SCHOOL-BASED HEALTH ALLIANCE
Redefining Health for Kids and Teens

Webinar Transcript: Addressing Adolescent Relationship Abuse in School-Based Health Care
Presented by Lisa James, Dr. Liz Miller, and Meg Kane
March 24th, 2021

Hi, everyone. Thanks for joining the School-Based Health Alliance webinar; Addressing Adolescent Relationship Abuse in School-Based Health Care presented by Lisa James, Dr. Liz Miller and Meg Kane. Will be for implementing to abuse in the clinical setting. Incorporating learnings from their practical experience.

The School-Based Health Alliance works to interview the children and youth. We believe that all children and adolescents deserve to thrive. School-Based Health Care can did solution. When health and education come together great things happen. And they're better managed and behavioral manage issues and we all know that healthy students have better learners.

Now, we have a fow housekeeping reminders. All attendees are in listen-only mode. To ask a question during the session, use the Q and A icon that appears on the bottom of your Zoom control. We will also Kerr closed captioning for this webinar. To turn it on click on the CC. At the end of this webinar attendants will be asked to complete survey. Please let us know how we are doing. This webinar will be recorded and will be archived on our website if one two three days. This webinar is the first in our three part IPB series. We will invite you to join us to the second webinar. It can also be found on our website. As we mentioned, this webinar is part of a three-part series on adolescent relationship abuse.

The series is part of a larger body of work funded by the Bureau of Primary Health Care (BPHC). Through BPHC, the School-Based Health Alliance has a National Training and Technical Assistance Partnership to support health centers in serving school-aged children. Before I introduce today's presenters, I would like to review the objectives for this session. After today's webinar, participants will be able to: Explain the dynamics of adolescent relationship abuse (ARA, identify three reasons why SBHC providers might consider discussing ARA with their patients, and describe the CUES approach to discussing ARA with patients.

Now I would like to introduce our presenters for today: Lisa James is Director of Health at Futures Without Violence – a national health and social justice organization that has been working for over 30 years to end violence against women and children in the US and around the world. Lisa has been working for 25 years to lead the organizations national health initiative on violence, partnering with health care providers and domestic violence advocates across the country to improve the health and safety of survivors and promote prevention. Dr. Liz Miller is Director of Adolescent and Young Adult Medicine and Medical Director of Community and Population Health at UPMC Children's Hospital of Pittsburgh, and a board member of the newly established Pennsylvania School-Based Health Alliance. She has over two decades of experience developing and testing clinical and community-based prevention programs to address interpersonal violence. Meg Kane is a pediatric nurse practitioner and pediatric sexual assault forensic examiner at Nationwide Children's Hospital in Columbus, Ohio. She works in the hospital's School Based Health Centers as well as serving as the Clinical Outcomes Coordinator, using Quality Improvement principles to advance departmental and institutional aims with a specific focus and interest in health equity and social justice. Now I will hand it over to Lisa and Dr. Miller.

Thank you. We can go to the next slide. Thank you so much for joining us. My name is Lisa and it's a great pleasure and honor to join you today. I want to take a moment before we start to thank you for everything

you do every day but particularly this year, during the pandemic, I know what a rough year it has been and I know how hard and professionals in general specifically have been working to reach kids in need of support and to promote education and safety. So I just want to start there and applaud you for all of your good work and thank you so much for that as we move forward for adolescent and relationship abuse. But I hope you'll come away with some strategies that will help you to think about this and promote prevention in a new way.

Like the School-Based Health Alliance, future without violence runs a network for community health centers. The National Health Network on Intimate Partner Violence, Human Trafficking, and Exploitation. If you want to dig deeper on any of these issues or want training or talk about as it relates to prevention and response, we have a number of tools and resources available to you. So you'll see a lot of links there on the slide. Please do reach out if you have any further questions. Just in terms of level setting, you know, there's a lot of terminology that's often used around domestic violence, sexual violence, all trying to capture the different ways in which people might use harm in the relationship. For the purposes of this webinar we're going to be using the term adolescent relationship abuse unless we're specifying a specific study. But this is the one we'll be using moving forward for today. And in thinking about the dynamics and what an unhealthy relationship really looks like, it's looking in a relationship where one person is using tactics to control or coarse their partner. It's not a one time event but it's really an ongoing pattern that is not just about physical violence but a lot of emotional abuse and other coercive behaviors. Particularly during the pandemic we've seen some unique ways in which coercive partners are using even something like shelter in place to try and control the ways in which their partners are connecting with their friends or family members. So just an example that coercive or abusive in order to again maintain that power and control.

