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Intimate Partner Violence Screening

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Abstract

Background: Intimate partner violence (IPV) has become pervasive in our society and is a major public health threat. More than one in three women (35.6%) and one in four men (28.5%) in the United States have experienced violence at the hands of an intimate partner at a cost of 12.6 billion annually. Intimate partner violence includes physical, sexual or psychological assault, including physical aggression, sexual coercion, psychological abuse and controlling behaviors by one who is, was or wants to be in an intimate relationship. Health care provider contacts are an appropriate place for an intervention aimed at reducing the rates of IPV; however that routinely do not screen clients because of time constraints, discomfort with the subject and lacking knowledge of resources for referral when a victim discloses abuse.

Methods: The effectiveness of providing training and resources to health care providers in increasing rates of screening for IPV was evaluated using response technology, with pre- and post-test questions embedded into the beginning and conclusion of the presentation, followed a week later by an online survey. *Results:* Eight professionals attended the presentation. Attendees indicated an increase in the intent to regularly screen clients for IPV between the pre- and post-tests. Participants also reported an increase in their comfort level in discussing the issue.

Discussion: Providing health care providers training in screening methods and available resources for referral can increase willingness to screen for IPV. The findings suggest that incorporating more comprehensive screening tools into medical practices may increase the number of IPV victims who receive appropriate referrals and support.

Keywords: Intimate Partner Violence, Domestic Violence, Screening

Intimate Partner Violence Screening

Intimate partner violence (IPV) has become pervasive in our society and is a major public health threat. More than one in three women (35.6%) and one in four men (28.5%) in the United States have experienced violence at the hands of an intimate partner (Black et al., 2011) at a cost of \$12.6 billion annually (Chamberlain & Levenson, 2011). Intimate partner violence includes physical, sexual or psychological assault, including physical aggression, sexual coercion, psychological abuse and controlling behaviors by one who is, was or wants to be in an intimate relationship. The harm caused by these types of violence can be lifelong and even span generations, adversely affecting the health, economics, education and employment in individuals, families and communities (World Health Organization, 2010). As most people have contact with a health care provider, that is an appropriate place for an intervention aimed at reducing the rates of IPV. Intimate partner violence survivors have reported that whether or not they chose to disclose to their provider, compassionate asking by their providers validated their feelings and helped them to change their situation and move toward safety. Providers are reluctant to ask either because they perceive they don't have time to address the issue, or because they don't have access to appropriate resources for referral (Gerbert, Caspers, Bronstone, Moe & Abercrombie, 1999).

Early in 2012 the University of Alaska conducted a random survey of 423 adult women in Kodiak. Extrapolating those results to the entire community, it was discovered that 38% had experienced IPV and 23% had experienced sexual violence in their lifetimes. Overall, 44% of the women in Kodiak experienced either IPV, sexual violence or both in their lifetime; far above the national average of one in three women (35.6%) (Black et al., 2011). The consequences of this violence have far reaching effects on

victims not only acutely, for instance when a victim presents to a hospital emergency department or physician's office with injuries needing medical attention, but also with adverse health effects long after the incident, or incidents, occurred. In a report on violence and health by Krug et al. for the World Health Organization (2002), this phenomenon is described at length. Physical sequelae to IPV include fractures, bruises, welts, chronic pain syndrome and fibromyalgia leading to long lasting disability, gastrointestinal disorders, and reduced physical functioning. A subset of physical problems, reproductive and sexual issues, may reveal themselves following a history of IPV. These might include such problems as gynecologic disorders, infertility, pelvic inflammatory disease, pregnancy complications and miscarriage, sexual dysfunction, unsafe abortion, unwanted pregnancy and sexually transmitted diseases, including HIV and AIDS. (World Health Organization, 2002)

Psychological and behavioral issues are another important aspect of consequences of IPV. Problems in this area may reveal themselves as alcohol and drug abuse, depression, anxiety, eating and sleep disorders, feelings of shame and guilt, phobias and panic disorders, physical inactivity, poor self-esteem, post-traumatic stress disorder, psychosomatic disorders, smoking, suicidal behavior, self-harm and unsafe sexual behavior (World Health Organization, 2012). Survivors are at a higher risk for substance and alcohol abuse (Decker et al., 2012; Hamberger, Rhodes & Brown, 2015). For some victims IPV is deadly whether through homicide, suicide, death from HIV and AIDS or maternal mortality from an unwanted pregnancy (World Health Organization, 2012).

Over time many different strategies have been used to address the issue of IPV. Perhaps the best known and most common is the use of law enforcement. While at times

this can be effective, it can also be a problem as often law enforcement agents share prejudice found in many communities surrounding IPV. Intimate partner violence often is viewed as somehow being deserved or a private matter not to be dealt with by outsiders (World Health Organization, 2002). A law enforcement intervention requiring arrest of the perpetrator has been shown to be effective only in some neighborhoods, or situations. For instance, arrest acted as a deterrent to men who were employed, married or both, but not for unattached men who were unemployed. In those instances, the threat of arrest often exacerbated the problem (World Health Organization, 2002).

