A Bibliography of Twenty Five Articles on Universal Screening of Domestic Violence in Health Care Settings

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Introduction

Even though the home is often thought of as the safest place, it is also believe to be the place of the most common manifestations of violence in society. The issue of violence has been a societal problem for many years and recent literatures have identify public health implications of such violence. The term “domestic violence (DV) has been used within this paper as it is the most commonly used and recognized term for family violence and intimate partner violence. Domestic violence has been defined differently by various authors. The World Health Organization (WHO) defines domestic violence “as violence committed by a current or former intimate partner involving the threat, attempt, or completion of physical, sexual, or psychological violence. This includes neglect, isolation, intimidation, and financial abuse” (cited in Raissi, Krentz, Siemieniuk, and Gill, 2015, p. 133). DeCherney, Nathan, Laufer and Roman (2012), also define domestic violence as “violence perpetrated against adolescent and adult females within the context of family or intimate relationships [and] is characterized by a behaviour pattern manifested in physical and sexual attacks, as well as psychologic and economic coercion” (para. 1).

According to The Royal College of Nursing (2000), domestic violence is “the actual or threatened physical, sexual, financial, or emotional abuse of a person by someone with whom they have or have had an intimate, familial, or emotional relationship” (cited in Olive, 2006, p. 1737) and the America Psychological Association (APA) define domestic violence as “physically and sexually abusive acts perpetrated against a woman by an intimate partner. These acts include, but are not limited to, threats of violence or acts of violence such as hitting, kicking, or other physical harm or forcing a woman to engage in sexual activity by use of physical coercion” (cited in Samuelson & Campbell, 2005, p. 277). One common

characteristic that runs through all the definition above is that domestic violence occurs within an intimate relationship either present or past and it involves physical or sexual attack as well as psychological and emotional attacks. For the purpose of this review, the definition by the WHO (cited by Raissi, Krentz, Siemieniuk, and Gill, 2015) was applied in the search of articles.

Domestic screening is considered as 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, 2009, p. 493). Screening has also been defined as

> the systematic application of a test or inquiry to identify individuals at sufficient risk of a specific disorder to benefit from further investigation or direct preventive action, among persons who have not sought medical attention on account of symptoms of that disorder (Spongers, Iwi, and Poulos, 2009, p. 56).

Phelan (2007), defined screening as "preventive healthcare service in which specific tests, standardized questions, or exam procedures are routinely used to identify people who require specific interventions to improve their health" (p. 204). In this review the definition from Phelan (2007), assisted in the search process.

The aim of this study is to:

1. To examine the evidence on some of the best and/ or promising practices of universal screening for domestic violence in health care settings.
2. Conduct a review of the most recent literature (in the past 10 years) in the U.S and Canada on the evidence on the best and/or promising practices of such policy.

3. Create a bibliography of 25 key study.

To incorporate information from the variety of disciplines in which research on universal screening of domestic violence takes place, the following data-bases were searched: Social Work Abstract, Social Services Abstract, Psych INFO, CINAHL, ClinicalKey, SocINFO and MEDLINE.

The term domestic violence, intimate partner violence and family violence are used interchangeably to mean the same in this paper.

Key words: Domestic Violence, Universal Screening, Emergency Departments, Health Care Settings, Intimate Partner Violence, Family Violence, Abuse.

The Prevalence Rate of Domestic Violence

Domestic violence has become a "global health problem of epidemic proportions" says the director-general of World Health Organization (cited in Krug, Mercy, Dahlberg and Zwi, 2002, p. 1083) that violates the fundamental human rights of victims causing serious socio-economic, psychological and health implications to individuals, families, societies and the globe. While victims of domestic violence may be male or female, DeCherney, Nathan, Laufer, and Roman (2012) suggest that between 90-95% of the victims are women. The Advocates for Human Rights (2013) reports that though the statistics of DV vary slightly, women are the victims of domestic violence in an expressively greater proportion. While women may use violence against intimate partners, The Advocates for Human Rights (2013) maintain that it is often use reactionary.

The World Health Organization in conjunction with the London School of Hygiene and Tropical Medicine and the South African Medical Research Council (2013) reports that 37% of

women in Africa, Middle East and South Asia have the highest incidence of DV. In Latin and South America the rate was 30%, 25% in Europe and Asia, and 23% in North America (WHO, 2013). In recent times WHO reports that a global prevalence of DV figures indicate that 35% of women worldwide have experienced intimate partner violence (IPV) in their lifetime. It suggests that on the average, 30% of women in intimate relationships report of having gone through abuse from a partner. Globally, as much as 38% of murders of women are committed by an intimate partner (WHO, 2013).

In the United States, domestic violence is said to be a “major health risk factor that affects people from all ethnic and socioeconomic groups” (Klap et al., 2007). It is reported that there are approximately 5.3 million violent incidents of DV being reported each year, costing about $4.1 billion a year for services including medical and mental health services for victims (Klap et al., 2007). Nelson, Nygren, McInerney, and Klein (2004) reports that one to four million women in the United States are physically, sexually, and emotionally abused each year and 31% of all women reports of abuse in their lifetime. A prevalence rates of violence and abuse in clinical samples ranged from 4% to 44% within a year and from 21% to 55% over a lifetime. The frequency of acute cases of DV within the emergency departments in 2004 was from 2% to 7%. (Nelson, Nygren, McInerney, and Klein, 2004).

A study conducted by Glass, Dearwater, Campbell, and Fla (2001) indicated that one in every seven women (14%) who reported at the emergency room departments in Pennsylvania and California was due to violence from an intimate partner. The U.S Centers for Disease Control and Prevention in 2010 National Intimate Partner and Sexual Violence Survey (NISVS) reported that at least one in three women have experienced physical violence in an intimate partner relationship (cited in Todahl and Walters, 2011). The NISVS report further stated that four

women representing 47% were more likely than men to experience multiple forms of intimate partner violence by age 18 and 24 (Todahl and Walters, 2011).

The high incidence domestic violence epidemic is not only prevalent in the United States. Statistics Canada reported in 2013 that there were 87,820 victims of DV across Canada as reported by the police with a rate of 252.9 victims (Statistics Canada, 2013). Violence between spouses was said to be the most common form of DV cases with 48% occurring between current or past spouses (married or common law) (Statistics Canada, 2013). It was revealed that in 2013, 68% of DV victims were female making two-thirds of the Canadian population. The year 2013 recorded more than 90,300 victims of police-reported violence by an intimate partner accounting for more than one quarter of police-reported victims of violent offences in Canada (Statistics Canada, 2013).

