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Texas Children's Hospital®

AN ASSESSMENT OF SCREENING FOR INTIMATE PARTNER VIOLENCE

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INTRODUCTION

Intimate partner violence (IPV) is a pattern of behavior used to establish power and control over someone through fear and intimidation and may include physical, sexual, emotional, or financial abuse.[1] Nearly one out of three women experience IPV in their life time.[2] Despite widespread recommendations for providers to screen women for IPV, screening rates are low in healthcare settings.[3] To address this gap in practice, the Section of Public Health Pediatrics at Texas Children's Hospital in Houston, Texas established a workgroup to address IPV screening, identification, and referrals in the greater Houston community. The workgroup consists of health care providers, academia, community nonprofits, and representatives of local government. In 2017 the workgroup conducted an assessment of IPV screening, which included the following components:

1) A review of the literature on IPV screening;

2) Twenty-six interviews with local experts on IPV, agencies that provide IPV services, and organizations that screen for IPV; and

3) Three focus groups with survivors of IPV.

After the assessment was complete, the work group developed recommendations on how to improve IPV screening, identification, and referrals in the greater Houston community.

BACKGROUND

IPV has immediate and long-term harmful consequences on the survivor as well as children that are exposed to IPV. In addition to physical injuries from the abuse, many survivors of IPV experience poor physical, social, and mental health and are more likely to report panic attacks, depression, anxiety, chronic pain, headaches, difficulty sleeping, activity limitations, asthma, and diabetes.[4,5] Furthermore, exposure to IPV during pregnancy is associated with late entry to prenatal care, lower infant birth weight, and is a leading cause of death during pregnancy.[6,7] Children that are exposed to IPV are at increased risk for abuse and neglect, mood and anxiety disorders, post-traumatic stress disorder, substance abuse, and school-related problems.[8]

Survivors of IPV access healthcare at higher rates than the general public[9] and the prevalence of IPV seen in primary care and emergency departments ranges from 12% to 45% depending on how IPV is defined and measured.[10,11] It is recommended by the American Academy of Pediatrics, American Congress of Obstetrics and Gynecology, U.S. Preventative Services Task Force, Joint Commission of Healthcare Administration, and Institute of Medicine that healthcare providers screen for IPV.[12–16] There are several validated screening instruments for IPV, including HITS, OAS, OVAT, STaT, HARK, CTQ-SF, and WAST.[17,18] Despite the recommendations and availability of screening tools, screening rates for IPV remains low.[3]

Most literature on IPV screening focuses on the healthcare setting. There is some evidence that screening results in higher rates of identification in obstetrics clinics as compared to emergency departments.[19]

Barriers to screening include time constraints, lack of policies and procedures for screening, discomfort with the topic, fear of offending the patient or partner, need for privacy, perceived lack of power to change the problem, and misconceptions regarding the patient population's risk of exposure to IPV.[20]

It is recommended that providers screen patients privately, use direct questions from a validated screening tool, and create a safe environment through effective communication.[21,22] There are no differences in IPV disclosure rates between self-administered written surveys versus face-to-face screens, but one review found that women may prefer self-administered computer screens.[17,23]

There is uncertainty as to whether screening improves outcomes for victims of IPV. A 2015 systematic review found evidence that screening increases identification of women experiencing IPV, especially pregnant women. However, the same systematic review concluded that there is no evidence that screening and identification leads to improved outcomes, such as referrals to advocacy organizations, exposure to violence, and health measures.[23]

One randomized controlled trial demonstrated a reduction of recurrent episodes of IPV during pregnancy and postpartum in a perinatal population compared to the control group. The intervention group received counseling for IPV and comorbid health risks such as smoking, depression, and safety behaviors. The intervention group also experienced better birth outcomes.[24]

REFERRAL

Referral is a critical component of IPV screening. In general, there is a lack of provider comfort in screening and referral. Providers' response to positive screens can include providing referrals to social workers or behavioral health (if available in the practice or hospital), providing referrals to local IPV agencies or the national hotline, and conducting danger assessments with safety planning.

INTERVENTIONS

Successful interventions to increase IPV screening go beyond educating providers to screen.[18,25] Ambuel et al. recommends the following components to create sustainable system-level screening programs:

- Development of internal on-site IPV expertise
- Saturation training
- Development of unit-based policies and procedures
- Collaboration with local advocacy agencies and IPV experts
- Continuous quality-improvement strategies
- Inclusion of primary prevention efforts[26]

Comprehensive programs boosted providers' self-efficacy to perform screening and boosted IPV screening rates and abuse disclosure rates.

