AMERICAN MEDICAL ASSOCIATION WOMEN PHYSICIANS SECTION

Resolution: (Assigned by HOD)
(A-25)

Introduced by: Rachel Rezabek, Lizzie Suschana, Rhea Nichani, Sanjna Prasad, Michaela Kelly, Kenzie Fergus, Jessica Duffy, Mitchell Hanson, Megan Sousa, Stephanie Humen, Henna Mohabbat, Myra Moghal

Subject: Intimate Partner Violence Survivor Debt Education and Protections

Referred to: Reference Committee (Assigned by HOD)

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Whereas, intimate partner violence (IPV) is defined by physical violence, sexual violence, stalking, and psychological aggression including coercive methods of a current or former intimate partner[1]; and

Whereas, according to the National Intimate Partner and Sexual Violence Survey, half of self-identified women experienced sexual violence, physical violence, and/or stalking in their lifetime[2]; and

Whereas, coerced debt is defined as all non-consensual, credit-related transactions that occur in a relationship where one person uses coercive control to dominate the other person[3]; and

Whereas, economic abuse is defined as “behaviors that control a person’s ability to acquire, use, and maintain economic resources, thus threatening their economic security”[4]; and

Whereas, 58% of people who have experienced IPV have stated that the perpetrator has monitored, accessed, withdrawn from, or controlled their bank account[5]; and

Whereas, 50% of intimate partner violence survivors report debt of up to $20,000 and 23% have over $20,000[6]; and

Whereas, people who experience economic abuse in the United States (US) face collective economic losses exceeding $8.3 billion per year[5]; and

Whereas, in a 2018 survey by the Institute for Women’s Policy Research on the impact of intimate partner violence on survivors’ education, careers, and economic security, 73% of respondents reported they had stayed with an abusive partner longer than they intended or returned to them for economic reasons[7]; and

Whereas, economic abuse is a leading cause of homelessness with 57% of women experiencing homeless due to IPV[8,9]; and

Whereas, multiple studies have determined that economic abuse is associated with depression, decreased self-esteem, cardiovascular disease, heart palpitations, pregnancy complications, reproductive conditions, weight loss, negative child-related outcomes, and overall decreased quality of life[10]; and

Whereas, lack of detection of economic abuse in healthcare settings can lead to progression and exacerbation of the many chronic health conditions associated with economic abuse[10]; and

Whereas, current IPV screening methods focus on physical and sexual abuse, often failing to identify financial abuse[11]; and

Whereas, the Screening for Emotional Abuse (SEA) tool is the only screening tool available in the US to detect economic abuse and is only currently used by programs, shelters, and helplines dedicated to IPV[10]; and

Whereas, studies have found that reducing physical violence in people experiencing IPV was not effective in reducing economic hardship, indicating that current healthcare-based interventions focused on physical and sexual violence are not sufficient in providing care to people experiencing economic abuse[12]; and

Whereas, people experiencing economic abuse who have consistent access to social support and resources that provide economic stability and resiliency have better personal and economic outcomes[13]; and

Whereas, economic empowerment services are critical to helping victims gain the financial independence needed to leave abusive relationships, decrease future abuse, and shift economic power dynamics within relationships[14]; and

Whereas, advocates need training to recognize and address economic abuse, including tools to identify hidden abusive behaviors, assess financial risks, and co-develop safety plans that increase financial safety, access to resources, and economic opportunities for victims of IPV[14]; and

Whereas, in 2022, the Consumer Financial Protection Bureau (CFPB) prohibited credit bureaus from reporting any negative item of information about a survivor of human trafficking in their credit report[15]; and

Whereas, the CFPB recently issued a notice to garner public input on amendments to the Fair Credit Reporting Act to protect those who experienced economic abuse or coerced debt as part of intimate partner violence[16]; and

Whereas, legislation that releases victims from debt and any credit reporting agencies are limited to state decision, with only Connecticut, California, Maine, and Texas having approved legislation that protects victims of financial abuse 17,[18]; and

Whereas, our AMA has supported the medical, legal, and social rights of sexual assault and intimate partner violence in H-80.998, H-80.999, H-65.966, and H-515.965; and