Unfortunately, we're seeing very very high rates of adolescent relationship abuse. One in five U.S. teen girls report either physical or sexual violence in an intimate relationship. And also when you're thinking a little bit about sexual violence, specifically, one in eight female and one in 26 male high school student report it. I want to note that some racial and ethnic minority groups are disproportionately impacted by different type of violence and I also want to recognize that the research is using and as we move forward we're trying to include a whole range of gender identities. But you may see that in the research moving forward. So we're seeing really high rates among the young people in which we're serving. And when you think about sexual harassment as many of 48 percent of high school and middle school students report this. So this is a problem that's definitely impacting the young people that you are working with and serving through your work. Again, in thinking ability those dynamics and trying to understand who is using violence and abusive and coercive behaviors in their relationships, we see with adolescent relationship abuse that violence is still gendered but young people still experience and perpetrate. So boys are more likely to be victims of psychological abuse. So I share that with you to just Exhibit 1s as you're working with young people to kind of consider the context and the impact of the abuse and its as you're working with young people to kind of consider the context and the impact of the abuse and its outcomes when you're working to promote both prevention. I'm happy to see that there's a whole session around technology. One in four teens in a relationship report have been called names, harassed, or put down by their partner. So this is a real red flag and it's important to be comfortable talking about that with young people in which you serve. And thinking about health, it's not just promoting the safety of the young people that we're working with but it's also reaching those goals that you all share. And unfortunately when we started this work most people were thinking about injuries as the major impact of adolescent relationship abuse or any kind of intimate or sexual violence. But you see here this is just a word of all the long-term of abuse that can last for many many years. And it really makes it very clear why it's critical for health care providers to be part of the solution because they're really seeing strong connections and consequences. I'll just lift up teen pregnancy because many of our programs are looking at that and they're nearly twice as likely to become pregnant as non-abused girls. So, again, not only do we want to promote health and safety of the young people but also prevent and a whole host of other negative consequences. And that's why we feel passionate about having health programs in general and school-based health specifically for

identifying and had responding to those that have experienced this. We know that you're saying very high rates in your centers and we know that school-based health interventions can make a difference in both decreasing violence and also creating a safe space for young people to come and talk about prevention and healthy and unhealthy relationships. And I know Dr. Miller will be talking about that. So with that I'm going to turn it over to Meg Kane. I know you've been doing great work to give it a detail in what this might look like.

Thank you so much, Lisa, I actually could listen to for you to talk. I have to disclosure my pharma relationship. My son was in the Pfizer. My name is Meg Kane and I'm in the Nationwide Children's Hospital Care. And our program was initiated in 2015 and now in 2021 we're in 14 schools and two districts. We have two mobile units that we use to leverage access to care. I don't have to tell this audience all the advantages of school-based health centers, but I will say as most on this call already know, they decrease truancy and decrease especially for marginalized use access care in a setting familiar and safer young people. Our goal as a program is to improve outcomes to learning which we do by encouraging our patients with the groan-ups and I will also say that this continuity of care which are adherent to school health are the reasons why they're specifically able and that are so key and ensuring and best outcomes in our young people.

We're going to talk a little bit today about Molly, this is not hear real picture and this is a patient of mine that I'm going to share about. Molly was a very funny and engaging 14-year-old girl and she made great grades and she was very popular and she came into my clinic one day and, you know, I started with my normal process, we did a history and kind of a normal history taking and she denied any concerns. As I started the physical I noticed that she had very faint bruising on her bilateral forearms and her neck and I asked her about it and she was pretty casual about it. She said her boyfriend got angry with her and got abusive. He always apologized and their parents both liked each other so she really didn't have any plans on ending the relationship. She did not find the behavior maladaptive or abnormal in any way. I was able to connect Molly with resources that day but my current safety screen and therefore I was providing sub par care. So if Molly didn't have bruising or come one day later I would not have caught that. I started wondering how many other kids could I have left in a dangerous situation or a I relied on a system that was not served very well and what was I going to do about this.

