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IPV: THE USPSTF EVIDENCE, WHAT HAPPENED DURING COVID, AND MOVING FORWARD

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OBJECTIVES

- Review IPV evidence from the USPSTF evidence review 2018
- Review IPV during the COVID-19 pandemic
- Based on my multiple lenses, discuss considerations moving forward

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PERSPECTIVES

- Former USPSTF member (2017-2020 and consultant 2020-2021)
- Current member of the Community Preventive Services Task Force
- Current member of the Advisory Committee for the NIH Office of Research on Women's Health
- Scientist (implementation science) with some publications in family violence (elder abuse and IPV)
- Practicing Obgyn clinician
- Survivor of IPV

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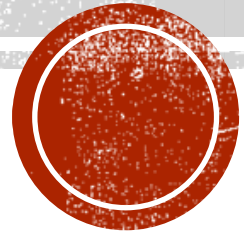
QUICK OVERVIEW/FRAMING



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WHAT IS INTIMATE PARTNER VIOLENCE

- A PATTERN of coercive and manipulative behaviors and assaults that are used to gain **POWER** and **CONTROL** over one's intimate partner or family member.
  - Many have also experienced multiple forms of abuse throughout their lives, impacting their health, mental health, and well-being, and increasing barriers to achieving safety and stability.
  - People who abuse are more likely to target vulnerable or previously exploited individuals who have experienced prior trauma.

- **IPV is multi-faceted and highly complex and entails a cycle, and thus an iterative process is required in order to identify and stop IPV.** There is not one screening encounter nor 1 treatment that will stop IPV immediately and for good. It often takes up to 7 times for someone to leave their abusive partner.

WHO IS AFFECTED BY IPV?

- IPV occurs among all races, ethnicities, religions, socioeconomic groups, and within all gender and sexual identities. It is a serious, preventable public health problem that affects millions of adults and children in the United States.
  - Minority and immigrant women are disproportionately impacted by IPV and often have higher rates of domestic homicide and depression.
  - Black women experience IPV at a rate 35% higher than that of White women.
  - 48% of Hispanic women report an increase in partner violence after immigrating to the US.
  - "The 2015 U.S. Transgender Survey found that 54 percent of transgender people experienced some form of IPV in their lifetime."
  - 1 in 15 children are exposed to IPV each year, and 90% of these children are eyewitnesses to this violence.
    - Many of these children also experience abuse and neglect, some resulting in death.

Note: Most cases of IPV are never reported to the police.

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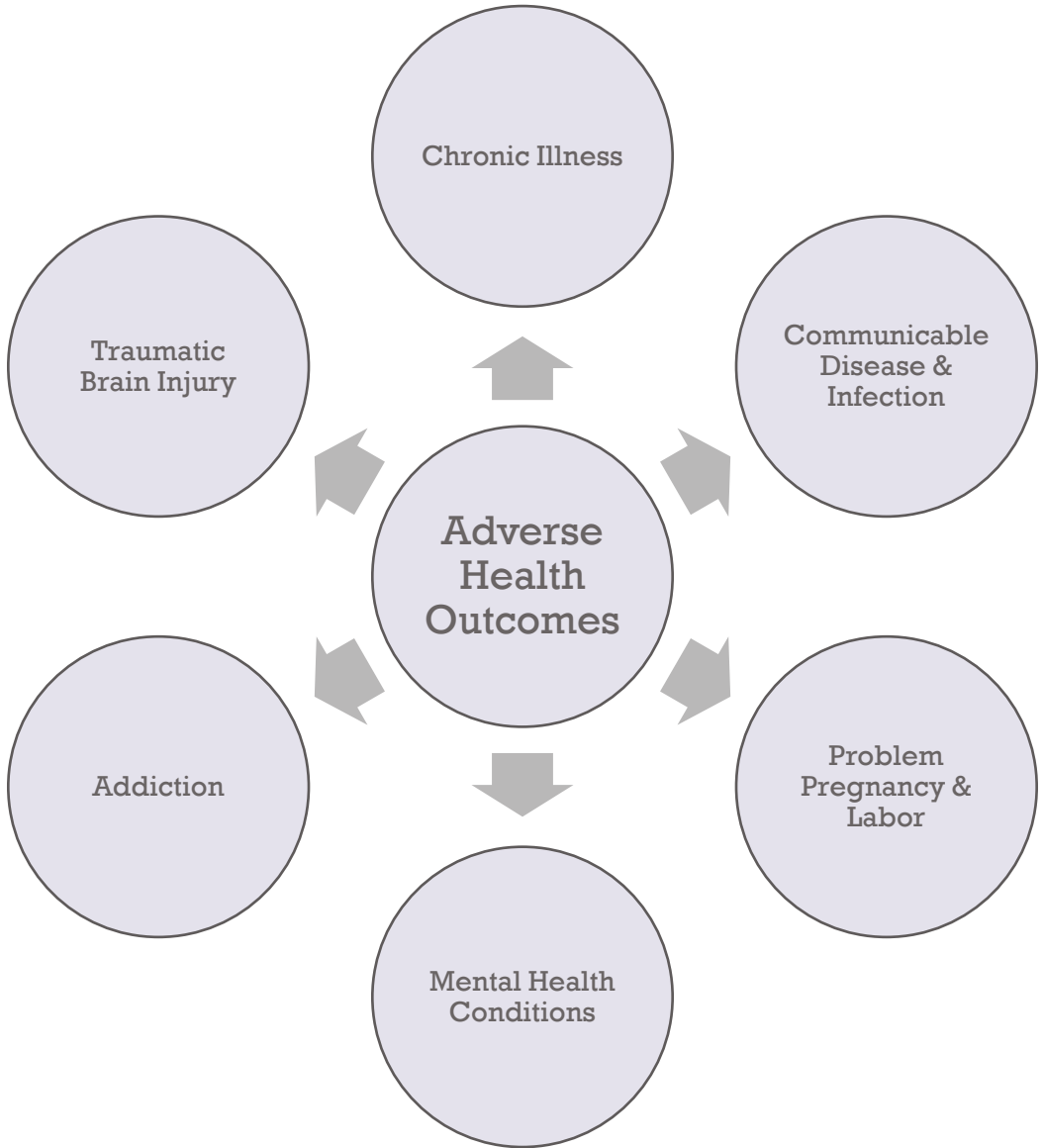
IPV'S IMPACT ON HEALTH OUTCOMES



