

How to identify, assess, and refer patients experiencing interpersonal violence across the lifespan: the role of US pharmacists in integrated pharmacy research and practice

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Catherine Cerulli¹
Sachi Inoue²
Jennifer Cerulli³

¹Laboratory of Interpersonal Violence and Victimization, Susan B. Anthony Center, Department of Psychiatry Research, University of Rochester Medical Center, Rochester, NY 14642, USA; ²Susan B. Anthony Center, University of Rochester, Rochester, NY 14642, USA; ³Medication Therapy Management Pharmacist, MyMedZ Medication Review Service, Selkirk, NY, USA

Abstract: Interpersonal violence is a public health crisis in need of multipronged interventions. Victims of violence experience both acute injuries and chronic illness and may seek acute self-care and/or have the need for chronic medication therapy. Thus, the community-based, ambulatory pharmacy setting can serve as a portal for identification of, and intervention for, victims of violence. This article provides background on four types of interpersonal violence, including intimate partner, child and elder abuse, in addition to sexual assault. This article briefly reviews the statutory reporting requirements for pharmacists in the United States, identifies educational needs for pharmacists with existing resources and suggests a method for the ambulatory pharmacist's intervention.

Keywords: interpersonal violence and victimization, pharmacy practice, protocols for pharmacy practice

Introduction

Interpersonal violence is an international public health problem affecting all countries to differing degrees. This article addresses the issue of injury and violence prevention as noted by Healthy People 2020 and potential roles for the pharmacy professional.¹ Traditionally, different fields of violence prevention practice and research are fairly siloed: child abuse and neglect (CAN), intimate partner violence (IPV), elder abuse and neglect (EAN), and sexual violence. However, these types of violence all have some commonalities which suggest that a uniform approach for screening, assessment and referral by health care professionals may be helpful. The role of community pharmacist is evolving with administration of vaccinations, Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived laboratory testing, active engagement in the quality of the medication use process and the expansion of over the counter medications. Often, the pharmacy is the first stop in the patient's health care journey as individuals seek self-care and/or turn to their pharmacists to triage and provide answers to some of their complex medical and medication questions.

Although the pharmacy setting provides a potential portal for victims of violence to enter the health care system, few pharmacists receive detailed training on interpersonal violence despite it impacting many of their patients. For those pharmacists working

Correspondence: Catherine Cerulli
University of Rochester Medical Center, 300
Crittenden Blvd., Rochester, NY 14642,
USA
Tel +1 585 275 5269
Email Catherine_Cerulli@URMC.
Rochester.edu

within hospital settings, the Joint Commission provides the requirements for mandatory education and response protocols.² But what about pharmacists that operate outside of hospital systems, sometimes completely on their own in independent practices? This article will provide a background on different types of interpersonal violence, briefly review the statutory reporting requirements for pharmacists in the United States (US), and suggest some signs pharmacists might observe and interventions that might be offered to patients. In addition to an overview of each type of violence, we will also provide a discussion about the pharmacist’s role in responding when they suspect their patient has experienced violence. For purposes of this article, we are focusing on community-based, ambulatory pharmacists working in independent, chain, mass merchandiser or grocery settings across the US.

According to the most recent data published by the Bureau of Justice Statistics (BJS), the approximate rate of victimization is 21.1 per 1,000 for people living in the US based on household survey data.³ As noted above, victimization occurs across the lifespan and happens at the hands of strangers, friends, neighbors, family members, and intimate partners. The World Health Organization provides a typology grid for violence types by relationship - See Figure 1.

Crimes of violence can include a range of outcomes, including those that affect emotional and physical health. It can also include abuse regarding deprivation of money, goods, or care, including medications. We begin with child abuse, IPV and elder abuse as they travel across the

lifespan and end with sexual violence, which can affect individuals regardless of age.

