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Lessons Learned About IPV Survivor-Centered Support During the COVID-19 Pandemic:

Recommendations for Pediatric Healthcare Providers

Project Overview

The **Improving Services for Violence Against Children and Women** project explores the state of intimate partner violence (IPV), child abuse and neglect (CAN), and community-based support agencies working to address the needs of IPV survivors during the COVID-19 pandemic. The project aims to identify unique needs, gaps, barriers, and potential improvements to service provisions within the context of a public health emergency. This brief focuses on best practices and innovative strategies that pediatricians and pediatric healthcare providers can implement to form stronger support networks for survivors of violence and abuse that continue to function in emergency conditions. This brief was developed through a collaborative effort by Futures Without Violence, the American Academy of Pediatrics, and from research by the UPMC Children's Hospital of Pittsburgh, which includes a series of interviews with survivors, IPV advocates and administrators, and Child Protective Services (CPS) advocates.

Introduction

The safety and wellbeing of child and parent survivors of family violence are inextricably linked. In 2018, approximately 678,000 children experienced child abuse and neglect (CAN) in the United States[1] . Intimate partner violence (IPV)[2] is also prevalent, directly impacting more than 1 in 4 women[34] , and exposure to IPV and domestic violence (DV) has profound consequences on a child's health and wellbeing. Research indicates that a child survivor's best interests are inseparable from their survivor parent's. Improving responses and outcomes for child and parent survivors require IPV to be treated as an experience that impacts multiple family members, and the safety, healing and wellbeing of adult and child survivors be addressed interdependently[5] . Ultimately, both IPV and CAN are national public health issues and critical social determinants of health.

The frequency and severity of IPV and CAN during the COVID-19 crisis has become

"Survivors do an incredible job of protecting their children to the best of their ability, and a lot of safeguards have been taken from survivors, so kids can't go to camp or school anymore. They're more likely to hear and to witness the abuse that one parent is engaging in with the safe parent."*

exceedingly concerning. The pandemic created unique opportunities for those who cause harm to assert power and control—a cornerstone of IPV and CAN—through isolation, threats, manipulation, and violence. Additionally, families are experiencing compounded levels of stress, economic strain, and restricted opportunities for connection with social networks hindering their ability to reach out for support. Parents have had to navigate the pandemic and ever-changing safety orders while simultaneously working from home without childcare.

Children and adolescents have also been deeply impacted. While the prevalence of COVID-19 is lower in youth populations, they nevertheless are experiencing significant and direct effects of the pandemic, including childcare and school closures, violence exposure at home, mental health symptoms, parental illness, parental job loss, poverty, and pandemic-related bereavement. With childcare and school closures, children have been isolated at home, lacking the safety, support systems, and food access found within their classrooms. These circumstances are having profound impacts on youth, especially those belonging to communities that have been historically marginalized and under-resourced—Black, Native, Latinx, and low-income youth, in particular. Over the past two years, with fewer families accessing preventative healthcare and fewer kids in school, there have been fewer opportunities to identify CAN, intervene, and support children and parents.

There are definitive links between family violence, structural racism, and health inequities that disproportionately affect youth and adult survivors' wellbeing, as well as their access to healthcare and critical support services. Survivors, particularly from communities that have been historically marginalized and under-resourced, are facing unprecedented intersectional challenges. Pre-pandemic disparities have become exacerbated and more deeply exposed. The syndemic[6] nature of the pandemic has created staggering challenges for youth survivors. Isolating stay-at-home orders and the national economic crisis are worsening barriers for families in meeting basic needs like housing, employment, childcare, and access to technology. Since family violence does not occur in a silo but rather within the broader context of political, social, and environmental factors, it is imperative that IPV, the nation's structural inequities, and COVID-19 be addressed concurrently.

Practices and systems rooted in structural racism and inequity restrict youth survivors—especially Black, Native, immigrant, gender and sexual minorities, and those who are low income and uninsured/underinsured—from accessing the resources, services and vital support they need, when they need it most. This brief aims to:

- Identify organizational policy and practice recommendations for healthcare organizations;

- Highlight systems-level improvements to promote equity across the service landscape and address disparity gaps and underlying root causes of IPV during and post-pandemic; and
- Inform institutional preparedness and response for future public health emergencies and/or natural disasters to ensure pediatric healthcare providers' capacity to meet inevitable growing demand and continue effective service provision.

Prevention and Upstream Approaches

IPV and CAN are associated with significant health consequences for youth and adult survivors. Pediatricians and pediatric healthcare providers are critical supporters for families experiencing violence and abuse, as they can intervene and respond to violence that has already occurred and provide anticipatory support to families before abuse occurs. Pediatricians and pediatric healthcare providers can advance their support and improve health disparities for all families by integrating primary prevention strategies, including addressing social determinants of health, in their approach to clinical care.