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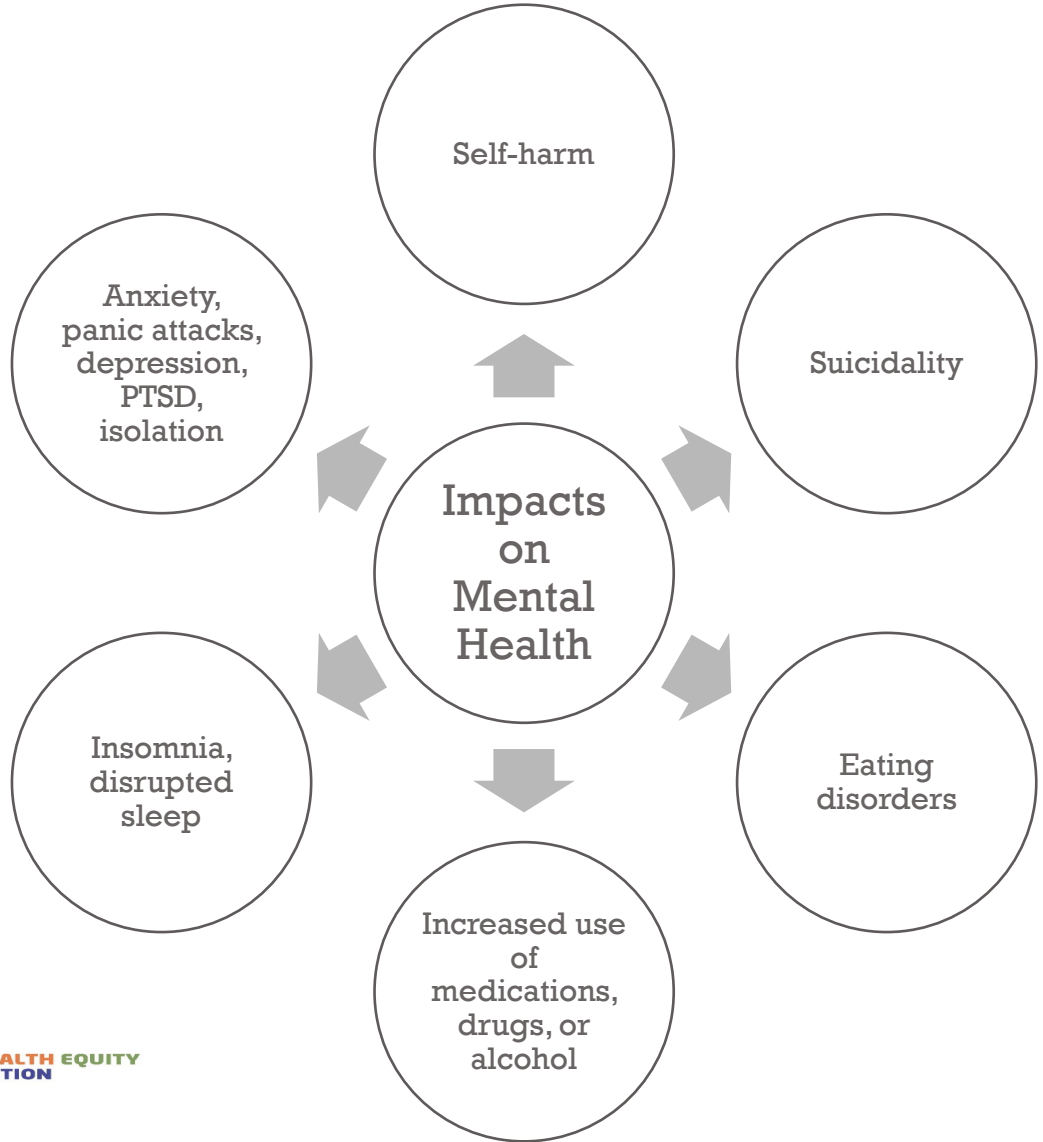
IPV AND MENTAL HEALTH



Valencia-Agudo: https://pubmed.ncbi.nlm.nih.gov/29522914/

Valencia-Agudo, F., Burcher, G. C., Ezpeleta, L., & Kramer, T. (2018). Nonsuicidal self-injury in community adolescents: A systematic review of prospective predictors, mediators and moderators. *Journal of Adolescence*, *65*, 25–38. https://doi.org/10.1016/j.adolescence.2018.02.012

