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APPLYING BEHAVIORAL INSIGHTS TO INTIMATE PARTNER VIOLENCE

Improving Services
for Survivors in
Latin America
and the Caribbean



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CONTENTS

Executive summary	5
Introduction	8
Chapter 1: Helplines	13
Chapter 2: Criminal justice system	22
Chapter 3: Health sector	33
Chapter 4: Mental health services	41
Chapter 5: Shelters	49
Conclusion	57
References	60

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EXECUTIVE SUMMARY

According to global survey data, 30 percent of women who have ever been in a relationship have experienced physical and/or sexual violence, perpetrated by their intimate partner. In Latin America and the Caribbean (LAC), it is estimated that 29.8 percent of ever-partnered women have been physically or sexually abused by their partners (WHO, 2013).

Intimate partner violence (IPV) is a leading cause of death, accounting for 34 percent of all female murders worldwide (UNODC, 2018). It has severe physical, mental, and reproductive health consequences for survivors and their dependents, and poses large social and economic costs to present and future generations (WHO, 2013).

Governments in the LAC region have undertaken a number of legislative and policy initiatives in an effort to prevent and respond to IPV. Providing high quality services that protect and empower survivors¹ is an essential component of the response by governments to IPV. While perpetrator-focused programs are still scarce in the region, survivor services reach millions of women every day. This report seeks to support governments in serving this population more effectively.

Aim of the Report

This report leverages insights from the behavioral sciences, including behavioral economics,

social psychology and neuroscience, to provide recommendations to improve the design of survivor services in the LAC region and, ultimately, to lead to better life outcomes for women. We aim to provide policymakers and service providers alike with:

- 1.** A diagnosis—informed by qualitative research—of potential behavioral barriers that service providers and survivors face in the process of delivering and accessing services, respectively; and
- 2.** Proposed interventions ideas, informed by a review of the behavioral science literature, that can be tailored to existing services and evaluated for impact.

Report Framework: Seeking, Responding, Sustaining

Even though the journey of IPV survivors may considerably differ across services and countries within LAC, this report is structured around the critical stages of interaction between survivors and service providers: seeking help, responding to survivors' needs, and sustaining survivor engagement.

Each stage is examined in terms of the services most commonly available in LAC, covering support helplines, the criminal justice system, the health sector, mental health services, and shelters.

¹ Reference to survivors relates to women who have suffered male-to-female violence, inflicted by heterosexual partners or ex-partners, since this is the most common type of survivor served by institutions in the region (Krug et al., 2002).



SEEKING: **Survivors' Help-seeking**

Survivors of IPV may never disclose that they have been subjected to IPV. If they do so, they are more likely to resort to informal support networks (i.e., relatives and friends) than formal institutions (Bott, Guedes, Goodwin, & Mendoza, 2014). This stage focuses on identifying some of the most important barriers that impede survivors from seeking help and accessing services, as well as the behavioral interventions to address them.



RESPONDING: **Service Providers' Response to Survivors**

In this section, we outline the potential challenges in service delivery as well as interventions aimed to provide survivors with the best possible response during their initial search for help. Beyond the wellbeing of survivors, the first encounter with service providers is important because it will determine survivors' perceptions of future interactions with the provider and their willingness to take further action.



SUSTAINING: **Sustaining Survivor and Service Provider Engagement**

Violent relationships are characterized by their cyclical nature. Tension-building and violent episodes are often followed by periods where the perpetrators will express remorse; this may lead survivors to leave and return to violent relationships on repeated occasions (Walker, 1979). While interventions in the two previous sections seek to disrupt this cycle, interventions at this stage aim to prevent it from reoccurring.

Conclusion

We all have behavioral biases, including service providers and IPV survivors. Leveraging this knowledge about human behavior to adjust elements in the design and delivery of services has improved the outcomes of government action in a wide range of policy areas. We believe IPV is no exception.

This report seeks to encourage policymakers to test new theory-driven approaches in a policy area where there is a significant need for evidence of interventions that have proven successful. To this end, we provide practical recommendations - intervention ideas - that can be implemented and tested within existing services, with a view to strengthening the response provided to IPV survivors by LAC governments.

Throughout this report, there are overarching themes that apply to multiple service providers, including the need to: i) emphasize confidentiality of support to minimize survivors' uncertainty aversion; ii) streamline processes to reduce decision fatigue among service providers; and iii) ease survivors' cognitive load during the referral process. These are detailed in the table overleaf, together with potential opportunities to implement relevant interventions across the three stages of a survivor's journey. We believe that these should be made a priority for piloting due to their potential for widespread applicability and impact within the region.



SEEKING



RESPONDING



SUSTAINING

Target Behaviors

Survivors do not report IPV or seek help through formal channels

Service providers do not provide adequate response to survivors

Survivors do not take up referrals

Key Behavioral Barriers

Uncertainty aversion. We tend to prefer known risks over those that are unknown (Fox and Tversky, 1995). Survivors may be uncertain about the potential repercussions associated with seeking help, particularly if they are unfamiliar with the type of support available or unsure whether their case will be treated confidentially

Burnout. IPV services are frequently under-staffed and in high demand, given resourcing constraints. Occupational stress, or burnout, can result from demanding and emotionally-charged interactions with survivors. This can lead to suboptimal decision-making, influenced by behavioral biases, on the part of service providers.

Self-efficacy. Self-efficacy is a belief in one's ability to complete tasks, achieve set goals, and overcome obstacles (Bandura, 1994). The abuse that survivors have experienced, accompanied by prolonged high levels of stress, may have eroded their self-efficacy, lowered their motivation, and reduced their capacity to engage with ongoing support.

Proposed Interventions Ideas

Helplines: Minimize fear of repercussions by removing call traces on mobile phones. Several mobile phone manufacturers have devised a function whereby calls to certain numbers do not show on the phone's list of outgoing calls. Ensuring that calls to helplines are not easily traced could help to minimize survivors' concerns and encourage them to seek help.

Criminal Justice System: Provide feedback to criminal justice staff on their social impact. Performance in professional settings increases when we are reminded that our work has a positive impact on others. Positive outcomes from IPV cases could be shared with criminal justice staff to overcome burnout, as well as highlight how their performance has positively impacted the lives of survivors. This is particularly relevant in a context where staff often become aware of only those cases that re-enter the justice system.

Shelters: Leverage social support from relatable individuals. Former shelter residents could be employed as mentors to convey how much staying in the shelter has helped them, and the importance of engaging with the services provided there. Friends and family could also be provided with supportive text messages that they could to send to survivors as a means to counteract the sense of isolation from their community that survivors may suffer from (Sullivan and Gillum, 2001).

Healthcare: Emphasize confidentiality and give clear information on reporting requirements. Survivor privacy could be enhanced through the creation of online and telephone health services. Stating the providers' reporting requirements upfront could reassure survivors that information about the abuse they suffer will not be shared with other public bodies without their consent.

Healthcare: Introduce training and conditional screening protocols. Training that assists medical staff in identifying signs of IPV could be combined with conditional screening protocols or decision aids to assist medical staff in avoiding judgement errors associated with burnout, as well as improve the rate of IPV identification

Mental Health: Show survivors their progress towards addressing their mental health conditions. Our motivation increases when we perceive progress. To help survivors realize their progress, mental health staff could provide them with a booklet that includes their treatment plan, progress made, and advice on how to persevere.

INTRODUCTION

1. Intimate Partner Violence in Latin America and the Caribbean

According to global survey data, **30 percent of women who have ever been in a relationship have experienced physical and/or sexual violence perpetrated by their intimate partner**. In Latin America and the Caribbean (LAC), it is estimated that 29.8 percent of ever-partnered women have been physically or sexually abused by their partners (WHO, 2013).

Intimate partner violence (IPV) is a leading cause of death, accounting for 34 percent of all female murders worldwide (UNODOC, 2018). It has severe physical, mental and reproductive health consequences for survivors and their dependents, and poses large social and economic costs to present and future generations (WHO, 2013).

Governments in LAC have undertaken a number of legislative and policy initiatives aimed at preventing and responding to IPV (see Essayag, 2017 for an overview). In recent years, this has been accompanied by unprecedented public support and civil society mobilization to demand more effective services for survivors (BBC, 2016; Rincón Henao, 2017).

Providing services that protect and empower survivors is an essential component of governments' responses to IPV. While perpetrator-focused programs are still scarce in the region, survivor

services reach millions of women every day. This report seeks to support governments in serving this population more effectively. We propose leveraging insights from behavioral science to expand policymakers' toolkits, improve the design of survivor services and, ultimately, lead to better life outcomes for women.

2. What is behavioral science?

Orthodox economic models assume that humans are perfectly rational, self-interested and that our preferences are consistent. Drawing on research from a number of disciplines - including behavioral economics, social psychology and neuroscience - behavioral science portrays a more nuanced model of human behavior.

Following pioneering work by Amos Tversky, Daniel Kahneman and others, a large body of psychology literature posits that decision-making can be divided into two systems: System 1 and System 2. System 1 is fast, automatic, largely unconscious, and highly susceptible to cues from the environment. System 2 is deliberative and voluntary. These two systems perform different functions and both are needed to navigate our daily lives. Indeed, without the efficiency of System 1, we would not be able to get through the hundreds of decisions we need to make every day, from how to commute to work, to how to answer the phone. And without the reflective thinking of System 2, we would not be able to solve problems, from how to follow a map when travelling

in a new country, to how to pass our school exams. However, automatic decisions (System 1) may not always lead us to the best course of action and our capacity to think deliberatively (System 2) is limited (Kahneman, 2011).

Encouragingly, behavioral science studies show how small changes to the environment in which people make decisions can ensure System 1 thinking leads to productive and positive outcomes. The Behavioural Insights Team (BIT) alone can point to major social impact from simplifying government communication, making it easier for citizens to access services, and making processes more timely to capitalise on automatic decision points (BIT, 2016).

Increasingly, policymakers around the world are applying insights from behavioral science to address a wide range of public policy challenges, from promoting healthy eating to increasing education attainment. We hope that this report can similarly start to shift the way policymakers think about IPV, and ultimately generate new solutions to a problem which occurs in all countries, all cultures, and at every level of society (García-Moreno, Jansen, Ellsberg, Heise & Watts, 2006; Vives-Casas et al., 2014).

3. Can behavioral science help us improve policymaking around IPV?

IPV is a public policy challenge characterized both by its heterogeneity and complexity. There is wide variation in the contexts in which IPV occurs, the nature of violent acts, and the populations affected. IPV is a phenomenon made up of multiple behaviors undertaken by different actors at different points in time (the survivor, the perpetrator, and the people they interact with, such as police officers, health staff, or their families and communities).

Behavioral science relies on a context-led approach to devising solutions. It could, therefore, prove particularly suitable for understanding and addressing IPV. As this report shows, by breaking down the problem to identify specific behaviors that should be encouraged or discouraged (such as encouraging police officers to gather better quality evidence) and experimentally testing interventions that aim to shift those behaviors, services can

become more effective and efficient, and achieve better outcomes for survivors.

4. Aim of the report

The objective of this report is to encourage policymakers in LAC to test new approaches to improving IPV survivor services in a policy area where evidence of successful interventions is scarce (Trabold, McMahon, Alsobrooks, Whitney, & Mittal, 2018).

This report therefore aims to provide:

- I. A diagnosis, informed by qualitative research, of potential behavioral barriers that service providers and survivors face in the process of delivering and accessing services respectively; and
- II. Intervention ideas, informed by a review of the behavioral science literature, to overcome these barriers, which can be tailored to fit existing services and evaluated for impact.

By creating a practical guide for governments in LAC to apply a behavioral lens to IPV survivor services, we hope to support them in strengthening their response.

5. Scope of the report

Survivors who seek support may potentially interact with a large number of services provided by government agencies and non-governmental organizations. In this report we focus on those services most commonly available in the region – support helplines, the criminal justice system, the health sector, mental health services and shelters.

It is important to make three caveats regarding the scope of this report and the recommendations put forward. First, we refer to survivors as women who suffer male-to-female violence, inflicted by heterosexual partners or ex-partners, given that this is the most common type of survivor served by institutions in the region (Krug, Mercy, Dahlberg, & Zwi, 2002). Violence can, however, be inflicted by a female on a male partner, bi-directionally or take place in same-sex couples. We believe that most of our recommendations are also applicable to these cases.

Second, we do not seek to identify and address all barriers that hamper effective access and use of services by IPV survivors, but only those which are amenable to a behavioral perspective. We recognize that there are challenges for which, given the nature of root causes, behavioral interventions do not provide an effective solution, and these challenges are not addressed in this report, for example, inadequate legal frameworks or severe understaffing of services.

Finally, we acknowledge that improving the quality of services provided to survivors does not address the underlying drivers of violent behavior—and that a comprehensive response to IPV that includes policies and programs to address perpetrators' behavior and the wider community's behaviour (including bystanders), must also be at the centre of public policy. Nonetheless, providing high-quality services that protect and empower survivors and their children, helping them escape violence and prevent further harm, is essential.

6. Report framework: Seeking, Responding and Sustaining.

While survivors' journeys differ greatly across service providers and countries within LAC, this report is structured around critical stages of interaction between survivors and service providers. These are: seeking help, responding to survivors' needs and sustaining engagement.



SEEKING: Survivors' Help-seeking

Help-seeking is the first step by which survivors come into contact with formal services. Survivors may reach out to services directly or third parties may do so if they become aware of an instance of IPV.

Survivors often never disclose that they have been subject to IPV. In a study in eight countries in LAC,

nearly half of the women who reported violence by an intimate partner in the past year stated they had never talked about it with anyone (Bott et al., 2014).

When survivors decide to seek help, they are more likely to resort to informal support networks (relatives and friends) than formal institutions. In the same study, the proportion of women who sought help from formal institutions ranged from 8.2 percent in Ecuador to 36.0 percent in El Salvador (Bott et al., 2014).

Lack of help-seeking behavior is driven by a myriad of reasons which differ from survivor to survivor. In each of the following chapters, we outline the most important barriers, identified through our qualitative interviews and desk research, as well as behavioral interventions to address those barriers.



RESPONDING: Service Providers' Response to Survivors

Once survivors—or others on their behalf—reach out to service providers, the response received will considerably affect subsequent interactions with the service. A negative response for instance, often associated with experiencing stigma or inadequate support, will impact on the feelings and thoughts survivors have about the value of the service and whether or not they will seek help again.

In many cases the geographical coverage of services for IPV survivors is limited and, where available, capacity is stretched thin. In this section, we outline potential challenges in service delivery as well as interventions aimed to provide the best response possible within existing constraints.



SUSTAINING:
Sustaining survivor and service provider engagement

Finally, violent relationships are characterized by their cyclical nature. Tension building and violent episodes are often followed by periods in which perpetrators express remorse and aim to convince the survivor that the abusive behavior will stop (Walker, 1979). This may lead survivors to leave and return to violent relationships on repeated occasions.

While interventions in prior sections seek to disrupt this cycle, here the aim is to prevent it from re-starting. Under this stage we outline barriers that may hinder sustained survivor-provider engagement and interventions to mitigate them.

