Beyond Screening: A Patient-Centered Approach to Intimate Partner Violence

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Objectives

• Goal: Improve health and safety of patients through intimate partner violence (IPV) prevention and response

• Promote a model trauma informed response to victims of IPV in health centers

• Promote collaboration between health centers and domestic violence/sexual assault community advocacy programs
At the end of this session

1) Discuss the limitations of IPV screening without a plan for those who don’t disclose or a plan for brief interventions for those who do.

2) Understand the role universal education can play in both prevention and intervention.

3) Understand the evidence behind a patient-centered and brochure-based intervention.
1 in 4 (25%) U.S. women report ever experiencing physical and/or sexual IPV.

(Source: 2010 CDC National Intimate Partner and Sexual Violence Survey)
Sexual Assault

1 in 5 women in U.S. has been raped at some time in their lives and half of them reported being raped by an intimate partner.

(Source: 2010 CDC National Intimate Partner and Sexual Violence Survey)
Having a significant impact on health…

Center for Disease Control and Prevention
What We’ve Learned from Research

Studies show:

- Patients support assessments
- No harm in assessing for IPV
- Interventions improve health and safety
- Missed opportunities: patients fall through the cracks when we fail to address IPV routinely and universally in our clinical practice
Support for Screening as a Prevention Strategy

The USPSTF recommends screening women of childbearing age (44 years) for IPV and conducting a follow up with any woman with a positive screen.

Strength of Recommendation - “B”
Affordable Care Act

As of August 2012:
Health plans must cover screening and counseling for lifetime exposure to domestic and interpersonal violence as a core women’s preventive health benefit.

As of January 2014:
Insurance companies are prohibited from denying coverage to victims of domestic violence as a pre-existing condition.
What does the screening brief counseling cover?

- The screening is broadly defined and varies from plan to plan.
- HHS says that it “may consist of a few, brief, open-ended questions.”
- HHS has said that counseling provides basic information, referrals, tools, safety plans, and provider education tools.
- Individual plans will make choices in what to cover.
How do we keep a focus on patient centered trauma informed response?

Not Just Adding a Question on a Form

- Validated assessment tools
- Adding questions to intake forms (electronic or written)
- Combined with universal education and direct inquiry:
  - Setting specific
  - Integrated
  - Brochure based
Why Universal Education?

- Screening alone, without a response is ineffective
  (Feder et al, 2014; O’Doherty et al. 2014)

- Survivors often choose not to disclose

- Missed opportunities to provide IPV educational resources and support services to increase safety and improve clinical and social outcomes.
  (Nelson et al. 2012; Bair-Merritt et al. 2014; McCloskey 2006; Miller et al. 2011)
Disclosure is not the goal

Survivors have many reasons they may not disclose experiences of trauma to their provider:

- Fear of consequences
- Mistrust of systems
- Desire for violence to end, not the relationship
- Potential loss of supports

(Chang 2005; Gerbert 1996)
Survivors request ...

What do survivors say that they want providers to do and say?

- Be nonjudgmental
- Listen
- Offer information and support
- Don’t push for disclosure

(Chang et al. 2006)
Why Universal Education continued

Shifting the health sector response from screening and disclosure to universal education, direct inquiry and brief counseling about the impact of IPV on health with all patients may serve as:

- **primary prevention** (for those never exposed)
- **secondary prevention** (for individuals with histories of IPV)
- **intervention** for those experiencing IPV (including those who do not disclose).
Defining Success

“Success is measured by our efforts to reduce isolation and to improve options for safety.”

Futures Without Violence
Women Who Talked to Their Health Care Provider About Experiencing Abuse Were 4 times more likely to use an intervention such as:

- Advocacy
- Counseling
- Protection orders
- Shelter
- or other services

McCloskey et al. (2006)
“No one is hurting you at home, right?” (Partner seated next to client as this is asked — consider how that felt to the patient?)

“Within the last year has he ever hurt you or hit you?” (Nurse with back to you at her computer screen)

“I’m really sorry I have to ask you these questions, it’s a requirement of our clinic.” (Screening tool in hand -- What was the staff communicating to the patient?)
To overcome barriers we need to combine universal education with screening for IPV.

Starting with universal education followed by face-to-face routine inquiry can facilitate conversation.

Combining universal education with routine inquiry shifts emphasis away from disclosure as the goal.

Health care setting is ideal setting for offering information, reducing isolation, and increasing options for safety.
“I talk about this with all my patients…”

Providing Universal Education on Healthy Relationships
Steps to CUES Intervention

1. **Confidentiality**: Disclose any limits of confidentiality

   **Universal Education** - "I've started giving information to all of my patients about IPV—in case it’s ever an issue for you and also so you can help a friend or family member if it’s an issue for them."

   *Make the connection: Open the card and do a quick review:*

   "It talks about healthy and safe relationships, ones that aren’t and how they can affect your health."

