Screening and Counseling for Intimate Partner Violence: A Vision for the Future

Reem M. Ghandour, DrPH, MPA,¹ Jacquelyn C. Campbell, PhD, RN, FAAN,²
and Jacqueline Lloyd, PhD, MSW³

Abstract

We describe a vision of screening and intervention for Intimate Partner Violence informed by deliberations during the December 2013 Intimate Partner Violence Screening and Counseling Research Symposium and the resultant manuscripts featured in this special issue of the *Journal of Women's Health*. Our vision includes universal screening and intervention, when indicated, which occurs routinely as part of comprehensive physical and behavioral health services that are both patient centered and trauma informed. Areas for future research needed to realize this vision are discussed.

Screening and Counseling for IPV: How Far We've Come

AS NOTED BY NOURSI ET AL. in this special issue of the *Journal of Women's Health*,¹ intimate partner violence (IPV) is an important public health problem that affects women from all backgrounds.² The evidence showing a substantial prevalence of IPV among women, both lifetime and recent, is clear,^{2,3,4} as is the evidence that both current and past IPV are associated with immediate and long-term physical and mental health problems.⁵⁻⁷ Tools to screen for IPV have been validated^{3,8} and at least one has been formulated as an "app" (R3 app containing HITS*)⁹ for easy use by clinicians. There is also considerable evidence supporting the efficacy of interventions for IPV in both community and health care settings as well as promising new electronic intervention strategies.¹⁰ Routine screening for IPV is supported by evidence, reflected in policy briefs by professional associations,^{11,12} and endorsed by both abused and non-abused women in population-based and setting-specific studies.⁴

In response, the United States Department of Health and Human Services (DHHS) has supported programmatic activities designed to increase IPV prevention, improve services to those affected, and better understand the nature, extent, and sequelae of current and lifetime exposure to

IPV.¹³ Within the context of these ongoing investments, and bolstered by the Affordable Care Act's commitment to preventive services for women,¹⁴ including IPV screening and counseling, the DHHS Coordinating Committee for Women's Health convened the Intimate Partner Violence Screening and Counseling Research Symposium on December 9, 2013.¹³ The goal of the Symposium was to identify research gaps related to IPV screening and counseling in primary healthcare settings and to identify and inform future research priorities to address these gaps, with the ultimate goal of informing guidelines, services and practice.^{1,13} The meeting demonstrated both the power and the possibility of a multi-agency, multi-sector approach to shaping, building, and strengthening the evidence base for IPV screening and intervention. Building on this foundation, the goals of this paper are twofold: (1) to describe a vision for the effective implementation of evidence-based IPV screening, assessment and intervention strategies based on the research featured in this special issue; and (2) to highlight specific research gaps that must be filled in order to realize that vision.

Screening and Counseling for IPV: A Vision

Advocates and practitioners have long called for the implementation of effective IPV screening and intervention in healthcare settings.¹⁵ The passage of the Affordable Care Act in 2010 gave new weight to these calls with its emphasis on disease prevention and health promotion through screening

*HITS = Hurt-Insult-Threaten-Scream.

¹U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Epidemiology and Research, Rockville, Maryland.

²Department of Community-Public Health, Johns Hopkins University School of Nursing, Baltimore, Maryland.

³U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, Division of Epidemiology, Services and Prevention Research, Prevention Research Branch, Bethesda, Maryland.

and early intervention.¹⁴ This focus was operationalized in 2011 with the release of a report by the Institute of Medicine which identified eight evidence-based, clinical services central to the health and well-being of women, including IPV screening and intervention, and the subsequent adoption of these recommendations by DHHS to implement the women's preventive services provision in the Affordable Care Act.¹⁶ Finally, in 2013, the United States Preventive Services Task Force issued a B-recommendation for IPV screening of women ages 14–46 years, indicating that all women of reproductive age should be screened by their healthcare clinicians and, in the event of a positive screen, referred to or provided intervention services.⁴ Unfortunately, significant work is still needed to address persistent challenges to the effective implementation of IPV screening and intervention in health care settings. Such challenges can include inadequately or ineffectively trained staff, organizational cultures not conducive to effective screening and intervention, or the absence of system-specific protocols and processes that enable providers to screen, intervene and make referrals as needed. The time is ripe for advancing a research agenda to extend the evidence base supporting this key preventive health service for women. We take this opportunity to share a vision for IPV screening and intervention in clinical settings which includes three key components: screening and assessment; intervention, referral, and follow-up; and trauma-informed health care operations and culture.