7. Methodology

The findings of this report derive from various sources. To better understand how services currently function and potential bottlenecks, we conducted interviews with service providers in El Salvador, Honduras, Dominican Republic and Argentina. We conducted semi-structured interviews with over 20 staff in 16 public sector and non-governmental organizations. We spoke with individuals of diverse professional backgrounds and hierarchical levels. However, given the focus of our research – how service provision works in practice – most of the interviews were with front-line staff. The content of the interviews covered current processes as well as areas for improvement. We did not interview survivors because of the difficulties in access to this population and ethical implications, yet we recognize that this is a limitation of our qualitative research.

We also examined existing documentation, such as service protocols, statistics, performance reports, and user satisfaction surveys. Further, we reviewed the academic literature on IPV and behavioral science.

To devise the interventions proposed in this report, we drew on insights provided by interviews, behavioral science research, and lessons learned from other types of service provision. The process we followed is depicted in Figure 1.

Figure 1: The methodological process for the report



8. From evidence to practice

To implement the intervention ideas outlined in this report, further work is needed to understand the local context and how these interventions could be adapted to fit existing processes.

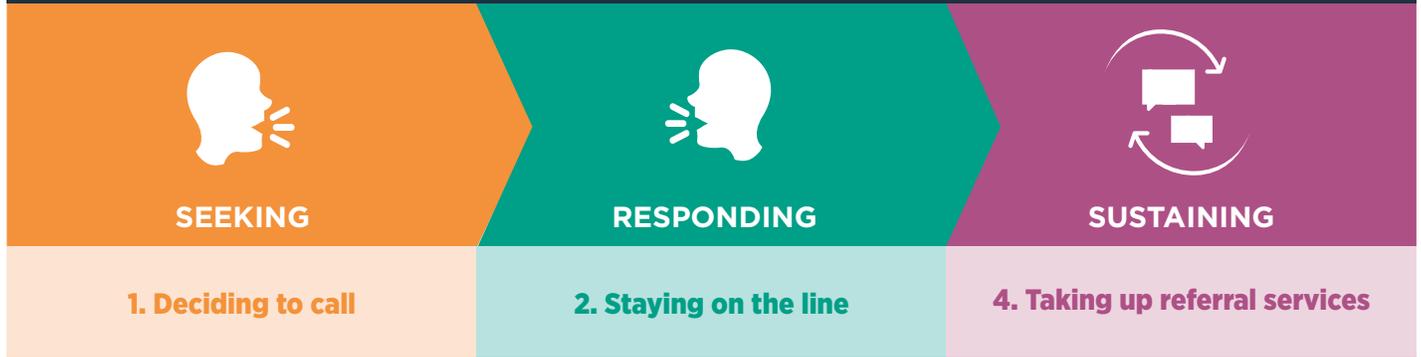
² The journeys described are intended to be indicative of the generic experience of survivors with that service in Latin America and the Caribbean, rather than representative of any particular country.

We suggest the intervention ideas put forward should be rigorously evaluated to ascertain what works and what doesn't and how governments in the region can best invest limited resources. We remain conscious that performing the target behaviors identified, for example, reporting IPV, may not bring the best possible outcome to all survivors because of increased risk of harm (Dugan, Nagin, & Rosenfeld, 2003). With this in mind, all the interventions proposed throughout the report are choice-preserving - women, service providers and bystanders can always abstain from performing the behavior promoted by the intervention. Furthermore, we recommend measuring impact, not only on the outcomes directly targeted (i.e., Did the service provider refer the survivor to other resources? Or, did the survivor collaborate in prosecution?), but also on survivor satisfaction with the service and long-term wellbeing. We would welcome feedback from governments on this report, the ideas contained in it and the feasibility of implementation.



CHAPTER 1: HELPLINES

CHAPTER 1: HELPLINES



1.1 Survivors not calling helplines



Re-frame helplines to encourage more reporting



Minimize fear of repercussions by removing call traces on mobile phones



Reduce concerns about being overheard by using online chat-based support

2.1 Survivors hang up before or during the call



Insert a message while survivors are waiting to overcome present bias



Plan for potential interruptions

3. Operators' handling of calls

3.1 Survivors not disclosing IPV status



Frame helpline operators as trustworthy

4.1 Lack of adequate follow-up conducted by operators



Introduce aids to counter operators' decision fatigue



Ease operators cognitive load with automated reminders

4.2 Lack of uptake of services by survivors



Employ direct referral as a default



Prompt survivors to plan for safety

Key:

X. User journey stage

X.X Target behaviour



Intervention idea

INTRODUCTION

This chapter discusses the experience of IPV survivors interacting with specialized helplines that aim to provide survivors with support and guidance, facilitating referrals to services such as legal assistance and mental health services.

For the most part, survivors' journeys accessing helplines are broadly similar across LAC. Many countries within the region have general emergency lines in addition to specialized helplines. The helplines reviewed in this chapter are provided by the Ministry for Women or a similar governmental body.³ The only exception is Honduras. While Honduras previously had a separate helpline (114) hosted by the Policía Nacional Preventiva it was later absorbed, and is now an extension within the general emergency services lines 911 (CONATEL, 2016; El Heraldito, 2014; La Gaceta, 2015).

While all of the helplines are staffed by trained operators, there are slight variations in the composition of helpline staff. For instance, some helplines are exclusively staffed by specialist police officers, whereas others are staffed by lawyers, psychologists and social workers, enabling the provision of support to be tailored, depending on the survivor's needs. Some helplines also have mobile units that can provide immediate assistance to survivors (Ministerio de la Mujer, 2016).

The journey of IPV survivors using helplines can be characterized in four stages: 1. Deciding to call; 2. Staying on the line; 3. Operator's handling of the call; and 4. Taking up referral services.

SEEKING

1. Deciding to call

In general, helplines operate 24 hours a day, all year round and are free to call. For the most part, helplines are widely advertised on mainstream media channels, most frequently in newspapers, on the television, radio, and online. There is often a surge in helpline promotion following high-profile cases of IPV.

Survivors or third parties may call to seek help, gain information about services that are available to them or they may just want to discuss their situation with an impartial, confidential source, without submitting a report to the police or pursuing legal advice.

Operators who were interviewed stated that one of the primary triggers for calling a helpline was a violent incident, and that the proportion of calls following a violent incident tends to increase on Friday and Saturday evenings.

³ Consejo Nacional de las Mujeres (CNM) in Argentina; Ministerio de la Mujer in Dominican Republic; Instituto Salvadoreño para el Desarrollo de la Mujer (ISDEMU) in El Salvador

Target behaviors and proposed interventions

In the seeking stage of the survivor's journey we have identified the following target behaviors and intervention ideas to shift those behaviors:

Target behavior	Intervention ideas to overcome target behavior
1.1 Survivors not calling helplines	<p>Re-frame helplines to encourage more reporting</p> <p>Minimize fear of repercussions by removing call traces on mobile phones</p> <p>Reduce concerns about being overheard by using online chat-based support</p>

1.1 Survivors not calling helplines

It is difficult to gauge what proportion of IPV survivors make use of helplines, as data on the prevalence of IPV in the target countries is limited. Nonetheless, it would appear that survivors hold off contacting helplines for a long time. For instance, 40 percent of survivors calling the helpline for the first time in Argentina reported having suffered abuse for between 1 to 5 years, with a further 40 percent stating they have been subjected to abuse for 6 years or more (INM, 2015).

There are a number of reasons why survivors may hold off calling a helpline:

- **Availability heuristic.** We tend to prescribe more weight to events that are easier to recall or are readily 'available' in our memory (Tversky & Kahneman, 1974) which is usually employed when people are asked to judge the probability that an object or event A belongs to class or process B; (ii. Survivors may struggle to acknowledge that their experiences constitute IPV or to identify themselves as a 'victim' (Kelly & Radford, 1990) and reinforced by the criminal justice system. The implications of inclusion and exclusion in definitions of sexual violence are explored, especially in relation of campaigns for legal reform, because representations of IPV in the media often focus on extreme, physical violence

and fail to represent psychological abuse and coercive control (Donovan & Hester, 2010). Survivors may therefore not think that a helpline is the right channel for them to seek support. Labelling helplines as exclusively for women (e.g., "SOS Mujer") may also exclude other victim groups, such as children or male victims.

- **Uncertainty aversion.** We tend to prefer known risks over unknown risks (Fox & Tversky, 1995). Survivors may be fearful of both the immediate consequences, such as the perpetrator finding them speaking to a helpline, as well as the long-term consequences, such as losing custody of their children. To avoid regret, survivors may change their mind about waiting for their call to be answered if they are uncertain about how their call will be dealt with, e.g., concerns about confidentiality or about what might happen to the perpetrator. Survivors may be particularly concerned about perpetrators monitoring or interfering with their mobile phones.

Behavioral interventions



Reframe helplines to encourage more reporting.

Framing helplines in a broader, more inclusive manner—rather than support for 'victims' or 'women who are threatened'—may encourage survivors struggling to recognize that their experiences constitute IPV to come forward. For instance, one of the support initiatives run by the *Instituto Salvadoreño para el Desarrollo de las Mujeres* (ISDEMU) in El Salvador is called Woman's Friend Line (*Línea Amiga de la Mujer*). Whilst not singling out IPV survivors may lead to a greater number of callers, about a wider range of issues, it may help to encourage those who are yet to acknowledge the gravity of their situation, to come forward, which could lead to earlier interventions.



Minimize the fear of repercussions by removing call traces on mobile phones.

If survivors are being subjected to psychological abuse or coercive control, perpetrators may be frequently checking the survivors' mobile phones and monitoring who they are contacting. Survivors

may hold back from contacting a helpline for fear that the perpetrator will be able to see the phone number in their outgoing call lists or on a phone bill. Several mobile phone manufacturers in Spain have devised a function whereby calls to the national IPV helpline will not show up on a mobile phone's outgoing call list (Sanz Fernández, 2017). Ensuring that calls to helplines are not easily traceable should help to minimize uncertainty aversion and fear of repercussions.



Reduce concerns about being overheard by using online chat-based support.

Disclosing an instance of IPV on an online platform may be less overwhelming and provide greater privacy than speaking on the phone. An online 'chat' platform should offer the same level of confidentiality, but greater flexibility and discretion, alleviating some concerns related to survivors' fear of repercussions and uncertainty aversion. The National Domestic Violence Hotline in the US has both a phone line and an online chat service. The online service also includes a 'pre-chat' survey so that operators can provide tailored support as soon as possible (NBC News, 2014).



RESPONDING

2. Staying on the line

Survivors calling a helpline have to wait for an operator to become available, with wait times dependent on the number of staff available and the time of day. Most helplines only have a small number of staff working each rotation (between one and five operators).

Although data are not captured on how long survivors or third parties have to wait for their call to be answered, or how many calls go unanswered, there are certain peaks in demand during which survivors may have to wait longer for their call to be answered. According to data from Argentina's helpline, the highest proportion of calls are received on weekdays during the afternoon and morning shifts; followed by the afternoon and night-time shifts during the weekend (INM, 2015).

When survivors call a helpline, their numbers are

stored in the helpline database so that operators are able to call them back if their call is cut short. However, they do not always do so, as there may be very rational reasons underpinning survivors' decisions to hang up (explored in section 2.1 below).

A prompt response to calls is vital. The Inter-American Development Bank's (IDB) evaluation of Colombia's 123 helpline found that women who were assisted within 10 minutes of their call were 25 percent less likely to report subsequent domestic violence events, compared to those who had to leave a message with their contact details and wait 36 hours for an operator to conduct a call-back (IDB, 2016).

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
2.1 Survivors hang up before or during the call	Insert a message while survivors are waiting to overcome present bias Plan for potential interruptions

2.1 Survivors hang up before or during the call

Generally, helplines do not capture the number of survivors or third parties who call the helpline but hang up before an operator answers. However, once a call has been answered, abandonment by the caller appears to be high. For instance, of the 15,462 calls made to the Salvadoran helpline in the first 6 months of 2014, 74 percent were labelled as "incomplete" (ISDEMU, 2015).

While waiting on the line or during the call, survivors may be affected by:

- **Representativeness bias.** Representativeness bias refers to the notion of interpreting the likelihood of an event based on its similarity to other events, rather than relying on more objective criteria (Tversky & Kahneman, 1974). Callers may base their expectations of calling a helpline on previous experiences of calling more routine government services, such as the tax office or passport office,

and therefore may overestimate the likelihood of there being a long wait until their call is answered or of their call being handled badly.⁴

• **Hot and cold states.** Hot and cold states refer to contrasting conditions that underpin decision-making. In a ‘hot state’ an individual will make a decision based on an emotional, visceral, impulse-driven reaction (Loewenstein, 2005). A ‘cold state’ refers to an action that is guided by more restrained reasoning, detached from emotion. Survivors may decide to call a helpline while in a ‘cold’ state. However, the majority of survivors calling a helpline will have been subjected to IPV for a prolonged period of time and are likely to be under a considerable amount of stress. Therefore, certain triggers, for example an interruption or unexpected question while on a call, or even having to wait for a call to be answered, could cause a ‘hot’ state which leads them to hang up.

- A recording of a story of a survivor who sought help via the helpline, the support she received and the difference it made in her life. Hearing positive accounts may help to reassure a caller with representativeness bias that their call will be handled well.
- Different variants of pre-recorded messages could be tested to assess which leads to the greatest number of answered calls.

 **Plan for potential interruptions and ‘hot’ state reactions.** Operators could be prompted to start the conversation by asking the survivor where they are and whether they could be interrupted by the perpetrator. If the survivor believes there is a chance that the call could be interrupted, the operator and survivor, together, could devise a strategy (e.g., call back the following day at an agreed time) to overcome any “hot” state response that may be triggered.

Behavioral interventions



Insert a message while survivors are waiting to overcome representativeness bias and uncertainty aversion. While survivors are

waiting for their call to be answered, a message could be played reassuring them that an operator will be with them shortly. The message could include:

- Expected waiting time and what to expect once their call is answered (e.g., the type of support and advice the caller is likely to receive). Richburg-Hayes et al., (2014) suggest that this kind of intervention would not only help to alleviate survivors’ concerns around lack of certainty, but also signal that there are other individuals in similar situations to reduce stigma.⁵

3. Operators’ handling of calls

The first thing that an operator will do when they speak to a survivor is check whether they are safe. This is generally done by conducting a risk assessment, establishing how recently a violent incident might have occurred, and the proximity of the perpetrator. If a survivor is in immediate danger, the call will be immediately transferred to the police, with the survivor’s consent.

If the operator believes that the survivor or third party is safe, they will ask them about their reason for calling. The operator will stress that any information the caller discloses will be treated as strictly confidential. Some helplines have scripts for operators, which they can use to guide the conversation and prompt the survivor to disclose information, but their use is not mandatory.

⁴ Whilst representativeness bias may skew survivors’ perception of the length of the wait for the call to be answered, it is also likely that, in many cases, waits for calls to be answered are lengthy as staff are frequently stretched. For further exploration, please see Richburg-Hayes et al., (2014).

⁵ Any intervention that seeks to leverage social norms around IPV prevalence would have to be carefully designed in order to ensure that IPV is not normalized.

