ABOUT THIS POLICY BRIEF

This ASPE Policy Brief on screening and counseling for domestic violence in health care settings is intended for policy makers, health care practitioners, and other stakeholders.

The brief, written by Madeleine de Boinville, presents the state of practice and research surrounding domestic violence screening. The brief discusses reasons for screening in health care settings, the current prevalence of screening and reasons this prevalence is relatively low, existing evidence about screening, and next steps toward ensuring that screening becomes an effective preventive service.

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SCREENING FOR DOMESTIC VIOLENCE IN HEALTH CARE SETTINGS

Background

In 2011 the Institute of Medicine (IOM) released, Clinical Preventive Services for Women: Closing the Gaps, an extensive report which identified eight key preventive services that would help ensure women’s health and well-being. That same year the U.S. Department of Health and Human Services (HHS) adopted these recommendations in the Women’s Preventive Service Guidelines (hereafter referred to as “the guidelines”). Under the Affordable Care Act, these services are generally covered in new health plans without requiring a co-payment, co-insurance, or deductible (Health Resources and Services Administration, 2012; The Patient Protection and Affordable Care Act, § 2713). One of the preventive services identified by the IOM and included in the guidelines is screening and counseling for “interpersonal and domestic violence.” Additionally, the U.S. Preventive Services Task Force (USPSTF) released a recommendation in January 2013 calling for clinicians to “screen women of childbearing age for intimate partner violence” (U.S. Preventive Services Task Force, 2013). Given the new policies in support of screening for domestic violence in health care settings, the purpose of this brief is to present the state of practice and research regarding effective screening.

Reasons for Screening in Health Care Settings

Domestic violence is prevalent among women

According to the 2010 National Intimate Partner and Sexual Violence Survey (NISVS), 1 more than one in three women have experienced physical violence at the hands of an intimate partner, including a range of behaviors from slapping, pushing or shoving to severe acts such as being beaten, burned, or choked. An estimated 3.6 percent of women reported experiencing these behaviors in the 12 months prior to taking the survey. Roughly one in four women (24.3%) have experienced severe physical violence, which includes having been slammed against something, having been hit with something hard, or having been beaten (Black et al.,

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1 The NISVS, fielded by the Centers for Disease Control and Prevention (CDC), is a nationally representative survey that collects information about experiences with sexual violence, stalking, and intimate partner violence among non-institutionalized English and/or Spanish speaking women and men aged 18 or older in the United States (Black et al., 2011).
Roughly one in four women (24.3%) have experienced severe physical violence by an intimate partner in her lifetime.

Intimate partner violence is associated with poor health outcomes

Intimate partner violence is associated with life-threatening injuries as well as other physical and mental health problems of both an immediate and long-term nature. In its most severe form, physical IPV can result in death or major injuries. According to the CDC’s National Violent Death Reporting System, in 2003, 20 percent of homicides were directly associated with intimate partner conflict. For victims aged 40 to 44 years old, intimate partner violence was the most common form of violence resulting in death (Centers for Disease Control, 2006).

Physical violence can also result in less severe injuries, including bruises, black eyes, cuts, scratches, or swelling (Salber and Taliaferro, 2006). These types of physical injuries are commonly associated with abuse and may trigger clinicians to ask their patients about IPV (Salber and Taliaferro, 2006). Sexual abuse can result in injuries or infections, such as vaginal and anal tearing, bladder or vaginal infections, and sexually transmitted infections. These types of injuries may also cause a clinician to ask about abuse (Campbell and Lewandowski, 1997; Letourneau et al., 1999).

IPV is also associated with a number of long-term health impacts that may be more difficult for a health care provider to identify as resulting from abuse. Sustained exposure to violence is linked with central nervous system problems, including back pain, headaches, and seizures, as well as gastrointestinal problems (Coker, Smith, et al., 2000; Dillon et al., 2013). Sexual abuse is associated with higher risk of contracting sexually transmitted diseases, such as HIV/AIDS, either through forced unprotected sex or through the increased likelihood of risky sexual behavior (Hess et al., 2012; Mittal et al., 2012; Stockman et al., 2012).