National Women's Study: https://mainweb-v.musc.edu/vawprevention/research/mentalimpact.shtml

Mental Health Impact of Rape. (2000). National Violence Against Women Prevention Research Center. https://mainweb-v.musc.edu/vawprevention/research/mentalimpact.shtml

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IPV INFLUENCES HEALTH-RELATED BEHAVIORS

- Due to multiple factors such as isolation, lack of trust, shame, re-traumatization, and fear of retaliation by their abusers, IPV survivors experience limited access to health care and may feel unable to engage with their health care provider about their health concerns.
- Only 34% of people who are injured by intimate partners receive medical care for their injuries (Truman & Morgan, 2014).
- IPV survivors who do seek care tend to have frequent visits to their doctor and overuse the Emergency Department due to their trauma reaction/panic mode.
- Survivors of violence are more likely to engage in unhealthy coping behaviors (e.g., smoking, drug use, drinking excessively, eating unhealthy foods, etc.).

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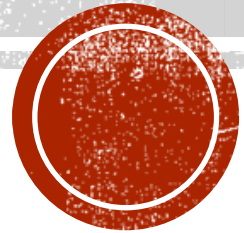
https://www.ojp.gov/ncjrs/virtual-library/abstracts/nonfatal-domestic-violence-2003-2012

Nonfatal Domestic Violence, 2003–2012 | Office of Justice Programs. (2014, April). U.S. Department of Justice. https://www.ojp.gov/ncjrs/virtual-library/abstracts/nonfatal-domestic-violence-2003-2012

THE USPSTF APPROACH



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https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening

THE USPSTF STEPS: BRIEF AND GENERIC

- Assess the evidence across the analytic framework, synthesizing the assessment of each key question:
  - Judge the ***certainty*** of the estimate of benefits and harms
  - Judge the ***magnitude*** of both benefits and harms
  - Determine and judge the *balance* of benefits and harms: the ***magnitude of net benefit***
- When evidence is not sufficient (low certainty), the USPSTF does not use "expert opinion" (explicit "evidence-based")
- Harms of Screening:
  - False positive rate and risks of diagnostic testing
  - Over diagnosis
  - Psychological harms
  - Incidental findings
- Recommendations are population-based for **average-risk, asymptomatic patients=** Thus, there are not always recommendations that apply directly to patients from diverse backgrounds.

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BASIC USPSTF METHODS FOR DEVELOPING RECOMMENDATIONS: THE LETTER GRADES

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D
Moderate	B	B	C	D
Low	I—insufficient evidence			

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USPSTF IPV RECOMMENDATION STATEMENT 2018

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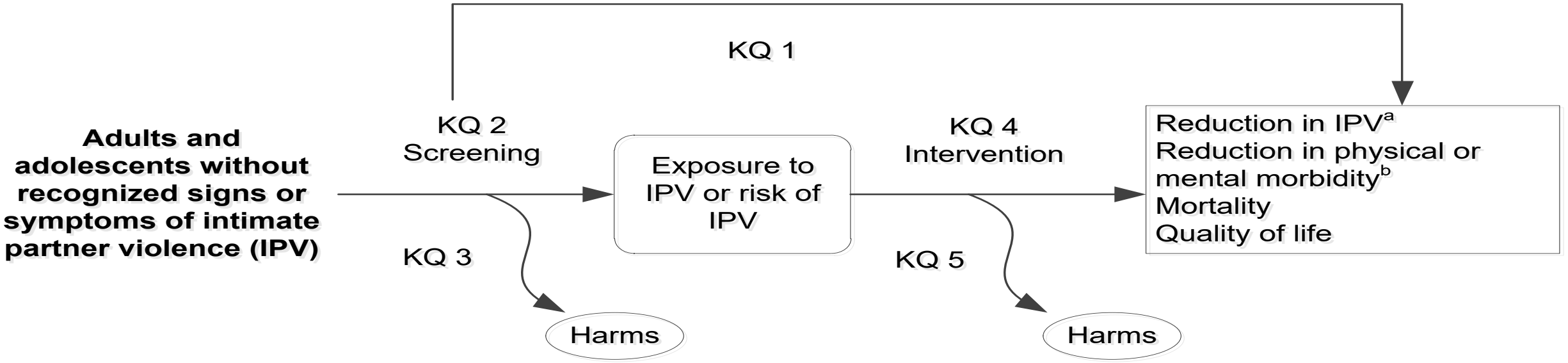
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening

Topic	Description	Grade	Release Date
IPV and Elder Abuse	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services.	B	October 2018
	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults.	I	

Scope of Review

The USPSTF commissioned a systematic evidence review to update its 2013 recommendation on screening for the prevention of IPV, elder abuse, and abuse of vulnerable adults. The scope of this review was similar to the prior systematic review, but in the 2018 recommendation statement review, the USPSTF also examined the evidence on men and adolescents as victims of IPV. This review did not examine screening or interventions for the perpetration of IPV.

IPV KEY QUESTIONS



Benefits:

KQ1: Does screening for IPV in adults and adolescents reduce exposure to IPV, physical or mental morbidity, or mortality?
KQ4: how well do interventions reduce exposure to IPV, physical or mental morbidity, or mortality?

Detection:

KQ2: what is the accuracy of screening questionnaires or tools for identifying adults and adolescents with IPV?