With consent from the survivor, the operator will collect information to tailor their response and identify relevant support services. This will often include collecting: the survivor’s name, age, address, phone number, relationship status, number of dependents, living arrangement (i.e., are survivor and perpetrator cohabiting), what type of abuse they have suffered, whether this is the first incidence of IPV and, if not, the history of abuse.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
3.1 Survivors not disclosing IPV status	Frame helpline operators as trustworthy

3.1 Survivors not disclosing IPV status

On speaking to an operator, survivors may be unwilling to discuss issues in detail and may only share certain information about the abuse suffered. This may be a result of the following:

- **Stigma.** Survivors may fear rejection from those they disclose to because they have internalized negative beliefs about ‘victims’ of IPV (Overstreet & Quinn, 2013).
- **Uncertainty aversion.** Survivors may be unsure how this information will be treated, raising fears about their safety and potential retaliation from perpetrators. In addition, survivors may not want to incriminate the perpetrator if they still have an emotional attachment.

Behavioral interventions



Frame helpline operators as trustworthy.

The person who communicates a message can affect the way in which we respond to it. For instance, we are likely to trust information conveyed by someone we like, someone we can relate to or someone we believe to be an expert (Durantini, Albarracin, Mitchell, Earl & Gillette, 2006). The IDB’s evaluation of the Colombian support helpline found survivors were more ‘receptive’ to psychologists answering calls than police officers (IDB, 2016).

Ensuring that the helpline operators are seen as trustworthy and impartial sources of advice may help to improve survivor engagement with the process. This could be done by requiring operators to state their name when they answer a call, and by giving them a job title that elicits feelings of trust such as ‘support worker’, ‘wellbeing officer’ or ‘survivor advocate’.



SUSTAINING

4. Taking up referral services

Once an operator has identified the type of help a survivor is seeking, they will refer them to the relevant support services. Depending on the country and the type of service, this will involve either: i) the call being forwarded; ii) the survivor being given details of the service for them to make contact; or iii) the survivors’ details being passed on to a support service.⁶ Support services that survivors may be referred to include legal assistance, mental health services, health centers, and social workers. Data is limited on the number of survivors that are referred to support services, including the proportion that are referred to each type of service.⁷

⁶ In cases where a support service contacts the survivor, operators must request survivor’s consent for their contact details to be shared.

⁷ Not all survivors call for a referral. Some call, as an operator interview stated, “just to be heard” and to discuss their experiences with an impartial and anonymous source. In fact, 32 percent of calls to Argentina’s helpline in 2015 pertained to “information relating to gender-based violence” rather than referrals.

Helplines generally store survivors’ phone number on their internal database. Helplines should therefore be able to conduct follow-up calls to check whether survivors have received the support needed and to take into account future demand. Follow-up calls are not systematically conducted, however, and they often depend on an individual’s circumstances.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
4.1 Lack of adequate follow-up conducted by operators	Use automated reminders to ease cognitive load Introduce aids to counter operators’ decision fatigue
4.2 Lack of uptake of services by survivors	Employ direct referral as a default Prompt survivors to plan for safety

4.1 Lack of adequate follow-up conducted by operators

The following behavioral biases may affect an operator’s ability to refer survivors to the right support services or conduct adequate follow-up:

- **Burnout.** Burnout can arise when individuals face prolonged emotional exhaustion and occupational stress. It can result in them feeling increasingly detached from their work and lead to increased errors made (Maslach, Schaufeli, & Leiter, 2001).
- **Decision fatigue.** On each call, an operator will make a series of choices about how to handle the case and which channels to refer the caller. Operators who have to respond to a high number of calls, each one with different, complex needs, can experience decision fatigue, leading to deteriorating quality of decisions towards the end of a rotation (Vohs et al., 2008).
- **Cognitive load.** In a similar vein to decision fatigue, trying to remember the details of

hundreds of cases and process complex information to support survivor wellbeing can overload an operator’s working memory. Depletion of cognitive resources can in turn reduce performance on tasks that rely on deliberative rather than automatic decision-making processes (Shiv & Fedorikhin, 1999).

Behavioral interventions

 **Introduce aids to counter operators’ decision fatigue.** Simple decision aids such as checklists, decision trees or rules of thumb have been shown to reduce errors and improve the consistency of decision-making in high pressure settings such as hospital operating theatres (Gigerenzer, 2008). A decision tree could improve referral decisions by helpline operators when they are experiencing decision fatigue.

 **Ease operators’ cognitive load with automated reminders.** To save operators having to remember when to follow-up survivors, they could be sent a reminder text message one month after they referred a survivor to a support service. To further simplify the process for operators, pre-drafted messages could be stored on the helpline’s system and automatically sent to survivors.

4.1 Lack of uptake of services by survivor

Survivors may not contact or access support services for the following reasons:

- **Friction costs.** Tiny amounts of effort can disproportionately deter us from performing a given action (Service et al., 2014). Even if a survivor is provided with the phone number and address of a support service, the additional step of actually making the call, rather than being directly referred, could deter them from accessing support.

• **Low self-efficacy.** Self-efficacy is the belief in one's ability to complete tasks, achieve goals, and manage to cope in spite of obstacles (Bandura, 1994). The trauma that survivors may have experienced could have eroded their self-efficacy, reducing their psychological capacity to sustain engagement with support services when faced with obstacles such as organizing childcare.

Behavioral interventions



Minimize friction costs by making direct referral the default. Instead of requiring survivors to contact the support service they require, the default could be altered so that survivors are always directly referred by the helpline (i.e., their call is forwarded to the support service or the support service is responsible for contacting the survivor). This may increase the uptake of services by reducing friction costs for survivors. While it may

not be practical in all countries, certain helplines have local teams of field psychologists who can respond and attend immediately to high priority cases.



Use implementation intentions to help survivors overcome obstacles to accessing services. Interventions called 'implementation intentions', which help people make concrete plans to achieve a goal, including preparing for obstacles, have proven effective in encouraging a range of behaviors (Gollwitzer & Sheeran, 2006). In the context of IPV, this approach has helped women who have suffered abuse to avoid unprotected sex (Melendez, Hoffman, Exner, Leu, & Ehrhardt, 2003) eight-session. To encourage survivors with low self-efficacy to access support services, implementation intentions could be used to assist them by setting personal goals and planning how to overcome obstacles, particularly with regard to the re-occurrence of violence.

CONCLUDING REMARKS

Helplines provide an impartial, anonymous, survivor-focused platform upon which to disclose and discuss instances of IPV. They can help to alleviate some of the fears associated with other formal help-seeking channels, such as the police and criminal justice system, by reducing the likelihood of unwanted repercussions. Interventions that seek to emphasize this aspect of helplines could encourage help-seeking amongst survivors.

Helplines also provide a vital stepping stone towards support services for survivors. Building

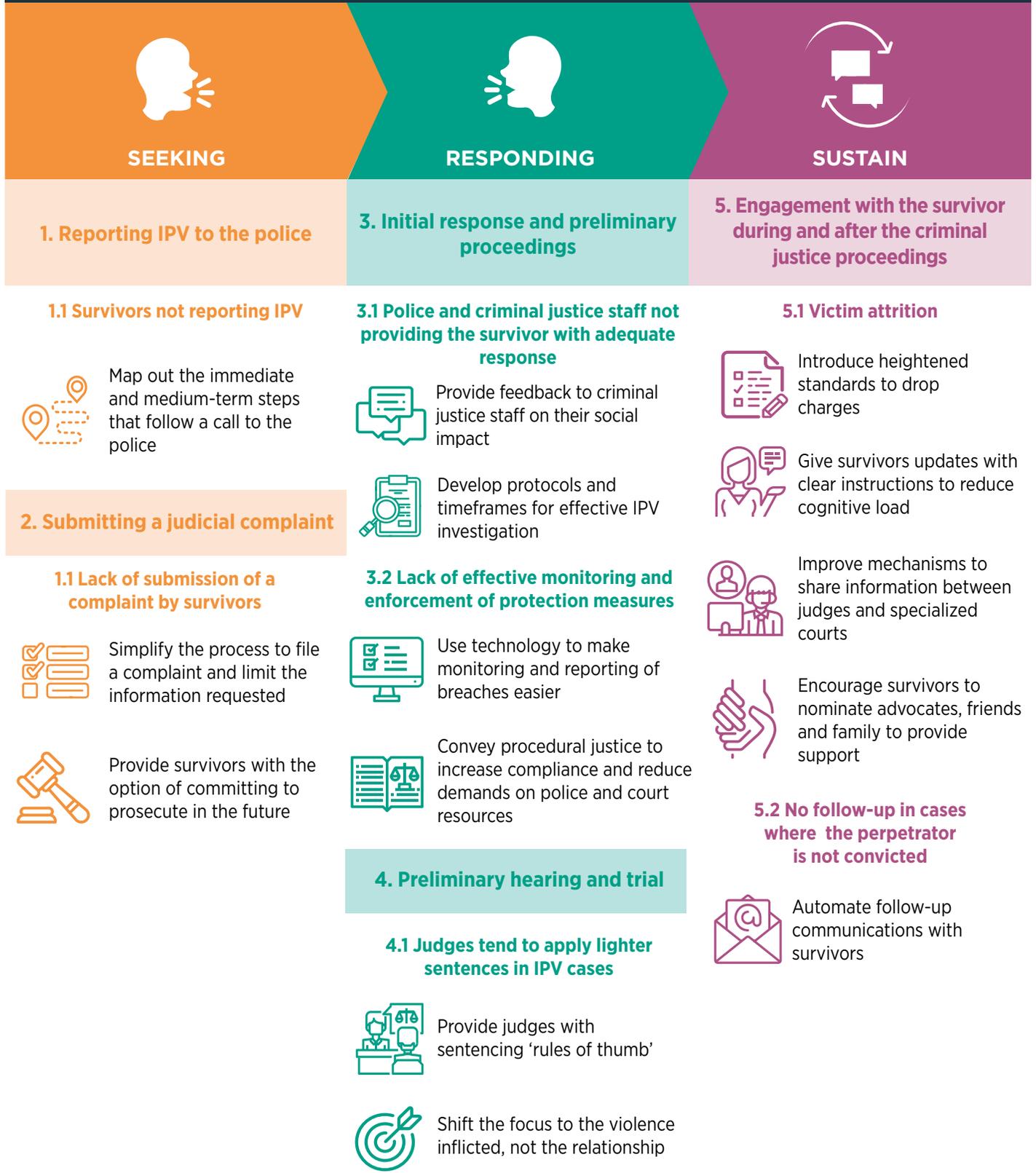
trust by considering how operators may be perceived by callers, and eliminating frictions associated with referrals, could improve survivor engagement with support services.

While resources may be stretched and helplines may be in high demand, our behavioral interventions aim to support existing practices by improving the quality of interactions between callers and operators, making it easier for survivors and service providers alike to achieve better outcomes.



**CHAPTER 2:
CRIMINAL JUSTICE
SYSTEM**

CHAPTER 2: CRIMINAL JUSTICE SYSTEM



Key:	X. User journey stage	X.X Target behaviour	Intervention idea
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INTRODUCTION

This chapter examines the experiences of IPV survivors interacting with the criminal justice system. In this chapter, we only address issues that are specifically-related to IPV cases. Police and court proceedings are further affected by barriers that more broadly hamper access to justice in the region, such as a lack of transparency, corruption, difficulties in accessing a court-appointed lawyer and capacity issues, including delays and lack of coverage in rural areas (Morrison, Ellsberg, & Bott, 2004) with special emphasis on good practice interventions to prevent GBV or offer services to its survivors or perpetrators. Intimate partner violence and sexual coercion are the most common forms of GBV, and these are the types of GBV that they analyze. GBV has serious consequences for women's health and well-being, ranging from fatal outcomes, such as homicide, suicide, and AIDS-related deaths, to nonfatal outcomes, such as physical injuries, chronic pain syndrome, gastrointestinal disorders, complications during pregnancy, miscarriage, and low birth-weight of children. GBV also poses significant costs for the economies of developing countries, including lower worker productivity and incomes, and lower rates of accumulation of human and social capital. The authors examine good practice approaches in justice, health, education, and multisectoral approaches. In each sector, they identify good practices for: (1, however, these sit beyond the scope of this chapter. Furthermore, we have limited the scope of our investigation to the most common agencies that survivors interact with - police forces, prosecutor's offices and criminal courts. However,

survivors' experiences with the justice system can be much more complex, including proceedings in civil and family courts (for example, custody and divorce cases).

While survivors' experiences with the criminal justice system are heterogeneous, the journey of IPV survivors can be characterized by the following stages: 1. Reporting IPV to the police; 2. Submitting a judicial complaint; 3. Initial response, investigation and protection measures; 4. Preliminary hearing and trial; 5. Engagement with the survivor during and after the criminal justice proceedings.

SEEKING

1. Reporting IPV to the police

The first point of contact with the criminal justice system is often a call or visit to the police station. According to survey data, 26.5 percent of IPV victims in El Salvador who sought help in 2008 first did so via a report to the police. This figure is 18.7 percent in the Dominican Republic, and 11 percent in Honduras (Bott et al., 2014). As one of the institutions with the widest coverage, in many cases the police may be the first, or in fact the only, port of call available to women.

As well as receiving direct reports from the survivor, the police may witness an incident or be notified of an instance of IPV by a concerned party such as a family member, neighbor or another agency.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
1.1 Survivors not reporting IPV	Map out the immediate and medium-term steps that follow a call to the police

1.1 Survivors not reporting IPV

Beyond reasons that more generally prevent help-seeking, survivors may abstain from reporting IPV to the police for the following reasons:

- **Uncertainty aversion.** Survivors may distrust the police and courts, and fear triggering a process they will no longer have control over. The unknown risks, such as being considered unfit to take care of children, could lead to a preference for known risks, such as living with IPV.

Behavioral interventions



Map out the immediate and medium-term steps that follow a call to the police.

Clarifying the normal police process after receiving an IPV report could help women estimate the risks, reassuring those who are concerned that the consequences of calling the police could be worse than their current situation. This could be done both in communications aimed to prompt survivors to report IPV and in their first contact with law enforcement agencies.

2. Submitting a judicial complaint

A judicial complaint for IPV may be filed by the survivor or by a third party who becomes aware of an instance of violence, including the police, prosecutor's office, local court and, where available, a specialized domestic violence unit. The individual filing a complaint is required to make a declaration describing the facts that led to the complaint and provide proof of identity.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
2.1 Lack of submission of a complaint by the survivor	Simplify the process to file a complaint and limit the information requested Provide survivors with the option of submitting a complaint in the future

2.1 Lack of submission of a complaint by survivors

Accurate statistics on the proportion of IPV cases that are prosecuted are limited, in large part due to deficient data recording practices in criminal justice systems. As a consequence, existing research relies overwhelmingly on self-reported data collected from women in victimization surveys. These surveys suggest that complaints against the abusive partner are only filed in a minority of IPV cases both in LAC (Bott et al., 2014), as well as elsewhere (García-Moreno et al., 2006).