Child abuse and neglect (CAN)

Millions of children are reported to child protective services (CPS) in the US each year. One recent study suggests that over the course of the lifetime, 1 in 4 American children are exposed to family violence, which can be considered a form of adverse childhood experiences (ACEs), contributing to morbidity and mortality.⁶ Child abuse affects both male and female children. In 2012, CPS referrals reached an estimated 3.4 million children.⁷ Four fifths of perpetrators (80.3%) are identified as parents.⁷

Many individuals experience ACEs, and as a result, they can suffer comorbid substance abuse and mental health problems. These events can include being neglected at the hands of a parent or guardian, having a parent incarcerated or be an alcoholic, or being exposed to IPV, as noted above. Decades of research documents the deleterious effects of ACEs⁸⁻¹¹ on individuals, such as worsening morbidity and early mortality (compared to those who do not experience ACEs), and suicide.

Intimate partner violence (IPV)

Intimate partner violence is defined as “physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner ... ”.¹² A US community-based survey reports 5.9% of women and 5% of men suffered abuse within their own homes in the past year,¹² yet lifetime rates are

A typology of violence

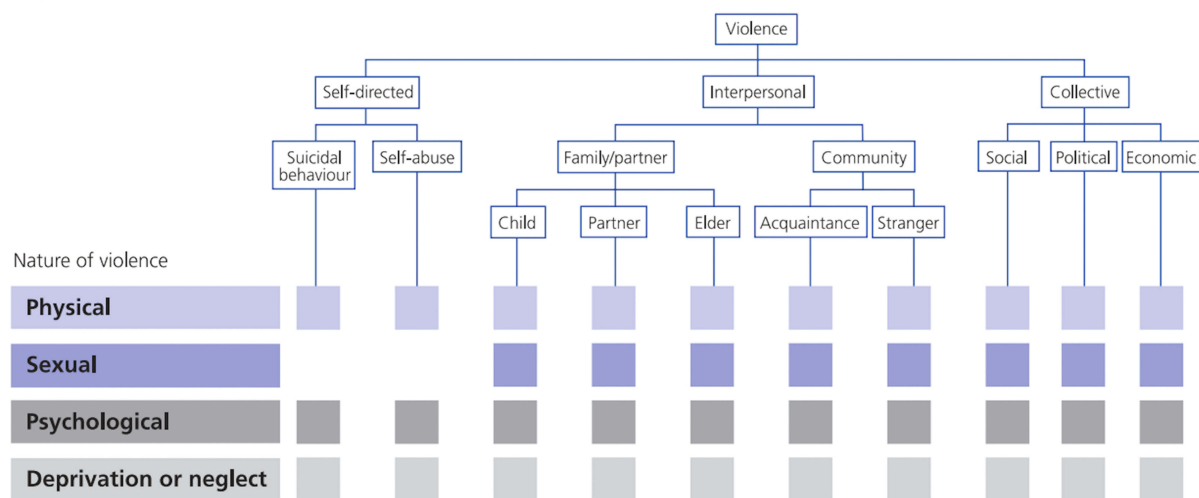


Figure 1 A typology of violence.^{4,5}

substantially higher. For example, 35.6% of women and 28.5% of men in the US report that they experienced physical violence, stalking, and/or sexual assault over their lifetimes.¹³ This suggests a large number of patients entering pharmacies may be suffering from abuse histories that may warrant intervention/specialized referrals to IPV providers such as shelters. IPV has enormous repercussions for the mental and physical health of victims, regardless of gender or sexual orientation. For example, studies suggest male and female victims of IPV experience depression more often than those without IPV, even when emotionally abused in isolation of physical violence.¹⁴⁻¹⁶ A community-level study revealed that those individuals reporting IPV reported higher use of medications for depression.¹⁷ Victims of violence also experience many comorbid conditions including chronic pain, fibromyalgia, chronic fatigue syndrome, and sexually transmitted diseases (STDs). The transfer of STDs can be a form of abuse as well, when a perpetrator won't allow a victim to utilize contraception barrier methods, such as condoms, or engage in coerced sexual activity. Survivors also report sleep deprivation and insomnia.^{18,19} As a result of these co-occurring mental and physical health issues, IPV victims often utilize healthcare generally at higher rates.²⁰⁻²² Therefore, in addition to obtaining medications for chronic depression and/or pain,²³ victims may also seek care in their pharmacies by purchasing items for wound care, sleep aids, and other potential signs of abuse when there is a pattern of their care seeking coupled with observable bruises and injuries such as cuts and burns. A United Kingdom study found a correlation between females reported exposure to IPV with general practitioner consultations for emergency contraception (EC).²⁴ Therefore, victims may be entering pharmacies for myriad treatments.