The severe and prolonged stress caused by IPV can be detrimental to mental health as well. IPV is a major risk factor for depression, deliberate self-harm, and suicide (Jaquier et al., 2012; Pico-Alfonso et al., 2006; Van Dulmen et al., 2012). One study found that women who had experienced domestic violence were over twice as likely to suffer from depression than women who had never experienced abuse (Dienemann, et al., 2000). IPV is also correlated with alcohol and drug abuse. One study found that survivors of IPV were over nine times more likely to be dependent on alcohol than women who had not experienced abuse, and eight times more likely to have used illicit drugs in the past 12 months (Lipsky et al., 2005).
IPV is associated with more subtle physical and mental health problems in addition to serious physical injuries.

Research indicates that the relationship between IPV and alcohol and drug abuse by the victim is complicated. Abuse may be more likely to occur when the victim is under the influence of alcohol or drugs (El-Bassel et al., 2005). However, survivors often “self-medicate” to cope with abuse, suggesting that identifying abuse as a root cause for alcohol and drug abuse may be useful in providing treatment (Campbell, 2002; El-Bassel et al., 2003; La Flair et al., 2012).

In addition to the direct linkage between IPV and physical and mental health problems, IPV can affect health outcomes in indirect ways. For example, the National Intimate Partner and Sexual Violence Survey reports that nearly 30 percent of women who have experienced any kind of violence, including physical violence, stalking, and/or rape, reported at least one major detrimental impact related to these experiences, such as being fearful or missing at least one day of work (Black et al., 2011; Kovac et al., 2003). The debilitative impact of abuse can potentially inhibit a woman’s ability to attend medical appointments, adhere to medical treatment plans, or overcome other adverse behaviors such as smoking, substance abuse, or overeating (Salber and Taliaferro, 2006).

Furthermore, abuse can have intergenerational health effects. IPV can result in unintended pregnancies either through forced unprotected sex, risky sexual behavior associated with abuse, or through reproductive coercion, which occurs when one partner interferes with the other’s method of birth control (Silverman et al., 2004). IPV that occurs during pregnancy is associated with preterm birth, low birth weight, and lower gestational age (Kovac et al., 2003; Shah and Shah, 2010). These health consequences may have negative effects on the cognitive and motor skill development of newborns (De Jesus et al., 2013; Hack and Fanaroff, 2000; Hutton et al., 1997). Moreover, children who witness domestic violence are at increased risk of experiencing emotional, physical, and sexual abuse themselves (Holt et al., 2008; Lewis-O’Connor et al., 2006; Peled et al., 1995). Witnessing IPV in childhood is one of 10 adverse childhood experiences linked to negative health outcomes across the life course, including depression, alcoholism, adolescent pregnancy, and suicide attempts (CDC, 2012). The numerous direct and indirect effects that IPV can have on short and long-term physical and mental health are frequently cited as justification for regular screening (American Medical Association, 1993; Family Violence Prevention Fund, 2004; Institute of Medicine, 2011; Salber and Taliaferro, 2006; U.S. Preventive Services Task Force, 2013).

**Intimate partner violence is associated with high health care costs**

In addition to the high cost of violence for society and for individuals who experience abuse, IPV is associated with high health care costs. In one study, researchers surveyed 3,333 randomly selected women ages 18 to 64 to assess their IPV history (Bonomi et al., 2009). The women, with their consent, were then linked with their health care records to determine usage of health services. The total adjusted health care costs for women who had disclosed physical abuse were 42 percent higher than for women who had never experienced abuse. Further, women who had disclosed types of abuse that were non-physical in nature had total annual health care costs 33 percent higher than those of women who had not experienced any form of abuse, suggesting that non-physical abuse can also be costly (Bonomi et al., 2009). The CDC estimated in 2003 that the costs of intimate partner rape, physical assault, and stalking exceeded $5.8 billion, with nearly $4.1 billion going directly for medical and mental health services (CDC, 2003).
Health care settings provide a unique opportunity for identification and intervention