So this was kind of the back of the envelope road map. Some of which was composed by Dr. Miller who is on this call. I want to be super clear, I'm giving myself a lot of credit here. We can realize that this blueprint has already been laid out for us. If we look at the other ways and let's think about things like vaccination rate and we can kind of understand that we have a very clear pathway. We just don't engage if one efforts and then consider the problems solved. We know that what is helpful and constructive are these multi tiered approaches and then subsequently change culture and then ultimately moving the needle and healthier habits and behaviors for kids. So when I was looking at this I thought, okay, I need to understand the problem. Am I doing preventable harm? Yes and then changing the culture of the setting. So a little bit of background here, Nationwide Children's Hospital to zero preventable harm. Here's why that matters, if we understand so we do understand that. And if we just saw with my own example we understand that our current practice for screening for safety is optimal. Then we understand the eyes that I'm achieving zero preventable harm and I'm letting kids stay in dangerous situations without addressing it. And that's not consistent without values as an institution nor my more or less as a person. And more broadly for all of us addressing violence and youth in the primary care setting speaks to specifically to the provision of care. So it's very consistent with what we need to do. So what we have here is all of these adult medicine and public health organization. In our hospital we weren't constantly doing this because that's a recommendation for pregnant women. What I want to focus is universal assessment being considered providers, but let's dial in even further on that word universal. When I hear the word universal it kind of makes me think of looking at all people in all settings. So talking to kids about the relationships in as very many different environments as possible and what I will say their uniquely positioned to make an importantly and powerful impact. And I think if you can even take that a step

further and leverage your relationship with your partner's school and talk to kids about healthy relationships, healthy boundaries, there's not really a disadvantage there. It's a wonderful way to strengthen your message. And the more ways the stronger your message is going to be and the more chance they're going to have to understand and realize that this is a safe space and this is a way they can address this with you and their peers. So a little bit about quality improvement. QI is the framework we use to systemically improve the care we deliver to patients. The best way I heard this explained is to think really really big and start really really small. Think about the things that you can talk about ad nauseam. So why do so many people order respiratory infection array panels in the outpatient setting? I don't know but they keep doing it. And second failed my patient population and relying on the status quo. And fortunately for me it was here that I can see the this and if you're not familiar with this that is the collaborative improvement and innovation network which I cannot recommend enough. This refind around improving our quality of care and using best practices and really provided a framework to which we can practice and process improvement. If you have an opportunity to engage on this I would encourage you to do so. It's a very powerful set of tools that you can use. Very briefly, this was my project aim, kind of like my goal of these intervention in the school-based health care setting. And presenting for a well check and sustained for at least one year. So there are already several experts and youth violence on this call today so you don't need me to share too many facts about that subject. However, I am going to talk very briefly about what IPV can look like because that can be very easy to overlook, friends. And if we're not looking at it we are also missing out our chance to prevent, right. And here you can see a list of long-term affects which are pretty significant but also what you're going to notice is that a lot of these are reasons that a young person might wilt your and the differential diagnosis that you think often can and should include the violence this violence does not occur in a have vacuum and can help to prevent significant complications for youth throughout their life span. Very briefly, if you remember our pilot phase, we had a very specific aim along with changing the culture of our clinic ebbing setting, in order to better facilitate conversation we had a specific time frame for that which COVID adjusted for us a little bit. Despite that, and then an abbreviated comparison period we were able to identify several kids in a brief time span and connect them with services. It happens but the goal ultimately is really to connect with these kiddos and support services and I was very pleased that we were able to do that and going forward based on the knowledge we gathered on that pilot phase. Since we knew this work we then had to repeatedly speak to our stake holders and evaluate our successes and increased risk and it was important to have a process that both inclusively addressed these kiddos and provided resources internally. We also realized that after gather experiences from our team that we were missing huge opportunities, huge opportunities to ask our patients about digital dating violence and monitoring behaviors in their relationships. And given how those factor into the pathway, we needed to incorporate that as well in, like, yesterday. And in here it was another area where I realize my failures, for lack of a better term, so I was doing -- was I doing zero preventable harm? No. I needed to do better but I needed to recognize that if I was not constantly looking at feedback from my stake holders. Also I don't know about you guys but our school-based health centers we have a providers and then an MA and LPN. Any additional work that we ask people to take on must be heavily considered. So when we have
--we have to consider the mental burden of additional task work. So we try to move things to the system level by utilizing things like electronic medical record whenever possible. Anything that we can do to kind of operationalize and that was helpful to our team. If we can go to the next slide.