Primary prevention strategies work to stop violence from occurring by promoting conditions that support healthy families and communities. In particular, social determinants of health— including economic security, safe housing, access to quality food, and healthy relationships— are environmental conditions that play a significant role in one's health, functioning and quality of life. By prioritizing prevention, addressing social determinants of health, and providing broad universal education about safe, stable, and nurturing family relationships, pediatricians and pediatric healthcare providers can be key partners in reducing the stressful conditions that make violence more likely.

Systems and Practice Change Recommendations

1. **Address root causes and build protective factors[7] as primary prevention strategies.** Within clinical practice, pediatricians and pediatric healthcare providers have the opportunity to support a child's health by intentionally and routinely assessing their social determinants of health. Such an assessment reveals areas for targeted support to improve child and family health and wellness with referrals for wraparound services. At the organization and systems level, providers can educate about approaches that address underlying inequities, foster community resilience, and promote prevention, such as a livable wage, universal healthcare, accessible healthy food options, accessible childcare in and out of the home, expanded affordable housing, and more.

   Recognize those with lived experience as valuable contributors and invite them to the table to strategize practice change in a survivor-centered way. Build upon survivor-centered solutions established during the pandemic to address the disparity gap and build resilience for families. For example, many agencies provide alternative housing options, like hotel stays, to offer immediate solutions for survivors and their families. Many of these solutions may be feasible and useful post-pandemic allowing for a more survivor-centered approach to care. Through a trauma-informed, cultural humility lens, providers can also promote positive parenting strategies and emphasize the importance of safe, stable, and nurturing relationships with adults as part of routine pediatric care.

2. **Integrate universal education and provide resources on IPV and CAN in all clinical visits.** Addressing the rising rates of family violence during the pandemic is needed to support youth and child health, mental health and wellbeing. Providers can adopt an organization and systems-wide primary prevention approach by utilizing the Confidentiality, Universal Education and Empowerment, and Support (CUES)[8] framework, for

example, to provide brief education and resources on family safety to all families. Universal education helps families make connections about the importance that the family environment has on health, recognize signs of violence early on, and seek support if violence has occurred. Universal education also creates opportunities for providers to reach unidentified survivors, offer support, and make direct linkages to support services through warm referrals. Through collaborative coordination, warm referrals can help healthcare providers address immediate safety concerns and ensure continuity of support for survivors that extends beyond the exam room.

Providers can also use the clinical space as a means for enhancing education and resource awareness in safe ways, such as displaying posters in restrooms and routinely distributing IPV and resources, including safety cards (available from the National Health Resource Center on Domestic Violence). Pediatricians and pediatric healthcare providers are encouraged to also be well-informed on the many community-based resources available for survivors and understand the important role that IPV agencies and community-based youth organizations play as they specialize in the survivor-centered support services needed.

3. **Support families experiencing IPV and CAN in pediatric clinical settings.** Providers can adopt a trauma-informed lens for improved response to child abuse and family violence, ensuring more effective interventions by creating a healing-centered space, where families recognize the health care setting as a trustworthy source of support. With the expansion of telehealth services, clinical response to family violence must accommodate unique confidentiality and privacy concerns survivors face. For example, some providers are integrating the use of code words to ensure safety when communicating virtually with youth and adult survivors. Within a trauma-informed approach, pediatricians and pediatric healthcare providers can provide validation and empathy for families regardless of a disclosure of abuse. Providers should understand that there are often multiple clinical encounters before disclosure happens. When experiences of abuse are disclosed during a clinical encounter, providers have the opportunity to validate and respond in meaningful ways.

"We're ensuring safety and making sure that the kids are not in harm's way. We've also got to think about the parents...how are we supporting them? With our role, it's pretty limited, so what can we do as an agency to connect with other agencies to fully come up with really good resources for these families to support them."

All pediatricians and pediatric healthcare providers are mandated reporters of CAN. It is imperative that providers and the entire care team understand their reporting requirements related to both CAN and exposure of children to IPV, and relevant laws within their respective states, as exposure to IPV itself is rarely a reason to file a report. If a report to CPS is mandated (e.g., if there is concurrent child abuse), it is critical providers consider ways to support families. Mandated reporting should always be accompanied by concurrent support for families experiencing IPV, including referrals to IPV agencies to provide safety planning in the case that the report escalates abuse or punitive actions toward the IPV survivor or child. Providers should be aware of local specialists in IPV and CAN; for example, IPV advocates who are co-located within child welfare offices can help survivors navigate the system. Further, healthcare agencies must have clear, written policies regarding reporting and responding to suspected child abuse but must recognize that healing does not come from the legal system but rather from empathy and family-centered support and resources.

