OVERCOMING BARRIERS TO SCREENING FOR INTIMATE PARTNER VIOLENCE IN FAMILY PRACTICE SETTINGS

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Overcoming Barriers to Screening for Intimate Partner Violence in Family Practice Settings

Abstract
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An estimated two to five million women are assaulted annually by an intimate partner, and 25% of women report a lifetime history of partner abuse (Gerber, Ganz & Lichter, 2005). In the United States annual costs of intimate partner rape, physical assault, and stalking exceeds $5.8 billion, nearly $4.1 billion of which is for direct medical and mental health care services (Plichta, 2004). Intimate partner violence (IPV) is a significant public health problem that has both short-term and long-term physical and mental health consequences for women and their families. Despite the statistics, magnitude of health consequences, and cost to society less than 10% of providers routinely ask about IPV (Zink, 2007). Providers need to recognize that women who are victims of IPV will be patients in every family medicine practice in this country because one in every four women has been a victim at some point in her life and one in seven women has been victimized in the past year (American Academy of Family Physicians [AAFP], 2005).

This paper focuses on the staggering statistics surrounding IPV, current screening practices, and the significant victim, provider, and systemic barriers that prevent adequate screening, treatment, and prevention of IPV. It also highlights the fact that overcoming these barriers requires a collaboration of changes in victim and provider attitudes, an increase in provide education and training, consistent screening techniques, and availability of multiple on- and off-site resources.
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OVERCOMING BARRIERS TO SCREENING FOR INTIMATE PARTNER VIOLENCE

Overcoming Barriers to Screening for Intimate Partner Violence in Family Practice Settings

Intimate partner violence (IPV) is defined as a pattern of assaultive or coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, threats and economic abuse (American Academy of Family Physicians [AAFP], 2005; Coker, Smith & Fadden, 2005; Hegarty, Gunn, O'Doherty, Taft, Chondros, Feder, Astbury & Brown, 2010). IPV occurs in one in four American families each year (AAFP, 2005). An estimated two to five million women are assaulted annually by an intimate partner, and 25% of women report at least one occurrence of partner abuse in their lifetime (AAFP, 2005; Birosack, Smith, Roznowski, Tucker & Carlson, 2006; Bonomi, Anderson, Rovara & Thompson, 2007; Gerber et al., 2005; Johnston, 2006; Sormanti & Shibusawa, 2008; Tower, 2007). It is also reported that more than 1,200 women are murdered each year in acts that are directly attributable to IPV (Tower, 2007). In 2008, females age 12 or older experienced about 552,000 nonfatal violent victimizations (rape/sexual assault, robbery, or aggravated or simple assault) by an intimate partner (a current or former spouse, boyfriend or girlfriend). In the same year, men experienced 101,000 nonfatal violent victimizations by an intimate partner (Catalano, Smith, Snyder & Rand 2009). Women make an estimated half-million Emergency Department (ED) visits annually seeking medical treatment for partner violence-related injuries and other conditions, which is three times greater than non-abused women (Birosack et al., 2006; Feder, Hutson, Ramsay & Taket, 2006).

A previous study (2004) found that women who screened positive for IPV are 46.5 times more likely to experience severe physical violence within the next 4 months. Of those who were murdered, 69% had been abused before their death and at least 41% of those women had been seen in a health care setting 12 months before the killing (Kramer, Lorenzon & Mueller, 2004).
The number of outpatient provider visits due directly to IPV each year is estimated by the Centers for Disease Control (CDC) to be more than 971,000 (Plichta, 2004). The CDC also estimated that more than 232,000 dental visits, and more than 1 million physical therapy visits each year are directly due to IPV (Plichta, 2004). More than 486,000 ED visits, 320,000 outpatient hospital visits, and 95,000 ambulance calls each year are directly because of IPV as well (Plichta, 2004). Approximately 18.5 million mental health care visits each year can also be attributed to IPV (Tower, 2007).

So great is the problem of IPV that Healthy People 2010, the report of the U.S. Department of Health and Human Services, specified a 20% reduction in the occurrence of IPV as a national health objective to be achieved by 2010 (McFarlane, Malecha & Gist, 2004). It is yet to be determined if there was a reduction and at what percentage.

**Literature Search Methods**

Using the Cumulative Index to Nursing and Allied Health (CINAHL), Pubmed (Medline), and UpToDate databases, an “intimate partner violence” literature search was done. Over 6,000 results were returned. Adding “family practice”, “primary practice”, published date of 2000 to 2011, and source types of academic journals and periodicals narrowed the search to 458 results. Several articles from this search were chosen from this literature review.