Proponents of expanded screening note that screening in health care settings provides a unique opportunity to identify patterns of violence and prevent future harm (Family Violence Prevention Fund, 2004). Existing research on IPV and emergency room utilization suggests that there is potential for identification and intervention before violence escalates. For example, one study examining emergency department utilization by women who were ultimately killed by an intimate partner found that 44 percent of the women had sought help in an emergency department within the two years prior to their death (Wadman and Muelleman, 1999). Clinicians also usually see patients individually, giving patients the ability to talk to someone without the abuser present. Clinicians can also discuss abuse in the health care context, helping patients understand the implications of abuse for their health and well-being. In addition, patients may feel more comfortable disclosing abuse to a physician or health care provider with whom they have built a trusting relationship, and because of physician-patient confidentiality expectations (American Academy of Family Physicians, 2005). There are some cases where confidentiality will be limited. Some states have mandatory reporting laws, which obligate health care providers to disclose IPV to authorities. Explaining confidentiality to patients during screening requires a clear understanding of such laws.²

Major medical associations and organizations recommend routine screening

There is growing consensus among major medical associations that asking women about their experiences with IPV is important for reducing its incidence and severity. Most recently, in 2013, the USPSTF released a recommendation stating that “clinicians screen women of childbearing age for intimate partner violence (IPV) such as domestic violence, and provide or refer women who screen positive to intervention services” (U.S. Preventive Services Task Force, 2013). The USPSTF is an independent group of national experts in prevention that makes evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. Its recommendations are widely accepted in the medical community (Agency for Healthcare Research and Quality, 2007). This recommendation was significant in that it updated a 2004 USPSTF determination which at the time found insufficient evidence to conduct universal IPV screening.

Screening and counseling for domestic violence was first institutionalized in 1992 when the Joint Commission on the Accreditation of Hospitals and Health Care Organizations (JCAHO) mandated that emergency departments develop written protocols for identifying and treating survivors of domestic violence in order to receive hospital accreditation (Joint Commission, 2009). Since then, many health associations have supported screening across health care specialties. The American Medical Association (AMA), American Congress of Obstetrician Gynecologists (ACOG), and the American Nurses Association (ANA) all recommend routine universal screening. These recommendations support screening not only in hospitals, but in a variety of health care settings, and not just when physical signs of abuse are present (ACOG, 1995; AMA, 1993; ANA, 2000).

² For more information on mandatory reporting laws, see the National Health Resource Center on Domestic Violence at http://www.futureswithoutviolence.org/content/features/detail/790/.
Prevalence of Screening

Research indicates that the prevalence of screening for intimate partner violence differs across health care specialties and is, overall, relatively low. One study synthesized the literature regarding screening rates from 1992 to 2005, finding that 3 to 41 percent of physicians reported routine screening for intimate partner abuse (Stayton and Duncan, 2005). Physicians caring for pregnant patients reported routine screening 11 to 39 percent of the time. Another study, conducted in 2002, examined screening practices among a large sample composed of family practitioners, gynecologists, and emergency medicine physicians. It found that 6 percent of clinicians always screened their patients for domestic violence, while 10 percent had never screened a patient (Elliott, et al., 2002).

Despite the evidence that women experiencing violence often seek help in emergency departments, research indicates that women are commonly not asked about IPV when treated there. A 2006 study examining emergency department utilization by women who had been identified by police as victims of IPV found that only one-third of them were asked when treated if their injury was a result of violence (Kothari and Rhodes, 2006). Research also indicates that not every clinician is equally likely to screen. In general, clinicians are more likely to screen patients regularly if they have received training on the subject (Stayton and Duncan, 2005), are female (Jaffee et al., 2005), are younger (Stayton and Duncan, 2005), and/or are nurses rather than physicians (Stayton and Duncan, 2005).

