

Intimate Partner Violence Screening and Counseling: Research Symposium^{*}

**Monday December 9, 2013
NIH Neuroscience Center
Rockville, Maryland**

**Abbreviated Annotated Review
Prepared by Michele Lynberg Black, PhD, MPH^{**}**

***Sponsored by the U.S. Department of Health and Human Services**

The Coordinating Committee on Women's Health (CCWH), representing Health and Human Services (HHS) agencies and offices throughout the Department, identified the prevention and intervention of domestic/intimate partner violence (IPV) as a Departmental priority focus. An IPV Screening and Counseling Research Symposium was convened on Friday October 4, 2013 at the National Institutes of Health (NIH).

In addition to the HHS Office on Women's Health, the Administration for Children and Families and the National Institutes of Health, agencies involved in planning for this symposium include the Administration for Community Living; the Agency for Healthcare Research & Quality; the Centers for Disease Control and Prevention; the Health Resources and Services Administration; the Indian Health Service; the Substance Abuse and Mental Health Services Administration; the Office of the Assistant Secretary for Health; the Office of the Assistant Secretary for Planning and Evaluation; and the Office of Population Affairs.

^{**} Extensive input to this document was provided by Samia Noursi. Valuable comments were also received by Frances AsheGoins, Lisa Begg, Camille Burnett, and Marylouise Kelley.

The intent of this document is to provide readers with an overview of some of the key overarching issues related to intimate partner violence (IPV) screening and counseling in primary health care settings. Specific topics included in this abbreviated review are: selected tools used for IPV screening in health care settings; barriers and facilitators to screening for IPV; IPV interventions, intervention effectiveness, and barriers to interventions.

This is not a formal comprehensive review of the literature. Rather, it is an abbreviated review and summary of select literature related to the overarching issues described above. This abbreviated annotated review may be used as a tool by the reader to facilitate a more comprehensive review of the existing literature. A number of other relevant and important topics that were beyond this review include: the ethics of screening versus not screening for IPV (for example, the risk of harm and missed opportunities); the relative costs of screening and IPV intervention compared to the health care costs of IPV victimization and the costs of long term mental and physical health consequences to victims of IPV; and the screening policies of professional health care provider organizations.

Finally, rather than re-summarizing well-written and eloquent summaries provided by the author(s), there are instances where the authors have been quoted either extensively or verbatim. Such passages are set in *italics*. For a complete review of the articles presented, please refer to the original author's work and the full citations for the specific work the authors have themselves referenced.

Content

Section 1: Tools Used for IPV Screening in Health Care Settings.....	3
IPV Screening Tools Recommended by the USPSTF	7
Examples of Other IPV Screening Tools	10
Section 2: Barriers and Facilitators to Screening for IPV	16
Health Care Providers' Perspectives/Perceptions	18
Patients' Perspectives/Perceptions	21
Mandatory Reporting	23
Cultural Barriers, Population Barriers, and Societal Level Barriers to Screening for IPV.....	27
Training Health Care Providers to Understand and Address IPV	28
Section 3: IPV Interventions, Intervention Effectiveness, and Barriers to Interventions	33
Section 4: Costs of IPV and Cost-Effectiveness of Screening for IPV among Women	44
Section 5: The Ethics of Screening for IPV	51
Section 6: Recommended Readings for IPV Screening and Counseling Research.....	55

Section 1

Tools Used for IPV Screening in Health Care Settings

Numerous manuscripts have measured the prevalence of IPV in a wide range of mental and physical health care settings and in a large number of research settings. Some IPV measurement tools are longer, more detailed and more extensive tools that are intended for a more comprehensive assessment of IPV experiences. These tools are often self-reports using paper and pencil and most often used in conducting research.

While there is some overlap between the tools used for IPV assessment in research settings and the tools used to screen for IPV, there are differences between the objectives and the tools that are used. Assessment generally involves a more comprehensive and detailed measurement tool that includes a wide range of more detailed IPV experiences. Alternatively, the intent of screening for IPV in a clinical setting is to efficiently and effectively identify victims who may not otherwise be recognized as victims of IPV to inform the provision of health care.

Definition of Screening:

Screening is defined as the presumptive identification of unrecognized disease by the application of tests, examinations or other procedures which can be applied rapidly. Prescriptive screening has the aim of early detection in presumptively healthy individuals of disease that can be controlled better if detected early. A screening test is not intended to be diagnostic. Persons with positive or suspicious findings must be referred for necessary treatment.

From Dictionary of Epidemiology, Last JM, ed., International Epidemiological Association, Oxford Medical Publications, 1983.

In January 2013, the U.S. Preventive Services Task Force (USPSTF) recommended that clinicians screen for IPV and provide or refer women who screen positive to intervention services. This applies to women who do not have signs or symptoms of abuse. The USPSTF recommended several screening tools with the highest levels of sensitivity and specificity. These include:

- **CTQ-SF** (Childhood Trauma Questionnaire – Short Form)
- **HARK** (Humiliation, Afraid, Rape, Kick)
- **HITS** (Hurt, Insult, Threaten, and Scream)
- **OAS** (Ongoing Abuse Screen)
- **OVAT** (Ongoing Violence Assessment Tool)
- **STaT** (Slapped, Threaten, and Throw) and
- **WAST** (Woman Abuse Screening Tool).

Each of these screening tools is provided, beginning on page 6. Other commonly used tools are listed below and are also provided, beginning on page 9.

- **AAS** (Abuse Assessment Screen)
- **AAS-D** (Abuse Assessment Screen-Disability)
- **PSQ** (Parent Screening Questionnaire)
- **PVS** (Partner Violence Screening)
- **SAFE** Screening Tool

- **SAFE-T** Screening Tool
- Screening tool options suggested by **Futures Without Violence**

Abbreviated Review of Selected Literature Related to IPV Screening and Assessment Tools for Use in Health Care Settings

Basile KC, Hertz MF, Back SF. Intimate partner violence and sexual violence victimization assessment instruments for use in health care settings: Version 1. Atlanta, GA: Centers for Disease Control and Prevention, 2007. Available at: <http://www.cdc.gov/NCIPC/pub-res/images/IPVandSVscreening.pdf>

- This compendium provides researchers and practitioners with a rich compilation of tools designed to measure victimization from and perpetration of IPV. The compendium includes more than 20 scales measuring either victimization or perpetration of physical violence, sexual violence, psychological/emotional abuse, and stalking. While helpful to researchers and practitioners seeking to complete an extensive assessment of victimization and perpetration, these assessment tools, in general, are not well suited for screening purposes in clinical settings. For example, the tools are primarily designed to assess one form of victimization or perpetration (e.g., emotional abuse victimization). Additionally, many of the tools include 30 or more questions and some include more than 60 questions.

Haggerty LA, Hawkins JW, Fontenot H, Lewis-O'Connor A. Tools for screening for interpersonal violence: state of the science. *Violence and Victims*. 2011;26(6):725-737.

- This article provides detailed information on a wide range of tools.
- Information is included on tools:
 - Rated good or fair in quality by the USPSTF in 2004
 - Not classified by the USPSTF as valid or reliable
 - Developed after the USPSTF report, and
 - For use in special populations, including persons with disabilities, older women, and Spanish-speaking populations

Hamby S, Cook SL. Assessing Violence Against Women in Practice Settings: Processes and Tools Practitioners Can use. In: Renzetti C M, Edelson JL, Bergen RK, eds. *Sourcebook on Violence Against Women, 2nd Edition*. Thousand Oaks, CA: Sage; 2010:49-71.

- This chapter provides a comprehensive overview of screening for violence against women in practice settings.
- The chapter includes information on:
 - What is screening and who does it
 - Challenges and benefits of implementing screening
 - The distinction between screening protocols and screening instruments
 - Evaluation of screening instruments
 - Dangerousness Assessment and Recidivism risk – identifying the most threatening cases
 - Safety planning
 - Children’s exposure, and
 - Integrating approaches – incorporating multiple life issues into safety planning

Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Prevention Services Task Force Recommendation. *Annals of Internal Medicine*. 2012;156(11):796-808,W-279 – W-282.

- This systematic review was funded by AHRQ in support of the work of the USPSTF.
- The authors reviewed *new evidence of the effectiveness of screening and interventions for women in health care settings in reducing IPV and related health outcomes, the diagnostic accuracy of screening instruments, and adverse effects of screening and interventions.*
- There were 5 key questions addressed in this review:
 1. *Does screening asymptomatic women in health care settings for current, past, or increased risk for IPV reduce exposure to IPV, physical or mental harms, or mortality? Health care settings include primary care clinics, EDs, and student health centers, among others.*
 2. *How effective are screening techniques in identifying asymptomatic women with current, past, or increased risk for IPV? Techniques include self-administered (e.g., computerized-enabled tool or patient self-report) as well as person-to-person (e.g., clinician-to-patient) methods.*
 3. *What are the adverse effects of screening for IPV?*
 4. *For screen-detected women with current, past, or increased risk for IPV, how well do interventions reduce exposure to IPV, physical or mental harms, or mortality?*
 5. *What are the adverse effects of interventions to reduce harm from IPV?*
- The review includes descriptions of:
 - Studies evaluating the diagnostic accuracy of screening instruments for IPV
 - Randomized trials of IPV interventions
 - Studies evaluating the potential harms of IPV screening
- The authors concluded that *screening instruments accurately identify women experiencing IPV. Screening women for IPV can provide benefits that vary by population, while potential adverse effects have minimal effect on most women.*

Ramachandran DV, Covarrubias L, Watson C, Decker MR. How you screen is as important as whether you screen: a qualitative analysis of violence screening practices in reproductive health clinics. *Journal of Community Health*. 2013;38:856-863.

- *This work diverges from previous studies that focus on provider-related characteristics that inhibit screening by focusing on the procedural details that influence how screening occurs and the factors that may contribute to inconsistent—and potentially ineffective—screening practices. We found that despite a universal screening tool in place, inquiry and referral practices can be inconsistent, which may, in turn, affect the ability of a screening program to effectively detect, intervene and prevent partner violence.*
- Reviewer's comments: this recently published manuscript addresses an important issue with respect to which screening tools should be used in health-care settings. Much attention is devoted to what tools are the most effective, which tools are most valid, and which are the best tools to screen for IPV. Often overlooked are the issues that are likely to greatly overshadow how well a specific screening tool can detect IPV. The demeanor and affect of the person administering the tool, the level of comfort and trust the patient has with the health-care provider, and the level of fear the patient has regarding their current partner may easily render any screening tool to be ineffective. If the patient is too afraid to tell anyone, the specifics of the screening tool becomes essentially irrelevant. Neither the simplest screening tool (e.g., are you afraid at home?) nor the most sensitive, valid, well-studied tool will result in having the IPV

victim disclose her experiences with IPV. Similarly, if the patient has a lack of trust for the administrator, feels like she is being judged, or is in an unsafe environment, disclosure will not occur. In clinical settings, just like telephone surveys on IPV, building trust and rapport is critical to disclosure. How you ask the questions is just as important as the content of the questions themselves.

IPV Screening Tools Recommended by the U.S. Preventive Services Task Force

Modified Childhood Trauma Questionnaire – Short Form¹ (CTQ-SF)

A 28-item questionnaire with five dimensions of childhood maltreatment:

1. Physical Abuse (PA)
2. Emotional Abuse (EA)
3. Sexual Abuse (SA)
4. Physical Neglect (PN)
5. Emotional Neglect (EN)

Five items on each scale, plus an additional three-item minimization/denial scale.

Answer Options: Never true, Rarely true, Sometimes true, Often true, Very often true

Humiliation, Afraid, Rape, Kick (HARK) Screening Tool²

H Humiliation

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?

A Afraid

Within the last year, have you been afraid of your partner or ex-partner?

R Rape

Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

K Kick

Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?

HITS Tool for Intimate Partner Violence Screening³

How often does your partner:

1. Physically **Hurt** you?
2. **Insult** or talk down to you?
3. **Threaten** you with harm?
4. **Scream** or curse at you?

Answer options: Never, Rarely, Sometimes, Fairly Often, Frequently

Ongoing Abuse Screen (OAS)⁴

1. Are you presently emotionally or physically abused by your partner or someone important to you?
2. Are you presently being hit, slapped, kicked, or otherwise physically hurt by your partner or someone important to you?
3. Are you presently being forced to have sexual activities?
4. Are you afraid of your partner or anyone of the following?

Circle if applicable:

husband/wife

ex-husband/ex-wife

boyfriend/girlfriend

stranger

5. (If pregnant) Have you been hit, slapped, kicked, or otherwise physically hurt by your partner or someone important to you during pregnancy?

Answer Options: Never, Rarely, Occasionally, Often, Always

Ongoing Violence Assessment Tool (OVAT)⁵

1. Within the last month my partner has threatened me with a weapon. True/False
2. Within the last month my partner has beaten me so badly that I had to seek medical help. True/False
3. Within the last month my partner has had no respect for my feelings.
Never, Rarely, Occasionally, Frequently, Very Frequently
4. Within the last month my partner has acted like he/she would like to kill me.
True/False

Slapped, Threatened and Throw (STaT) Screening Tool⁶

1. Have you ever been in a relationship where your partner has pushed or **Slapped** you?
2. Have you ever been in a relationship where your partner **Threatened** you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken or punched **Things**?

