Family Violence
PREVENTION &
HEALTH PRACTICE
AN E-JOURNAL OF THE FAMILY VIOLENCE PREVENTION FUND

Jun 25, 2010

Implementing Intimate Partner Violence Screening in Family Planning Centers

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Acknowledgements
The authors would like to thank the many people who have contributed over time to the work described in this paper, including Drs. Leslie Davidson and Vaughan Rickert at Columbia University, and Anne Robinson, Leslie Rottenberg, and Jini Tanenhaus from Planned Parenthood of New York City. The opinions expressed in this article do not necessarily reflect those of Planned Parenthood Federation of America, Inc. Research discussed in this paper were funded by the Centers for Disease Control (U49 CE000731) and the Robert Wood Johnson Foundation.

Implementing Intimate Partner Violence Screening in an Urban Family Planning Center

At Planned Parenthood of New York City (PPNYC), which serves a large number of clients annually from diverse racial, ethnic, and age groups, staff from our three health care centers perceive intimate partner violence (IPV) as a pressing and critical issue. In 1998 when revisions were being made to medical history forms, PPNYC recognized the importance of incorporating brief standard screening questions to identify clients who had experienced sexual and physical

assaults. The screening questions were chosen from the available research literature about health care and IPV screening. With this change came a new policy and procedure for screening and referral processes, which included training of health care staff and required universal screening and referral. All health care clients are screened for IPV, regardless of gender or type of relationship, including marital, dating, and same-sex partnerships. Since PPNYC's clients are primarily women (98%), this paper focuses on female clients.

Research to Develop a New Screening Tool

In 2003, researchers from PPNYC and Columbia University began a collaborative investigation into the prevalence and nature of intimate partner violence in young women ages 15 to 24 years. The focus of this project was to develop an IPV screening approach to identification, management, and referral within health care settings that would be acceptable to younger women, who had not been the focus in previous publications about screening. It included the development and testing of a comprehensive IPV screening tool and a provider training component focused on working with young women. Before the project began, PPNYC conducted a brief survey to assess provider attitudes and practices regarding screening for IPV (N = 15). Eighty-seven percent of providers were overwhelmingly supportive of the need for screening but more than half (60%) were generally concerned about how to incorporate the screening into an already busy schedule. It was, therefore, critical for the project to develop a new screening tool that would enhance clinical practice and not deter from other tasks and activities of the health care setting. The definition of IPV we used to guide this project was as follows: a pattern of assaultive and coercive behaviors that may include physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. We looked at these behaviors as perpetrated by someone involved in an intimate relationship where the actions were aimed at establishing control by one partner over another. The initial research project had two phases.

In Phase I of the project (see Zeitler et al., 2006), we conducted an anonymous survey to investigate the attitudes and expectations of young women concerning physical, verbal, and sexual intimate partner violence as well as their attitudes toward screening by health care providers. Women completed an audio-assisted computer survey that employed the validated Conflict in Adolescent Dating Relationship Inventory (Wolffe, Reitzel-Jaffe, Wekerle, Rasley, & Straatman, 2001). This tool measured self-reported experiences with an intimate partner's violent behavior and included several open-ended questions. Of the 645 ethnically diverse women aged 15 to 24 who were family planning patients, 45% (290) reported having EVER been abused by a partner (physical, sexual, or emotional). Of those who had been abused, 55% (159) reported that they had been asked by a provider, but only 20% (58) had disclosed the information when asked. Ninety percent (580) of women responded positively to being screened, saying that they would not mind answering screening questions in the health care setting. Among the choices for whom they would want to talk to about IPV more women reported that they wanted to speak with a health care provider (95%) compared to their mother (90%) or a counselor (89%).

55% of women who disclosed abuse said that they had been asked about IPV by a provider, but only 20% had disclosed the information when asked.

The survey results were augmented by women's qualitative comments on the necessity of talking about one's problems in order to solve them. Women said that screening could serve an educational purpose to help young women recognize different forms of control. In addition, we found that the language used to ask the questions was of paramount importance. For example, women reported discomfort with the word "abuse" and said that they preferred responding to descriptions of behaviors rather than labels. Based on the results of Phase I, we developed training for providers and provisional screening tools that were piloted in the same health center six months later.