Survivors may refrain from submitting a judicial complaint due to:

- **Friction costs.** Survivors may be deterred from submitting a complaint if it is too effortful. This may include small friction costs, such as an extra step or seemingly irrelevant detail that disproportionately makes submitting a complaint seem more challenging.
- **Cognitive load.** We all have limited cognitive capacity to perform deliberative tasks. The experience of IPV, and navigating a complex criminal justice system, can tax survivors' cognitive resources, making it difficult to submit a complaint.
- **Hot and cold states.** Women may mispredict how they will act in different affective states (Loewenstein, 2005) they fail to fully appreciate

how “hot” states will affect their own preferences and behavior. When in hot states, they underestimate the influence of those states and, as a result, overestimate the stability of their current preferences. The same biases apply interpersonally; for example, people who are not affectively aroused underappreciate the impact of hot states on other people’s behavior. After reviewing research documenting such intrapersonal and interpersonal hot-cold empathy gaps, this article examines their consequences for medical, and specifically cancer-related, decision making, showing, for example, that hot-cold empathy gaps can lead healthy persons to expose themselves excessively to health risks and can cause health care providers to undertreat patients for pain. Given the cyclical nature of violence (Walker, 1979), if the option of prosecution is presented when the violence has ceased, in what is called the “honeymoon period”, women are unlikely to be willing to prosecute because of a desire to protect the relationship or the perpetrator. They may overestimate the stability of their preferences and not be able to appreciate that these will change when the cycle of violence starts building up again.

Behavioral interventions



Simplify the process to file a complaint and limit the information requested.

For IPV survivors to submit a complaint, the process should be as simple and manageable as possible. For instance, survivors should be asked to provide only the information which is strictly necessary at that point.



Provide survivors with the option of submitting a complaint in the future.

It is not clear from the literature or practice when is the best moment to offer survivors the opportunity to file a complaint - at the moment of an incident (with the risk that high cognitive load will limit the survivor’s capacity to provide all of the necessary details for a successful prosecution) or when the situation has stabilized (with the risk that the survivor has reconciled with the perpetrator) (Crown Prosecution Services, 2014). An approach

that may help conciliate competing theories is encouraging survivors to make a commitment to submit a complaint in the future. Rigorous testing would be needed to determine whether survivors’ commitments are effective at prompting filing of complaints or, on the contrary, dissuade survivors because they feel they have taken sufficient action just by making the commitment.



RESPONDING

3. Initial response and preliminary proceedings

Upon receiving a complaint, the judge may impose precautionary measures ex-officio or per the prosecutor or the complainant’s request. In high risk cases, the police or prosecutor may dictate immediate protection measures, which are contingent on a judge’s subsequent approval.

Precautionary measures are aimed at preventing further victimization and may include measures such as a restraining order or granting temporary custody of children to one of the parents. The judge who imposes protection measures is responsible for monitoring compliance and will determine the veracity of a breach and the associated penalty.

The judge assigned to the case will decide whether the complaint is admitted to court, based on whether it fulfils a number of mostly formal requirements. If the complaint was submitted by the police, it will then be referred to the Prosecutor’s Office so that the prosecutor can conduct or complete the preliminary investigation.

The investigation, conducted with the assistance of the police, aims to determine if there are grounds to press judicial charges against the perpetrator. The most common preliminary proceedings include:

- Gathering of survivor and accused partner’s statements
- Gathering of witness statements
- Forensic and mental health exams
- Gathering of evidence from other sources, e.g., visiting the crime scene, compiling documentary evidence, etc.

At the end of the investigation, the prosecutor issues a reasoned statement in which he/she either presses criminal charges against the perpetrator or concludes that there are no grounds to do so. Instances of IPV can be subsumed under a variety of criminal statutes (from harassment to grievous bodily injuries or murder).

If criminal proceedings move forward, the parties are notified of the charges, their rights in the judicial process and the date of the preliminary hearing.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
3.1 Police and criminal justice staff not providing the survivor with adequate response	<p>Provide feedback to criminal justice staff on their social impact</p> <p>Develop protocols and timeframes for effective IPV investigation</p>
3.2 Lack of effective monitoring and enforcement of protection measures	<p>Use technology to make monitoring and reporting of breaches easier</p> <p>Convey procedural justice to increase compliance and reduce demands on police and court resources</p>

3.1 Police and criminal justice staff not providing the survivor with adequate response

Poor quality of investigation (e.g., negligence in gathering evidence, negligence in identifying the survivor and responsible parties, delays and slowness in these proceedings etc.) has been identified as a key obstacle to women’s access to justice in the region (IACHR, 2007).

A number of challenges were raised in interviews with service providers, and in the existing literature, with regards to criminal justice personnel’s response to, and investigation of, IPV complaints:

- Promoting private resolution of IPV. It was reported that in some cases, particularly in rural areas, the police and lower level judges (“Jueces de Paz”) prompt survivors to solve problems privately with the perpetrator.

- Disregarding the violence as not serious enough. Similarly, interviewees expressed it was difficult to get both the police and, to a lesser extent, the prosecutors, to take allegations of IPV seriously, particularly regarding psychological violence.
- Blaming the victim. When filing a complaint for IPV, survivors report being accused by criminal justice personnel of provoking the violence, or at least submitting to it. Such questioning of the survivor’s legitimacy to file a complaint is most common when substantial time has elapsed between the violence starting and survivor’s reporting.
- Disregarding complaints submitted by a third party. When the complaint is submitted by a third party, the police or prosecutors may not want to invest time and resources in the case. This is because it is very difficult for the prosecution to succeed when the claims are not verified by the survivor.

It should be noted that survivors’ experiences are very different depending on where they seek help. As expected, specialized domestic violence units have a comparative advantage regarding: i) the range of services available; ii) staff’s specialist knowledge and responsiveness to the issue; and iii) capacity to follow-up after a survivor initially seeks help. However, these advantages may not materialize when such entities are not adequately staffed and resourced (Malacalza, 2016).

Inadequate response on the part of criminal justice staff, exemplified by the behaviors described above, may be driven by the following factors:

- **Burnout.** Occupational stress or burnout (Ullman & Townsend, 2007) resulting from demanding and emotionally charged interactions with service recipients has been identified as a major barrier for adequate provision of services by those working with IPV survivors (Maslach, 1982; Schaufeli, Maslach, & Marek, 2017). There is also emerging evidence that burnt-out service providers are more susceptible to behavioral biases (Linos, Ruffini, & Wilcoxon, 2018; Michailidis & Banks, 2016) that could lead

IPV responders to behave according to their own morals or beliefs about a survivor's ability to deal with an abusive relationship, rather than enforcing the law in a completely neutral way (Sherman et al., 1992; Roa, Cabal, & Lemaitre, 2001).

- **Lack of knowledge.** Prosecutors and the police may lack knowledge and training on how to respond and investigate IPV cases. For example, gathering evidence on psychological violence is inherently difficult given the lack of physical traces.

Behavioral interventions



Provide feedback to criminal justice staff on their social impact. Studies on motivation have found that performance

in professional settings increases when we are reminded that our work has a positive impact on others (Grant, 2008). For instance, when radiologists scanned an x-ray that included a photo of the patient, their diagnostic accuracy increased by 46 percent (Turner, Hadas-Halperin, & Raveh, 2008). A similar approach could be applied to overcome burnout among IPV responders, e.g., data and personal stories could be used to highlight to criminal justice personnel how their performance positively impacted survivors' lives.



Develop protocols and timeframes for effective investigation. Clear instructions, in the form of checklists and target

timeframes that prompt prosecutors and police officers to exhaust all possible sources of evidence early in the investigation (e.g., take photographs of the scene, interview all witness, etc.) can contribute to a successful prosecution. Similar interventions have been implemented in San Diego and other US cities (Ellison, 2002), however, to the best of our knowledge, the impact of such interventions on subsequent prosecution success has yet to be rigorously evaluated.

3.2 Lack of effective monitoring and enforcement of protection measures

The main drivers reported for lack of adequate monitoring are:

- **Lack of court and police capacity.** Due to court and police capacity constraints, it is normally the survivor who communicates to the court any violation of protection measures. Perpetrators' impunity may in turn encourage future breaches (Rioseco Ortega, 2005).

Behavioral interventions

Use technology to make monitoring and reporting



of breaches easier. Courts in the region are increasingly making use of technology to better monitor compliance with protection measures. Two initiatives implemented in Argentina stand out as promising (Amaya, 2015). First, the provision of panic buttons to survivors for whom there is a protection order in place. Panic buttons can be activated whenever there is an incident of violence and, when pressed, do not only alert the police, but also start recording audio which may later be used as evidence in a trial. Second, in high-risk cases, both the survivor and the perpetrator are provided with georeferenced bracelets, which automatically alert the police when both devices come into closer contact than that permitted by the provisions of the restraining order. This measure may reinforce a survivor's feeling of powerlessness and therefore should be used only in high-risk cases.

An alternative, less expensive and less intrusive approach would be to provide both parties with a mobile app which alerts police when they are within a certain distance of each other. Additional functionalities could include sending compliance reminders to perpetrators and prompting survivors to report a breach. While there is promising evidence from Australia on the impact of sending compliance reminders to IPV offenders (New South Wales Behavioral Insights Unit, 2018), it is essential that any monitoring interventions are evaluated before implementation.



Convey procedural justice to increase compliance and reduce demands on police and court resources.

We can all fail to comply with rules when we don't understand how to comply or perceive the rules as unfair (Brockner, 2002; Nagin & Telep, 2017). A study in the US found that when police acted in a procedurally fair manner when arresting assault suspects, the rate of subsequent domestic abuse assaults decreased relative to when they did not (Paternoster, Bachman, Brame, & Sherman, 1997). To increase IPV perpetrators' compliance with protection orders (which reduces the need for enforcement and frees up resources for monitoring), they should be provided with clear information on how to comply and the way in which the decision was reached.⁸

4. Preliminary hearing and trial

During a preliminary hearing, the judge assesses whether there are grounds to believe that the defendant may be responsible for the offenses charged, including if there are any flaws in the inquiry conducted by the prosecutor or the charges pressed. The timing of the preliminary hearing varies depending on the court's caseload. Interviewees reported it can take place between two and five months after the complaint is submitted.

The outcome of the preliminary hearing is a statement in which the judge may either terminate the process or open the trial stage. This statement may also impose, renew, replace or lift protection or precautionary measures.

During the trial, the prosecutor will present the charges and the defense will state its position. If the defendant pleads guilty or an agreement has been reached between the parties, the judge will impose a sentence. If the defendant pleads not-guilty, the evidence put forward by the parties will be appraised. The trial can be completed in one or several hearings, depending on the complexity of the case. The trial will be finalized by the judge delivering a verdict and, if the defendant is found guilty, imposing a sentence.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
4.1 Judges tend to apply lighter sentences in IPV cases	<p>Provide judges with sentencing 'rules of thumb'</p> <p>Shift the focus to the violence inflicted, not the relationship</p>

4.1 Judges tend to apply lighter sentences in IPV cases

A number of studies from high-income countries (Bond & Jeffries, 2014; Dawson, 2003; Dawson, 2016) have found that, for equivalent offenses, the probability of a guilty verdict and the severity of the sentence are lower for domestic abuse cases relative to non-domestic abuse cases. It must be noted though, that the literature is not consistent (Donnelly & Poynton, 2015) and to the best of our knowledge, such studies have not been conducted in Latin America.

While our qualitative interviews with criminal justice staff supported the hypothesis, trial outcome and sentencing data should be analyzed to develop a better understanding of the situation in the region.

Like the rest of us, judges may have unconscious biases (Greenwald & Krieger, 2006; Levinson & Young, 2009). Although judges aim to be impartial and typically believe themselves to be that way, this can lead to greater likelihood of

acting on their biases because of 'moral licensing' (Uhlmann & Cohen, 2007). In addition, working under time pressure, for example when there is a backlog of cases to review, increases automatic decision-making which can exacerbate behavioral biases. Two factors which may lead to biased conviction and sentencing decisions on the part of judges in IPV cases are:

- **Relationship stereotypes.** IPV is often

⁸ In Australia, BIT collaborated with the New South Wales Department of Premier and Cabinet Behavioral Insights Unit to redesign Apprehended Domestic Violence Orders. The impact was not evaluated but more information can be found here <https://bi.dpc.nsw.gov.au/projects/reducing-domestic-violence/>

believed to be motivated by intense emotion or passion rather than an active choice on the part of the perpetrator. Delays in survivors' reporting of IPV or not wanting to end the relationship, further reduces the perceived culpability of the perpetrator. On the other hand, violence between strangers is perceived to be instrumental and thereby worthy of more severe punishment. As a result, the law is more severely applied as the degree of intimacy of the relationship between parties decreases (Dawson, 2006).

- **Identifying with the perpetrator.** During a court hearing, perpetrators may appear calm, respectful and persuasive while survivors can be anxious, overwhelmed by the situation, or suffer Post Traumatic Stress Disorder. As a result, judges may find it easier to identify with the perpetrator rather than the survivor, which can lead them to apply heightened standards of proof and less severe sentences compared with other types of violence (Epstein, 1999).

Behavioral interventions



Give judges sentencing 'rules of thumb'. In the US, sentencing guidelines were found to decrease 'noise' or inter-judge discrepancies in sentencing decisions not explained by case characteristics (Anderson, Kling, & Stith, 1999). Rules of thumb could similarly encourage judges to grant sentences that are commensurate with the severity of the IPV offense, independent of the relationship between parties.



Shift the focus to the violence inflicted, not the relationship. When judges assess the evidence for a case, they may be drawn to certain details according to their unconscious biases. Changing the way evidence is presented could steer judges' attention to specific information that can improve domestic abuse sentencing outcomes. For example, the cover sheet of both accusation and defense statements could be designed with a

large space at the top to summarize the severity of the offense and the culpability or innocence of the perpetrator, with only a small section at the bottom to summarize the nature of the survivor-perpetrator relationship.

 **SUSTAINING**

5. Engagement with the survivor during and after the criminal justice proceedings

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
5.1 Victim attrition	<p>Introduce heightened standards to drop charges</p> <p>Give survivors regular updates with clear instructions to reduce cognitive load</p> <p>Improve mechanisms to share information between judges and specialized courts</p> <p>Encourage survivors to nominate advocates, friends and family to provide support</p>
5.2 No follow-up in cases where the perpetrator is not convicted	<p>Automate follow-up communications with survivors</p>

5.1 Victim attrition

Victim attrition, understood as survivor's lack of engagement with criminal proceedings, is a major challenge in the prosecution of IPV cases. This may entail survivors retracting their initial complaint statement, as well as not collaborating with the investigation, or not attending court hearings.

There is a dearth of statistics on victim attrition in LAC. Data from high-income countries, nevertheless, suggests that survivors make the decision to retract their declaration in the first days, even hours, after submitting a complaint (Barrow-Grint, 2016; Robinson & Cook, 2006).

