

THE EVIDENCE BEHIND **CUES** AN INTERVENTION TO ADDRESS INTIMATE PARTNER VIOLENCE IN HEALTH SETTINGS

With the CUES intervention, healthcare professionals talk with all patients about how relationships can affect health and how to get support. Unlike traditional screening methods, CUES does not rely on disclosure of abuse to provide a patient with information and resources they might need. By using CUES, providers can ensure that patients are aware of available survivor support services and have information to pass to friends and family who might need it. To adopt a team-based approach to supporting survivors, healthcare settings should foster strong partnerships between domestic and sexual violence advocacy agencies.

CUES stands for Confidentiality, Universal Education + Empowerment, and Support

C: Confidentiality

- ▶ Know your state's medical mandated reporting requirements and share any limits of confidentiality with your patients.
- ▶ Ensure that you can bring up relationships and violence safely by seeing patients alone for at least part of the in person or telehealth visit.

UE: Universal Education + Empowerment

- ▶ In-Person Visits: Share two safety cards with each patient to start the conversation about relationships and how they affect health. Make sure patients know that you're a safe person for them to talk to. Encourage patients to share a safety card with a friend or family member.
- ▶ Telehealth visits: Normalize with all patients that stress from relationship struggles or previous trauma can affect health. Ask if you can send them a link to resources should they need them for themselves or a friend or family member.



Safety cards are available for different settings, communities, and languages.

S: Support

- ▶ Though disclosure of violence is not the goal, it will happen -- know how to support someone who shares that they have experienced abuse.
- ▶ Offer health promotion strategies and a care plan that takes surviving abuse into consideration.
- ▶ Make a warm referral to your local domestic/sexual violence partner agency or national hotlines (on the back of all safety cards).

The building blocks of the CUES intervention have been evaluated in reproductive, college, and adolescent health settings. The development of this intervention was based on research done over the last fifteen years about addressing IPV in healthcare and has been tailored for and shows promising results in HIV testing and care, home visitation, primary care, and other settings.

What Survivors of IPV Want from Health Professionals

Autonomy Survivors want to be able to make their own decisions when it comes to health care.¹⁻⁵ This includes choosing their own providers, disclosing in their own time, and having multiple pathways for potential interventions.^{1,4-6} Additionally, health professionals should always explain procedures thoroughly and allow patients to ask questions or signal discomfort.¹ Intimate partner violence can strip people of control—provider awareness can serve as a powerful tool to combat this.⁵

Empathy & Compassion People who have been exposed to intimate partner violence want providers to validate their experiences.^{1,2,4} Providers should strive to be nonjudgmental and supportive, regardless of how survivors of intimate partner violence respond to interventions.^{4,5} A judgmental, intrusive or controlling provider may recall trauma for survivors.¹

Informed Providers Providers with knowledge about intimate partner violence make a significant difference in the experiences of patients. Survivors cite the value of having health professionals who understand the depth and complexity of IPV.⁶ This includes the impact of trauma on health, the long-term nature of this violence, and its intersection with accessing a variety of other needs (employment, childcare, transportation, etc.).^{1,4,5}

Limitations of Screening for IPV without Universal Education

Low Disclosure Rates Disclosure rates among patients screened for intimate partner violence in health care settings are not the same as known prevalence of intimate partner violence from research studies. While 1 in 4 women and 1 in 9 men are estimated to be survivors of intimate partner violence in the general population, disclosure rates in clinical settings range from 1%-14% with screening, typically hovering around 7%.⁷⁻¹¹ Among known survivors, only 21.1% of women and 5.6% of men report disclosing to a healthcare professional.⁷

Non-Differential Outcomes for Screening Alone Outcomes for survivors are comparable between screened and non-screened patients in the absence of universal education or warm referrals.¹¹ No significant differences emerge in quality of life, number of emergency room visits, or number of hospitalizations.¹² Beyond this, no significant differences have been found in referral behaviors.¹⁰

Importance of Confidentiality and Patients' Reasons for Non-Disclosure

Patient Concerns Patients who have experienced IPV are concerned about the privacy of their data, particularly with electronic medical records.¹³ A perceived lack of privacy is a reason for non-disclosure by survivors.^{13–16} Assured confidentiality of providers, as well as a clear explanation of how patient information will be used (including in pediatric settings), is recommended.^{13,17,18}