Another legal remedy that has had some effect is the use of protective orders. Court orders restricting an offender from contact with a victim have had the effect of reducing repeated abuse even though the follow-through and subsequent arrest of offenders has not been consistent. In some parts of the world deterrents such as public shaming and picketing an abuser's home or workplace have been used effectively. (World Health Organization, 2002)

One approach to the problem of IPV has been to address the issue within the health care system. If women are to be empowered to seek assistance with IPV, they first must know what resources are available and perhaps most importantly, that they are not the only ones to whom this is happening. Most women encounter the health system through either treatment of injuries or routine health maintenance visits. Research has shown that while women welcome providers inquiring about a history of IPV, many providers do not routinely ask the questions (Krug et al., 2002). Gerbert et al. (1999) studied the matter with two main issues emerging. One was that providers felt they didn't have time to deal with the consequences of an affirmative reply to questioning

regarding IPV. The other identified problem is the perception of a lack of resources and support or knowledge of what to do for a person who discloses such a history.

There is a lack of consensus on definitive interventions for IPV, but there are ways that have been shown to decrease the incidence. One strategy that has seemed to work is the use of protective orders against an offending partner (Krug et al., 2002). Women need to have access to resources to obtain such orders. Health care providers, who see women for a variety of health related issues, also need to have resources to which they may refer those who are in need (Gerbert et al., 1999). An effective approach would, therefore, would be for providers to have lists of resources so they know who to call, or refer clients, when the situation arises. Recent research has shown that having the ability to link survivors or victims with an IPV advocate soon after disclosure increases the odds of identification and access to services. Intimate partner violence is progressively being seen in light of the chronic care model requiring system wide changes. (Hamberger et al., 2015).

The first step in any IPV reduction model is screening (Hamberger et al., 2015). Providers must be able to ask questions of clients regarding IPV. As Gerbert et al. (1999) assert, often providers believe that if someone discloses IPV they need to do something about it, or fix it somehow. These authors found that when providers were given efficient tools to use when inquiring it was helpful, but what was most helpful was changing the attitudes of providers. According to their study, providers were more likely to ask the questions if they saw the actual asking of the question as a success and not necessarily getting someone to seek help. Providers were encouraged to view asking about IPV as relaying a “preventive antiviolence message” to clients (p.583). It also gives potential

victims the message that abuse is wrong, they do not deserve it, and that the provider cares. Survivors have reported that whether or not they chose to disclose to their provider, compassionate asking by their providers validated their feelings and helped them to change their situation and move toward safety. (Gerbert et al., 1999)

Problem Statement

Intimate partner violence is pervasive throughout our society today and there are ways that health care providers can help victims. One important place to begin is for providers to ask questions regarding IPV history. As Campbell et al. (2002) note, providers who don't ask questions may land up treating signs and symptoms of health problems that are never resolved because the true, underlying issue at hand is IPV.

Review of the Literature

Intimate Partner Violence

Intimate partner violence has been defined in many ways. Chamberlain and Levenson (2011) describe IPV using the definition from the Family Violence Prevention Fund's National Consensus Guidelines. The Guidelines definition identifies IPV as "a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and threats." Abusers are delineated as "someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other (p. 5)." Other definitions include same sex partners and use the word co-habiting to mean living at least some of time together as a married couple might live (Tjaden & Thoennes, 2000). When the abuse repeats itself in the same relationship, the term battering is used (World Health

Organization, 2002). Intimate partner violence lies on a continuum from a single incident to ongoing battering (National Center for Injury Prevention and Control Division of Violence Prevention, 2011), so it may look differently in different relationships.

Kimberg (2008) notes that not only women, but men too, are affected by intimate partner violence. She observes that in North Carolina 4% of men killed were murdered by an intimate partner and 13% of male homicide victims were involved in IPV in some way. Intimate partner violence victimization also contributed to heavy alcohol use, depressive symptoms, recreational and “therapeutic” drug use and a history of physical injuries. Chronic disease was found to be sequelae in men as well as women victims and psychological abuse was found to lead to chronic mental illness. Outlaw (2009) notes that women are equally, or even more likely, to abuse their partners in a non-physical manner than men. Edwards (2005) notes that in the United Kingdom 19% of domestic violence incidents involve male victims with about half of those being committed by a woman abuser.

While physical abuse and sexual assault are the most commonly considered facets of IPV, there is also non-physical abuse. Outlaw (2009) describes four major kinds of non-physical abuse, including emotional, psychological, social, and economic. Emotional abuse involves undermining a victim’s self-respect and sense of worth through comments and actions such as complaints, insults, public embarrassment, name-calling and accusations. Psychological abuse is a bit different in that is intended to challenge a victim’s sense of personal logic and reasoning. The abuser effectively makes the victim feel as though she is going crazy, even sometimes convincing her that black is white and vice versa. Social abuse includes isolating the victim by cutting her off from family and

friends through persuasion, threats or force. Finally, economic abuse occurs when the abuser inflicts economic dependence of the victim by the abuser. The abuser decides how much money the abused may have if any at all. Often the victim is forced to steal, borrow from others or beg the abuser for money. Iverson et al. (2015) found greatly increased rates of depression, post-traumatic stress disorder, alcohol abuse and multiple mental health complications in veterans who reported a history of IPV. Respondents in Outlaw's (2009) study of 16,000 men and women indicated that non-physical abuse is more than 4 times as common as physical violence and that emotional abuse was the most prevalent.