Okay. Much like other campaigns and pediatric we with visual cues with what is serving our aim and reminders of clinic that's a safe space. And actually this allows them to start having conversations about when they feel moved or speak with each other and our patients really have taken to this initiative. They bring posters and then they bring in posters and this has all been critical for having ownership for this space and that term allows them to provide a healthy reference point for each other. We know that they're going to go to their peer first for counsel before coming to an adult. We know that. And then it gives us a sense of youth friendliness and I want them to do that. I mean, they've heard feedback on the entire process. I had a kiddo

that says, oh, that's great that you guys ask those questions. And they come in and give me feedback all the time sometimes things such as my clothes which I never asked about but I will take it. Again, you probably didn't think you were going to see a picture of the bathroom but joke is on you. Amongst those resources are these little cards that we have them everywhere. So we also have them in the bathrooms and kids and adults who find themselves in violent situations. So the cards themselves and they're available in English and Spanish and somali. And the one we have in the bathroom is specifically because it's more of a private setting. We also monitor how frequently they're taken and if one language is taken more often than another. Certainly I've taken notes from this panel and this is one of the wins that we keep tabs on. Very briefly this is a digital rights poster that they have the rights to not be monitored online. And this is one that we adopted and it's just another visual cue that you are your own person and you deserve to be safe. We have a few community agency partners, I have goal that's trying to encourage. And as I mentioned briefly earlier we are broadening and healthy boundary education with our middle schoolers in our district and we report frequently with our team, we also do a lot of data sharing, right. We check on our compliance and our assessment data and then we share that data with our partners and we say we're doing a great job getting this done. But, again, what is your take on the process. Certainly whenever you're trying something new is really hard to get someone on board and it's going to be harder to launch, it's hard to help people feel empowered to tackle tough topics but I think when you add in the challenges such as add adolescent confidentiality limitations, working with the media criminal justice systems especially women and children I think it can be even more difficult and has benefitted us is going one day at a time and again going through the QI principles. I know I'm running out of time so I'm going to go a little bit faster. So our Sprotte constantly evolving, I already marginalized and comfortable that the commercial sexual exploitation of children and we're finding our clinical tools there and also the survivors of IEP has a lot of overlap and we're really focusing on this area a lot at the moment. And around this topic so we're hopeful that we can continue of local and national experts for kids in our area as safe as possible. So thank you so much for your time.

Wonderful, Meg, you're like my new best friend. It's so great and Nationwide Children's Hospital is really one of the leaders and what you're seeing is right and super focused on culture change. So I'm going to take us to the end and hopefully to some discussion as well, but really thelic about, and Meg alluded to this as well, that we have some significant barriers. Or uncomfortable and don't have enough time and particular serving minors and so just want you all to focus what those barriers might be.

In the next slide the, you know, patient-centered approach is that patient want us to talk to them about the relationships, they have concerns about how any information will be used, right. So they want to make sure that we're documenting things confidentially and empower patients with information regardless of disclosure. And this is such an important part of what Meg was saying as well because the perfect screening question is not going to necessarily increase disclosure. And what if December CLOESH and case identification is no disclosure and case identification is no longer our goal? And that has health professionals we are there to create relationships with young people. And we know that screening is just not great. They're not actually what survivors want us to do and in order to get referred and in order to get resources. So the many many of our patients who would say no including the story that Meg shared with us as well is that the resources are only offered based on a patient's disclosure and therefore we miss an opportunity. And I'm going to keep this going but I want you all to think about in the chat, right, why might a person not talk about or experiences of violence and trauma during your health visit. So think about all of the reasons that young people may choose not to disclose to us.