A 2012 study in Alberta reported that "every hour of every day, a women is a victim of some form of violence" by a partner or ex-partner (Wells, Boodt and Emery, 2012, p. 4). Within the Province, over 74,000 Albertans are said to have reported physical abuse by a partner within the last five years (Statistics Canada, 2013). Between the year 2000 and 2010, Alberta recorded 121 deaths resulting from intimate partner violence. Wells, Boodt and Emery (2012) reports that "$600 million dollars is spent over 5 years period in Alberta on certain costs that are directly attributable to domestic violence" (para.1). These costs include "accessing basic health services, emergency room and hospital visits, counselling, employment insurance and social assistance" (para. 1). The majority of the cost $ 521 million is reported to have come from the pockets of the ordinary Albertan in the form of tax (Wells, Boodt and Emery, 2012). In 2010, victims of police-reported violent crime in Alberta was 13,574 with a homicide rate of 11.8 for the same period within the Province. It is reported that Alberta has the 5th highest rate of police reported DV and

rates 2nd highest of self-reported spousal violence in Canada (Wells, Boodt, and Emery, 2011). Violence against women in Alberta is on the ascendency. Wells, Boodt, and Emery (2011), reported that violence against Albertan Women was 2.3% high than average in Canada.

In 1992, the American Medical Association, recommended that all adult women entering the primary health care setting (emergency room departments, primary health care and community health centers) should be routinely screened by asking them of their recent experiences of violence in spite of their reason for seeking health care (cited in Todahl and Walters, 2011). Since this recommendation, many countries including United States and Canada have adopted the routine screening of intimate partner violence in health care settings. As suggested by many studies the health care settings is an important place for victims of domestic violence, it is subsequently critical that health care professionals be knowledgeable in the screening (assessment), evaluation and treatment of such DV victims/patients.

Methods

Selection Criteria

Due to the high amount of search articles on universal screening on domestic violence in health care settings (over 2500 articles), the selection of articles was based on the following:

1. Articles published in the United States and Canada within the last years, that is, from 2005-2015.
2. The articles focused on best and promising practices on universal screening of domestic violence.
3. The search was narrowed down to health care settings

4. The study meet minimum quality standards of research such as qualitative, quantitative or mixed methods design.
5. Cross-sectional surveys that reported universal screening of domestic violence in health care settings were also included.
6. And peer reviews on domestic violence universal screening in health care settings.

Some Best and Promising Practices of Universal Screening in Health Care Settings

Domestic violence victim's disclosure of abuse to health care professionals has become another issue of concern to researchers. Many victims fear disclosing such abuse due to various reasons including fear of retaliation from the abuser, concern of legal issues, protection of personal identity and pride, and concern for children (Todahl and Walters, 2011).

Various researchers have recommended best and promising practices in the identification of victims of violence in health care settings. Developing evidence suggests that screening increases patient's disclosure of violence. Todahl and Walters (2011), reported that about 80% of DV survivors disclosed their abuse when screened.

Samuelson and Campbell (2005) suggested that Psychologists in health care settings can initiate screening by the methods and wording used to assess the experiences of domestic violence. They indicate again that detection of domestic violence events increases when abused women are asked "behaviorally specific questions (e.g. Punch, kick) rather than questions that label events (e.g., abuse, rape)" (p. 280).

Todahl and Walters (2011) have mentioned that IPV universal screening instruction increases health care provider confidence in the ability to screen in a safe manner and

subsequent screening and detection rates. They maintained that screening policies, procedures, and practitioner accountability have been successful in identifying victims of IPV. They suggests that patients are more likely to support universal screening under certain conditions that include "(a) privacy; (b) a nonjudgmental, non-pressured, and supportive environment; and (c) informed consent—especially with regard to why a screen is being conducted, who will have access to the information, and how the information may be used" (p. 363).

The Calgary Health Region in 2007 implemented a domestic violence screening protocol in its urgent care settings as a way of creating awareness, a means of identification and intervention providing information on community resources and supporting personal safety plans (Thurston et al., 2009). According to the protocol guidelines, nurses were asked to screen all patients in the Center's urgent care for domestic violence as part of the assessment process. It included screening all adults, seniors, adolescents, and parents/guardians and both male and female patients. The guidelines further instructed nurses to ask about abuse in a clear and direct manner, and offered the following statement:

> We know that violence and the threat of violence in the home is a problem for many people and can directly affect their health. Abuse can take many forms: physical, emotional, sexual, financial, or neglect. We routinely ask all clients/patients about abuse or violence in their lives. Is this or has this been a problem for you, your family, or your child (re) in any way? (Thurston et al., 2009, p. 612).

In their study, Duncan, McIntosh, Stayton and Hall (2006), applied Individualized Performance Feedback (IPF) with peer comparison to DV services in a hospital-based, ambulatory, prenatal clinic. They reported that IPF was associated with a tremendous increase in the amount of DV screening provided by Obstetrics & gynecology resident doctors. These

doctors screened at 60% of appropriate encounters before IPF and 91% of appropriate encounters after IPF. The possibility of screening after the intervention was seven and a half times greater than the chances of screening before the intervention. The researchers noted that the improvement they observed was important because resident doctors provide most of the routine physician care in this setting (65% of routine physician care to prenatal patients).

Forms of screening tools and its strengths

Many screening tools have been developed by various researchers to identify victims of IPV. The Calgary Health Region in 2007 implemented a domestic violence screening protocol in its urgent care setting at 8th & 8th Community Health Center in Calgary. As a screening protocol, nurses at the center routinely ask all clients/ patients about abuse or violence in their lives. Thurston and colleagues (2007) reported that this universal screening at the center increased the screening rate at the center to a highest of 52% from 28% in the last month of the implementation.

In a study to rate patients attitudes towards the use of computer-assisted screening, Ahmed, Hogg-Johnson, Stewart and Levinson (2007), reported that participants had positive attitudes towards computer-assisted screening. On a scale of 1-5, the researchers reported that participants agreed with the benefits of a computer-assisted screening with a mean score of 3.6 and participants expressed interest in such programs. The researchers concluded that computer “would help doctors with routine lifestyle questions, are good way to ask lifestyle questions, would save doctor’s time, will help doctors make better assessments, would make patients feel comfortable answering questions and can be trusted” (p. 467).

Waltermaurer (2005) has identified 33 screening tools from health care settings for IPV that were developed between 1979 --2003 that have proven to be effective. These include:

"AAS-Abuse Assessment Scale, HITS-Survey assessing how often women's partners had Hurt, Insulted, Threatened, with harm, and Screamed at them, PVS- partner Violence Screening, WEB- Women's Experience with Battering, VAWS- Violence Against Women Survey, WAST- Women Abuse Screening Tools, OVAT-Ongoing Violence Assessment Tools & ISA- Index of Spouse Abuse" (Phelan, B. M., 2007, p. 205). All from one source.