The World Health Organization (2012) has done extensive research into IPV as it is seen across the globe. The organization concluded that the effects of physical abuse last long after the abuse itself has stopped. The more severe the abuse, the larger the impact on a woman's life, and the effects tend to be cumulative over time. Campbell et al. (2002) found that the most common locations for acute injuries are the abdomen, breast, upper torso, neck and face, but physical symptoms attributed to abuse-induced stress are also considerable. These symptoms include hypertension, irritable bowel syndrome, and increases in colds and flu. Women affected by IPV also have increased rates of gynecologic, urinary, musculoskeletal and neurologic symptoms, along with higher risks for chronic pain, sexually transmitted infections, poor pregnancy outcomes and elective abortion. (Cronholm, Fogarty, Ambuel & Harrison, 2011) The World Health Organization (2010) describes lifelong costs to many spheres of life encompassing educational and economic under-performance, unsafe sexual practices, a reduced ability to bond with offspring, partaking in risky behaviors such as alcohol and drug use and the

perpetration of IPV and sexual violence. In the United States alone, 1,200 homicides of women are attributed to IPV each year (Hamberger, et al., 2015).

The statistics are startling. Approximately 25% of women in the United States have been sexually or physically assaulted by a current or former partner (Chamberlain & Levenson, 2011; Tjaden & Thoennes, 2000). The U.S. Preventive Services Task Force (USPSTF, 2012) notes this likely underrepresents the actual rates due to the underreporting of IPV. Its sequelae cost the United States \$12.6 billion annually when taking into consideration the costs of direct medical services, legal services, incarceration, the cost of shelters, lost earnings and opportunities, cost of time, unemployment and reduced workers' productivity (Waters et al., 2004). Intimate partner violence occurs in all countries, irrespective of economic, social, religious or cultural group. In fact, 75% of married women living in Bangladesh report physical or sexual violence, whereas only 17% of married women in the Dominican Republic report the same (World Health Organization, 2012).

Battling the epidemic

The World Health Organization (2002) found that law enforcement is one of the most common resources used to combat IPV. In the developed world crisis centers and shelters are readily available. In other parts of the world picketing an abuser's home, community service and even public shaming have been used as deterrents. The advent of legal remedies for domestic violence has helped bring the issue of IPV out into the open.

In some countries, special courts have been created to work specifically with victims of IPV. While arrest is one form of enforcement, it has been met with varied responses. For some it acts as a deterrent, whereas for others it only serves to inflame the

perpetrator (World Health Organization, 2002). Beaulaurier, Seff, Newman and Dunlop (2007) found that many victims are reluctant to involve the police due to a fear that they will be biased in favor of the abuser. Mandatory arrest has become popular in recent years, but Akers and Kaukinen (2008) note that it can work against victims by taking away their power and control over the situation. While arrest has been met with mixed results, the World Health Organization (2002) found that restraining orders can be effective in preventing further IPV for at least a year.

In recent years, much attention has been brought to the role health care providers can play in response to IPV victims. Most women encounter the health care system either for themselves or as caretakers of others. In fact, according to Allen, Lehrner and Mattison (2007) 10-50% of women who seek medical care either have a history of, or are currently in a relationship affected by IPV. This makes health care settings an important arena for potential intervention. Unfortunately, studies have shown that in most countries physicians, nurses and other health care providers rarely inquire about IPV (World Health Organization, 2002).

Spangaro, Zwi, Poulos and Man (2010) discovered that for one in five women who disclosed abuse, routine screening for IPV was the first time an opportunity had been provided to tell someone about their abuse. Punukoilu (2003) reports that while only 10% of primary care physicians routinely screen for IPV, 92% of women who experienced IPV and did not share these incidents with their providers, would have liked their providers to have asked about abuse. In fact, Elliot, Nerney, Jones and Friedman (2002) discovered that many providers did not ask about IPV because they believed that women would volunteer a history of violence.

Health care providers are accustomed to inquiring about intimate personal health questions such as substance or alcohol use that have a much lower base rate than IPV. However, IPV has only recently been recognized as a health care issue and tends to carry substantial social stigma. Often providers feel that screening for IPV is an invasion of a patient's privacy or that it is unlikely to result in positive outcomes. (Allen, Lehrner & Mattison, 2007)

The American Medical Association, the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists in the United States all have guidelines citing the importance of screening for IPV during visits (U.S. Preventive Services Task Force, 2004). Among the free preventive health services identified in the Affordable Care Act is screening and brief counseling for IPV (Miller, McCaw, Humphreys & Mitchell, 2015). The U.S. Preventive Services Task Force (USPSTF) in 2004, however, "found insufficient evidence to recommend for or against routine screening of ... women for IPV" (USPSTF, 2004, p.1)."

In 2009, in a report to the U.S. Centers for Disease Control (CDC), Klevens and Saltzman defended this stance. The focus became a question of what screening is, as compared to whether the questions should be asked. The definition of screening used by USPSTF is the use of "an accurate test that is able to detect the target condition earlier than without screening" and that the resulting outcome, after treatment, will be measurably better. In conclusion the CDC stated, "regardless of the outcome of the screening debate, we assert that healthcare providers should continue to inquire about exposure to IPV in patients who have signs or symptoms associated with IPV" (p. 145).

Tacket, Wathen and MacMillian (2004) also make an argument against universal screening for IPV. These authors declare that until there are interventions available to help those identified through screening, that screening should not be universal. They too recognize that the term “screening” is usually used in the context of looking for a diagnosable disease.