Elder abuse and neglect (EAN)

The abuse of those in their older years is not a new phenomenon. Elders suffer physical, sexual, and emotional abuse, as well as confinement, passive neglect, willful deprivation, and lastly, financial exploitation, sometimes at the hands of a loved one or caregiver.²⁵ Elder abuse is more common than people realize, with approximately 1 in 10 people 60+ years of age reporting having experienced elder abuse in the US.²⁵ However, out of fear, shame, and sometimes confusion, elderly victimizations are not often reported, with one study estimating only 1 in 14 cases are reported to the authorities.²⁵ Because 90% of elder abuse and neglect incidents happen at the hands of

the victim's own family, whom the elder may rely on for transportation, food, shelter and medications, reporting it is complicated.²⁵ This abuse results in increased mortality, as those who experience abuse have approximately a 3-fold increased risk of death than those who aren't mistreated.²⁵ Many of these elders see their pharmacists as a trusted individual, often seeking guidance from them for any number of issues.

Sexual violence

As shown in Figure 1, sexual violence spans a number of categories including intimate partner, child and elder abuse, in addition to acquaintance and stranger assaults. Rape and sexual assault are public health issues that affect 1 in 5 women and 1 in 71 men in the US.¹³ Lesbian, gay, bisexual and transgender (LGBT) populations experience rape at even higher levels than those in the heterosexual community.²⁶ There is an urgent public health need to prevent sexual violence to reduce the morbidity and mortality associated with its aftermath, including serious physical health consequences, post-traumatic stress disorder (PTSD), depression, and suicide. Most victims knew their perpetrators, as intimates or acquaintances, and were victimized before the age of 25.¹³ An alarming 42.2% of female victims of completed rape were first raped before they turned 18, with 30% experiencing first victimization between 11 and 17 years of age.¹³ Among a US sample of youth in high school, 10% of females and 5% of males reported a lifetime history of forced sex.²⁷ For male victims, very early victimization is devastatingly common, with nearly 28% of males reporting their first completed rape victimizations at 10 years of age or younger.¹³ If rape victims seek medical care for a rape experience, they may seek it from a Sexual Assault Nurse Examiner (SANE)²⁸ or their primary provider or gynecologists. SANE exams can include an examination and collection of forensic data, treatment for injuries, assessment and treatment for STDs, pregnancy prevention, mental wellness care, victim and legal services.²⁹⁻³³ Some rape victims may not have physical injuries that need attention, but rather the fear of an unplanned pregnancy or STD becomes the primary issue leading them to seek a pharmaceutical intervention. The risk of pregnancy after sexual assault is 5%, while the risk of contracting a STD is 30%. Before the over-the-counter availability of Plan B One-Step® (Foundation Consumer Healthcare, Pittsburgh, Pennsylvania), fear of pregnancy was one of the main reasons survivors sought emergency department care.³⁴ In a survey of emergency contraception

users on a US university campus, 7.3% sought EC due to sexual assault. Thus, pharmacists are encountering sexual assault victims in the provision of EC, who may have not sought the additional post-assault support available to them as noted above via SANE programs.³² Thus, they may not be obtaining treatment for their injuries, STDs, or the acute and chronic psychological impacts of the assault. The World Health Organization issued a 2013 report promulgating best practices for post-sex assault care, strongly recommending EC as well as post-exposure prophylaxis HIV treatment.³⁵ These guidelines only reinforce the important role of pharmacists for women seeking this care.

Role of pharmacists

We address three primary questions regarding the role of pharmacists: 1) What is the pharmacist's legal obligation to report abuse; 2) How to incorporate abuse information in pharmacists and pharmacy student educational efforts; and 3) What can pharmacists do when they identify abuse happening in a patient's life. These issues will be discussed in brief.