COMMUNITY-BASED INTERVIEWS

In addition to a literature review on IPV screening, we interviewed 26 local experts on IPV, agencies that provide IPV services, and organizations that screen for IPV to understand current local practices related to screening and supporting survivors of IPV. A list of organizations that were interviewed is included in Appendix A.

OVERVIEW

Several community-based organizations and health care institutions in Houston have created institutional policies to screen for IPV. The screening protocols vary dramatically regarding who is screened, who does the screening, how the patient is screened, how often the patient is screened, and which screening tool is used. Responses included:

- Who is screened: all patients aged ≥14, pregnant women, moms at well-child check-ups, all clients that access their services, women in the ER, all adults receiving clinical services
- Who does the screening: nurse, patient care technician, medical assistant, therapist
- How is screening conducted: in-person interview, paper form
- How often are patients screened: annually, ER visit, once during pregnancy, once per trimester, intake, at all well-child check-ups
- Screening tools used: OAS, HITS, informal (no standard questions), 5 standard questions

Generally speaking, local organizations do not have protocols in place to track compliance, and the interviewees were uncertain if or how to pull data to see the number of people screened, the rate of positive screens, the follow-up to the positive screens, and the outcomes of patients referred to services. Some of the organizations provided estimates, which ranged from just a few positives each year to 5% of the patient population.

Locally, there is consistency in the response to a positive screen including:

- Referral to social worker, nurse, or designated internal IPV advocate
- Safety assessment
- Connection to an IPV agency if the patient consents

Local interviews with agencies that provide services for survivors of IPV all point to interpersonal communication as a key component of successful screening. IPV agencies report that they receive some referrals from healthcare organizations, but it is relatively small number of referrals.

LOCAL VOICES FROM HEALTHCARE ORGANIZATIONS AND SERVICE PROVIDERS

The key stakeholder interviewees provided valuable insight and ideas on barriers and solutions to IPV screening and referrals. A few of these ideas and perspectives are included below.

"We need more than healthcare providers screening, it is going to take a bigger response. It needs to be at the community level and all subsets need to play a role."

"Early identification of IPV is complicated because there is shame. Screening must be authentic, compassionate, and realistic. Survivors are scared of being reported to authorities. It must be realistic because the available services are limited."

"The shelters in greater Houston do not have the capacity to take on more families. There will never be enough capacity until we dispel the myth that the only way out of a violent relationship is to go to a shelter. There are programs and services that allow families to transition directly into their own housing and not go through a shelter. Shelters and communal living are terrible places for victims recovering from trauma to be. There is so much chaos and tension as families are forced to live in close quarters with others."

"Organizations that are training their employees to screen for IPV need to involve their Employee Assistance Programs. We had employees that needed to speak with someone about IPV after every IPV staff training."

"Organizations need to set aside a small pocket of money to help survivors of IPV. We have had cases where mom showed up at our site fleeing from abuse and all the shelters were full."

"When our team (behavioral health) receives the IPV referral, it is typically not a top priority for the mom. We conduct the safety assessment and discuss options, but typically they have other concerns that are a bigger priority to them."

"It is not practical for ER nurses who are dealing with life threatening emergencies to stop, get the patient by themselves, and screen for IPV. Unless there are outward signs [of IPV] the ER is the wrong place for IPV screening."

"There is a distrust of social workers in the population we work with. They think we are going to take their kids away or deport them."

"CPS should not separate the kids from the mom because the mom is the most protective factor for the child's overall well-being."

FOCUS GROUP WITH IPV SURVIVORS

In May – July 2017, we conducted three focus groups with survivors of IPV to understand how to improve the effectiveness of IPV screening and connect survivors with resources. Participants were recruited from two agencies that provide non-residential IPV services and one agency that provides residential IPV services. There were a total of 17 participants in three focus groups. Detailed information and the results of the study have been submitted to the Journal of Interpersonal Violence for review and publication.

DEMOGRAPHICS

The participants represented a diverse group of 17 women that had experienced IPV.