In May of 2012, however, the USPSTF updated its stance on the issue. After considering current research, the organization decided there is adequate evidence available and that screening can identify past and current, or increased, risk for abuse. They also found there is sufficient evidence demonstrating that effective interventions can reduce abuse and violence. The task force asserted that the risk for harm to the individual from screening is no greater than small, so changed their recommendation to a B level recommendation. A B level recommendation means that this service is recommended by the USPSTF, and that there is a high certainty that a moderate to substantial net benefit exists in its provision.

Hegarty et al. (2010) describe a study done in the United Kingdom that suggests the opposite of the USPSTF’s recommendation as that systematic review showed that there was insufficient evidence to justify implementing screening programs. This recommendation was based on a definition of screening that uses as a major criterion the availability of an effective treatment once abuse is identified or disclosed. Hegarty et al. (2010) then performed their own study involving 40 primary care clinics in Australia. They determined that an effective response to intimate partner abuse requires a safety assessment of women and children while respecting and promoting their dignity and understanding the diversity of individual experiences.

To Screen or Not to Screen

Considering the controversy, the question remains, why implement universal screening for IPV in health care settings? Many studies have shown that such screening does help victims of IPV implement positive changes in their lives. Gerbert et al. (1999) and Ahmad et al. (2009) both discuss the reportedly positive impact screening had on a woman's self-worth, and provided validation even if choosing not to disclose the abuse at the time of the interview. Tacket, Wathen and MacMillian (2004) too noticed that women who experienced abuse were in favor of, and valued, being asked directly. Chang et al. (2010) report that women victims they studied described change as a gradual process that takes place over months to years. These past victims stated that women may not always be ready to disclose violence, but appreciate being asked until such time as they are ready. Clearly, screening for IPV has been shown to not only identify survivors, but in many instances to also reduce future abuse, increasing safety and eventually result in better social and clinical outcomes (Decker et al., 2012; Miller et al., 2015).

Community members who are in positions of authority, such as health care providers may be the "key" to ending the cycle of abuse. These professionals may be able to help women find help before their children witness the abuse and perpetuate the cycle (Akers & Kaukinen, 2008). Providers, however, often do not feel comfortable with the subject. Baig, Shadigian, and Heisler (2006) report that only 10% of primary care providers routinely screen for IPV. Colarossi, Breitbart and Betancourt (2010) discuss this at length. They found that providers have many reasons why they don't routinely screen clients including time constraints and feelings of fear or discomfort. They sense that their potential response to the problem will be inadequate to "fix" the problem.

Another issue that arose for providers was a lack of training and education in the subject. Miller et al. (2015) found other barriers to screening include few incentives for providers to screen and a lack of institutional policies guiding appropriate screening and referral.

Beynon and colleagues (2012) considered barriers to screening in their study of 931 nurses and physicians from a variety of practice types. While they too found that lack of time was cited most frequently as a barrier, the next most reported barrier was behaviors attributed to women living with abuse. These providers admitted that it was frustrating to spend time with a client who discloses, referring her to resources, only to have her return to her abuser. They explored reasons that women return to abusive relationships and found these women often experienced financial challenges, fear of reprisal, and child custody battles. Frequently these women, as they navigate the justice system, require numerous appointments at a time when access to resources such as child care, transportation and finances are limited. Often there are strong emotional ties to the abuser as well. One interesting aspect of this particular study was that the authors also sought to find facilitators as well as barriers to IPV screening. They found that the most commonly mentioned facilitators to screening for IPV were training, community resources and professional supports.

Bryant and Spencer (2002) looked at the practice of screening for IPV from the perspective of nurse practitioners. Significant differences were found between nurse practitioners who had personal experience with IPV when compared to those who didn't. Those with personal experience were more likely than those without to report short appointment times as a barrier to identifying victims. Those with personal experience recognized that it can take time for a client to feel comfortable disclosing violence to a

health care provider, and that the short time they were allowed with clients did not give them enough time to screen, identify and report IPV. These same nurse practitioners were more likely to report the abuse to authorities when a victim's safety was of concern.

Time constraints were an issue Shattuck (2002) addressed in her study. She considered universal screening within a public health department. The screening of 182 women was evaluated and it was discovered that the time needed for screening averaged 1.5 minutes. For those who responded "yes" to any of the screening questions, the total time increased to 11 minutes. Shattuck (2002) concluded that the time required for screening was relatively short compared to what she saw as the potential benefits of prevention and early detection.

Rhodes et al. (2007) studied screening in emergency rooms where time is often limited. They found that open-ended questions, with a follow up question, were the most effective method of screening. They were unclear as to whether the asking of a follow up question was effective because it conveyed a sense of interest by the provider, or if it provided a bit more time for an answer. The authors concluded that although it may appear to be counterintuitive, the screening process used did not add substantial time to the visit.

Training might be one method used to increase providers' comfort with screening for IPV. Colarossi et al. (2010) speak to this subject recommending training for both how to screen as well as how to effectively follow up on positive disclosures. They discuss the fact that several studies have shown positive associations between provider training and subsequent adherence to screening protocols, as well as attitudes about the

importance of screening, knowledge about IPV and communication skills surrounding the subject.