Screening and assessment

Our vision includes universal IPV screening for all adolescent girls and women who enter a health care or behavioral health care setting, regardless of point of entry (e.g., primary, urgent, emergency, or behavioral health care). In short, every health care setting is the “right door” for accessing IPV services. This vision is predicated on the consistent use of validated IPV screening tools that are brief, easy to use, and developmentally and culturally appropriate and adaptable to diverse patient populations. Using such tools, IPV screening is part of a comprehensive behavioral health assessment that screens for multiple health and behavioral risk factors associated with current and lifetime exposure to IPV, such as a history of trauma, substance abuse, sexual risk behaviors, posttraumatic stress disorder (PTSD), and depression. Comprehensive screening occurs routinely during wellness visits and annual exams as well as during visits for chronic disease management and emergency encounters. Following a chronic care management model, screening and assessment also occur during follow-up visits to assess for important changes in risk and/or safety. Prior work discussed throughout this special issue has highlighted important considerations regarding the mode, timing, and use of personnel to implement IPV screening in various healthcare settings. Areas for further research needed to realize our vision of universal screening are described below.

Intervention, referral, and follow-up

Our vision is that all women who screen positive or are at-risk for IPV (e.g., those with a history of trauma or abuse) will receive intervention services at the time of the visit, in the form of a brief intervention (e.g., brief counseling) and/or receive an appropriate referral to internal and/or external service pro-

viders as determined by the comprehensive health and behavioral health assessment described above. This referral is “warm” in nature¹⁷ and facilitates connections between the abused woman and needed services, such as making sure that appointment(s) are made with the patient before she leaves the visit and/or putting the woman in voice or electronic contact with referral agencies of her choice. Research indicates that this type of facilitative referral is effective in ensuring follow-up care.^{18,19} We envision that providers on the receiving end of these “warm referrals” are knowledgeable about IPV and the associated risks as well as with the association between exposure to traumatic experiences and long-term physical and mental health problems. For women currently in abusive relationships, we envision that the intervention will also include referrals to community agencies which provide safety planning and related services, as described by Dutton and colleagues in this Issue.²⁰ Research needs related to the development and implementation of systems of care that support the provision of culturally competent and developmentally appropriate services are discussed below.

Operations and culture

We envision that primary care and other healthcare settings will organize and deliver IPV screening and related services as part of high-quality, comprehensive care provided in a medical home or other healthcare setting that subscribes to related principles and practices. The medical home model is based on five principles: a patient-centered orientation to care; comprehensive, team-based care; coordinated care and services that are integrated across all sectors of the health care system; continuous and prompt access to care including alternative methods for communicating with members of the care team; and a systems-based approach to safe and high-quality care predicated on the use of evidence-based medicine and clinical decision support tools to guide decision making.²¹

Within the context of this operating model, we envision that all healthcare services are delivered using a trauma-informed approach. Service settings that deliver trauma-informed care design, organize, and implement all aspects of the service- or clinical-encounter to reflect “a basic understanding of how trauma affects the life of an individual seeking services.”²² Further, they seek to avoid retraumatization and maximize the therapeutic impact of services for individuals exposed to trauma, including those who have experienced IPV.²² For the purposes of our vision, this approach includes (1) recognition of the prevalence of IPV and trauma, (2) recognition of how trauma affects everyone in the healthcare setting, including providers and staff, and (3) utilization of this knowledge to inform all practices within the health care setting.²²