Reasons for Non-Disclosure Amongst patients with a history of IPV, reasons for non-disclosure include fear of judgment, emotional distress, fear of not receiving adequate support from healthcare professionals, concern about mandated reporting procedures, religious beliefs, language barriers, and having children in the home.^{14–16,19–26}

Value of Universal Education & Empowerment

Universal Education and Empowerment The National Sexual Violence Resource Center encourages a trauma-informed framework that focuses on being sensitive to potential trauma in survivors, rather than responding solely to disclosure.²⁷ Comprehensive approaches including education, assessment, intervention, and prevention are recommended to empower and uplift survivors.^{28,29}

Outcomes for Patients In an intervention centered around reducing unintended pregnancies in women who experience intimate partner violence, utilization of a universal education model was associated with a 71% reduction in pregnancy pressure, and women being 60% more likely to end a relationship because it felt unsafe.³⁰ Additional universal education models have demonstrated a threefold increase in disclosure amongst youth who experienced relationship abuse as well as decreased self-reported isolation and reduced reproductive coercion in women with high baselines of RC.^{31,32} College students seeking care in campus health and counseling centers reported greater knowledge of and confidence to use available services and harm reduction strategies.³³ Patients exposed to these interventions have positive feedback, and report them to be more helpful than comparable resources.³⁴

Outcomes for Providers Providers exposed to a universal education and empowerment curriculum report improved confidence in discussing IPV, as well as increased awareness about the complexity of issues faced by survivors.³⁴ This approach helps overcome commonly cited barriers among providers about routinely assessing for IPV.^{8,35}

Peer-to-Peer Education Patients who receive universal education do not only directly benefit, but also share the information with their peers. Studies have demonstrated that participants who received UE were almost twice as likely to share the number for the domestic violence hotline with someone.³² Additionally, patients who receive palm-sized cards have cited the empowerment they feel when sharing concrete resources with their peers.^{30,34}

Cross-Sector Partnerships & Survivor Health and Safety

Coordinating Care Systems approaches, rooted in strong cross-sector networks, show important outcomes for women who have experienced IPV. Community partnerships create an easier “warm referral” process, allowing providers to facilitate the connection between survivors and resources. These warm referrals increase the likelihood of survivors utilizing interventions.³⁶

Collaborative Learning Network models and cross-sectoral curricula demonstrate an improved knowledge base for all participants. Collaborative groups successfully challenge misconceptions around intimate partner violence and build meaningful relationships.³⁷⁻⁴⁰ Culturally competent care is also improved through these collaborations.³⁸ These networks foster easier referral processes and stronger understandings of the field.³⁷⁻³⁹

Evidence compiled and outlined by Elizabeth Miller, MD, PhD and Elizabeth Walker, MPH at the University of Pittsburgh. Updated 2024.

National Health Resource Center on Domestic Violence at Futures Without Violence

Learn more: ipvhealth.org
For community health centers: ipvhealthpartners.org
Order [safety cards](#) and more: store.futureswithoutviolence.org
Email: health@futureswithoutviolence.org