Below we outline the main factors that, according to the literature and interviews with criminal justice staff, prevent survivors from engaging in criminal proceedings:

- **Hot and cold states.** Criminal proceedings may not commence until a long time after survivors experienced the hot affective state that led them to file a complaint. Once in a cold state, their attachment to the relationship may lead them to disengage with the criminal justice process, retract their statement and, ultimately, return to the perpetrator (Aizer & Dal Bó, 2009; Griffing et al., 2002; Sleath & Smith, 2017).
- **Optimism bias.** Studies show that we are wired to look on the bright side (Sharot, 2011). Survivors may optimistically believe that having filed a complaint and/or the arrest itself will be sufficient to deter the perpetrator.
- **Cognitive load.** The piecemeal nature of the justice system means that submitting a complaint can trigger several civil and criminal proceedings, potentially under different procedural rules, and in different courtrooms. Survivors can find it difficult to actively engage in each of these processes when their cognitive bandwidth is already greatly taxed by coping with violence.
- **Economic barriers.** Engaging in the judicial process entails time and financial costs that can deter survivors from participating. Further, if the survivor or the family are economically dependent on the perpetrator, the prosecution may have a negative impact on their livelihood.
- **Secondary victimization.** The term ‘secondary victimization’, often used in the context of sexual assault (Campbell & Raja, 1999), refers to negative responses towards a survivor, such as victim blaming, who experiences these as a further violation of her rights (Orth, 2002). Secondary victimization has been associated with loss of self-esteem and faith in the future, lack of trust in the legal system (Orth, 2002) and

decreased willingness to seek help from courts in the future (Rivera, Sullivan, & Zeoli, 2012).

- **Social isolation or rejection.** Qualitative studies suggest that survivors with access to stronger social support networks are more likely to collaborate with prosecution (Goodman, Bennett, & Dutton, 1999).

Behavioral interventions



Introduce heightened standards to drop charges.

To overcome survivors’ optimism bias and emotional attachment to the perpetrator during a cold affective state, heightened standards could be introduced to withdraw a complaint. For instance, this could be implemented in the form of a cooling off period requiring women to confirm their wish to drop the charges a few hours or even days after their initial request.

No-drop policies, which state that once a woman files a complaint the prosecution will continue independently of her stated wishes to drop the charges, have been found to increase reporting of IPV (Aizer, & Dal Bó, 2009). However, these policies may have unintended consequences, such as contributing to survivors’ sense of powerlessness, as control is transferred from the perpetrator to the prosecutor (Larrauri, 2003). More research would be needed to assess the impact of these policies on survivor wellbeing.



Give survivors regular updates with clear instructions to reduce cognitive load.

Breaking down a survivor’s engagement with the multiple judicial proceedings that IPV may trigger, into small steps, could reduce cognitive load. This would require regularly updating survivors (e.g., by SMS) on how their case has progressed, the remaining steps and instructions on what is expected from them next.



Improve mechanisms to share information between judges and specialized courts.

One drain on a survivor’s cognitive resources is having to submit the same information to different courts in different formats. To the extent possible, prosecutors and defense lawyers

should have access to, and be able to submit to the judge, the evidence already provided by survivors in other judicial cases. If prosecutors are provided with a standardized indictment form for IPV cases, or if they have to fill other forms when submitting this to the court, prompts could be included to encourage prosecutors to seek the declarations and other evidence used in past court cases. A more radical approach would be to centralize cases in a specialized court, a solution that has been embraced by several countries in the region. Evidence from high-income countries suggest that specialized courts increase the likelihood that survivors will appear in court (Hartley & Frohmann, 2003).



Encourage survivors to nominate advocates, friends and family to provide support.

In a study conducted in the US, IPV survivors receiving support in accessing services from lightly trained college volunteers experienced a significant reduction in primary victimization, depression rates, and increased self-efficacy (Sullivan & Bybee, 1999). To connect survivors to an advocate or supporter, who would guide them through the criminal proceedings, they could be asked to nominate someone when they submit a judicial complaint for IPV. Supporters would contact survivors at points when attrition is most likely, such as before the preliminary hearing, and support them in staying engaged, for instance by physically accompanying survivors to court on hearing days. The supporter could be part of the Prosecutor's Office staff, but also a volunteer or a friend or relative.

5.2 There is no follow-up in cases where the perpetrator is not convicted

In cases where the perpetrator is not convicted, or is convicted but the sentence does not involve imprisonment, the end of the judicial process may entail increased risk for the survivor (Dugan, Nagin, & Rosenfeld, 2003) Protection measures are lifted when the judicial process terminates but prosecution can trigger a retaliation effect.

The main driver for lack of follow-up is:

- **Lack of protocols and capacity.** Courts and prosecutors often do not have any professional obligation to follow-up with the victim once criminal proceedings end. Further, even if they were to deviate from established protocols, they often would not have the capacity to contact victims after a trial.

Behavioral interventions



Automate follow-up with survivors.

Survivors will be more willing to report post-trial abuse if they are prompted to do so. Independent of the trial outcome, survivors could be contacted by SMS for a set time period after the end of the proceedings to confirm their wellbeing. Messages could be automated and would only require criminal justice staff to actively follow-up with the victim if they report any subsequent incidence of violence.

CONCLUDING REMARKS

Laws that criminalize IPV not only provide a framework for action, they also convey a powerful message. They define a clear injunctive norm, dictating that individuals under the jurisdiction of those laws must not perpetrate or tolerate IPV (Cooper, Paluck, & Fletcher, 2013).

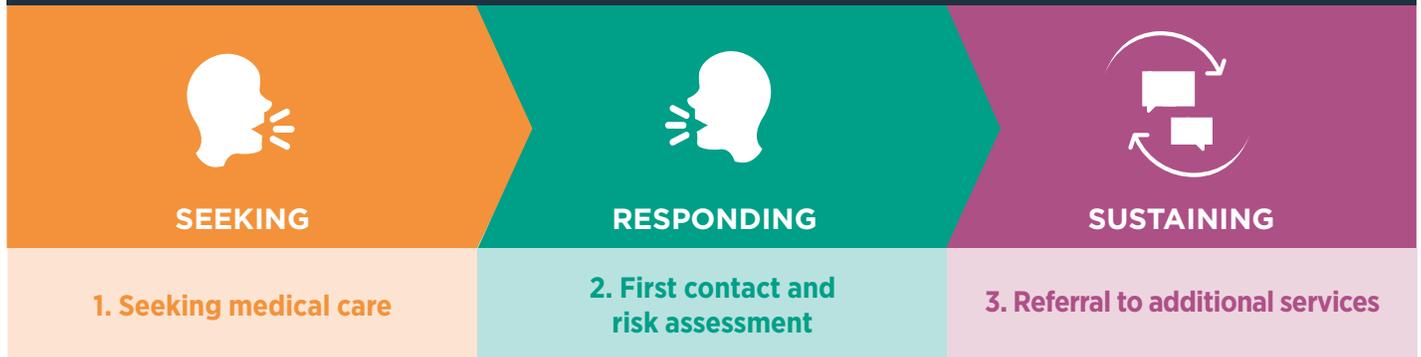
The impact of landmark legislation enacted in the region in recent decades has, however, been

hampered by a criminal justice system that is not always responsive to survivors' needs (Epstein, 1999). The target behaviors identified here often exemplify inconsistencies between what criminal proceedings ought to be according to the law, and what they are in practice. Our proposed behavioral interventions seek to help policymakers working in this space to bridge this gap.

CHAPTER 3:
HEALTH
SECTOR



CHAPTER 3: HEALTH SECTOR



SEEKING

1. Seeking medical care

1.1 Survivors' lack of help-seeking behavior for medical care



Use discrete channels and emphasize confidentiality



Create opportunities through children's visits to build self-esteem



RESPONDING

2. First contact and risk assessment

2.1 Lack of adequate identification of IPV by health staff



Train health care professionals with protocols to spot signs and conduct conditional IPV screening



Use social recognition to shift peer behavior

2.2 Hesitancy to disclose to health workers



Use computer assisted questionnaire (CASI) to reduce stigma



Capitalize on doctor-patient relationship to improve detection



SUSTAINING

3. Referral to additional services

3.1 Lack of follow-through by health staff



Provide feedback on survivor progress

3.2 Lack of take-up of services



Simplify referral choices



Create one-stop services sites

Key:

X. User journey stage

X.X Target behaviour



Intervention idea

INTRODUCTION

This chapter discusses the experiences of IPV survivors interacting with the health sector, with the objective of improving services for IPV. The utilization of general health services is higher among IPV survivors than other women (García-Moreno et al. 2015) even though survivors do not necessarily enter the health system with an explicit strategy of seeking help for IPV (Liang, Goodman, Tummala-Narra & Weintraub, 2005). In recent decades, there have been considerable improvements across the region in overall levels of health, although great disparities continue to exist with respect to access to quality health services. Individuals and families in rural areas face the greatest barriers to accessing services. Access to preventive care is a broader challenge encountered throughout the region, given the relatively low levels of financing.⁹

For IPV survivors, contact with medical services is often the initial point of entry into a larger pool of potential advocates and services. While the user journey in the health sector varies across countries, the journey of IPV survivors can be characterized by the following stages: 1. Seeking medical care; 2. First contact and risk assessment; and 3. Referral to additional services.

SEEKING

1. Seeking medical care

Survivors can seek medical care for IPV or other general health conditions through a variety of facilities or providers. The facilities can be

distinguished by their location (e.g., hospitals, community health centers or in-situ for some emergency services), as well as by the nature of the services (i.e., those focused on new or acute conditions versus those focused on preventative care or chronic conditions).

According to interviews with health workers, the most common entry point for IPV survivors is through acute services in health clinics and emergency rooms. It is important to note that survivors can enter the health sector if emergency medical services are called by relatives, bystanders or the police. This often happens at the scene of an IPV incident. Therefore, these entries into the health sector do not necessarily occur directly at health facilities nor at the direct request of the survivor.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
1.1 Survivors' lack of help-seeking behavior for medical care	Use discrete channels and emphasize confidentiality Create opportunities through children's visits to build self-esteem

1.1 Survivors' lack of help-seeking behavior for medical care

To avoid detection of IPV, survivors may delay or avoid seeking medical care, even for urgent situations. This puts their health status at risk from

⁹ Mental health services are addressed in Chapter 4.

untreated health conditions in addition to the vulnerability from undisclosed IPV.

The behavioral barriers that may be impeding survivors from seeking help from the health sector include:

- **Information avoidance.** Survivors may expect – often based on past experience – that a doctor or health professional will recommend actions to escape the violence which may be very difficult to carry out, e.g., change living situation, seek professional support, etc. To avoid this advice, survivors may choose not to seek medical care even though they have a medical concern. To justify this choice, they may tell themselves that the problem will resolve on its own over time, or that they can personally address it (Golman, Hagmann and Loewenstein, 2017; Taber, Leyva, & Persoskie, 2015).
- **Low self-esteem.** Low levels of self-esteem have been shown to be related to the avoidance of medical care. A recent study in the UK found that women reported that they avoided seeing a doctor with symptoms related to cancer because they didn't want to make a fuss (Moffat, Hinchliffe, Ironmonger, & Osborne, 2016).
- **Uncertainty aversion.** Survivors may be concerned that seeking medical care will entail health staff becoming aware that IPV is taking place and inquire further or report it to the police. Because seeking care has these unknown risks, survivors may prefer the known risks associated with not seeking care.

Behavioral interventions



Use discrete channels and emphasize confidentiality. To overcome information avoidance, survivors could be offered confidential telephone and online health services for an initial consultation. This type of service could ensure that referral for an in-person appointment is

made to the most appropriate type of health care facility, e.g., a women's only facility. Further, in their initial contact with health professionals, survivors should be provided with clear information on what circumstances health professionals are obliged to reveal patient information to the police or other public agencies. Having clear ground rules from the outset would contribute to building trust and help to overcome uncertainty aversion.¹⁰



Create opportunities to build self-esteem through children's visits.

Survivors may interact with health services on behalf of their children, e.g., post-natal and well-child visits. These are key moments to build survivor self-esteem and self-efficacy through positive feedback about their parenting skills. Emphasizing that effective parenting relies on mothers being proactive about their own health, as well as their children's health, could encourage women to realize that investing in their own health is worthwhile and that they have the ability to do so successfully.



RESPONDING

2. First contact and risk assessment

Survivors may choose to voluntarily disclose their IPV status upon first contact with a health professional. Among those who do not initially disclose, and conditional on a health worker suspecting possible IPV, they will ask an initial set of basic screening questions. A survivor can continue to decline to reveal her status, in which case a note about the observations is included in her medical record.

While the conditional basic screening varies by country, many include broad-based questions to encourage disclosing such as: "In the past year has anyone close to you abused you physically or emotionally?" or "In the past year have you been forced to have sexual relations?". It is important to note that screening is not universally applied to all female patients,¹¹ nor are the conditional screening questions scored for severity.

¹⁰ Mandatory reporting has not been rigorously evaluated as an evidence-based policy and in various focus groups of survivors has been criticized as infringing on autonomy and confidentiality.

¹¹ Universal screening has failed to generate a convincing evidence base in terms of improving women's outcomes as synthesized in the systematic review (O'Doherty et al.2014). The WHO does not recommend universal screening as a policy instrument.

Medical personnel are encouraged to look for overt physical signs of IPV such as cigarette burns, fractured and twisted arms, as well as bruises that look like they come from choking or punching. Other physical and psychological signs include chronic conditions such as gastrointestinal problems, sleep difficulties, anxiety, and depression. In addition to physical signs, suspicions can be raised by the health worker's observations of interactions between the person seeking health care and her partner, including: i) very close monitoring or accompaniment by the partner; ii) denial or minimization of violence by the partner; and iii) refusing to speak or disagree in front of the partner.

A more comprehensive risk assessment is prompted if a survivor provides a voluntary disclosure, or the conditional basic screening reveals an affirmative response. This assessment is intended to diagnose the severity of risk of imminent injury or death from the perpetrator and comprises a systematic questionnaire which is scored to categorize high risk versus lower risk cases. Medical personnel receive basic training in the administration of the risk assessment. To avoid further traumatization to the survivor, the risk assessment is preferably administered by a victim advocate who has received specialist training in working with IPV survivors. In rural and underserved areas this task is handled by general practitioners rather than victim advocates.

While questions and scoring systems vary from country to country, common questions include: i) Are you currently in a relationship where you have been injured or threatened by your partner?; ii) Are there weapons in your home?; and iii) Does anyone threaten to use them when they are angry?

Certain factors contribute to a higher assessment of risk, such as:

- The abuse of minors
- A formal legal accusation of the aggressor within the last 6 months
- The violation of protection orders by the aggressor
- A history of violent behavior by the aggressor, either with the survivor or others
- A risk of suicide by the survivor

Information is also collected regarding the current assault, with the aim of detecting and treating injuries, assessing exposure to sexual diseases and pregnancy risks, and guiding the collection of forensic evidence. This information is typically collected in the same interview with the victim advocate but may be recorded in a separate intake form.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
2.1 Lack of adequate identification of IPV by health staff	<p>Train health care professionals with protocols to spot signs and conduct conditional IPV screening</p> <p>Use social recognition to shift peer behavior</p>
2.2 Hesitancy to disclose to health workers	<p>Use computer assisted questionnaire (CASI) to reduce stigma</p> <p>Capitalize on doctor-patient trust to improve detection</p>

2.1 Lack of adequate identification of IPV survivors by health staff

The lack of identification, and even lack of awareness, of IPV by health professionals was articulated as an important barrier to effective service provision during our interviews. Front-line staff reported positive results from training programs with respect to raising awareness but continued challenges with respect to promoting treatment.

The barriers affecting medical staff's identification of IPV include:

- **Feelings of inadequacy.** Various reviews of health care professionals have noted that health care professionals voice more confidence in their clinical areas and lack of competency in domestic violence (Rose et al., 2011).