Harms:
KQ3: what are the harms of screening for ipv in adults and adolescents?
KQ5: what are the harms of interventions for ipv in adults and adolescents?

OVERALL DATA CONSIDERATIONS

- The recommendation for IPV screening applies to **women of reproductive age**, because the evidence demonstrating benefit of ongoing support services is predominantly found in studies of pregnant or postpartum women. The USPSTF **extrapolated the evidence** pertaining to interventions with ongoing support services from pregnant and postpartum women to all women of reproductive age.

- The studies that were more effective generally involved ongoing support services, which included multiple visits with patients, addressed multiple risk factors (not just IPV), and provided a range of emotional support, behavioral and social services

- Studies that only included brief interventions and provided information about referral options were generally ineffective.

OVERALL DATA CONSIDERATIONS

- Although no studies were able to definitively prove which intervention components resulted in positive outcomes, effective interventions generally included ongoing support services that focused on counseling and home visits and addressed multiple risk factors (not just IPV) or included parenting support for new mothers

- 5 good- or fair-quality RCTs assessing IPV interventions reported on harms. No study found significant harms associated with the interventions.

- Adequate evidence that available screening instruments can identify IPV in women. There was limited evidence about the performance of IPV screening instruments in men

- There were no screening or intervention studies to reduce IPV victimization in men.

CLINICAL CONSIDERATIONS

- **Patient Population Under Consideration**

This recommendation applies to women of reproductive age with no recognized signs and symptoms of abuse. The studies reviewed for IPV included women from adolescence to women in their 40s.

- **Assessment of Risk**

Although all women of reproductive age are at potential risk for IPV and should be screened, there are a variety of factors that increase the risk of IPV, such as exposure to violence as a child, young age, unemployment, substance abuse, marital difficulties, and economic hardships. However, the USPSTF did not identify any risk assessment tools that predict greater likelihood of IPV in populations with these risk factors.

CLINICAL CONSIDERATIONS

- Several screening instruments can be used to screen women for IPV.

with reasonable accuracy to detect IPV in the past year among adult women:

- **Humiliation, Afraid, Rape, Kick (HARK)**- HARK includes 4 questions that assess emotional and physical IPV in the past year.
- **Hurt/Insult/Threaten/Scream (HITS)**- HITS includes 4 items that assess the frequency of IPV and Extended Hurt/Insult/Threaten/Scream (E-HITS) includes an additional question to assess the frequency of sexual violence.
- **Partner Violence Screen (PVS)**-PVS includes 3 items that assess physical abuse and safety.
- **Woman Abuse Screening Tool (WAST)**-WAST includes 8 items that assess physical and emotional IPV.

CLINICAL CONSIDERATIONS

- Most studies only included women who could be separated from their partners during the screening and/or intervention, so the screening and intervention could be delivered privately.

- State and local reporting requirements vary from one jurisdiction to another, with differences in definitions, whom and what should be reported, who should report, and to whom. Some States require clinicians (including primary care providers) to report abuse to legal authorities, and most require reporting of injuries resulting from firearms, knives, or other weapons.

- The USPSTF found no valid, reliable screening tools to identify IPV in men when there are no recognized signs and symptoms of abuse.

CLINICAL CONSIDERATIONS

- **Screening Interval**

The USPSTF found no evidence on appropriate intervals for screening.
Randomized, controlled trials of screening and IPV interventions often screen for current IPV or IPV during the past year.

- **Interventions**

No studies were able to definitively prove which intervention components resulted in positive outcomes.
However, based on the evidence from three studies, effective interventions generally included ongoing support services that focused on counseling and home visits, addressed multiple risk factors (not just IPV), or included parenting support for new mothers.

CLINICAL CONSIDERATIONS

Potential preventable burden

Women not of reproductive age. Based on the age groupings reported by the CDC, approximately 4% of women ages 45 to 54 years and more than 1% of women age 55 years or older have experienced rape, physical violence, or stalking by an intimate partner in the past 12 months.

Men. More than 33% of men have experienced sexual violence, physical violence, or stalking by an intimate partner in their lifetime. Approximately 34% of men report any psychological aggression by an intimate partner in their lifetime. Among men who experience sexual violence, physical violence, or stalking, more than 10% experience at least one form of an IPV-related impact, such as feeling fearful, feeling concerned for safety, injury, missing days of work/school, and needing medical care.

Other population considerations (TLGBQT+) were not included in the USPSTF 2018 statement

CLINICAL CONSIDERATIONS

- **Potential Harms of IPV Screening-**

shame, guilt, self-blame, retaliation or abandonment by perpetrators, partner violence, and the repercussions of false-positive results (e.g., labeling and stigma).

- **Current Screening Practice-**
  - **Women.** While not specific to age, evidence suggests that screening for IPV is not commonly occurring in practice. A recent systematic review found that rates of routine screening vary and are typically low, ranging from 2% to 50% of providers reporting "always" or "almost always" routinely screening for IPV.

  - **Men.** No data are available on current screening practice in men.

CLINICAL CONSIDERATIONS

Additional Approaches to Prevention – Tools and Resources for Clinicians

- The **Health Resources and Services Administration (HRSA)** Strategy to Address Intimate Partner Violence (2017–2020)(there will be an updated one 2023) identifies priorities for reducing IPV, including training the Nation's health care and public health workforce to address IPV. They developed a toolkit for providers and health centers to help implement IPV screening and interventions.