Samuelson and Campbell (2005) noted that physical and psychological abuse against women is best measured with the following instruments Conflict Tactics Scale (CTS) and the Index of Spouse Abuse. They also suggested that the Partner Violence Screen (PVS) has proven useful as screening instrument for victim of IPV. They maintained PVS is very short and takes an average of 20 seconds to administer. The rates for detection of domestic abuse using the CTS and the ISA were 24.3% and 27.4%, respectively. The prevalence rate for the PVS was 29.5% (Samuelson & Campbell, 2005).

In summary, evidence provided above suggests the prevalence rate of DV in health care settings in the United States and Canada. Many authors, practitioners and researchers have recommended universal screening of DV in health care settings using a concise screening instrument or procedure. In this paper, the writer collated 25 articles that focused on universal screening in health care settings in the U. S and Canada. It also identified some of the screening tools that have been reported to be useful or effective which included AAS-Abuse Assessment Scale, HITS-Survey assessing how often women's partners had Hurt, Insulted, Threatened, with harm, and Screamed at them, PVS- partner Violence Screening, WEB- Women's Experience with Battering, VAWS- Violence Against Women Survey, and WAST- Women Abuse Screening Tools.

BIOBLIOGRAPHY

1. Ambuel, B., Hamberger, K. L., Guess, C. E., Melzer-Lange, M., Phelan, M. B., & Kistner, A. (2013). Healthcare can change from within: Sustained improvement in the health response to intimate partner violence. *Journal of Family Violence*, *28* (8) 833-847.

Abstract

There is a great need to demonstrate sustained improvement in healthcare-based inquiry, intervention, and prevention provided to patients exposed to intimate partner violence (IPV). We evaluated implementation of the Healthcare Can Change from within model (HCCW) in three primary care clinics and an emergency department within a large healthcare system, using two other primary care clinics for a usual-care comparison on selected variables. Outcome measures included individual-level variables (staff knowledge and attitudes) and system characteristics (clinic policies, procedures, patient education materials, and IPV documentation in patient records). Doctors and nurses reported increased self-efficacy, understanding of referral resources, and understanding of legal issues; IPV knowledge was unchanged. Intervention clinics implemented new policies and procedures, increased patient education, and increased documentation of IPV screening, an improvement which was sustained at 2- year follow-up. Results suggest HCCW is a promising practice for improving the healthcare response to IPV.

Rational For Selection

This article provided a concise inquiry into domestic violence screening in three primary care clinics and factors that hinder effective screening. It suggested that systemic characteristics such as good policies and procedures, patients education materials, proper DV documentation and individual staff knowledge and attitudes when taken care off could be a positive practice for the improvement of the health care systems' response to domestic violence.

2. Hussain, N., Sprague, S., Madden, K., Hussain, F. N, Pindiprolu, B., & Bhandari, M. (2015). A comparison of the types of screening tool administration methods used for the detection of intimate partner violence: A systematic review and meta-analysis. *Trauma, Violence & Abuse 16 (*1) 60-69.

Abstract

The objective of this systematic review and meta-analysis was to assess the rate of IPV disclosure in adult women (>18 years of age) with the use of three different screening tool administration methods: computer-assisted self-administered screen, self-administered written screen, and face-to-face interview screen. A comprehensive literature search was conducted in the MEDLINE, EMBASE, PsycINFO, CINAHL, Database of Abstracts of Reviews of Effectiveness, and the Cochrane library databases. We identified 746 potentially relevant articles; however, only 6 were randomized controlled trials (RCTs) and included for analysis. No significant differences were observed when women were screened in face-to-face interviews or with a self-administered written screen (Odds of disclosing: 1.02, 95% confidence interval [CI]: [0.77, 1.35]); however, a computer-assisted self-administered screen was found to increase the odds of IPV disclosure by 37% in comparison to a face-to-face interview screen (odds ratio: 0.63, 95% CI: [0.31, 1.30]). Disclosure of IPV was also 23%

higher for computer-assisted self-administered screen in comparison to self-administered written screen (Odds of disclosure: 1.23, 95% CI: [0.0.92, 1.64]). The results of this review suggest that computer-assisted self-administered screens leads to higher rates of IPV disclosure in comparison to both face-to-face interview and self-administered written screens.

Rational For Selection

Many of the studies reviewed reported a low disclosure rate of intimate partner violence. This article evaluated the IPV disclosure rates of women aged 18years and above. It evaluated three major screening tools namely: computer-assisted self-administered screen, self-administered written screen, and face-to-face interview screen. It concluded that computer-assisted self-administered screening increases the IPV disclosure rate when compare to the other two. This study provided the evidence on computer-assisted screenings as a best practice.

3. Reem, M. G., Campbell, C. J., & Lloyd, J. *(*2014). Screening and counseling for intimate partner violence: A vision for the future. *Journal of Women's Health*. *24* (1) 80-85.

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.

Rational For Selection

The researchers of the article provided information of universal screening of domestic violence and interventions for victims. Although intervention was not included in the assignment, this article was selected based on its policy implications on providing god interventions to victims of DV after identification within the health care settings. It will aid me in writing my policy recommendations for the third assignment.

4. Miller, M., McCaw, B. Humphreys, B. L., & Mitchell, C. *(*2014). Integrating intimate partner violence assessment and Intervention into Healthcare in the United States: A Systems Approach. *Journal of Women's Health*. *24* (1) 80-85.

Abstract

The Institute of Medicine, United States Preventive Services Task Force (USPSTF), and national healthcare organizations recommend screening and counseling for intimate partner violence (IPV) within the US healthcare setting. The Affordable Care Act includes screening and brief counseling for IPV as part of required free preventive services for women. Thus, IPV screening and counseling must be implemented safely and effectively throughout the healthcare delivery system. Health professional education is one strategy for increasing screening and counseling in healthcare settings, but studies on improving screening and counseling for other health conditions highlight the critical role of making changes within the healthcare delivery system to drive desired improvements in clinician screening practices and health outcomes. This article outlines a systems approach to the implementation of IPV screening and counseling, with a focus on integrated health and advocacy service delivery to support identification and interventions, use of electronic health record (EHR) tools, and cross-sector partnerships. Practice and policy recommendations include (1) ensuring staff and

clinician training in effective, client-centered IPV assessment that connects patients to support and services regardless of disclosure; (2) supporting enhancement of EHRs to prompt appropriate clinical care for IPV and facilitate capturing more detailed and standardized IPV data; and (3) integrating IPV care into quality and meaningful use measures. Research directions include studies across various health settings and populations, development of quality measures and patient-centered outcomes, and tests of multilevel approaches to improve the uptake and consistent implementation of evidence-informed IPV screening and counseling guidelines.

