, 1 in 3 women and 1 in 4 men in the US have experienced violence from an intimate partner in their lifetime.¹ However, for many individuals, the COVID-19 pandemic and the resultant sheltering at home have increased levels of stress, panic, and financial and emotional strain. The World Health Organization defines intimate partner violence (IPV) as behavior by a partner, spouse, or ex-partner that can cause



Supplemental content

or causes physical, sexual, or psychological harm.² A United Nations report cited a global surge in IPV accompanying the stay-at-home and lockdown orders.³ It is possible that IPV cases in many countries have significantly increased. While a recent *JAMA* Clinical Insights focused on recognizing and responding to IPV during in-person clinical care visits,² the context of IPV identification and supportive care approaches using telehealth modalities warrants attention.

Telehealth and telemedicine have been defined by the Centers for Medicare & Medicaid Services as “the exchange of medical information from one site to another through electronic communication to improve a patient’s health.”⁴ One of the transformative effects of the COVID-19 pandemic has been a substantial increase in telehealth use across many health care service disciplines. For example, in a survey of 3500 family physicians and pediatricians, only 12% worked in a practice that used telehealth in 2016, whereas more than 90% of primary care physicians offered telehealth after the first 2 months of the COVID-19 pandemic.⁵ It is important to note that there have not been any large randomized trials evaluating the accuracy of identifying IPV in telehealth formats. However, there have been studies documenting acceptability and feasibility of trauma-informed, digitally delivered interventions focused on preventing violence to increase safety and decision-making of persons in abusive relationships and linking them to online support.⁶ Thus, this move to telehealth has posed new challenges to both IPV screening and support. Namely, compromised privacy at home may enable a controlling partner to overhear responses to screening questions about IPV and become suspicious or even violent, and supportive care for IPV-related injury or provision of resources may require an in-person visit. To help facilitate access to and use of IPV screening questions and resource lists, it is recommended that “smartphrases” be created in the electronic health record.

Because the experience of violence and trauma can affect physical, sexual, reproductive, and mental health, it is important to support clinicians in screening, identifying, and responding to IPV, including within the context of telehealth encounters such as those occurring during the COVID-19 pandemic. Often clinicians do not want to ask about IPV because of logistical concerns (eg, ensuring patient privacy), or they may not know how to address an affirma-

tive answer. The US Preventive Services Task Force (USPSTF) supports screening for IPV among reproductive-aged women (B grade recommendation, “There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial”), albeit telehealth screening has not yet been addressed.⁷ Owing to the pandemic, telehealth communications with health care workers and frontline essential workers may conceivably be the only external points of contact available to some persons experiencing IPV. Regardless of the modality of screening, the same basic approach remains: to first recognize that violence and abuse could be occurring, and proceed with caution so that the person experiencing IPV is approached in a person-centered way, with access and privacy prioritized (**Box**).

Suggested approaches for assessing IPV via telehealth are listed in the Box. Key recommendations include initiating IPV screening with yes or no responses to ascertain if it is safe for the respondent to answer questions about IPV and then provide subsequent supportive care resources through email or referral to online information. Follow-up with the person experiencing IPV is essential and may be best provided through an in-person visit. Alternatively, offering universal education about IPV to patients and referring those who disclose IPV to a social worker or hotline is emerging as a strategy for informing them about available resources. The evidence base for universal education is still in its infancy but has promising potential for changing the landscape of future screening approaches to IPV.

Persons experiencing IPV need to know that their clinicians are available to help and support them. Clinicians should know how to help refer them to people and organizations that can intervene in IPV. If a person experiencing IPV is not ready to seek help, they can be referred to a social worker who can assist them in creating a home safety plan (**Box**). Regardless of the modality of health care delivery, follow-up should occur because patients may not feel comfortable discussing IPV with their clinicians until after they have developed a trusting relationship. The trust and comfort engendered by an established relationship with a clinician may be particularly important in telehealth, as suggested by survey results of patient preferences.⁸ This may also be true of in-person components of hybrid telehealth visits, as masks worn by clinicians have been found to affect patient perception of both physician empathy and relational continuity.⁹

At a time when many patients rely on telehealth for connection and support from their health care team, clinicians should provide universal education of IPV resources to all patients during telehealth appointments. If IPV is disclosed in a telehealth context, clinicians should tailor support to their patient’s circumstance. Types of support include referral to a social worker within the clinical care team, online support services, local community-based organizations that specialize in IPV, or support groups with

Box. Suggested Questions and Advisements for IPV Screening in Clinical Practice

How to Approach a Person Experiencing IPV**Who May or May Not Be Alone**

"Is now a safe time to talk?"

"Are you alone?"

How to Approach a Person Experiencing IPV**When Someone Else Is Present**

The clinician should state "HIPAA laws require that I conduct the telehealth visit with no one else present."

Once the other person has left the room, questions should be framed in yes/no response format to include the following:

"I'd like to ask some questions that I ask everyone right now," and start with COVID symptom questions.

Follow-up with "Are you feeling stressed?" or "Do you feel safe at home?"

Alternate ways to approach the subject include the following statements. It is the patient's choice whether or not and when to take action.

"I care, and I am concerned about your (and your child or children's) safety. I can help connect you with counseling and support, legal resources, and shelter. Everything is free and confidential. Would you be interested?"

Asking is an important first step. Proceed with referring support if the person experiencing IPV agrees. Ask if it is ok to check back in, and ask about how to safely do so using the yes/no format.

If the clinician prefers to use the universal education approach, it is suggested to use CUES (Confidentiality, Universal Education and Empowerment, and Support)

Ensure confidentiality.

This includes knowing your state's reporting requirements and sharing any limits of confidentiality

Universal Education and Empowerment.

Speak with the patient about healthy relationships and how they affect health, and provide a hotline number or a website with online resources. Emphasize that you are a safe person to speak with.

Support.

In the universal education approach, disclosure of violence is not the goal, but disclosure will happen. It is important to make a warm referral to a social worker, partner agency, or hotline.

Safety Plans

Advise that packed bags now also include acetaminophen or ibuprofen, face masks, hand sanitizer, important medications, and an extra phone charger.

IPV indicates intimate partner violence; HIPAA, Health Insurance Portability and Accountability Act.

text/chat options. In addition to providing such resources to all patients, an in-person health care visit may be needed due to the inextricable links between IPV and physical ailments (a list of resources for persons experiencing IPV is provided in the eAppendix in the [Supplement](#)). Since telehealth-based clinical care is likely

to persist beyond the current pandemic, universal IPV training, regardless of the health care delivery modality and including continuing medical education for practicing clinicians, should be considered to teach health care clinicians how to recognize, support, and refer persons experiencing IPV.

ARTICLE INFORMATION

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