Demographics of focus group participants	
Age	Average age is 42; ages range from 22 to 70 years of age
Race and Ethnicity	36% white non-Hispanic, 29% Hispanic, 29% Black, and 6% American Indian
Education	23% did not complete high school, 12% graduated high school, 41% had some college, and 23% graduated college
Housing	41% live in a shelter, 29% live alone or with their children, 24% live with other adults (not their abuser), and 6% live in a permanent housing program
Children	94% have children
Public Assistance	65% receive public assistance

THEMES

The following themes were identified from the three focus groups.

1. IPV GOES BEYOND PHYSICAL ABUSE AND ITS EFFECTS ARE LONG-LASTING.

In addition to describing serious physical and sexual abuse, many of the participants shared stories of emotional, verbal, and financial abuse and the importance of recognizing signs and symptoms of non-physical abuse. Many of the participants did not realize they were in abusive relationships for years because the abuse was not physical. Some participants reported having to sign their paychecks to their abusers and losing their jobs because they weren't allowed to return to work until their bruises healed. Guns and the threat of guns were also used by the abusers to control the behaviors of the survivors.

> *"They, they can control you so well, they don't have to hit you."*
>
> *"He would put the gun to me, if I didn't want to have sex with him"*
>
> *"I just kept my mouth shut. You know, I was always walking on eggshells like I didn't want to look up at anybody. I didn't want to talk to nobody because if I said something wrong that might piss him off, I was getting beat."*
>
> *"He started choking me and stuff. And he said, 'well, I didn't do anything to you. I didn't leave you any marks. As long as there are no marks left, it's not abuse.' and that was his thing. He would get right to that point where he felt that there will be no marks."*

The participants reported the effect of the IPV causing chronic illness and long lasting fear, anxiety and mental illness.

"And now, I have to take therapy and see a psychiatrist for the rest of my life. And take medicine for the rest of my life 'cause my mind is messed up."

"I have been hospitalized for mental illness twice… I am realizing that there is nothing wrong with me; what was wrong was the toxic, sick relationship that I was in"

2. FAMILIES PLAY A PIVOTAL ROLE IN STAYING IN OR LEAVING A VIOLENT RELATIONSHIP.

Families and children are a key driver to a survivor's decision to stay or leave a violent relationship. Many of the participants reported that their family and the family of the abuser were aware of the abuse. Several participants reported that their abuser's family noticed and asked the survivor about the abuse. Many of the survivors disclosed the abuse to their own family and received a wide variety of responses ranging from not believing the survivor to providing tremendous support and a safe place for the survivor and the survivor's children to live. In other cases, it seemed that the families accepted the abuse. Culture also played a role in the survivor's decision to stay or leave an abusive relationship.

"There was an intervention… which my brother-in-law actually said it out loud to his brother, 'you're abusing your wife'. So when I heard it from someone else, that's when I actually, uh, registered that it is abusive."

"In the Hispanic culture, we are raised; women are raised that if your husband is an abuser, you hush your mouth about it. If he is an alcoholic, you hush your mouth about it. If he's a cheater, you don't, um, basically you put up everything for the sake of your children and you do what the man says because if you get divorced that's very bad for your family."

"Yes. I was just looking for somebody to save me, basically. When I would tell people, like my mom or my sister, they knew 'cause it started at my mom's house. Um, but, my parents didn't know how to help me. They were just, 'Why are you with him?'"

"His sister saw bruises on me and she said, 'did John [her abuser] do that to you?' and I'm like, said 'yeah' but it wasn't a surprise to her because that all her family ever knew was abuse."

The participants were all in agreement that their children were a top priority, but in some cases the children were the reason that the survivor stayed in the abusive relationship and in other cases the children were the reason the survivor left the relationship. Participants also shared their fears of their children being taken away if they left the relationship or reported the abuse.

"I had a kid so I really didn't want to leave him 'cause kids need their dad."

"It finally started getting to the point where it was leading to physical abuse and that's when I said, 'that's it.' I have two boys and they're, one is a preteen and one is a teen. And I didn't want them to grow up feeling like that, that was normal and that's a relationship."

3. IPV COPING AND PROCESSING IS NOT UNIFORM, AND SURVIVORS' RESPONSES ARE DYNAMIC OVER TIME.

The survivors provided different perspectives on how they perceived their abuse, how they disclosed their abuse, and what types of screening and programs would be the most effective. Many of the participants went through a phase where they were not aware they were in an abusive relationship, and some of the participants experienced a phase where they either accepted the abuse, but were not ready to leave the relationship. Some participants disclosed their abuse to family, friends, co-workers, and professionals, while others did not tell anyone for years. Some participants reported that they projected a perfect family to the outside world. Many of the participants sought help by themselves when they reached a point of wanting to leave the relationship.

