Screening and Brief Intervention for Intimate Partner Violence in Primary Care Settings

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Why should we screen for IPV?
Medical and Mental Health Impact

- Injuries
- Mental and physical health and well-being
- Health Care Utilization
Disguised presentations of IPV
• As a Mental Health problem
  • Depression, Anxiety
  • Alcohol/drug abuse
• As a Relationship problem
  • Sexual dysfunction
  • Partner as identified patient
• As a Child-Related problem
  • Suspected child abuse
  • Child behavior problem
• As multiple, stress-related physical complaints
As a “compliance” problem

- Medication
- Obstetrics
- Follow-up for specialty care
Compared to no IPV, healthcare utilization by victims was higher across all categories.

As time from the last assault increased, utilization rates decreased.

5 years after the final assault, victims’ utilization 20% higher than non-victims.

Rivera, et al. (2007)
Children of battered women experience more healthcare utilization and costs than children of non-battered women

- Mental health services
- Primary care visits
- Specialty care
- Pharmacy services
- Emergency services (for children directly exposed)
  - Rivera et al. (2008)
Some case examples
PTSD/ASD

- **KC**
  - 50 y/o African American woman, self-employed

- Presentation to FP: “I’m having problems sleeping, feeling stressed all the time, and depressed.”
Symptoms

- Sleep onset and interruption insomnia
- Headaches
- Nightmares
- Crying spells
- Worry
- Difficulty concentrating and inability to do her job
- Decreased appetite
- She **did not** mention the assault to her PMD
  - Family gathering
  - Punched and strangled by husband
  - Feared for her life
- Intrusive thoughts
- Avoidance of certain situations
Depression

- **B.H.**
  - 55 y/o African American woman
  - Married 30 years; 4 adult children
  - Homemaker and part time work with her church
- **Frequent clinic visitor**
  - High blood pressure and headaches
  - Depression
Key Symptoms

- Sadness
- Guilt feelings
- Sleep interruption insomnia
- Overeating and weight gain
- Low energy and decreased motivation
- Feelings of hopelessness
  - Not suicidal
- Low self-esteem
- Frequent crying spells

- PMD uncovered abuse via case finding
Functional Disorders

- C.O.
- 28 y/o White female
- Currently unemployed
- History of bi-polar disorder and alcohol abuse
- Complaints of low back pain
No pathophysiology identified following comprehensive testing and diagnostic studies

- abuse was discovered via case finding
Anxiety

- P.T.
- 58 Y/O White female
- Married 33 years
- Recent empty nest
- Recent part time employment after years of homemaking
- Presented to PMD with anxiety that was not responsive to medications
Key Symptoms

- Uncontrollable worry and apprehension that “something bad” was going to happen
- Increased muscle tension
- Fatigue
- Restlessness
- Increased absenteeism from work
- IPV unveiled through case finding
Should we screen for IPV or rely primarily on case finding?

- Ongoing debate
  - Studies have not uniformly shown screening to result in decreased violence or improved health
    - MacMillan et al. (2009), Klevens et al. (2012)
Affordable Care Act and IPV Screening

- IPV screening and counseling one of 8 prevention services to be offered to women with no cost sharing
US Preventive Services Task Force gives IPV screening in primary care settings a B recommendation – IPV screening has moderate net benefit

- Service is recommended and should be offered
- Adequate screening instruments
- Adequate evidence of effective interventions
- Risk of harms from screening no greater than small
Speaking of screening instruments...
• HITS – Hurt, Insult, Threaten, Scream (Sherin et al., 1998)
• OVAT-- Ongoing Violence Assessment Tool (Ernst et al., 2004)
• STaT -- Slapped, Threatened, Throw (Paranjape et al., 2006)
• HARK– Humiliation, Afraid, Rape, Kick (Sohal et al., 2007)
• WAST -- Woman Abuse Screening Tool (Brown et al., 2000)
• PVS – Partner Violence Screen (Feldhaus et al., 1997)
Prior Efforts to Enhance IPV Screening in Healthcare Settings Have Not....

- Resulted in large-scale screening
- Been sustainable
• External attempts to induce change have not been effective
  • Professional association position statements
  • Accreditation efforts
  • Required cme for licensure

• Reliance on community resources to support change has been successful......
  • But there not enough resources
  • And when the funding goes......
Training and education efforts
Training increases:

- Knowledge
- Self efficacy
- Clinical skill
  - Hamberger et al. (2004)
Education on IPV is Necessary, but Not Sufficient

- **Systematic reviews**
  - Waalen et al., (2000)
  - O’Campo et al., (2011)

- **Empirical studies**
  - Minsky-Kelly et al. (2005)
  - Hamberger et al. (2010)
  - Sims et al. (2011)
Compliance with Screening After Training Only

% of patients screened

High-Risk Departments

Beh Health 95% 100%
Emer. A 44% Heath
Emer. B 0% Emer. B
Lab & Del 40% Lab & Del
OB/GYN 0% OB/GYN
Goal 100% Goal

% screened Goal
Why might this be?
System-Wide Barriers

Minsky-Kelly et al. (2005)

• Privacy concerns

• Time constraints

• Patient flow

• Professional/Personal discomfort with subject
The Fix (not necessarily quick or easy)

- System-level interventions at the departmental level
  - Increase privacy
  - Modify patient flow
  - Provide department-level CQI feedback
  - Stress/vicarious trauma management
  - Ongoing in-service skills training review
Emergency Department A
DV Screening Compliance

% of Patients Screened

Month/Year of Chart Review

Sep. 99  Dec. 99  Feb. 00  May-00  Jul. 00  Goal
44%    22%    62%    68%    83%    100%
OB/GYN
DV Screening Compliance

