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Reaching Out

Asking about partner violence in
Toronto teaching hospitals

CRICH

CENTRE FOR RESEARCH ON INNER CITY HEALTH

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About this Report

This study looks at intimate partner violence (IPV) screening practices in several teaching hospitals across Toronto. The project was completed as part of an educational partnership between the Centre for Research on Inner City Health at St. Michael's Hospital (CRICH), and the University of Toronto Faculties of Medicine, Public Health, and Public Policy. Three graduate students in medicine and public policy completed the project over a 7-week period.

The scientific literature suggests it is good practice for health care providers to ask women if they are experiencing violence. At the same time, research from CRICH demonstrates that, to be effective, screening programs require institutional support, training for providers, protocols, and access to appropriate external and internal services (O'Campo et al, 2011).

To help direct future, solutions-based research, we conducted this partial environmental scan of hospital-based screening practices in Toronto. Our goal: begin to explore current screening practices, as well as barriers and facilitators to screening. The resulting report provides some insight into the current IPV screening landscape across 8 Toronto teaching hospitals. Recommendations are informed by interviews with health care providers, administrative staff and scientists engaged in IPV research.

Intimate Partner Violence (IPV)

Intimate partner violence (IPV) is the systematic use of tactics to establish and maintain power and control over the thoughts, beliefs, and conduct of a person through the inducement of fear and/or dependency. It includes emotional, financial, physical, and sexual abuse as well as intimidation, isolation, threats, using the children and using social status and privilege (Registered Nurses Association of Ontario, 2005).

IPV is a widespread public health issue. Previous research indicates that as many as 54 per cent of women presenting to clinical settings have experienced IPV in their lifetimes (Coker et al, 2000). Victims of IPV use health care services at higher rates than non-victims (Campbell, 2002) and evidence suggests that use of medical services increases with the severity of physical assault (Coker et al 2000; Koss et al, 1991), offering health care providers an opportunity to detect and intervene.

Screening for IPV

Screening for IPV in health care settings can improve health outcomes for women. Effective interventions can reduce violence, abuse, and physical and mental harms. At the same time, evidence suggests there are minimal to no adverse effects of screening (Moyer, 2013; Spangaro et al, 2009). Studies indicate that most women – whether they are experiencing violence or not – do not mind being asked about IPV (Campbell et al, 2002; Dienemann et al, 2005). Health services are widely used by women, making hospitals a primary point of contact for many experiencing violence.

A number of professional groups (Registered Nurses Association of Ontario, The Canadian Orthopedic Association, The Society of Obstetricians and Gynaecologists of Canada, and the U.S. Preventative Services Task Force) have recommended universal screening, yet response by providers has been inconsistent (Sprague et al, 2014). Research has shown that doctors rarely screen all patients for IPV, often doing so only if the patient presents obvious physical signs of possible abuse. Barriers to provider screening for IPV have been well documented in the literature and align with the findings from our study (see pg. 6). As a result, IPV continues to be under-identified in hospitals.

There are two main approaches to screening for IPV:

- **Universal screening:** occurs when health care providers regularly ask every woman about her experience with IPV. Although this may not happen at every visit, it is a routine part of most health care encounters. Evidence demonstrates that universal screening is more effective at uncovering violence than case-finding. As an example, health care providers are able to uncover high blood pressure in patients by taking everyone's blood pressure on a routine basis.
- **Case-finding:** occurs when health care providers ask women about their experiences with IPV only if they observe one or more indicators that suggest a woman may have been abused.

Further reading on prevalence and consequences of IPV

Campbell, J., Snow-Jones, A., & Dienemann, J. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, 162, 1157-1163.

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Cleary, B. S., Keniston, A., Havranek, E. P., & Albert, R. K. (2008). Intimate partner violence in women hospitalized on an internal medicine service: Prevalence and relationship to responses to the review of systems. *Journal of Hospital Medicine*, 3, 299-307.