Rational For Selection

This article provided a framework for a systems approach to a successful implementation of IPV screening in health care settings. It provided some of the best practices of DV screening focusing on combined health and advocacy service delivery to support identification of victims and offer appropriate interventions. It also recommended the use of electronic health record (EHR) tools, and cross-sector partnerships for universal screening of DV in the health care settings.

5. Hamberger, L. K. Rhodes, K., & Brown, J. (2014). Screening and intervention for intimate partner violence in healthcare settings: Creating sustainable system-level programs. *Journal of Women's Health*. *24* (1) 80-85.

Abstract

Among the barriers to routine screening for intimate partner violence (IPV) are time constraints, a lack of protocols and policies, and departmental philosophies of care that may conflict with IPV screening recommendations. To address these barriers, systems-level

interventions are needed; in this article, we describe one model that may overcome these obstacles. We discuss how this systemic approach may best be implemented in both out-patient clinics and emergency departments (EDs) and note that evidence for its success will be required.

Rational For Selection

This article recognised potential barriers to successful screening of DV in health care settings and it was selected to aid in the identification of such barriers and make appropriate recommendation in the third paper.

6. O'Campa P., Kirst M., Tsarist C., Chambers C., & Ahmad F. (2011). Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review. *Science & Medicine. 72* (6) 855-866.

Abstract

We undertook a synthesis of existing studies to re-evaluate the evidence on program mechanisms of intimate partner violence (IPV) universal screening and disclosure within a health care context by addressing how, for whom, and in what circumstances these programs work. Our review is informed by a realist review approach, which focuses on program mechanisms. Systematic, realist reviews can help reveal why and how interventions work and can yield information to inform policies and programs. A review of the scholarly literature from January 1990 to July 2010 identified 5046 articles, 23 of which were included in our study. We identified studies on 17 programs that evaluated IPV screening. We found that

programs that took a comprehensive approach (i.e., incorporated multiple program components, including institutional support) were successful in increasing IPV screening and disclosure/identification rates. Four program components appeared to increase provider self-efficacy for screening, including institutional support, effective screening protocols, thorough initial and ongoing training, and immediate access/referrals to onsite and/or offsite support services. These findings support a multi-component comprehensive IPV screening program approach that seeks to build provider self-efficacy for screening. Further implications for IPV screening intervention planning and implementation in health care settings are discussed.

Rational for Selection

This article reviewed the evidence of a successful implementation of domestic violence screening in health care settings and its selection was based on the fact that it provided evidence on programs that took an all-inclusive approach towards DV screening in health care settings. It identified four major programs that seemed successful to increase health professional's self-efficacy for screening. These are institutional support, effective screening protocols, thorough initial and ongoing training, and immediate access/referrals to onsite and/or offsite support services.

7. Nicole, E. A., Sadie E. L., Shabnam, J., & Lehrner, A. L. (2012). Council-based approaches to reforming the health care response to domestic violence: promising findings and cautionary tales, *American Journal of Community Psychology. 50,* (1-2) 50-63.

Abstract

Councils are commonly formed to address social issues including intimate partner violence (IPV). Research suggests that councils may be well positioned to achieve proximal outcomes,

but that their success may depend on contextual factors. The current study compared providers and health care settings at two points in time to explore the degree to which the Health Care Council achieved proximal outcomes in the health care response to IPV, including: (a) providers' reported capacity to screen for IPV, (b) providers' beliefs about IPV as a health care issue and about the IPVscreening process, (c) providers' screening behaviors and (d) organizational policies and protocols to encourage screening. This study, while preliminary, provides support for council-based efforts to stimulate change in the health care response to IPV and also highlights the central role that organizational environment plays in shaping desired outcomes.

Rational For Selection

This article gave an evidence on how health care policy makers can be the pivot of implementing universal screening policies of DV within health care setting. It provided suggestion for institutional commitment towards universal screening of DV in health care setting.

8. MacMillan, L.H., Wathen, N., Jamieson, E., Boyle, H. M., Shannon, S. H., Ford-Gilboe, M., Worster, A., Lent, B., Coben, H. J., Campbell, C. J., & McNutt L. A. (2009). Screening for intimate partner violence in health care settings: A randomized trial. *Journal of the American Medical Association. 302,* (*5*). 493-501.

Abstract

Context: Whether intimate partner violence (IPV) screening reduces violence or improves health outcomes for women is unknown. Objective: To determine the effectiveness of IPV

screening and communication of positive results to clinicians. Design, Setting, and Participants: Randomized controlled trial conducted in 11 emergency departments, 12 family practices, and 3 obstetrics/gynecology clinics in Ontario, Canada, among 6743 English-speaking female patients aged 18 to 64 years who presented between July 2005 and December 2006, could be seen individually, and were well enough to participate. Intervention: Women in the screened group (n=3271) self-completed the Woman Abuse Screening Tool (WAST); if a woman screened positive, this information was given to her clinician before the health care visit. Subsequent discussions and/or referrals were at the discretion of the treating clinician. The non-screened group (n=3472) self-completed the WAST and other measures after their visit. Main Outcome Measures: Women disclosing past-year IPV were interviewed at baseline and every 6 months until 18 months regarding IPV exposure and quality of life (primary outcomes), as well as several health outcomes and potential harms of screening. Results: Participant loss to follow-up was high: 43% (148/347) of screened women and 41% (148/360) of non-screened women. At 18 months (n = 411), observed recurrence of IPV among screened vs non-screened women was 46% vs 53% (modeled odds ratio, 0.82; 95% confidence interval, 0.32-2.12). Screened vs non-screened women exhibited about a 0.2-SD greater improvement in quality-of-life scores (modeled score difference at 18 months, 3.74; 95% confidence interval, (0.47-7.00). When multiple imputation was used to account for sample loss, differences between groups were reduced and quality-of-life differences were no longer significant. Screened women reported no harms of screening. Conclusions: Although sample attrition urges cautious interpretation, the results of this trial do not provide sufficient evidence to support IPV screening in health care settings. Evaluation of services for women after identification of IPV remains a priority.

Rational For Selection

It was interesting to know that the article mentioned above that the results of the trail did not provide evidence for screening but provided a major recommendation for the provision of services for women who were identify with IPV. I chose it because the recommendations were promising.

