

Understanding dating violence screening practices: lessons learned from MD healthcare workers

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BACKGROUND

- **Prevalence: ~30% of adolescents in the United States (2009 YRBS)**
- **Consequences - STIs, unplanned pregnancy, school achievement, depression**
- **Evidence supports routine screening in clinical settings**
- **Most research on IPV screening has focused heavily on their effectiveness in improving health outcomes and establishing best practices**
- **Far less attention has been devoted to understanding how screening occurs once a program is implemented**

RESEARCH AIMS

- **To determine if and how providers are screening for dating violence**
- **To describe screening practices, including attitudes towards, barriers and motivations for screening**

DATA COLLECTION METHODS

- **Semi-structured in-depth interviews with clinicians and healthcare workers 18 years of age or older who had direct contact with patients and worked in one of the reproductive health clinics managed by the Baltimore City Health Department**
- **Each interview respondent was interviewed once, with each interview lasting approximately 45 to 60 minutes.**
- **82% response rate (14 of 17 eligible participants participated)**
- **Data collected between September –December 2011**
- **All interviews were recorded and transcribed**

DATA ANALYSIS

- **Inductive content analysis**
- **Using Atlas.ti, two team members coded interviews (6 were double coded) based upon both predetermined themes as well as new themes that emerged from the interviews.**

THE EXISTENCE OF A SCREENING TOOL DOES NOT TRANSLATE TO ITS CONSISTENT APPLICATION

“We’re too busy with STDs ...No.”

~ Health Educator

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Every time I see a patient, regardless of what the visit is for, I ask her if she has a partner. I ask if it's a he or a she, I ask if he or she is nice to them, and if they hit or kick or punch them, and if they feel safe. So I do that every visit, but it's not required for every visit.

~Clinician

VARIATION IN REFERRAL AND FOLLOW-UP PROCESSES DURING A GAP IN SUPPORT SERVICES

When I do see a patient, we're supposed to ask them, have they experienced any violence, or so and so and so and so. We would refer them to our social worker. We don't have a social worker now. We have another way of handling it, I suppose, but no one has said yes, so I haven't been forced to figure out what we're going to do.

~Health Educator

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Interviewer: Has [the social worker's absence] impacted your ability to screen? Do you screen less, would you say?

Medical Office Assistant: Yes. I'm not going to say less, but what can I do? I don't have as many resources as she did so if I had someone who was in a bad situation, outside of letting the provider know, I really don't have any resources for them outside of maybe the number to the [local shelter].

Interviewer: OK. Do you often give that out?

Medical Office Assistant: I don't, no. I know I don't.

VARIATION IN REFERRAL AND FOLLOW-UP PROCESSES DURING A GAP IN SUPPORT SERVICES

■ REFERRAL

You'd have to call [local domestic violence program], and get them linked up that way”
~Clinician

I usually just try to just give them my number and email and resources. And be like, you know, please, if something changes, you know, come back to me, or whatever.
~ Clinician

■ FOLLOW-UP

We get more information, and then we give the referrals. I have a little box where in a little bit I'll call – like in a week, it depends on what it is – call the patient back and see what happened.
~Clinician

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Interviewer: How do you follow up on the screening?

Medical Office Assistant #4: I don't, unless it's a patient who follows up with me.

FACTORS THAT CONTRIBUTE TO VARIATION IN SCREENING

- 1.LACK OF SHARED VISION ON WHY TO SCREEN**
- 2.ROLES ARE NOT CLARIFIED**
- 3.TIME CONSTRAINTS**
- 4.LACK OF CONFIDENCE**

1. THERE ARE MANY REASONS TO SCREEN

To get them help, if they need help and they want to get out of their situation. And to identify to them that they need to get out of that situation.

~Clinician

The goal is ... to find out, one, what percentage of our patients are really being abused. Two, what can we do to prevent this from happening. Three, once let's say that we identify that out of 100 percent of our patients, 75 percent of them are being abused... OK, so we have this number. What are we going to do with this number?

~Health Educator

2. ROLES ARE NOT CLARIFIED

Interviewer: Who do you think should be responsible for identifying and helping with dating violence in a clinic?

Health Educator: All of us...I do. All of us.

~

It would probably be the health educators just because they have that one-on-one time with our new patients, speaking to them about different STDs and how to prevent pregnancies and abstinence and things like that. They have quite a bit of time with our patients so I probably would say the health educators and the clinicians, actually.

~ Medical Office Assistant

2. ROLES ARE NOT CLARIFIED CONT.

It's definitely a social work issue.

~Clinician

You know, I'll give up some of my medications; I'll give up some of my contraception ... if I could have someone who could play that role.

~Clinician

If I had someone who had dating violence or something else, here was somebody that I could fill out a referral and I would know most likely that that social worker was going to follow up on it and maybe have a better ability to help the person than myself.

~Clinician

3. TIME CONSTRAINTS

I hate opening up a door to someone and then being like I am not going to deal with it, you're going to meet with somebody else. . . unfortunately, when you're really busy, knowing that, you know, a certain conversation could end up making this an hour long visit, and you have three people on your door. It does kind of, you know, like, ah, you want to do more than what time will allow.

~Clinician

We're so entrenched in our objective with doing what we do that a lot of times we don't have time to address those types of issues when they come up the way they need to be addressed. We will make a referral out. . . But just to donate the time and effort it takes to deal with two people in a situation where one is being abused and one is an abuser, it's just something that time doesn't allow for either.

~Health Educator

4. LACK OF CONFIDENCE

We're trained to ask the questions, we're trained to make sure, are you feeling safe, blah, blah, blah. But then someone says yes and then you're like, oh no, because now I really have no idea what to do with them ... I've never had any real sense of, OK, now what's the appropriate follow-up? And obviously, I know that you need it, but do I tell them they can call a hotline? Are they really going to do that? Do I make them an appointment while I'm in the office with them to speak with someone? It's really hard to know, what we do now ... like, here, let me just give you this list, and I have no follow-up with you, and I have no idea of anything that took place.

~Clinician#1

SUMMARY

- The presence of a screening tool does not ensure consistent application
- Referral and follow-up varied during a gap in support services
- Several factors contributed to variation in screening practices:
 1. Lack of shared goal of screening
 2. Roles are not clarified
 3. Clinicians don't always feel confident about handling screening,
 4. Time constraints

LESSONS LEARNED

- **Relatively easy task to understand implementation challenges**
- **Developing protocol is vital to consistent screening and alleviates challenges related to goals, roles, confidence and time**
- **A systems approach that integrates clinical and socio-behavioral services is valuable in supporting the screening process and delivering appropriate services**

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