Central to our vision is that all staff, at every level of the health care system, are trained and have the competencies to interact with individuals who are at risk for or currently experiencing IPV. This includes training for all administrative staff, doctors, nurses, social workers, and other behavioral health care providers and staff who work in the setting. In addition to the “saturation”²³ of personnel with relevant information and skills, we envision that all healthcare settings would establish and disseminate a protocol outlining procedures for universal IPV screening and intervention. This protocol would include evidence-based approaches and

processes to support staff in implementing, facilitating, and managing disclosure of both current and former IPV as well as the delivery of follow-up assessments and interventions. Because disclosure of IPV can occur in multiple ways¹⁵ and a positive IPV screen (or suspected case) can require a range of responses, the protocol should provide a portfolio of evidence-based recommendations for clinical action that are relevant and actionable within the particular healthcare setting. Examples might include clinical requirements for contacting authorities in the case of imminent danger, options for selecting a community-based service provider and points of contact to facilitate the warm referral, or recommendations (and requirements) for inquiring about the health and safety of dependents who may be IPV- or trauma-exposed. Delivered in a trauma-informed, patient-centered setting, the latter can provide a critical opportunity to link others—particularly children—to needed services and resources. Beyond these types of first-line responses, research suggests more intensive interventions involving tailored educational and therapeutic services may improve health outcomes.^{24–27} The successful implementation of such a protocol; however, may be dependent on the presence of systems-level facilitators. Additional research needed on tools and operational processes critical to effective implementation of IPV screening and intervention practices is discussed next.

Research Gaps

The articles featured in this special issue pose multiple research questions related to the effective implementation of evidence-based IPV screening, assessment and intervention in healthcare settings. Together, these perspectives shape a robust research agenda that reflects four primary areas for future investigation: (1) chronic illness and disease pathways between current and lifetime exposure to IPV and adverse health outcomes; (2) the efficacy of screening and intervention for co-occurring health risk behaviors, exposures, and conditions; (3) the specification of systems-level facilitators, including tools and processes, to support effective and efficient implementation of IPV screening, assessment and intervention in a range of healthcare settings serving diverse patient populations and their families; and (4) opportunities and challenges associated with the extension of evidence-based IPV identification and treatment practices to diverse populations.

Disease pathways between IPV and adverse health outcomes

It is important to identify the specific pathways between IPV and chronic illness and/or disease outcomes well established in epidemiological studies in order to determine effective interventions to mitigate or delay the onset of these deleterious outcomes. There is some evidence that previous or inadequately treated injuries contribute to these outcomes,^{6,28} as do mental health problems and the cumulative stress and related physiological responses that may have origins in early exposure to trauma frequently experienced by IPV victims. We have considerable evidence of the neurophysiological sequelae of childhood trauma but less information about the physiological pathways to physical health problems, for instance through immune system dysfunction,²⁹ and even less about effective interventions that may be targeted to specific developmental stages in children, ado-

lescents, and adulthood. Although there is some evidence of resilience to traumatic events in childhood, much more needs to be known about these processes, other protective mechanisms that may be brought to bear, and how interventions targeted to individuals and communities can protect against the development or mitigate the seriousness of related mental and physical health impacts.

Screening and intervention for co-occurring health risk behaviors, exposures, and conditions

The complex interacting mental and physical health sequelae of IPV and other trauma often results in co-morbid conditions, such as PTSD co-occurring with depression,³⁰ traumatic brain injury and neurological sequelae,³¹ suicidality, and PTSD co-occurring with depression and substance abuse as described by Weaver and colleagues in this issue.³² Although a few validated interventions exist for IPV-exposed women who are pregnant²⁵ or suicidal,³³ we have yet to have persuasive evidence supporting the efficacy of interventions for IPV and other comorbidities, such as mental health and substance use disorders.²⁸

Systems-level facilitators

Institutional and operational barriers that exist within healthcare settings in relation to universal IPV screening, assessment and intervention have been well documented.^{23,34} These challenges are compounded by the fact that the process of screening and identifying individuals who have experienced (or are at risk for) IPV can vary with each patient and is frequently complicated by legal, safety, and privacy considerations as well as victim-perpetrator,¹⁵ victim-provider, and even setting-specific dynamics. As a result, researchers and advocates have concluded that systems-level strategies are needed to help health care practices craft and implement systematic approaches to improve identification of and support for IPV-exposed girls and women consistent with our vision described above.²³ Based on the work presented in this special issue and proceedings from the Symposium we identify six areas for additional research which we believe will contribute to a better understanding of the systems-level facilitators needed to support effective IPV screening and intervention.

