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# Improving the Health Care Response to Intimate Partner Violence

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# IPV

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- ◆ Global Issue
- ◆ Human Rights Issue
- ◆ Public Health Issue

# OBJECTIVES

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- ◆ Know the Incidence and Prevalence
- ◆ Recognize Barriers
- ◆ Learn How to Ask About DV
- ◆ Learn How to Assist

# MEDICAL LITERATURE

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- ◆ Definition of DV
- ◆ Population studied
- ◆ Method of inquiry
- ◆ Incidence vs. prevalence

# DEFINITION

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- ◆ DOMESTIC VIOLENCE-is a pattern of coercive behavior designed to dominate and control an intimate partner through fear and intimidation. The tactics used include: physical assault, financial control, sexual abuse, and emotional abuse.

# PREVALENCE OF DOMESTIC VIOLENCE IN US

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- ◆ annual prevalence 8-12%
- ◆ lifetime prevalence 20-30%
- ◆ during pregnancy 10-17%
- ◆ among women treated in ER:
  - current 14-26%, lifetime 11-54%
- ◆ outpatient primary care
  - current 14%, lifetime 20-40%

# US Impact

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- ◆ 1995-1996 in the 50 States and DC, 25% of women and 7.6% of men were raped and/or physically assaulted by a current or former partner during their lifetime.
- ◆ ~1.3 million women and 835,000 men are physically assaulted by an intimate partner annually in the United States.

Patricia Tjaden & Nancy Thoennes, U.S. Dep't of Just., NCJ 181867, *Extent, Nature, and Consequences of Intimate Partner Violence, at iii* (2000), available at <http://www.ojp.usdoj.gov/nij/pubs-sum/181867.htm>

Patricia Tjaden & Nancy Thoennes, U.S. Dep't of Just., NCJ 183781, *Full Report of the Prevalence, Incidence, and Consequences of Intimate Partner Violence Against Women: Findings from the National Violence Against Women Survey, at iv* (2000), available at <http://www.ojp.usdoj.gov/nij/pubs-sum/183781.htm>

# Intimate Partner Violence

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- ◆ Trauma Registry & Coroners' Database study- all female victims firearm assaults
  - 44% were fatally injured
  - 37% assailant were IP
  - 54% of assaults occurred at home
- ◆ Firearm assault by IP was 10 times more lethal than assault by strangers

Finlay-Morreale HE, et al. J Trauma. 2009 Apr;66(4): 1207-11

# Young Adults & Teens

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- ◆ 18-24 year-olds comprised 11.7% of the population in 1998 and 2002, but were the majority of victims of violence committed by a boyfriend or girlfriend (42%).
- ◆ Approximately one in five female high school students reports being physically and/or sexually abused by a dating partner.

Matthew R. Durose et al., U.S. Dep't of Just., NCJ 207846, Bureau of Justice Statistics, *Family Violence Statistics: Including Statistics on Strangers and Acquaintances*, at 11 (2005), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/fvs.pdf>

◆ Jay G. Silverman et al., *Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality*, 286 J. Am. Med. Ass'n 572-579 (2001).

# Relationship Violence-Young Adults & Teens

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- ◆ 45% experienced partner or relationship violence (emotional, physical, sexual)
- ◆ Rates higher prior to college than during
- ◆ Rates higher for women than men, but 27% of men reported victimization

Forke, CM. Arch Pediatr Adolesc Med. 2008 Jul;162(7):634-41.

# Physical Abuse During Pregnancy

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- ◆ 24% mothers with pre-term infants reported abuse vs 8% with full-term infants
- ◆ Adjusted OR =3.1 (2, 4.9)
  - controlled for maternal age, marital status, education, income, parity, planned pregnancy, antenatal care, tob, alcohol, illicit drug use

Rodrigues T. Am J Obstet Gynecol. 2008 Feb;198(2):171.e1-6

# COSTS OF DOMESTIC VIOLENCE

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- ◆ increased utilization of medical care
- ◆ 2x's as likely to give birth to low birth wt. baby
- ◆ accounts for ~50% of the murders of women each year
- ◆ Crime costs Americans \$450 billion a year. Adult victims of domestic violence incurred 15% of the total cost of crime on victims (\$67 billion).
- ◆ Avg. charge for medical services provided to abused women, children and older people was \$1,633 per person per year. National annual cost est. = \$857.3 million.