"Honestly, I didn't know. I really thought it was the norm and I have been dealing with it for a long time. I knew something wasn't right. I just thought it was, 'you know, he has anger because, you know, he is military. He's been deployed', different things like that…. It didn't really, like, really hit me that it was 'abusive'."

"I was also in an abusive marriage for about sixteen years, I told no one until I had the money to leave. No one."

"We put up a front, nobody knows but we're dying inside and that affects so much more."

4. SCREENING IN HEALTH CARE SETTINGS MUST BE IMPROVED TO EFFECTIVELY IDENTIFY AND REFER IPV SURVIVORS.

Approximately half of the participants reported they had been screened for IPV by a healthcare professional, but the participants shared many reasons as to why they did not disclose the abuse to a healthcare provider and how screening can and should be improved.

- Screen alone. Many of the participants said their abuser was with them when they were screened for IPV so they were unable to answer truthfully.
- Tell patients what you will do if they respond, "yes" before you screen. Some of the participants expressed fear on not knowing what would happen if they responded truthfully to the screen and suggested that they would be more likely to disclose if they knew what would happen next. In addition, many participants shared that they did not understand the legal system and were fearful of losing custody of their children if they disclosed.
- Providers should improve rapport. Many of the participants reported that they would be more likely to disclose if the providers had better rapport such as listening, making eye contact, and caring for the patient.
- More specific questions. Many of the participants were not aware they were in abusive relationships so they recommended asking specific and direct questions that included questions on non-physical abuse.
- Referral / follow-up. The referrals and follow-up from a positive disclosure must be tailored to the individual patient's circumstance to decrease the risk of violence for the patient.

"It's hard to fill out forms when they're right next to you, watching you…Number one you have to admit to yourself that there's a problem at home. You know, and you don't want to do that. Number two, they're right there next to you and you're like, 'Mmmm, no issues!' You know? So, you just kind of have to just hope for the best."

"You can't even, like, signal to them because it's scary. It's, it's like you're being held hostage. You can't tell nobody."

"Then he finds out you told them and it's like all like hell broke loose again."

"You're always faced with the question of 'should I tell or should I not?'

"The 'do you feel safe?' [question]. No, I, because I couldn't see past that question. If I said yes, 'No, I don't feel safe. No.' Then what happens?

In addition to discussing how to make screening more effective in a healthcare setting, many of the participants shared stories of abuse during pregnancy and said they would disclose IPV at an OB/GYN visit.

"I had been pushed outside the window when I was pregnant. My back got cut all up. Um, I done had my head 'round up against bricks. He used to punch my stomach when I was pregnant… I had done lost a child before too and I had a miscarriage."

"He beat me up when I was pregnant and then, um he was there was there in the hospital talking shit to me right before I was about to have my C-section. … No one knew. The OB, the pediatricians and all them didn't know anything because we look 'regular'. … They never asked if I was okay."

"Especially when you are pregnant because the abuse becomes more."

5. IPV AWARENESS AND INTERVENTIONS SHOULD BE EXPANDED AND REDESIGNED: HELP-SEEKING AT THE COMMUNITY LEVEL

Participants agreed that solely screening in the healthcare setting is not sufficient and a broader community-wide strategy is needed to effectively screen, identify, and connect survivors with community resources. Participants felt that more education and public awareness is needed around IPV, especially non-physical abuse. Participants recommended a variety of venues to educate the community on IPV including public bathrooms, grocery stores, libraries, schools, daycares, hair and nail salons, churches, and pediatric offices. In addition to these venues, several participants shared that their work place played a critical role in identifying and leaving the violent relationship. Two participants became aware that they were in an abusive relationship from a presentation and research at work. Participants also shared that their workplace played a critical role in leaving the abusive relationship by transferring them to a different office and through the services offered by an employee assistance program (EAP).

"I had a policeman come to speak to my office, um, about, um, workplace violence and he was really nice. I had only really met him once and I went to his office. And I talked to him and I said, 'here's what's really going on: he hasn't really hit me but he's put a gun to [my daughter's] head. And I don't know what to do' and he connected me with the shelter."

"That [hair salons] is awesome. That is freaking awesome. Oh my gosh, because let me tell you, I don't know about – but for us, African American women that place, getting our hair done. That is like our sanctuary."