Mandatory reporting and the health insurance portability and accountability act of 1996 (HIPAA)

Currently, to the best of our knowledge, there is no unified database or website that documents mandatory reporting laws in the US for suspected cases of CAN, IPV, EAN, or sexual violence as it pertains to pharmacists. This makes it difficult for pharmacists to become aware of their possible status as mandatory reporters or easily access information to prepare them to properly respond should they identify a case of abuse in a pharmacy-specific context. The Child Welfare Information Gateway published a report on state statutes valid through August 2015 on mandatory reporters of child abuse and neglect and documented that seven states (see Table 1) explicitly identify pharmacists as mandatory reporters.³⁶ Additionally, a compilation of state statutes on the different forms of abuse exist and were used to ascertain the incidence of state legislation identifying pharmacists as mandatory reporters. The Family Violence Prevention Fund, currently known as Futures Without Violence, published a compendium of state statutes and policies on IPV and health care in 2010.³⁷ In this report, five states (see Table 1) were found to require pharmacists to report treatment of an individual for injury that was caused by a gunshot, or in some instances, injuries caused by a knife, other deadly weapon, or by other

means of violence.³⁷ Lastly, the New York County District Attorney's Office and NAPSA Elder Financial Exploitation Advisory Board released a report in 2014 that documented reporting requirements by state as it relates to EAN.³⁸ Laws in eleven states (see Table 1) at the time of the report identified pharmacists as mandatory reporters of EAN.³⁸ We did not locate anything for mandatory reporting of sexual assault. SANE programs operate within the federal and state patient privacy laws.

Search strategy and selection criteria

A pharmacist, attorney, and public health student independently conducted a search for peer-reviewed articles and other relevant resources that addressed the intersection between pharmacists or pharmacy students with CAN, IPV, EAN, or sexual assault. PubMed was searched for relevant journal articles, while Google Scholar and Google were searched for relevant materials released by organizations and other stakeholders. Search terms were a combination of the two key categories, pharmacist and type of abuse, with a connecting term related to knowledge, identification, referral or assessment. Examples of this include "pharmacist knowledge of child abuse" or "identification of elder abuse by pharmacy students". In addition, the term "healthcare professional" and similar terms were used to replace pharmacist in the initial search to identify material. Afterwards, the document would be scanned to see if there was any portion specifically for the pharmacist reader. This search yielded a diverse set of resources including reports from national organizations, peer-reviewed studies, and educational materials. Each author then compiled a grid with articles found and each item was then reviewed for inclusion in the paper based off relevance to practice for community pharmacists.

Current preparedness of pharmacy students and pharmacists

Despite a noteworthy number of states in the US identifying pharmacists as mandatory reporters, initiatives ensuring that pharmacists are aware of their status to report suspected cases and in preparing them to properly respond seem to be missing based on our review of available literature.

When reviewing the literature on pharmacists as it relates to abuse, there was no body of work that assessed pharmacists' knowledge, experiences, or readiness to respond to all three forms of abuse at once. Instead, studies

Table 1 State reporting statutes identifying pharmacists as mandatory reporters of violence across the lifespan

Child abuse and neglect³⁶	Injury from knife, firearm or other deadly weapon, or other means of violence³⁷	Elder abuse and Neglect³⁸
Alabama (Ala. Code § 26-14-3)	Maryland (Md. HEALTH-GENERAL Code Ann. § 20–703)	Alaska (Alaska Stat. § 47.24.010 (a))
Colorado (Rev. Stat. § 19-3-304)	Michigan (MCLS § 750.411)	Colorado (Colo. Rev. Stat. §18-6.5.102 (11))
Connecticut (Gen. Stat. §§ 17a-101; 53a-65)	Minnesota (Minn. Stat. § 626.52)	Connecticut (Conn. Gen. Stat. § 17b-451 (a))
Hawaii (Rev. Stat. § 350-1.1)	Pennsylvania (18 Pa.C.S. § 5106)	Georgia (G.A. Code. Ann. §30-5-4 (a)(1)(A))
Oregon (Rev. Stat. §§ 419B.005; 419B.010)	Tennessee (Tenn. Code Ann. § 38-1-101)	Hawaii (Haw. Rev. Stat. §346-224 (a))
Vermont (Ann. Stat. Tit. 33, § 4913)		Idaho (Idaho Code Ann. §39-5303 (1))
Washington (Rev. Code § 26.44.030)		Illinois (320 Ill. Comp. Stat. 20/2 (f-5))
		Maine (Me. Rev.Stat.tit.22, §3477 (1)(A))
		Missouri (Rev. Stat. Mo. § 192.2405, 192.2475, 198.070, 208.912)
		New York (N.Y. Pub. Health Law § 2803-d (1))
		North Dakota (N.D. Cent. Code §50-25.2-03 (1))

separately evaluated samples of pharmacists or pharmacy students to assess various aspects of awareness of one specific form of abuse, resulting in varied amounts of research on each topic.