- Ostrich effect. A defeatist attitude of ‘burying their head in the sand’ may be adopted by health care workers when follow-up services are not available. For example, a lack of appropriate follow-up services for children, such as foster-care or shelters, was described by one expert as a factor discouraging health professionals to inquire about the situation of children.
- Burnout. The heavy workload and difficult mental challenges experienced by medical professionals may contribute to poor decision-making (Burgess, Irvine, & Wallymahmed, 2010).

Behavioral interventions



Introduce training and screening protocols.

Given the evidence against universal screening, it should only be applied when suspicions have been raised (O’Doherty et al. 2014).¹² An intervention in the UK that trained physicians to identify women experiencing abuse had very promising results. A small experimental evaluation of the intervention found that the physicians who received training were approximately 20 times more likely to have patient records with self-disclosed IPV than physicians who had not received the training (Feder et al., 2011). Training to identify IPV should ideally be combined with screening protocols to avoid medical staff making judgement errors due to high cognitive load (Burgess, Irvine, & Wallymahmed, 2010).



Use social recognition to shift peer behavior.

Professionals are heavily influenced by the behavior of their peers (Gould and Lawes, 2016). Without violating survivor confidentiality, examples of health care workers who regularly apply screening protocols could be presented to other staff. This would show that these procedures are recognized by high level administration as an important component of general health care provision, and should be adopted as the norm.

2.2 Hesitancy to disclose to health workers

Healthcare workers have been reported to be the preferred formal source of disclosure for survivors of IPV (García-Moreno et al., 2006). Moreover, the disclosure to medical workers increases relative to informal networks (friends and family) when abuse becomes more severe (Ansara & Hindin, 2010) correlates, and consequences of intimate partner violence (IPV). Still, survivors may be hesitant to disclose IPV to a healthcare professional for similar reasons to those described in earlier chapters.

Behavioral barriers that may limit survivor disclosure of IPV include:

- **Stigma.** Further to the fears of stigmatization that have been explored in previous chapters (for example, see Chapter 1, section 3.1), qualitative studies around the world have found that victims commonly voice concern regarding a fear of stigmatization on the part of health care workers who may judge the victim as responsible for the abuse (Rose et al., 2011; McCleary-Sills, Crockett, & Cooper, 2018). The feelings of shame by the victims are anticipated by potential verbal statements or non-verbal cues by the health care professionals (Battaglia, Finley, & Liebschutz, 2003). While the fear of being judged applies more widely, the concern regarding stigmatization tends to be stronger with respect to health care professionals as they often come from higher socioeconomic backgrounds (Battaglia, Finley, & Liebschutz, 2003).

In the interviews conducted with front-line staff, the lack of an ongoing relationship with the health care provider was raised as a key barrier to the victim disclosing their status, with barriers to disclosing described as higher at the acute entry points. Women receiving care for chronic or more standard conditions (related to IPV or

¹² Universal screening has failed to generate a convincing evidence base in terms of improving women’s outcomes as synthesized in the systematic review by O’Doherty et al.2014. The WHO does not recommend universal screening as a policy instrument.

otherwise) may find it easier to disclose to their health professional because the multiple visits enabled the health professional to demonstrate a non-judgmental attitude and establish a rapport with the victim.

- **Uncertainty aversion.** See Chapter 3.

Behavioral interventions



Use Computer-Assisted Self-Interviewing (CASI) to reduce stigma.

The use of CASI technology or paper questionnaires would enable women to answer sensitive questions with less interaction with potentially poorly trained health workers. An affirmative screening could then be followed by an interview with a victim advocate with specialized training on IPV.

In a randomized control trial (RCT) that compared interviews with health workers, written self-reports, and CASI, women reported higher satisfaction with the self-reported options and had lower rates of non-response with the computerized questionnaire (MacMillan et al., 2006). However, the impact of CASI screening beyond improved disclosure has not been shown. Studies have typically been underpowered, i.e., not sufficiently large enough to demonstrate statistically significant differences and, in some cases, have also suffered from differential attrition in the control and treatment groups (MacMillan et al., 2009).



Capitalize on longer-term doctor-patient relationships to improve detection.

Training for detecting and treating IPV should be extended to health professionals working with non-acute conditions. In this context, IPV symptoms may be far subtler to detect but women may be more willing to disclose their experiences after developing a trusting relationship with a health professional.



SUSTAINING

3. Referral to additional services

Survivors assessed to be at lower risk following risk assessment are referred to a set of services according

to their profile and needs. These typically include the opportunity to denounce the perpetrator, and access counseling services and social workers. Survivors at high risk of imminent injury or mortality are referred to additional services including shelters and legal services. Specific child protection protocols are applied if minors have been abused.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
3.1 Lack of follow-through by health staff	Provide feedback on survivor progress
3.2 Lack of take-up of services	Simplify referral choices Create one-stop service sites

3.1 Lack of follow-through by health staff

Health workers may face the following barriers when referring survivors to additional services:

- **Lack of knowledge and options.** In addition to health care workers receiving limited training about how to respond to IPV, formal referral systems frequently do not exist. Therefore, it should not be surprising that—while evidence is limited and only from developed country contexts—three rigorous studies found no evidence that screening in health settings increases referrals to other services for IPV, including shelters (O’Doherty et al., 2014). Inappropriate referrals may in turn be interpreted as invalidating the victim’s disclosure (Keeling & Fisher, 2015), making her less likely to disclose in the future.
- **Availability heuristics.** Referrals that have better outcomes are unobserved while those with poor outcomes often re-enter the health sector. This may lead health workers to believe that there is no point in referring survivors to additional support services because their outcomes are unlikely to improve.

Behavioral interventions



Provide feedback on survivor progress.

With survivors' consent, health workers could regularly be sent feedback on a sample of survivors they referred to additional services, in order to understand their progress towards recovery. This could be in the form of testimonials, which are more emotionally engaging than aggregate data, to make the benefits of referring more salient and drive new referrals for other survivors.

3.2 Lack of take-up of services

According to interviews with health staff, the take-up of referrals amongst survivors is low.

Key barriers to survivor take-up of additional services are:

- **Cognitive load.** IPV survivors may feel overwhelmed by the numerous choices in front of them at the same time, from whether to pursue criminal proceedings to how to achieve economic security and care for children without their partner. This heavy cognitive load may lead to low take-up of additional services.
- **Friction costs.** Small hurdles may deter survivors from taking-up services. For instance, formal denouncement through legal proceedings was reported to be more likely if the legal resources were on-site at the medical facility. Similarly, take-up of counseling services was reported to be high because they were in the same location.

Behavioral interventions



Simplify referral choices. Survivors should be provided with a few options of additional services they could access, rather than a long list that will add to decision fatigue. The referral process should not be a one-time event because the survivor may not be in the best state of mind to decide at that point. The victim advocate or social worker should help the survivor navigate and re-evaluate their situation.



Create one-stop service sites. Survivors are often provided with the contact details of relevant service providers and then have to make their own arrangements to visit multiple service locations. Integrating as many services as possible on the same site reduces the effort to take up services.

If one-stop service sites are not feasible, the referring health worker or victim advocate should ensure the survivor has adequate transport and social support to take up the recommended additional services. Turan et al., (2013) report positive qualitative findings on a pilot project in rural Kenya where community volunteers provided support to IPV survivors, including covering transport costs, escorting women to services, telephoning ahead to service providers and offering emotional support. Guedes, Bott, Güzemes, & Helzner, (2002) note that some health clinics in Latin America have assigned clinic staff to accompany women when they seek forensic examinations and interactions with the police and the courts, and that these supported referrals were positively evaluated by survivors.

CONCLUDING REMARKS

Given the severe health consequences that can stem from IPV, the health sector provides invaluable services to this population. Further, being often the first point of contact survivors make with formal services, it poses a key opportunity to detect IPV and channel survivors to other services.

Many of the opportunities for improving survivor services in the health sector are the same as other sectors – reducing stigma and uncertainty, and simplifying processes. However, the key difference is that survivors may come into contact with the

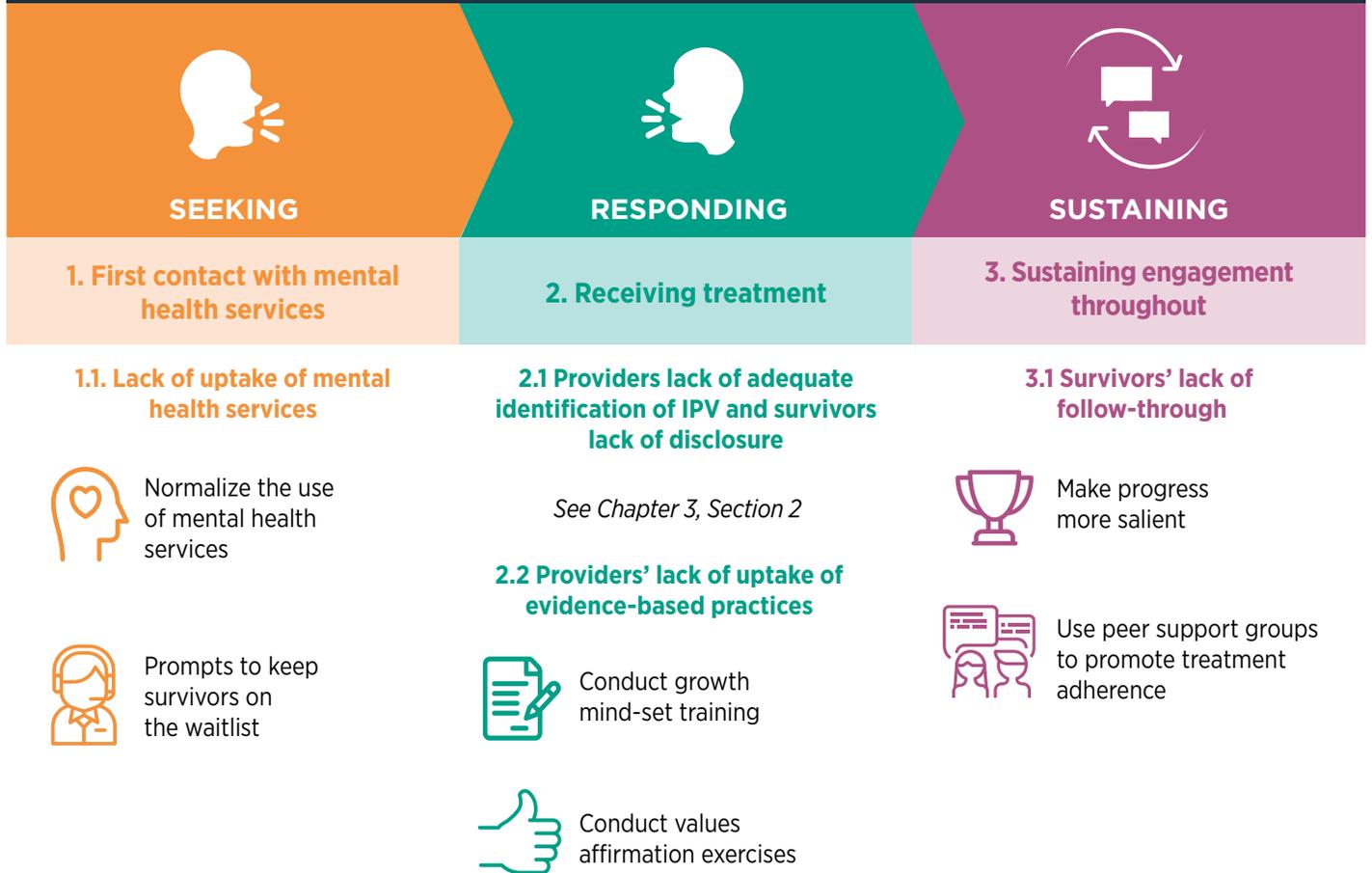
health sector through unrelated health needs, and the health needs of their children. This creates unplanned opportunities for detection and response to the abuse, including building survivor self-esteem and trust in service providers. To respond to these opportunities effectively, health workers need adequate training and tools.

The behavioral interventions proposed in this chapter would be relatively straightforward to implement and would in many cases scale what is already working well to create more equitable access to high quality services.



CHAPTER 4:
MENTAL HEALTH
SERVICES

CHAPTER 4: MENTAL HEALTH SERVICES



Key:	X. User journey stage	X.X Target behaviour	 Intervention idea
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INTRODUCTION

Survivors of IPV can suffer from a range of mental health issues, including depression, post-traumatic stress disorder (PTSD), anxiety, self-harm, alcohol and substance abuse problems, and sleep disorders. These mental health conditions have been found to be aggravated when the violence is more severe, sustained and when more than one form of violence has been inflicted (Dillon, Hussain, Loxton, & Rahman, 2013). However, independently of whether or not survivors leave the abusive relationship, these conditions can diminish their wellbeing in the long-term (Zlotnick, Johnson, & Kohn, 2006).

Mental health services offered through the public health system are scarce in Latin America, particularly in primary care settings (Aparicio, Saxena, & Rodríguez, 2009). Private mental health care is available but is not affordable to a large proportion of the population.

Survivors can access both specialized and non-specialized mental health services. Those targeted to IPV survivors are delivered by specialized domestic violence units, health centers, civil society organizations and shelters. These services are normally staffed by psychologists and, in a minority of cases, psychiatrists. Coverage is however limited, particularly in rural areas. In a study of national policies and clinical guidelines for IPV in LAC, specialized mental health services were available only in 7 out of 12 countries.

Whilst survivors' journeys vary across countries, the journey of an IPV survivor interacting with mental health services can be divided into three stages: 1. First contact with mental health services; 2. Receiving treatment; and 3. Sustaining engagement throughout.

SEEKING

1. First contact with mental health services

Survivors may access mental health services through self-referral or referral from other services, such as the health system, the police or the courts. The survivor may also come in contact with mental health professionals in cases of immediate crisis. For instance, mental health staff are called when the police respond to an incident of violence. Crisis interventions are normally focused on guaranteeing victim safety, actively listening to her account of the facts and concerns, and planning next steps (IMO, 2008).

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
1.1 Lack of uptake of mental health services	<p>Normalize the use of mental health services</p> <p>Prompts to keep survivors on the waitlist</p>

1.1 Lack of uptake of mental health services

Despite lack of systematic statistics regarding use of mental health services by IPV survivors in the region, in line with studies in high income countries (Próspero & Vohra-Gupta, 2008), we expect uptake to be low.

Epidemiological studies have found that the treatment gap – the proportion of individuals affected by a mental health condition that do not receive treatment – remains high in LAC (Kohn, Saxena, Levav, & Saraceno, 2004). Studies analysing treatment access among the general population have found that more than half of individuals with anxiety disorders, and three-quarters of those suffering alcohol abuse or dependence, never receive treatment (Kohn et al., 2005).

Despite underutilization, qualitative research in high income countries indicates that mental health services are one of the services most demanded and valued by survivors (Chang et al., 2005; Ford-Gilboe et al., 2015). With regards to the triggers that lead survivors to seek mental health services, qualitative studies find that survivors are more likely to seek help in cases of severe depression as well as when children present symptoms of mental health disorders (Álvarez & Pernía, 2007).