Next slide. And certainly I'm seeing all of the in the chat here judgment and stigma. And as you're putting ideas in the chat make sure you're sending it to everyone so they can see. Fear that that person could find out what those consequences might be and not being aware of one's right. We all get that, right. And so what

happens then if we shift to creating a safe place? It's about build building trust and promoting safety and displaying highly visible educational posters. Having information about hot line safety cards in common areas as well as in the bathroom and having to take forms and acknowledge. The paradigm shift here then is really pushing us even beyond trauma-informed care. And I don't have a lot of time to go into this today but I want to plant a seed in you all. We want to go to the what happened. And I want to encourage us and prenyl that I think many of us and totally do already it's asset-driven and focuses of their control and well-being and it is explicitly political because what we're thinking about with the engagement and this is involving culture spirituality and collected healing recognizing that there are multiple reasons in particular for our young people who are experiencing marginalization who a disclosure-driven practice doesn't seem adequatable. So the intervention that I'm going to share very briefly is called CUES, C for confidentiality, U for Universal education. So we do this so routinely in case I don't want you to feel like you have to share anything to get support. And if I have a young person that tells me either X, Y, or Z, I do have to get others involved. And then universal education it takes ten seconds or less. And put us situations or where adults are taken advantage of them. If this is part of your experience I want to make sure you have support should you ever need it. This is just an example of offering youth education.

Next slide. The safety cards I started giving two of these cards in case you're struggling on the relationship so you have the information to help a friend or family member. So that last part about sharing with a friend or family member actually was one as we were creating this intervention and working with survivors and working with practitioners and develop the adding take this information in case you can help somebody else actually occurred in a clinic although that's not happening and goes could I have three of those cards and that's what we're doing here development, right. It's tapping with the and I'm sharing this information with all young people because I think it's important to help each other and super helpful crisis lines to other young people. And so while in a moment I'm going to introduce to this safety card, there's some instances where in particular because I take care of young people who are safely housed and I will actually have the young person put my name into their phone and all the crisis hot liens. So Liz is in a lot of people's phone in Pittsburg. So while there is certainly I'm at theing you and you heard from Meg disclosure our own you can help somebody else with it inevitably I have a person who leans and says I feel like I can tell you anything and disclosures do happen. And for me I think this is the most incredible gifts so I thank them for trusting me with the story. And I hear them saying that things are complicated and would you like me to offer some thoughts and asking for permission to provide the resources. Next slide.

In addition and I said earlier the S is for support as practitioners we cannot forget that there's harm reduction strategies that we can offer. And the opportunity that a partner doesn't have to know about it and I did this actually yesterday with one of the patients and helping to note fie about a partner of supporting a young person or about an infection and how to navigate that. The S is also promote thing health of students who are survivors, right. So when a young person does choose to share their story, like would you like me to help and I can pretend to be the health department to and we can be really creative with how we work with young people to support their safety. And certainly reducing harm and remember where a young person is in harm this is one of the situations. And I do need to involve people to help keep you safe. Every call I make to Child Protective Services I do it together with the young person in the room and I find that incredibly important to do. So in terms of supporting a patient what I want to share is including the patient we know that our child protective services our reporting requirements are clunky and certainly not forcing our patient to proofed information or details they're not ready to share that they don't feel safe sharing and providing the safety card, the educational safety card that is designed for young people by young people. Offering to let them use the office phone and certainly arrange to have follow up visits who sits in our clinic once a week and we are in our clinic able to set up follow up appointments but it in fact is for the young person and I see a comment in the chat the teen dating abuse does not fall under mandated reporting guidelines in Pennsylvania. So it's really the confidential ways to victim service advocate. So national support lines and the kinds of information

that we want to make sure are readily available before. They're super accustom at this point and I just wanted to check out what it was like to reach out to you so I can talk to my patients about this. And next slide.

I did tell you that this approach, the CUES approach is an evidence-based approach. And we actually have evaluated this in school-based centers as well and with every clinic visit and offering some more direct assessment during this. And then because it's school-based health centers, right, we encourage so this was funded by the Institute of Justice.