Studies looking at pharmacists' awareness of child abuse or readiness to respond to the issue would be relevant since at least seven states identify pharmacists as mandatory reporters, however, we could not locate any research studies. However, we did locate one continuing education training for pharmacists in the state of Pennsylvania, "Recognizing and Reporting Child Abuse in Pennsylvania", which provides state specific guidelines on pharmacists as mandatory reporters in that state.³⁹

Research relating to IPV training for pharmacists has shown their lack of awareness, readiness, and knowledge among pharmacists on how to respond to suspected cases

of IPV. In a cross-sectional study with 144 community pharmacists, 67.4% of participants reported no IPV-related training at all.⁴⁰ A majority of those surveyed (77.6%) were also uncertain if there was a legal mandate in their state of practice to report suspected cases of IPV.⁴⁰ The Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) was adapted to assess the same sample of pharmacists for actual knowledge about IPV.⁴¹ The mean score of pharmacists on the actual knowledge scale was 20.83±6.04, lower than the reported scale mean in a sample of physicians (26.0±5.18) and a sample of health care students (23.9±5.68).⁴¹

Although work on the detection of EAN as relating to pharmacists has been limited, one significant research work was found.⁴² The study involved surveying 328 third- and fourth-year pharmacy students to assess their

awareness of state reporting laws for EAN and recognition of associated signs and symptoms. The study found that despite 98% of respondents stating that identifying EAN was important, and 76% responding that educational content on EAN should be included in the curriculum, only 23.4% of respondents felt adequately trained to report a case of suspected EAN. In addition, while 24% of responding students had suspected a case of EAN, only 1.8% had ever reported a case of EAN.⁴² Furthermore, only 44% of responding students correctly identified that in Illinois, the state in which they practiced, state law required them to report suspicion of EAN.⁴² Clearly, more training is needed and there are a series of trainings available.

Educational efforts

Institutions do not need to reinvent the wheel when considering how to offer training to their students or pharmacists on abuse as many professional organizations provide training. One such example is The Center of Excellence on Elder Abuse and Neglect that offers free information on interdisciplinary efforts, discipline specific information, research summaries and advocacy and policy insight.^{43,44} Geropharmacists from universities partnered with community-based agencies to create a training for pharmacists on EAN, no matter the setting: in-patient, outpatient, ambulatory, and long-term settings. The training covers the warning signs, how to intervene, and reporting obligations. There is also a companion course for pharmacy students. Lastly, the website provides algorithms regarding reporting requirements which can easily be adapted for local providers and institutions.⁴⁰

Training for pharmacists regarding all forms of interpersonal violence, including child abuse, IPV, elder abuse and sexual assault should include federal, state, and local reporting requirements, as well as the necessary forms which must be completed, and any follow-up required. There is no doubt that understanding the intersection of these laws and professional guidelines can be overwhelming. In a 2004 letter written by the Director of the Office of Civil Rights for the Department of Health and Human Services, then Former Director Richard Campanelli acknowledges the complexity of understanding how federal HIPAA laws requiring releases before sharing personal health information intersect with state and federal laws meant to protect vulnerable people:

With respect to the first of these issues - whether some health care providers resist disclosing protected health information

to CPS/APS [Adult Protective Services] agencies without an authorization from the individual or a court order - the Privacy Rule recognizes that protected health information can be essential to agencies charged with protecting individuals against abuse and neglect and domestic violence. To allow covered entities to appropriately share information in this context, and to harmonize the Privacy Rule with existing state and federal laws mandating uses and disclosures of protected health information, 45 CFR § 512(a) permits covered entities to comply with laws requiring the use or disclosure of protected health information, provided the use or disclosure meets and is limited to the relevant requirements of such other laws. Where and to the extent that such disclosures are required by law, no authorization or court order is required for the disclosure. 45 CFR § 512(a). Further, to the extent that such disclosures are required under State law, as described at 45 CFR § 164.512(a), the minimum necessary standard does not apply. (45 CFR § 164.502(b)(2)(v)). While the Rule itself does not require disclosures in compliance with State laws, neither does it interfere with such State law requirements.⁴⁵