**Literature Review**

The literature review begins by presenting statistical background on health consequences and costs of IPV in an attempt to illustrate the staggering effects on the person, community, and society. This is followed by current screening practices and concludes with barriers to effective screening and treatment including victim, provider, and systemic.
Health Consequences

Multiple studies have shown significant associations between lifetime experiences of physical or sexual violence, or both, by a male intimate partner, and a wide range of self-reported physical and mental health problems in women (Coker et al., 2005; Ellsberg, Jansen & Heise, 2008; Plichta, 2004). This is also true for same-sex couples in which male-on-male and female-on-female violence is estimated to occur in 25-50% of relationships (Hardesty, Oswald, Khaw & Fonseca, 2011). Same-sex victims of IPV face abuse, not only from their partner, but from other loved ones who disapprove of their sexual orientation. IPV in the lesbian, gay, bisexual, and transgender community is largely unrecognized due to the marginalization of the community, coupled with the hesitancy to report violence (Blosnic & Bossarte, 2009; Spinks, Andrews & Boyle, 2000). Additionally, a paucity of laws for protection, or advocacy in this population promotes continued victimization.

Lower health status, lower quality of life, and higher utilization of health services by abused women have been reported (Coker et al., 2005). The physical consequences of battering range from immediate outcomes such as minor injuries to long term effects such as permanent disability, disfigurement, and death (Kramer et al., 2004). Minor head injuries, broken bones, abrasions, and lacerations are a few of the injuries initially observed (see Figure 1). High blood pressure, abdominal pain, loss of appetite, headaches, fainting, back pain, and seizures are immediate results of IPV that can become chronic illnesses and diseases. Victims of IPV are at an increased risk of traumatic head injuries, resulting in cognitive deficits that can often be permanently disabling (Coker et al., 2005; Plichta, 2004). Strangulation is also commonly reported by IPV victims and may be associated with neurological disorders such as dizziness, stroke, paralysis, memory loss and chronic headaches (Coker et al., 2005; Plichta, 2004).
Physically and sexually violent acts by intimate partners are consistently associated with a broad array of negative health outcomes, including gynecological disorders, adverse pregnancy outcomes, irritable bowel syndrome, gastrointestinal disorders, and various chronic-pain and stress-related syndromes (Bonomi et al., 2007; Eberhard-Gran, Schei & Eskild, 2007; Ellsberg et al., 2008; Gillum, Sun & Woods, 2009; Plichta, 2004).

Physical and sexual violence has also been associated with psychiatric diagnoses, including depression, anxiety, phobias, post-traumatic stress disorder, nightmares, suicidality, and alcohol and drug abuse (Bonomi et al., 2007; Ellsberg et al., 2008; Gerber et al., 2005; Gilchrist, Hegarty, Chondros, Herrman & Gunn, 2010). Emotional distress, such as crying, fear, guilt, humiliation, self-blame, inability to enjoy life, and tiredness also plague victims long after the physical scars and bruises have healed (Bonomi et al., 2007; Ellsberg et al., 2008).

Intimate partner violence is not only a substantial health problem by virtue of its direct effects, such as injury and mortality, but also in that it quite possibly contributes to the overall burden of disease as a risk factor for several other serious health problems (Ellsberg et al., 2008).

Cost of IPV

In the United States annual costs of intimate partner rape, physical assault, and stalking exceed $5.8 billion, nearly $4.1 billion of which is for direct medical and mental health care services (Plichta, 2004; Sohal, Eldridge & Feder, 2007). Other costs not easily captured include absenteeism from work, law enforcement responses, legal interventions, social work involvement, damaged property, and relocation expenses (Edwardsen & Morse, 2006). These outrageous figures point to a need for change in current screening practices and treatment. In
particular, one cannot help but wonder if more rigorous screening practices, and subsequent identification and treatment of victims, would in fact reduce such costs.