Increased training is a recurrent theme in the literature. At the conclusion of her study looking at barriers in screening for IPV, or as she terms it, domestic violence (DV) Tower (2006) states that “education impacts DV barriers; DV barriers impact screening behaviors; and screening behavior impacts victims identified” (p.255). Allen, Lehrner and Mattison (2007) note that training may play an important role in providers implementing the process, as both comfort and confidence levels surrounding the subject of IPV were greater with increased knowledge and skills. Comfort with screening also increased with frequency of screening. While Hamberger et al. (2015) also cite lack of training as an issue for providers, they allude to the fact that often there is little systemic support for screening. Facilities could benefit from having established policies, protocols and procedures in place as well as evaluation processes to assure consistency among providers. At times, there can be a perceived negative attitude among providers in a practice toward screening that can further affect providers’ willingness to screen.

Intimate partner screening is not only a clinical service, but an outreach and educational tool. Discussing violence brings it out into the open and frequent screening of all clients helps to transform a private family matter into a public problem. Screening provides a place for afflicted victims a place to go with their concerns whether or not they choose to disclose. It also serves to raise awareness among the unaffected. (Duncan, McIntosh, Stayton & Hall, 2006) In fact, screening for IPV can be seen to fulfill several layers of prevention. Screening and counseling act as primary prevention for clients with no exposure, secondary prevention for those who have been affected in the past, and

tertiary prevention for clients who are currently in, or have recently ended, an abusive relationship (Miller et al., 2015).

Screening, defined by MacMillian et al. (2009), as a “standardized assessment of patients, regardless of their reasons for seeking medical attention” (p. 493), has been shown to be one method of identifying those experiencing IPV. Health care providers have cited many barriers to screening including lack of time, lack of training, reaction to behaviors attributed to women living with abuse, and the presence of a partner (Beynon, Gutmanis, Tutty, Wathen & MacMillan, 2012). Women, however, wish to be asked about abuse and feel that their providers will maintain confidentiality while keeping an open mind. (Usta, Anton, Ambuel & Khawaja, (2012).

A recurring theme throughout the literature is that providers need education or training in screening as well as the availability of referral resources (Allen et al., 2007; Baig et al., 2006; Beynon et al., 2012; Colarossi et al., 2010; Edwardsen et al., 2011; Miller et al., 2015; Tower, 2006; Williamson et al., 2004). Obtaining education or training increased providers’ identification and documentation of IPV through a heightened awareness of the issue. It also increased providers’ comfort with screening clients (Allen et al., 2007; Colarossi et al., 2010; Edwardsen et al., 2011).

Theoretical Framework

Theory of Planned Behavior

The theory of planned behavior explores the relationship between attitudes, intentions, beliefs and the resulting behavior (National Cancer Institute, 2005). Ajzen (1991), the author of the theory of planned behavior, states that the theory has three independent components of intention. The first, as described above, is attitude. This is

the degree to which a person has either a favorable or unfavorable appraisal of a behavior. Next is what he terms the subjective norm. Subjective norm refers to the perceived social pressure surrounding either doing or not performing a behavior. Finally, there is the degree of perceived control over the implementation of a behavior. This includes how easy the behavior is to perform, a person's history with the behavior as well as obstacles and impediments. Ajzen (1991) asserts that the more favorable the subjective norm and the attitude, the greater the perceived control over the behavior, and therefore the stronger the person's intention to perform the behavior. The theory of planned behavior was used to gauge whether there was a change in providers' attitudes and intent to screen for IPV increases after training. The training provided the knowledge and tools needed to remove barriers providers experience in routinely screening for IPV, thereby allowing them to gain control over the behavior and incorporate it into their practice.

Project Design and Methods

Using Ajzen's (1991) theory of planned behavior as a framework, the DNP student used training and education of health care providers as an avenue to improve attitudes toward routine screening for intimate partner violence (IPV), as well as normalize the practice and increase perceived control over the process. A PowerPoint presentation was provided to the group. In the beginning of the presentation several questions were asked regarding the attendees' current attitudes and practices around screening clients for IPV. The results of those questions were captured using response technology. At the end of the presentation questions were again imbedded gauging an increased intent of the providers to routinely screen clients in their practice. An outreach

coordinator from the Kodiak Women's Resource and Crisis Center (KWRCC) as well as the Child Advocacy Center (CAC) assisted with the trainings and provided resources for client referral. One week after the training an electronic survey was sent to participants to evaluate the effectiveness of the training in changing their practice.

Setting and resources

Description of the group, population or community. Kodiak is a community with a population of about 12,000 people sitting on the Northeast corner of Kodiak Island Alaska. The primary industry is commercial fishing and processing. There is also a large Coast Guard base. There are six medical clinics on the island each associated with between one and six medical providers. There is also an established domestic violence shelter on the island that assists both male and female victims of IPV.

According to a survey performed by the University of Alaska Anchorage in 2012, 38% of women living in Kodiak have experienced IPV in their lifetime, which is well above the national average of about 25% (National Coalition Against Domestic Violence, 2007). Each year, more than 6% of women on Kodiak Island experience IPV or sexual violence or both.

Organizational analysis of project site. Kodiak is a culturally diverse community. According to the State of Alaska Department of Commerce (2010) Kodiak's population is comprised of 9.9 percent Alaskan Native, 40.3 white, 0.5 percent black, 37.4 percent Asian with an additional one percent identifying themselves as Pacific Islanders. Those who identify as multi-racial makeup 6.3 percent of the population and finally, 9.4 percent are of Hispanic descent.