The Woman Abuse Screening Tool (WAST)⁷

1. In general, how would you describe your relationship?
A lot of tension? Some tension? No tension?
2. Do you and your partner work out arguments with ...?
Great difficulty? Some difficulty? No difficulty?
3. Do arguments ever result in you feeling down or bad about yourself?
4. Do arguments ever result in hitting, kicking, or pushing?
5. Do you ever feel frightened by what your partner says or does?
6. Has your partner ever abused you physically?
7. Has your partner ever abused you emotionally?
8. Has your partner ever abused you sexually?

Examples of Other IPV Screening Tools

Abuse Assessment Screen (AAS)⁸

1. Within the last year, have you been pushed, shoved, slapped, hit, kicked, choked*, or otherwise physically hurt by someone?
If yes, by whom?
Total number of times
2. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
If yes, by whom?
Total number of times
3. Within the last year, has anyone forced you to have sexual activities that you did not want?
If yes, by whom?
Total number of times
4. Are you afraid of anyone?
If yes, who?

* "Choked" was added to the revised AAS (see Laughon et al., 2008)

Abuse Assessment Screen - Disability (AAS-D)⁹

1. Within the last year, have you been hit, slapped, kicked, pushed, shoved, choked*, or otherwise physically hurt by someone?
If yes, who? (Circle all that apply)
Intimate partner
Care provider
Health professional
Family member
Other
2. Within the last year, has anyone forced you to have sexual activities?
If yes, who? (Circle all that apply)
Intimate partner
Care provider
Health professional
Family member
Other
3. Within the last year, has anyone kept you from using a wheelchair, can, respirator, or other assistive devices?
If yes, who? (Circle all that apply)
Intimate partner
Care provider
Health professional
Family member
Other

* "Choked" was added to the revised AAS (see Laughon et al., 2008)

Partner Screening Questionnaire (PSQ)¹⁰

1. Have you ever been in a relationship in which you were physically hurt or threatened by a partner?
2. In the past year, have you been afraid of a partner?
3. In the past year, have you thought of getting a court order for protection?

Partner Violence Screen (PVS)¹¹

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by who?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?

SAFE Tool¹²

- | | |
|------------------------------|--|
| S for stress/safety: | What S tress do you experience in your relationship? |
| A for afraid: | Are there situations in your relationships where you felt A fraid? |
| F for friends/family: | Are your F riends aware that you have been hurt? |
| E for emergency: | Do you have a safe place to go and the resources you need in case of an E mergency? |

Note: these questions are examples that may be used. For other suggestions, refer to the original citation.

SAFE-T Screening Tool¹³

1. I feel comfortable/**S**ecure in my home/apartment.
2. My husband/partner **A**ccepts who me just the way I am.
3. My **F**amily likes my husband/partner.
4. My husband/partner has an **E**ven/calm disposition.
5. If my husband/partner and I disagree, we resolve our differences by **T**alking it out.

Note: this screening tool differs from other tools in that it asks indirect questions to screen for abuse.

Screening Options Suggested by Futures Without Violence¹⁴

Option 1:

Have you ever been hurt or threatened by your boyfriend/husband/partner?

OR

Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?

OR

Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner during this pregnancy?

AND

Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:

Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid?

Option 3:

Have you ever been forced or pressured to have sex when you did not want to?

Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?

Option 4:

Abuse Assessment Screen (see above)

Relationship Assessment Tool¹⁵

1. He makes me feel unsafe even in my own home.
2. I feel ashamed of the things he does to me.
3. I try not to rock the boat because I am afraid of what he might do.
4. I feel like I am programmed to react a certain way to him.
5. I feel like he keeps me prisoner.
6. He makes me feel like I have no control over my life, no power, no protection.
7. I hide the truth from others because I am afraid not to.
8. I feel owned and controlled by him.
9. He can scare me without laying a hand on me.
10. He has a look that goes straight through me and terrifies me.

Answer Options: Disagree strongly, Disagree somewhat, Disagree a little, Agree a little, Agree somewhat, Agree strongly

See also screening tools used by Miller et al., 2011 (page 37):

Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception*. 2011;83:274-280.

Screening Tool References

1. Bernstein DP, Stein JA, Newcomb MD, Walker E, Pogge D, Ahluvalia T, Stokes J, Handelsman L, Medrano M, Desmond D, Zule W. Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child Abuse and Neglect*. 2003;27(2):169-190.
2. Sohal H, Eldridge S, Feder G. The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. *BMC Family Practice*. 2007;8:49.
3. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. *Family Medicine*. 1998;30(7):508-512.
4. Weiss SJ, Ernst AA, Cham E, Nick TG. Development of a screen for ongoing intimate partner violence. *Violence and Victims*. 2003;18(2):131-141.
5. Ernst AA, Weiss SJ, Cham E, Hall L, Nick TG. Detecting ongoing intimate partner violence in the emergency department using a simple 4-question screen: the OVAT. *Violence and Victims*. 2004;19(3):375-384.
6. Paranjabe A, Liebshutz J. STaT: a three-question screen for intimate partner violence. *Journal of Womens Health*. 2003;12(3):233-239.
7. Fogarty CT, Burge S, McCord EC. Communicating with patients about intimate partner violence: screening and interviewing approaches. *Family Practice*. 2002;34(5):369-375.
8. Laughon K, Renker P, Glass N, Parker B. Revision of the abuse assessment screen to address nonlethal strangulation. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*. 2008;37(4):502-507.
9. McFarlane J, Hughes RB, Nosek, MA, Groff JY, Swedlend N, Mullen PD. Abuse assessment screen-disability (AAS-D): measuring frequency, type, and perpetrator of abuse toward women with physical disabilities. *Journal of Women's Health & Gender-Based Medicine*. 2001;10(9):861-866.
10. Dubowitz H, Prescott L, Feigelman S, Lane W, Kim J. Screening for intimate partner violence in a pediatric primary care clinic. *Pediatrics*. 2008;121:e85-91.
11. Houry D, Feldhaus K, Peery B, Abbott J, Lowenstein SR, al-Bataa-de-Montero S, Levine S. A positive domestic violence screen predicts future domestic violence. *Journal of Interpersonal Violence*. 2004;19(9):955-966.
12. Ashur MLC. (1993). Asking about domestic violence: SAFE questions [Letter to the editor]. *Journal of the American Medical Association*. 1993;269:2367
13. Fulfer JL, Tyler JJ, Choi NJS, Young JA, Verhulst SJ, Kovach R, Dorsey JK. Using indirect questions to detect intimate partner violence: the SAFE-T questionnaire. *Journal of Interpersonal Violence*. 2007;22:238-249.
14. Futures without Violence. Available at: http://new.vawnet.org/Assoc_Files_VAWnet/screpol.pdf

15. Adapted from: Smith PH, Earp JA, DeVellis R. Measuring battering: development of the Women's Experience with Battering (WEB) Scale. *Women's Health: Research on Gender, Behavior, and Policy*. 1995;1(4):273-288.

Section 2

Barriers and Facilitators to Screening for IPV

A wide range of factors contribute to barriers and facilitators for IPV screening in health care settings. Factors considered in this review include:

- Health care providers' perceptions/perspectives (page 18)
- Patients' perspectives (page 21)
- Mandatory Reporting (page 23)
- Cultural barriers, population barriers and societal level barriers (page 27)
- Training health professionals (page 28)

Overview of Barriers from Hamberger and Phelan

Hamberger LK, Phelan MB. *Domestic Violence Screening and Intervention in Medical and Mental Healthcare Settings*. New York, NY: Springer Publishing Company, 2004.

Chapter 8: Barriers to Screening, Identifying, and Helping Partner Violence Victims in the Health Care Setting.

- Health care provider barriers
 - Lack of knowledge/education
 - Fear of offending patients
 - Perceived time pressures
 - Perceived irrelevance of domestic violence to health care practice
 - Fear of loss of control of the provider-patient relationship
 - Provider attitudes and accountability
 - Lack of comfort with the topic
- Patient barriers
 - Lack of trust
 - Fear of retribution
 - Fear of loss of control
 - Sense of futility
 - Love for partner
 - Lack of knowledge of helping resources
 - Embarrassment and humiliation
- Barriers involving patient and providers interactions
 - Communication problems
 - Gender differences
 - Unclear expectations
- System-level barriers
 - Insufficient training
 - Work load and time pressure
 - Lack of referral networks or on-site patient advocates
 - Lack of infrastructure to support screening (space, privacy, presence of children)
 - Lack of process to give feedback to providers regarding screening
 - Overall environment (is it safe? are the staff compassionate?)
- Authors' recommendations for future research

- More robust research on system-level and other screening barriers – examples include
 - Construct validity of items used to measure attitudes and barriers
 - How do specific barriers inhibit screening (e.g. health care provider gender, racial and cultural differences)
- Impact of screening on productivity and cost
- Additional research on social norms and practices that informally or formally undermine clinicians who screen

Health Care Providers' Perspectives/Perceptions

If this [domestic violence] were an infectious disease, we would have a treatment center in every neighborhood. There is a huge disconnect between the prevalence of domestic violence and what is done in the health system.

—Peter Sherman, MD, Director, Residency Program in Social Pediatrics, Montefiore Medical Center

Chamberlain L, Perham-Hester KA. The impact of perceived barriers on primary care physicians' screening practices for female partner abuse. *Women & Health*. 2002;35(2):55-69.

- Cross-sectional survey of 305 physicians in Alaska including family and general practice, internal medicine, and OB/GYN practitioners
- 85.7% of primary care physicians screened for IPV when females presented with injury
- 6.2% screened at initial visits
- 55.3% indicated time constraint was not an important barrier
- 77.9% agreed that physicians have responsibility to address abuse
- 70% were comfortable asking and believed they could help the patient
- Physicians who were comfortable were more likely to screen
- Physicians who estimated higher percentages of IPV among women were more likely to screen and more likely to believe they had a responsibility to address partner abuse
- Female physicians, younger physicians and physicians trained within the previous 2 years on partner abuse were more likely to screen at annual exams and among injured patients
- Authors' research recommendations: Rigorous studies are needed to identify and evaluate predictors of screening for abuse.

Garimella R, Plichta SB, Houseman C, Garzon L. Physician beliefs about victims of spouse abuse and about the physician role. *Journal of Women's Health & Gender-Based Medicine*. 2000;9(4):405-411.

- Perspectives of 76 physicians practicing in a large general hospital
- 4 specialties were represented: emergency medicine, family practice, OB/GYN, psychiatry
- Positive and negative beliefs were examined related to
 - Beliefs about the physician's role in assisting victims of spouse abuse
 - 97% of physicians believed it is part of their role to assist DV victims
 - Beliefs about victims of spouse abuse
 - 30% held victim-blaming attitudes
 - Beliefs about resources available to physicians to assist victims of spouse abuse
 - 70% did not believe that they had resources available to them to assist DV victims
- Physicians who were younger, female, practicing OBGYN, and with fewer years of practice were significantly more likely to hold supportive/positive beliefs
- Majority of negative beliefs were around resource availability
- Authors' recommendations: Training should be developed locally and tailored to individual community characteristics with an emphasis on understanding victims and not blaming victims.

Herzig K, Huynh D, Gilbert P, Danley DW, Jackson R, Gerbert B. Comparing prenatal providers' approaches to four different risks: alcohol, tobacco, drugs, and domestic violence. *Women & Health*. 2006;43(3):83-101.

- Six focus groups were conducted with prenatal care providers, including OB/Gyn physicians, nurse practitioners and nurse midwives
- Perspectives and practices were explored with respect to providers' approaches to addressing alcohol use, drug use, smoking, and DV during their patients' pregnancies
- Comparisons in the ability to address the risk factors were based on the 5 "A's" construct: Assess, Advise, Agree, Assist and Arrange
- All four areas (alcohol use, drug use, smoking, and DV) were challenging to prenatal care providers, with unique issues being articulated for each risk factor
- While all areas indicated the need for improvement, providers had the most difficulty with DV.

Humphreys J, Tsoh JY, Kohn MA, Gerbert B. Increasing discussions of intimate partner violence in prenatal care using doctor plus provider cueing: a randomized controlled trial. *Women's Health Issues*. 2011;21(2):136-144.

- From earlier manuscripts (e.g., Gerbert, Abercrombie, Caspers, Love, & Brownstone, 1999) evidence indicates that *when physicians ask about DV in a compassionate manner, it helps victims take their situation seriously and "plants seeds for change"*
- As such, it is important to increase the likelihood that health care providers discuss IPV with their patients
- This manuscript reports the effectiveness of a 15-minute "Video Doctor plus Provider Cueing Intervention" in improving the likelihood of provider/patient discussions about IPV
- Patients received a 15-minute video doctor assessment and interactive tailored counseling
- Provider's received a printed Cue Sheet Alert and suggested counseling statements
- Authors' conclusions: This intervention *significantly increases the likelihood of provider-patient IPV discussion with pregnant women with a history of abuse.*

Sprague S, Madden K, Simunovic N, Godin K, Pham NK, Bhandari M, Goslings JC. Barriers to screening for intimate partner violence. *Women & Health*. 2012;52:587-605.