Next slide, what we sound is increased recognition of what constitutes sexual coercion. So they were aware of relationship abuse resources. And this was not a disclosure-based intervention, we really didn't talk it was really intended as a supportive and safe intervention but we actually found less relationship and even though it's not a disclosure driven practice increased any to the provider. And we have now evaluated this approach in college health and counseling centers and family planning clinics demonstrating pretty similar outcomes as well. And so the work that we do within our school-based centers is profound, right. We have an incredible combined with the clinic-based intervention and providers do not have to be and help patient experience their violence. If there's one bit of homework is if you don't know well who your victim service advocates are please work on that. Set up memorandums of understanding. Some of the work that we do in the National Training is also helping set up these memorandums of understanding and would really encourage all of us to do this. So rethinking the way in which we define our success, right. What happens if we think about success is measured by efforts to reduce again person and to improve their options for safety. So the safety cards that I have been referring to please check out ipvhealthpartners.org. And really helping to be the evaluator of this work and it brings me so much joy to have work that it's readily accessible and it's free and we are there help with the implementation. I think I've left some time for questions.

Thank you so much, Lisa and Meg and Dr. Miller. That was great. I now invite everyone to ask questions in the Q&A box and I will pass it to Emily to moderate.

Thank you so much Dr. Miller, Meg, Lisa, this has been wonderful for me. There were a couple of questions that came through during the session that Lisa very generously answered by typing but I'd like to sort of bring them up again here. Someone asked about for plans for working directly along and agencies to holistically address this concern, but I'm wondering if anyone would like to chime in about strategies? Yes, thank you so much. I'll just jump in and say thank you for the question and the comment to reach out and understand what are your local programs, what services do they offer, what happens if you make a referral so that you are familiar and it's not just handing a form, basically, but that you know how might the young person get there, what languages are spoken, really understand the types of services that are provided -- specifically so definitely reaching out is critical and building meaningful partnerships can look a lot of different ways but really working together to think about how would referrals be accepted and how might you communicate around what's happening and how those referrals were handled. So we've seen so many beautiful partnerships and there is some cross learning and even opportunities for health providers to go through the program and offer the services so lots of great models around partnerships and particularly measuring OUs. Thank you, Lisa. And I will say that many years I worked at a domestic violence program and it would have been my dream for a provider to give me a call and say let's work together. So I think folks would be thrilled to receive those calls.

Someone shared that we need to be careful putting explicit hot line names so putting the name of the grocery store Lisa suggested. I think that's great. Someone asked about if teen dating violence does not fall in your state, are there still cases where it would be advised to report? So I can jump in here and just note that since this is national, every state has different rules and different laws and in fact every community and county implements those differently. So you can feel free to reach out and has a state-by-state review and then

definitely understanding how they get implemented in your county. And, again, just understanding what happens if you have to make a report. And we didn't have much time to go into too much but how to make a full report. And Meg and Liz you might have more to add there. I would just actually -- I mean, I think you covered it, Lisa, I would just say I think there have been times when it doesn't meet reporting guidelines and the local agencies won't take the report. So there's that but also I think I have also seen reporting through maybe the school to try to get more protection at a school. Often people date people at school. So I think that there's some validity to that too because if you're having trouble getting a child -- keeping a child safe at school if the abuser is there there's reporting pathway that some schools have that can maybe be more productive depending on their policy or what policies they have in place. I have seen more productivity there. And I would add and with the process with that they want. Thank you, Meg.

Another question that came through about teens who are quiet and spending time alone doesn't want to talk. I would like of open it up to get some feedback. I think that's a super common reason to refer. I mean, we see a lot of kids for behavior changes or low mood and I think if, you know, someone is noticing that there's an acould you tell change in a child's presentation then I have having them evaluated and looking at physical as well as other mental and emotional contributors to that is really valid. Indeed. And I think what Meg was saying earlier is having this on our radar all the time I think is really the key, right. Recognizing that people are in an abusive relationships and they're much and they just want to share with a person and three times OBGYN and finally they were like go see adolescent medicine and like within three minutes came out with this story because she's doing universal education and she's, like, yeah, this person hasn't left her room because her boyfriend is constantly checking up on her and making sure she's online in front of her computer and not going anywhere else and it was remarkable getting permission from a young person and getting permission from her mom. So, again just being able to open up the conversation this young person was so ready to share what she was experiencing.

Thank you, Dr. Miller. Thank you for the questions. Thank you for attending and participating in our chat. I'm so glad that all of you attending were able to join us as well. I'd like to invite you to complete our poll questions. They are very useful for us in terms of evaluating our content. So we invite to take a moment to complete those and you're welcome to sign off but certainly follow up if you have questions or additional feedback we would love to hear from you. Thank you so much.