The following factors could affect survivors' uptake of mental health care, both through self-referral as well as when referred by other service providers:

- **Lack of awareness about mental health disorders.** As opposed to physical health problems, survivors may experience difficulties in recognizing they are suffering a mental health condition due to lack of knowledge or awareness.
- **Stigma.** Mental illness is associated with stereotypical views and stigma which survivors may not want to identify with (e.g., “Psychological or psychiatric services are only for mentally ill people. I do not want to see

myself or be seen by others as someone with mental health problems”).

- **Lack of motivation to endure long wait lists.** Waiting times to receive mental health support can be long due to lack of capacity of mental health services. Therefore, despite having expressed initial interest, survivors may drop-out while waiting to receive treatment.

Behavioral interventions



Normalize the use of mental health services.

Outreach campaigns as well as information provided to IPV survivors when referred to mental health services should aim to normalize treatment, with a view to overcome stigma and increase adoption (Álvarez & Pernía, 2007). This could be done by portraying mental health patients' diversity in terms of race, socioeconomic status and other characteristics, as well as by disseminating the different types of psychological problems that survivors can experience (i.e., challenging the misconception that only those with serious mental health problems need psychologists).

Outreach campaigns could further leverage the fact that we are heavily influenced by social norms – following the way we perceive people around us to behave. In this regard, when accurate, information campaigns should convey high use of mental health services (e.g., “over 3,000 women used mental health services in this centre in the past 12 months”).



Prompts to keep survivors on the waitlist.

Regular reminders, for example through SMS, could keep survivors engaged with mental health services while on the waitlist. Reminders could incorporate a number of behavioral insights:

- **Goal gradient hypothesis and endowed progress effect.** ‘Goal gradient hypothesis’ says that our motivation increases as we approach our desired goal (Hull, 1932), while ‘endowed progress effect’ refers to our greater persistence on a task when we perceive progress towards it (Nunes & Drèze, 2006). Both could be used to motivate survivors to

stay on waitlist, by conveying how close they are to their goal and how much progress they've already made by joining and progressing in the queue (e.g., "Asking for help is the most difficult step, congratulations in getting so far. You'll be seen within x days.").

- **Loss aversion and sunk cost bias.** We prefer avoiding a loss than experiencing an equivalent gain, even if the resulting outcome is the same. We also tend to continue investing in a losing proposition if we have previously invested a lot of time, money or effort. Drawing on these insights, waitlist messages could emphasise how dropping out would mean losing your place and represent a loss of time already spent waiting (e.g., "You have spent 10 days in a queue to access to free psychological treatment – don't lose your place and the time you have invested").
- **Reciprocity.** We have a natural tendency to treat others based on how they treat us (Service et al., 2014). This insight could be harnessed in messages to survivors, for instance by sending supportive messages from the psychologist that is going to treat them (e.g., "I have already reviewed your case and I am looking forward to meeting you").

RESPONDING

2. Receiving treatment

Survivors receiving psychological support are first subject to an assessment, normally entailing an in-depth interview as well as psychological tests.

Based on this diagnosis, the mental health professional defines a treatment plan. There is a lot of variance in the nature of the psychological intervention, its duration, and whether it is delivered in individual or group sessions. These features depend both on the practices of the entity delivering the service (for instance, shelters tend to deliver shorter interventions as the duration of a survivor's stay is limited) and the survivor's mental health condition based on the initial assessment. Anecdotally, service providers interviewed in our case study countries

reported that mental health interventions normally involve both individual and group sessions and range in duration from 1.5 months to 9 months.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
2.1 Providers' lack of adequate identification of IPV and survivors lack of disclosure	See Chapter 3, Section 2
2.2 Providers' lack of uptake of evidence-based practices	Conduct growth mindset training Conduct values affirmation exercises

2.1 Providers' lack of adequate identification of IPV and survivors' lack of disclosure

To adequately diagnose and treat psychological disorders associated with IPV, mental health professionals need to have a comprehensive understanding of the patient's situation. This is hindered by mental health professionals' lack of adequate identification of IPV, and survivors' lack of disclosure of their experiences of abuse, whether total or partial.

Potential drivers of these behaviors and interventions to address them are discussed in Chapter 3 "Health services".

2.2 Providers' lack of uptake of evidence-based practices

Our interviewees reported that the psychological interventions implemented by mental health providers are not always supported by rigorous research. In some cases this may be because providers' lack the time, human and financial resources to deliver evidence-based treatments (Belizan et al., 2006; Majid et al., 2011). In the region, on-the-job training for primary health care providers in mental health is very limited (Aparicio et al., 2009). However, beyond these capacity constraints, behavioral factors may also contribute.

Providers' lack of adoption of evidence-based practices, whether at the individual or at the institutional level, may be driven by:

- **Fixed mindset.** Two self-theories of intelligence are: 'fixed mindset' – our abilities cannot be changed; and 'growth mindset' – our abilities are malleable and can improve with effort (Dweck, 2006). People with a growth mindset have been shown to work harder, use more effective learning strategies, and achieve better results (Dweck, 2012; Yeager et al., 2014; Yeager & Dweck, 2012). If providers have a fixed mindset, they may not believe that they have the ability to adopt new practices and improve outcomes for survivors.
- **Status quo bias.** We often prefer things to stay the same by doing nothing or sticking with a previous decision. Mental health professionals may continue implementing therapy techniques they are skilled or experienced in, independently of what is supported by evidence (Belizan et al., 2006; Majid et al., 2011), because they prefer familiar ways of working rather than potentially losing control or experiencing negative professional consequences from trying a new approach.
- **Burnout.** The demands of complex cases with heavy workloads and time pressures may lead to burnout amongst mental health professionals.

Behavioral interventions¹³



Conduct growth mindset training.

Interventions to promote a growth mindset can take as little as 30 minutes (Schleider & Weisz, 2018). They usually involve explaining the malleable nature of the brain and how the brain grows with effort (Dweck, 2006). Experimental research has found that growth mindset interventions can increase employee creativity and wellbeing (Holm, 2015). Further, managers' growth mindset

has been associated with more effective coaching and in turn increased willingness of employees to contribute to team effectiveness with actions that are not strictly required as part of their job (Özduran & Tanova, 2017). Conducting growth mindset training before introducing new evidence-based practices to mental health workers may increase their willingness to adopt these practices.



Conduct values affirmation exercises.

Values-affirmation exercises can make people more open to accepting new information and to changing their views, while boosting their self-efficacy (Sherman & Cohen, 2006; Salles, Mueller, & Cohen, 2016; Miyake et al., 2010). A simple way to implement this strategy is to ask people to identify and reflect on their values, for example, by selecting values they consider important from a list and write about why those are relevant to them. Mental health workers could be asked to complete a values affirmation exercise before being introduced to new evidence-based practices. BIT successfully incorporated this technique to shift teacher attitudes towards corporal punishment in a refugee camp in Tanzania (De Filippo & Rodrigues, 2017).



SUSTAINING

3. Sustaining engagement throughout treatment

Given the shortage of mental health services, particularly publicly provided, it is often the case that psychologists and psychiatrists cannot hold sessions with survivors as often as they would deem necessary (HAI, 2016). Further, providers often lack capacity to maintain communication with survivors in between appointments and to follow-up if a survivor fails to attend a session.

When the treatment sessions are completed, a second evaluation is conducted. If counselling is deemed successful, the mental health intervention ends at that point. If not, additional sessions are programmed. Treatment may also terminate due to survivor drop-out or when the intervention is finalized and there is no capacity to hold subsequent sessions.

¹³ We outline promising psychological interventions which draw on insights from the behavioral sciences. This is not intended to be an in-depth review of the clinical evidence on effective interventions to address mental health disorders associated with IPV, which falls outside the scope of this report.

Target behaviors and proposed interventions

Target behavior	Intervention ideas to overcome target behavior
3.1 Survivors' lack of follow-through	<p>Make progress more salient</p> <p>Use peer support groups to promote treatment adherence</p>

3.1 Survivors' lack of follow-through

Survivors who start psychological treatment may drop-out before treatment ends for a variety of reasons, most commonly involving:

- **Not perceiving progress.** If survivors do not feel they are making progress, either because that is objectively the case or because they don't perceive it, they may lose motivation and stop attending mental health sessions. Survivors who attribute low progress to themselves, rather than the situation, are likely to show lower motivation to further pursue their goal (Zhang & Huang, 2010).
- **Lack of self-efficacy.** Low self-efficacy may impede survivors' ability to maintain sustained engagement with ongoing support.
- **Economic barriers.** Survivors may not be able to afford the direct costs of private mental health treatment, or when provided free, its indirect costs in terms of time, transportation, and associated expenses such as childcare. Further, psychotropic medications are highly expensive. For instance, in El Salvador the cost of the daily dosage of antidepressants amounts to 28 percent of the minimum salary (Aparicio et al., 2009).

Behavioral interventions



Make progress more salient. To help survivors realize their progress, mental health staff could provide them with a booklet which includes their treatment plan and the steps they have completed towards their end goal. This could be updated at each therapy session, to ensure regular recognition of progress and to overcome the tendency to only focus on unresolved issues. Survivors could be asked to write comments in the treatment plan, to acknowledge where situational factors have led to slow progress, and to develop strategies for mitigating these factors, in order to reassure survivors that the end goal is attainable.



Use peer support groups to promote treatment adherence. Peer support groups, which bring together survivors using mental health services, could be employed to encourage survivors to continue treatment. There are two main advantages to such an approach. First, having stronger social support networks has been associated with a reduced risk of mental health disorders among IPV survivors (Coker et al., 2002). Second, survivors who are in a more advanced stage or have successfully finalised therapy can act as positive role models to survivors with similar experiences (Sowards, O'Boyle, & Weissman, 2006). A potential third advantage is the opportunity to share indirect costs, particularly childcare which could be cheaper if organized for a group of children.

CONCLUDING REMARKS

Mental health services are a key component of the recovery process for survivors affected by mental health disorders which may last long after the abusive relationship is over.

A first barrier for receiving the help they need is lack of available services. There are stark socio-economic and geographical inequalities in coverage of mental health services in the region. There is a shortage of specialized services for IPV survivors and the ones available do not always utilize evidence-based interventions. Further, beyond supply issues, survivors face a number of challenges – from economic barriers to stigma – which prevent them

from fully benefiting from psychological support interventions.

In this chapter, we suggest immediate actions that services can take to increase uptake with virtually no cost, for example, changing their outreach strategies to convey the diversity of users of psychological support. Further, one of the most promising areas for experimentation is innovative psychological interventions, such as growth mindset and values affirmation exercises, which could support mental health providers to adopt more evidence-based treatment practices.



CHAPTER 5:
SHELTERS

CHAPTER 5: SHELTERS



1.1 Survivors not accessing shelters



Create a directory of shelters and the services they offer



Review the use of the term 'shelter'

2.1 Survivors do not choose the most appropriate services



Simplify the choices of services



Default survivors into essential services upon entering the shelter to reduce stigma and choice overload.

3.1 Survivors leave shelters before they are ready to do so



Re-frame rules to be more welcoming and less alienating



Give survivors additional privileges as their length of stay increases



Bolster social support from mentors, family and friends



Facilitate access to financial resources

Key:	X. User journey stage	X.X Target behaviour	 Intervention idea
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INTRODUCTION

The following chapter explores the experiences of IPV survivors interacting with shelters. Shelters relate to temporary housing and protection for women escaping violence.¹⁴ Shelters for IPV survivors have existed for some time in LAC. Of the 18 Latin American countries in the most recent comprehensive inventory of shelters, all had at least one shelter, with the exception of Uruguay. Some countries, like Brazil and Peru, had government-run shelters in multiple locations while others, like the Dominican Republic and Nicaragua, had a few shelters run by non-governmental organizations (NGOs) (MESECVI, 2008). The number of shelters has risen since 2008, but no comprehensive updated inventory exists. As in other parts of the world, shelters in LAC vary in the range of services they provide, from exclusively accommodation to counseling, health services and vocational training.

While survivors' journeys vary from country to country, their journeys interacting with shelters can be divided into three stages: 1. Entering shelters; 2. Arrival and use of services; and 3. Departure from shelters and follow-up.

SEEKING

1. Entering shelters

Survivors may arrive at a shelter via a referral from other service providers, most frequently the police, health services and helplines, or on their own volition

(self-referral). According to our interviews, the general consensus among experts in El Salvador and Honduras is that the health sector provides a more effective referral pathway to shelters than the police and judicial system.

Targeted behaviors and proposed interventions

Targeted behavior	Intervention ideas to overcome target behavior
1.1 Survivors not accessing shelters	Create a directory of shelters and the services they offer Re-frame the term 'shelter'

1.1 Survivors not accessing shelters

Beyond the lack of availability, survivors may not self-refer to shelters or act upon referrals for the following reasons:

- **Lack of information.** Service providers in El Salvador and Honduras identified lack of information about the availability of shelter services as a limiting factor to women self-referring to shelters. This lack of information may extend to the types of services provided, or even to the ultimate aim of shelters, to empower women to lead lives free of violence, rather than temporarily shelter them from violence.

¹⁴ In developed countries, there may be a range of different types of shelter: emergency centers offering short term housing; first-stage emergency housing, also known as transitional housing, which offers short- or medium-term housing; second-stage housing offering long-term housing with support and other referral services; and safe home networks, which are networks of private homes in remote or rural areas where there are no shelters (see Beattie and Hutchins, 2014). However, in developing countries there are generally only one or two types of shelter services available.

- **Economic and logistical challenges.** Entering a shelter may entail a number of economic hardships and logistical difficulties for survivors. For example, shelters may be far away from survivors' workplaces and their support networks. Furthermore, survivors' dependents may not be allowed to reside in the shelter, particularly their parents and older children, which means survivors would need to arrange care for them. If they are allowed to bring their children, the shelter may be far from school or childcare facilities.
- **Uncertainty aversion.** IPV survivors may distrust the ability of publicly-provided shelters to protect them from the perpetrator, particularly violent men linked to gangs or organized crime.¹⁵ They may even prefer knowing the probability of violence from staying in their current housing and how to cope with it, compared to not knowing the probability of violence from entering a shelter and the consequences.
- **Availability heuristic.** Survivors may underestimate the risk that they face from staying in their current housing (Fugate, Landis, Riordan, Naureckas, & Engel, 2005). They may not personally know anyone who has experienced severe physical violence or was murdered by an abuser, or such an event may not have occurred recently.
- **Stigma.** Survivors who seek refuge at shelters may believe that they are violating social norms (e.g., family unity). This anticipated social stigma may prevent them from seeking help and taking up these services.

¹⁵ Some women in Central American countries view the shelter system as being “compromised” (“el sistema está infiltrado”). There has been at least one case in Honduras of corruption in the criminal justice system leading to the location of a woman and her shelter being divulged to her abuser, who then arrived at the shelter with a group of masked men and physically removed her. At the same time, new types of violence such as trafficking and threats from men involved in the drug trade are perceived as leading to an overall increase in the demand for shelter services.

¹⁶ See [domesticshelters.org](https://www.domesticshelters.org), “List of Top Rated Domestic Violence Shelters and Programs”.
<https://www.domesticshelters.org/domestic-violence-reports-and-rankings/best-domestic-violence-programs>.
 Accessed January 21, 2019.

Behavioral interventions



Create a directory of shelters and the services they offer.