% of Patients Screened

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Oct-99  | Jan-00  | Apr-00  | Jul-00  | Goal

Month/Year of Chart Review

0% 45% 71% 82% 100%
Emergency Department B
DV Screening Compliance

% of Patients Screened

Month/Year Charts Reviewed

Oct. 99 | Jan. 00 | Mar. 00 | Apr. 00 | Jun. 00 | Goal

0% | 0% | 11% | 32% | 27% | 100%
Healthcare Can Change From Within

- L. Kevin Hamberger, Ph.D.
- Bruce Ambuel, Ph.D.
- Mary Beth Phelan, M.D.
- Marlene Melzer-Lange, M.D.
- Marie Wolff, Ph.D.
- Amy Kistner, M.S.
- Clare Guse, M.S.
Change from Within Components

1) Health Care Advocates—Selected staff receive intensive training in IPV & health
2) Collaboration w/ advocacy agencies & experts
3) Saturation training of all staff
4) Policies & procedures
5) Continuous Quality Improvement
6) Primary prevention
Teaching Healthcare Providers to ask about and respond to IPV
Key Training Components

- Integration of facts into the healthcare picture
  - Why is this a healthcare problem?
  - Why is this information relevant to HCPs?
  - Why should HCPs make IPV part of their practice?
- What skills are involved to effectively work with IPV survivors?
7 Key Intervention Components

- Assure confidentiality
- Provide emotional support
- Provide community resource information
- Danger assessment
- Safety planning
- Offer follow-up
- Documentation
How it works: A couple case examples
Case 1: Introduction

- A couple came in to the clinic – each with their own appointment
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• The male checks in for both self and partner
Case 1

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- The male checks in for both self and partner
- Another receptionist observes suspicious behavior
  - He was talking for his partner
  - Woman partner looked subservient
  - He was rude and aggressive with reception staff
A couple came in to the clinic – each with their own appointment

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Another receptionist observes suspicious behavior
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Receptionist observed bruises on the female patient
Case 1: Taking Appropriate Action

- Receptionist surreptitiously called the MOA
  - Described the male patient’s behavior
  - Described bruises noted
  - Expressed concern about abuse
• Receptionist surreptitiously called the MOA
  • Described the male patient’s behavior
  • Described bruises noted
  • Expressed concern about abuse
• MOA decides to call the female patient separately from the male to room separately
  • (invoked clinic policy)
Female patient was roomed
MOA notified MD of the situation and separate rooming strategy and MD agreed
MD begins to see female patient with aid of interpreter
MOA rooms male patient in a NON-Adjacent room
Case 2: Screening

- 28 y/o AAF attends clinic for CPE
- Reports upon screening that she is in a violent relationship
Case 2: Patient response

- Partner has threatened to kill her
- Partner followed her into local police station where she attempted to make a report
- She was referred to family court for TRO
- Partner accompanied her to family court offices and threatened to kill her if she followed through with TRO
- She desisted and returned home
- Partner took her rent money
Case 2: Health care Response

- Physician asked if she wanted to speak to the Health Advocate
- Health Advocate invited to exam room
  - Conducted violence assessment
  - Conducted safety planning
  - Provided resource information
  - Scheduled follow-up contacts
Case 2: Referring

- Patient asked for help accessing shelter
- Advocate contacted shelter
  - No room
  - No alternatives provided
  - Advocate located area shelter alternatives
- Shelter director later contacted for problem solving
Active Components
Education
• Education
• Discipline and job-specific roles
• Education
• Discipline and job-specific roles
• Clinic policies and procedures
  • IPV screening
  • Patients seen alone for part of medical encounter
  • Collaboration with community agencies
Strategies to Measure Effectiveness of Healthcare-Based Domestic Violence Screening and Intervention
Ideal Goal: End IPV

- May not be under the control of either the patient/survivor or the healthcare provider
  - Hamberger, Rhodes, & Brown (2014)
Three Levels of Analysis

- Practitioner
- Health system
- Patient
OUTCOMES: Healthcare Can Change from Within
Clinicians reported significant increases in:

1) Self-efficacy

2) Understanding of referral resources

3) Understanding of legal requirement

4) Clinic’s capacity to facilitate IPV intervention

5) Staff well prepared

6) Increased screening
CLINIC OUTCOMES

- Compared to “usual care” control clinics, intervention clinics showed:
  - Implementation of new policies and procedures for IPV screening and intervention
  - Increased locations and numbers of patient education materials on IPV
  - Increased screening documentation

- Changes continued at 2-year follow-up, suggesting sustained change
PATIENT OUTCOMES (Hamberger et al., 2014)

• SIGNIFICANT FINDINGS favoring intervention clinics
  • IPV screening by doctor or nurse
  • Disclose IPV to doctor or nurse
  • Discuss IPV with someone at a clinic or hospital

• Fewer symptoms of injury
• Drop in clinic visits over time
Randomized controlled trial – 48 total clinics
Similar components to Healthcare Can Change From Within
  • Practice-based training sessions
  • Embedded domestic violence advocate
  • Prompt to ask about abuse

Results
  • Intervention practices recorded significantly more
    • IPV referrals to advocacy
    • Disclosures of IPV from patients
  • Intervention is cost-effective
    • Devine et al., 2012
Summary

- IPV is a public health problem with a tremendous morbidity burden for individual survivors and for society.
- Efforts to address IPV as a health problem are evolving and showing promise.
- Systems change that involves a multi-disciplinary approach appears to be the most promising approach to increasing office-based IPV screening and brief intervention.
- More research using RCTs are needed to validate the impact of healthcare-based screening and brief interventions to prevent and end IPV.
- Methodological improvements are needed.
REFERENCES


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