Ted R. Miller, Mark A. Cohen, & Brian Wiersema, U.S. Dep't of Just., NCJ 155282, *Victims Costs and Consequences: A New Look* (1996), available at <http://www.ncjrs.gov/btxfiles/victcost.txt>; Harris Meyer, The Billion Dollar Epidemic, 35 Am. Med. News 7 (1992).

# CURRENT DV IS ASSOCIATED WITH

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- ◆ Substance abuse
- ◆ Partner who is abusing drugs or alcohol
- ◆ Psychological distress, mental illness
- ◆ Poorer physical health, physical disability, negative health outcomes

# CLINICAL EXAM

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- ◆ Focus depends on presentation
- ◆ Issues can be addressed as HPI, PMH, Social History or ROS

# SUSPICIOUS FINDINGS

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Usually none !!!

# SUSPICIOUS FINDINGS

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- ◆ Any traumatic injury
- ◆ Multiple injuries in various stages of healing
- ◆ A delay in seeking medical care
- ◆ Inconsistencies b/w history and physical exam
- ◆ Psychological and somatic symptoms
- ◆ Repeat visits

# OB/GYN PRESENTATIONS

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- ◆ Injuries to breast, abdomen, and genitals
- ◆ Premature labor
- ◆ Spontaneous and elective abortions
- ◆ Recurrent vaginal, sexually transmitted, and urinary tract infections
- ◆ Dyspareunia and pelvic pain
- ◆ Non-adherence to contraception
- ◆ Poor pre-natal care/misplaced appointments

# MENTAL HEALTH/PSYCH

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- ◆ Depression
- ◆ Suicide attempts
- ◆ Anxiety disorders
- ◆ Alcohol and/or drug abuse

# OTHER MEDICAL FINDINGS

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- ◆ Exacerbation of chronic illness
- ◆ Sleep disturbances, fatigue
- ◆ Eating disorders
- ◆ Vague or nonspecific symptoms

# Does Screening Help or Hurt?

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- ◆ Systematic reviews note a lack of evidence to address this question.
- ◆ ED study of screening at kiosk in waiting room, positive screens provided with referral info.
  - Outcomes: 1-wk & 3-mo f/u interviews- injuries, violence, f/u referral information, 911 calls from residence 6-mo pre- and post-screen
  - No change in 911 calls, 35% f/u with referral

# SCREEN ALL WOMEN FOR ABUSE

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- ◆ Self-report on screening questionnaires
- ◆ In-person screening

# UNIVERSAL SCREENING

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- ◆ AMA-routine screening “at the entry points of contact between women and medical care”
- ◆ AAFP-initiative to teach its members to screen, recognize and treat
- ◆ ACEP-calls for hospital protocols for ED identification, treatment and referral
- ◆ ACOG

# RADAR

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- ◆ Routinely screen
- ◆ Ask direct questions
- ◆ Document findings
- ◆ Assess safety
- ◆ Review options and referrals

# PATIENT PREFERENCE

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- ◆ 78% favored routine physical abuse inquiry
- ◆ 68% favored routine sexual abuse inquiry
- ◆ 90% believed that physicians could help with problems from physical and sexual abuse

# PHYSICIAN/PROVIDER BARRIERS

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- ◆ lack of education
- ◆ “Pandora’s box”
- ◆ close identification with patient
- ◆ fear of offending
- ◆ feelings of powerlessness
- ◆ lack of time

# Asking About DV (ED study)

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- ◆ 293 audiotapes where DV discussed
  - Queries often perfunctory- limited follow-up or open-ended questions
  - Of 77 DV disclosures
    - » 24 were documented
    - » 19 referred
- ◆ Providers knew they were being audiotaped, knew intent of study

# Asking About DV- 2 (ED study)

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- ◆ Poor questioning: 3rd party in the room, negative question, lack of f/u to clues, ignoring disclosures
- ◆ Good questioning: mentioning stress, stress' relationship to health, empathy, open-ended

Rhodes KV. Ann Int Med. 2007;147:620-627

# LESSONS LEARNED

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- ◆ Women respond positively to inquiries about their safety and health
- ◆ Screening should be done routinely
- ◆ Further questioning may be appropriate when there is a high degree of suspicion
- ◆ Relationship definition can vary
- ◆ Patient needs to meet you halfway, but you need to invite them to do so
- ◆ Asking makes a stand

# INTERVENTION

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- ◆ ASK! ASK! ASK!
- ◆ Silence, disregard or disinterest convey tacit approval or acceptance of domestic violence

# ASK! ASK! ASK!

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- ◆ “Because abuse and violence are so common in women’s lives, I’ve begun to ask about it routinely.”
- ◆ “Are you in a relationship in which you have been physically hurt or threatened by your partner?”
- ◆ We all fight at home. What happens when you and your partner fight or disagree?