- A systematic review of 22 studies examining health care providers' perceived barriers to screening for IPV
- Provider-related barriers were reported more often than patient-related barriers
- *Five categories of IPV screening barriers were identified: personal barriers, resource barriers, perceptions and attitudes, fears, and patient-related barriers*
- Most frequent provider barriers identified were personal discomfort, lack of knowledge and time constraints
- Authors' conclusions: *Barriers to screening for IPV are numerous among health care providers of various medical specialties. Increased education and training regarding intimate partner violence is necessary to address perceptions and attitudes to remove barriers that hinder intimate partner violence screening by health care providers.*

Tower LE. Barriers in screening women for domestic violence: a survey of social workers, family practitioners, and obstetrician-gynecologists. *Journal of Family Violence*. 2006;21:245-257.

- Based on mail surveys from 388 Florida board certified social workers, family practitioners and obstetrician/gynecologists
- Education about DV

- 40% of participants reported no exposure to DV in their professional education
- 39% reported that DV content was included in a separate course
 - 7.2% as an elective
 - 27.1% as a required course
- An average of 12.5 hours of CEUs/CMEs in DV
- An average of 5.9 hours of in-service in DV
- <16% obtained additional training from conferences and workshops
- Factors that increased screening behaviors and lead to increased victim identification
 - Education (especially the number of in-service hours)
 - Presence of institutional supports
 - Decreased barriers to screening (for example, lack of time)
- Only 20.8% of participants always or nearly always routinely screened for DV
- 24.0% reported that routine screening did not apply to their role
- Institutional barriers and facilitators
 - 28.5% reported that their institution had screening guidelines
 - 14.4% were not sure if guidelines existed
 - 67% reported DV check lists or other paper reminders to screen for DV
- Health professionals with DV content included in their education perceived fewer barriers and reported more screening
- Predictors of screening behavior
 - Institutional and legal barriers
 - Professional barriers
 - Fear of offending
 - Safety concerns
 - Educations and training
 - CEUs/CMEs
 - In-service hours
 - Societal and cultural barriers (e.g., blaming the victim) – biggest predictor of identifying victims

Patients' Perspectives/Perceptions

Chang JC, Decker MR, Moracco KE, Martin SL, Petersen R, Frasier PY. Asking about intimate partner violence: advice from female survivors to health care providers. *Patient Education and Counseling*. 2005; 59:141-147.

- Researchers collaborated with IPV programs in North Carolina and Pennsylvania to conduct focus groups with women who had a past or current history with IPV who had accessed DV services, including some women who were in shelters at that time
- 5 focus groups with 4 – 9 participants were conducted in English and 2 were conducted in Spanish
- Each group was asked
 - How would you like doctors and nurses to ask about domestic violence?
 - What do you want doctors to do to help women experiencing violence from their partners?
- The participants emphasized that they viewed a provider's asking about IPV as an opportunity for a woman to receive information and support, rather than just a method to identify IPV
- Participants wished to be asked while unaccompanied in a safe, confidential setting and in a kind, nonjudgmental manner
- Participants also said that providers
 - Should give a reason for why they are asking about IPV to reduce women's suspicions and minimize stigma
 - Create an atmosphere of safety and support
 - Provide information, support, and access to resources regardless of whether the woman discloses IPV

Dienemann J, Glass N, Hyman R. Survivor preferences for response to IPV disclosure. *Clinical Nursing Research*. 2005;14:215-233.

- A qualitative study, analyzing focus group data from a larger study testing an instrument to assess survivors of DV (Dienemann, Campbell, Surry, and Landenburger, 2002)
- 26 abused women in five focus groups at three agencies were asked "how a hospital or doctor's office can be most helpful to a woman who is experiencing domestic violence?"
- Participants identified seven preferences for responses:
 - Treat me with respect and concern
 - Protect me
 - Documentation
 - Give me control
 - Provide and immediate response
 - Give me options, and
 - Be there for me later
- Author's conclusions: *These findings indicate that women prefer an active role by health care providers when responding to disclosure.*

Feder GS, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Archives of Internal Medicine*. 2006;166(1):22-37.

- Qualitative meta-analysis of 25 articles to answer 2 questions:
 - How do women with histories of IPV perceive the response of health care professionals?

- How do women with histories of IPV want their health care providers to respond to disclosures of abuse?
- Key constructs were consistent across studies
 - *Women wish for responses from health care professionals that were nonjudgmental, nondirective, and individually tailored, with an appreciation of the complexity of partner violence.*
 - *Repeated inquiry about partner violence was seen as appropriate by women who were at later stages of an abusive relationship.*
- *Women's perceptions of appropriate and inappropriate responses partly depended on*
 - *The context of the consultation*
 - *Their own readiness to address the issue*
 - *The nature of the relationship between the woman and the health care professional*

Plichta SB, Duncan MM, Plichta L. Spouse abuse, patient-physician communication and patient satisfaction. *American Journal of Preventive Medicine.* 1996;12(5):297-303.

- Using a nationally representative telephone survey, the authors examined differences in physician communication and patient satisfaction among 1,082 women who had and had not been abused by their intimate partners.
- Authors' conclusions: *Spouse abuse creates barriers to the quality of patient-physician communication and poor communication contributes to lower satisfaction with care. Careful interviewing by trained clinicians is essential to identify and address abuse situations and to prevent further damage to women's physical and mental health.*

Robinson L, Spilsbury K. Systematic review of the perceptions and experiences of assessing health services by adult victims of domestic violence. *Health and Social Care in the Community.* 2008;16(1):16-30.

- A quality assessment of 10 studies conducted in the UK, US, or Australia were reviewed
- Thematic analysis identified recurrent themes
 - Victims of domestic violence experience difficulties when accessing health care services
 - Victims perceive that these difficulties can be attributed to
 - Inappropriate responses by health care professionals
 - Discomfort with the health care environment
 - Perceived barriers to disclosing domestic violence
 - Lack of confidence in the outcomes of disclosure to a health professional

Webster J, Stratigos SM, Grimes KM. Women's responses to screening for domestic violence in a health-care setting. *Midwifery.* 2001;17:289-294.

- Cross-sectional cohort study of 1500 women from 5 Queensland hospitals
- Women were asked to complete an anonymous self-report questionnaire following a consultation in which they had been screened for DV
- 98% of respondents believed screening for DV was a "good idea"
- 96% felt "ok" during the process
- 77% of the women who felt uncomfortable still agreed that screening was a good idea
- Authors' conclusions: *Women in Queensland found screening for domestic violence acceptable and, where health care providers are suitably educated, it should be included when taking a routine health history.*

Mandatory Reporting

The summary information below is taken directly from the *Futures Without Violence* website. Available at:

http://www.futureswithoutviolence.org/userfiles/file/HealthCare/mandatory_policypaper.pdf

State specific codes are available at:

http://www.futureswithoutviolence.org/userfiles/file/HealthCare/mandatory_reporting_tables1.pdf

See also Policy Paper available at:

http://www.futureswithoutviolence.org/userfiles/file/HealthCare/mandatory_policypaper.pdf

Mandatory Reporting of Domestic Violence by Health Care Providers

Most states in the United States have enacted mandatory reporting laws, which require the reporting of specified injuries and wounds, suspected abuse or domestic violence for individuals being treated by a health care professional. Mandatory reporting laws are distinct from elder abuse or vulnerable adult abuse reporting laws, in that the individuals to be protected are not limited to a specific class, but pertain to all individuals whom the health care professional provides treatment or medical care, or who come before the health care facility.

The laws vary from state-to-state, but generally fall into four categories:

- 1. States that require reporting of injuries caused by weapons*
- 2. States that mandate reporting for injuries caused in violation of criminal laws, as a result of violence, or through non-accidental means*
- 3. States that specifically address reporting in domestic violence cases*
- 4. States that have no general mandatory reporting laws*

Reporting Abuse of Adults

Health care providers should know their state's domestic violence reporting law, including who is required to report, and under what conditions. In order to maximize patient input regarding law enforcement action, providers should also familiarize themselves with how their local law enforcement agency responds to such reports. Becoming familiar with such procedures will allow the provider to better assist the patient in safety planning, and in knowing what to expect. Mandated reporting responsibilities should be discussed with teens seeking primary care prior to assessing for dating violence or domestic violence in their homes. Additionally, recent federal privacy regulations require providers to inform patients of health information use and disclosure practices in writing, and whenever a specific report has been made. Health care facilities should ensure that their domestic violence protocols and training materials address their state reporting laws and federal regulations. In the majority of states, neither statutory nor case law specifies if a health care provider must report a parent's injuries if they are observed or discovered during a health care visit with that parent's child. Therefore, under a strict reading of most laws, if a child's health care provider is not providing treatment or medical care to the abused parent during the child's visit, the health care provider would not be required to make a report. In family practice situations where the child and parent are the provider's patients, and the current visit appointment is for the child, the same reasoning could be applied, although it is less clear-cut. That is, the health care provider would not be required to report since he or she is not treating the parent for the specified injuries during the appointment. This issue merits further discussion among health care providers, advocates, licensing authorities, and other professionals, as it is uncharted territory.

Reporting of Child Exposure to IPV/Child Abuse

Whenever a child is abused, either intentionally or unintentionally, as a result of domestic violence, state laws require health care providers to report this abuse to child protective services (CPS). State laws are less clear about whether exposure to domestic violence in the absence of injury or serious risk of injury to the child would require a report to the CPS. Health care providers should also know their state or county's child abuse reporting laws and its specific policies on defining child exposure to intimate partner violence as child maltreatment. In a state that requires mandated reporting in all cases of Intimate Partner Violence (IPV), the provider should inform the non-offending parent of the obligation to file a report to CPS, assess the safety needs of the victim, and inform CPS about the specifics of the perpetrator, his anticipated response and the potential for danger. In states where there is more discretion left to the provider, the provider should assess the specifics of each situation as a means of making a decision about whether it is necessary to make a report. The assessment should include inquiries about injury or abuse to children, the current safety of the homes, and whether the perpetrator has made threats to the children. Depending on the answers to these questions, the provider can make a decision about the imminent risk of harm to the child and victim. If the situation is not currently dangerous, the provider can refer the victim to voluntary services: battered women's services, counseling (preferably with a provider who had worked with victims of IPV), or child focused services. If the situation is currently dangerous to the child, a report needs to be filed. Consider involving the mother in filing the report and follow the recommendations above to maximize the protection afforded to the mother during the CPS investigation.

Abbreviated Review of Selected Literature Related to Mandatory Reporting

Gielen AC, O'Campo PJ, Campbell JC, Schollenberg J, Woods AB, Jones AS, Dienemann JA, Kub J, Wyne EC. Women's opinions about domestic violence screening and mandatory reporting. *American Journal of Preventive Medicine*. 2000;19:279-285.

- Case-control study including 202 abused women and 240 randomly selected non-abused women
- Abused women were more likely than non-abused women to support routine screening
- 86% of the women thought screening would make it easier to get help
- Interventions including counseling services, shelters, and confidential hotlines would be well-received
- 43% of women were concerned about increased risk due to screening and 52% were concerned about increased risk due to reporting
- 2/3 of women thought that women would be less likely to tell their health care providers about abuse under mandatory reporting

Hyman A, Schillinger D, Lo B. Laws mandating reporting of domestic violence: do they promote patient well-being?" *Journal of the American Medical Association*. 1995;273(22):1781-1787.

- Comprehensively discusses issues surrounding mandatory reporting including:
 - Who is required to report
 - Level of knowledge or suspicion required
 - Who receives the report and what is the response
 - Penalties for failing to report
 - Reporter immunity from liability
 - Provisions for confidentiality, and

- Provider-patient privileges
- Addresses the implications of mandatory reporting for DV, including:
 - Risk of retaliation
 - Limitations in improvement of care for battered patients
 - Limited response to reports of abuse
 - Inaccurate data collection
 - Bias in reporting, and
 - Documentation
- Ethical issues discussed include health provider experiences with conflict between mandatory reporting, what is in the best interest of their patients and whether or not the patient wants the abuse to be reported. *Practitioners may be caught between their obligations to society and their duties to the patient. In analyzing these dilemmas, clinicians need to keep in mind the basic ethical principles of non-maleficence, beneficence, autonomy, and confidentiality.*
- Authors' summary: *There are laws in 45 states [at time of publication; for the most recent information please refer to links provided above] and the District of Columbia mandating reports of injuries due to weapons, crimes, violence, intentional acts, or abuse. These laws may require, to different extents, reporting in cases of domestic violence. Mandating a coercive intervention that may fail to offer adequate protection may further jeopardize the patients we are trying to help. Mandatory reporting may threaten the safety of battered women, discourage them from seeking care, fail to improve the health care of battered patients, lead to inadequate responses to reports of abuse, result in biased case identification, and violate patient autonomy and confidentiality. Health care workers and the facilities in which they practice should strive to implement policies that promote the well-being and autonomy of survivors of domestic violence and minimize the harms of existing mandatory reporting laws.*

Rodríguez MA, Sheldon WR, Rao N. Abused patient's attitudes about reporting of intimate partner abuse injuries to police. *Women & Health*. 2002;35(2-3):135-147.