Because mandated reporting may initiate a process of involving a family in the child welfare system, it is especially critical for providers to be aware of how intersecting racism, sexism, and classism have led to deep disparities within child welfare where parents of color (particularly Black and Indigenous families) are more likely to have a report filed against them or have their children removed from the home, and less likely to receive services from CPS. Racial, gender, and class bias can impact our individual actions as well as systems and policies and should

be considered at multiple levels in the context of IPV, CAN, and mandated reporting. Ultimately, disclosures and reports should be treated as a request for non-judgmental help and understanding and must always be accompanied by supporting[9].

Pediatricians and pediatric healthcare providers should always consider their primary goal of supporting all families to ensure child safety and wellbeing. This can be facilitated through healing-centered conversations with caregivers that consider both survivor autonomy and child safety. When CPS reporting is indicated for CAN in the context of IPV, providers should inform the IPV survivor of the need for reporting. Additionally, providers **should consider a full range of support and resources for all families**, including IPV resources. Developing formalized partnerships with IPV agencies can help in providing support and safety planning for survivors as well as support in navigating the CPS system. In cases where CPS is not required, the care team should have a safe and effective alternative plan to support the family as much as possible using trauma-informed, survivor-centered approaches.

4. **Enhance training for pediatricians and pediatric healthcare providers.** Capacity building and training is imperative for medical professionals. Using a team-based approach, healthcare organizations can provide ongoing training to all staff year round, including clinicians, medical students, residents, fellows, nurses, administrative and support staff. Training should cover essential topics, including:

- the fundamentals of IPV and CAN (recognizing signs, identification, response and intervention) and their intersection;
- adverse childhood experiences (ACEs) and their impact on health and behavioral health;
- the state's mandatory reporting laws and practices; and
- social determinants of health.

Pediatricians are encouraged to build rapport and relationships with their patients and families so anyone needing support feels comfortable disclosing family violence and abuse. Given this practice, organizations should also offer trainings on cultural humility, disability identity, queer and trans affirming care, and building rapport with families to affirm their commitment to patient and survivor-centered care and create spaces that cultivate trust. Additionally, training should cover the practice of equitable, trauma-informed, and youth-friendly services across all service delivery methods—in person clinical health visits and telehealth services.

"I feel like normally, all of our agencies throughout the community, we help each other but we also stay in our lanes. Now...we're all coming together to help each other because there's so much going on."

5. **Prioritize partnerships with IPV agencies and community-based organizations to develop systems for transformative collaboration.** Pediatricians and pediatric healthcare providers can reduce silos to build collaborative services that leverage the collective capacity of a multi-disciplinary network of resources and ensure comprehensive, whole-person care for survivors and their families through strategies that include:
   - Centering racial equity in initiatives to develop partnerships with social support service providers who continue operations during a pandemic such as IPV agencies, schools, youth programs, childcare agencies, places of worship and culturally specific grassroots organizations. The context of the pandemic has underscored the need for organizations to proactively develop strong partnerships that directly tackle racial disparities in access to services and outcomes.
   - Formalizing mutually beneficial partnerships with Memorandums of Understanding (MOUs). Through these agreements, partners can delineate methods for survivor-centered care and response, establish procedures for coordinated systems of care, and facilitate warm referrals.
   - Embedding routine assessment of IPV and CAN, universal education, and trauma-informed response into ongoing clinical services to more quickly identify those experiencing abuse, better respond to survivors' health needs, and make warm handoffs to trusted partners streamlining access to support. For example, partnerships can implement co-location, placing family violence advocates within the healthcare setting to make warm handoffs seamless.

Developing these networks represents an opportunity to improve community support networks for survivors post-pandemic. Including the voices of youth and adult survivors engages them in the collaborative process to identify their needs and define key trauma-informed practices and services. Ensuring language access across service delivery and collaborations for survivors with

limited English proficiency is also critical. Pediatricians and pediatric healthcare providers can adopt resources from existing collaboration frameworks to develop partnerships, such as www.ipvhealthpartners.org.

Partnering with pediatric mental health agencies can also facilitate access to equitable, culturally responsive and culturally-specific care. To ensure sufficient access to services for children, project findings indicate that maintaining and expanding school-based services during a pandemic and beyond would support continuity of care and address access inequities for children of color. Lastly, project findings suggest expanding mental health resources for youth and parent survivors would also increase access and equity; for example, improving Medicaid policy to cover parent-child therapeutic interventions, expand availability of services, and ensure language access to care.