# ASK! ASK! ASK!

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- ◆ “Do you feel safe in your current relationship?  
(Partner Violence Screen)
- ◆ Is there a partner from a previous relationship who is making you feel unsafe now? (PVS)
- ◆ “Have you ever been hit, kicked, punched or otherwise injured by your partner?” (PVS)
- ◆ “It looks as though someone may have hurt you. Can you tell me what happened?”

# ASK (Woman Abuse Screening Tool)

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- ◆ In general how would you describe your relationship ( a lot, no, some tension)
- ◆ Do you & your partner work out arguments (with great, some, or no difficulty)
- ◆ Do arguments result in:
  - You feeling bad or put down
  - Hitting, kicking or pushing

# ASK- WAST continued

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- ◆ Do you ever feel frightened by what your partner says or does
- ◆ Has your partner ever abused you:
  - physically?
  - Emotionally
  - Sexually?
- ◆ PVS and WAST sensitivities 47-49%, spec 94-96% compared with Composite Abuse Scale

MacMillan H, et al . Approaches to Screening for IPV in Health Care Settings  
JAMA, 8/2/06, 296:530-536.

# THE INTERVIEW

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- ◆ Talk to the patient alone in a private setting
- ◆ Explain confidentiality
- ◆ Remain nonjudgmental
- ◆ Maintain advocacy-validate the patient's experience
- ◆ Avoid victim blaming
- ◆ Acknowledge the difficulty of his/her situation

# Does What We Do Matter?

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- ◆ Disclosure of violence to a healthcare provider was associated with increased odds of using an intervention.
- ◆ And receipt of an intervention was associated with exiting an abusive relationship

# REFERRALS

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- ◆ Involve social workers
- ◆ Provide a list of shelters, resources, and legal advocacy
- ◆ Provide local hotline number

# INTERVIEW

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- ◆ Provide community resource information
- ◆ What is she ready to accept now
- ◆ Suggest she develop a safety plan
- ◆ Offer continued support
- ◆ Make follow-up arrangements
- ◆ Leave the “door open”

# SAFETY PLAN

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- ◆ Money, ATM card, checks
- ◆ Arrangements for shelter and transportation
- ◆ Clothing for herself and children
- ◆ Extra set of house and car keys
- ◆ Important documents

# DOCUMENTATION

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- ◆ Use the patient's own words!
- ◆ Include a detailed description of all injuries
- ◆ Use a body map
- ◆ Include an opinion on whether the injuries are consistent with the explanation
- ◆ Take Polaroid photographs of injuries
- ◆ Police name and badge number

# REMEMBER!

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- ◆ Do not judge the “success” of your actions based on a woman’s decision to leave an abusive situation

# ASSESS SAFETY

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- ◆ Is it safe to go home?
- ◆ Are children being abused?
- ◆ Can the patient stay with family or friends
- ◆ Does the patient want access to a shelter
- ◆ Does the patient want police intervention

# LEGAL RESPONSIBILITIES

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- ◆ It shall be the duty of every physician who attends or treats a bullet wound, a gunshot wound, a powder burn or any other injury arising from the discharge of a firearm, or injury caused by a knife, an ice pick or any other sharp or pointed instrument which the physician believes to have been intentionally inflicted upon a person, *or any other injury which the physician has reason to believe involves a criminal act*, INCLUDING INJURIES RESULTING FROM DOMESTIC VIOLENCE, to report such injuries at once to the police... (12-36-135)

# LEGAL RESPONSIBILITIES

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- ◆ Colorado- mandatory reporting
- ◆ Physicians have absolute(civil and criminal) immunity for good faith reporting
- ◆ Failure to report shall be punished by a maximum fine of \$300 and/or by imprisonment for not more than 90 days
- ◆ Reporting should be made to the police or sheriff of the city, town or county in which the physician is located

» Statute 12-36-135

# REPORTING

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- ◆ “Do with, not to”
- ◆ Call police in the district where you are located
- ◆ Report intentional injury
- ◆ If perpetrator is in clinic, arrange for discrete arrival of police
- ◆ DV advocates warn that reporting may escalate violence