- Telephone interviews with 358 randomly selected women patients from 3 primary care clinics in San Francisco
- Among the 358 abused women
 - 68% did not support mandatory reporting (MR) of DV injury reporting that did not allow for consideration of patients' wishes
 - 92% favored some form of police reporting by medical clinicians
 - Women abused within previous year were more likely to oppose MR compared to women who had not been abused in prior year
 - Author's recommendation: more research needed to determine if benefits of MR outweigh the risks to those intended to benefit from MR

Sachs CJ, Koziol-McLain J, Glass N, Webster D, Campbell J. A population-based survey assessing support for mandatory domestic violence reporting by health care personnel. *Women & Health*. 2002;35(2-3):121-133.

- Telephone survey of 845 women in 11 US cities
- 72% of women overall supported mandatory reporting
- 59% of abused women supported mandatory reporting
- Patients' reasons for supporting mandatory reporting: easier to get help; would like health care personnel to call the police

- Patients' reasons for not supporting mandatory reporting: victims less likely to disclose, resenting someone else taking control, increase of perpetrator retaliation

Cultural Barriers, Population Barriers, and Societal Level Barriers to Screening for IPV

A wide range of barriers exist with respect to screening for IPV. These include, but are not limited to, cultural competency, barriers at the population level (e.g., different beliefs in different populations about what is abusive behavior) and societal barriers (e.g., victim-blaming).

Futures Without Violence. Special collection: immigrant women and domestic violence.

Available at: <http://snow.vawnet.org/special-collections/DVImmigrant.php#300>

- The above link provides access to a large number of articles related to barriers that immigrant women face in accessing DV support services. Although these documents do not necessarily focus directly on interventions in the health care setting, many of the barriers discussed are relevant to the health care setting.

Tower LE. Barriers in screening women for domestic violence: a survey of social workers, family practitioners, and obstetrician-gynecologists. *Journal of Family Violence*. 2006;21:245-257.

- Author's conclusion: *Among predictors of screening behavior (institutional and legal barriers, professional barriers and societal and cultural barriers, societal and cultural barriers (e.g., blaming the victim, societal and cultural barriers are the biggest predictors of identifying victims. (See more complete review of this manuscript under Health Care Provider Perspectives/Perceptions, page 15.)*

Wrangle J, Fisher JW, Paranjape A. Ha sentido sola? Culturally competent screening for intimate partner violence in Latina women. *Journal of Women's Health*. 2008;17(2):261-268.

- Cross-cultural barriers to IPV include beliefs that clinicians lack time and interest, legal concerns such as immigrant status, confidentiality and an inability to communicate effectively in English/Spanish
- Evidence suggests that Latina women may have different perceptions and attitudes toward abuse and do not label as many events to be "abusive", compared to non-Hispanics
- Given these cultural differences – IPV screening tools developed and validated in English-speaking populations may not be as effective when the tools are translated into Spanish
- To overcome barriers to detecting IPV among Latina women, an identification tool must be brief and culturally appropriate
- The HITS tool and the WAST tool, translated into Spanish were compared, lower cut off points were needed to maximize sensitivity of the Spanish version
- Authors found that two questions that deal with emotional IPV were more sensitive when translated into Spanish
 - Have you ever been in a relationship where you felt controlled by your partner?
 - Have you ever been in a relationship where you felt lonely?
- Authors' conclusion: Cultural differences in perception of IPV, such as lower intolerance of certain forms of IPV, may result in a difference in screening efficacy.

Training Health Care Providers to Understand and Address IPV

Carefully designed and comprehensive training for health care providers is central to improving the health care system's response to IPV. A number of key components are necessary to adequately prepare providers to appropriately address IPV in clinical settings.

Overview from Hamberger and Phelan

Hamberger LK, Phelan MB. *Domestic Violence Screening and Intervention in Medical and Mental Healthcare Settings*. New York, NY: Springer Publishing Company, 2004.

Chapter 11: Medical School Training Curricula: Philosophy, Components, Process, and Outcomes

- Extent of training in medical schools (as of 1998)
 - Prevalence of DV training curricula
 - 86% of medical school deans reported school based curricula; 55% of students reported being aware of DV training
 - 13% of deans reported no curricula; 45% of students reported no curricula
 - Breadth and depth of training
 - 35% of deans reported providing DV material in 1 course; 32% of students reported DV training included in 1 course
 - 22% of deans reported providing material in 2 courses; 17% of students reported DV training included in 2 courses
 - 2 hours was the median number of training hours (ranging from 0-16 hours)
 - Most training occurred in pre-clinical training years
 - 23% provided training during clinical years
 - The number of schools offering DV training increased 18% over 7 years (1991-1998)
- Recommended components of medical school curricula include the development of:
 - An appropriate knowledge base including
 - The definition of DV
 - A range of behaviors (e.g., physical, sexual, emotional)
 - Pervasive pattern of domination and control
 - DV is a continuum of severity
 - An understanding of the dynamics of DV
 - Perpetrator is responsible – no victim blaming
 - Adoption of nonjudgmental, empathetic and supportive approaches
 - Enforced dependency and risk associated with leaving a violent relationship
 - Appropriate professional attitudes regarding DV as a health problem
 - Understanding a physician's responsibility to address DV, including legal ramifications and reporting
 - Developing clinical skills for screening, intervening and managing patients struggling with DV
 - Trainees ability to cope with their feelings and reactions to DV
 - Considering patients to be autonomous, competent, and able to make their own decisions
 - Clinical skills including
 - Screening and diagnosing DV in a private and confidential setting

- Case finding – asking about abuse after identification of other signs and symptoms that may be associated with abuse
 - Interacting with patients in an empathic way that enhances patient/provider relationship and facilitates patient comfort
 - Providing patients with information regarding resources and how to access them (e.g., community resources, ongoing emotional and legal support, safety plan development)
 - Offering patient follow-up for several reasons
 - Validating abuse as an important health problem
 - Providing patient an understanding that the clinician is concerned, supportive and interested in the patient’s well-being
- Building a collaborative relationship with advocates
- Understanding the public health approach and the need for working toward a systems change
- Curricular evaluation is needed including
 - Medical school students confidence
 - Materials assessment
 - Delivery of curriculum
- Factors associated with a successful DV curriculum
 - Student endorsement
 - Faculty development
 - Integration into the larger curriculum
 - Collaborative teaching with non-faculty and community experts
 - Innovative teaching methods

Abbreviated Review of Selected Literature Related to Training Health Care Professionals

Abel S, Kowal HC, Brinlow D, Uchin M, Gerbert B. A collaboration to enhance oral health care for survivors of domestic violence: women’s domestic violence shelters and Nova Southeastern University’s College of Dental Medicine. *Journal of Dental Education.* 2012;76(10):1334-1341.

- This project was informed by the understanding that dentists are in a key position to address domestic violence
- However, dentists are less likely than other health care providers to ask about abuse
- Dentists need skills-based education (vs. didactic information only)
- The collaboration was designed to provide oral health care to survivors of domestic violence by creating a comprehensive collaboration between DV shelters and the dental school
- Needs assessments were conducted with a sample of patients and dental school residents to “*guide program development and optimize the curriculum, clinical rotations, and establishment of care protocols*”
- The importance of such programs was demonstrated by the response from both patients and providers
- Several aspects of the program were deemed to be critical to success, including:
 - Preliminary needs assessment
 - Identification of liaison and site champions
 - Formation and active participation of an advisory board

- Incorporation of expertise from experts in diverse fields
- Cross-training of dental providers and community organization staff
- Authors' conclusions: *We believe it is critical to provide dental providers with education, both didactic and practical, about domestic violence and dentistry.*

Ambuel B, Trent K, Lenahan P, Cronholm P, Downing D, Jelley A, Lewis-O'Connor A, McGraw M, Marjavi A, Mouden L, Wherry J, Callahan M, Humphreys J, Block R. Competencies Needed by Health Professionals for Addressing Exposure to Violence and Abuse in Patient Care. Academy on Violence and Abuse. Eden Prairie, MN, April 2011.

- Details training competencies related to the full spectrum of violence and abuse (e.g., domestic violence, family violence, neglect, bullying, sexual violence hate crimes, human trafficking)
- Proposed competencies to address specific issues that are related to the:
 - Health system
 - Accreditations systems that embody violence competencies
 - Professional health cultures that recognize health consequences of violence
 - Specialized competencies and training programs tailored to each profession and specialty
 - Continuing education standards
 - Strong research programs
 - Integrated knowledge across professions
 - Implementation of systematic environmental change
 - Requirements for academic institutions and training programs
 - Interdisciplinary approach to violence and abuse
 - Focus on prevention including healthy relationships
 - Partner with the community in education, intervention and prevention
 - Develop curricula and provide learner-centered training opportunities
 - Assure learner safety and promote self-care
 - Assure an institutional environment free of violence
 - Requirements for individual learners
 - Demonstrate general knowledge about violence
 - Demonstrate clinical skills appropriate to profession and specialty including ability to identify, assess and intervene
 - Effective communication with patient
 - Effective communication with physical and behavioral health care team
 - Intervene to promote safety and reduce vulnerability
 - Recognize individual and cultural variations in relationships and distinguishing between health and unhealthy behaviors
 - Identify and assess relationship health
 - Know legal issues
 - Know ethical requirements
 - Engage in multi-disciplinary collaboration
 - Practice effective self-care
 - Obtain necessary training and skills to advance the field
 - Apply the concept of a systems-based practice

Bonds DE, Ellis SD, Weeks E, Palla SL, Lichstein P. A practice-centered intervention to increase screening for domestic violence in primary care practices. *British Medical Journal of Family Practice*. 2006;7:63-70.

- Conducted in North Carolina with 15 primary care practices
- Tested the effectiveness of primary care practice-centered interventions with the purpose of increasing screening for domestic violence
- The overall baseline screening rate was 16% (ranging from 2% to 49%)
- A 10% increase in screening was achieved (ranging from an increase of 0% to 22%)
- Female patients were 79% more likely to be screened after the screening intervention
- Authors' conclusion: *An intervention that allowed practices to be tailored to certain aspects to fit their needs increased screening for domestic violence.*

Davidson LL, Grisso JA, Garcia-Moreno C, Garcia J, King VJ, Marchant S. Training programs for healthcare professionals in domestic violence. (Review) *Journal of Women's Health & Gender-Based Medicine*. 2001;10(10):953-969.

- Davidson et al. (2001) found that IPV educational programs for health care providers are quite limited
- Most consisted of a single 1 to 3 hour elective seminar
- Most of the clinically-based training occurred in emergency department or prenatal care clinics
- Participation in these sessions was low, in general
- Very few programs repeated trainings or organized follow-up sessions to reinforce the training material
- Very little information regarding course content exists and little information was available with respect to how the course was designed, making evaluation of effective programs difficult
- Clinicians need appropriate knowledge and attitudes to develop effective screening and counseling techniques
- Authors' conclusions: *Training in DV that is limited in time and scope would not present a problem if we knew what training was effective. ..Research needs to be designed more rigorously, and randomized controlled trials using quasi-experimental approaches should be conducted to determine the most effective approaches to training and education of healthcare students and clinicians about recognition and treatment of women who have experience domestic violence.*

Feder G, Davies RA, Baird K, Dunne D, Eldridge S, Griffiths C, Gregory A, Howell A, Johnson M, Ramsey J, Rutterford C, Sharp D. Identification and referral to improve safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomized controlled trial. *Lancet*. 2011;378:1788-1795.

- 48 general practices in Hackney and Bristol were randomized to IPV training vs. no IPV training
 - 24 received a training and support program
 - 1 year follow-up
 - 641 disclosures
 - 233 referrals to of patients to advocacy
 - 24 did not receive training or support program
 - 1 year follow-up
 - 236 disclosures
 - 12 referrals

- Practices with training were more likely to lead to patient disclosure (intervention rate ratio 22.1, (95% CI 11.5,42.4) and more likely to refer patients (intervention rate ratio 3.1 (95% CI 2.2-4.3)
- Authors' Conclusions: *A training and support program targeted at primary care clinicians and administrative staff improved referral to specialist domestic violence agencies and recorded identification of women experiencing domestic violence. Our findings reduce the uncertainty about the benefit of training and support interventions in primary care settings for domestic violence.*

Hamberger LK, Guse CE, Patel D, Griffin E. Increasing physician inquiry for intimate partner violence in a family medicine setting: placing a screening prompt on the patient record. *Journal of Aggression, Maltreatment & Abuse*. 2010;19(8):839-852.

- The authors *investigated the impact of a prompt on patient records reminding physicians to inquire about intimate partner violence (IPV) during a complete history and physical examination. During the baseline, education-only period, 2% of women patients had documented domestic violence inquiry. Following addition of the chart prompt, 92% of women received documented IPV screening. Following chart prompt removal, the percentage of women with documented screening was 36%, and the overall percentage screened, including those inquiries documented in the chart and those documented only by a nurse following the visit, was 72%. These findings suggest that a written prompt to ask about IPV increases inquiry rates among primary care physicians.*

Section 3

IPV Interventions, Intervention Effectiveness and Barriers to Interventions

Overview

There is a great deal of literature regarding interventions for IPV in the health care setting including several published reviews incorporated below. While research on the effectiveness of interventions is important, understanding what works and what doesn't work is complicated by a multitude of factors. Many of these are described well and in detail in Hamberger and Phelan's text, Domestic Violence Screening and Intervention in Medical and Mental Healthcare Settings, and summarized in Section 2: Barriers and Facilitators to Screening for IPV.