9. Wathen, N. C., Jamieson, E., MacMillan, L. H., & the McMaster Violence Against Women Research Group (2008), who is identified by screening for intimate partner violence? *Women's Health Issues. 8* 423-432

Abstract

Background: Intimate partner violence (IPV) against women is prevalent and has significant physical and mental health consequences; accurate identification of IPV in health settings can be an important first step in appropriate response and referral to services for women. Methods: As part of a randomized controlled trial assessing IPV screening, we assessed exposure to IPV in the past year in 5,607 women visiting one of 26 health care sites across Ontario, Canada, between August 2005 and December 2006. Women completed both the brief (8-item)

Woman Abuse Screening Tool (WAST) and the longer (30-item) Composite Abuse Scale (CAS), which served as the criterion standard. This paper describes the agreement between these 2 instruments, and identifies covariates associated with being positive on both the screen and the criterion standard versus positive on the screen only. Results: The WAST identified 22.1% of women as experiencing past year abuse, in contrast with the CAS, which identified 14.4% (k ¼

.63; standard error [SE], .01). Women were more likely to have the following characteristics when identified as IPV positive on both the

WAST and CAS than on the WAST alone: being married (odds ratio [OR], 2.7; 95% confidence interval [CI], 1.3–5.5; p ¼ .009), having a mental health issue (OR, 2.3; 95% CI, 1.3–4.0; p ¼ .002), having a drug problem (OR, 1.7; 95% CI, 1.1–2.9; p¼.036), and having a partner with a substance problem (OR, 2.0; 95% CI, 1.2–3.2; p ¼ .006). Conclusion: Screening in health care settings may over identify IPV and care needs to be taken in decisions regarding how abuse is identified. However, screening alone may under identify specific characteristics of women, partners, and relationships that could enable more accurate identification of abuse and specific mental health concerns through clinical case finding.

Rational For Selection

It provided that rational for screening of DV maintaining that screening may over identify DV victims within the health settings and measures should be put in place by health care institutions regarding how abuse is identified.

10. Thurston, E. W., Tutty, M. L., Eisener, C. A., Lalonde, L., Belenky, C. & Osborne, B. (2009). Implementation of universal screening for domestic violence in an urgent care community health center, *Health Promotion Practice. 10* (4) 517-526.

Abstract

Given the morbidity and mortality associated with domestic violence (DV), there is international recognition that the health sector has a responsibility to prevent violence. In North America, the health sector has commonly responded by developing protocols for identifying victims of abuse. This utilization-focused evaluation describes the process involved in the

implementation of universal DV screening protocol undertaken by nurses in the urgent care clinic of a community health center. Dealing with the challenges of the urgent care setting, the strong and supportive urgent care team approach helped integrate the screening procedure into routine nursing practice. Understanding the purpose of asking about DV, quickly recognizing problems, validating staff concerns, and adapting procedures resulted in a strong commitment to implementation. This research has implications for others looking to implement or evaluate screening protocols in other health care settings.

Rational For selection

This article clearly stated the successful implementation of DV screening protocol in Alberta. An area which is of interest to my third paper.

11. Glutamines, I., Beynon, C., Tutty, L. Wathen, N. C., & MacMillan. H. (2007), Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses, *BMC Public Health., 7* 12.

Abstract

Background: Intimate partner violence against women (IPV) has been identified as a serious public health problem. Although the health care system is an important site for identification and intervention, there have been challenges in determining how health care professionals can best address this issue in practice. We surveyed nurses and physicians in 2004 regarding their attitudes and behaviors with respect to IPV, including whether they routinely inquire about IPV, as well as potentially relevant barriers, facilitators, experiential, and practice-related factors. Methods: A modified Dillman Tailored Design approach was used to survey 1000 nurses and 1000 physicians by mail in Ontario, Canada. Respondents were randomly selected from professional directories and represented practice areas pre-identified from the literature as those

most likely to care for women at the point of initial IPV disclosure: family practice, obstetrics and gynecology, emergency care, maternal/newborn care, and public health. The survey instrument had a case-based scenario followed by 43 questions asking about behaviors and resources specific to woman abuse. Results: In total, 931 questionnaires were returned; 597 by nurses (59.7% response rate) and 328 by physicians (32.8% response rate). Overall, 32% of nurses and 42% of physicians reported routinely initiating the topic of IPV in practice. Principal components analysis identified eight constructs related to whether routine inquiry was conducted: preparedness, self-confidence, professional supports, abuse inquiry, practitioner consequences of asking, comfort following disclosure, practitioner lack of control, and practice pressures. Each construct was analyzed according to a number of related issues, including clinician training and experience with woman abuse, area of practice, and type of health care provider. Preparedness emerged as a key construct related to whether respondents routinely initiated the topic of IPV. Conclusion: The present study provides new insight into the factors that facilitate and impede clinicians' decisions to address the issue of IPV with their female patients. Inadequate preparation, both educational and experiential, emerged as a key barrier to routine inquiry, as did the importance of the "real world" pressures associated with the daily context of primary care practice.

Rational For Selection

The researchers of this article identified the health care system as an important place for the identification of victims of DV and also a place for the provision of intervention for victims. It was conducted within a health care setting in Canada and provided important policy recommendation from the Canadian perspective.

12. Sadaf E., Krentz B. H., Siemieniuk A. C. R., 7 GILL, M. (2015) Implementing an Intimate Partner Violence (IPV) Screening Protocol in HIV Care, *Journal of AIDS Patients Care and STDS. 29,* 3.

Abstract

HIV and intimate partner violence (IPV) epidemics propagate and interact in a syndetic fashion contributing to excess burden of disease and poorer health outcomes. In order to understand the impact of IPV on HIV disease management, a universal screening program was implemented in the Southern Alberta Clinic in May 2009. We evaluated our IPV screening protocol and made recommendations for its usage in HIV care. IPV data obtained from patients were evaluated, supplemented with responses from a subset of in-depth interviews. 35% of 1721 patients reported experiencing IPV. Prevalence was higher among females (46%), Aboriginal Canadians (67%), bisexual male/females (48%), and gay males (35%). Of 158 patients interviewed, only 22% had previously been asked about IPV in any health care setting. Patients were responsive to routine IPV screening emphasizing that referral services need to be easily accessible. 23% of patients disclosing IPV subsequently connected to additional IPV resources after screening. We recommend that universal IPV screening be incorporated within regular HIV clinic care. The IPV survey should be given after trust has been established with regular follow-up every 6–12 months. A referral process to local agencies dealing with IPV must be in place for patients disclosing abuses.

