Ask the Question, Don’t Fear the Answer:
Detecting, Documenting and Doing Something About Family Violence in Primary Care

Ann Loewen, MD, CCFP, FCFP
Manitoba College of Family Physicians ASA
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- **Faculty:** Ann Loewen, MD, CCFP, FCFP, student in Community Health Sciences, University of Manitoba

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Pitfalls of dealing with family violence in primary care
Or, why good intentions are not enough:

Health care practitioners want to do the right thing, and sometimes that is difficult in the area of family violence.

• Subtlety of presenting signs and symptoms
• Potential for alienating patients (e.g. broaching topic of corporal punishment)
• Relative unacceptability of screening women for IPV
• Mistakes can be made (e.g. failure to thrive versus child neglect)
• Infringement on personal autonomy (e.g. older adult self-neglect)
• Stress of potential interface with the law, court appearance etc.
• Awareness, but under-recognition, of certain forms of family violence (eg female-on-male and bidirectional relationship violence)
Who are primary health care practitioners, what is their importance in family violence?

Practitioners who are the first point of contact with the health care system. Usually, they provide long-term care to individuals and often to more than one family member.

- Family physicians (FPs), aka General Practitioners (GPs)
- Emergency physicians and Pediatricians
- Nurse Practitioners (NPs)
- Public health nurses (PHNs)
- Physician assistants (PAs)
- In some countries (e.g. USA and Germany) - Internists, Geriatricians and Obstetrician/Gynecologists
Examples of encounters with family violence as they present in primary care:

- Infants, children and their parents: corporal punishment
- Teens and adults: intimate partner violence (IPV), including gender symmetric and bi-directional relationship violence
- Seniors: elder abuse and neglect
Premise: violence begets violence, and society does not advance itself by the replacement of one form of inequality by another.
The concept of screening in primary care

- Screening is the use of simple tests (or questionnaires) across an apparently healthy population in order to identify individuals who have risk factors or early stages of disease, but do not yet have symptoms (WHO definition).

- Some common examples of successful screening programs include mammography for breast cancer prevention, and BP monitoring and treatment for stroke and heart attack prevention.

- Many common conditions do not have good screening tests, or they lack effective interventions if detected e.g. developmental delay in children and prostate cancer in adult men. Therefore they do not meet criteria for screening.
Spare the Rod, Save the Child: Detecting, Documenting and Doing Something About Corporal Punishment in Primary Care
In many countries, corporal punishment is not illegal. And yet,

“Punishment accounted for 75% of substantiated incidents in which physical maltreatment was the primary category for maltreatment.”


As well as the robust evidence that corporal punishment negatively affects development, as well as mental and possibly physical health outcomes.
US Preventive Services Task Force (USPSTF) Recommendations on Screening for Child Maltreatment

- USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care interventions to prevent child maltreatment. This recommendation applies to children who do not have signs or symptoms of maltreatment.

- Grade of evidence for this recommendation: I (Insufficient)
Case-finding, as opposed to screening, to detect corporal punishment

**Case-finding:** A strategy for targeting individuals or groups who are suspected to be at risk for a particular disease. It involves actively and systematically searching for at risk people, rather than waiting for them to present symptoms or signs of active disease.

- Allows more efficient use of scarce resources, including primary caregiver time
- Maintains trusting and mutually respectful relationship
- Recognizes lack of evidence for effective interventions at the primary care level (other than contacting child protection)
- Disadvantage: under-detection, stereotyping or profiling in settings where risk factors are less obvious or non-existent
Rourke Baby Record (RBR) - an underutilized treasure trove of support in detection, documentation, and doing something about family violence. . .
• Evidence-based
• Online and paper formats
• Extensive footnotes and links
• Organized
• Legible

From the first page (0 - 1 month) the RBR has the following items pertinent to family violence in the Behaviour and Family Issues section:
• Crying
• Parenting/bonding
• Parental fatigue/postpartum depression
• Soothability/responsiveness of infant
• Family conflict/stress
• High risk infant/assess home visit need

Every milestone visit has questions of similar relevance.
Does conservative Protestantism moderate the association between corporal punishment and child outcomes?