Further complicating our efforts to examine intervention effectiveness is determining what actual outcomes should be used as a measure of success. How is effectiveness defined and what is considered to be sufficient evidence for intervention effectiveness? Here are examples of a wide range of outcomes that may be considered:

- Improved patient health
- Patient wellbeing
- Decreased risk for harm or lethality
- Decrease in IPV experienced by victim (a change in the perpetrator's behavior)
- An increase in the patient's awareness about the problem and its potential health impact
- Increased patient help seeking behaviors
- Increased likelihood of leaving the violent relationship
- An improvement in doctor/patient relationship
- Assisting the patient to move further down the path to change and forward on the path to improved health

Hamberger and Phelan capture these issues well in their text (page 296): *Domestic violence wrests a high cost from society in general, the health care system, and from the very patients who are caught in its snare. Implementation of health care-based intervention programs also represents a significant investment of resources. Because such interventions are designed to impact the lives of patients, it is imperative that evaluations demonstrate a measurable benefit to them. At present, however, the way in which such outcomes and impacts are defined is uncertain and subject to debate. For example, is the ultimate goal of health care-based screening and intervention initiatives to help victims get out of violent relationships? Given that violence and lethality may increase as a victim attempts to leave a violent relationship, is the health care system sufficiently equipped to help manage victim safety once they leave the clinic setting? Perhaps another, slightly different, but more realistic goal of such initiatives is to decrease isolation of victims through asking about domestic violence, providing support and information and giving direction about community resources, while maintaining a non-prescriptive stance regarding relationship status. Another evaluation goal could be to demonstrate improved health status as a function of screening, intervention, and provision of options for community-based resources. Perhaps another goal of such interventions is to help victims feel less isolated and alone in their pain, whether they seek outside resource assistance, or end their relationship or not. The point is, there are many possible outcomes to be garnered from health care-based intervention efforts. It will be necessary to evaluate such initiatives from a number of perspectives, and move beyond simple, omnibus questions such as "Do they work?" Instead, it will be necessary to ask about how various interventions work and under which circumstances.*

Abbreviated Review of Selected Literature Relevant to IPV Interventions, Intervention Effectiveness and Barriers to Interventions

Casteel C, Sadowski L. Intimate partner violence towards women. *Clinical Evidence*. 2010;2:1013.

- Intent of review: to determine the effects of interventions initiated by health care professionals aimed at women victims of intimate partner violence. Twenty-six articles met their inclusion criteria. Please refer to the manuscript itself for specific information on the articles included in the review.
- The review focused on evaluating the impact of interventions that aim to
 - Improve quality of life
 - Improve psychological and physical well-being
 - Reduce the risk of physical and mental illness, injury, or death
- Outcomes of interest
 - Reported rates of IPV
 - Psychological well-being
 - Recurrence of IPV
 - Knowledge and utilization of IPV services
- Conclusions based on the review:
 - Advocacy may reduce recidivism
 - Cognitive therapy may reduce PTSD
 - Cognitive behavioral counseling may reduce minor physical or sexual IPV, psychological IPV and depression
 - Career counseling plus critical consciousness awareness may increase a woman's awareness of the impact of IPV
 - Peer support groups may improve psychological distress and decrease health care utilization
 - Safety planning may reduce the rate of subsequent abuse

Eddy T, Kilburn E, Chang C, Bullock L, Sharps P, and the DOVE Research Team. Facilitators and barriers for implementing home visit interventions to address intimate partner violence: town and gown partnerships. *Nursing Clinics of North America*. 2008;43(3):419-435.

- Describes the development of a 'town and gown' partnership to assist pregnant women in violent relationships
- DOVE (Domestic Violence Enhanced Home Visitation) is based on Parker and McFarlane's (1999) evidence-based IPV empowerment intervention, *providing prenatal visitors (town partners) with a research driven strategy (gown intervention) to use with pregnant women in their caseloads who are experiencing intimate partner violence*
- The DOVE intervention includes:
 - A structured tailored brochure with information regarding the cycle of violence, designed to meet each women's special needs
 - Risk factors associated with increased risk of homicide
 - Options available to women
 - Safety planning
 - IPV resources specific to their locale
 - National hotline numbers

- Barriers and facilitating factors to the working partnership were identified in focus groups conducted with home-visitors
- Barriers include the lack of knowledge and training received by health care professionals related to
 - Violence and warning signs
 - How to ask about violence
 - Legal options and social services
 - How to help in general
 - Issues related to rural communities (limited services, lack of anonymity, the home visitor and the women being visited knowing one another)
- Facilitators included multiple sessions providing the home visitors to communicate openly and honestly about their experiences and feelings of dealing with women in abusive relationships. This reinforces that the work they are doing is important and helps to alleviate some of the fear.
- Authors' conclusions: *The town/gown partnership provides home visitors with evidence-based knowledge and the hands-on experience needed to assist and empower the women they are working with.*

Gunter J. Intimate partner violence. *Obstetrics and Gynecology Clinics of North America*. 2007;34:367-388.

- Many significant health outcomes have ineffective interventions but this does not decrease recommendations or practices toward screening
 - Smoking example: smoking is one of the most common preventable causes of substantial negative health consequences and death
 - The long-term quit rate for smoking is between 14% and 20%
 - Yet, it is recommended that all clinicians screen all adults for tobacco use and provide smoking cessation interventions
- Factors that may affect how patients respond to screening
 - Stages of change
 - Many women identify screening itself as helping them move forward in being ready to change
 - Barriers to leaving are multifaceted and patient specific
 - Fear of reprisal
 - Self esteem
 - Prior experience with medical and legal services
 - Provider skills
 - Screening format
- Efficacy
 - Efficacy of specific interventions is unclear
 - The most appropriate outcomes to measure have not been identified
 - Possible interventions to track include:
 - Advocacy services
 - Frequency of abuse episodes
 - Injury rates
 - Efficacy could vary depending on factors described above
 - Health care providers do not necessarily have the ability to facilitate desired outcomes because of complex multiple factors (e.g., financial, social, legal issues)

- Leaving a violent partner does not guarantee freedom from being stalked, further abuse, or murder

Kirst M, Zhang YJ, Young A, Marshall A, O’Campo P, Ahmad F. Referral to health and social services for intimate partner violence in health care settings: a realist scoping review. *Trauma, Violence, and Abuse*. 2012;13(4):198-208.

- Using a realist scoping review methodology, the authors provide information about what is currently known about IPV referral programs in health care settings. A realist scoping review is *designed to examine the mechanisms or facilitators related to the success or failure of a “complex service intervention.” Realist syntheses are helpful for understanding the effectiveness of health care programming as they involve the review of evaluative evidence to “unpack” the inner mechanisms of an intervention by making explicit the underlying theory about how programs work, and then systematically gathering evidence to test these theories, in consideration of the role of contextual factors on program workings.*
- The review includes an extensive exploration of interventions and evaluates a wide range of outcomes as defined by the researchers, rather than evaluating a specific preconceived outcome measure (e.g., improved health). Kirst et al., (2012) also provide a concrete description of how success and failure were measured. Please refer to the manuscript for specific information on the articles included in the review.
- 6 qualitative studies considered “non-evaluative” were included because they discussed important themes on barriers and facilitators to making IPV referrals (see results for qualitative studies on page 31)
- 13 evaluative articles were included that examined the impact of a specific referral program based on the following criteria:
 - Referral research must be in the health care setting
 - Articles provided detail of the IPV referral programs and processes
 - Potential mechanisms or facilitators were identified that relate to program success or failure
- The 13 evaluative studies included a wide range of heterogeneous measured outcomes such as:
 - Changes in safety behaviors (completion of a safety plan or changes in perceived safety over time)
 - Changes in the occurrence of IPV (self reported end of violence and other proxy measures such as changes in the number of police calls, repeat emergency department visits)
 - Changes in IPV victims’ use of community resources
 - Reasons for acceptance of referral
 - Quality of domestic violence management/referral
 - Predictors of IPV service use
 - Effectiveness of a computer-based health survey for referring IPV victims to social work services
 - A national scan to determine whether IPV screening and referral policies existed in maternity services and exploring provider perceptions of screening and referral processes (but without assessment of program effectiveness)
- Findings regarding victims reasons for seeking referral and health care providers reasons for making referrals
 - Reasons for victims’ seeking referral:

- Concern for their children
 - Fear for their physical well-being
 - Wanting to change their situation by self-disclosing to health care providers
 - Convenience and immediacy of a within-hospital referral was also cited as a motivating factor
 - Reasons why health care providers made referrals:
 - Key reason was having an institutional policy in place or an agreed-upon practice regarding referrals
 - Receipt of training on how to provide referrals
 - Having an on-site IPV advocate
- Findings regarding victims reasons for not seeking referrals and health care providers reasons for not making referrals
 - Reasons for victims' not seeking referral:
 - Limited time
 - Limited availability of on-site IPV referral resources
 - Fear of losing custody of children
 - Coming from a culture which may perpetuate abusive situations
 - Immigration status
 - Fear of retribution
 - Reasons why health care providers did not make referrals:
 - Lack of knowledge and training
 - Lack of support to handle referrals
 - Barriers to screening which in turn leads to decrease referral rates
- Patient and provider perceptions of referral process
 - Patient perceptions – only 1 study provided in-depth information on the victims' perceptions regarding the referrals they received
 - Provider perceptions - interventions were successful in increasing providers' comfort with referring and increasing awareness that there is a need for referral
- Explanations for success, failure, or challenges in the referral process
 - Success
 - Victims' acceptance of a referral relates to the supportive approach taken by providers
 - Community resource use after referral relates to severity of IPV experience
 - Improved outcomes (e.g., increased safety behaviors, decreased violence, group counseling access) relate to the victim's readiness to change and accept intervention
 - Increase in service use by way of referrals attributed to easy access to resources and strong links between health care setting and community services
 - Lower use of services and challenges
 - Among ethnic minority women - attributed to cultural barriers
 - Lower referral rates after screening and low access to services due to logistical issues
 - Victim service refusal
 - Low social worker coverage
- Qualitative study results
 - Provided rich discussions of both victim and provider perceptions regarding the process of referral and the various barriers and facilitators to referrals

- Unique barriers facing minority and/or marginalized women (e.g., same sex relationships)
- Emphasized need for providers to take a holistic view of the victim's situation and needs
- Victims noted that it would be beneficial to have resources discretely advertised
- Victims identified the need for health care providers to respect their choices about their decision to follow-up on referrals
- Victims emphasized a need for immediate referral with IPV specialists on-site as being essential

Kulkarni S, Bell H, Wylie L. Why don't they follow through? Intimate partner survivors' challenges in accessing health and social services. *Family & Community Health*. 2010;33(2)92-105.

- While not directly related to the evaluation of health care interventions per se, Kulkarni et al. (2010) provide insight into the difficulties and challenges that IPV survivors face with regard to accessing and utilizing health care and social services, and the implications such difficulties have for health care providers. In their discussion, the authors provide a compelling argument regarding why challenges that survivors face in receiving services are important for health care providers to consider when evaluating screening, referral and intervention effectiveness, and more effectively deal with patients that are experiencing IPV.
- The researchers conducted 8 focus groups (four 24-person focus groups with DV hotline worker advocates and four 30-person focus-groups with IPV survivors) on the health and social service needs of IPV survivors with intentionally diverse participants with respect to ethnicity, race and language
- DV hotline workers explored:
 - Types of calls received
 - Ranking of services needed
 - Identification of which services were and were not generally available
 - Identification of regional variations in services
 - Discussions of service needs of callers who had special needs such as those with disabilities or callers from particular ethnic or cultural groups
 - Advice to local service providers
- The survivor groups explored:
 - The process by which survivors realized they needed help
 - Types of help needed
 - Ranking of service needs
 - Identification of services that were most helpful and least helpful
 - Special needs from specific populations (e.g., ethnic or cultural groups, survivors with disabilities)
 - Advice to agencies
- Three themes relevant to health care provider practice emerged
 - Understanding survivor challenges in prioritizing health needs (e.g., concerns about daily survival; although the survivor's health conditions may be serious, there is a tendency to put children's needs over survivor's needs)
 - Identifying and accessing appropriate resources
 - Coaching survivors to surmount potential service barriers
- Barriers to survivors seeking health care
 - Fear of being reported to the criminal justice or child protection systems

- Not having medical insurance or insurance for routine health care (meaning many presented at health care settings with more advanced problems)
- Controlled access to health insurance by abuser
- Placing low value on routine health care
- Threats from abusers which discouraged them from seeking doctor or emergency care
- Survivors don't want the violence to be reported and are afraid of getting their batterers in trouble
- Survivors' perspectives on the most important resources needed include:
 - Shelter
 - Information about DV and available resources
 - Counseling and emotional support
 - Law enforcement
 - Financial assistance
 - Child care
- Availability of needed resources
 - Some communities offer DV shelter and counseling services but resources such as transportation, child care and financial assistance were not offered in most communities
 - IPV survivors most difficult challenges were the lack of shelter, counseling and law enforcement (law enforcement was found to be non-responsive, victim blaming, non-supportive and providing overtly threatening responses (arresting victim, calling CPS))
- Advocates perspective on unmet needs include:
 - Transportation
 - Emergency funds for food, rent and transportation
 - Longer term housing
 - Disability services
 - Services for family members and children
 - Low-cost legal aid
 - Services in languages other than English,
 - Shelter for male survivors
 - Child care
- Authors' discussion: *Health care providers struggle to define an appropriate and effective role with the IPV survivors to whom they provide care. Health care providers have much to learn from experienced IPV advocates, as well as the survivors themselves. This study highlights the complexities of survivors' needs and the challenges they face in seeking help from community agencies. While health care providers may not always be called upon to be IPV specialists, in many contexts they may be required to provide information or refer patients to community resources when they learn about IPV. A deeper understanding of IPV survivors' needs and the service delivery system will help health care providers to be more effective in these roles.*

IPV may result in and exacerbate a variety of chronic and acute health problems. In addition, health issues often create significant challenges for women who would like to access community resources. As a growing body of research on the multiplicity and interconnectedness of abused women's many needs suggests, IPV survivors often struggle with difficult choices in establishing their priorities. Therefore, health care providers should entertain a more holistic orientation of the ways in which health needs may compete with survivors' other concerns. Adopting such a perspective will allow for more successful patient provider collaborations, more realistic treatment recommendations, and better treatment compliance.