**Current Screening Practices for IPV**

Screening for IPV refers to a standardized assessment of patients, regardless of their reasons for seeking medical attention, aimed at identifying women who are experiencing or have recently experienced IPV (MacMillan, Wathen & Jamieson, 2009). Screening is a preventive healthcare service in which specific tests, standardized questions, or examination procedures are routinely used to identify people who require specific interventions to improve their health (Nelson, 2004). A positive screen indicates that a victim answered in the affirmative to one of three general questions: is violence/abuse a concern in your relationships; has anyone, hit, punched, slapped or threatened you in the past year; and do you fear for your safety? Universal screening means asking every person, regardless of their socioeconomic status, educational level, or ethnicity, about their exposure to intimate partner violence (Hindin, 2006). It includes asking the same direct questions about abuse, whether symptoms are present or the provider suspects abuse; asking the questions with sensitivity and in person instead of using a written questionnaire; asking the questions in complete privacy to ensure the woman’s safety, with no children present; asking the questions using a standardized tool; and asking the questions in a culturally competent manner (Hindin, 2006).

Over the past 15-20 years, routine screening for IPV has been introduced in many health settings to enable health services to address the twin problems of underidentification of abuse and high use of health services (Spangaro, Zwi & Poulos, 2009). Screening recommendations from the American Medical Association in 1992 suggested that all adult women entering the
primary care setting be routinely asked about recent experiences with violence regardless of the reason for presentation (Spangaro et al., 2009). This recommendation was updated in 2005 to include the routine screening of men for IPV and family violence (American Medical Association, 2005). However, these recommendations have been implemented at an alarmingly low rate with less than 10% of providers routinely asking about IPV (Zink, 2007).

Universal screening for IPV remains controversial. As of 2007, without published, randomized clinical trials to measure the effectiveness of IPV risk assessment compared with no assessment in terms of its potential benefits or its potential harm to abused women, the US Preventive Services Task Force issued a “grade I” recommendation on routine screening of adult women for IPV. This means that the evidence to support the effectiveness of screening women for IPV in the primary care setting is lacking or of poor quality or that the balance of the benefits and harms cannot be determined (Coker et al., 2007; Gerber et al., 2005;). There also exists the suggestion that there are possible adverse effects of IPV screening, including reprisal violence, psychological distress, family disruption, and a child being removed from a mother’s care (Colarossi, Breitbart & Betancourt, 2010; MacMillan et al., 2009; Taket et al., 2003). However, recent reviews of IPV statistics have not shown significant increases in reprisal violence after reporting abuse (MacMillan et al., 2009; Nelson, Nygren, McInerney & Klein, 2004). The consensus amongst The Joint Commission, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Nurse Midwives, American College of Emergency Physicians, American Academy of Nurse Practitioners, Emergency Nurses Association, and the American Medical Association is that the potential benefits outweigh the possible risks and that all women should be routinely screened for IPV (AAFP,
One of the most important issues in IPV policy is the need to implore health care providers to consistently screen all women for IPV (Plichta, 2004). Currently, general practitioners detect IPV in less than a fifth of female patients (Gilchrist et al., 2010). Providers need to recognize that women who are victims of IPV will be patients in every family medicine practice in this country as one in every four women has been a victim at some point in her life and one in seven women has been victimized in the past year (AAFP, 2004). Primary care provider screening may be the only help women seek as many will never seek help from a legal or stand-alone service, but will go to a health provider during their adult lifetime (Colombini, Mayhew & Watts, 2008). Screening and intervention is a professional, ethical, and sometimes legal responsibility.

A goal of healthcare providers is to identify all possible etiological exposures and pathways contributing to disease and symptoms manifested in patients seeking health services (Bonomi et al., 2007). This must include victims of IPV; otherwise we are doing a disservice to a large population of our patients by ignoring and/or denying the abuse.

Primary care providers are in an ideal position to assess for IPV and are ethically required to do so in an effort to ensure autonomy, justice, and beneficence. In this setting, primary care providers gain patient confidence over time and can serve as sympathetic listeners and patient advocates. They can provide early intervention to break the cycle of violence through routine screening and the identification of abuse (AAFP, 2005; Taket et al., 2003). Routine abuse screening of all women by healthcare providers will identify those potentially at risk for poorer
health outcomes and disabilities. Early identification may reduce cumulative and long-term effects of IPV on risk of disabilities (Coker et al., 2005). Studies show that screening for IPV in medical settings creates opportunities for providers to target interventions toward decreasing a victim’s isolation and enhancing her safety via referrals to community agencies (Kramer et al., 2004). Bybee and Sullivan (2005) found that battered women with lower social support are at increased risk of attempting suicide. This makes universal screening all the more detrimental in that providers can prevent death at the hands of the abuser and the victim herself. Universal screening by women’s healthcare providers increases women’s knowledge of IPV, offers them support, and can contribute to creating safer communities for women and children (Koziol-McLain, Giddings, Rameka & Fyfe, 2008).