First, research has shown that provider education, while not sufficient to support our vision, is necessary to the success of such efforts. Additional research is needed on the best tools and approaches for ongoing staff education and training to achieve the level of “saturation”²³ needed to support a “no wrong door” to identification and service provision for IPV-exposed girls and women. Second, research is needed to demonstrate the validity of existing screening tools and the efficacy of interventions for use in diverse health care settings serving multiple patient populations, particularly racial, ethnic, and sexual minority girls and women as well as dually affected individuals (e.g., those using or abusing substances or who have mental health problems).³² Third, critical elements of the model linking health care settings and community-based service providers need to be identified. The “warm” referral has been shown to be a key factor in determining whether a survivor will successfully access services. While highly effective linkages may exist, little is known about specific components of these mutually

reinforcing relationships that can be replicated across settings. Fourth, additional work is needed pertaining to the safe, smart and appropriate use of technology to increase screening and follow-up. As discussed by Miller et al. in this special issue,¹⁵ electronic health records (EHRs) hold tremendous potential for the implementation of universal screening and improved follow-up with IPV-suspected or IPV-exposed individuals. While EHRs have already shown to be capable of increasing IPV screening and documentation,³⁵ significant work is needed to test and validate EHR-based screening tools and algorithms for interventions in a variety of health-care settings with diverse patient populations. EHR data may also be used to drive and sustain clinical practice changes as part of continuous quality improvement efforts.¹⁵ Research is needed on how this type of feedback can be incorporated into educational strategies discussed above to improve provider engagement in IPV screening and intervention. Fifth, future evaluations of both screening and intervention strategies should consider including multiple outcomes of interest that reflect both intermediate and long-term goals in addition to violence reduction and safety planning, including improved overall health and chronic disease management.²³ Sixth, research is needed on how to replicate successful models of IPV screening and intervention in health care settings, which highlights special considerations for expansion to new settings and different patient populations within the context of resource constraints (i.e., both physical and human). Critically, research is needed on the sustainability of such programs and how healthcare practices and community partners can plan for long-term sustainability of investments.²⁰ Finally, research is needed on the applicability of such approaches to non-health care settings where IPV-exposed or at-risk populations also seek services.²⁰

Extension of IPV identification and treatment practices to diverse populations

Screening and counseling for IPV and trauma among adolescent girls and women is an important step towards the goal of improving and maintaining public health and wellness, for females in particular. Central to this goal is the extension of IPV and trauma screening and counseling to other vulnerable populations such as individuals with disabilities; lesbian, gay, bisexual, and transgender youth and young adults; veterans; and people living with HIV wherever they may seek and receive healthcare services.¹³ Significant work is needed to determine to what extent existing screening and intervention models can be effectively implemented with these populations. Individuals from these communities should be engaged early and often in the development of these tools and models. Additionally, with substantial evidence of increased prevalence of IPV among ethnic minority populations and potential connections with physical and mental health inequities for these groups,^{36,37} special consideration of culturally specific approaches and the context of screening for these groups becomes necessary. Such approaches include targeted training on IPV and other sensitive topics for translators and acknowledgement of fear among victims that disclosure of IPV might lead to involvement of child protective services, criminal justice, immigration, or other officials or systems which may be perceived to be culturally insensitive or discriminatory.