In Phase II (see Rickert et al., 2009), we piloted three sets of screening questions that were added to the standard medical history form completed by all health center clients as follows: a version that asked about IPV victimization only, a version that asked about a broader range of relationship issues, and one that asked about the woman's use of violence in addition to her victimization. Young women, 15 to 24 years of age, were randomly assigned to complete one of the three tools for violence screening (N = 799). No significant differences emerged between the three screening tools for reports of physical and/or sexual abuse ever or within the last year. We also assessed provider feasibility and acceptability across the three screening approaches and found no significant differences. Providers, on the average, were comfortable talking about IPV with any of the approaches. Overall, the findings from Phase II of the study suggested that brief screening for IPV could easily be incorporated into health care services without interrupting the patient flow.

Policy and Practice Changes Resulting from the Initial Phases of Research

The researchers brought these findings to PPNYC health care providers and administrators for a discussion about how the study could impact their practice. Additionally, other new studies provided evidence that the use of standardized screening questions increased the frequency of provider discussions with patients about IPV and of higher identification rates among OB/GYN clinics that implemented screening protocols versus those that did not (e.g., Trabold, 2007). This may be due to the "normalizing" of IPV screening questions for both patients and providers by including the questions within the routine context of collecting medical history information (Owen-Smith et al., 2008). This also signals to patients that abuse is viewed as an important health care issue.

There was overwhelming support for revising the policy for identifying IPV with a new set of questions that would contain language focused more on specific behaviors rather than on abstract labels of "abuse." Providers also wanted to ensure that the new screening questions would help situate any questions about IPV into the context of the woman's relationship. Due to the growing body of evidence on the impact of both past and current abuse, providers wanted to screen for both. With this in mind, a committee of health care professionals collaborated with the researchers to develop the new policy and screening tool. The revised screening tools included the new questions shown in table 1. The revised policy included universal screening of all patients as part of their medical history. A written and verbal screen is conducted, and patients are referred to an on-site social worker for further assessment and planning and additional referrals to local IPV organizations and hotline numbers. Not only did this research impact the policy and practices of PPNYC, but the umbrella organization for this agency center, Planned

Parenthood Federation of America, also developed a policy that encourages IPV screening by all of its affiliates.

Table 1. Screening questions

Old Screening Form	New Screening Form
Has anyone ever raped you? [ ] Yes [ ] No My partner hit, slapped or abused me. [ ] Yes [ ] No	<u>In the past year:</u> Things have been going well in my relationship. 1=Never, 2= Seldom, 3=Sometimes, 4=Often, 5=Always My partner threatened or frightened me. 1=Never, 2= Seldom, 3=Sometimes, 4=Often, 5=Always My partner forced me to have sex when I didn't want to. 1=Never, 2= Seldom, 3=Sometimes, 4=Often, 5=Always My partner hit, slapped or physically hurt me. 1=Never, 2= Seldom, 3=Sometimes, 4=Often, 5=Always <u>Ever:</u> Have you ever been slapped, hit or physically hurt by a partner? [ ] Yes [ ] No Has anyone ever raped you or forced you into a sexual act? [ ] Yes [ ] No

Evaluation of the New Screening Tool

After the new screening tool and policy were in place for one year, a comparative study was conducted to compare IPV disclosure rates of women who had completed the original older screening tool in 2006 (n=420) and those who completed the new screening questions in 2007 (n=385) (see table 1; Colarossi, Breitbart, & Betancourt, 2009a). Data were collected from chart reviews of randomly selected patients across the three PPNYC health centers. Twenty-two percent (85) of women completing the newer form disclosed current and/or past IPV, compared to 9% (38) of women who answered the older questions. No reporting differences were found by race/ethnicity, health center location, marital status, primary language, payment, or service type. Further logistic regression analyses revealed that after controlling for age, women completing the new screening form were more than 2.5 times more likely to report past and current violence (mutually exclusive) and over 4 times more likely to report experiencing both past and current violence compared to women who reported the original screening form.

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We believe that asking only a few more screening questions, which used language about specific behaviors and allowed for more response options (a scale rather than yes/no for most questions), and specifying the time frame provided options for women to report IPV that were not as constraining or stigmatizing as using language such as "abuse" and definitive yes/no responses without a context that were used on the older form.