The Joint Commission requires hospitals to have policies and procedures in place for identification and referral of IPV victims (Houry, Feldhaus & Peery, 2004). Why is this not required of primary care practice settings? Why do we not expect those providers we see for our annual health care needs to inquire as to our safety at home and in our relationships? Why is it acceptable for a stranger checking a person into the Emergency Department to ask “do you feel safe at home?”, but not for the same to be expected of primary care physicians and nurse practitioners that see these same individuals on a much more personal and regular interval?

**Barriers to Screening**

**Victim Barriers**

Identified barriers to screening in primary care practices include the patient’s fear of retaliation from an abusive partner, the patient’s lack of disclosure during history-taking, the patient’s fear of police involvement, and cultural differences (AAFP, 2004). A lack of privacy,
concerns regarding continuity of care, and time constraints have also been cited as reasons that prevent victims from disclosing abuse (Johnston, 2006). Financial constraints and the fear of losing one’s children in a custody battle are barriers to disclosing IPV. Many victims have few, if any, resources (i.e. money, insurance, and support network) that would allow them to seek help or even leave their situation (Zink, Regan, Goldenhar, Pabst & Rinto, 2004). Even when the above barriers do not exist victims rarely volunteer information about abuse without being asked (Rodriguez, Sheldon, Bauer & Pérez-Stable, 2001).

One study identified important provider characteristics that would encourage victims to disclose IPV, including: the ability to communicate a sense of personal concern; open communication; willingness to negotiate issues of control; confidentiality of medical information; shared decision-making; competency in medical care; careful listening; and taking ample time to address participant concerns (Liebschutz, Battaglia, Finley & Averbuch, 2008). However, if any of these are lacking it becomes a barrier to the victim feeling comfortable and safe in disclosing abuse. Victims often report provider attitudes as judging, pitying, blaming or trivializing (Feder et al., 2006). Battaglia et al. (2003) found that victims are looking for open communication, professional competency, an accessible practice style, caring attitudes, and emotional equality in their interactions with providers. If even one of these elements is lacking that may be enough to prevent the victim from discussing their abuse and accepting help.

Provider Barriers

Time pressure, inadequate knowledge of referral options, and poor access to management information have been identified as reasons for not asking about IPV (Colarossi et al., 2010; Eberhard-Gran et al., 2007; Johnston, 2006; Taket et al., 2003; Zink, 2007). Discomfort amongst
providers about raising the issue may be a potential barrier as well as uncertainty on what to do with such information once obtained. Providers often do not have access to social work services within or outside of the organization. There are also often not enough written materials about community services to give to clients, either due to a lack of access or affordability for the office or because no such material exists. A fear of offending the patient and concerns about confidentiality also can present as a barrier. Frustration with patient denial has also been raised as a potential barrier to screening in that providers may suspect abuse, but often are unable to convince the victim to admit to it, which can effectively prevent any further treatment or help from being given (Zink, 2007).

Several myths about IPV exist, including, but not limited to: the misconception that victims are poor, inner-city women; the belief that violence is rare or does not occur in families that appear normal; the feeling that family violence is a private matter; and the notion that victims are in some way responsible for their own abuse (AAFP, 2004; Taket et al., 2003; Tower, 2007). These myths are still held to be true today by many providers, creating a barrier between the victim and those that could provide life-saving help. Providers, instead, should aim to build a therapeutic relationship with IPV survivors that empowers and educates patients and does not demand disclosure. The subject of IPV may be too uncomfortable in the providers’ own lives as 12-15% has witnessed IPV in their own lifetime (AAFP, 2004).

Much of the provider’s reluctance to screen for abuse and the patient’s barriers to disclosure could be overcome by a provider’s understanding of the emotions surrounding abuse and the unique concerns of the patient (Kramer et al., 2004). Providers exhibit greater comfort with screening for tobacco and alcohol use than they do for IPV (Gerber et al., 2005). However, the list of barriers and obstacles are similar to those identified in the past for assessment of
smoking, substance abuse, and high-risk sexual behaviors (Nelson, 2004). But most providers and healthcare systems have now developed approaches to manage these issues as part of routine healthcare screening. IPV deserves and requires the same diligence toward screening and treatment as the aforementioned issues.

**System Barriers**

Intimate partner violence is embedded in the values and knowledge systems of a male-dominated Western medical system (Tower, 2007). According to Tower:

“In order to effectively meet the needs of women affected by IPV it requires macromanagement of the health system and the exposure of the social discourses that drive it, for it is the structure of the health system and society itself that perpetuates and maintains the inadequacy of health service responses” (2007, p.440).