Conclusion

We propose a vision of universal IPV screening and intervention that occurs, routinely, as part of comprehensive physical and behavioral health services that are both patient centered and trauma informed. The recent symposium and resulting manuscripts featured in this special issue demonstrate significant investments to date to implement IPV screening and interventions in health care settings and highlight the research needed to extend and advance this practice as part of high-quality, comprehensive health care. It is our hope that current and future investments will be informed by the research priorities detailed in this paper and throughout the special issue and will pursue innovative and collaborative approaches to expand and refine the existing evidence base on IPV screening and intervention.

Author Disclosure Statement

No competing financial interests exist.

References

1. Noursi S, Begg L, Lee N, Clayton JA. Introduction to the special issue: intimate partner violence, consequences on women's health, and promising interventions. *J Womens Health* 2015;24:54–55.
2. Black MC, Basile KC, Breiding MJ, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2011.
3. Institute of Medicine. Clinical preventive services for women: Closing the gaps. Washington, DC: The National Academies Press, 2011.
4. Moyer VA. Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. preventive services task force recommendation statement. *Ann Intern Med* 2013;158:478–486.
5. Black MC, Breiding M. Adverse health conditions and health risk behaviors associated with intimate partner violence—United States, 2005. *MMWR Morb Mortal Wkly Rep* 2008; 57:113–117.
6. Humphreys J, Epel ES, Cooper BA, Lin J, Blackburn EH, Lee KA. Telomere shortening in formerly abused and never abused women. *Biol Res Nurs* 2012;14:115–123.
7. Wuest J, Ford-Gilboe M, Merritt-Gray M, et al. Pathways of chronic pain in survivors of intimate partner violence. *J Womens Health (Larchmt)*. Sep 2010;19:1665–1674.
8. Rabin RF, Jennings JM, Campbell JC, Bair-Merritt MH. Intimate partner violence screening tools: a systematic review. *Am J Prev Med* 2009;36:439–445.e434.
9. Moats CC, Edwards FD, Files JA. More than meets the eye: the importance of screening for intimate partner violence. *J Womens Health (Larchmt)* 2014;23:275–277.
10. Glass N, Eden KB, Bloom T, Perrin N. Computerized aid improves safety decision process for survivors of intimate partner violence. *J Interpers Violence* 2010;25: 1947–1964.
11. Amar A, Laughon K, Sharps P, Campbell J. Screening and counseling for violence against women in primary care settings. *Nurs Outlook* 2013;61:187–191.
12. American College of Obstetricians and Gynecologists. Intimate partner violence. Committee Opinion No. 518. *Obstet Gynecol* 2012;119:412–417.