Coker, A. L., Smith, P. H., McKeown, R. E., & King, M. J. (2000). Frequency and correlates of intimate partner violence by type: Physical, sexual, and psychological battering. *American Journal of Public Health*, 90, 553-559.

Sprague, S., Goslings J.C., Hogentoren, C., de Milliano, S., Simunovic N., Madden, K. and Bhandari, M (2014). Prevalence of Intimate Partner Violence Across Medical and Surgical Healthcare Settings: A Systematic Review. *SAGE*, 20, 118-136.

Further reading on IPV screening

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- Taket, A., Nurse, J., Smith, K., Watson, J., Shakespeare, J., and Lavis, V. (2003). Routinely Asking Women About Domestic Violence in Health Settings. Education and Debate. *British Medical Journal*, 327, 672-676.
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Dienemann, J., Glass, N. and Hyman, R. Survivor Preferences for Response to IPV Disclosure. *Clinical Nursing Research*, 14, 215-233.
- Feder, G., Ramsay, J., Dunne, D., Rose, M., Arsene, C., Norman, R., et al. (2009). How far does screening women for domestic (partner) violence in different health care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment*, 13(16).
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- Phelan, M.B. (2007). Screening for Intimate Partner Violence in Medical Settings. *Trauma, Violence, and Abuse*, 8, 213.
- Ramsay, J., Richardson, J., Carter, Y. H., Davidson, L., & Feder, G. (2002). Should health professionals screen women for domestic violence? Systematic review. *British Medical Journal*, 325, 314.
- Spangaro, J., Zwi, A., & Poulos, R. (2009). The Elusive Search for Definitive Evidence on Routine Screening for Intimate Partner Violence. *Trauma, Violence & Abuse*, 10, 55-68.

Key findings

- Intimate partner violence (IPV) screening processes are not uniform across Toronto teaching hospitals. Hospitals and departments use different approaches when screening for IPV.
- There are a number of barriers and enablers to screening patients for IPV. These must be considered when taking steps to improve IPV screening practice.
- Debate remains around the most effective ways to screen women for IPV.

What we did (methodology)

Study question and design

We wanted to identify how IPV is being addressed in Toronto hospitals to better understand how to improve IPV screening practices. To do this, we created a study design to:

- Investigate screening practices in sub-specialty departments across Toronto teaching hospitals.
- Identify perceived barriers and enablers to screening as well as screening preferences among providers.

Interviews

Using a snowball sampling technique, we conducted 20 key informant interviews with health care providers (doctors, nurses and social workers), administrative staff, and scientists from 8 teaching hospitals across Toronto. These teaching hospitals were easily accessible given their relationship with the University of Toronto and the Centre for Research on Inner City Health, and, in some cases, contacts and relationships had already been established. Due to logistical constraints, we were unable to systematically interview individuals from all departments across each hospital. Interviewees worked in departments and specialties identified in the literature as important points of contact for individuals experiencing IPV, including but not limited to emergency medicine, orthopedics, obstetrics and gynecology, psychiatry, pediatrics, and women's medicine.

Who was not included in our interviews?

- Community and private/individual practices: While these practices are an important part of IPV screening and prevention efforts, it was outside the scope of this project.
- Health care providers in other jurisdictions: The context of the project is Toronto teaching hospitals and so providers outside of this jurisdiction and non-teaching hospitals within Toronto were excluded.
- Other providers in the IPV service delivery network (police, shelters, social services, community agencies): Although these institutions and individuals have unique perspectives on the overall landscape of IPV screening-associated practices, it was outside the scope of this project.

Analysis of Interviews

Interviews lasted approximately thirty minutes and were conducted in person and over the phone by two team members. One team member led the discussion while the other transcribed responses. Interviews were not recorded or transcribed verbatim. The interviews were then coded using NVivo 10.0 for recurring themes, which informed our findings and recommendations. Themes from the interviews were supported by a review of the literature on hospital IPV screening and a review of data or documentation provided by hospitals such as institutionalized screening protocols.