In simpler terms, the letter cites relevant statutes stating that mandated reporters are permitted to disclose protected health information to the proper government agencies given that the disclosure is limited to only the relevant requirements to report the suspected abuse. No authorization or court order is required for the disclosure if the reporter is mandated to do so under the law. Given the need to provide pharmacists and student pharmacists with the knowledge on signs of abuse and guidance on properly responding to suspected cases of abuse, as well as their mandatory reporting requirements, we undertook a review of educational material specific for pharmacists.

We began with CAN. The materials found on child abuse were developed in the United Kingdom and included guidelines, learning articles, and educational modules. The National Institute for Health and Care Excellence (NICE) in the United Kingdom recently released comprehensive guidelines to support health and social care professionals in recognizing and responding to abuse of individuals under eighteen years old.⁴⁶ Certain portions of this guide were then emphasized in a learning article published for pharmacists and pharmacy teams to be better prepared to recognize and respond to child abuse and neglect.⁴⁷ Along with this body of work, the Center for Pharmacy Postgraduate Education (CPPE), also based in the United Kingdom, developed educational modules, specifically for individuals in the pharmaceutical setting.⁴⁸

These modules are designed for pharmacists and pharmacist technicians to understand legislation relating to the issue and their associated role, increase knowledge on forms of child abuse and neglect, and inform them of actions to be taken should they suspect abuse.⁴⁴ Any trainings for pharmacists regarding CAN must include the emotional toll being a mandatory reporter can take on the professional. In 2017, McTavish, et al.⁴⁹ reported on results from a meta-synthesis about the impact of mandatory reporting for CAN on the reporter. Their search resulted in 44 articles which discussed the experiences with mandatory reporting: 14% of the studies reported positive experiences but 73% reported negative experiences including harming the therapeutic relationship. More research is needed for pharmacists specifically as none of the studies reported included pharmacists.

When reviewing educational material focusing on IPV, a recent meta-analysis surfaced which reported on educational programming for healthcare providers that met criteria for having evaluated their programs.⁵⁰ No articles noted pharmacists as a target audience. There was a study, however, examining human simulators and standardized patients to teach about how to have difficult conversations involving sensitive information such as IPV to interprofessional health care teams that included pharmacists.⁵¹ Aware of the lack of educational material for pharmacy students on IPV, our past work described the first steps towards creating training tools for pharmacists to improve their knowledge and readiness to respond to IPV.⁵² This was accomplished through the evaluation of an IPV didactic session adapted for student pharmacist to identify what future pharmacists want to know in relation to the topic.⁵² This work continues as students and faculty have raised interesting questions, such as: a) what if a small town pharmacist approaches patients where they live with and have neighboring relations; b) what if a pharmacist is afraid for his or her own safety; c) how does one walk through the quagmire of mandatory reporting laws and regulations if one is a solo practitioner? While not specific to pharmacists, there is a wealth of information on the Futures Without Violence website for healthcare professionals, in addition to addressing IPV within the workplace. Given many pharmacists work within large healthcare entities or retail chains, it is possible that pharmacists have colleagues or patients they encounter who may be experiencing victimization, as well as personal histories and experiences.⁵³ Any training initiatives should include resources should the participant

potentially be experiencing victimization or have a childhood history triggered.

While CAN and IPV overlap, we could not find any educational initiatives in which both were addressed for pharmacists. In 2017, Turner et al⁵⁴ conducted a systematic review of interventions to reduce the impact of CAN on children as a result of IPV. They found 21 articles that met their criteria, 3 randomized control trials and 18 training initiatives. None of these studies indicated pharmacists were part of the target audience.⁵⁴ So below, we offer some recommendations targeting pharmacists.

What to do?