Rational For Selection

This article was selected for providing a lot of recommendation on universal screening in HIV clinic care. Many research recommendation of DV screening are mostly made to the general health care system. This article specifically provided a link between HIV and IPV and the need

to provide screening in HIV clinics to aid in the quick identification of victims and to provide appropriate interventions.

13. Phelan, B. M. (2007). Screening for Intimate Partner Violence in Health Care Settings. *Trauma, Violence and Abuse. 8* (2)

Abstract

Intimate partner violence (IPV) is associated with negative health consequences. Universal screening for IPV offers many opportunities for successful intervention, yet this practice in medical settings is controversial. This article examines the potential impact of the U.S. Preventive Services Task Force (USPSTF) recommendations for IPV screening and the emerging literature supporting measurable health benefits resulting from screening interventions in medical settings. Several screening tools and methods of administration that have been evaluated in various clinical settings, with goals to increase their sensitivity and to determine a best method of administration, are reviewed in this article.

Mandatory reporting is closely linked to screening practices and may influence healthcare worker practice and patient disclosure. Mandatory reporting studies are lacking and show variable physician compliance, victim acceptance, and scant outcome data. Informed consent prior to screening, explaining the process of mandatory reporting statutes and victim options should be evaluated to increase sensitivity of screening tools.

Rational For Selection

This study provided evidence supporting quantifiable health benefits resulting from screening interventions in health care settings. It also provided evidence of a number of screening tools and

methods of administration that have been assessed to be useful in many clinical settings. These evidence are useful for future research and practice recommendation

14. Coker, L. A., Flerx, C. V., Smith, H., P. Whitaker, J. D., Fadden, K. M., Williams, M. (2007). Partner Violence Screening in Rural Health Care Clinics**.** *American Journal of Public Health. 97* (7) 1319-1325

Abstract

Objectives: We sought to determine the frequency of intimate partner violence by type in a large, clinic-based, nurse-administered screening and services intervention project. Methods: A brief intimate partner violence screen, which included items to measure sexual and physical assaults and psychological battering (using the Women's Experience with Battering scale) was administered to consenting women receiving care at 1 of 8 rural clinics in South Carolina. Results: Between April 2002 and August 2005, 4945 eligible women were offered intimate partner violence screening, to which 3664 (74.1%) consented. Prevalence of intimate partner violence in a current (ongoing) relationship was 13.3%, and 939 women (25.6%) had experienced intimate partner violence at some point in the past 5 years. Of those ever experiencing intimate partner violence, the majority (65.6%) experienced both assaults and psychological battering; 10.1% experienced assault only, and 24.3% experienced psychological battering only. Most women (85.5%) currently experiencing both psychological battering and assaults stated that violence was a problem in their current relationship. Conclusion: The intimate partner violence screening technique we used was feasible to implement, acceptable to women seeking health care at the targeted clinics, and indicated a high proportion of women reporting intimate partner violence in the past 5 years, with a majority of those women stating that such violence was a problem in their relationships. These findings demonstrated the viability of the

screening technique, which supports the growing importance of implementing intimate partner violence screenings in clinical settings in order to reduce the prevalence of violence in intimate relationships.

Rational For Selection

This article showed the evidence-based clinical effectiveness of the Women's Experience with Battering scale as a tool for DV identification in the health care settings. Though the tool focused on Battering, it provided important information for screening DV victims in health care settings.

15. Sybil, V. R. (2010), Intimate partner violence: screening and intervention in the health care setting. *The Journal of Continuing Education in Nursing. 41* (11) 490-495.

Abstract

Background: The prevalence of intimate partner violence (IPV) has been documented in numerous populations and cultures. IPV is a universal social problem that affects individuals, families, and communities throughout the world. Research supports the idea that victims of IPV view health care providers as a source of help. However, nurses report feelings of inadequacy in their ability to screen for IPV. Methods: This quality improvement project was undertaken to increase awareness of IPV by educating nursing staff working in the health care setting. The educational program was evaluated through pretests and posttests. A universal IPV screening question was added to the hospital admission intake procedure. Through retrospective chart reviews before and after the educational session, screening for IPV by the nursing staff was

evaluated by examination of disclosure rates and referral data. Populations served or affected include nurses and ultimately victims of IPV.

Results: The findings support the idea that an educational program can increase nurses' confidence and competency in screening for IPV. The results of chart review will determine whether there is a significant change in behavior relative to the increase in knowledge.

Conclusion: Additional measures may be needed to enhance nurses' screening and interventional work with patients regarding IPV victimization.

Rational For Selection

The writers of this article supported the idea of universal screening in health care settings and recommended that health care providers such as nurses should be given educational support to enhance their confidence and competence in the identification of DV victims in health care settings.

16. Duncan, M. M., McIntosh, P. A., Stayton, C. D., Hall, B. C. (2006), Individualized performance feedback to increase prenatal domestic violence screening. *Maternal& Child Health Journal. 10 443–449.*

Abstract

Objectives: Universal domestic violence (DV) screening once per trimester of pregnancy is recommended but rarely accomplished. Clinical leaders in this setting sought to improve adherence with this protocol. This prospective study used medical record audit and individualized performance feedback (IPF) with peer comparison to improve DV screening among first and second year obstetrics and gynecology (ob/gyn) residents. Methods: The setting is a northeastern, urban, hospital-based, prenatal clinic serving low-income women. Most

patients are Latina (75%); 11% are black and 9% are white. Few begin care in the first trimester (8.5%). We gave all residents DV training. Next we gave IPF–four reports at seven-week intervals. We reviewed medical record notes on patient visits corresponding to the first medical encounter and week 16 and week 28 of pregnancy. We used this data to compare screening immediately before IPF and following each IPF report. Results: Screening increased steadily over time, from 60% of appropriate visits before IPF to 91% after the fourth report (Chi Square 28.4, $p < .001$). Adjusting for key factors, the odds of screening after the last IPF report were seven and a half times greater than the odds of screening before IPF (Odds Ratio: 7.6; 95% Confidence Interval: 3.0, 19.0). Conclusions*:* IPF was associated with increased DV screening among first and second year ob/gyn residents in this setting. Increased screening improved compliance with the clinic protocol and increased opportunities for patient disclosure, education, and treatment, critical public health objectives.

Rational For Selection

The article talked about universal screening within the health care setting and suggested ways that could increase the identification and disclosure of abuse.