The practice environment in which clinicians work also appears to play a role in predicting the likelihood of screening. For example, a study looking at the prevalence of screening across health care settings found that the highest rates occurred in settings where clinicians were prompted to screen (Stayton and Duncan, 2005). Kaiser Permanente, the largest nonprofit health plan in the United States, implemented an electronic medical record system to integrate IPV screening into everyday care, which resulted in a 600 percent increase in IPV identification from 2000 to 2011 in Kaiser Permanente’s Northern California region (Decker et al., 2012). The use of such system prompts may be increasingly relevant as more clinicians implement electronic health information technology that requires clinicians to respond to certain fields in client health records (Rhodes, 2012). Finally, research has also found increases in screening rates associated with “environmental enablers,” such as posters, pamphlets, on-site social workers, and reminder stickers on charts, as well as staff training (Stayton and Duncan, 2005).

Reasons for Relatively Low Screening Prevalence

Clinician-reported barriers to screening

Several studies have focused on identifying what obstacles, both real and perceived, clinicians face in conducting regular IPV screening. Sprague et al. conducted a meta-analysis of this research in 2012, identifying 22 studies that surveyed clinicians about barriers to IPV screening. The three most common barriers included time constraints (cited in 82 percent—or 18 out of 22—of the studies reviewed); lack of knowledge, education, or training on the issue (cited in 68 percent of studies); and inadequate follow-up resources and support staff (63 percent of studies). Clinicians also reported discomfort discussing IPV, concerns for their personal safety, and apprehension about misdiagnosis. Half of the reviewed studies reported that the health care provider feared invading their patients’ privacy or offending them. Several reviewed studies (46 percent) also reported that health care providers did not think it was their role to screen for IPV or felt that they had more pressing issues to address (Sprague et al., 2012).

3 Among the studies included in the Stayton and Duncan article, the date the study was conducted was not correlated with the reported prevalence of screening. In other words, according to the article, screening is not becoming more or less common.
There is debate within the medical community over what the appropriate frequency and conditions of screening should be given clinicians’ limited time and resources. One question is whether asking about IPV should be done through a “case finding” approach or through universal screening (Wathen and McMillan, 2012). Case finding involves evaluating whether the patient has specific symptoms associated with IPV, such as cuts, bruises, or broken bones. It also considers whether something in the patient’s history or status indicates that she is at greater risk. For example, IPV occurs across socioeconomic statuses, but the risk is higher if the patient is from a lower socioeconomic status (Rennison and Welchans, 2000; U.S. Department of Justice, 2004) or has a history of drug or substance abuse (McCloskey et al., 2005). These physical symptoms or other warning signs would signal to the clinician that additional questioning about IPV may be necessary.

Universal screening, on the other hand, involves a standardized assessment of all patients, regardless of their reasons for seeking medical attention or patient history (Wathen and McMillan, 2012). For example “The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings,” developed in 1999 by Futures without Violence (formerly the Family Violence Prevention Fund), recommends that screening occur regularly including as part of routine health histories and during every new patient encounter.4

These guidelines, recommending screening frequently, regardless of risk factors or warning signs, demonstrate a universal screening approach. The USPSTF recommendation takes a modified universal screening approach, stating that all women should be screened regardless of risk factors, but it places an age restriction, limiting the recommendation to women of childbearing age, and does not specify in what conditions screening should occur. The IOM recommendation does not provide guidance on when and how often screening should occur or within which contexts.