Facilitators and barriers. The Kodiak Women's Resource and Crisis Center (KWRCC), which serves women, men and families, was used as a resource for providers to contact when a disclosure of IPV is made during a clinic visit. KWRCC created a packet medical providers could use to give to women who either disclose or are otherwise at risk of IPV, as well as in the training of the providers in the routine screening for IPV.

The community of Kodiak has recently engaged in a training focused on developing a Coordinated Community Response to IPV. Multiple agencies have committed to making changes and raising awareness in the community. Absent from the conversation thus far have been the medical providers that this project will be targeting. The largest barrier to the project was encouraging individual providers to attend a training session.

Goals, Objectives, and Expected Outcomes. The goal of this project was to assess whether training of health care providers would improve their attitudes toward, and subsequently increase the rates of, screening and referral for IPV. Survivors of IPV reported that whether or not they chose to disclose to their provider, compassionate asking by their providers validated their feelings and helped them to change their situation and move toward safety (Gerbert et al., 1999). When providers screen clients for IPV, and people disclose violence, victims will find the appropriate referrals and resources they need. As more and more people are empowered to leave violent relationships, and a community's views against IPV become more prevalent, the rates of IPV will drop.

The ultimate objective of this project was to discover whether there would be an improvement in providers' intent to screen after the training. The goal was for 80% of

the providers responding to the questions at the end of the presentation to show an increase in their intent to screen for IPV after receiving training.

Implementation Plan. Invitations were sent to all health care providers in the community including alternative health providers, mental health providers and physical therapists. The training was based on Ajzen's (1991) theory of planned behavior and focused on increasing providers' intention to screen. An outline of the training is in Appendix A. Questions gauging providers' knowledge and use, or intent to use, IPV screening techniques were imbedded into the training before and after the presentation. A copy of these questions may be found in Appendices B and C. A week later, an online survey, found in Appendix D, was sent to participants that allowed for more open-ended questions. The before and after presentation questions, as well as the survey, were evaluated to see if there was an improvement in the rates of screening after educating providers and offering resources for their own use and to distribute to clients as needed. The data collected was evaluated through the response technology.

Ethics and Protection of Human Subjects. This project was an educational intervention to increase health care providers' rates of screening for IPV. The participants were from different practices and no identifiable information was collected. After review, an exemption by the University of Massachusetts Institutional Review Board was provided for the project.

Results

The invitation for the IPV screening training was extended to all professionals including medical providers, chiropractors, mental health and physical therapists and members of the multi-disciplinary teams that work with IPV victims and perpetrators. An unintended consequence was that fewer health care providers attended than

professionals from other fields who also encounter victims of IPV. Two nurses, one mental health counselor, one law enforcement officer and four IPV advocates attended the training. A pre-test and post-test were imbedded into the PowerPoint presentation and the attendees answered the questions through response technology. The response technology calculated the responses and percentages for each answer. One week later a follow up survey was sent to all participants. Unfortunately, there were no responses retrieved from this survey. Furthermore, not all attendees answered every question in the pre- and post-tests, which resulted in missing data for analysis.

The first section of questions involved demographics. Seventy-five percent of the participants responded that they personally, or someone they cared about, had experienced IPV. The majority (75%) had worked in their respective fields for over 20 years. All respondents stated that they knew clients who had been affected by IPV, and all agreed that talking about IPV was an important part of providing basic medical care to clients.

Before the presentation, 71.43% of the respondents stated that they discussed IPV with all clients, 28.57% exclusively with women clients. After the training, 75% stated they would screen all clients, and 25% reported they would screen only women. Two respondents indicated they would only screen women both before and after the presentation. All declared their intention to screen more clients for IPV because of the training. Please see tables 1 and 2 below.

Table 1

Pre-test - In your practice do you talk with clients about DV/IPV?

Response	%	N
Yes, all clients	71.43	5
Yes, when women present by themselves with any complaint	28.57	2
Yes, only at women's health visits or if you have specific concerns	0	0
No	0	0
Total	100	7

Table 2

Post-test - Do you believe you will be able to include DV screening into routine care?

Response	%	N
Yes, universal screening	75	6
Yes, I am planning on screening all women	25	2
Not at this time	0	0
Total	100	8

Different methods of screening were discussed during the training. Face to face conversations were preferred by the group both before (66.67%) and after the training (62.5%). After the presentation, each stated they knew where to call in the event of a disclosure, whereas before the training 20% had admitted to not knowing what to do when there was a positive screen. Please reference tables 3 and 4 below.

Table 3

Pre-test - Which screening method do you prefer?

Response	%	N
Face to face conversation	66.67	4
Verbal use of tool	0	0
Written tool	16.6	1
Computer assisted	16.67	1
Safety Cards	0	0
None of the above	0	0
Totals	100	6

Table 4

Post-test - If you were to screen which method would you prefer?

Response	%	N
Face to face conversation	62.5	5
Verbal tool	0	0
Written tool	37.5	3
Computer assisted	0	0
Safety Cards	0	0
None of the above	0	0
Totals	100	8

Since most the attendees regularly worked with victims of IPV, it was not surprising that 60% were comfortable talking with clients about the issue. The 40% of

the participants that said they weren't comfortable doing so before the training asserted that they would be able to broach the subject afterwards. See tables 5 and 6 below.