It's early Sunday morning in the pharmacy. A young woman alone comes toward the pharmacy counter, but not too close. She has on long sleeves despite a warm summer day and she seems a bit disoriented and disheveled. You wonder whether she is alright, tired, or perhaps hungover from a late night with friends. She seems anxious and her eyes darting, making no eye contact with your pharmacy team. She waits until your pharmacy technician steps away to attend to a task and moves closer to the counter making eye contact with you ever so briefly. It is the familiar way patients approach the counter when they only want to talk with you, the pharmacist, about something private and personal that they are hesitant to discuss or share. Things like "I think my kid has lice", "How much is Viagra", or inquiring how to treat a vaginal yeast infection etc. As you walk towards her, she looks down and quietly asks you for the morning after pill. Her embarrassment shows through as she blushes, but as you look more closely you see a faint bruise below her left cheek. She doesn't want you looking at her and looks away. You pause ... there is more here than needing EC.

What might a pharmacy-based intervention look like? It is difficult to know where to begin. It is possible the patient has experienced a sexual assault, or perhaps had consensual unprotected sex. How comfortable would this patient or future victims be receiving interventions at the pharmacy level for such personal issues? Research on IPV has looked at the practicality of pharmacists screening for IPV by examining their unique role as suppliers of EC and by evaluating perspectives of female pharmacy consumers on the acceptability of IPV screening in the pharmacy setting. A research group from the United Kingdom found that women with experiences of IPV in the last 12 months were 2.06 times more likely to have a consultation for emergency contraception than women with no exposure to

IPV.²⁴ The odds ratio for a woman seeking consultation for EC increased to 2.8 times among women aged 25–39 with exposure to IPV compared with unexposed women.²⁴ Another study surveyed 60 female pharmacy customers on their knowledge, attitudes, and perspectives on community pharmacists as a source of healthcare advice about IPV and IPV screening.⁵⁵ Approximately 85% of respondents thought that IPV screening is an important thing to do and 33.3% agreed that it should happen in a pharmacy.⁵⁵ Time and availability of appropriate space for IPV screening were identified as potential barriers to screening in the pharmacy environment.⁴⁹

Survey data collected from women purchasing EC at university pharmacies and students in an undergraduate women’s studies class collected ideas from vaginal rape survivors on suggested interventions which could aide in increasing awareness of services for rape survivors and address their unmet needs. Several suggested flyers, pamphlets within packing of EC which includes hotlines and resources for survivors. One survivor wrote, “ ... attach a flyer with resources inside the Plan B package” but also indicated she would not want a pharmacist intervention by writing “I personally would NOT want the pharmacy (a public environment) to give me a run-down of support/services just b/c I am purchasing Plan B. It’s embarrassing enough.”²⁸

Despite limited educational efforts, research on patient’s/victim’s opinions on the possible role of pharmacists as portals for help provide a basis for more to be done. An important component to understanding one’s mandatory reporting obligation and how to screen and

identify the issues of abuse is knowing what to do once it is identified. To that end, we recommend the following acronym, KIND, which we have developed as a simplified summary of best practices for pharmacists to remember in situations of encountering a person experiencing interpersonal violence (Figure 2).

K – Know: Be mindful to consider whether your patient is in a safe space to have a discussion about the potential abuse. If the client is a child, understand your mandatory reporting laws and how HIPAA might impact your actions. We do not recommend intervening in such a situation but rather notifying the authorities if warranted. Even if pharmacists are not specifically noted, it may possible to make a referral under certain circumstances. If the client is an adult, be mindful of whether they are alone in the store or are accompanied by another person, who could potentially be the abuser. Don’t assume because the friend is a same gender that they are not a potential abuser, as the rates among people in gay and lesbian relationships are similar to those in heterosexual relationships. Assess whether you can ask the patient to move to a quiet area of the store, perhaps to a private or semi-private counseling area if they are alone and you can step away from the counter.

