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Intimate Partner Violence: Updated Screening Tool and Approach to Screen Positive Patients

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INTIMATE PARTNER VIOLENCE: UPDATED SCREENING TOOL AND APPROACH TO SCREEN POSITIVE PATIENTS

MILTON FAMILY PRACTICE

MICHAEL J. HALL – ROTATION #7 2018



PROBLEM IDENTIFICATION AND DESCRIPTION OF NEED

- The CDC defines Intimate Partner Violence as “actual or threatened physical, sexual, psychological, emotional, or stalking abuse by an intimate partner.” Further clarification includes, “An intimate partner can be a current or former spouse or non-marital partner, such as a boyfriend, girlfriend, or dating partner. Intimate partners can be of the same or opposite sex.”
- According to the National Intimate Partner and Sexual Violence Survey 2010 Executive Summary, 35.6% of women and 28.5% of men in the United States have experienced intimate partner violence in their lifetime.
- In Vermont during 2016, 19,816 calls were made to the Vermont Network against Domestic and Sexual Violence hotline and 30% of homicides were related to domestic violence.
- Currently, routine screening of IPV is recommended for females of childbearing age by the USPSTF, AAFP,AMA, and ACOG.
- Review of the UVMHC Family Medicine well-patient visit questionnaire demonstrates an opportunity to update to a AAFP recommended screening tool, assessing risk of those patients who screen positive, and strategies to minimize barriers to patients seeking additional IPV resources, while maintaining sensitivity to provider time constraints

PUBLIC HEALTH COST

- The CDC estimates the costs of intimate partner violence exceeds \$5.8 billion annually
 - Of this \$5.8 billion, approximately \$4.1 billion is for direct medical and mental health care services
 - Nearly \$1 billion is accounted for in lost productivity of victims
- Estimates range between \$2.3 to \$8.3 billion annually as the true cost of IPV is difficult to determine due to victim underreporting and chronic health burdens
- Known health outcomes include: increased rates of miscarriage, low-birth rates, preterm labor, STIs, type 2 diabetes, chronic pain, anxiety, depression, PTSD, substance abuse, and suicide

COMMUNITY PERSPECTIVE

Kerry Stout, LICSW, LADC *Howard Center*

“As a rural state the barriers of confidentiality, culture and consequences really play a huge part. My experience has been when someone has gained some trust in a provider, medical, mental health, or any other, there is an opportunity. ... Most of the time just having someone who will listen, believe them and not tell them what they ‘should’ do is the most helpful. It is important to remember that for people who live in a violent relationship, they are actually very good at negotiating it on their [own], but need support if they think they may want to change things.”

Anna Perrelli, LICSW *Community Social Worker*

“The most challenging part of working with those experiencing IPV is often these individuals do not feel safe even sharing that this is something happening in their lives... As providers we are sometimes left analyzing the collective warning signs. Creating a sense of safety and a trusting relationship is the most important intervention anyone can provide... [and] happens when we approach the interactions in the most nonjudgmental way we can. Often times this means not only in what we are saying to them but in the attitudes we hold going into the conversation... Providers have to be honest with themselves regarding their own attitudes and biases, build self-awareness of what they may be bringing to those interactions, and process with supervisors/colleagues.”

INTERVENTION AND METHODOLOGY

- Literature review regarding the recommended guidelines for intimate partner violence screening was reviewed
 - 2016 – AAFP recommends all women of childbearing age should be screened for IPV, noting a low risk of negative effects from screening (SORT evidence rating A); and screen positive women should receive intervention services (SORT evidence rating C).
 - 2013 – AAFP Clinical Preventive Service and USPSTF recommends clinicians screen women of childbearing age for IPV, and refer those who screen positive to intervention services (Grade B recommendation).
- Recommendations for screen positive patients: Assessment of risk of immediate harm (High risk if “yes” answer to three or more; Sensitivity 83%, Specificity 56%)
 1. Has the physical violence increased over the past six months?
 2. Has your partner used a weapon or threatened you with a weapon?
 3. Do you believe your partner is capable of killing you?
 4. Have you been beaten while pregnant?
 5. Is your partner violently and constantly jealous of you?

INTERVENTION AND METHODOLOGY – CONT.

- The AAFP recommends using screening tools that have been proven sensitive and specific for identifying IPV and cites a list of validated tools provided by the CDC
 - Given the time constraints of a busy primary care practice, the shortest screening tool, with highest sensitivity and specificity was chosen as the recommendation
 - WAST (Woman Abuse Screening Tool) – Short Form is a two question screening tool with a sensitivity of 91.7% and a specificity of 100%. It has been validated by both the CDC and the NIH.

WAST-SF

- Questions:
 1. In general, how would you describe your relationship?
 - a. No tension
 - b. Some tension
 - c. A lot of tension
 2. Do you and your partner work out arguments with
 - a. No difficulty
 - b. Some difficulty
 - c. Great difficulty
- Interpretation: Screen positive if answered with “A lot of tension” or “Great difficulty”

RESULTS

- Educational information and resource flyers with pull-away hotline numbers were posted in all patient bathrooms in Milton Family Practice
- Recommendations regarding screening and immediate risk assessment was compiled and delivered to the Milton office Clinical Practice Supervisor for clinical review by the Department of Family Medicine
- Engagement with the Howard Center, STEPS, and HOPE Works initiated for continued support for IPV awareness within the Milton community and clinic, as well as willingness to provide continuing education for clinical staff

EVALUATION OF EFFECTIVENESS AND LIMITATIONS

- Often, perpetrators of IPV are overbearing and it can be difficult to safely distribute information to women. Providing information and local resource availability for those in violent relationships in restrooms is a strategy to ensure privacy and secure communication.
- Having general information available throughout the clinical setting (waiting room, front desk, patient rooms) increases the general awareness of IPV in the community. The World Health Organization supports such awareness campaigns.
- For the same reasons it is difficult to truly estimate the prevalence of IPV, it is difficult to assess the effectiveness of awareness campaigns and updated screening techniques. While screening has been proven to identify those experiencing IPV, the data is inconclusive as to if identification and referral to resources reduces morbidity and mortality.
- Evaluation of effectiveness
 - Tracking the frequency of having to replace pull-away hotline numbers
 - Comparing the frequency of screen positive patients to historical data

RECOMMENDATIONS FOR FUTURE INTERVENTIONS

- Ongoing and periodic community engagement for IPV awareness
- Continued collaboration with the Howard Center to identify evolving needs of the community as well as specific strategies for resource referral to patients in abusive relationships to reduce any sense of guilt or shame
- Monthly “IPV Clinic” with the Community Health Team to discuss appropriate follow-up and availability of resources to patients referred to or engaged with services
- Ensuring continued replacement of IPV educational resources within the clinic
- Tracking the frequency of screen-positive rates in the practice over time with comparison to national rates

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