As mentioned earlier, annual costs of IPV in the United States exceed $5.8 billion. As the health care system spirals out of control cost is often at the top of the list of problems that must be solved in order to continue providing quality care to all. However, by not spending money up front to prevent and universally screen for IPV the medical system and society are allowing for an even greater expense in the form of treatment for ER visits, chronic health problems, absenteeism from work, legal interventions, and other costs that could have been avoided if prevention was more highly valued. Society is often so blinded by the initial costs that the eventual savings, in dollars and lives, is missed.
Screening Techniques

The prevalence of abuse and the sensitivity and specificity of screening instruments depend on definitions of abuse (physical, sexual, emotional, and combination) and acuity (current, past, and any). These definitions are not standardized across instruments. The effectiveness of specific screening methods and interventions will vary by setting, delivery, culture, and population (Nelson et al., 2004). The HARK questionnaire devised by Sohal et al. (2007) is an example of a screening tool that can easily be utilized by practitioners during office visits (see Table 1). Four questions identify risk factors for those who may be a victim or potential victim of abuse. It is simple and straightforward and provides a pneumonic, HARK, that is easy to remember.

Computer screening may help to overcome some of the barriers to discussing risk for IPV (Ahmad, Hogg-Johnson, Stewart, Skinner, Glazier & Levinson, 2009; Coker et al., 2002). According to Ahmad et al. (2009) hospital emergency departments have reported higher frequency of patient disclosure and provider detection of IPV when interactive computer screening was used, compared with patients receiving standard medical care. This involves the patient using a computer touch screen in which a questionnaire regarding IPV can be answered privately and without initial discussion. Subsequently, the questionnaire would be reviewed by a nurse, social worker or provider to determine appropriate follow-up including treatment and interventions. This type of screening may also be useful in primary care settings. It would provide victims with a more private and less judgmental screening and would also give providers a more accurate estimate of who needs help. According to Rhodes, Drum, Anliker, Frankel, Howes & Levinson (2006) computer screening has the potential to lead to a 75% increase in the odds of IPV discussion.
Discussion and Recommendations

The first and most important aspect of IPV to be addressed is the lack of universal screening in primary care settings. Universal screening entails asking every woman at each healthcare visit about IPV. Nurse Practitioners, Physicians, and Physician Assistants are in a perfect position to identify and facilitate treatment and prevention for victims of IPV. However, we can only do this if every practitioner is required to perform a screening evaluation, even if it is something as simple as adding two or three questions to standardized patient intake forms. The key for providers is to ask the question.

While health practitioners are widely encouraged to assume a role in supporting abused women, there are limited guidelines available on how to do this. Most tend to focus on identification and referral rather than on appropriate ways of responding to and counseling women following disclosure (Hegarty et al., 2010). However, the American Academy of Family Physicians (2004) proposed seven initiatives (see Table 2) to decrease IPV, which provide a guideline for how practitioners can begin to increase identification and treatment of IPV in practice. The most effective interventions must include provider continuing education, the implementation of an institutional policy and protocol on IPV, and additional on-site resources, such as a victim advocate or social worker as well as written and visual resources (Soglin, Bauchat, Soglin & Martin, 2009). Implementation, however, could be much more difficult than imagined.

Change in Attitude

Providers should respect patients' autonomy, try to understand their perspective, provide a safe and private environment in which confidentiality is maintained, and be aware of the
impact of their own behavior and attitudes on the victim. Provider communication skills include nonjudgmental language, providing validation and empowerment, not pressuring the victim, listening, being empathetic, and trustworthy (Feder et al., 2006). Cultural awareness must also be considered and included in each interaction. Health care providers must first address and change our own preconceived notions before expecting to provide compassionate and effective care to victims of IPV. This requires not only a self-assessment, but more education on IPV.

Provider Education

Women need to be asked about abuse in a non-judgmental manner and to receive clear information on resource options, especially about agencies offering support or advocacy services, and help with plans to ensure safety. To be most effective, health professionals cannot be expected to undertake this task without training (Taket et al., 2003).

Training on IPV is needed for the healthcare provider to understand the issues and raise awareness. Training should also focus on relevant communication skills required to discuss the issue. Training should occur every few years on screening for and following up on disclosures of intimate partner violence. Training should include a review of the latest research findings about the potential effects of IPV, screening methods, and available resources (Colarossi et al., 2010). The use of role-playing and scripts related to asking about IPV should be included in continuing education. Screening should be included in one’s job description and responsibilities.