Providing survivors with a directory of shelters that is easy to use and contains standardized information on the services available could help overcome limited knowledge and logistical barriers to access. Including a typical user journey or scenario for survivors entering, staying and leaving a shelter could reduce uncertainty aversion.



Re-frame the term ‘shelter’.

Instead of ‘shelter’, a more empowering word could be employed, which characterizes it as a transitional step toward a life free of violence. The new term should ensure that the stigma associated with the word “shelter” (failure, inability to protect oneself) is replaced by an association with positive change and empowerment that provides a more accurate description of the long-term aim of shelters. According to a ranking of the top 100 domestic violence shelters and programs in the United States, the top four programs—which all offer shelter services—do not mention shelter; their names are “Project Woman”, “Safe Center”, “What is Your Voice”, and “Rise”.¹⁶



RESPONDING

2. Arrival and services used at shelter

Whether survivors are referred to shelters by other service providers or they self-refer, when they arrive at a shelter, they typically face one of three situations:

- I. There is no space available. Across the region, there is a limited supply of shelter beds compared with the high prevalence of severe violence. Estimates of excess demand for shelter space ranged from 40 percent in Honduras to 60-70 percent in El Salvador based on our interviews with expert informants.¹⁷
- II. If there is space available, shelter staff administer an intake questionnaire to determine if a survivor is eligible for shelter services, the survivor’s history of violence and her future risk. In most cases, survivors are offered entry and decide to stay in the shelter. It should be noted that reporting violence to the relevant authorities is not a condition of entry.
- III. In some cases, a survivor is denied entry for reasons other than lack of available space. The most frequent reasons for being denied entry are because a survivor is not within the appropriate age range (they may be too young to be admitted) or because of a drug or alcohol dependency.

Once admitted to the shelter, survivors are required to agree to a code of conduct. This code of conduct can vary significantly by shelter and can sometimes be quite restrictive (e.g., no contact with outside world, surrendering of cell phone). It frequently includes rules regarding use of shared space, how children are to be treated (e.g., no corporal punishment), and agreement to participate in shelter activities and programs.

Survivors are also presented with the range of services beyond lodging and meals, including: legal counseling, entrepreneurial or job training, basic medical services, education on women’s rights, individual and group counseling, safety planning, arranging for children’s schooling, and sometimes support for future housing (Castillo-Ruiz, 2001; Macy, Giattina, Sangster, Crosby, & Montijo, 2009;

Sullivan, 2011). In El Salvador and Honduras, a wider range of services is available in shelters run by NGOs compared with those run by municipal governments.

Targeted behaviors and proposed interventions

Targeted behavior	Intervention ideas to overcome target behavior
2.1 Survivors do not choose the most appropriate services	Simplify the choice of services Default women into essential services

2.1 Survivors do not choose the most appropriate services

There is limited evidence about whether services provided by shelters across the region are meeting survivors’ needs. Lyon, Lane, & Menard (2008) gathered such data for the U.S. through a survey of women residing in 215 shelters in eight U.S. states. Women were asked to identify their principal needs—ranging from “safety for myself” and “emotional support” to “leaving my relationship” and “budgeting and handling my money”—and whether their stay in shelter had helped address their needs. For each of the 27 needs identified, at least 75 percent of respondents said that some of their needs had been met, and at least 50 percent said that all of their needs had been met.¹⁸ Assuming the statistics are similar for LAC, if a large proportion of women do not have their needs met, an important question is whether shelters effectively support women to identify and choose services optimally.

The following barriers may prevent survivors from accessing the services they are most in need of:

- **Choice overload.** The wide range of services offered, combined with a survivor-defined practice model, may result in choice overload for survivors. They may be overwhelmed by

¹⁷ No formal data exist on the percentage of violence survivors in Latin American countries who are turned away from shelters because no space is available. In the U.S., estimates of the percentage of women turned away range from 3.5% (DomesticShelters.org, 2018) to 14.5% (thinkprogress.org, 2018).

¹⁸ The three most common needs identified were safety for myself, finding affordable housing, and learning about my options and choices.

the number of choices open to them, which may lead them to make worse decisions and be less satisfied with the decisions made than if a smaller number of alternatives were available (Iyengar & Lepper, 2000).

- **Regret aversion.** To avoid self-blame for disappointing outcomes, we often overreact (either by behaving extremely conservatively or by exhibiting herd behavior) under uncertainty. If survivors are unfamiliar with the types of services on offer and what is expected of them as participants, they may choose sub-optimally to avoid future regret.

Behavioral interventions



Simplify the choice of services. Decision aids, such as “rules of thumb” or “decision trees”, that allow women to quickly make informed choices about which services they should access may lead to better outcomes (Schoar & Datta, 2014).



Default survivors into essential services. If there are services which shelter staff deem most important for the large majority of women, these should become the default, to reduce the chances of women feeling overwhelmed by the options or making choices based on expected regret. Where feasible, service providers for these most important services could offer them inside the shelter or via video link, so that women do not have to leave an environment in which they have begun to feel safe. These services also could be offered in the most desirable time slots.

SUSTAINING

3. Departure from shelter and follow-up

The length of survivors’ stays in shelters varies significantly both across different types of shelters and across countries. Some emergency shelters have maximum stays of only one day (which may be occasionally extended if it was not possible to

accommodate the survivor in alternative housing), while others allow stays of several months or more.

If shelter staff and the survivor agree that it is time to leave, the survivor will typically produce a life plan (“plan de vida”) before she departs that identifies a series of actions she will take to achieve her life goals. In Honduras, approximately 70 percent of shelter residents leave at a mutually agreed time.

In some cases, a survivor may leave the shelter before staff consider it is the right time for her to do so, either because she reached the maximum length of stay or because she “dropped out”.

Shelters may or may not follow-up on ‘graduates’, depending upon capacity constraints. In Honduras and El Salvador, follow-up was described as occurring infrequently. See relevant discussion in Chapter 3, Section 3 on encouraging health services follow-up.

Targeted behaviors and proposed interventions

Targeted behavior	Intervention ideas to overcome target behavior
3.1 Survivors leave shelters before they are ready to do so	Reframe rules to be more welcoming and less alienating Give survivors additional privileges as their length of stay increases Bolster social support from mentors, friends and family Facilitate access to financial resources

3.1 Survivors leave shelters before they are ready to do so

There is evidence that survivors in shelters systematically underestimate the probability that they will return to their abuser (Griffing et al., 2002). This occurs for a wide range of reasons, including: fear of retribution; because they think it is best for the children; lack of self-esteem; guilt and desire to help their mate; economic dependence; the stigma associated with dissolving a marriage or relationship; satisfaction with the relationship apart from the episodes of violence; or (frequently misplaced) optimism that their partner will change. Many of these

issues are dealt with in previous chapters; the focus here, therefore, is on alternative reasons survivors leave shelters before they are ready to do so.

Factors reducing the length of survivors' stay in shelters include:

- **Oppressive rules.** Survivors may be dissatisfied with shelter rules which govern their behavior. The most common rule complaints from a study of US shelter residents were: time limits on shelter residence; curfews; child discipline and monitoring; and chores expected of shelter residents (Lyon et al., 2008). Service providers in El Salvador and Honduras did not see restrictive rules as a disincentive for women entering shelters. However, such rules may have negative consequences for survivors' recovery process – exacerbating emotional distress and social isolation – which induce them to leave shelters prematurely (Glenn & Goodman, 2015; Haj-Yahia & Cohen, 2009; Sullivan & Gillum, 2001).
- **Financial strain.** Survivors may leave shelters prematurely because they need income to support their family, and they may be unable to work as many hours (or at all) while residing in a shelter as they could while outside. Note that even though survivors are likely to have younger children with them in shelters, there are still expenditures on children—such as school fees—that will continue while the survivor is in shelter. In addition, other family members, who are not residing in the shelter with the survivor, may economically depend on her.
- **Present bias.** Survivors may place less weight on future gains that could be made from staying at the shelter relative to the present challenges, such as oppressive rules and financial strain.
- **Self-efficacy.** Survivors may suffer from low self-efficacy and self-esteem, lacking belief in their own ability to achieve goals and complete tasks.

Being isolated from family members and their community might also compound these feelings of helplessness.

Behavioral interventions



Reframe rules to be more welcoming and less alienating.

In addition to simplifying rules, shelters could change the way rules are written and posted, focusing on positive messages rather than command-and-control. The term 'rules', which sounds controlling and repressive, could also be relabeled as 'expectations' or 'guidelines'.



Give survivors additional privileges as their length of stay increases.

Survivors' frustrations about rules may build over time. A way of counteracting this might be to reduce the number of rules residents must obey based on their time spent at the shelter. For example, after three weeks in a shelter, phone usage could be permitted, or curfews could be relaxed.¹⁹

In shelters intended for longer term accommodation, residents themselves could be involved in the process of deciding which rules remain and which go, how rules will be monitored and enforced, and what the punishments would be for their violation. Increasing the sense of procedural justice could lead to increased compliance and satisfaction with rules (Gover, Brank, & MacDonald, 2007) and contribute to alleviate the sense of powerlessness attached to residing in a shelter.



Bolster social support from mentors, friends and family.

We are more likely to respond to encouragement from people we identify with. Former shelter residents and supportive friends or relatives could be asked to keep residents motivated to stay in the shelter. Former residents could be employed as mentors to transmit how much shelter services helped them,

¹⁹ Any intervention would carefully consider any potential safeguarding risks prior to implementation

and why it is important to complete courses rather than depart prematurely. If phones are allowed in the shelter, friends and family could be provided with examples of supportive text messages they could send to survivors, in order to counteract survivors' sense of isolation or separation from their community (Sullivan & Gillum, 2001).²⁰



Facilitate access to financial resources.

After an initial period, when survivors are not allowed to leave the shelter in order to ensure physical safety, shelters could facilitate economic activity that will generate income for survivors. They could do this by providing daycare for children while survivors work, or by directly connecting survivors with job opportunities.

CONCLUDING REMARKS

Shelters provide temporary accommodation that is key to enable survivors to leave abusive relationships and guarantee their physical safety. The interventions proposed here aim to facilitate survivors' access to shelters, and to ensure that services provided in shelters respond to survivors' needs.

Framing shelters in a way that makes their benefits

more salient and seeks to overcome the associated stigma could increase their uptake. Once survivors have accessed shelters, interventions that seek to counter present bias and leverage social support could be key to ensuring survivors' needs are met and that they depart at the right time, in the best conditions possible to continue their recovery process.

²⁰ Recent work from the Behavioral Insights Team has confirmed the importance of social supports and mentors. In one study, students were invited to nominate a "study supporter"—a parent, parent, older sibling, mentor or friend - to receive regular text messages. These text messages reminded supporters to talk regularly with the student about their studies. Results showed that students with study supporters had 7% higher attendance rates and 27% higher attainment. Another Behavioral Insights study found that students at low-performing schools who received a letter from a role model encouraging them to apply to university were 34% more likely to do so. See <https://www.bi.team/blogs/helping-everyone-reach-their-potential-new-education-results/>



CONCLUSION

CONCLUSION

Behavioral science has been used by governments and non-governmental organizations to deliver more effective services for citizens in a wide range of policy areas (BIT, 2016; OECD, 2017). This report has attempted to show how a more realistic and nuanced understanding of human behavior could also improve outcomes for IPV survivors.

Throughout this report, we have identified some of the barriers that hamper the take-up and effective provision of IPV services in LAC, informed by our interviews with professionals in the region. These include both behavioral biases and structural barriers, which we recognize are neither exhaustive nor applicable in all cases. However, we hope that by highlighting a wide range of barriers across the three key stages of a survivor's journey – Seeking, Responding and Sustaining – we will encourage service providers to look more closely at their own services to understand where survivors' needs are not being met.

We propose interventions informed by behavioral science to address the barriers we identified, targeting both survivors and service providers. It is important to remember that we are all susceptible to behavioral biases but the extent to which they steer us towards poor choices depends on the design of our environment. In this report we have tried to provide examples of interventions that are low

cost and relatively easy to implement. While many in number, these ideas do not represent the limits of what is possible. Rather, we hope that they will spread excitement among service providers about the power they have to innovate and make small changes to their service environment which could potentially transform the lives of survivors.

What is the message readers should take away from this report?

A behavioral lens can be systematically applied to a diverse set of services, at all stages, to improve outcomes for IPV survivors. There are key themes that arise throughout the report that we believe should be prioritized. These are:

 **SEEKING:** Give survivors clarity about processes to overcome uncertainty aversion which can reduce their willingness to take up services

 **RESPONDING:** Equip service providers with decision aids to overcome decision fatigue and improve the quality of their response to IPV

 **SUSTAINING:** Build in support for survivors where possible to overcome low self-efficacy and foster motivation to sustain long-term engagement with services

SEEKING	RESPONDING	SUSTAINING
Target behavior		
Survivors may not take up services due to uncertainty about the process ahead, including fear of perpetrator retaliation and stigma	Providers may not identify the best options for survivors after making many decisions within a shift	Survivors may not maintain engagement with services because of the disruption this causes to their life
Behavioral barriers		
Uncertainty aversion	Burnout and decision fatigue	Low self-efficacy
Intervention example		
Give survivors upfront clarity on the steps involved in accessing a service and use technology interfaces to increase confidentiality when asking survivors sensitive information	Introduce decision aids such as ‘rules of thumb’, ‘decision trees’, protocols, and automated processes to help service providers respond adequately when they don’t have the mental capacity to think through the full breadth of a problem	Build in opportunities for survivors to receive support, encouragement and positive reinforcement from peers and service providers to bolster self-efficacy

Next steps for policymakers and practitioners to build evidence

There are numerous opportunities to apply behavioral science to IPV services, yet the evidence on what works remains scarce. Much of the existing research focuses on improving survivors’ behavior, however, there is great potential for more research to be focused on improving service providers’ behavior. Further, despite promising interventions (Steel, Blakeborough, & Nicholas, 2011), there is a paucity of evidence on how to better coordinate services across agencies.

As stated in the introduction to this report, while some of the interventions we have proposed have already been tested in the context of IPV services, many others have not. In either case, to bring these ideas to practice, they should be rigorously evaluated within the local conditions where they are implemented as small details can have a large influence on effectiveness. In a policy area where the dangers to women are very high, it is fundamental to have robust evidence on the impact of government action on survivors’ wellbeing. We hope to

collaborate with governments in the region to rigorously evaluate interventions to improve IPV services.

It is important to keep in mind that data limitations pose an overarching barrier to conducting evidence-based policymaking in this area. While we know much more than we did a decade ago about the prevalence of IPV in LAC, much less is known about the use, quality and impact of services provided to women survivors. Priorities here include the development of monitoring and reporting systems that capture women’s use of services (and, in the best case, span multiple service providers), quality control systems that allow survivors to give feedback to providers on the quality of services received, and data collection systems that track the long-term impact that the provision of services have on women.

Guaranteeing women’s rights to a life free of violence is not only a commitment that countries in the region have entered into under international law²¹ but it is also a moral obligation. This report aims to support governments in LAC to better deliver on this responsibility.

21 Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (“Convention of Belem do Para”) (1994). Declaration on the Elimination of Violence against Women (1994). Convention on the Elimination of All Forms of Discrimination against Women, CEDAW (1979) and Optional Protocol to the Convention (1999).

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