Health care providers need to be aware of primary and ancillary resources for IPV survivors who live in their communities. Along with other research, this study highlights critical

gaps in available services for IPV survivors, many of whom are in need of multiple types of services. Therefore, it may be unrealistic for health care providers to assume that patients will have ready access to needed services when they are provided a resource list without additional support and information about how services are delivered. These data highlight the importance of comprehensive training for health care providers conducting screening and providing community referrals with IPV survivors. In addition to understanding the dynamics and health consequences of IPV, health care providers can benefit from a greater understanding of how survivors prioritize their needs and what challenges they may face in accessing services to meet those needs. Because of the potentially poor fit between survivors' needs and available services, health care providers should also receive basic coaching and advocacy skills training to better assist survivors.

Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception*. 2011;83:274-280.

- Longitudinal study 1,207 women attending one of 4 family planning clinics
- Examined the efficacy of a family planning clinic-based intervention to address IPV and reproductive coercion
- 2 urban family planning clinics were randomized into the intervention and 2 were randomized into standard care clinics
- Data were collected via baseline and follow-up surveys at 12 and 24 weeks post intervention
- Women in the standard care clinics were screened using the following 2 questions:
 - Have you ever been hit, kicked, slapped or choked by your current or former partner?
 - Have you ever been forced to have sex against your will?
- For women who screened positive in the standard care clinics
 - Mandated reports were filed as necessary
 - IPV was documented on patient's chart
 - Patient was provided a list of violent victimization resources
- Women in the intervention clinics were screened using an enhanced IV screening tool
Two domains of reproductive coercion were assessed.
 - Recent (past-3-months) pregnancy coercion was assessed using an investigator-developed set of four items:
 1. In the past 3 months, has someone you were dating or going out with told you not to use any birth control (such as pills, shot, ring, etc.)?
 2. In the past 3 months, has someone you were dating or going out with said he would leave you if you did not get pregnant?
 3. In the past 3 months, has someone you were dating or going out with told you he would have a baby with someone else if you did not get pregnant?
 4. In the past 3 months, has someone you were dating or going out with hurt you physically because you did not agree to get pregnant?
 - Recent (past-3-months) birth control sabotage was assessed via five items.
 1. In the past 3 months, has someone you were dating or going out with taken off the condom while you were having sex so that you would get pregnant?
 2. In the past 3 months, has someone you were dating or going out with put holes in the condom so you would get pregnant?
 3. In the past 3 months, has someone you were dating or going out with broken a condom on purpose while you were having sex so you would get pregnant?

4. In the past 3 months, has someone you were dating or going out with taken your birth control (such as pills) away from you or kept you from going to the clinic to get birth control so that you would get pregnant?
In the past 3 months, has someone you were dating or going out with made you have sex without a condom so you would get pregnant?"
- Women in the intervention clinics were also asked about awareness and recent use of IPV services, relationship changes between time 1 and time 2
 - Results
 - Women in the intervention group had a 71% reduction in pregnancy compared to women in the control group
 - Women in the intervention group were more likely to report having stopped dating because the relationship was unhealthy or they didn't feel safe
 - Authors' conclusion: *Exposure to this brief and sustainable intervention to reduce male partner reproductive coercion was associated with a large reduction in pregnancy coercion among women who had recently experienced IPV.*

Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Prevention Services Task Force Recommendation. *Annals of Internal Medicine*. 2012;156(11):796-808,W-279 – W-282.

- Systematic review funded by AHRQ in support of the work of the USPSTF
- The purpose of this manuscript was *to review new evidence of the effectiveness of screening and interventions for women in health care settings in reducing IPV and related health outcomes, the diagnostic accuracy of screening instruments, and adverse effects of screening and interventions.*
- There were 5 key questions addressed in this review:
 1. *Does screening asymptomatic women in health care settings for current, past, or increased risk for IPV reduce exposure to IPV, physical or mental harms, or mortality? Health care settings include primary care clinics, EDs, and student health centers, among others.*
 2. *How effective are screening techniques in identifying asymptomatic women with current, past, or increased risk for IPV? Techniques include self-administered (e.g., computerized-enabled tool or patient self-report) as well as person-to-person (e.g., clinician-to-patient) methods.*
 3. *What are the adverse effects of screening for IPV?*
 4. *For screen-detected women with current, past, or increased risk for IPV, how well do interventions reduce exposure to IPV, physical or mental harms, or mortality?*
 5. *What are the adverse effects of interventions to reduce harm from IPV?*
- The review includes descriptions of
 - Studies evaluating the diagnostic accuracy of screening instruments for IPV
 - Randomized trials of IPV interventions
 - Studies evaluating the potential harms of IPV screening
- Authors' conclusion: *Screening instruments accurately identify women experiencing IPV. Screening women for IPV can provide benefits that vary by population, while potential adverse effects have minimal effect on most women.*

Sharps P, Campbell J, Baty M, Walker R, Bair-Merritt M. Current evidence on perinatal home visiting and intimate partner violence. *Journal of Obstetrical, Gynecological and Neonatal Nursing*. 2008;37(4):480-491.

- Article reviews 8 research reports that assessed IPV and home visitation in the prenatal period to improve maternal-infant health outcomes. Please refer to the manuscript for specific information on the articles included in the review.
- Findings related to IPV
 - Failure to provide sufficient focus, time and resources on IPV may limit the effectiveness of perinatal home visitation programs in promoting positive child
 - Home visitation programs were not as effective in reducing child abuse and neglect in households with IPV
- These findings emphasize the importance of screening and intervening for IPV
- If IPV is left unaddressed the risks can substantially impact the family environment
- None of the home visitation studies reviewed targeted IPV content as part of the intervention program, only identifying when signs were clear(e.g., bruising)
- Comfort in screening and referrals for IPV varied among home visitors; many cited limited IPV training as a barrier, in addition to confidentiality issues, time restrictions, providers experiences with IPV, and inadequate screening.

Taft A, O'Doherty L, Hegarty K, Ramsey J, Davidson L, Feder G. Screening women for intimate partner violence in healthcare settings (review). *Cochrane Database of Systematic Reviews* 2013, Issue 4.

- Please refer to the manuscript for specific information on the articles included in the review.
- While this review does not address effectiveness of interventions, it is worth including in the overall discussion because the premise of the review is important when considering screening for IPV.
- In short, the authors' perspective is that if there is no evidence that screening for IPV alone (without intervention) improves health, then universal screening cannot be justified. This perspective is not consistent with the definition and purpose of screening.
- The following language is taken from A Dictionary of Epidemiology^{*}: Screening is defined as the presumptive **identification** of unrecognized disease by the application of tests, examinations or other procedures which can be applied rapidly. Prescriptive screening has the aim of early detection in presumptively healthy individuals of disease that can be controlled better if detected early. A screening test is not intended to be diagnostic. **Persons with positive or suspicious findings must be referred for necessary treatment.**

^{*}A Dictionary of Epidemiology, Last JM, ed., International Epidemiological Association, Oxford Medical Publications, 1983.

Thus, by definition, screening is not intended to nor expected to improve the health of those who are experiencing IPV. For improvement in health outcomes, those who are affected must be referred to care providers.

- The authors state *this review is focused on screening only. It does not include any advocacy or psychotherapeutic interventions...The review focuses on two questions:*
 - 1) *whether or not there is evidence that IPV screening increases the number of women identified and the number of women referred to services; and*
 - 2) *whether or not screening results in health benefits to women or causes harm.*

- Summary of the findings for question 1: Based on 11 studies, screening for intimate partner compared to not screening is significantly more likely to identify victims of abuse (RR 2.3, 95% CI 1.4-3.6). The likelihood of referrals by health professionals was also increased but the confidence interval was wide and the difference was not statistically significant (RR 2.7, 0.99-7.1).
- Summary findings for question 2: *The 2 studies (MacMillan, 2009; Koziol-McClain, 2010) that have measured the impact of screening [alone] on a reduction of partner violence over time [3 - 18 months] provided no evidence that it can reduce abuse without any further intervention.*
- Based on 1 study (MacMillan, 2009), the authors note that physical health outcomes were significantly improved at the 6 and 12 month follow ups, but not at the 18 month follow ups. Findings were inconclusive with regard to improved psychological health.
- Authors' conclusion: *Insufficient evidence exists to justify screening for IPV in healthcare settings on the basis of demonstrated benefit to women. We do not agree with other reviews that screening is effective.*

Zolotor AJ, Denham AC, Weil A. Intimate partner violence. *Obstetrics and Gynecology Clinics of North America*. 2009;36:847-860.

Rigid evaluation of evidence is difficult to apply to IPV screening for several reasons. Screening for IPV should not be compared with radiographic tests for breast cancer or sigmoidoscopy for colon cancer screening but rather to the type of analysis used for more similar and morbid conditions, such as counseling for depression (Lachs, 2004). Many clinicians agree that good evidence for screening for IPV might be hard to obtain. Some clinicians worry that the "insufficient" recommendation would cause even lower detection rates of IPV than before (Marks et al, 2004) whereas advocates urge more research to be done. Although evidence does not exist to definitively prove that knowing about IPV reduces harm, common sense and prior experience suggest that knowing about such a difficult, potentially dangerous situation would be helpful toward understanding and assisting patients with health problems and would even prevent needless deaths. Smoking cessation counseling may be a good analogy, as described by Janssen and colleagues (Janssen, Dascal-Weichhendler, McGregor, 2004):

'When primary care physicians routinely ask about smoking as part of patient history taking, they do not do so in the belief that asking the question will stop their patients from smoking. Instead, knowledge of smoking status may guide the physician to undertake more frequent monitoring of cardiovascular and pulmonary health status, including measurement of blood pressure, evaluation of exercise tolerance, etc. Similarly, asking about intimate partner violence and obtaining a positive response identifies an opportunity for prevention of health-related sequelae.'

Section 4

Costs of IPV and Cost-Effectiveness of Screening for IPV among Women

Overview

Information on the public health and social costs of IPV in the U.S. is important because it provides both a measure of the magnitude of the problem and the relative benefits of prevention and intervention strategies. However, determining the health and social costs of IPV is difficult and complex and, by most accounts, likely to be a substantial underestimate of the actual costs. There are many factors that contribute to this reality. For example, information on the use of medical and mental health care, criminal justice and social services is often limited or unavailable. Even when such data are available, they are only able to capture the costs of those who seek such services. It is well understood that for a number of reasons, a substantial number of IPV victims are not able to access such resources. Furthermore, when factoring in the long-term health impact; the impact of IPV on children, other family members and loved ones; and the impact on communities, the costs of IPV are magnified exponentially. The loss of productivity, the decrease in the quality of life, and the negative impact on human potential caused by IPV is intangible.

Finally, because of changes in the value of the dollar over time, to be most meaningful, cost estimates must take into account time differences between the availability of the data, the year of publication and the future use of these findings in subsequent research. Researchers who want to cite the literature in later years must adjust the cost estimates accordingly or provide appropriate caveats. For example, see Arias and Corso, 2005 (cited below). At the time of publication, the authors were using data from 1995. Now, in 2013, without taking into account the 18 year time period between the use of 1995 data and today's review, the following statement would be misleading. "Based on a CDC report, the average medical care cost per woman victimized by a male intimate partner was \$948 overall." Beyond misleading, quoting the \$948 estimate without clarifying the costs are in 1995 dollars will further contribute to the substantial underestimation of the costs of IPV.

Despite these difficulties, it remains important to estimate the costs of IPV with the data that are available. Knowing that cost estimates are likely to be underestimates further underscores the importance of intervention and prevention strategies, and the likelihood that such efforts are cost-effective. The articles reviewed below represent the lion-share of research that has been published with respect to the health care costs of IPV. The methods, data used, and years of publication vary; therefore, the findings are not directly comparable. None-the-less, in combination, they provide ample evidence that IPV places a heavy burden on the victims, their families and the communities they live in. Studies comparing health care costs between those who have experienced IPV and those who have not provide clear evidence that IPV substantially increases the cost of health care. The research that evaluated the overall annual costs of IPV in the U.S. provided estimates as high as \$8.3 billion. While data regarding the costs of IPV training and screening are limited (see Cerulli et al, 2010 below), it is difficult to imagine a scenario where screening for IPV and providing referrals would not be cost effective.