To further evaluate our updated screening policy for provider barriers to screening, we conducted five focus groups with seventy-five PPNYC health care providers, of whom 65 (87%) also completed written surveys about barriers to screening in family planning clinics (see table 2 for sample questions from the survey). Providers included certified nurse-midwives, nurse practitioners, physician assistants, social workers, and health care associates. Barriers included lack of time, training, and referral resources. Attitudes toward screening were positive overall, but a number of providers expressed frustration with clients' lack of follow-up to recommended referrals, were concerned about taking too much time away from other health care matters, and believed that certain job roles were more appropriate for conducting screening than others. Providers also expressed a desire for more training about the connection between IPV and reproductive health as well as for responding to disclosures of violence (Colarossi, Breitbart, & Betancourt, 2009b). As a result, a training session was scheduled with a trainer from the Family Violence Prevention Fund on reproductive control and related counseling techniques.

Future Directions

In the last 10 years, research on IPV and reproductive health has expanded in both breadth and depth from studying the association among IPV and reproductive health outcomes to identifying mechanisms of influence and empirically based screening practices. Evidence for mechanisms of influence, including birth control sabotage, pregnancy manipulation, health care monitoring, and partner refusal to use a condom (Levenson, 2009; Miller, 2007; Williams, Larsen, & McCloskey, 2008; Wingood & DiClemente, 1997) support an expanding role for reproductive health professionals. Future directions for research should include a focus on the ways to reduce pregnancy risks associated with partner control or coercion of birth control such as the provision of long acting contraceptives. We will be considering how to integrate general IPV screening questions with questions focused on reproductive control. Partner control over condom use also presents challenges for new interventions to reduce STI and HIV infections.

In our practice, we believe that universal IPV screening should be implemented in all reproductive health care settings using standardized, empirically tested screening instruments and response protocols. While significant strides have been made in understanding how IPV affects sexual and reproductive health, providers need to be aware that this is a prevalent health care issue that requires universal screening and appropriate follow-up assessment and referral. This includes improvements in youth-friendly services for teen dating violence and health care, and expanded education and outreach services to immigrant communities with specialized expertise in language and cultural barriers.

PPNYC has also made recent efforts to increase coordinated community responses between health care professionals and IPV specialists by convening an initial discussion group of interdisciplinary providers across New York City. Screening for IPV is only as helpful as the

response that follows. Health care providers can discuss health care needs and safety plans specifically for reducing the risk of reproductive health problems, but bridging social service providers and health care providers is needed to coordinate a full range of services for clients experiencing abuse. Making a referral is not as helpful as facilitating access for a survivor between well-trained health care and social service providers knowledgeable about partner violence. To promote such relationships, increased cross-training is needed about the specific connections between physical and sexual violence, reproductive coercion, and reproductive health, including relationship dynamics that: inhibit the use of condoms, interfere with birth control methods and lead to unwanted pregnancy; monitor or restrict access to health care; and impact pregnancy continuation and termination.

Finally, the public must be aware of the range of behaviors associated with partner violence and its effects on reproductive health. Health care recipients who do not have knowledge about the connection between relationship dynamics and reproductive health problems, including increased risk for sexually transmitted infections and HIV, unwanted pregnancy, miscarriage, and urinary tract infections, may not understand why they are being screened for IPV by a reproductive health provider nor be able to take advantage of health care options that may be helpful. There is a need for more provider training, but also for public campaigns and health center waiting room visual materials to increase knowledge and understanding about the link between reproductive health and intimate partner violence.

Table 2. Examples of questions on the provider survey
Please indicate how much you agree or disagree with each statement

	Stro ngly Disagree	D isagree	eutral	gree	Str ongly Agree
It is important for reproductive care providers to ask patients about relationship violence.	1	2			5
If both partners had better communication skills, relationship violence would not occur.	1	2			5
Asking patients about violence opens the door to time-consuming activities that aren't part of my job.	1	2			5
Asking patients about violence is frustrating because they don't want to leave their partner.	1	2			5
Violence in dating relationships is not as serious as violence in marriage or longer-term relationships.	1	2			5
It is easier to discuss relationship violence with a teen than with an adult.	1	2			5

It is the patient's responsibility to seek out referrals for help with relationship violence.	1	2			5