Ellison, C, Musick, M. 2011 Journal of Marriage and Family 73

Used a 5 year span of the National Survey of Families and Households, with children 2-4 years of age at baseline. They concluded the teachings and mitigations of corporal punishment function according to their literal interpretation of Biblical teachings (the “inerrantist” view of the Bible) and do not harm, in that:

“early spanking alone was not associated with adjustment difficulties, but spanking that began or persisted into middle childhood was associated with difficulties (in social adjustment).”

In their view, the “omission of potentially confounding variables such as parental support, warmth and nurturance, and cognitive stimulation” as well as the fact that adherents to evangelical Protestant Christianity are not singled out in studies of corporal punishment effects are some of the reasons why only negative impacts are detected with its use.
An educational initiative from St Justine Hospital in Montreal

Emphasis on emotional regulation, self-awareness and impulse control, skills that parents will benefit from throughout their years of raising children.


Begin with an expression of empathy with the challenges of parenting, then proceed to some specific suggestions and/or recommendations for harm reduction as time permits:

• Tell parents that successful discipline requires a ‘bag of tricks’
• Explain extinction (when a technique stops working because of overuse)
• Recommend against spanking when angry
• Recommend avoiding spanking in young children (less than 2 years old) as well as avoiding use of a belt, switch, or other object
• Give alternatives
• Time in (praise and reward for positive behaviour) & Time out
• Describe positive and negative reinforcement techniques
• Passive inattention (ignore low level misbehaviors that are not a priority, which does require some understanding of normal development and prioritization)
• Avoid precipitating circumstances
• Provide resources (books, websites, local parenting classes).
The Relationship Wars: Detecting, Documenting and Doing Something About IPV in Primary Care
Some definitions:

Intimate Partner violence (IPV)
Bi-directional IPV
US Preventive Services Task Force (USPSTF) recommendations on screening for IPV and Abuse of Elderly and Vulnerable Adults
(released January 2013)

- USPSTF recommends that clinicians screen women of childbearing age for IPV, such as domestic violence, and provide or refer women who screen positive to intervention services.

- Grade of evidence for this recommendation: B (good)

- USPSTF concludes that current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect.

- Grade of evidence for this recommendation: I (Insufficient)

- No mention in either section about male victims of abuse
Canadian Task Force on Preventive Health Care (CTFPHC) - Their take on the subject:

- Appraises the USPSTF recommendations on screening for IPV and concludes that the evidence does not justify routinely screening Canadian residents of any age for IPV, or for abuse of elderly or vulnerable people.

- Further reference points in CTFPHC indicate women only in IPV context, while no gender is specified in elder abuse.
Limits & shortcomings of IPV screening research

• Female victims of IPV are almost exclusively the target of research, interventions, recommendations and screening programs. Male victims are rarely studied, and when they are the screening tools have largely been validated on female populations. Gender symmetry and bi-directionality in IPV, for example, are not considered in the USPSTF recommendations or references.

• Most research that includes male victims of IPV is done in emergency rooms (therefore not representing population), with exclusion criteria including severity of illness or injury, reduced level of consciousness, intoxication, inability to read the survey.

• Patients report relatively high levels of ‘unacceptability’ for being screened. Conversely, health care providers report high levels of acceptability for providing screening if they are sufficiently supported (eg Grandall 2009).

• Lack of good evidence for effective interventions for patients who screen positive. For example, difficulty with controls, and few have been corrected for assessment reactivity (the focus of attention on a behaviour during a research study that can independently affect the expression of that behaviour, regardless of other interventions).
Identifying domestic violence: a cross sectional study in primary care

The problem of under-detection, under-documentation, and un-acceptability of IPV screening in a primary care/ GP office setting in Great Britain:

• Of those completing written survey (N= 1207), 41% reported they had ever experienced physical violence, 74% indicated they had experienced controlling behaviour and 46% had been threatened.
• When medical records of the 41% experiencing physical violence were reviewed, 17% were found to have documentation of it.
• Among all charts reviewed (n=258), IPV was identified, or thought likely, in 10%.
• When validated against a set of randomly pulled charts, true rate of documentation of IPV found to be 7%.
• 8% of those surveyed found being asked about IPV objectionable, and 11% felt that way about being asked about forced sex.
• Overall, 20% would rather not be asked about IPV if they were coming in to see their doctor about something else, and that was the same whether they were or were not experiencing IPV

This (relative) un-acceptability of IPV screening has also been noted in other settings.