Abbreviated Review of Selected Literature Related to the Costs of IPV

Arias I, Corso P. Average cost per person victimized by an intimate partner of the opposite gender: a comparison of men and women. *Violence and Victims*. 2005;20(4):379-391.

- *This study explored gender differences in service utilization for physical IPV injuries and average cost per person victimized by an intimate partner of the opposite gender.*
- The data used for this study came from the 8,000 women and 8,000 men participating in the National Violence Against Women Survey (NVAWS) telephone survey.
- All cost estimates are provided in 1995 dollars.
- All respondents who reported IPV victimization and associated injuries were asked about their use of emergency and outpatient services, overnight hospital stays, physician and dental services, use of ambulance or paramedics, physical therapy, or home care.
- Medical care cost estimates were based on data from the National Center for Injury and Prevention's 2003 report on the *Costs of Intimate Partner Violence Against Women in the United States* (reviewed below).
- Daily wage and productivity costs were also estimated.
- The average cost per woman victimized by a male intimate partner was \$948 overall (in 1995 dollars), including:
 - \$207 in mental health services
 - \$257 in productivity losses
 - \$483 in medical services
 - \$429 for inpatient
 - \$54 for outpatient (including MD, dental, ambulance, and PT visits)
- The average cost per man victimized by a female intimate partner was \$387 overall (in 1995 dollars), including:
 - \$80 in mental health services
 - \$224 in productivity losses
 - \$83 in medical services
 - \$77 for inpatient
 - \$5 for outpatient (including MD, dental, ambulance, and PT visits)
- Authors' conclusions: *Significantly more women than men reported physical IPV victimization and related injuries. A greater portion of women than men reported seeking mental health services and reported more visits on average in response to physical IPV victimization. Women were more likely than men to report using emergency department, inpatient hospital, and physician services, and were more likely than men to take time off from work and from childcare or household duties because of their injuries. The total average per person cost for women experiencing at least one physical IPV victimization was more than twice the average per person cost of men.*

Bonomi AE, Anderson ML, Rivara FP, Thompson RS. Health care utilization and costs associated with physical and nonphysical-only intimate partner violence. *HSR: Health Services Research*. 2009;44(3):1054-1067.

- The objective of this article was *to estimate health care utilization and costs associated with the type of IPV women experience by the timing of their abuse.*
- 3,333 women between the ages of 18-64 who were part of a large health plan were randomly sampled and participated in a telephone interview to assess IPV history.
- Questions were asked about
 - Physical and non-physical abuse (only) and
 - The timing of the abuse (ongoing; recent; not ongoing but occurred in the past 5 years; and previously occurred, but not in the past 5 years)
- Annual health care utilization and costs were assembled over a 7.4 year period

- Findings:
 - Total annual health care costs were higher for physically abused women.
 - Health care costs were higher among physically abused women compared to non-abused women.
 - Costs among women experiencing ongoing abuse were 42% higher than costs among non-abused women.
 - Costs among women who had experienced abuse within the 5 years prior to the survey were 24% higher than costs among non-abused women.
 - Costs among women who had experienced abuse more than 5 years prior to the survey were 19% higher than costs among non-abused women.
- Authors' conclusions: *Physical and non-physical abuse contributed to higher health care utilization.*

Brown DS, Finkelstein EA, Mercy JA. Methods for estimating medical expenditures attributable to intimate partner violence. *Journal of Interpersonal Violence*. 2008;23:1747-1766.

- *This article compares three methods for estimating the medical cost burden of intimate partner violence against U.S. adult women (18 years and older), 1 year postvictimization.*
- *To compute the estimates, prevalence data from the National Violence Against Women Survey are combined with cost data from the Medical Expenditure Panel Survey, the Medicare 5% sample, and with relative risk estimates from published studies.*
- *Results are compared and reasons for difference are explored, including the advantages and disadvantages of each approach.*
- *Estimates of the medical cost burden of intimate partner violence within the first 12 months after victimization range from \$2.3 billion to \$7.0 billion, depending on the method used. Although limited to women victimized in the last year, each method reveals that intimate partner violence imposes a substantial burden on the health care system. Among the approaches, there is no clear gold standard nor any evidence of bias.*

Cerulli C, Edwardsen EA, Duda J, Conner KR, Caine E. Protection order petitioners' health care utilization. *Violence Against Women*. 2010;16(6):679-690.

- This article provides a different perspective on the need to provide referrals for IPV victims. With respect to IPV and health care, researchers and service providers generally focus on the need for health care providers to refer IPV victims to domestic violence advocacy groups. Conversely, these researchers address the need for referrals to accessible health care for women who are petitioning for protection orders.
- The researchers provide information on health care usage and insurance coverage among 95 women seeking protection orders at family court.
- The researchers found:
 - 85% of petitioners had private or public health insurance
 - None-the-less, 39% reported delayed medical care
 - 14% had not obtained any health care
 - Among those who delayed or did not obtain health care, the reasons frequently
 - Among those who made an appointment to seek health care, the appointments were frequently for chronic diseases like asthma, diabetes, heart conditions, hypertension, or cancer
- The researchers also found:

- 42% of participants visited an ER in the past year (compared to 225 in the overall population);
 - 15% of these visited the ER 3 or more times
- Reasons for delays in seeking medical care were:
 - Concerns about cost (23%)
 - Being too busy (15%)
 - Didn't think it was serious enough (15%)
 - Other reasons given included insurance plan not paying for treatment, couldn't get an appointment soon enough, and could not get to the office when it was open
- Authors' conclusions: *This study raises an important question regarding whether an IPV survivor who is unable to afford a deductible or copay or to take time off from work has access to health care, despite being insured. The provision of on-site health care services or referrals from advocates within the courthouse, available as these women seek legal action, might remove some of their barriers to care. On-site health care may begin to relieve the potential long-term health consequences of the abuse from which they are seeking safety. At court, victims might access more timely health care, seek assistance for securing insurance if not currently carried, and receive appropriate referrals indicated by the petitioners' health status.*
- Reviewer's comment: This research also raises an important issue with respect to the costs of IPV on health. Although it is difficult to estimate, delayed health care or lack of health care among victims of IPV is an important component to consider when evaluating the overall costs of IPV. Delays in receiving health care that is key to effectively manage chronic illness are likely to exacerbate the victim's health problems and may increase the overall costs related to such illnesses.

Coker AL, Reeder CE, Fadden MK, Smith PH. Physical partner violence and medicaid utilization and expenditures. *Public Health Reports*. 2004;119(November-December):557-567.

- *In this family practice-based cross-sectional study, women were screened for current IPV using a 15-item Index of Spouse Abuse-Physical (ISA-P) between 1997 and 1998.*
- *More than 1100 women completed screening and health interviews. Consents were also obtained from study subjects to review Medicaid expenditure and utilization data for the same time period.*
- *Mean physician, hospital, and total expenditures were higher for those women with higher IPV scores compared with those who scored as not currently experiencing IPV, after adjusting for confounders.*
- *Higher IPV scores were associated with a three-fold increased risk of having a total expenditure over \$5,000 (95% confidence interval [CI] 1.3, 8.4). The mean total expenditure difference between the high IPV and no IPV groups was \$1,064 (95% CI \$623, \$1506). The adjusted risk ratio for high IPV score and the log of total Medicaid expenditures was 2.3 (95% CI 1.2, 4.4).*

Max W, Finkelstein E, Bardwell RA, Leadbetter S. The economic toll of intimate partner violence against women in the United States. *Violence and Victims*. 2004;19(3)259-272.

- *This study provides estimates of the economic cost of intimate partner violence perpetrated against women in the US, including expenditures for medical care and mental health services, and lost productivity from injury and premature death.*
- As did Brown et al, 2008 (reviewed above) the data for this manuscript came from the National Violence Against Women Survey and the Medical Expenditure Panel Survey.

- *Intimate partner violence against women cost \$5.8 billion dollars (95% confidence interval: \$3.9 to \$7.7 billion) in 1995, including \$320 million (\$136 to \$503 million) for rapes, \$4.2 billion (\$2.4 to \$6.1 billion) for physical assault, \$342 million (\$235 to \$449 million) for stalking, and \$893 million (\$840 to \$946 million) for murders.*
- *Updated to 2003 dollars, costs would total over \$8.3 billion.*
- *Authors' conclusions: Intimate partner violence is costly in the US. The potential savings from efforts to reduce this violence are substantial. More comprehensive data are needed to refine cost estimates and monitor costs over time.*

National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States*. Atlanta (GA): Centers for Disease Control and Prevention; 2003.

- *The costs of intimate partner rape, physical assault, and stalking exceed \$5.8 billion each year, nearly \$4.1 billion of which is for direct medical and mental health care services.*
- *The total costs of IPV also include nearly \$0.9 billion in lost productivity from paid work and household chores for victims of nonfatal IPV and \$0.9 billion in lifetime earnings lost by victims of IPV homicide.*
- *The largest proportion of the costs is derived from physical assault victimization because that type of IPV is the most prevalent. The largest component of IPV-related costs is health care, which accounts for more than two-thirds of the total costs.*

Norman R, Spencer A, Eldridge S, Feder G. Cost-effectiveness of a programme to detect and provide better care for female victims of intimate partner violence. *Journal of Health Services Research & Policy*. 2010;15(3):143-149.

- *The purpose of this research was to evaluate the feasibility and effectiveness of primary care based identification and intervention for women in the UK who were experiencing IPV.*
- *The system-based intervention aimed to change the behaviour of clinicians towards women experiencing IPV, and was designed to increase enquiry about IPV, assessments of women who disclose recent violence and referrals to an advocate in a community domestic violence agency or a psychologist with specific training in relation to IPV survivors. An initial educational session for all clinicians within the practice emphasized a pragmatic approach to enquiry and referral and also gave an overview of the wider community response. Referrals from health care professionals were facilitated by a direct referral pathway to a domestic violence advocate and a psychologist. The advocate regularly attended practice meetings to give feedback on referrals and any organizational or management issues.*
- *Four practices were included in the study, including 3 intervention sites and one control site*
- *Women attending the intervention sites were assessed for IPV using a probe for IPV during routine consultations. The assessment template included the HARK questions and a prompt for referral were included in the electronic medical record. Professionals in the control practice had no training in the recording of abuse and did no prompts included within the medical record.*
- *The authors used a Markov model to estimate the costs and outcomes among 435 women over a 10 year period.*
- *Examples of costs include:*
 - *Criminal justice*
 - *Civil justice*
 - *Employment loss due to injuries or fatalities*
 - *Temporary housing*
 - *Social and childcare services*

- Mental health
- Treatment (e.g., advocacy and assistance, psychologist, use of HARK by a doctor or nurse)
- Administrative costs
- Examples of outcomes include:
 - Disclosure of abuse
 - Acceptance or declination of referral
 - Improvement or lack of improvement in quality of life
 - Death
 - The analysis of data suggested that the system-based intervention used is likely to be a cost-effective use of societal resources
- Authors' conclusions: *Our model suggests that this programme is likely to be a cost-effective use of societal resources. The projected benefit of identification and referral following the system-based intervention compared to normal care and the relatively modest cost of the intervention makes it competitive with other health care interventions.*

Rivara FP, Anderson ML, Fishman P, Bonomi AE, Reid RJ, Carrell D, Thompson RS. Healthcare utilization costs for women with a history of intimate partner violence. *American Journal of Medicine.* 2007;32(2):89-96.

- This was a longitudinal cohort study based on more than 3000 women between the ages of 18 and 64 attending an HMO.
- 1546 women reported IPV in their lifetime; 86% had IPV that had ceased, on average 16 years prior to the interview.
- Healthcare utilization was higher across all forms of service during the time when IPV was occurring compared to women who had not experienced IPV
- Increased costs decreased over time after cessation of IPV.
- However, healthcare utilization was still 20% higher 5 years after the IPV stopped.
- Overall, annual total healthcare costs were 19% higher in women with a history of IPV (amounting to \$439 annually) compared to women without IPV.
- Based on prevalence for IPV of 44%, the excess costs due to IPV are approximately \$19.3 million per year for every 100,000 women enrollees aged 18–64.
- Authors' conclusions: *Women with a history of IPV had significantly higher healthcare utilization and costs, continuing long after IPV ended. Given its high prevalence, IPV has a major impact on medical care resource utilization and efforts to prevent its occurrence and consequences are clearly indicated.*

Snow Jones A, Dienemann J, Schollenberger J, Kub J, O'Campo P, Carlson Gielen A, Campbell JC. Long-term costs of intimate partner violence in a sample of female HMO enrollees. *Women's Health Issues.* 2006;252-261.

- The objective of this study was *to compare costs associated with intimate partner violence (IPV) overall and for selected physical health problems in a nonpoor, privately insured sample.*
- 185 women aged 21–55 who were physically and/or sexually abused between 1989 and 1997 and enrolled in a multisite metropolitan HMO were compared to 198 women in the same HMO who had never been abused.
- Costs associated with doctor visits, hospital stays, referrals, and emergency room (ER) visits, prescriptions, and radiology were evaluated and based on the Medicare Resource-Based Relative Value System, expressed in 2005 dollars.