6. **Continue and expand successful practices launched during the pandemic through an equity lens.** Adapted services and innovative practices launched during the pandemic have proven beneficial for survivors of family violence. Telehealth services, in some ways, have enhanced equity by increasing accessibility and reducing barriers to in-person services, such as the need for transportation, extra time for transportation and childcare. Maintaining and expanding these successful telehealth and communication practices will continue to improve safety, confidentiality, and accessibility for survivors by reducing technology barriers.

7. **Educate on broader policy and systems change across healthcare.** Healthcare providers are key players in the service landscape and need to be included as important partners when strategizing policy and systems change. Pediatricians and pediatric healthcare providers have a role not only in improving family safety and CAN support, but also in

wide scale health education and policy development. Highlighting IPV and CAN as both public health issues and key social determinants of health is critical to improved care. Pediatricians and pediatric healthcare providers can be instrumental in centering prevention, anti-racist approaches, anti-poverty work, and strategies that address root causes of violence and inequity in healthcare delivery and patient outcomes. Additionally, IPV and family violence advocates must be considered as essential workers given their unique roles.

Pediatricians and pediatric healthcare providers can have a role in creating transformative systems change using their direct experience in collaboration with survivors and IPV support programs, mental health providers and social service providers to shape policy and practice. Within their offices and exam rooms, providers are positioned to identify the infrastructure that promotes multi-sector collaboration and partnerships as an ongoing part of clinical care, which can benefit their patients' holistic needs.

Conclusion

The negative health impacts of IPV and CAN are well documented. The COVID-19 pandemic highlighted both strengths and vulnerabilities in the systems of care surrounding adult and child survivors. The pandemic and its many impacts on programs, policies, and funding also created a context of rapid change and innovation that, in some cases, led to service innovations that are forming a new body of best practices. Pediatricians and pediatric healthcare providers can play an important role in creating access to much needed health and social services for survivors of all ages during the pandemic and beyond. By committing to practice, program, and systems level changes that promote prevention and increase access to integrated care, the health and safety of child and parent survivors will ultimately be improved.

Endnotes

1 Child Maltreatment 2019 (2019). the Children's Bureau (Administration on Children, Youth and Families, Administration for Children and Families) of the U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2019.pdf

2 Intimate partner violence, also referred to as domestic violence, is the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, psychological violence, and emotional abuse. The frequency and severity of domestic violence can vary dramatically; however, the one constant component of domestic violence is one partner's consistent efforts to maintain power and control over the other. Learn more about the dynamics, signs, and prevalence of domestic violence at the National Coalition Against Domestic Violence: http://www.ncadv.org/learn-more/what-is-domestic-violence

3 National Intimate Partner and Sexual Violence Survey (2015). Center for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

4 IPV affects more than 1 in 10 men in their lifetimes and impacts LGBTQ populations at even higher rates. National Intimate Partner and Sexual Violence Survey (2015). Center for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

5 Domestic Violence and Child Abuse Reports: A complex matter (2021). Futures Without Violence. https://promising.futureswithoutviolence.org/program-readiness/programpractices/child-abuse-mandatory-reporting/

6 Syndemics have been used to describe the interaction between diseases and the social, environmental, and economic factors that worsen and amplify intersecting conditions such as IPV, COVID-19, and health. Mendenhall, E. (2017). Syndemics: a new path for global health research. The Lancet, 389(10072), 889–891. doi:10.1016/S0140-6736(17)30602-5

7 Issue brief on protective factors for survivors of domestic violence (2019). Quality Improvement Center on Domestic Violence in Child Welfare. https://dvchildwelfare.org/resources/issue-brief-on-the-protective-factors-for-survivors-of-domestic-violence/

8 CUES: Addressing domestic and sexual violence in health settings. Futures Without Violence. https://www.futureswithoutviolence.org/wp-content/uploads/CUES.pdf

9 Lessons Learned during COVID-19: Well-being as a Pathway to Safety (2021). Quality Improvement Center on Domestic Violence in Child Welfare. https://dvchildwelfare.org/wp-content/uploads/2021/05/Tipsheet-COVID-Well-being-as-a-Pathway-to-Safety.pdf

Resources

- Futures Without Violence Improving Services for Women and Children During COVID-19 project page and links to other issue briefs
- Futures Without Violence, Resources for Safety and Support during COVID-19
- Child Welfare Information Gateway, Covid-19 State Child Welfare and Related Health Resources
- American Academy of Pediatrics, Critical Updates on COVID-19
- AAP Family Snapshot: Intimate Partner Violence in the Home During the COVID-19 Pandemic
- Intimate Partner Violence: The Role of the Pediatrician
- Reimagining Child Welfare: Recommendations for Public Policy Change
- The Praxis Project, Social Determinants of Health
- CDC, Social Determinants of Health

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