- The **National Hotline on Domestic Violence** also has information about local programs and resources across the country. The Administration for Children and Families has funded a compendium of state statutes and policies on domestic violence and healthcare. **Futures Without Violence** is another great resource.

- **CDC, Substance Abuse and Mental Health Services Administration (SAMHSA)-HRSA Center for Integrated Health Solutions,**
- **Department of Veterans Affairs, Administration for Community Living**

RECOMMENDATION OF OTHER GROUPS

- American Academy of Family Physicians, American College of Obstetricians and Gynecologists (ACOG), American Academy of Neurology, American Academy of Pediatrics, Institute of Medicine Committee on Preventive Services for Women, and the HRSA-supported Women's Preventive Services Guidelines are in favor of screening for IPV.

- The American Academy of Family Physicians recommends screening for IPV in all women of childbearing age and providing interventions for those who screen positive.

- ACOG recommends screening all pregnant women and offering ongoing support services.

- The American Medical Association Code of Medical Ethics says that clinicians should routinely ask about physical, sexual, and psychological abuse

- The Canadian Task Force on Preventive Health Care and the World Health Organization indicate that current evidence does not justify universal screening for IPV.

- The Community Preventive Services Task Force (CPSTF) recommends primary prevention interventions that aim to prevent or reduce intimate partner violence and sexual violence among youth.

USPSTF IDENTIFIED RESEARCH GAPS

- There are several key research gaps related to IPV.
- A significant body of evidence is lacking for men. The CDC has conducted studies demonstrating the prevalence and importance of IPV against men. For men, research is needed in all areas related to the accuracy of screening tools, and trials are needed that examine the effectiveness (benefits and harms) of screening for and interventions to prevent IPV in men without recognized signs and symptoms of abuse in the primary care setting.
- In the 2018 statement there was no mention of 2SLGBTQIA+ community needs with respect to screening and interventions.

USPSTF IDENTIFIED RESEARCH GAPS

- More research is also needed on the most effective characteristics of ongoing support services for reducing IPV.

- In particular, more RCTs that compare the benefits and harms of screening (plus an ongoing support service or referral for women who screen positive) versus no screening are needed, where support services may include more frequent and intensive interventions such as home visits, cognitive behavioral therapy, or other forms of ongoing support services that address multiple risk factors. These studies should evaluate the optimal duration, format, and method of delivery.

- Trials of ongoing support services should enroll women of all ages, including nonpregnant women and women beyond reproductive age. These trials will help with understanding the types of post-screening, ongoing support services that can be most effective and the patients for whom they are most effective.

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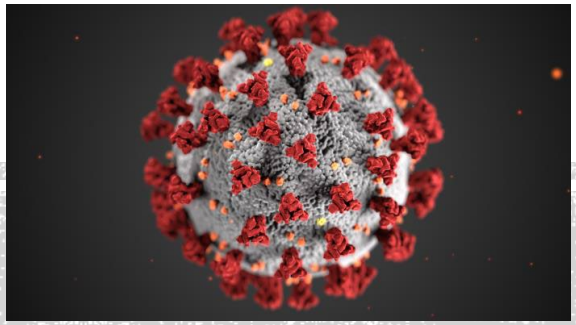
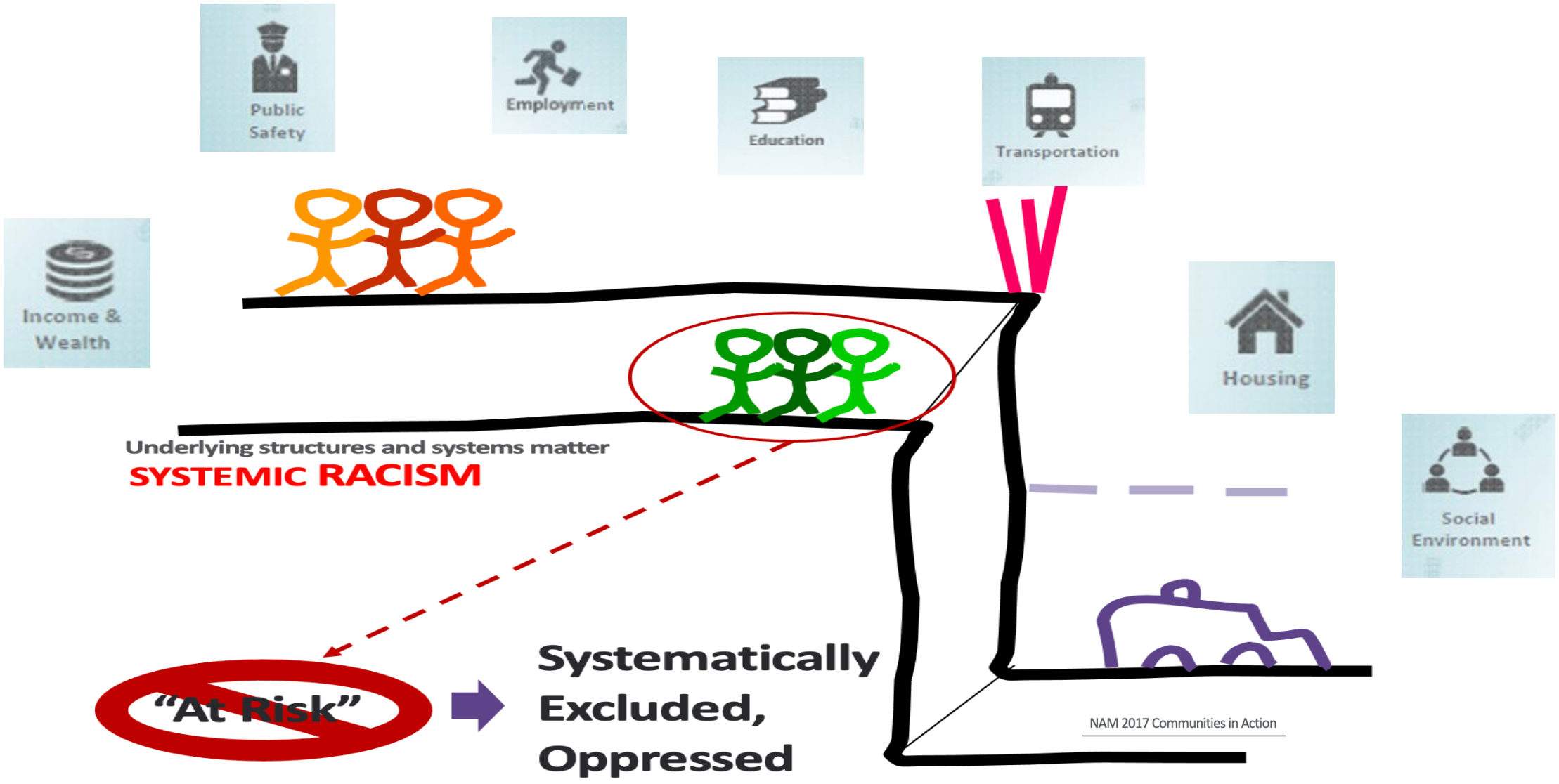