Whereas, our AMA has supported the unique financial implications of cost of medical care for people who have experienced human trafficking and survivors of sexual assault in H-80.991 and H-185.976; therefore be it

RESOLVED, that our American Medical Association supports increased screening for economic abuse and debt coercion in healthcare settings, especially in patients who have already screened positive for IPV; and be it further

**Commented [1]:** No additional edits. Looks ready to go.

RESOLVED, that our AMA supports training initiatives for advocates and healthcare providers to recognize and address economic abuse and co-develop safety plans that increase financial safety and independence of IPV survivors; and be it further

RESOLVED, that our AMA advocates for federal and state policies to mitigate coerced debt, support financial rehabilitation, and expand access to financial resources and debt relief programs for IPV survivors, regardless of whether the violence has been reported to authorities.

Fiscal Note: (Assigned by HOD)

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**RELEVANT AMA POLICY**

**Sexual Assault Survivor Services H-80.998**

Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.

[Res. 56, A-83 Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: CSA Rep. 8, A05 Reaffirmed: CSAPH Rep. 1, A-15 Modified: Res. 202, I-17]

**Sexual Assault Survivors H-80.999**

1. Our American Medical Association supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing clinicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to:
    a. receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, drug testing for drug-facilitated assault, treatment of injuries, and collection of forensic evidence;
    b. preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (
    c. notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation;
    d. be informed of these rights and the policies governing the sexual assault evidence kit; and
    e. access to emergency contraception information and treatment for pregnancy prevention free of charge.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. Our AMA will advocate at the state and federal level for;
    a. the timely processing of all sexual examination kits upon patient consent;
    b. timely processing of "backlogged" sexual assault examination kits with patient consent; and
    c. additional funding to facilitate the timely testing of sexual assault evidence kits.
6. Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.

[Sub. Res. 101, A-80 Reaffirmed: CLRPD Rep. B, I-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CSAPH Rep. 1, A-10 Modified: Res. 202, I-17 Appended: Res. 902, I-18 Appended: Res. 210, A-22 Modified: Res. 211, A-23 Modified: Res. 805, I-24]

**Physicians Response to Victims of Human Trafficking H-65.966**

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

    Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

    The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

    The Polaris Project –
    In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
    - Operates a 24-hour National Human Trafficking Hotline
    - Maintains the National Human Trafficking Resource Center, which provides

a. An assessment tool for health care professionals
b. Online training in recognizing and responding to human trafficking in a health care context
c. Speakers and materials for in-person training
d. Links to local resources across the country

The Rescue & Restore Campaign –
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

[BOT Rep. 20, A-13 Appended: Res. 313, A-15]

**Coverage for Care for Sexual Assault Survivors H-80.991**
Our American Medical Association advocates for federal and state efforts to reduce financial barriers that limit sexual assault survivors' ability to seek physical and mental health care and social services after sexual assault, including funds to cover emergency, acute inpatient, and follow up services including testing, medications, and counseling without out-of-pocket costs for any patient.
[Res. 805, I-24]

**Family and Intimate Partner Violence H-515.965**

1. Our American Medical Association believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.
2. Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.
3. The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to:
    a. Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care.
    b. Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before they leave the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course.
    c. After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible.

   d. Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid.
   e. Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence.
   f. Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV.
   g. (Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves.
   h. Give due validation to the experience of IPV and of observed symptomatology as possible sequelae.
   i. Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made.
   j. Become involved in appropriate local programs designed to prevent violence and its effects at the community level.
4. Within the larger community, our AMA:
   a. Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
   b. Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
   c. Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
5. With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, our AMA believes the laws must incorporate provisions that:
   a. do not require the inclusion of survivors' identities;
   b. allow competent adult survivors to opt out of the reporting system if identifiers are required;
   c. provide that reports be made to public health agencies for surveillance purposes only;
   d. contain a sunset mechanism; and
   e. evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
6. Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
   a. Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
   b. Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
   c. Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
   d. Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about

barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

e. The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

[CSA Rep. 7, I-00 Reaffirmed: CSAPH Rep. 2, I09 Modified: CSAPH Rep. 01, A-19 Modified: Speakers Rep. 02, I-24]

**Insurance Discrimination Against Victims of Domestic Violence H-185.976**
Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.
[Res. 814, I-94 Appended: Res. 419, I-00 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19]