We acknowledge that you follow the PPNYC protocol on partner violence. We would like to know whether you agree or disagree that each factor below makes it more difficult to discuss partner violence with patients.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
There is not enough time to identify and refer patients for partner violence in addition to attending to other health concerns.	1	2			5
There is a lack of adequate training in identifying and referring victims of abuse.	1	2			5
Once identified, there is a lack of resources to refer patients to outside of PPNYC.	1	2			5
I fear for the patient's safety	1	2			5
I am uncomfortable discussing abuse with my patients.	1	2			5
I do not think my patients want me to ask them about it, if they haven't told me themselves.	1	2			5
The patient is from a different background than mine.	1	2			5
Language differences make this discussion difficult.	1	2			5
My patients' relationship violence history is none of my business.	1	2			5
I am afraid that patients will have an emotional response if I ask them about it.	1	2			5
Patients rarely desire a referral or want help with relationship violence.	1	2			5
If the patient won't leave the relationship, I shouldn't spend my time talking to them about it.	1	2			5
My personal experiences make it difficult for me to discuss this topic with my patients.	1	2			5

For the following items, please indicate how much you would like more professional development on each of the topics below.

	Not prepared	A little prepared	Somewhat Prepared	Prepared	Very prepared
Asking directly about any observed physical injury.	1	2	3	4	5
Asking directly about emotional state, such as depression, stress, or sadness.	1	2	3	4	5
Accepting the patient's decision, whatever it is.	1	2	3	4	5
Documenting a statement from a patient about abuse.	1	2	3	4	5
Documenting injuries related to abuse.	1	2	3	4	5
Referring the patient to a social worker.	1	2	3	4	5
Bringing up the issue when the patient returns for another visit.	1	2	3	4	5
Doing a risk assessment with the patient.	1	2	3	4	5
Providing appropriate treatment or referral for injuries.	1	2	3	4	5
Creating a safety plan with the patient.	1	2	3	4	5
Talking about the dynamics of abuse with the patient.	1	2	3	4	5
Calling the Domestic Violence Hotline with a patient.	1	2	3	4	5
Asking about relationship violence at every appointment, whether or not patient discloses on the medical history.	1	2	3	4	5
Informing the patient she is not to blame.	1	2	3	4	5

References

Colarossi, L. G., Breitbart, V., Betancourt G. (2009a). *Screening for Intimate Partner Violence in Reproductive Health Settings: An Evaluation Study.* Biannual meeting of the Family Violence Prevention Fund, New Orleans, LA.
Colarossi, L. G., Breitbart, V., Betancourt G. (2009b). *Provider Barriers to Screening for Partner Violence in Reproductive Health Clinics: A Mixed Method Study.* Biannual meeting of the Family Violence Prevention Fund, New Orleans, LA.
Hathaway, J.E., Willis, G., & Zimmer, B. (2002). Listening to survivors' voices: Addressing partner abuse in the healthcare setting. *Violence Against Women,* 8(6): 687-719.
Levenson, R. R. (2009). Male reproductive control of women who've experienced intimate partner violence in the United States: An unexplored dimention. Biannual meeting of the Family Violence Prevention Fund, New Orleans, LA.
Miller, E. Male partner pregnancy-promoting behaviors and adolescent partner violence: Findings from a qualitative study with adolescent females, *Ambulatory Pediatrics,* 2007; 7(5):360-366.
Owen-Smith, A., Hathaway, J., Roche, M., Gioiella, M.E., Whall-Strojwas, D. & Silverman, J. (2008). Screening for domestic violence in an oncology clinic: Barriers and potential solutions. *Oncol Nurs Forum,* 35(4): 625-633.
Rickert, V.I., Davidson, L.L., Breitbart, V., Jones, K., Palmetto, N.P., Rottenberg, L., Tanenhaus, J., Steven, L. (2009). A randomized trial of screening for relationship violence in young women. *Journal of Adolescent Health,* 45, 163-170.
Trabold, N. (2007). Screening for Intimate Partner Violence within a health care setting: A systematic review of the literature. *Social Work and Health Care,* 45, 1-18.
Williams, C. M., Larsen, U., and McCloskey, L. A. (2008). Intimate partner violence and women's contraceptive use. *Violence Against Women,* 14(12), 1382-1396.
Wolfe, D. A., Reitzel-Jaffe, D., Wekerle, C., Grasley, C., Straatman, A. (2001). Development and validation of the conflict in adolescent dating relationships inventory, *Psychological Assessment,* 13, 277-293.
Zeitler, M.S., Paine, A.D., Breitbart, V., Rickert, V.I., Olson, C., Stevens, L., Rottenberg, L., Davidson, L.L. (2006). Attitudes about intimate partner violence screening among an ethnically diverse sample of young women. *Journal of Adolescent Health,* 39, 119.el-119.e8.

ISSN 1556-4827