Table 5

Pre-test - What barriers do you encounter?

Response	Percent	Count
Time Constraints	0	0
Not comfortable with subject	40	2
Don't know what to do with positive screen	20	1
None of the above	40	2
Total	100	5

Table 6

Post-test - As a result of this presentation, do you think you will screen more clients for DV?

Response	%	N
Yes	100	5
No	0	0
Total	100	5

Discussion

Intimate Partner Violence affects 35.6% of women and 28.5% of men in the United States (Black et al., 2011). As most of those impacted by IPV encounter members of the medical profession during their lifetime, it is an appropriate place for an intervention. Optimally, this intervention will, in time, reduce the incidence of IPV. Health care providers report they are often reluctant to ask clients about IPV because they

don't have believe there is enough time to address the issue within the visit.

Additionally, providers may not know where to refer victims. This project provided training to providers that would show how screening can fit into regular visits as well as presented an array of readily available local resources.

Screening for IPV is an important part of comprehensive medical care. The American Medical Association, the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists in the United States all have guidelines citing the importance of screening for IPV during visits (U.S. Preventive Services Task Force, 2004). Screening and brief counseling for IPV is found among the free preventive health services identified in the Affordable Care Act (Miller, McCaw, Humphreys & Mitchell, 2015). The USPSTF has given the practice a B level recommendation as they believe that there is a high certainty that a moderate to substantial net benefit exists in screening for IPV.

Intimate partner violence survivors have reported that whether or not they chose to disclose to their provider, compassionate asking by their providers validated their feelings and helped them to change their situation and move toward safety. Providers are reluctant to ask either because they perceive they don't have time to address the issue, or because they don't have access to appropriate resources for referral (Gerbert et al., 1999).

This project focused on improving health care providers' intention to screen clients for IPV. The goal was for 80% of the attendees to show an increase in their intent to screen for IPV after receiving training on timely and effective screening methods.

Local resources for referral and follow up for victims who disclose abuse were included for participants' use.

Following Ajzen's theory of planned behavior, this educational opportunity provided the knowledge and tools needed to remove barriers providers often describe when discussing IPV screening. By removing the barriers, providers were afforded the ability to gain control over the behavior of routine screening and incorporate it into their practice. The training provided several validated screening tools that providers could use that could be administered in a short period of time. This helped to remove the barrier of time constraint that providers have often cited. Moreover, personnel from local agencies were present to discuss with providers the services their organizations provide for victims and how providers could assist clients in accessing them.

Before the training, 40% of the attendees responded that they felt uncomfortable talking with clients about IPV. After the training, all the participants indicated they would be able to screen clients. This was an improvement and exceeded the original goal of the project.

The education included several forms of screening methods. Face to Face screening involves talking with a client and asking questions directly either following questions found in a validated screening tool, using a prompt such as a safety card, or initiating a conversation about the subject. Written tools were introduced which could be used either in the clinic room, while a client was completing other paperwork for the visit, or incorporated into a computer program. Computer assisted screening could be used by a provider through a script, or clients could complete the screening process

themselves on a tablet, or desktop in a waiting room, with the provider reviewing the results during the subsequent visit.

Before the presentation, the respondents stated they preferred face to face screening over other methods. Face to face methods of screening have been shown to be the least effective method of screening, followed by written tools and computer assisted methods resulting in the greatest number of disclosures (Rhodes et al., 2006, McMillan et al., 2006). The presentation introduced this information along with the introduction of a number of validated, brief written tools which could be completed quickly by clients, or integrated into a computer program. The expectation was that providers would consider methods that would be most effective in eliciting disclosures. In the post-test providers again chose face to face as the preferred method of screening. This finding may be a result of makeup of the audience.

Because this training was offered to all professionals in the community, there was more of a mixture of professionals than anticipated. The group consisted of mental health providers, victims' advocates, and law enforcement as well as medical providers. This led to richness in the conversation, and showed the generalizability of the training and results to the greater community. These other professionals, however, have different time constraints and purpose in their interactions with potential victims which may explain the preference for face to face conversations. In future events, greater efforts to increase the number of medical providers who would be able to use these methods in their medical practice will be used.

An important feature of the training was the inclusion of presenters from local agencies who work with victims of IPV and child abuse. Providers were able to learn

directly what these agencies offer, and how to access them easily. This proved to be an invaluable component, which participants appreciated. Due to this focus on introducing local resources, however, this presentation may not be as effective in other communities, but could be modified if desired.

After analyzing the results gathered after the event, it was found that more closely correlating the pre- and post-test questions may have been beneficial to the overall understanding of the impact of the training. The ultimate goal of increasing awareness and intent to screen was evident despite the discrepancy in wording. There has been interest from local medical organizations to provide this education to staff within their facilities.

Conclusion

The training that was created for this project will continue to be used to train providers throughout the community. As violence such as IPV is addressed and tolerance is decreased in the community, there is potential for decrease in other types of interpersonal violence.

Screening is a first step in working with victims of IPV. More research is needed into integrating prevention and increasing resilience for victims into the health care system. Once IPV is seen more as a chronic disease, providers will become more comfortable talking with clients, working and supporting victims as they work to resolve the violence in their own, and their families', lives.