4. **Support**: Visit-specific harm reduction

5. **Warm Referral & Follow up next visit**
Before any discussion of D/SV in the health setting providers must:

• Understand their reporting requirements
• Always talk to patients alone and not within earshot of a partner or family member
• Never use a family member or friend as an interpreter, use medically trained interpreters only
• Disclose the limits of confidentiality
“Before I get started, I want you to know that everything here is confidential, meaning I won’t talk to anyone else about what is happening unless you tell me that you are being hurt physically or sexually by someone or planning to hurt yourself”
UE: How to begin Universal Education

"We’ve started talking to all our patients so they know how to get help for themselves or so they can help others.”

Open safety card or other resource that can be shared with peers.
Opportunity to talk about healthy relationships

Provide primary prevention by identifying signs of an unhealthy relationship.

Educate clients about what they can do if they have a friend or family member who may be struggling with abuse.

Plant seeds for individuals experiencing abuse but not yet ready to disclose.

Help survivors learn about safety planning, harm reduction strategies and support services.
Direct Inquiry

“Is this happening in your relationship?”
Help your patient make the connection between their relationship and health outcomes.

How is my health being affected?

Ask yourself:

- Are you over-eating and gaining weight?
- Do you often find yourself depressed or anxious?
- Do you have frequent headaches and/or chronic back or abdominal pain?
- Have you been diagnosed with hypertension or heart disease?

Any of these health problems may be the result of chronic stress from an abusive relationship. Making these connections can help you take steps towards better health.
S – Support: Positive Disclosure: What now?

- Thank patient for sharing
- Convey empathy for the patient who has experienced fear, anxiety, and shame
- Validate that IPV is a health issue and offer harm reduction strategies
- Let them know you will support them unconditionally without judgment
- Ask patient if they have immediate safety concerns and discuss options.
- Refer to a D/SV advocate for safety planning and additional support.
- Follow up at next visit.
Visit Specific Harm Reduction

- **Adolescent Health**: Anticipatory guidance on healthy relationships
- **Mental Health**: address connection between depression and abuse
- **Primary Care**: trauma informed care plan: (follow up visits, medication adherence, exercise plan, etc.)
- **Reproductive health**: alternate birth control, EC and safer partner notification
- **Urgent Care**: safety planning/lethality assessment
Reproductive Health Example

Futures Without Violence Reproductive Health Safety Card

(Funding: NICHD and HHS, ACF and OWH)
Intimate partner violence increases young women’s risk for Unintended Pregnancies

(Sarkar, 2008)
Women tell us that controlling reproductive health is used as a tool for abuse.

"He [used condoms] when we first started, and then he would fight with me over it, and he would just stop [using condoms] completely, and didn't care. He got me pregnant on purpose, and then he wanted me to get an abortion."
Behaviors to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent.

- Explicit attempts to impregnate a partner against her wishes or interfering with contraception
- Controlling outcomes of a pregnancy
- Coercing a partner to have unprotected sex

Definition: Reproductive and Sexual Coercion
Among a sample of 1278 women ages 16-29 in 5 Family Planning clinics, 53% experienced DV/SA. This mirrors findings from studies nationwide – family planning clients have a high prevalence of violence. Miller, et al 2010.
After Universal Education we offered harm reduction:

- Harm Reduction Counseling

- Birth control that your partner doesn’t have to know about (IUD, Nexplanon)
- Emergency contraception
- Regular STI testing
- STI partner notification in clinic vs. at home
- Opting NOT to engage in partner notification
Supported referral: health providers help client contact relevant DV/SA resources:

- Annotated referral list for violence related community resources
- Staff should know names of staff, languages spoken, how to get there etc.

- Educate clients that the clinic is safe place for them to connect to such resources
- Normalize use of referral resources
- Encourage clients to share information with other friends, loved ones
Among women in the intervention who experienced recent partner violence:

- **71% reduction** in odds for pregnancy coercion compared to control

Women receiving the intervention were **60% more likely** to end a relationship because it felt unhealthy or unsafe

(Miller et al. 2010)
Cluster-randomized controlled trial

25 family planning clinics in Western PA (3600+ women ages 16-29)
4 month and 12 month follow up after clinic visit

- **Primary outcomes**: partner violence victimization and reproductive coercion
- **Secondary outcomes**: unintended pregnancy; knowledge and self-efficacy related to harm reduction strategies and victim services

Funding: NICHD R01HD064407 (Miller et al. 2016)
Key findings:

• Intervention had no effect on RC, IPV, or unintended pregnancy for the entire sample.

• Intervention increased:
  ▪ Self-efficacy to implement harm reduction behaviors
  ▪ Knowledge of IPV-related resources (33.5% vs. 9.9%)
  ▪ Use of the National Domestic Violence Hotline (93% vs. 87%)
  ▪ Sharing National Domestic Violence Hotline number with someone else (9.5% vs. 4.8%)

▪ Reproductive coercion declined by 90% one year later among women with higher RC scores at baseline

(Miller et al. Contraception 2016)
Adolescent Health

- Anticipatory guidance on healthy relationships
- Direct assessment
- Harm reduction
- Warm referral

Everybody Texts

Getting a lot of texts can feel good—“Wow, this person really likes me.”