13. Trans-HHS Intimate Partner Violence Screening and Counseling: Research symposium. 2013 <http://whr.nlm.nih.gov/ipv-symposium.html#b00> Accessed April 25, 2014.
14. Affordable Care Act rules on expanding access to preventive services for women. National Institutes of Health, Department of Health Human Services, 2013. www.hhs.gov/health-care/facts/factsheets/2011/08/womensprevention08012011a.html Accessed May, 1, 2014.
15. Miller E, McCaw B, Humphreys BL, Mitchell C. Integrating intimate partner violence assessment and intervention into healthcare in the United States: A systems approach. *J Womens Health* 2015;24:97–104.
16. Gee RE, Brindis CD, Diaz A, et al. Recommendations of the IOM clinical preventive services for women committee: implications for obstetricians and gynecologists. *Curr Opin Obstet Gynecol* 2011;23:471–480.
17. Chamberlain L, Levenson R. Addressing intimate partner violence, reproductive and sexual coercion: A guide for obstetric, gynecologic and reproductive health care settings, 2nd ed. San Francisco, CA: Futures Without Violence, 2012.
18. Hathaway JE, Willis G, Zimmer B. Listening to survivors' voices: Addressing partner abuse in the health care setting. *Violence Against Women* 2002;8:687–719.
19. McCloskey LA, Lichter E, Williams C, Gerber M, Wittenberg E, Ganz M. Assessing intimate partner violence in health care settings leads to women's receipt of interventions and improved health. *Public Health Rep* 2006;121:435–444.
20. Dutton MA, James L, Langhorne A, Kelley M. Coordinated public health initiatives to address violence against women and adolescents. *J Womens Health* 2015;24:85–90.
21. Agency for Healthcare Research and Quality. Patient-centered medical home resource center: Defining PCMH. <http://pcmh.ahrq.gov/page/defining-pcmh> Accessed May 1, 2014.
22. Substance Abuse and Mental Health Services Administration. Trauma-informed care and trauma services. www.samhsa.gov/nctic/trauma.asp Accessed May 1, 2014.
23. Hamberger LK, Rhodes K, Brown J. Screening and intervention for intimate partner violence in healthcare settings: Creating sustainable system-level programs. *J Womens Health* 2015;24:91–96.
24. Iverson KM, Gradus JL, Resick PA, Suvak MK, Smith KF, Monson CM. Cognitive-behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. *J Consult Clin Psychol* 2011;79:193–202.
25. Kiely M, El-Mohandes AA, El-Khorazaty MN, Blake SM, Gantz MG. An integrated intervention to reduce intimate partner violence in pregnancy: A randomized controlled trial. *Obstet Gynecol* 2010;115:273–283.
26. Ramsay J, Carter Y, Davidson L, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database Syst Rev* 2009;CD005043.
27. Warshaw C, Sullivan CM, Rivera EA. A systematic review of trauma-focused interventions for domestic violence survivors. Chicago: National Center on Domestic Violence, Trauma and Mental Health, 2013.
28. Anderson JC, Stockman JK, Sabri B, Campbell DW, Campbell JC. Injury outcomes in African American and African Caribbean women: The role of intimate partner violence. *J Emerg Nurs* 2014. DOI: 10.1016/j.jen.2014.01.015. [Epub ahead of print].
29. Woods SJ, Wineman NM, Page GG, Hall RJ, Alexander TS, Campbell JC. Predicting immune status in women from PTSD and childhood and adult violence. *ANS Adv Nurs Sci* 2005;28:306–319.
30. Cavanaugh C, Campbell JC, Messing J. A longitudinal study of the impact of cumulative trauma on co-morbid posttraumatic stress and depression among female nurses and nursing personnel. *Workplace Health Saf* 2014;62:224–232.
31. Kwako LE, Glass N, Campbell J, Melvin KC, Barr T, Gill JM. Traumatic brain injury in intimate partner violence: A critical review of outcomes and mechanisms. *Trauma Violence Abuse* 2011;12:115–126.
32. Weaver TL, Gilbert L, El-Bassel N, Resnick H, Noursi S. Identifying and intervening with substance-using women exposed to intimate partner violence: Phenomenology, co-morbidities and integrated approaches within primary care and other agency settings. *J Womens Health* 2015;24:56–61.
33. Kaslow NJ, Leiner AS, Reviere S, et al. Suicidal, abused African American women's response to a culturally informed intervention. *J Consult Clin Psychol* 2010;78:449–458.
34. Campbell JC, Coben JH, McLoughlin E, et al. An evaluation of a system-change training model to improve emergency department response to battered women. *Acad Emerg Med* 2001;8:131–138.
35. McCaw B. Using a systems-model approach to improving IPV services in a large health care organization. Washington, DC: Institute of Medicine, 2011.
36. Stockman JK, Campbell JC. Intimate partner violence and its health impact on disproportionately affected populations, including minorities and impoverished groups. *J Womens Health* 2015;24:67–84.
37. Alhusen JL, Ray E, Sharps P, Bullock L. Intimate partner violence during pregnancy: maternal and neonatal outcomes. *J Womens Health* 2015;24:105–111.

Address correspondence to:

Reem M. Ghandour, DrPH, MPA
 Director, Division of Epidemiology
 Office of Epidemiology and Research
 Maternal and Child Health Bureau

Health Resources and Services Administration
 5600 Fishers Lane, Room 10-77
 Rockville, MD 20857

E-mail: rghandour@hrsa.gov