17. Thurston, E. W., & Eisener, C. A. (2007), Successful integration and maintenance of screening for domestic violence in the health sector: Moving beyond individual responsibility. *Trauma, Violence & Abuse. 7* (2) *83-92.*

Abstract

Domestic violence (DV) screening and prevention interventions have been implemented in the health sector; however, few health care settings have successfully implemented protocols that

have been fully integrated and sustained within the larger organization. Researchers have tended to focus on individual-level characteristics of health care providers to explain this. The authors argue that organizational, structural, social, and cultural factors, especially related to gender, also play roles in adoption and integration of these interventions. It is important for policy analysts and program evaluators to use this larger framework to ensure sustainable integration of DV screening programs within health care systems.

Rational For Selection

This article talked of the successful implementation health policy of universal screening in the health care sector and few implementation protocols within some health settings. It identify barriers to the effective implementation of DV screening such individual characteristics that may hinder such screening protocol. It made a lot of policy recommendations and they will be explored in the final report.

18. Trinkley, K. D, Bryan, S. H., Speroni, G. K., Jones, A. R., Allen, A. H. (2012). Evaluation of Domestic Violence Screening and Positive Screen Rates in Rural Hospital Emergency Departments. *Journal of Rural Nursing and Health Care. 12* (1).

Abstract

Introduction: Although Emergency Departments (ED) patients are to be screened for the domestic violence (DV), not all patients are screened. The objective of this study were to quantify rural community hospital overall ED patients DV screening rates and positive DV screening rates. Methods: In this retrospective chart review, a total of 1,200 0f 13, 336 patients Ed visits were randomly selected. Patients were excluded who presented with cardiac or

respiratory arrest, mental health diagnosis, or major trauma; were transferred or arrived from long term care facilities; or were victims of sexual assault. Data was collected on demographics, language, and three key factors for DV per nurse documentation (reported physic or sexual assault, fear, and objective signs). This study was reviewed by an International Review Board. Results: Eighty-eight percent (N=1,056) of rural ED patients in this study sample had documentation for DV screening being completed. Of these, 2% (n=21) had documentation positive for DV. Of these positive, the majority were females (62%). English speaking (86%) patients with an average age of 29 years. Eight-six percent reported assault, 33% reported fear, and 19% had objective signs of DV. Conclusion: The overall DV screening rate of 88% supports the recommendation that all hospitals should ensure they have 100% DV screening rate compliance. The low 2% positive DV screening rate suggests the need for future research to determine DV screening barriers for both nurses and patients.

Rational For Selection

The study recommended 100% screening rate compliance for all health care institutions based on its findings that 88% of the study had documented DV screening. This indicated that Universal screening was useful for health care settings to identify DV victims.

19. Nelson, D. H., Bougatsos, C., & Ian Blazina, I. (2012). Screening women for intimate partner violence: A systematic review to update the U.S. preventive services task force recommendation. *Annals of Internal Medicine, 156* (11) *796-808.*

Abstract

Background: In 2004, the U.S. Preventive Services Task Force determined that evidence was insufficient to support screening women for intimate partner violence (IPV) in health care settings.

Purpose: To review new evidence on the effectiveness of screening and interventions for women in health care settings in reducing IPV and related health outcomes, the diagnostic accuracy of screening instruments, and adverse effects of screening and interventions. Data Sources: MEDLINE and PsycINFO (January 2002 to January, 2012), Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews (through fourth quarter 2011), Scopus, and reference lists. Study Selection: English-language trials of the effectiveness of screening and interventions, diagnostic accuracy studies of screening instruments, and studies of any design about adverse effects. Data Extraction: Investigators extracted data about study populations, designs, and outcomes and rated study quality by using established criteria. Data Synthesis: A large fair-quality trial of screening versus usual care indicated reduced IPV and improved health outcomes for both groups, but no statistically significant differences between groups.

Fifteen fair- and good-quality studies evaluated 13 screening instruments, and six instruments were highly accurate. Four fair- and good-quality trials of counseling reported reduced IPV and improved birth outcomes for pregnant women, reduced IPV for new mothers, and reduced pregnancy coercion and unsafe relationships for women in family-planning clinics. Fourteen studies indicated minimal adverse effects with screening, but some women experienced discomfort, loss of privacy, emotional distress, and concerns about further abuse. Limitation: Trials were limited by heterogeneity, lack of true control groups, high loss to follow-up, self-reported measures, and lack of accepted reference standards. Conclusion: Screening instruments

accurately identify women experiencing IPV. Screening women for IPV can provide benefits that vary by population, while potential adverse effects have minimal effect on most women.

Rational For Selection

The study countered the U.S Preventive Services Task Force recommendation that evidence was insufficient to support screening women for intimate partner violence in health care settings. It provided a new evidence on the usefulness of DV screening and interventions for women victims in health care settings. It provided the evidence that screening decreases the incidence of IPV and its related health outcomes.

20. Lutgendorf M., Thagard, A., Rockswold, P. D., Busch, J. M., & Magann, E. F. (2012) Domestic violence screening of obstetric triage patients in a military population. *Journal of Perinatology. 32* 763-769.

Abstract:

Objective: The objective was to estimate the self-reported prevalence of domestic violence in a pregnant military population presenting for emergency care, and to determine the acceptability of domestic violence screening. Study Design: A prospective observational survey of patients presenting for obstetric emergency care. Women were anonymously screened for domestic violence using the Abuse Assessment Screen. Result**:** A total of 499 surveys were distributed, with 26 duplicate surveys. After excluding the 12 blank surveys, a total of 461 surveys were included in the final analysis. The lifetime prevalence of domestic violence (including physical, emotional and sexual abuse) was 22.6% (95% CI = 19.0 to 26.4) with 4.1% (95% CI = 2.3-6.0) of women reporting physical abuse in the past year and 2.8% (95% CI = 1.3-4.3) reporting abuse since becoming pregnant. The majority of women 91.8% (95% CI = 88.7-94.2) were not

offended by domestic violence screening and 88.8% (95% CI = 82.0 -88.9) felt that patients should be routinely screened. Conclusion: The self-reported prevalence of domestic violence in a pregnant military population presenting for emergency care was 22.6%. Most women are not offended by domestic violence screening and support routine screening.

Rational For Selection

It was interesting to note the prevalence of abuse in a pregnant military population and how screening was beneficial in the identification of victims. The article met the aim of the assignment and provided extra research on DV within the military population.

21. Eisener, C. A., Thurston, E. W. (2006). Successful integration and maintenance of screening for domestic violence in health care sector: Moving beyond Individual Responsibility. *Trauma, Violence and Abuse. 7* (2) 83-92.