COVID-19 EXPOSED EXISTING HEALTH INEQUITIES AND EXACERBATED THEM ACROSS THE BOARD



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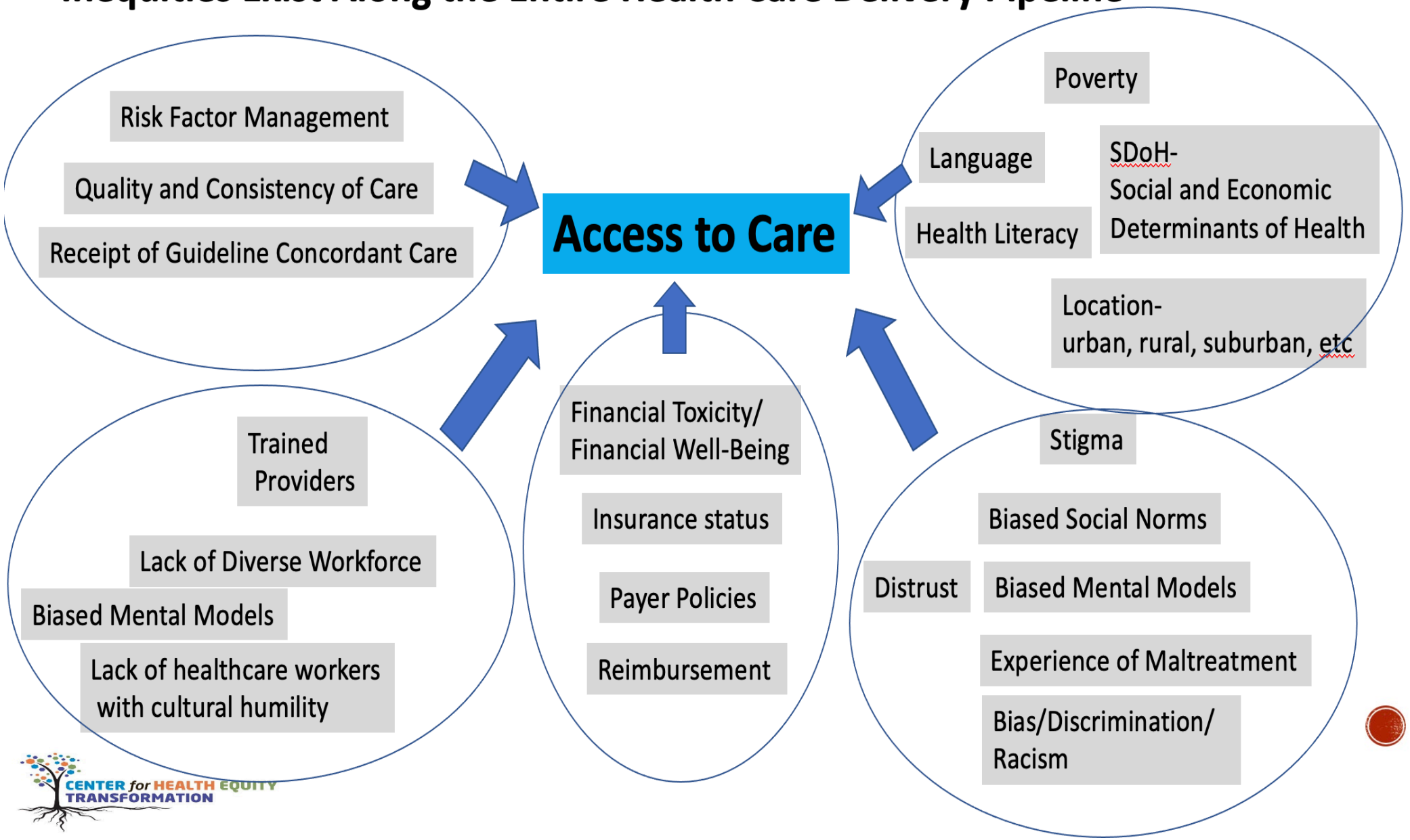
Source: Jones CP *et al.* ***J Health Care Poor Underserved*** **2009.**

Inequities Exist Along the Entire Health Care Delivery Pipeline



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SYSTEMS OF OPPRESSION, IPV, AND COVID-19

-Racism exposed Black, Latinx and Indigenous people to Covid-19 more and protected them less than their White counterparts. Intersectionality of being minoritized and female or from SGM identifying population augmented these lack of protections.