BMJ  Feb 2002 Vol 324, Richardson, J Coid, J Petruckevitch A
Another way to identify and support IPV victims: Identification and Referral to Improve Safety (IRIS)

- 51 practices randomized ➔ 25 received IRIS intervention, 26 control practices provided usual care
- Intervention consisted of staff training, EMR enhancement, and ongoing support
- “Clinicians were trained to have a low threshold for asking about domestic violence as a clinical enquiry, not screening”

- Primary outcome: number of referrals to specialist domestic violence agencies for women aged 16 and older for the 12 months after a training intervention, and documentation in the EMR.
- Study clinics referred 223 women to services, control clinics referred 12, i.e. 21 times higher.
- 641 disclosures of IPV were recorded in the EMR of the intervention clinics, as opposed to 236 in controls.

Using indirect questions to detect IPV: the SAFE-T questionnaire

Developed and tested a new mnemonic for screening:
S  Secure: I feel comfortable/secure in my home.
A  Acceptance: My husband/partner accepts me just the way I am.
F  Family: My family likes my husband/partner.
E  Even disposition: My husband/partner has an even disposition.
T  Talk: If my husband/partner and I disagree, we resolve our differences by talking it out.

Compared to the CTS-type questions (considered the ‘gold standard’ of family violence investigation, but not always considered acceptable in clinical settings),

  Sensitivity for detecting IPV compared to lay person = 85%
  Specificity for detecting IPF “ “ “ “ = 87%

Fulfer, J., Tyler J. et al 2007 Journal of Interpersonal Violence  Feb 22 (2) 238-49
Still, USPSTF says to screen.
“I just keep my antennae out”

Qualitative research study of 19 internists, family practitioners and ob/gyn practitioners in rural Pennsylvania about their experience with women and IPV.

Most did not screen, citing

• Conflicting time demands
• Lack of training
• Limited access to referral services, and low confidence in the effectiveness of those services
• Concern that inquiry could harm the patient-physician relationship

Case-finding opportunities abound in primary care, such as...

- Contraception counselling and prescribing
- STI work-up
- Prenatal visits
- Sexual dysfunction
- Mood disorders, especially depression and anxiety
- Substance use disorders
- Physical complaints without evidence of underlying disease (e.g. recurrent/functional abdominal pain, non-migraine headaches that do not respond to usual treatments)

This list is not exhaustive, merely illustrative of the variety of occasions when questioning about IPV, current or past, could be appropriate to the context.
Should We Let
The Lady in the Van Alone?

Detecting, Documenting and Doing
Something About
Elder Abuse & Neglect
A Physician's Perspective: Elder Abuse and Neglect Over 25 Years

Physicians’ lack of involvement with elder abuse “stands in stark contrast to the role physicians played in combating child abuse, where they have acted in a leading role in screening, detecting, intervention and effecting policy changes.”


However, this view fails to take into account two features that are unique to elder neglect and abuse:

- Complexity
- Autonomy
Reporting Elder Abuse

- 44 of 50 US states have mandatory elder abuse reporting laws, with questionable benefit.
- In Canada, no jurisdiction has mandatory elder abuse reporting, but all provinces and territories have laws protecting vulnerable adults.
- And all Canadians have access to health care, along with home care in many jurisdictions (Manitoba is a national leader in that regard).

Mandatory reporting may put health caregivers in an intractable position, one that can alienate both the patient and their support systems from the primary care provider.
Elder Abuse Suspicion Index (EASI)

- Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?
- Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?
- Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
- Has anyone tried to force you to sign papers or to use your money against your will?
- Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?
- Question to primary caregiver re: behaviours associated with elder abuse (eg poor eye contact, malnourishment, cuts and bruises etc).

Hope for the future: Future directions in research and policy development

- Families First/Healthy Start home visiting programs
- Roots of Empathy school program
- Customary Care for First Nations fostering
- National Home Care program for delivery of equitable elder care, and elder abuse monitoring
- Recognition of, equitable resourcing for and harm reduction around gender symmetry and bi-directionality in IPV