References

1. Reeves EA, Humphreys JC. Describing the healthcare experiences and strategies of women survivors of violence. *J Clin Nurs*. 2018;27(5-6):1170-1182. doi:10.1111/jocn.14152
2. Munro-Kramer ML, Dulin AC, Gaither C. What survivors want: Understanding the needs of sexual assault survivors. *J Am Coll Health*. 2017;65(5):297-305. doi:10.1080/07448481.2017.1312409
3. Kulkarni SJ, Bell H, Rhodes DM. Back to basics: essential qualities of services for survivors of intimate partner violence. *Violence Against Women*. 2012;18(1):85-101. doi:10.1177/1077801212437137
4. Feder GS, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Arch Intern Med*. 2006;166(1):22-37. doi:10.1001/archinte.166.1.22
5. Chang JC, Cluss PA, Ranieri L, et al. Health care interventions for intimate partner violence: what women want. *Women's Health Issues*. 2005;15(1):21-30. doi:10.1016/j.whi.2004.08.007
6. Chang JC, Decker MR, Moracco KE, Martin SL, Petersen R, Frasier PY. Asking about intimate partner violence: advice from female survivors to health care providers. *Patient Educ Couns*. 2005;59(2):141-147. doi:10.1016/j.pec.2004.10.008
7. Black MC, Basile KC, Breiding MJ, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.; 2011. Accessed March 25, 2024. https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf
8. Ahmad I, Ali PA, Rehman S, Talpur A, Dhingra K. Intimate partner violence screening in emergency department: a rapid review of the literature. *J Clin Nurs*. 2017;26(21-22):3271-3285. doi:10.1111/jocn.13706
9. Hussain N, Sprague S, Madden K, Hussain FN, Pindiprolu B, Bhandari M. A comparison of the types of screening tool administration methods used for the detection of intimate partner violence: a systematic review and meta-analysis. *Trauma Violence Abuse*. 2015;16(1):60-69. doi:10.1177/1524838013515759
10. Taft A, O'Doherty L, Hegarty K, Ramsay J, Davidson L, Feder G. Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev*. 2013;(4):CD007007. doi:10.1002/14651858.CD007007.pub2
11. Feder G, Davies RA, Baird K, et al. Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *Lancet*. 2011;378(9805):1788-1795. doi:10.1016/S0140-6736(11)61179-3
12. Klevens J, Kee R, Trick W, et al. Effect of screening for partner violence on women's quality of life: a randomized controlled trial. *JAMA*. 2012;308(7):681-689. doi:10.1001/jama.2012.6434
13. Dichter ME, Wagner C, Goldberg EB, Iverson KM. Intimate partner violence detection and care in the veterans health administration: patient and provider perspectives. *Women's Health Issues*. 2015;25(5):555-560. doi:10.1016/j.whi.2015.06.006

14. Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force recommendation. *Ann Intern Med.* 2012;156(11):796–808. W. doi:10.7326/0003-4819-156-11-201206050-00447
15. Othman S, Goddard C, Piterman L. Victims' barriers to discussing domestic violence in clinical consultations: a qualitative enquiry. *J Interpers Violence.* 2014;29(8):1497–1513. doi:10.1177/0886260513507136
16. Montalvo-Liendo N. Cross-cultural factors in disclosure of intimate partner violence: an integrated review. *J Adv Nurs.* 2009;65(1):20–34. doi:10.1111/j.1365-2648.2008.04850.x
17. Randell KA, Ragavan MI, Query LA, et al. Intimate partner violence and the pediatric electronic health record: A qualitative study. *Acad Pediatr.* 2022;22(5):824–832. doi:10.1016/j.acap.2021.08.013
18. Randell KA, Ragavan MI. Intimate partner violence: identification and response in pediatric health care settings. *Clin Pediatr (Phila).* 2020;59(2):109–115. doi:10.1177/0009922819879464
19. Heron RL, Eisma MC. Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research. *Health Soc Care Community.* 2021;29(3):612–630. doi:10.1111/hsc.13282
20. Narula A, Agarwal G, McCarthy L. Intimate partner violence: patients' experiences and perceptions in family practice. *Fam Pract.* 2012;29(5):593–600. doi:10.1093/fampra/cms008
21. Spangaro JM, Zwi AB, Poulos RG. "Persist. persist.": A qualitative study of women's decisions to disclose and their perceptions of the impact of routine screening for intimate partner violence. *Psychol Violence.* 2011;1(2):150–162. doi:10.1037/a0023136
22. Ravi KE, Robinson SR, Schrag RV. Facilitators of Formal Help-Seeking for Adult Survivors of IPV in the United States: A Systematic Review. *Trauma Violence Abuse.* 2022;23(5):1420–1436. doi:10.1177/1524838021995954
23. Hulley J, Bailey L, Kirkman G, et al. Intimate Partner Violence and Barriers to Help-Seeking Among Black, Asian, Minority Ethnic and Immigrant Women: A Qualitative Metasynthesis of Global Research. *Trauma Violence Abuse.* 2023;24(2):1001–1015. doi:10.1177/15248380211050590
24. Waller BY, Joyce PA, Quinn CR, Hassan Shaari AA, Boyd DT. "I Am the One That Needs Help": The Theory of Help-Seeking Behavior for Survivors of Intimate Partner Violence. *J Interpers Violence.* 2023;38(1-2):NP288–NP310. doi:10.1177/08862605221084340
25. Jock BWI, Dana-Sacco G, Arscott J, et al. "We've Already Endured the Trauma, Who is Going to Either End that Cycle or Continue to Feed It?": The Influence of Family and Legal Systems on Native American Women's Intimate Partner Violence Experiences. *J Interpers Violence.* 2022;37(21-22):NP20602–NP20629. doi:10.1177/08862605211063200
26. Calton JM, Cattaneo LB, Gebhard KT. Barriers to help seeking for lesbian, gay, bisexual, transgender, and queer survivors of intimate partner violence. *Trauma Violence Abuse.* 2016;17(5):585–600. doi:10.1177/1524838015585318
27. The National Sexual Assault Coalition Resource Sharing Project, National Sexual Violence Resource Center. Building Cultures of Care: A Guide for Sexual Assault Services Programs. The National Sexual Assault Coalition Resource Sharing Project and National Sexual Violence Resource Center; 2013. Accessed March 25, 2024. http://www.nsvrc.org/sites/default/files/publications_nsvrc_guides_building-cultures-of-care.pdf
28. Decker MR, Frattaroli S, McCaw B, et al. Transforming the healthcare response to intimate partner violence and taking best practices to scale. *J Womens Health (Larchmt).* 2012;21(12):1222–1229. doi:10.1089/jwh.2012.4058