-Make up more frontline worker positions, few to no benefits, hard to impossible to take time away from work to attend a clinic visit(s).

-There also are greater proportions unhoused, or doubled up or in prisons, jails and immigration detention centers. It is much harder to physically distance or isolate.

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D. Ellinghaus *et al.*, N. Engl. J. Med. 10.1056/NEJMoa2020283 (2020).;
M. W. Hooper, A. M. Nápoles, E. J. Pérez-Stable. JAMA **323**, 24 (2020).
A. van Dorn, R. E. Cooney, M. L. Sabin, Lancet **395**, 10232 (2020).; C. Wallis, "Why racism, not race, is a risk factor for dying of COVID-19," Scientific American (2020).

MORE TO CONSIDER

- **Unemployment rate** were at rates higher than at any other point since the Great Depression – Latinx women's unemployment rate= 19.5%; Black women 17.2% and White women 11.9%. Those who remain employed are more likely to be frontline workers

- **Reduced use of AND reduced access to pre- and post-natal care**
  - **Fear** of Covid-19 exposure; telehealth visits; hybrid visits (even before Covid-19 only 75% of Black and 79% Latinx pregnant patients initiated care in first trimester (vs. 89% White).
  - **Telehealth** options are less feasible in rural areas and on tribal lands and in low-income communities with limited internet access, limited cell service.
  - Patients with **physical and/or cognitive disabilities** may face challenges when accessing telehealth.
- **Food Insecurity** has risen
- **Child Maltreatment** increased
- **Substance use** increased
- **Depression and anxiety, suicide** ideation and suicide have increased
- **Limited social support**

MORE TO CONSIDER

- We have to take a **broader perspective** and include the essential role that privilege of being able to take control over when someone decides to be pregnant is imparted to some women over others- and this is an important point that is often left out of the maternal and child health disparities discussions, especially given Covid-19, the overturning of Roe, and lack of access to preventive services.

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DURING COVID-19 PANDEMIC- ACTIONS THAT NEEDED TO BE DONE QUICKLY AND WITH VARYING LEVELS OF KNOWLEDGE, TRAINING, CAPACITY, ENGAGEMENT/RECEPTIVITY

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Simon, MA. Responding to IPV During Telehealth Clinical Encounters JAMA 2021;321(22): . Published online June 8, 2021

HEALTHCARE PROVIDERS MAY BE A PATIENT'S ONLY REFUGE

- Survivors may not have safe and confidential opportunities to disclose their experiences of abuse through the same channels that were available before the pandemic (family, friends, co-workers).
- In the context of the COVID-19 pandemic, IPV survivors were at more risk than ever before of being isolated from everyone other than their abuser and suffering more abuse. And there were less opportunities to have touchpoints with a primary care provider/clinic
- Hence, in-person, outpatient, and virtual telehealth and phone call visits with health care providers created a unique opportunity for providers to offer an alternative safe and confidential intervention.

- One does not need to be an IPV or mental health expert to help survivors.

TELEHEALTH

- There have not been any large RCTs evaluating the accuracy of identifying IPV in telehealth formats
- There have however been studies documenting acceptability and feasibility of trauma-informed, digitally delivered interventions focused on preventing violence to increase safety and decision-making of persons in abusive relationships and linking them to online support.
- Telehealth poses new challenges to ipv screening and support
  - Compromised privacy at home and supportive care for IPV-related injury or provision of resources may require an in-person visit.
  - To help facilitate access to and use of IPV screening questions and resource lists, it is recommended that "smartphrases" be created in the EHR-for provider use.
  - Often clinicians do not want to ask about ipv because of logistical concerns (either because of privacy, or lack of training or lack of referral resources if an affirmative response is received.

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Emezue C. Digital or Digitally Delivered Responses to Domestic and Intimate Partners Violence During COVID-19: Viewpoint. JMIR Public Health and Surveillance 2020;6(3):e19831

REGARDLESS OF MODALITY OF SCREENING

- The **same basic approach remains**: to first recognize that violence and abuse could be occurring and proceed with caution so that the person experiencing IPV is approached in a **person-centered way**, with **access and privacy prioritized**
- Initiating IPV screening with **yes or no responses** to ascertain if it is safe for the respondent to answer questions about IPV and then provide subsequent supportive care resources through email or referral to online information.
- Regardless of the modality of healthcare delivery, **follow-up should occur** because patients may not feel comfortable in discussing IPV with their clinicians until after they have developed a relationship with the clinician.
- The **trust and comfort** engendered by an established relationship with a clinician may be particularly important in telehealth, as suggested by survey results of patient preferences.
- Once identified by telehealth approaches, clinicians should support patients experiencing IPV **tailored to their patient's circumstance**.