I – Inquire: Conduct the inquiry in a safe space. There are trainings offered by US-wide organizations noted above, as well as local providers, regarding how to ask the questions about one’s experiences of violence. You can start by noting that you have made an observation, that you are worried about the patient’s safety, and you are there to offer help. There are plenty of online resources that have extensive prepared materials to help in instances

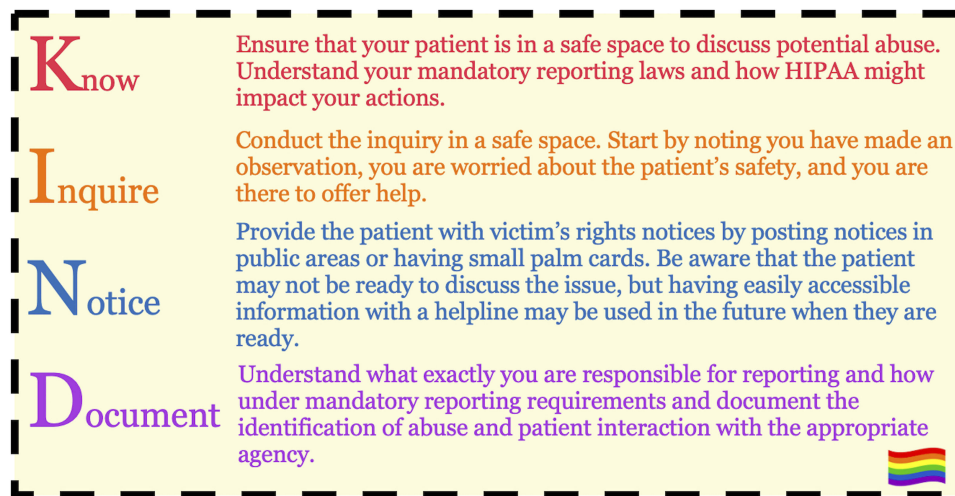


Figure 2 KIND Card Caption: The above is a sample card that may be cutout with the KIND acronym and a brief description of each step to be used by pharmacists for easy reference. A rainbow flag is included on the bottom to serve as a reminder that interpersonal violence reaches all ages and communities.

of suspected abuse to be used by the observer or given to the individual for which you suspect abuse. This could include providing cards, or a safe quiet office for the patient to make a call to a national US hotline. If language is a barrier, some hotlines offers instantaneous translation services. Be non-judgmental and supportive.

N- Notice: Provide the patient with victim's rights notices – which you can find on your state office of crime victim's website - potentially by posting notices in your pharmacy or bathroom areas, having small palm cards available for ease in the patient taking and hiding them in a safe manner, or providing takeaways at the counter such as lip gloss or nail files with phone numbers that are not identified. Be aware that a patient may not be in a state of readiness to discuss the issue but having the information with a helpline, both 1–800 national numbers and local providers in the US, may be extremely helpful when he or she is ready to make a call.

D – Document: If you have a mandatory reporting requirement to document the identification of the abuse and patient interaction with the appropriate state agency, be sure you are prepared to do that and understand the correct forms to be completed and where they are sent. Realizing that not every encounter requires you to know someone's contact information, be aware of what exactly you are responsible for reporting and how, and the consequences for your failure to do so. You also need to be aware of your HIPAA requirements, both at the federal and state levels.

As acknowledged, there are many nuances to understanding how all the federal and state laws intersect with local and organizational policies, as well as being aware of your own ethical and moral obligations. While it is impossible in the scope of this article to cover each state's reporting mandates, the take away message is don't wait to find out. Don't wait until you witness abuse in your professional setting, such as a child being abused or a victim with a black eye and contusions, standing before you at the counter. Contact your local domestic violence, EAN, and child abuse prevention programs and seek partnerships and training to be prepared. Ask your professional organizations to provide guidelines and continuing educational credit programs. Email your supervisor and ask for guidance on your institutional policies and procedures. What you don't want is to be in the moment and wished you knew how to be KIND to your patients.

In 2013, the World Health Organization recommended clinical and policy guidelines for how to respond to intimate partner violence and sexual assault.³⁵ The report defines a healthcare provider as "...an individual or an organization

that provides health-care services in a systematic way."³⁵ (p. vii) The report suggests that healthcare providers can facilitate disclosures, offer support, and referrals.³⁵ In addition to providing guidelines for protocols for best-evidence responses to IPV and sexual assault, the report notes "Intimate partner violence and sexual violence have been recognized as violations of ... human rights, including ... rights to freedom from discrimination"^{35,56} Pharmacists can play a key role in ensuring that the human rights to safety are insured for the patients they encounter in their practices.

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