29. Ghandour RM, Campbell JC, Lloyd J. Screening and counseling for Intimate Partner Violence: a vision for the future. *J Womens Health (Larchmt)*. 2015;24(1):57–61. doi:10.1089/jwh.2014.4885
30. Miller E, Decker MR, McCauley HL, et al. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception*. 2011;83(3):274–280. doi:10.1016/j.contraception.2010.07.013
31. Miller E, Goldstein S, McCauley HL, et al. A school health center intervention for abusive adolescent relationships: a cluster RCT. *Pediatrics*. 2015;135(1):76–85. doi:10.1542/peds.2014–2471
32. Miller E, Tancredi DJ, Decker MR, et al. A family planning clinic–based intervention to address reproductive coercion: a cluster randomized controlled trial. *Contraception*. 2016;94(1):58–67. doi:10.1016/j.contraception.2016.02.009
33. Miller E, Jones KA, McCauley HL, et al. Cluster randomized trial of a college health center sexual violence intervention. *Am J Prev Med*. 2020;59(1):98–108. doi:10.1016/j.amepre.2020.02.007
34. Miller E, McCauley HL, Decker MR, et al. Implementation of a Family Planning Clinic–Based Partner Violence and Reproductive Coercion Intervention: Provider and Patient Perspectives. *Perspect Sex Reprod Health*. 2017;49(2):85–93. doi:10.1363/psrh.12021
35. Williams JR, Halstead V, Salani D, Koermer N. An exploration of screening protocols for intimate partner violence in healthcare facilities: a qualitative study. *J Clin Nurs*. 2017;26(15–16):2192–2201. doi:10.1111/jocn.13353
36. Miller E, McCaw B, Humphreys BL, Mitchell C. Integrating intimate partner violence assessment and intervention into healthcare in the United States: a systems approach. *J Womens Health (Larchmt)*. 2015;24(1):92–99. doi:10.1089/jwh.2014.4870
37. Whitaker DJ, Baker CK, Pratt C, et al. A network model for providing culturally competent services for intimate partner violence and sexual violence. *Violence Against Women*. 2007;13(2):190–209. doi:10.1177/1077801206296984
38. Mason R, Wolf M, O’Rinn S, Ene G. Making connections across silos: intimate partner violence, mental health, and substance use. *BMC Womens Health*. 2017;17(1):29. doi:10.1186/s12905-017-0372-4
39. Laing L, Irwin J, Toivonen C. Across the divide: using research to enhance collaboration between mental health and domestic violence services. *Australian Social Work*. 2012;65(1):120–135. doi:10.1080/0312407X.2011.645243
40. Miller–Walfish S, Kwon J, Raible C, et al. Promoting Cross–Sector Collaborations to Address Intimate Partner Violence in Health Care Delivery Systems Using a Quality Assessment Tool. *J Womens Health (Larchmt)*. 2021;30(11):1660–1666. doi:10.1089/jwh.2020.8438