Abstract

Domestic violence (DV) screening and prevention interventions have been implemented in the health sector; however, few health care settings have successfully implemented protocols that have been fully integrated and sustained within the larger organization. Researchers have tended to focus on individual-level characteristics of health care providers to explain this. The authors argue that organizational, structural, social, and cultural factors, especially related to gender, also play roles in adoption and integration of these interventions. It is important for policy analysts and program evaluators to use this larger framework to ensure sustainable integration of DV screening programs within health care systems.

Rational For Selection

This study explicitly provided information to DV policy makers to consider organizational, structural, social and cultural factors for the successful implementation of DV screening in health care settings. It provided a lot of policy suggestions which are important for paper three.

22. Daugherty, J., & Houry, D. (2008), Intimate partner violence screening in the emergency department*, Journal or Postgraduate Medicine. 54* (4) 301.

Abstract

Background: Every year between 1.5 and 4 million women are abused by a partner in the United States and many abused women turn to the Emergency Department (ED) as their first source of care. Even though the vast majority of patients would feel comfortable disclosing intimate partner violence (IPV) to their physician, identification and referral is inconsistent. Aims: The aim of this paper was to discuss prevalence statistics of IPV, current screening recommendations and practices in ED settings, and future directions to improve the screening and identifying of victims of IPV that present to the ED.

Material and Methods: The authors conducted a Medline search for articles discussing IPV screening in the ED. Results: Intimate partner violence results in approximately 1,300 deaths and 2,000,000 injuries annually among women and up to a third of ED patients have a history of IPV. Despite patients' reported willingness to disclose this information, identification of IPV by healthcare practitioners remains very low, with some estimates ranging between 4-10%. Conclusions: If we do not identify victims of IPV in the ED, this may result in continuation of the abuse, routine returns to the ED for treatment of injuries, and possibly even death.

Rational For Selection

The writers of this article examined the prevalence of DV within the emergency departments in the U.S. It provided information on the need for health care institutions particularly emergency departments to have a universal screening for DV within their outfit. The researchers maintained that failure for emergency departments to screen for DV will consequently increase the number of reported cases of DV in the emergency departments and the DV trend will remain a problem not only to the emergency departments but society as a whole. This article have a strong findings and will aid in policy recommendation.

23. Ramachandran, V. D., Covarrubias, L., Watson, C., & Decker, R., M. (2013). How you screen is as important as whether you screen: A Qualitative Analysis of Violence Screening Practices in Reproductive Health Clinics, *Journal of Community Health, 38* (5) 856-863.

Abstract

Adolescent and young adult women are disproportionately burdened by violence at the hands of dating and intimate partners. Evidence supports routine screening in clinical settings for detection and intervention. Although screening for intimate partner violence in reproductive health care settings is widely endorsed, little is known about screening practices. We conducted qualitative in-depth interviews with healthcare providers (n = 14) in several urban reproductive health clinics in Baltimore City, Maryland to understand screening practices, including related barriers and motivations. Interviews were transcribed verbatim and analyzed using inductive content analysis. Findings demonstrated substantial variation in screening practices as well as related referral and follow-up, despite the existence of a screening tool. Factors that appeared to undermine consistent and successful screening implementation included lack of a common goal

for screening, lack of clarity in staff roles, a gap in on-site support services, as well as lack of time and confidence. Findings affirm the value of applying a systems model to intimate partner violence (IPV) screening programs. This research advances the understanding of the implementation challenges for violence-related screening for high-risk populations such as adolescents and young adults in reproductive health care settings and is particularly relevant given the recent endorsement by the DHHS to cover IPV screening under the Affordable Care Act.

Rational For Selection

The article provided the basis for screening adolescents and young adult women in a reproductive health clinics whom to them are the most vulnerable. The study provided evidence that intimate partner violence screening tool was included into the health history form that was completed during new-patient and annual visits. This is a very promising practice.

24. Miller, E., Decker, R. M., Raj, A., Reed, E., Marable, D., Silverman, G. J. (2009). Intimate partner violence and health care-seeking patterns among female users of urban adolescent clinics. *Maternal & Child Health Journal. 14* 910–917.

Abstract

To assess the prevalence of intimate partner violence (IPV) and associations with health care-seeking patterns among female patients of adolescent clinics, and to examine screening for IPV and IPV disclosure patterns within these clinics. A self-administered, anonymous, computerized survey was administered to female clients ages 14–20 years (N=448) seeking care in five urban

adolescent clinics, inquiring about IPV history, reasons for seeking care, and IPV screening by and IPV disclosure to providers. Two in five (40%) female urban adolescent clinic patients had experienced IPV, with 32% reporting physical and 21% reporting sexual victimization. Among IPV survivors, 45% reported abuse in their current or most recent relationship. IPV prevalence was equally high among those visiting clinics for reproductive health concerns as among those seeking care for other reasons. IPV victimization was associated with both poor current health status (AOR 1.57, 95% CI 1.03–2.40) and having foregone care in the past year (AOR 2.59, 95% CI 1.20–5.58). Recent IPV victimization was associated only with past 12 month foregone care (AOR 2.02, 95% CI 1.18–3.46). A minority (30%) reported ever being screened for IPV in a clinical setting. IPV victimization is pervasive among female adolescent clinic attendees regardless of visit type, yet IPV screening by providers appears low. Patients reporting poor health status and foregone care are more likely to have experienced IPV. IPV screening and interventions tailored for female patients of adolescent clinics are needed.

Rational For Selection

The study provided evidence that patients reporting poor health status are most likely to be victims of DV. It provided a clue for health care providers in the identification process and encouraged universal screening within female adolescent's clinics.

25. McMahon, S., & Armstrong, Y. D. (2012). Intimate partner violence during pregnancy: Best practices for social workers. *Health and Social Work. 37* (1) 9-17.

Abstract

Intimate partner violence (IPV) during pregnancy is a major problem in the United States, with estimates that 3 percent to 17 percent of women experience violence during the perinatal period. Research indicates that IPV during pregnancy is associated with serious, negative health outcomes for the mother and her unborn child. As such, many researchers have suggested that pregnancy offers a unique window for IPV intervention, particularly for social workers in health-care settings. Although assessing for IPV more generally has received increased attention in the social work literature, there is a lack of information about the specific needs for pregnant women. Thus, the purpose of this article is to provide a focused literature review on the scope and impact of IPV during pregnancy and to identify best practices for social workers for intervention and prevention.

Rational For Selection

The study provided an in-depth research support for social workers in health care settings in the identification of IPV survivors. It provided social workers in the health care settings some of the best practice that they can use in the identification of victims including the use of Temporary Assistance for Needy Families (TANF).

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