**Existing Evidence on Screening and Intervention**

The 2013 USPSTF recommendation supporting screening of all women of childbearing age for intimate partner violence was based on the 2012 Annals of Internal Medicine’s “Systematic Review of Evidence to Update the 2004 U.S. Preventive Services Task Force Recommendation” (Nelson et al. 2012). That review of 36 studies about IPV screening in health care settings concluded that there are effective screening tools, that screening tools do not cause significant harm, and that some interventions, primarily for pregnant or post-partum women, have had positive results.5

The review examined 15 studies that evaluated 13 existing screening instruments. Six screening instruments were found to be highly accurate, including: the Hurt, Insult, Threaten, and Scream (HITS) instrument; the Ongoing Violence Assessment Tool (OVAT); the Slapped, Threatened, and Throw (STA'T) instrument; the Humiliation, Afraid, Rape, Kick (HARK) instrument; the Women Abuse Screening Tool (WAST); and the Partner Violence Screen (PVS) (Nelson et al., 2012). Fourteen studies included in the review determined that screening patients for IPV did not result in adverse outcomes (Nelson et al., 2012).

The review also looked at evidence related to interventions. An intervention is the response provided by the clinician or by a different service provider after a women discloses abuse through the screening process. The review included six studies that showed evidence that an intervention had a positive effect

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5 For a listing of studies and more detail on the evidence thresholds used to assess them, see Nelson et al., 2012.
on reducing exposure to IPV, physical or mental harms, or mortality (Blair-Merritt et al., 2010; El-Mohandes et al., 2011; Kiely et al., 2010; McFarlane et al., 2006; Miller et al., 2011; Taft et al., 2009). Five of these six studies conducted interventions that targeted pregnant and postpartum women, and found modest improvements, including fewer episodes of IPV, reduction in reproductive coercion, and improved child gestational age and birth weight (Blair-Merritt et al., 2010; El-Mohandes et al., 2011; Kiely et al., 2010; Miller et al., 2011; Taft et al., 2009). One of the six studies assessed an intervention targeted to women in urban primary care public clinics and tested the difference between two intervention approaches (providing a wallet-sized referral card versus a 20-minute nurse case management session). The study found that both groups experienced a reduction in the number of threats of abuse, assaults, risks for homicide, and events of work harassment, and there was no statistically significant difference between the two interventions (McFarlane et al., 2006).

The systematic review also found one study that addressed the question of whether screening for IPV, without a follow-up intervention, reduced exposure to IPV, physical or mental harms, or mortality. Comparing outcomes for screened and non-screened women, the study found there was no statistically significant difference (MacMillan et al., 2009).

While the review provided sufficient evidence for the USPSTF to recommend universal IPV screening for all women of childbearing age, further research remains to be done to identify the most effective approaches to screening and to understand better the relationship between screening, intervention, and women’s health outcomes.

Next Steps

The implementation of the Women’s Preventive Services Guidelines—and the release of the 2013 U.S. Preventive Services Task Force recommendation—create new opportunities for identifying women experiencing IPV through the increased use of screening by health care providers. The National Health Resource Center on Domestic Violence, funded by HHS, has produced materials to explain the importance of IPV screening to health care providers in an effort to increase screening use.

Additional research could help policy makers and practitioners understand more fully how IPV screening and counseling can most effectively contribute to positive health outcomes. Several areas of research could be particularly helpful. First, evidence is needed to identify effective screening and assessment tools and the best methods of administration. The theoretical basis for improving health outcomes through screening starts when the patient discloses abuse to the clinician, so research to determine what types of questions and methods of inquiry enable patients to feel comfortable enough to discuss abuse would be useful. In addition, further study of the use of electronic health records and prompts could provide valuable information about how to effectively integrate screening into clinicians’ usual routine.

Further, the field could benefit from well-conducted research identifying effective ways of making referrals and of facilitating patients’ connection to services. Since additional services may be required to reduce a patients’ exposure to violence, it is essential for clinicians to make referrals in a way that results in patient follow-through and use of the services.

Finally, research is needed to develop and evaluate effective post-screening interventions. Intimate partner violence has real short and long term direct and indirect negative consequences for physical and mental health. Screening for intimate partner violence has potential to improve health outcomes for women especially when tied to effective and evidence-based interventions that help women prevent or reduce their exposure to violence, when possible. Further research is needed to identify these interventions and the strategies clinicians can use to connect their patients with these interventions.
References