With the expanded use of electronic medical records, it is important that IPV screening be included in the templates providers use regularly in practice. Successful screening needs to consist of more than a generalized question regarding individual

safety. This change will require more than training individual providers, but moving into changing the greater systems that develop such programs.

In conclusion, IPV is pervasive in our society, and especially in the State of Alaska. Through this project, there was an increase medical providers' intent to screen clients for IPV. With the change in attitude towards screening, there are more opportunities for victims of IPV to safely disclose abuse and be appropriately referred for services and support. The more people in the community talk about IPV, the tolerance of violence in the community will decrease. Eventually social norms will shift enough that rates will begin to decline.

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Appendix A

Outline of training

Warm up

Introductions

Pre-training questions

Description of the problem

Definition

Effects on individuals and families

Rates of IPV in Alaska and Kodiak

Why screen?

Most victims come into contact with the health care system

Client reactions to screening

Perceived barriers to screening

Screening techniques

Face to face vs. written vs. computer based

Available validated tools

Use of safety cards

What to do with a positive screen

What is a positive screen?

What to say

Who to call

What to give client

Basic safety planning

Resources

KWRCC packets

Safety Cards

Websites for further training

Websites/apps for clients

Conclusion

Prevention activities in Kodiak

Coordinated Community Response

Green Dot bystander intervention

Post-training questions

Appendix B

Pre-training questions

1. Have you, or someone you care about, experienced domestic, or intimate partner violence?
 - a. Yes
 - b. No

2. How long have you been practicing?
 - a. 0-5 years
 - b. 5-10 years
 - c. 10-20 years
 - d. 20+ years

3. Have you had clients in your practice that you know are, or have been, in a violent relationship?
 - a. Yes
 - b. No

4. Do you believe talking about domestic violence, or intimate partner violence is an important part of providing basic medical care to clients?
 - a. Yes
 - b. No

5. In your practice do you talk with clients about domestic or intimate partner violence?
 - a. Yes, all clients
 - b. Yes, when women present by themselves with any complaint
 - c. Yes, only at women's health visits or if you have specific concerns
 - d. No

6. What barriers do you encounter?
 - a. Time constraints
 - b. Not comfortable with subject
 - c. Don't know what to do with positive screen
 - d. None of the above

7. Which screening method if any do you currently use?
 - a. Face to face conversation
 - b. Verbal administration of a validated screening tool
 - c. Written administration of a validated screening tool
 - d. Computer assisted screening
 - e. Safety cards
 - f. None of the above

8. Which screening method would you like to have more information about?
 - a. Face to face conversation
 - b. Verbal administration of a validated screening tool
 - c. Written administration of validated screening tool
 - d. Computer assisted screening
 - e. Safety cards
 - f. None of the above

Appendix C

Post-training Questions

1. As a result of this presentation, do you think you will screen more clients for intimate partner violence?
 - a. Yes
 - b. No

2. Do you believe you will be able to include domestic violence, intimate partner violence screening into your routine care of clients?
 - a. Yes, I intend to implement universal screening
 - b. Yes, I am planning on screening all women
 - c. Not at this time

3. If you were to screen for intimate partner violence, which method would you prefer?
 - a. Face to face conversation
 - b. Verbal administration of a validated screening tool
 - c. Written administration of a validated screening tool
 - d. Computer assisted screening
 - e. Safety cards
 - f. None of the above

4. Do you feel you have the resources available to provide to a client who has a positive screen?
 - a. Yes, I am well aware of the resources available in the community
 - b. No, I am still unsure of what course to follow when a screen is positive

Appendix D

Follow up survey

Thank you for attending the presentation on screening for intimate partner violence and community resources. If you could take a few minutes to complete this brief survey to share your thoughts on the subject of screening for intimate partner violence in your practice it would help us ascertain what might be helpful in the future.

1. How long have you been in practice?
2. What is your discipline?
3. Do you regularly screen clients for intimate partner violence?
 - a. Yes, all clients
 - b. Yes, women at every visit
 - c. Yes, women at reproductive health visits
 - d. No
4. What barriers do you encounter to screening?
5. What method do you use for screening? (i.e. face to face, written tool, etc.)
6. Do you use safety cards?
 - a. Yes
 - b. No
7. Do you have an IPV champion in your worksite?
 - a. Yes
 - b. No
8. Do you know where to refer a victim or survivor?
 - a. Yes
 - b. No
9. Are you interested in learning more about
 - a. Kodiak Coordinated Response to DV/SA
 - b. Green Dot violence prevention
 - c. Other?
10. Any other comments on the subject or the training?

Appendix E

Additional Pre-test questions*Have you, or someone you care about, experienced domestic, or intimate partner, violence?*

Response	%	N
Yes	75	6
No	25	2
Total	100	8

How long have you been working in Health Care?

Response	%	N
0-5 years	12.5	1
5-10 years	12.5	1
10-20 years	0	0
20+ years	75	6
Total	100	8

Have you had clients in your practice that you know are, or have been, in a violent relationship?

Response	%	N
Yes	100	8
No	0	8
Total	100	8

Do you believe talking about DV or IPV is an important part of providing basic medical care to clients?

Response	%	N
Yes	100	6
No	0	0
Total	100	6

Additional Post-test question*Do you know where to call when there is a disclosure?*

Response	Percent	Number
Yes	100	7
No	0	0
Total	100	7