Study highlights/key findings

Screening practices vary across hospitals

Our study found that IPV screening practices vary across hospitals, as does the success of screening programs. Of the 12 departments we contacted across 8 hospitals, we found three departments (two emergency departments and one antenatal department) that engaged in routine, universal screening practices. These three departments all had related training and protocols in place. The remaining departments described case-finding approaches, and two of these required initial IPV training for new staff. In one case, an informant suggested that case-finding was used across the entire hospital. It should be noted that we were unable to include all departments across all 8 Toronto teaching hospitals in this study. As a result, other departments might conduct universal screening, and the question of the degree to which universal screening is used in Toronto hospitals is a subject for future study.

Perceived barriers to universal screening

A number of barriers to universal screening were identified during our interviews. Barriers discussed most frequently included:

Lack of knowledge on IPV – Participants voiced concerns about their lack of understanding around how to screen and the benefits of screening patients universally for IPV. Participants also explained that because of a limited ability to follow up with patients, they did not know whether patients used or benefited from the services and resources provided to them.

“There isn’t an even distribution of knowledge. What I see as warning signs may not come up for my colleagues. They might only notice the blatantly obvious signs (bruises etc.) or correlates (number of emergency visits, returns, etc.) but not notice signs of emotional or psychological abuse.”

Competing priorities and lack of time – Participants, particularly those involved in fast-paced departments with time constraints, explained that screening for IPV is not always a top priority compared to other health concerns when seeing patients.

“The ER is busy and asking [about IPV] may slow things down because if someone discloses abuse, then you have to do something about it.”

Harming patient – Participants discussed the additional problems that can be caused for women when a provider does screen properly.

“You get a lot of people who are not necessarily good at it [asking about IPV] and women who have experienced abuse may actually feel re-victimized as a result.”

Lack of privacy – Participants explained that screening women for IPV might be particularly difficult due to privacy constraints. A partner's presence or a lack of private space within the department poses challenges to screening.

“A clinic filled with cast technicians, nurses, and a thin curtain between patient gurnies offers no privacy for the kind of questions that might uncover or illuminate IPV in follow-up visits.”

Perceived enablers to IPV screening

Interview participants also discussed the factors that would enable them to screen and facilitate successful screening practices within health care settings. The most commonly discussed enablers included:

Institutional Support – Participants explained that support throughout all levels of their organizations was necessary to facilitate and promote screening programs and processes.

“The CEO thinks it is important and supports everything we do. We are allowed to put posters everywhere and put brochures in all waiting rooms.”

IPV training – Participants suggested providers receive IPV training as a response to the lack of knowledge of the issue. Some participants felt that providers would be more comfortable and effective at screening if they received the proper training.

“If you are going to screen there should be an orientation or workshop on it since it is not the easiest thing to approach.”

Personal motivation – Some participants explained that their personal knowledge and experiences with IPV encouraged them to screen women. They recognized the negative impacts of violence on the health of women and felt a responsibility to screen.

“I’m motivated by personal experiences I’ve had with friends and family, and because I care about making women safe in their own homes.”

Differing personal opinions on IPV screening

Our interview participants had differing opinions on which approach to IPV screening is most appropriate and effective. We found that participant opinions on screening approaches were shaped by what they thought was best and most beneficial for the patient.

I do believe in universal screening

“[It] gets you off the hook for making assumptions or offending someone. You can say, ‘This is a question we ask everyone.’ It gives health care providers an out because they can diffuse any discomfort.”

I do not believe in universal screening

“You can’t screen if you don’t do it the right way. It can almost be more harmful to take someone off guard, like a woman who has protected herself by hiding it for years... We can’t have a prompted disclosure if nothing happens after. Let’s NOT ask people if we aren’t prepared to do anything.”