- *Average health care costs for women who reported physical, sexual, and/or emotional abuse exceeded those of never abused women by \$1,700 over the 3-year study period. Women who reported abuse within 12 months of interview had higher average costs, as did women who reported physical abuse.*
- *However, sexual or emotional abuse and previous abuse also elevated costs. Costs associated with neurologic symptoms, injuries, mental health care, and unclassified symptoms account for most of these differences.*
- *Authors' Conclusions: IPV elevates health care costs, not only among women currently experiencing abuse, but also among women for whom the abuse has ceased. Efforts to control health care costs should focus on early detection and prevention of IPV.*

Ulrich YC, Cain KC, Sugg NK, Rivara FP, Rubanowice DM, Thompson RS. Medical care utilization patterns in women with diagnosed domestic violence. *American Journal of Preventive Medicine.* 2003;24(1):9-15.

- This study compared visits and costs of 62 women with medical-record confirmed cases of DV to 2,287 women without evidence of DV in the record.
- These two groups were selected from women making visits for any one of following four reasons: (injury, chronic pelvic pain, depression, or physical examination associated with higher risk of DV or higher likelihood of its discussion.
- A second comparison group of 6032 from the general population of enrolled women was also included.
- *Authors' conclusions: Women with medical-record–documented DV demonstrate a pattern of increased utilization and costs across all levels of care and types of diagnoses. Being a DV case-patient is associated with between 1.6- and 2.3-fold increases in total utilization and costs.*

Section 5

The Ethics of Screening for IPV

Overview

There are relatively few manuscripts that are specifically focused on the ethics of asking or not asking about IPV. Most are related to asking about IPV in research and intervention studies. While there are differences between health care providers and researchers, there is substantial overlap in the ethical issues and commonly held beliefs related to whether or not we should be asking about abuse (Becker-Blease and Freyd, 2006). Examples include:

- If we ask about abuse, does it have to be reported?
- Is it ethical to ask victims to disclose stigmatizing information?
- Survivors are not stable enough to be asked about past trauma.
- Asking about abuse has no benefits.

From the health care-provider's and public health perspectives, there are additional issues to consider. Examples include:

- Are there resources that can be provided to those who disclose?
- Do providers have adequate training to ensure they are not distressing or further harming their patients? For example, being judgmental, paternalistic, or dismissive?
- Are we asking the right questions in the right way so patients are willing to disclose?
- Are patient/provider relationships affected by asking about IPV?
- What harm on long-term health are we doing if we don't ask about IPV?
- Is screening cost-effective?
- Not asking about abuse is best because there is no harm in not asking.
- Is screening for IPV treated differently than other types of screening (e.g., smoking, high blood pressure)? If so, why?

Many of these questions and beliefs are discussed in the literature reviewed below.

Abbreviated Review of Selected Literature Related to the Ethics of Screening for IPV

Becker-Blease KA, Freyd JJ. Research participants telling the truth about their lives: ethics of asking and not asking about abuse. *American Psychologist* 2006;61(3):218-226.

- This manuscript addresses the ethics of asking and not asking about abuse in research settings.
- *Most discussions of the ethics of self-report research on abuse and interpersonal violence focus on the risks of asking participants about their experiences. An important element of the cost-benefit analysis—the costs of not asking about child abuse—has largely been ignored. Furthermore, little research has been conducted on the costs and benefits of child abuse research, leaving researchers to make decisions based on individual beliefs about such issues as the prevalence of abuse, the likelihood of disclosure, the effects of child abuse, and the ability of abuse survivors to give informed consent. The authors suggest that these beliefs tend to overemphasize survivors' vulnerability and ignore the costs of avoiding asking about abuse. In fact, these beliefs may reinforce societal avoidance of abuse and ultimately harm abuse survivors.*
- Several thoughtful and relevant commentaries to Beck-Blease and Freyd were also included in the same issue of the *American Psychologist* (pages 325-332). Commentaries were provided by:

- John Read: To ask, or not to ask, about abuse – New Zealand Research
- David Gleaves et. al: What are we teaching our students by not asking about abuse?
- Valerie Edwards et. al: It's ok to ask about past abuse
- Michele and Robert Black: A public health perspective on "the ethics of asking and not asking about abuse"
- Sarah Ullman: Asking research participants about trauma and abuse
- Kathryn Becker-Blease and Jennifer Freyd: The ethics of asking about abuse and the harm of "don't ask, don't tell"

Cook RJ, Dickens BM. Ethical and legal issues in reproductive health: dilemmas in intimate partner violence. *International Journal of Gynecology and Obstetrics*. 2009;106:72-72.

- This article addresses dilemmas that occur while dealing with IPV at the international level whilst considering cultural differences and availability of resources. While the ethics of evaluating and addressing IPV in varying cultures increases the level of complexity, much of what is discussed is applicable for clinicians in the U.S.
- Healthcare providers face a dilemma in reconciling two aspects of the ethical principle of showing respect for persons, namely respecting the self-determination of those able to exercise autonomy, and protecting the interests of vulnerable people.
- *Suggestions for clinicians include:*
 - *Providers must decide whether to take their own initiatives to intervene, such as by approaching abusive partners to discuss the effects of their behavior on the patients, seeing if any community agency should be involved, or taking measures to inform law enforcement authorities.*
 - *However, partners should not be approached without patients' approval, since patients will better know how approaches would be received and, for good or ill, will bear the consequences.*
 - *Involving community agencies may be feasible in urban and suburban areas, but less so in remote rural or desert areas, and in any event bears on patients' confidentiality.*
 - *There is more license to bring in law enforcement authorities where criminal violence is apparent, but here again patients will bear the major consequences, and should be prepared to accept them.*
 - *The ethical principle of beneficence, the duty to do good, has to be balanced against the duty not to do harm, or at least to minimize the risk of harm.*
 - *Intervention in a patient's home circumstances to promote her protection against IPV may be paternalistic, unless she gives prior consent, having taken account of the foreseeable consequences.*
 - *The dilemma in observing the Do No Harm (nonmaleficence) principle is assessing whether there may be foreseeable harm from interventions.*
 - *Forms of providers' intervention range from the more benign, such as speaking with the partner, to the more coercive, notably involving criminal law enforcement agencies; as against this, there is the option of remaining uninvolved in the domestic setting, and just giving due treatment for the injuries the patients present.*

Hyman A, Schillinger D, Lo B. Laws mandating reporting of domestic violence: do they promote patient well-being? *Journal of the American Medical Association*. 1995;273(22):1781-1787.

- There are laws in many states that mandating reports of injuries due to weapons, crimes, violence, intentional acts, or abuse. These laws may require, to different extents, reporting in cases of domestic violence.

- *Mandating a coercive intervention that may fail to offer adequate protection may further jeopardize the patients we are trying to help. Mandatory reporting may threaten the safety of battered women, discourage them from seeking care, fail to improve the health care of battered patients, lead to inadequate responses to reports of abuse, result in biased case identification, and violate patient autonomy and confidentiality.*
- *Health care workers and the facilities in which they practice should strive to implement policies that promote the well-being and autonomy of survivors of domestic violence and minimize the harms of existing mandatory reporting laws.*

Palmer VJ, Yelland JS, Raft AJ. Ethical complexities of screening for depression and intimate partner (IPV) in intervention studies. *BMC Public Health*. 2011;11(Suppl 5):S3.

- This manuscript discusses extensively a number of ethical complexities related to screening for IPV.
- Issues addressed include:
 - Beneficence – balancing benefits against risk
 - Screening, new diagnoses and disclosure: doing no harm?
 - Screening may bring new information and burdens to patients, for example, changes in sense of self, and potential changes in pathways that had not previously been considered
 - Screening and autonomy
- Other ethical considerations described include:
 - Issues related to environment and settings
 - Political and policy contexts
 - Organizational support
 - Professional training in conducting screening
 - Provision of follow-up resources
 - Access to care and services
 - Socio-cultural issues
 - Labeling groups “at-risk”
 - Victim blaming
 - Different cultural understandings
 - Culturally competent screening tools
 - Patient/participant issues
 - Dealing with new health information
 - Personal values
 - Identity disruption
 - Stigma and shame due to screening results
 - Relational issues
 - Relational responsibilities
 - Impact on families
 - Patient disclosing information to others
 - Attitudes of health professionals

Valente SM. Evaluating and managing intimate partner violence. *The Nurse Practitioner*. 2000;25(5):18-33.

- This manuscript addresses a broad range of issues relevant to managing IPV in clinical settings.
- One section addresses ethical considerations, including:

- Mandatory reporting may discourage women from seeking care in order to keep their abuse confidential and to keep their abuser from being arrested
- Clinicians' competing obligations pose ethical dilemmas – wanting to protect patients from harm while wanting to respect their confidentiality and autonomy
- It is difficult for clinicians to evaluate danger and predict what will lead to the escalation of violence
- To assist and guide clinicians in addressing ethical dilemmas that may hinder evaluation and treatment, policies and practices should be put in place
- *Clinicians may be frustrated when they cannot protect the woman when she returns to the abuse, recants complaints, and rejects protective services. A challenge for the clinician is to witness the woman's suffering and pain while understanding that only the woman can determine the right time to separate from the destructive relationship ...Professionals should demonstrate compassion and support even when the woman refuses to confirm abuse or take action.*

Additional literature relevant to the Ethics of Screening for IPV

Ellsberg M, Heise L, Pena R, Agurto S, Winkvist A. Researching domestic violence against women" methodological and ethical considerations. *Studies in Family Planning*. 2001;32(1):1-16.

Kulkarni SJ, Bell H, Rhodes DM. Back to basics: essential qualities of services for survivors of intimate partner violence. *Violence Against Women*. 2012;18(1):85-101.

Sharps PW, Koziol-McLain J, Campbell J, McFarlane J, Sachs C, Xiao Xu. Health care providers' missed opportunities for preventing femicide. *Preventive Medicine*. 2001;33:373-380.

Sullivan CM, Cain D. Ethical and safety considerations when obtaining information from or about battered women for research purposes. *Journal of Interpersonal Violence*. 2004;19(5):603-618.

Section 6

Recommended Readings for IPV Screening and Counseling

Ambuel B, Trent K, Lenahan P, Cronholm P, Downing D, Jelley A, Lewis-O'Connor A, McGraw M, Marjavi A, Mouden L, Wherry J, Callahan M, Humphreys J, Block R. Competencies Needed by Health Professionals for Addressing Exposure to Violence and Abuse in Patient Care. Academy on Violence and Abuse. Eden Prairie, MN, April 2011.

Black MC. Intimate partner violence and adverse health consequences: implications for clinicians. *American Journal of Lifestyle Medicine*. 2011;5:428-439.

Eddy T, Kilburn E, Chang C, Bullock L, Sharps P, DOVE Research Team. Facilitators and barriers for implementing home visit interventions to address intimate partner violence: town and gown partnerships. *Nursing Clinics of North America*. 2008;43(3):419-435.

Feder GS, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Archives of Internal Medicine*. 2006;166(1):22-37.

Futures Without Violence information on mandatory reporting. Summary available at:
http://www.futureswithoutviolence.org/userfiles/file/HealthCare/mandatory_policypaper.pdf

State specific codes are available at:

http://www.futureswithoutviolence.org/userfiles/file/HealthCare/mandatory_reporting_tables1.pdf

Policy Paper available at:

http://www.futureswithoutviolence.org/userfiles/file/HealthCare/mandatory_policypaper.pdf

Gunter J. Intimate partner violence. *Obstetrics and Gynecology Clinics of North America*. 2007;34:367-388.

Haggerty LA, Hawkins JW, Fontenot H, Lewis-O'Connor A. Tools for screening for interpersonal violence: state of the science. Tools for screening for interpersonal violence: state of the science. *Violence and Victims*. 2011;26(6):725-737.

Hamberger LK, Phelan MB. Domestic violence screening and intervention in medical and mental health care settings (New York: Springer; 2004).

Hamby S, Cook SL. Assessing Violence Against Women in Practice Settings: Processes and Tools Practitioners Can use. In: Renzetti C M, Edelson JL, Bergen RK, eds. *Sourcebook on Violence Against Women, 2nd Edition*. Thousand Oaks, CA: Sage; 2010:49-71.

Hyman A, Schillinger D, Lo B. Laws mandating reporting of domestic violence: do they promote patient well-being?" *Journal of the American Medical Association*. 1995; 273:1781-1787.

Kirst M, Zhang YJ, Young A, Marshall A, O'Campo P, Ahmad F. Referral to health and social services for intimate partner violence in health care settings: a realist scoping review. *Trauma, Violence, and Abuse*. 2012;13(4):198-208.

Kulkarni S, Bell H, Wylie L. Why don't they follow through? Intimate partner survivors' challenges in accessing health and social services. *Family & Community Health*. 2010;33(2):92-105.

Lachs MS. Screening for family violence: what's an evidence-based doctor to do? *Annals of Internal Medicine*. 2004;140(5):399-400.

Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception*. 2011;83:274-280.

Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Prevention Services Task Force Recommendation. *Annals of Internal Medicine*. 2012;156(11):796-808,W-279–W-282.

Norman R, Spencer A, Eldridge S, Feder G. Cost-effectiveness of a programme to detect and provide better care for female victims of intimate partner violence. *Journal of Health Services Research & Policy*. 2010;15(3):143-149.

Palmer VJ, Yelland JS, Raft AJ. Ethical complexities of screening for depression and intimate partner (IPV) in intervention studies. *BMC Public Health*. 2011;11(Suppl 5):S3.