CREATIVE TOUCHPOINTS ARE IMPORTANT

- We have to think outside of the box with increasing the number of touchpoints for outreach and connection for survivors, community organizations, providers.
- During the Covid-19 pandemic, we saw creative ways women were reaching out to signal for help
  - Via zoom and hand signals, IPV hotlines on zoom backgrounds
  - Asking people to wear headsets
  - Passing others in cars with hand signals
  - Providers and organizations contacting women about food delivery
  - Grocery store and convenience stores and pharmacy workers receiving and passing information for support, guidance, referral, and etc
- We need more safe havens that can be open during phe's
- We need more support with escape plans during phe's

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TRAINING

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WE NEED TO UPDATE TRAINING EFFORTS

- The current workforce is inadequately trained or not trained especially when considering numerous opportunities for non-traditional touchpoints for survivors of IPV- (e.g. those who work inside and outside of healthcare)

- Universal education is rarely known outside of those who are in IPV serving organizations.

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CUES:
ADDRESSING DOMESTIC AND SEXUAL VIOLENCE IN HEALTH SETTINGS

As easy as **CUES**

C: Confidentiality

Know your state's reporting requirements and share any limits of confidentiality with your patients before discussing domestic and sexual violence.

Always see patients alone for at least part of the visit. It is unsafe to discuss relationships if their partner, friend, or family member is with them.

TIP! Make sure you have access to professional interpreters and do not rely on family for friends to interpret.

"Before we get started I want to let you know that I won't share anything we talk about today outside of the care team here unless you were to tell me about [find out your state's mandatory reporting requirements]."

UE: Universal Education + Empowerment

Give each patient two Safety Cards to start the conversation about healthy relationships, those that are not healthy, and how they can affect their health. Normalizing this conversation as a health issue is crucial.

TIP! Offering Safety Cards to <u>all patients</u> ensures that everyone gets access to information about relationships, not just those patients who choose to disclose experiences of violence.

"Because relationships can affect our health, I give two of these cards to all patients in case you or someone you know needs it. It talks about healthy relationships and what to do if your relationship is not healthy. Take a look... Is any of this a part of your story?"

S: Support

Though disclosure of violence is not the goal of CUES, it will happen. Know how to support someone who says "yes, this happened to me."

Make a warm referral to your local domestic violence partner agency or the National Domestic Violence Hotline (on the back of all Safety Cards!) and document support provided in order to follow up the patient at their next visit.

Offer health promotion strategies and a care plan that takes surviving abuse into consideration.

TIP! What resources are available in your area for survivors of domestic and sexual violence? How about for LGBTQ folks, immigrants or youth? Partnering with local resources makes all the difference.

"Thank you for sharing this with me, I am so sorry this is happening. What you're telling me makes me worried about your safety and health....

Would you like me to share some options and resources that folks with similar experiences are often interested in hearing about? I would be happy to connect you if you are interested."

ipv health

National Health Resource Center on Domestic Violence
M-F 9am-5pm PST | 415-678-5500 TTY: 866-678-8901
health@futureswithoutviolence.org
to get safety cards and other resources: ipvhealth.org

FUTURES WITHOUT VIOLENCE
futureswithoutviolence.org

Source: Futures Without Violence

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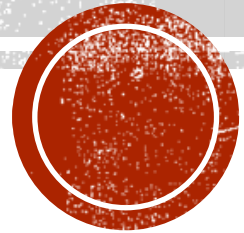
SOME CLOSING THOUGHTS



WE NEED MORE RESEARCH IN MANY AREAS

- Telehealth and other touchpoints (including physical and virtual spaces) that can be mobilized quickly in PHEs
- There is a vast lack of evidence for screening for IPV and the types of health care services needed for 2SLGBTQIA+ communities and men in and outside of public health emergencies.
- Elder abuse intersects with ipv- and we are still with an I statement from the USPSTF for screening in asymptomatic elders
- How to scale training on universal education and other screening approaches (and tools) across these multiple potential touchpoint sites- and how to mobilize such a trained workforce quickly with a phe.

FINAL THOUGHTS

- Leaving is a process and breaking the cycle of violence is a process
- Multiple opportunities for touchpoints, ipv screening often needs to be iterative and conducted by a trusted person in a safe space- and that survivor will then be able to choose a time that is appropriate for them. (it takes about 7 times for a person to leave)
- Multiple places/people who are safe spaces
- Trust- people who are trustable/trustworthy and places that are safe
- This will vary across numerous identities (race/ethnicity, culture, gender identity, age, circumstance, etc
- Addressing communication with respect to health literacy, language, and disinformation
- Tackling disinformation- especially in non-English languages

FINAL THOUGHTS

- Training for all – including universal education, what to do if screen is positive, multiple ways and opportunities for referral. When referral happens, follow-up because of the frequent need to reach out again for another referral- it may take many times before someone actually connects with organization(s) to which they were referred.
- Support for organizations so they can best tailor their services to the specific populations they serve- this could include a variety of touch points and care/support/resource delivery they use to support their clients. (e.g. having cash on hand that can be given to clients for immediate emergency support- connections to ride services, housing, etc)
- The support needed for these types of services need to be rendered and mobilized quickly in a PHE
- Housing options need to include not just the survivor but the ones for which they provide care (children, elders, etc)

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THANK YOU!

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