Aneja, Gottlieb & Feller (2009) proposed and implemented a step-by-step protocol in a small Rhode Island community in which an IPV desk reference was created as a resource for providers in order to increase screening, early detection, and treatment of victims of IPV. It addressed screening, how to speak to a victim, safety assessments, interventions, documentation,
red flags, and provides local numbers for shelters and help lines. Provider resources such as these give providers a cue from which to work and perhaps more confidence in addressing the issue.

Clear, complete, and concise documentation is one crucial factor in effective surveillance and cannot occur without education about screening, interventions, and documentation (Biroscak et al., 2006). Education can be accomplished through a variety of activities such as participating in clinic protocol development; participating in continuing education programs; reading books and journal articles; and collaborating with local domestic violence programs/shelters (Biroscak et al., 2006).

On-Site and Off-Site Resources

Wallet-sized referral cards from a local women’s center, posters in restrooms and exam rooms, and confidential packets on IPV are just some of the resources that can be provided to victims in the primary care setting (McFarlane, Groff, O'Brien, & Watson, 2006). The availability of resources communicates the message to patients that IPV affects health and that it is an issue that can be discussed in the medical office, and provides the resource information for those who are not yet ready to verbally disclose their abuse. Services for women, their children, and their intimate partners must include advocacy, legal assistance, emergency shelter, counseling, victim support groups, batterers’ groups, children’s services, education, and financial assistance (Coker et al., 2002).

Another issue that can be addressed with adequate resource availability and knowledge is that of assuring patient safety once they have been identified as a victim of abuse. Patient confidentiality must be maintained and sensitivity to the situation must also be exercised by all involved. An IPV desk reference as mentioned above should contain local resources for
emergency shelters, hotlines, childcare, food banks, and legal consultants that can assist in providing a safe environment. It is also important to create a brochure or plan that can be discussed with someone who has disclosed or is suspected of abuse, but is not ready to leave the abuser. This should include the above resources along with ways in which to prepare for leaving such as having a bag of clothing, money, and toiletries hidden and ready for the time when the victim decides to leave.

**Conclusion**

IPV is clearly a national epidemic that currently threatens the health and well-being of millions of men and women each year. With annual costs in the billions, IPV is also a financial disaster that threatens to spiral out of control as we face the current health care crisis.

Although universal screening is typically mandated in emergency departments, the same is not true for private practice clinics, where only 10% of providers routinely ask about IPV. Providers as a group are doing a great disservice to their patients by ignoring, avoiding, and circumventing universal screening. Victim, provider, and system barriers to screening can all be overcome if a multipronged approached is utilized in which attitudes are changed, providers receive timely and continued education on IPV, and an array of on and off-site resources are made available to all patients.

Further research is needed in this area and should encompass pilot trials in which specific clinics are chosen to implement increased education for providers and the use of resources for victims. The aforementioned Rhode Island trial in which an IPV desk reference was created is an example of research that must continue on a larger scale (Aneja et al., 2009). Every practice must
have some form of reference that can be relied upon when screening, intervening, and documenting for IPV.

We also must call for a national mandate in which all providers are required to universally screen their patients at least once yearly. I believe this would create a significant improvement in our goal of reducing the occurrence of IPV by 20% as it increases women's knowledge of IPV, offers them support, and can contribute to creating safer communities for women and children. It is our ethical and professional responsibility to actively screen all patients for IPV in an effort to decrease and even prevent its consequences.
References


Table 1. HARK questionnaire for IPV

| H | HUMILIATION | Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner? |
| A | AFRAID | Within the last year, have you been afraid of your partner or ex-partner? |
| R | RAPE | Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? |
| K | KICK | Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner? |

Table 2. American Medical Association 7 Initiatives to Decrease IPV

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<td>• develop teaching modules for members to present to medical students, residents, and hospital staff</td>
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<td>• create an ongoing education program on screening, recognition and treatment of violence</td>
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<td>• support or develop university-, hospital-, or office-based protocols and policies about IPV</td>
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<td>• publicize the hot-line numbers for organizations that help providers and patients deal with IPV</td>
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<tr>
<td>• offer continuing medical education to increase skills for screening, identifying, and treating IPV</td>
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<td>• participate in public policy initiatives and legislative reform to protect victims</td>
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<td>• promote reasonable and responsible control of firearms and other weapons</td>
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Figure 1. Primary injury diagnoses by body region for female intimate partner violence victims.