In addition to increasing education and awareness of IPV in the community, most of the participants shared stories of calling the police to report abuse. A few of the participants shared positive stories about the response from the police, but the majority of participants described negative experiences with the police. A couple participants also shared that they tried to call 2-1-1, a helpline that connects callers with social services, but they were unable to talk to a person in a timely manner.

"He got arrested and that's the last time I ever got beat by him."

"They [the police] have been out to my house 38 times in a year. 'You guys are common law and you need to stop fighting' and that's all they say."

"Well, my issue with the law enforcement… was that I couldn't get them to come out to my house… they actually called me back six hours later and asked me, 'Did I still need help, an officer to come out?'"

RECOMMENDATIONS TO IMPROVE IPV SCREENING AND RESPONSE IN HARRIS COUNTY

The ACE Coalition IPV Workgroup identified the following recommendations to improve IPV screening in Harris County based on the literature review, interviews with key stakeholders, and focus groups with the survivors of IPV.

SHORT TERM RECOMMENDATIONS

- Meet with 2-1-1 to obtain call statistics and to reduce wait time for survivors of IPV.
- Meet with organizations that are currently screening for IPV and share the results of our assessment. Emphasize the importance of:
    - Screening alone
    - Asking specific, direct questions that address physical and non-physical abuse
    - Adding a statement about normalizing violence and what will happen if screen is positive
    - Showing compassion and developing a rapport with patients
    - Tracking data
    - Systems approach
- Revise Texas Children's training for healthcare providers and school professionals on recognizing signs of child abuse (SCAN) to include more information on IPV.
- Share the results of the assessment with local collaboratives .
- Identify 3 – 5 OB or pediatric practices that are interested in partnering to pilot a comprehensive IPV screening protocol and conduct a pilot.

LONG TERM RECOMMENDATIONS

- Provide support and monitor the outcomes of the CMS social determinants of health screening initiative.
- Improve data collection and tracking of IPV screening in healthcare practices.
- Conduct research studies on rates of IPV screening, positive responses, and referrals to gain knowledge on best practices.
- Conduct research studies looking at the outcomes of survivors with IPV.
- Partner with community partners such as faith based organizations, hair salons, schools, and daycares on IPV recognition, screening, and response.
- Incorporate IPV recognition, screening, and response into various professional training and licensures such as cosmetologists and hair stylists.
- Partner with work places and employee assistance programs (EAP) on IPV education and response
- Based on the results of the pilot (if successful), partner with a variety of healthcare facilities including primary care, emergency departments, OBs, pediatric practices to improve IPV screening.
- Increase community education and public awareness on IPV and available services.
- Increase capacity of IPV agencies to be able to meet the needs of survivors.
- Identify and implement strategies to improve response from law enforcement. Strategies should include more training and focus on providing relief and keeping survivors safe.
- Embed education on screening and responding to IPV into the education and training of medical professionals.

CONCLUSION

IPV is prevalent and negatively impacts the health and well being of the survivor and the survivor's children. Despite widespread recommendations to screen for IPV, screening rates remain low. In order to increase the identification, screening, and referral a community response is needed. Healthcare providers must do a better job of screening for IPV. Providers must make it a priority to screen patients alone, ask specific direct questions, show compassion, maintain high screening rates, and track data. More community education is needed to better educate the public on IPV, especially non-physical IPV, and the resources available. Resources and information needs to be available in a variety of locations including hair salons, places of faith, schools, grocery stores, and day cares. Police need more training on how to respond to family violence calls. Finally, more evaluation and research is needed to understand best practices for screening, referral, and intervention and improving outcomes for survivors and their families.

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APPENDIX A

Individuals from the following organizations were interviewed:

Archdiocese of Galveston-Houston, AVDA, Baylor College of Medicine, Ben Taub Hospital, Bridge Over Troubled Waters, Children's Assessment Center, Children's Memorial Hermann, City of Houston Health Department, Council on Recovery, Fort Bend Women's Center, Gateway to Care, Harris County Domestic Violence Coordinating Council, Harris County Public Health, Harris Health, Houston Area Women's Center, Kelsey Research Foundation, Legacy Community Health, Memorial Hermann, Northwest Assistance Ministries, Texas Children's Health Plan-- Centers for Children and Women, Texas Children's Hospital, Texas Woman's University, UT Physicians and, University of Houston.