Further reading on barriers to screening

Salber, P.R., McCaw, B. (2000). Barriers to Screening for Intimate Partner Violence: Time to Reframe the Question. *American Journal for Preventative Health*, 19, 276-278.

Sprague, S., Madden, K. Simunovic, N, Godin, K, Ngan, K. Bhandari, M., and Goslings, J.C. (2012) Barriers to Screening for Intimate Partner Violence. *Women and Health*, 52, 587-605

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Summary and recommendations : Creating a community of practice to identify and respond to IPV in health care settings

Screening women for intimate partner violence across hospitals must be tailored to meet the needs of patients, health care providers and various clinical settings. This includes ensuring women feel comfortable and safe, supporting providers so they are well-informed and competent to screen, improving awareness of the various cultural perceptions and sensitivities around IPV screening, and responding to department-specific constraints (structural barriers, privacy, time). Providing the necessary institutional support, protocols, training and support services will aid in implementation of successful screening programs across hospital settings and will require efforts between researchers, policy makers, and health care providers and administrative staff.

Our project found that there are different approaches to IPV screening across hospitals. We believe it is important to identify the strengths and weaknesses of these screening programs, and use these to improve our understanding of the benefits of universal screening across health care settings.

For Policy Makers

Make IPV screening a public health priority. With the right supports, universal screening can be effective in healthcare settings (O'Campo et al 2011) and improve health outcomes for women (Blair-Merritt et al, 2010; McFarlane et al, 2006). Justice Canada estimates that IPV costs \$7.4 billion annually in health care and other related costs; earlier identification and effective intervention can help reduce these costs while lessening the burden on thinly-stretched health care systems. With this in mind, the Ministry of Health and Long Term Care should continue its support of research into IPV screening. The Ministry should also engage in consultations with key stakeholders including health care providers hospital administrators about how it can best support universal screening for IPV within these settings.

Consider adopting a provincial or national definition of intimate partner violence. Standardizing the definition of IPV will ensure that researchers, policy makers, and clinicians are basing decisions on a universal understanding of what IPV is and will allow for more comparable evaluation studies of screening tools and approaches.

For researchers

Address the need to determine appropriate outcomes for IPV screening programs. In general, the success of most clinical screening programs (such as mammography or checking blood pressure) are evaluated based on their ability to improve specific health-related outcomes for patients. When trying to identify and respond to IPV, researchers need to consider that measurable health improvements may not be appropriate markers for success for IPV screening. Rather, more proximate outcomes should be considered, including increased disclosure rates and/or referrals to IPV services (Kirst et al, O'Campo et al). Engage in research on the translation of policies to practice in health care departments. The real-life practicality of policies (lack of time, competing priorities, lack of privacy) was a concern throughout our interviews.

Conduct research on patient referrals to (and their subsequent use of) IPV support services following IPV identification. Patient referrals to support services are an important part of a coordinated health care response (Kirst et al, 2012). However there is a literature gap in terms of the description of effective referral processes in health care settings and patient access to and use of these services. This was raised as a concern/barrier to screening during our interviews.

For health care administration

Build partnerships between health care providers and IPV service providers. Health care providers need to be aware of available referral services for women who disclose, including services related to safety, shelters, and provider training. These should be provided in partnership with community support organizations.

Provide the necessary policies, protocols, and institutional supports for IPV screening programs. This could include screening guidelines, standardized or suggested screening questions, and access to resources should providers have any screening-related questions.

Educate and train healthcare providers. Many of our interview participants discussed the need for training to ensure that screening for IPV is done properly. Providers should receive the education and training that they need. Our interviews also showed that providers know what would enable them to screen. As such, they should be involved in developing provider training programs.

Implement flexible screening programs in health care settings. Such programs will require institutional support, protocols, training, and access to support services to be effective. This will require strong partnerships and communication between administrative staff, health care providers and IPV service providers.

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