What happens when the texts start making you uncomfortable, nervous, or they keep coming nonstop?

Figuring out what to say can be hard, especially if you like the person.

Be honest. “You know I really like you, but I really don’t like it when you text me about where I am all the time or pressure me for naked pics.” For more tips on what to say go to: www.thatseatcool.com.
Cluster-randomized trial in 8 school health centers in California -- School Health Center Healthy Adolescent Relationships Program (SHARP)

**Intervention components:**
healthy relationships card distributed with every clinic visit
direct assessments for sexual health related visits
school-wide youth advisory-led relationship abuse awareness

Funding: National Institute of Justice
2011-MU-MU-0023
### Findings from the NIJ randomized controlled trial in school based health centers

- Increased recognition of what constitutes abusive behavior and sexual coercion
- Increased awareness of ARA resources
- Among youth with recent ARA victimization, less ARA victimization reported at three month follow up
- Increased likelihood of disclosing any ARA to the provider during clinic visit

(Miller et al. *Pediatrics* 2015)
Clients were overwhelmingly positive about receiving this information from their provider:

- **84%** state they would bring a friend to the health center if they were experiencing an unhealthy relationship
“I was in a really bad relationship and talked to them [providers at SBHC], I got out of it. Like, they helped me to realize that I’m way better and I deserve better, and it actually helped. It boosted my confidence in myself and I became a more independent young woman, I think.”
Evidence-based Interventions

Reproductive coercion intervention: decreased RC and increased awareness of harm reduction
Adolescent relationship abuse intervention: decreased ARA

Both interventions:
- Increased knowledge of local IPV/SV resources
- Clients indicated high likelihood of sharing with friends/family
- Clients appreciated opportunity to discuss relationships with providers
Other Setting/visit-specific Resources

Reproductive Health

Adolescent Health

Pediatrics

Behavioral Health

Did You Know Your Relationship Affects Your Health?

Connected Parents/Connected Kids

Hanging out or Hooking up?

Relationships, Support and Wellness
“I think all of us had that epiphany. We didn’t make the connection between women that were perpetually late for their Depo, or women who kept calling and saying they lost a pack of pills or coming in 3 months late to refill their pills… Reframing our thinking on various obstacles in women’s lives and how they are affecting their reproductive choices.”
Provider perspectives

“(The safety card) made me feel empowered because... you can really help somebody,... somebody that might have been afraid to say anything or didn’t know how to approach the topic, this is a door for them to open so they can feel... more relaxed about talking about it.”
“They would bring out a card, basically walk in with it and she would open it and ask me had I ever seen it before. ... It was awesome. She would touch on having, no matter what the situation you’re in, there’s some thing or some place that can help you. I don’t have to be alone in it. That was really huge for me because I was alone most of the time for the worst part.”
Client perspectives

“I went in for a pregnancy test… And it was the nurse practitioner [who gave me the card]. Me and her were talking and I was able to tell that she genuinely cared, that’s what I felt from her. They just let me know that there was the help out there.”
Client perspectives

“[Getting the card] makes me actually feel like I have a lot of power to help somebody…”
“So there’ll be times where I’ll just read the card and remind myself not to go back. I’ll use it so I don’t step back. I’ll pick up on subtle stuff, cause they’ll trigger me. I remember what it was like. I remember feeling like this, I remember going through this. I’m not going to do it again. For me, it just helped me stay away from what I got out of. I carry it with me actually, I carry it in my wallet. It’s with me every day.”
Your Role is Important - **DOABLE**

- Providers do not have to be IPV experts to recognize and help patients experiencing domestic and/or sexual violence
- You have a unique opportunity for education, early identification, and intervention
- And to partner with domestic and/or sexual violence agencies to support your work and promote health outcomes.
Partnering with a Domestic/Sexual Violence Program

- Advocates provide their clients risk assessment, safety planning, and support.
- Assist survivors and children who have experienced IPV to think and act in a way to increase personal safety while assessing the risks based on the perpetrators behaviors.
- Connect clients to additional services like:
  - Housing; Health; Legal advocacy; Support groups/counseling
- Strengthen clinical responses to D/SV in many ways.
Sustainable Programs: Systems Reform Model

• Changing environment to be client-centered, trauma-informed, inclusive of diverse backgrounds
• Multi-disciplinary team approach
• Systems reforms
  - Policies and procedures
  - Forms and electronic records
  - Measurement and benchmarks
• Addressing staff exposed to violence
• Implementing reflective supervision
National Health Resource Center on Domestic Violence

For free technical assistance and tools including:

- Patient education safety cards
- Training curricula
- Clinical guidelines
- State reporting information
- Documentation tools
- Pregnancy wheels
- Posters

For more information, please visit the National Health Resource Center on Domestic Violence website.